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the dipping inspectors and, in one district with a matter of 800 deaths, the divergence was only 19. I was surprised that they got so near. Of course, it may have been an accident, but it certainly was an interesting accident.

DR. ROBERTS: I thought you had some form of registrations of deaths in Natal ?- Yes, that is so. I may just say this, which I have in my statement, - the medical requirements of the Native population are being inadequately met, with the result that there exists much preventable disease. The Native's idea on medicine is rapidly changing and even the herbalists use European drugs when they can get them and the Native is rapidly losing faith in the herbalists. The herbalists who exist in consequence of a need for medical attention, which is common to all communities, uncivilised and otherwise, must be replaced by a class of Native with a training in European methods. In towns and urban communities, a certain amount of medical attention can be got. In the rural communities, the amount of skilled relief obtainable is quite inadequate to the needs of the Native community. In consequence of this lack of skilled relief and ignorance, the Native is at present being grossly exploited by the vendors of quack nostrums, who sell anything from 'lion's fat' to panaceas for venereal disease. This sort of trade has gone up by leaps and bounds in the last few years. The areas are swamped with advertisements and there are chemists selling 'lion's fat' and such things all over.

It is not only medical treatment within the means of the Native that is wanted, he has an even greater need of skilled nursing, a knowledge of the causation of disease, dangers

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of infection, etc., common to the European, but at present unknown to him. Until such knowledge percolates the Native masses, our hope of dealing adequately with diseases such as malaria, tuberculosis, leprosy, venereal disease, typhus, etc., and the appalling child mortality common to their people, is vain. The Native is avid for such knowledge, and it is best presented to him by persons of his own race. The only medical help available to the Natives in many rural districts is the district surgeon, whose official duties are not Native practise. In some districts, the district surgeon is supposed to run a dispensary in opposition to his Native practise. As matters standx at present, Natives are unlikely to bring cases of disease to the district surgeon, except if he happens to live close by,until such disease is well advanced.

Sir Edward Thornton estimated that the staffing of the Native districts with medical practitioners in the ratio of one to each 5,000 Natives, would require 900 medical men. What I want to point out, in regard to these matters,is this. We do not altogether want to give the Native simply medical treatment. The Native at the present time wants to know a little more about disease and the means of preventing disease than what he does. His ideas are absolutely embryonic and the more information we give him at present the better and the easier it is to put them on to good lines.

CHAIRMAN: You mean, it is desirable that he should know ?- Yes, it is desirable that he should know.

Do you mean that he is crying out for it ?- I am developing that point.

DR. ROBERTS: Do you think that is really given to him now in a more and more general way by the requirements of the Government and the schools ?- Well, it is not the schools

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that we want to get at altogether. We are doing something in the schools, but the adults want to know more about it, too.

But the boys become adults by and by ?- Yes, but what a boy learns in school, he very often does not remember all his life, and that especially applies to a Native and I say that we are not going to make any real headway in this matter of treating diseases and preventing them, until the Natives themselves know more about things.

MR. LUCAS: You say that in some districts the district surgeon is supposed to run a dispensary in opposition to his Native practise. Is the district surgeon by law required to keep a dispensary ?- Only in some cases.

And does he have to issue medicines free of charge from that dispensary ?- There were two districts surgeoncies in Zululand, as far as I can remember, where the district surgeon was supposed to run a dispensary. I was district surgeon myself at Knutu for some time and, in all the time I was there, I issued two lots of medicine from the dispensary. As a matter of fact, I had two bottles standing on the shelf and the Native could take his choice from them.

Then I deal here in my statement with the necessity for a Native health service. I say here that the necessity for a Native health service is pressing. Two schemes, that of Sir Edward Thornton and Dr. McCord, are embodied in a Government report. These schemes were discussed at the Annual Medical Conference of the South African Medical Association, held in July 1930, together with a third scheme formulated by me. An outline of these three schemes is given in the journal of the South African Medical Association of the 13th September 1930, and illuminating criticisms of all three will be found in the January number of the same Journal.

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Since the original schemes were placed before a Government commission, I have inaugurated and I am at present working a malaria service for Natives, staffed by trained Natives. This is in its third season, and I have been able to watch the reactions of the Natives to it, and I have formulated my scheme, which resembles the others, except in one important detail, on the experience gained from this work. At present, I have 25 trained Natives working in Natal and Zululand and a reservoir of another 30 to draw from, should malaria needs demand it. All three schemes adumbrate a system of hospital centres under skilled medical direction, linked up with a chain of Native nurses and Native health assistants in the areas to be served, working directly under the officer in charge of the hospital centre. The Association referred the matter to the Federal Council, which has now issued its recommendation in somewhat broad terms, and, in my opinion, has placed the question of a medical service for Natives on the basis of a sort of poor relief and omitted any reference to the important educative propaganda in medical matters which is desirable, such as I have just outlined.

I may say that the men whom I employ in connection with this malaria service are all junior certificate or matric. men, and one man is a B.A. Now, I say that the standard (Seventh) for health assistants adumbrated by the Medical Council is too low, and I can get men of better education now. I feel also that, if such a service is to be a sort of poor relief, paid for our of general revenue, that it will have to wait until the poor White population have been catered for first, it being almost impossible to imagine any Government in South Africa giving the Natives a free State service before

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the same is afforded to the Whites. For the same reason, I consider proposals to train Native medical men at the expense of the State, visionary and impracticable and I think that propositions on those lines afford opportunity for delay which may prevent the Natives from getting anything at all within a reasonable time. Anything too grandiloquent is going to be of no use. On the other hand, if it is to be on the lines of poor relief, then it is a danger. We shall never see it within a reasonable time, but I do consider that anything like a free service which might tend to pauperise the Native is to be deprecated. The Native is not a pauper requiring doles. If a free service is to be given to the individual, then the cost of such service should come out of the areas served. I consider that the Native should have a direct interest in the service which he pays for, and I have found that, where such is afforded it is much more appreciated and is much more useful. That is my experience of the only Native area in Natal, Msinga, where we have a Native council which takes a keen interest in malaria matters and runs the only community anti-malarial scheme in the Union, outside the area of duly constituted local authorities.

DR. ROBERTS: How would an additional tax to what is now known as a development tax strike you? Make the poll tax, say, £1.5.- ?- Yes, I come to that. In regard to what I have just said, I think we might get the Government to do something, but if we know the Government and if we expect everything for the Native to come out of Native revenue, then I think we are on very thin ice. The Native will get nothing, and, as I have said, if we have to settle the poor White problem first, before we do anything for the Native, then it will be

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the end.

I have outlined the administrative side of my scheme as follows:-

(a) Government should make provision forthwith to train Native health assistants and nurses.

(b) A system of health centres under State control to which these trained Natives could be attached, should be inaugurated in the Native districts of the Union.

(c) A beginning be made in those Native districts where Native Councils are established and revenue for local purposes is raised.

(d) The servants of such an organization receive no direct benefit from the individual in the form of fees.

(e) Free service when the individual can pay is not desirable, Fees should be charged at least for medicine and should go to the maintenance of the health centre.

(f) The Natives themselves should be given a direct interest, administrative and financial, in a service designed for their own benefit.

(g) Over and above assistance as to training, the State undertake such definite financial obligations in connection with establishment and maintenance of health centres as will promote their formation in Native areas.

It will become apparent that Government will have to foot the bill for training, and this training for nurses and health assistants will take three years.

I think it would be best to start in a small way and to try out the nucleus of such a service complete with hospital nurses, etc., in certain districts with local councils. I find, however, that even the provision of Native malaria assistants who give lectures and initiate treatment

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on lines described in pages 517-518 of the September number of the Nournal quoted, is creating a demand for general medical assistance on European lines, even in the most backward districts where, until recently, the herbalist has ruled supreme, and this will have to be reckoned with.

I think all Natal magistrates are in favour of a medical service for Natives staffed largely by Natives; many district surgeons are, others are antagonistic unless they were assured that the organisation would be controlled by them. Where possible, district surgeons should be employed, but instances will be found where a centre, based, say, on a mission hospital, would be best controlled by the Doctor in charge, who,incidentally,is often the district suggeon, but sometimes is not.

The refund system under which venereal clinics, etc., inaugurated by local authorities, are subsidised by the Health Department, affords an example as to how the State might exercise ultimate control of this service in local council areas but, as stated, initiation, at least asfar as staff training for nurses and health assistants,would have to be paid by the State.

The question as to whether the income obtained by the State from direct taxation of Native districts and paid to general revenue, justifies expenditure on training, etc., is one which fails to be considered.

Local revenue, plus State refunds, could fairly be charged for upkeep. There is, at present, a reluctance to pay anything for health matters out of the only Natal district with a local council, but contributions come from the Natives themselves.

The difficultyxregarding utilisation of local revenue

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for local health purposes has led to a serious anomaly in Natal which I have already pointed out to my Department.

DR. ROBERTS: Your proposal would not apply to the Development Fund but to the local fund ?- I would rather not go into that, as I am not versed with it. So long as one gets away from these rigid proposals to make it a poor relief service. It may be that, knowing the amount of revenue coming out of certain Native areas, and where there is not much return, that one could make a reasonable request for portion of that revenue to be diverted to this, but that is another matter. What I say is that the money should come out of the Natives for the main part. At the present moment, in regard to malaria, we find that there is only one way of tackling it. There Native was first of all bound up with these Native herbalists and he had to get tired or disappointed with him before he would do anything. Well, we allowed him to get tired of the herbalist. The Native then got up a scheme,---- I got up a scheme and trained Native malaria assistants and gave them a knowledge for the handling of the disease. I sent them round to lecture to the people and shew them how to treat these things. I found that the herbalists very rapidly took second place. And then the lecture side of the thing was also appreciated and the result has been that there have been requests from every Native area, all over the country, for the continuation of this scheme. I have referred to the Msinga district which has its own local council and there I got up an anti-larva scheme, whereby we oiled the rivers and generally keep the larva down and I got the Natives themselves to pay for it. In this district, they pay for their own work.

DR. ROBERTS: What you did was to prevent the outbreak ?-

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Yes, that is so.

You say they oiled the rivers ?- Yes, shale oil and paraffin are used in some cases. All these things have to be adjusted. Where the Native has a lot of cattle drinking, he will not put down shale oil. These things have to be carried out under the supervision of a trained man. The Native is paying the expense and is prepared to do so in certain cases. Of course, we have certain local revenue there. In this particular area of which I have spoken, we have the only co-operative anti-malaria scheme in the Union and it is run by the Natives outside of a local authority. It is a Native scheme and the money for running it comes from the Natives themselves by subscriptions.

When I asked to get a grant from the local revenue to help me with my malarial scheme, the reply which I got was that it was not clear that this was in the interest of general welfare. That was the reply, inspite of the fact that I explained that I wanted the grant to fight malaria in a malaria district. That is why, under the regulations, more clarification is required.

But you have the power to spend the money ?- Yes, I can spend the money in a Native area, but I have to get that money from the Province.

CHAIRMAN: Perhaps the authorities thought that they could not spend the money and that the Natives themselves should do it ?- Perhaps they did. At anyrate, there it was. You will see what the position is from what I say here in my statement. I say here that, from a health point of view, extension of local government in Natal and Zululand is desirable. At present the inauguration of local government is a function of the Province.

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All local expenditure on health matters in areas other than those of local authorities constituted under some ordinance, has to be paid for out of provincial funds. If the Province does not like to pay and the Health Department can incur the expenditure and force the Province to pay, it has its remedy. It can institute local government under its ordinances, one of which, No.14 of 1930, provides for compulsory institution of local government. Eight new areas have taken on local government during the past six months.

In a Native area, however, the provinces meet expenditure on, say, malaria; it cannot institute local government and thus get rid of its burden in the way intended by law, and the Native Affairs Department is in a position to refuse, and does refuse to meet such expenditure, even where there is local revenue to pay from. This is pauperising the area and is unfair to the Province. In a similar Indian area, a local authority would be formed and the money recovered willy nilly.

The net result, if this continues, is that health progress in the Native areas will be retarded to a degree which does not reflect the capacity of even the will of a given district to pay for its own health measures.

Now, in a Native area, we have exactly the same position, we have the same powers and we can make the province pay, but the unfortunate province has no means of getting away from its burden at all. It has to pay the whole thing out of general revenue. Now, suppose that, on the one hand, we we have a European and Indian area and, on the other hand, a purely Native area, and there is precisely the same amount of work to be done from a health point of view. Say that they

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have to spend £500 in each area. The work has to be done, say, on malaria prevention. I could say to the Province, "This work will require at least £500 to be spent on it, and I am going to charge you with it unless you get out of it in some way", --- that is to say, they can force the local government to pay. But if it comes to a Native area, then I can say to the Province, "I am going to spend this money and you must pay". They have no redress at all. They can go to the Native Affairs Department and the Native Affairs Department would simply say to them, "We are not spending the money". You see, the position is that, when the money has to be spent in a Native area, it has to be paid for by the Province, but when it is spent in a European area, it is the local authority which has to pay for it.

Well, the Province will simply say, in the long run, "We cannot do it", and we, the medical authority, cannot simply go on doing it, we cannot go on loading up the Province with all sorts of expenses. If I want a first class malaria scheme in one place, they can simply sit down and the Province has to pay it -- that is, if it is in a Native area, but if I were to spend the same amount of money at Tongaat, the local people would have to pay. Briefly, the Province has to pay for a Native area, but in a local area the local people have to pay -- in an Indian or European area.

CHAIRMAN: Do you suggest that some provision should be made for local government in Native areas ?- No, but I do think that a Native area should be put on the same footing with regard to what I want to spend, that is to say, if we consider that it is necessary in a Native area to spend so much money, we should have the opportunity of getting the

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money out of Native funds and the Department of Native Affairs should not be in a position of being able to say to us, "No, we are not going to pay, the Province must pay for it".

DR. ROBERTS: But, under the Financial Acts, you cannot make the Province responsible ?- But they are responsible. For instance, I have 25 Native assistants at £6. per month and the Province have to pay the salary of the whole lot of them.

That is very good of them ?- They do not like it. I simply engaged them and I charge the Province.

MR. LUCAS: That is one of the few occasions where the Province are caught for the Natives ?- But they do not get any revenue from the Natives. The whole of the revenue does not go to the Province, they get nothing at all. Well, that was the point which I wanted to bring out. We cannot go on charging the Province for ever. This is a check on the Health Department in Native areas and it is a very serious check.

Now, in my statement, I have a chapter giving an outline of the position as it affects certain diseases for which the Government accept a measure of responsibility. First of all, in respect of malaria, there is the education ~~in~~ of the Native population, in schools in the reserves and so on. There is the provision in regard to the use of quinine and anti-~~xxxxx~~ larval measures. I thought that I would just set down a number of these heads and if you wish to ask me any questions on that, I shall be very pleased to give you the information. In regard to malaria, of course, as you know, Professor Swellengevel will issue a report on malaria in the Transvaal and Natal. That report will probably be

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published in June, so it is not necessary for me to say much about it, but the fact remains thatwe are at present working a system right along the Native reserves and the sugar belt where, by trained Native assistants, we are giving a certain amount of education and shewing these people how to use quinine and we are initiating treatment, and, as far as the Natives themselves go, these methods have been a very great success. Now, with regard to the schools, in a Native school every child above the Fourth Standard has to learn what I would call a sort of catachism in Zulu. It is the most up-to-date catachism there is in regard to anti-malaria treatment. It deals with everything and, once a week, there is nature study at which mosquito larva and other things are shewn. Every possible information is given and we have inspecting schoolmasters who are training other people in regard to these matters. These inspector schoolmasters have been trained by us with the idea that they should pass on this knowledge. Then we have our staff going round and giving lectures even in the churches on Sundays. In addition, I have one lecturer who is going right through the compounds at the coast and, I think, that that is really a very good move and he is a most excellent lecturer.

Is he a Native ?- Yes, and he is tremendously popular. His average attendance at these lectures is from 300 to 400 people, men and women. The lecture is quite short, but after the lecture there are questions and I understand that the duration of his lectures runs from 3 to 4 hours. Part of my training is to give them short lectures and subject them to questions by their audiences and interruptions and they have to be quite good and have to put up with heckling

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and this is having a very useful effect, an effect which I should like to extend to other diseases, because there is no doubt about it, that we have to get greater knowledge into the Natives on these matters.

CHAIRMAN: Is the quinine supplied free of charge ?- Yes.

By district surgeons and Native commissioners?- No, that would be quite useless. We have to go a great deal further than that.

But supplies are kept by district surgeons and Native commissioners and police ?- No. The supplies are only kept at the magistracies. The bulk of the supplies are ordered down by the magistracies and every magistrate has a number of distributing centres, sometimes at stores or depots or dips, and the dipping inspectors and practically every other official is there to help. You have the mission stations, police, inspectors of all kinds, and they all draw their supplies as they require them. Our Native malaria assistants draw their supplies from these depots, so when I say that there are over 230 depots going on with this work, you will see that it is far beyond the purview of a Native commissioner. I do not think that, at present, any Native in these parts of the country has to go more than five miles for quinine, but then, unless you bring it to the door, it is of no use. It must be very easy to get. Another point which is interesting is the dosage of quinine and unless you take the greatest care in teaching them these things, it goes into one ear and comes out of the other. I let them have careful and very simple instructions, both in Zulu and in English and, even in the most backward district, if there is not a person who can read in the one

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kraal there is always someone in the next kraal. Things are made a s simple as possible. Anyone coming in can get 50 5-grain tablets at one time -- it is no use playing with this thing, you have to give them a good course and, unless you do that, all your work comes to nought.

DR. ROBERTS: I see that, under your next heading you deal with venereal disease. Do you consider that venereal disease is on the increase or on the decrease ?- Before,I come to that, may I just mention one thing. There is a question of anti-larva measures. Now, anti-larval measures at the kraals in general, where there is no district control, are never going to amount to much. You cannot expect the ordinary Native to do the necessary work in regard to cleaning his water supply. There are instances of kraals where they are taking measures for dealing with their water and where they are actually moving their kraals under advice from our men and, as a matter of fact, we have moved any number of kraals in that way. Incidentally, it is rather interesting to note that these Natives are able to diagnose the kind of mosquitos which they are dealing with, and they send mosquitos to us so as to get expert advice. A Native can be told definitely today, whether there is a danger from a particular kind of mosquito. But referring to the kraals in general, that can only be done in an individualistic way, but where we have Native government areas, I find that it is going to be possible to run community schemes and my opinion is that community schemes must be limited, for the present at anyrate, to areas which are self-governing.

Now, I come to your question, Dr. Roberts, whether

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venereal disease is increasing. I think that this disease is increasing and, in this connection. I want to say thatthe ignorance in the kraals of the disease, especially in Zululand, is appalling. Many people do not know what they have got and I do think that lectures on this question would be very desirable if they are done by the proper men with some knowledge of the disease.

DR. ROBERTS: You mean, by Natives ?- Yes, it must be by Natives and there is no reason why these lectures should not be given to both sexes at the same time. You must realise there is not the same feeling among the Natives as among the Europeans, not the slightest. When I mention lectures, I consider that there should be a systemmatic series of lectures and it all hinges on the provision of some kind of service. We cannot have the position dealt with satisfactorily by dealing with one thing, one disease only, and not with another disease. What I mean is that the whole question must be linked up, it must be one service. Then there is the question of clinics. That is for the country in general. We have one clinic in Durban and one in Maritzburg. There are one or two places in the Native areas which are visited regularly by district surgeons and where the people living there can get advice, but I do not think that anything systemmatic can be done in the Native areas in that way, unless you are prepared to link it up with the whole of the health service, that is, to make it part and parcel of the whole scheme.

In regard to clinics which we have at Durban and Maritzburg, Maritzburg is quite allright, but in Durban we have only one clinic and that is at the Addington and it is very desirable that there should be another one somewhere to

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deal with the Mayfair and the Sydenham areas, because you can hardly expect these people to go down, to trek right down to the Addington Hoppital to be treated there. This question was raised some time ago with Dr. McCord who arranged to have a clinic at his hospital as well, but that fell through owing to the difficulty of getting sufficient funds at the moment, but I do say that, until there is a clinic set up in that area, one cannot consider that the question has been adequately tackled and that the disease is being adequately coped with here.

Now, I have, on occasions, addressed the Government and asked them that they should be a little more free with anti-venereal remedies and, while the district surgeons are all supplied with these remedies, it does not follow that the district surgeon is the best man, or the only man, to handle a matter of this kind. Let us, for instance, take the question of a mission hospital. It is quite obvious that if we had provision made for such remedies there, it would mean that we would attract a much larger population, or that we shall be in closer touch with a much larger population than the district surgeon could ever hope to be. It is for that reason that I say that I should like the thing to be extended to include mission hospitals and also mines. All my efforts so far have failed in that regard.

You know, of course, the system under which these clinics are set up. That is to say, a local authority initiates a clinic and pays all the expenses and the Government refunds two thirds of the treatment expenditure. Now, the small local authorities in Natal have absolutely refused to incur any expenditure whatever of any kind and so far the Government have

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not seen their way to revise the whole scheme, but so pressing has the Government considered the need of something being done that we are taking the cases from the small local authorities and treating them in the clinics of Durban and Maritzburg for nothing, on the same basis as patients from the country would be treated by the local authority. The trouble is today, that the small local authorities will not do anything and I do not see how you are going to force them to do it, or, as a matter of fact, how they will manage it.

MR. LUCAS: Would it not be cheaper, under those circumstances, to bear the whole of the cost and have cases attended to in small local areas ?- But the cases are supposed to be attended to in the small local areas.

But you say that they are not ?- Yes, that is so.

Then would it not be cheaper to bear the other one third and attend to the other number of cases, attend to the cases now sent to Durban or Maritzburg ?- It would not be cheaper, but it would be better. And the more you do that kind of thing, the nearer you get to your public.

CHAIRMAN: I think we have got to a rather technical point, which does not fall within our terms of reference. We are interested in the condition of health, rather than in what should be done ?- The position as reflected by the District Surgeon's reports, which you can get, does not, I think, cover the whole of the trouble, because I do not think that the district surgeons see one-tenth of the venereal cases in the district. I do not see how they can. The district surgeons as a general rule, are supposed to treat cases as out-patients and those who cannot so be treated, are supposed to be sent to hospital. Except for one or two district surgeons who

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are always asking for cases to be sent to hospital, very few requests of that kind come in. We have one of our hospitals, which is a clinic, at Hulett's Mill. Now, if you were to ask for the district surgeon's returns and if you were to ask how many cases were reported as out-patients, I do think that you would see a very small number in Natal, because very few of the district surgeons ----- These people are not very keen on attending at the district surgeon's place and I am not sure myself that the surgeon is keen on having these people come in. The position is very unsatisfactory and will not be right until we have a proper hospital service.

MR. LUCAS: On what do you base your statement that venereal disease is on the increase ?- I was once district surgeon in Zululand, in the Knutu district, and I may say that I had a pretty big practise there. It was a very big Native practice, as one understood it in those days, and I know that, when I was there, there was very little venereal disease, but the present incumbent in the same district told me what he sees. He has a smaller practice than I had in my time, but his experience is that there is a great deal more venereal disease. And I also hear from missionaries and others, men who have great experience of the country, that there is a great increase in that sort of thing, and when you hear of many cases of that kind, ---- we hear a lot about abortions and premature labour and, when that comes to your notice, you always suspect venereal disease.

DR. ROBERTS: Is that not because knowledge has become a great deal more prominent? When you were district surgeon there, you did not meet all these cases,but now the Natives themselves talk about it?- Yes, that is so. Although

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a large part of my work as district surgeon was of the usual kind, such as comes to surgeons; there was a great deal of surgical work, I also had a large private practice, and I know that this sort of thing would have come to my notice if there had been much of it.

CHAIRMAN: Did you take the trouble, when you got a case, whether that case came with venereal disease or not, to make enquiries whether there were venereal symptoms ?- In my district surgeon's work ---- well, that is part of a medical diagnosis. You have to be pretty thorough in making your enquiries.

And, therefore, In your cases the fact that you saw fewer venereal cases must be taken as an indication that the probability was that there were fewer cases ?- That is absolutely indoubted. I was at one time in practise in the Free State in the Winburg district and there my entire practise, or at least nine tenths of my practise, consisted of venereal disease cases from Basutoland and, when I went to Zululand it was an amazing thing to me to find the change at once. At Winburg and Ventersburg we did practically nothing else. You never hear anything like that in Zululand, but it is more so now than it was ever before.

MR. MOSTERT: Could you give us any percentage ?- No, I could not, it would be absolutely impossible.

DR. ROBERTS: You are willing to allow that to a certain extent the effect of the dissemination of knowledge may lead to a larger number of cases being known ?- Undoubtedly. But what I want to say is this. I said that my practise was for women's diseases largely and one of the things I had to think of was previous venereal disease and we saw very little of that. Nowadays, they see probably not so much of the

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late features as of the early ones, but the fact that I did not see the late features does shew certainly that venereal disease was not as prevalent as it is now.

Now I come to leprosy. I am not prepared to say whether leprosy is common or uncommon in Natal, but this I do know that we have an average of 300 lepers at Ntanikulo(?) and another 300 or more under observation and not under observation in the reserves in the locations. The Native in Natal does not know as much about leprosy as he might and would be glad to know more than he does. The policy which the Government has been following the last few years is undoubtedly increasing our knowledge of the number of cases. The system is briefly this. A leper is sent down from his district to me in Durban and is isolated at Salisbury Island and I decide whether or not that man could safely be segregated in his own district or whether he should come and be completely isolated at our Institution. Once a year we have a board which sends lepers from Ntanikulu (?) back to the reserves , that is when we consider that the disease is more or less stationary and, once they are back, we keep them under observation and we make a point of sending these Natives back as soon as the disease is definitely stationary, but if they shew further symptoms again, then they are not allowed to leave.

If it is at all possible, we allow them to go back. Well, the Native is now beginning to find out that the Government does not want to imprison him for life and I had given a whole series of lectures to chiefs and others and I pointed out that we only want to keep them at our Institution not only for their own benefit but so that they shall not be a danger to others, and we assure them that, if they go up there, we

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shall only keep them so long as it is absolutely necessary until they are no longer a danger to the community. Now, I may say that that policy is having its effect and we are realising that that is the best way of establishing the confidence of the Native in our methods, and it certainly had led to a very great improvement. At one time, the average duration of a leper's confinement after he was sent to us, was about seven years, but now the average duration is less than three years. That really means to say that earlier cases are coming forward and we have actually got several instances where Natives have come forward on their own initiative and have asked that they might be segregated, knowing and realising that as soon as the disease has stopped being active, they will be sent back.

But things are not all quite as good as that. Quite lately, there has been a very great difficulty in connection with the police. The point is this, you cannot get Natives suffering from leprosy, you cannot get lepers out of a district unless you have judicial action of some kind to back you up. It is no use thinking that you can do without it. After all, only a very small number come on their own, and you must have some way of forcing the others. Now, it is part of the duties of the chief of a kraal to inform the authorities about lepers. Some chiefs carry out their duties, but we hear about lepers in other places as well and, unless we have police co-operation and police coersion, we are not going to get our lepers out. Now, quite lately, the police service in this respect has been withdrawn and we have been given nothing instead. We have been told that we must appoint out own men to bring the lepers out. Well, if you try and

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get a man who is not an official to go into a Native area or into a kraal and bring out a person suffering from leprosy, particularly if that person is unwilling to come, you are in for serious trouble. That man himself will get into serious trouble. Only lately we had an instance of that. We had a man who was in a temporary job and we had to transfer him, we had to give him another job in the gaol so as to prevent him from being blotted out. The whole of the leprosy fabric is now being prejudiced by this new policy.of our not getting judicial action to back us up.

I do not know what is going to happen. If the magistrates had officials whom they could send out, if they had Native officials like Native policemen, there would be no difficulty, but the trouble is that they have nobody. It has been said to us that we could do this sort of thing and have the police looking out for cases of that kind when they are on patrol, but that is not sufficient. The result of it all is that the number of lepers is on the increase. It is a great pity to be hung up in this way. I think it was advisable for me to bring it forward in the hope that the Commission may see its way to recommend some steps to be taken.

Now, I come to the prevalence of typhus. Typhus is not a very serious thing in Natal. Typhus, the incidence of typhus, was a legacy from the Transkei some years ago, when it was fairly bad. We tried to combat it and we did so by the establishment of what I might call typhus gangs. We de-verminised certain districts and I did a lot of work in that connection and I originated these gangs and parties and we found that we were able to compete with the disease. But what we did find also was this, that the more we did for people, the less they

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did for themselves. Now, we have done a great deal by means of education in typhus matters and we expect, in the Native locations that the people themselves shall largely deal with these matters themselves, naturally under supervision, and that policy appears to be working satisfactorily. At one time, we had a good deal of typhus in Zululand, but today, I think, we have got it out of that country by the help of the chiefs and by the chiefs insisting upon certain measures at the kraals. The whole thing was done without a special staff and I am not worrying very much about it in the Native areas today.

We were told that one must expect a good deal of typhus ---:- I would rather not criticise that view. I know of no way of spreading typhus except by lice. It has nothing to do with water.

Yes, but if water has to be carried so very far, it makes it all the more difficult for a man to have a bath, and not having a bath, a man might have these other vermin on his body and typhus might spread?- That might apply in the Transkei.

Would the lice be drowned in a bath ?- Well, lice do not like baths, but how do you make a Transkei Native have a bath?

MR. LUCAS: That is the point involved. If they get an opportunity of having baths, then it is easy to deal with ?- The Health Department has given up trying to make the Transkei Native bathe. In Natal and Zululand we issued the Natives with soap. We just do the issuing and the Native is delighted to get this and to wash with it, but it is of no use giving soap to a Transkeian Native. He simply does not use it.

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We give naphthalene oil and they like it, but in Natal we prefer soap.

DR. ROBERTS: Would you not think that that is perhaps the reason why the population is increasing so fast in the Transkei and not in Zululand ?- No, I do not think so.

Now I come to enteric. That, of course, is a serious thing among the Natives. In my opinion, there is a very considerable amount of enteric fever among the Native population and, unfortunately, enteric in a Native, does not take the same clinical form as enteric among the Europeans, with the result that we get a tremendous amount of undiagnosed enteric among the Natives. Further, the Native does not take enteric in the same way as Europeans do and, as you know, one of the serious sequals of enteric is perforation. In the Europeans, it can usually be expected in the third week, but it is quite a common thing among the Natives - evidence of which we have had at the Addington Hospital -- to get perforation when the day before the man has been working at the Point, or somewhere else. He may have been loading coal the day before. The Natives can get a very serious attack of enteric and most of them get better.

CHAIRMAN: Do they get better in spite of perforation?- Oh, no, but a great deal of enteric is suffered by Natives without their knowing anything about it at all. It is quite a common thing for a Native to be indisposed for about five or six days with enteric fever and then get better. I speak very feelingly on this matter. My own Native nurse, a few weeks ago, had an attack of enteric and is now getting better, because we keep an eye on these cases, but what about the ordinary houseboys who are hardly ever

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looked after. This, of course, is a very wide question and I say that we are never going to make any headway in regard to Native enteric until the Natives know more about it and know more about sanitation. We do absolutely nothing today, we can do absolutely nothing. This is rather an important fact - the fact is that we have Native carriers all over the country and some of these Native carriers have been responsible for the production of some of the most serious outbreaks that we have had. You will remember the Kokstad outbreak, that was caused by a Native carrier. Similarly, the Cedara outbreak, that was produced by a carrier and there are dozens of cases of a similar kind, and nothing will do any good until the Native is educated up to the danger.

Now, I should like to say a few words about tuberculosis. The position in the Native reserves is very difficult to estimate. Dr. Allen has reported on it and, if I am correct, my impression is that he has reported to the effect that it is decreasing. Well, I think that possibly it is decreasing to a certain extent, where cattle are on the increase and where there are plenty of cattle. There it is decreasing, but I should hesitate to say that tuberculosis is actually decreasing there where conditions are becoming more urbanised.

Would you explain that a little further - why should the increase in the number of cattle cause a decrease in tuberculosis ?- Because the children are getting more milk and the feeding is better.

Yes, but our evidence is to the contrary. Almost all over the country where your cattle are increasing too much,

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the milk supply is going down ?- I think that, if you went to Eshowe and got evidence there, - which is the only part of Natal which Dr. Allen examined - you will find that things are different there.

Your statement may apply to areas which are not overstocked, but in all overstocked areas, the experience goes to shew that the milk supply is going down, although the number of cattle is going up ?- That might be so. All I can say is that, where we looked into it in the Eshowe district, there is no doubt that there was an improvement to be recorded in regard to tuberculosis. Every place would become overstocked, of course, if it is allowed to.

There are portions of Eshowe which are overstocked, but other portions are not. Your observation may be in those parts which are not overstocked ?- That may be.

MR. LUCAS: Your point is that the improvement is due to better feeding ?- Yes. There has been improvement in certain parts, but I am not at all sanguine that there has been a general improvement, in fact, I think the reverse is the case.

DR. ROBERTS: You do not favour the view that the Natives are becoming a great deal more immune, if not altogether ?- I have no evidence on which to base such a view. I regard the position in the town areas, and especially the areas round about the towns here, as disquietening, especially in those areas where we have large numbers of detribalised Natives, and I know that there are a great many Natives whom I have to sign refunds for, and in seeing the refunds for the hospitals, there is no doubt that lots of these Natives go to areas round about the towns where they are under

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no supervision and where the hygienic conditions are bad. It is in those conditions where there is a great menace. When the Native goes to the Native reserve, generally the position in some cases will be bad for the people in the kraal, but in other cases it will do no harm at all.

CHAIRMAN: Where does the line of demarcation come in ?- It depends on how the Native lives. Where he lives cheek by jowl with other Natives, things are bad, but where he lives on an open hillside alone, it is there that you find that he is much better off than in the town.

I need not go into the question as to what responsibility the Government takes in the way of refunds to local authorities; they give half, but again, the small local authority will have nothing at all to do with tuberculosis. They will not move either for the European or for the Native, in fact, they will take no steps at all to deal with the position. The result is that we get these people at the hospitals in Durban and Maritzburg. We get these unfortunate people presenting themselves at the gate; they have got phthisis and they come to us, we will say, from the area of the small local authority. Well, that local authority can do nothing, so the hospital has to take them in and the hospital has to pay the whole cost excepting if there is a proved danger to public health, in which case the Government may regard the local authority as being responsible. In that case, the responsibility does not fall on the hospital, of course.

CHAIRMAN:

I notice that recreation and rotary action are mentioned by you here. Your other headings seem to me as to what treatment should be provided ?- Yes, noone will do

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anything.

MR. LUCAS: Is the number of cases such as to constitute a serious social danger to the Natives of the country, or to threaten us with a serious economic loss ?- I think it is serious enough to cause a considerable local danger. I do not say generally, but less us take the area outside Durban, for instance. The amount of tuberculosis that may prevail in an Indian boardinghouse, in these shanties which are used for that purpose, to my mind is a distinct menace to the community as a whole. Take the question of treatment. We are supposed -- that is to say, I represent the Central Government -- we are supposed to pay refunds on cases which are a danger to public health. I have certain instructions in regard to that and I interpret those instructions liberally and, when I find people whose only domicile is an Indian boardinghouse in the slums of Durban, I certainly do regard them as a danger to public health and I leave them in hospital. But the hospitals cannot keep them there continually. You cannot keep these people there for five or six months or for a year. You cannot go on with that for ever and the point I am trying to make is that there is no proper provision for these people. There is no sanatorium to which you can send them. I tried to get a section of a Native reserve to be set aside for them, where they would be in a proper reserve located so that we could get these cases sent there and looked after, but everything I have tried to do in that connection has failed.

Now, on the question of recreation I have very little to say. I think that, in the towns, the recreation

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facilities for Natives are grossly defective and it would pay us all if there were very much more interest taken in a matter of that kind. Two years ago I dealt with that question at the Rotary Conference and I expressed the opinion that that should be regarded as a special subject, and that it should be taken up as such and, as a matter of fact, it has been more or less taken up throughout the country, but I do not think that the question has yet been dealt with as it might. I merely wish to record the fact that it is my opinion that proper recreation facilities for Natives are a very important thing, if only for the reason that, if they are given such facilities, it will keep them out of mischief, because today they are not adequately provided for.

MR. HARRY CAMP LUGG, Magistrate of Verulam,

called and examined:

CHAIRMAN: You have put in a statement, Mr. Lugg in which you deal with a number of matters on Native administration. You refer in your statement to the amendment of Natal Native Code. Will you tell us, please, what steps have been taken in that connection ?- The final revision of the Code took place about a month ago and, I understand, that it will not be long now before it becomes law. We made the final revision in Maritzburg and Mr. Rogers, who has been assisting in the matter, took the revision back to Pretoria and I take it now that the final suggestions will be submitted to the Minister.

Can you tell us on what lines the suggestions have

Dr. Lugg

been made? Have they been made with a view to bringing the Code more up-to-date with present-day conditions ?- Yes. The Code, in a few respects, was found to be in conflict with the Native Administration Act and the position was such that, where the Code was found to be in conflict with the Native Administration Act, the Code prevailed over the Administration Act. This created a ~~xxh~~ somewhat impossible position, so that we had to revise the Code so as to provide ~~with~~ that the principles laid down by the Administration Act should not be conflicting with the principle laid down in the Code.

May I just illustrate. Under the Administration Act, a Native may make a Will, but under the Code he cannot make a Will. A Native in Natal cannot make a Will except in regard to immovable property, but under the Administration Act, a Native has the right to make a Will in regard to any form of property, so long as it is not house property.

MR. LUCAS: Quitrent ?- Yes, it is enumerated in the Administration Act.

DR. ROBERTS: With regard to the Administration Act - that is tentative as all Acts are. They may change that Act next year. What will happen to the Code then ?- The Code can be modified as time goes on, by proclamation by the Governor General. If the Administration Act can be amended and if it is amended, so can the Code be amended.

CHAIRMAN: Is that a new provision ?- Yes, government by proclamation.

That is under the general provision of government by proclamation ?- Yes. It is only since that has come in that a certain amount of elasticity has been brought in.

Originally, the Code was drafted to be in uniformity with what the Natives regarded as their law before the White