

INSTITUTE for
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RESEARCH



A Study of the Social Circumstances
and Characteristics of the
Bantu in the Durban Region

Report No. 2: The Social Circumstances
of the Bantu

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UNIVERSITY OF NATAL, DURBAN, SOUTH AFRICA

A STUDY OF THE SOCIAL CIRCUMSTANCES AND
CHARACTERISTICS OF BANTU IN THE DURBAN REGION

Report No. 2

THE SOCIAL CIRCUMSTANCES OF THE
POPULATION

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E R R A T A.

Page 19. line 16: For "mostserious" read "most serious".

Page 22. footnote 1]: For "Poverty, the study of townlife"
read "Poverty, the Study of Town Life".

Page 24. line 17: For "preventative" read "preventive".

Page 187. paragraph 2, line 1: For "organisatoon" read
"organisation".

Page 192. line 2: For "Parents" read "Parents'".

Page 211. line 7: For "quantitities" read "quantities".

Page 262. lines 1 & 2: For "Boy's and Girl's Clubs" read
"Boys' and Girls' Clubs".

Page 323. line 13: For "Co-ordingting" read "Co-ordination".

Page 332. lines 12 & 13: For "in-oolve" read "in-volve"

Page 332. line 23: For "th" read "to".

PREFACE

With the issue of this final report on the sociological survey of the Bantu population of the Durban region, I should like to take the opportunity of acknowledging the generous assistance the Durban Non-European Children's Fund has received from the Oxford Committee for Famine Relief. Without their munificent grant of R6,000.00 it would not have been possible for this research project to have been undertaken.

With a sound scientific assessment of the full extent and nature of the problems involved now available, it is earnestly hoped that the six Organisations which we represent, as well as the many other Organisations working in the same field, will be able so to direct their activities in the future that the maximum benefits will derive from the resources made available to them.

I should also like to pay tribute to the generous contribution to this study made by the University of Natal through its Institute for Social Research. It is the policy of the Institute to conduct work for recognised Welfare bodies at considerably less cost than the full commercial rates charged for other types of applied research. This policy represents a financial contribution by the University to welfare for which we are most grateful.

SIR BRUCE HUTT

CHAIRMAN

DURBAN NON-EUROPEAN CHILDREN'S FUND.

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The overall editing was in the hands of H. L. Watts.

I N T R O D U C T I O N

This is the second of two reports dealing with the social circumstances and characteristics of Bantu in the Durban region. Sponsored by the Durban Non-European Children's Fund, the survey examines the welfare problems of the Bantu population - particularly the children - and attempts to assess the needs involved, with a view to guiding the planning for future social action.

As was pointed out at the beginning of the first report in this series, intelligent social planning must start with the factual situation to be tackled. It is true to say that if one is to solve problems, one must first of all understand them. The main burden of this second report is to describe factually the present size of the Bantu population in the Borough and region of Durban; to establish the socio-economic level of the population, and assess the extent of the health and welfare needs, especially for children; to describe how these various needs are, or are not, being dealt with by the variety of voluntary and statutory welfare and health organisations operating at present within the region; and finally, in the light of the findings, to make recommendations for the future handling of the problems uncovered - recommendations intended to provide a foundation for further efforts.

A considerable amount of what is described, or recommended, by the report will not be new or surprising to those working in the field - but then, as one social scientist has said, the function of social research is often not to discover the new, or the unexpected, but rather to substantiate what has already

been expected, and to confirm the experience already accumulated.^{1]} In this unspectacular function, social science is nevertheless fulfilling a vital role - for the history of man's endeavours has shown often enough that what is expected is not always what is actually true, nor is what people regard as their experience, always a reliable indication of the factual situation. Thus research is necessary if we are to be sure of the problems that face us. Knowledge is essential if we are to be able to plan, and tackle problems constructively.

In studying the results of the project as a whole, both the first and second reports should be consulted. However, for the convenience of the reader, several of the findings of the first report which bear particularly on this second report, are quoted herein. The first report deals with the characteristics of the population, and prepares estimates of the future growth and size and structure of the Bantu population of the region; this second report deals in detail with the social circumstances and welfare problems and needs of the population, bearing in mind the characteristics and growth of the number of Bantu in and around Durban.

1] Edward Batson has written as follows :

"It is not the most usual function of scientific research to make startling discoveries outside the range of previous expectation. For the most part, research detects phenomena whose existence is already suspected, or classifies phenomena whose existence is already known, or measures phenomena that have already been classified. Research of this unsensational kind is a foundation of most engineering and administration in our day." See; Committee on Socio-economic Surveys for Bantu Housing Research (1960): A Survey of Rent-Paying Capacity of Urban Natives in South Africa: S.A. Council for Scientific and Industrial Research, Pretoria: p.ix.

CHAPTER 1.

POVERTY AND PROGRESS^{1]}

H. L. WATTS

1.1 INTRODUCTION:

A key factor in the incidence of health and welfare problems amongst any population is that of the socio-economic status of the people concerned. It is a truism to say that the health and welfare of a people are inversely related to their socio-economic status and standard of living. Whatever problems the relatively well-off may have, they are not the problems which the Social Worker, or the Clinic, are likely to have to deal with. On the other hand, from at least the time of the industrial revolution onwards, the problems associated with poverty in towns have followed a common pattern, and are well known - poverty means bad housing and malnutrition, tuberculosis, ignorance, a high infant mortality rate, and problems of broken homes, illegitimacy, and child neglect. It is not necessary here to try and unravel which of these factors are symptoms, and which are causes - suffice to say that where extreme poverty in urban areas has been found - in whatever part

1] The title of this chapter "Poverty and Progress" is unashamedly copied from B.S. Rowntree's second classic study of poverty in York, published in 1941. (See Rowntree, B.S. (1941) Poverty and Progress: Longmans, London). The study of poverty and socio-economic conditions in South Africa follows closely in the steps of Rowntree, and his successor Bowley, so that it is as a tribute to their pioneering work (in England), during the early part of this century, that this chapter is named after one of Rowntree's books.

of the world it may be - this unholy complex of problems exists. South Africa and Durban are no exceptions to this rule, as health and Welfare Workers know only too well. Thus it is important to assess the extent and depth of poverty prevailing among the Bantu in Durban.

Before proceeding to attempt to measure the incidence of poverty, some indication should be given of the size of the population concerned - of the population "at risk" so to speak. It is estimated that in 1964 there were a total of about 285,500 Bantu living within the Durban Metropolitan Region.^{1]}

Over 75% of the population were living in recognised townships and hostels. It is estimated that by 1970, the population will total 289,100 persons,^{2]} of whom the majority will be housed in townships, with the Kwa Mashu and Umlazi Townships as the largest in the region. If children are classed as persons under the age of 15 years, then in 1965 an estimated total of 82,200 Bantu children were living within the region, while by 1970 the figure may be about 106,200.^{3]} Thus in 1965 about 28% of the population consisted of children, while by the year 1970 about 31% will be children under the age of 15 years. This means that roughly three out of every

1] Margaret A. Young (1965) : A Study of the Social Circumstances and Characteristics of Bantu in the Durban Region : Report No.1: Characteristics and Future Growth of the Population : Institute for Social Research, Durban. (Mimeographed). See Table III, p.10.

2] *ibid.* : p.83

3] *ibid.* : p.84

ten Bantu in the region are children. In the foreseeable future, the proportion of children is likely to grow.

Excluding the effects of migration, (either immigration or emigration), it is estimated that in 1965 there were about 22,200 Bantu males aged 0 - 4 years, 10,300 aged 5 - 9 years, and 8,200 aged 10 - 14 years, within the Durban Metropolitan Region. The corresponding figures for girls were 21,400; 10,900; and 9,100. This yielded a total of 43,600 children aged 0 - 4 years, 21,200 aged 5 - 9 years, and 17,300 aged 10 - 14 years. For 1970, the figures (regardless of sex) are likely to be about 45,800 aged 0 - 4 years, 39,400 aged 5 - 9 years, and 21,000 aged 10 - 14 years. ^{1]} It is the above population ^{2]} of adults and more particularly of children, whose socio-economic status must be measured, in order to gain an understanding of the background to the welfare and health problems described in later chapters of this report.

1.2. THE MEASUREMENT OF POVERTY.

Since the turn of the Century, when Rowntree first

1. *ibid* : p.81 - 82

2. It must be pointed out that the above estimates are based on the best available data, but due to the deficiencies of existing statistical information about the Bantu, are subject to an unknown margin of error. They are based on the assumption that the present socio-economic-legalistic conditions surrounding the Bantu population in Durban will continue in the short run. The likely effects of any future socio-economic changes, or administrative and legal changes, on the size and distribution of the Bantu population in the Durban region cannot be predicted, and so were not taken into account in the above estimates.

developed a poverty datum line in his attempt to assess poverty in York, England,^{1]} most authorities have regarded the poverty datum line in one form or another as the best available method for assessing the socio-economic status and level of a household. The poverty datum line defines the costs of the minimum theoretical needs for a household to maintain decent and healthy survival under short-term conditions. In South Africa, work on poverty datum lines has been undertaken by Batson at the University of Cape Town^{2]}, the Council for Scientific and Industrial Research^{3]}, and the Department of Economics at the University of Natal^{4]}. The technique has been used in this study to establish the amount of poverty amongst the Bantu in Durban.

1. Rowntree, B.S. (1901): Poverty : A Study of Town Life : MacMillan, London.
2. Batson, E. (1941 onwards) : Series of Reports and Studies issued by the Social Survey of Cape Town : Department of Sociology and Social Administration, University of Cape Town, Cape Town. (Mimeographed). Reports Nos. S.S.1-30.
3. Committee on Socio-economic Survey for Bantu Housing Research (1960) : op. cit., also Watts, H.L. (1959) : An analysis of some of the housing requirements of the Urban White population of the Union of South Africa : National Institute for Personnel Research, C.S.I.R., Johannesburg. (Mimeographed) ; and Watts H.L. (1962) Survey of the Housing requirements of Coloureds in towns of the Western Cape Province : National Institute for Personnel Research, C.S.I.R., Johannesburg. (Mimeographed). Confidential Report.
4. Unpublished manuscript on "Rent paying capacity and the cost of living of Urban African families in Durban" : Department of Economics, University of Natal, Durban; Date unknown, about 1959.

1.3. THE AMOUNT OF POVERTY AMONGST BANTU IN DURBAN :

Using a poverty datum line adapted for Durban from the figures used by the Council for Scientific and Industrial Research, Young (in the first report on this study) estimated that about four-fifths of the households in the Bantu townships in the region fell below the secondary poverty datum line.^{1]} The actual values used for the poverty datum line calculation are shown in Table AI, Appendix A of this report. Young's estimates of poverty are subject to an unknown margin of error, in that average income figures, and the estimated cost of the secondary poverty datum line for an average Bantu household, were used in her calculations. This was necessary in view of the fact that no up-to-date detailed figures of the total household income, and household composition, for individual households amongst the Bantu in the Durban region are available. It is wise therefore to try and check the accuracy of these estimates, before proceeding on the assumption that more or less every four out of five of the Durban Bantu are in poverty :

The above figures for poverty can be compared with a carefully controlled sample survey of the position in the city of Durban itself, undertaken in about 1953 by the Council for Scientific and Industrial Research. This survey obtained data relating to the total income for a household, and compared this with the specific poverty datum line for each individual household. Thus the data obtained were far more accurate than those used by Young. The survey found that out of a representative sample of 400 Bantu households in Durban, 336 consisted of two or more

1. Young, M.A. (1965) : op. cit., pp. 66 - 69: specially p.68.

persons - and for these households the poverty datum was calculated. Of the 336 family-type households, only 98 (or 29.2%) had an income sufficiently above the primary poverty datum line plus transport costs, to allow the household to afford an economic rent for accommodation. This means that about seven-tenths of the family-type Bantu households in Durban in 1953 were below the secondary poverty datum line. These households could safely be considered to be in poverty.^{1]} This figure is not greatly different from the figure of four-fifths in poverty, given by Young.

A more recent study was undertaken in 1958 by the Department of Economics at the University of Natal. Using a poverty datum line calculated specially for Durban, (and independent of the C.S.I.R.'s scales) the Department arrived at the conclusion that 71% of the Bantu households were in poverty.^{2]} The close correspondence of this figure with the earlier figure prepared by the C.S.I.R. is noteworthy.

The sample field survey conducted in the Kwa Mashu township in 1964, as part of the current investigation, obtained data for the detailed household composition, and household income from all sources (including reported illegal earnings)^{3]}

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1. Committee on Socio-economic Surveys for Bantu Housing Research (1960) : op. cit., Chapter 4, p.91.
 2. Department of Economics, University of Natal, (no date) unpublished manuscript : op. cit.
 3. While an attempt was made to obtain information on income from illegal sources, only just under 5% of the households reported this type of income - a figure probably lower than the true position.

for a sample of households. Consequently the poverty datum line for each household can be calculated with a fair degree of accuracy. While it cannot be said that Kwa Mashu is representative of the Bantu population of Durban region as a whole, an estimate of the extent of the poverty in that township will be useful in so far as there is no reason to expect that the figure for the whole region would be markedly different. With this in mind, an analysis of the socio-economic levels of the households from the sample was undertaken.

In analysing the Kwa Mashu data, the choice had to be made between using the poverty datum line based on the C.S.I.R.'s work, or that prepared by the Department of Economics. The latter is a somewhat more conservative scale than the former, and was also specifically prepared for Durban conditions - while the C.S.I.R.'s scale is based on average conditions in South Africa generally. ^{1]} The decision was made to use the latter scale in view of its greater applicability to Durban, and also because as a more conservative scale it would tend to under-estimate rather than over-estimate the amount of poverty. If conservative figures are used, then we can be fairly confident that the position is at least as bad as that found, if not worse- and this seems preferable to over-estimating the amount of poverty in the region.

1. While the figures for the C.S.I.R.'s poverty datum line were adjusted for Durban in terms of the consumer price indices for that city, the pattern of expenditure (particularly in regard to clothing) assumed by this line were such as are likely to be applicable throughout South Africa, rather than under the special sub-tropical conditions prevailing in Durban. On the other hand the Dept. of Economics' scale has taken into account the particular conditions prevailing in Durban.

Table I below estimates the costs of the various poverty datum line items combined, in Durban in 1964. (The 1958 figures prepared by the Department of Economics were suitably adjusted by means of consumer price indices in order to allow for the rise in cost of living, between 1958 and 1964):

TABLE I

ESTIMATED WEEKLY^{1]} POVERTY DATUM LINE VALUES
FOR DURBAN, OCTOBER, 1964:
(Derived from Figures prepared by the Department
of Economics, University of Natal).

AGE GROUP	ALL ITEMS FOR THE POVERTY DATUM LINE, EXCLUDING RENT AND WORKERS' TRANSPORT	
	MALES	FEMALES
Infant	R1-18	R1-18
2 - 3 years	1-28	1-26
4 - 6 years	1-35	1-33
7 - 9 years	1-56	1-54
10 - 12 years	1-72	1-70
13 - 15 years	2-06	1-94
16 - 20 years	2-38	1-99
Adult : Very Active	2-54	2-08
Adult : Moderately Active	2-14	1-91
Adult : Sedentary	1-97	1-83
HOUSEHOLD *	0-25	

1] Monthly values can be obtained by multiplying the weekly figure by a factor of 4.3

* The 0-25 for a household is added in irrespective of the size of the household, as a minimum for fuel and lighting.

Applying the above scales to the individual households sampled from Kwa Mashu, and using the figures for actual rent paid and the household costs for workers' transport, the position of each household in relation to the secondary poverty datum line was established. The results of the calculations are shown in Table II below :-

TABLE II

A SAMPLE OF BANTU HOUSEHOLDS FROM KWA MASHU
CLASSIFIED IN RELATION TO THE SECONDARY
POVERTY DATUM LINE, DURBAN 1964.

POVERTY CATEGORY, HOUSEHOLD INCOME ;	NO. OF HOUSEHOLDS.	% KNOWN CASES.	CONFIDENCE LIMITS. 1]
More than R5 below S.P.D.L. ^{2]}	154	71.6	65% - 76%
Not more than R5 below S.P.D.L.	15	7.0	4% - 9%
Equal to S.P.D.L.	0	0.0	0% - 2%
Not more than R5 above S.P.D.L.	12	5.6	3% - 10%
More than R5 above S.P.D.L.	34	15.8	11% - 22%
TOTAL	215	100.0	-
Insufficient information	13		
Non-response	10		
GRAND TOTAL	238		

1. Read from a nomograph and ignoring the stratification of the sample, (which produced negligible gains in precision). The 95% confidence limited are used.

2. S.P.D.L. = Secondary Poverty Datum Line

From the table it will be seen that nearly four-fifths of the households fell below the secondary poverty datum line, and so can be regarded as being in poverty. A clearer idea of the distribution of the households by economic level can be obtained by calculating the "relincome" for each household. This shows the income of the household as a percentage of the household's secondary poverty datum line. Thus a relincome of 100 indicates that a household has an income which just meets the cost of the secondary poverty datum line; 200 means an income twice the size, or again, 50 means an income half the size of the secondary poverty datum line - and so on. ^{1]}

The Table shows that about a third of the sample cases have incomes which are less than half of what they should be, as defined by the secondary poverty datum line, and almost a tenth have an income which is less than one quarter of the size it should be for healthy survival. Clearly in terms of these figures there is a serious problem of poverty in Kwa Mashu, and by inference, in Durban.

1. For a slightly fuller description of relincome and its application see : Watts, H.L. (1959) : op. cit., p. 16, and also appendix G.

Table III below shows the relincome.

TABLE III.

RELINCOMES* FOR A SAMPLE OF BANTU
HOUSEHOLDS FROM KWA MASHU, DURBAN 1964.^{1]}

POVERTY CATEGORY	RELINCOME	No. OF HOUSEHOLDS	% OF KNOWN CASES	CUMULATED PERCENTAGES	CONFIDENCE LIMITS FOR CUMULATED PERCENTAGES
BELOW SECONDARY POVERTY DATUM LINE	0-24	20	9.3	9.3	6-14
	25-49	53	24.7	34.0	28-42
	50-74	59	27.4	61.4	55-68
	75-99	37	17.2	78.6	72-83
EQUAL TO OR ABOVE SECONDARY POVERTY DATUM LINE	100-124	26	12.1	90.7	84-94
	125-149	13	6.1	96.8	93-98½
	150-174	2	0.9	97.7	93½-99
	175-199	2	0.9	98.6	94-100
	200-299	3	1.4	100.0	98-100
	300-399	-	-	-	-
	400-499	-	-	-	-
500+	-	-	-	-	
TOTAL		215	100.0	100.0	
INSUFFICIENT DATA		13			
NON-RESPONSE		10			
GRAND TOTAL		238			

* The Relincome of a Household = $\frac{\text{Household Income}}{\text{Secondary Poverty Datum Line of Household}} \times 100$

The 95% Confidence limits have been read off from a nomograph, ignoring the stratification of the sample (which produced negligible gains in precision).

1. For the comparative picture of the relincomes of Whites in South Africa, see Watts, H.L. (1959) *ibid.*, Appendix H and for Coloureds in the Western Cape, see Watts, H.L. (1960) : *op. cit.*, page following p.11 and Appendix F.

FIGURE 1

THE PERCENTAGE DISTRIBUTION OF RELINCOMES

FOR A SAMPLE OF BANTU HOUSEHOLDS,

KWA MASHU, 1964.

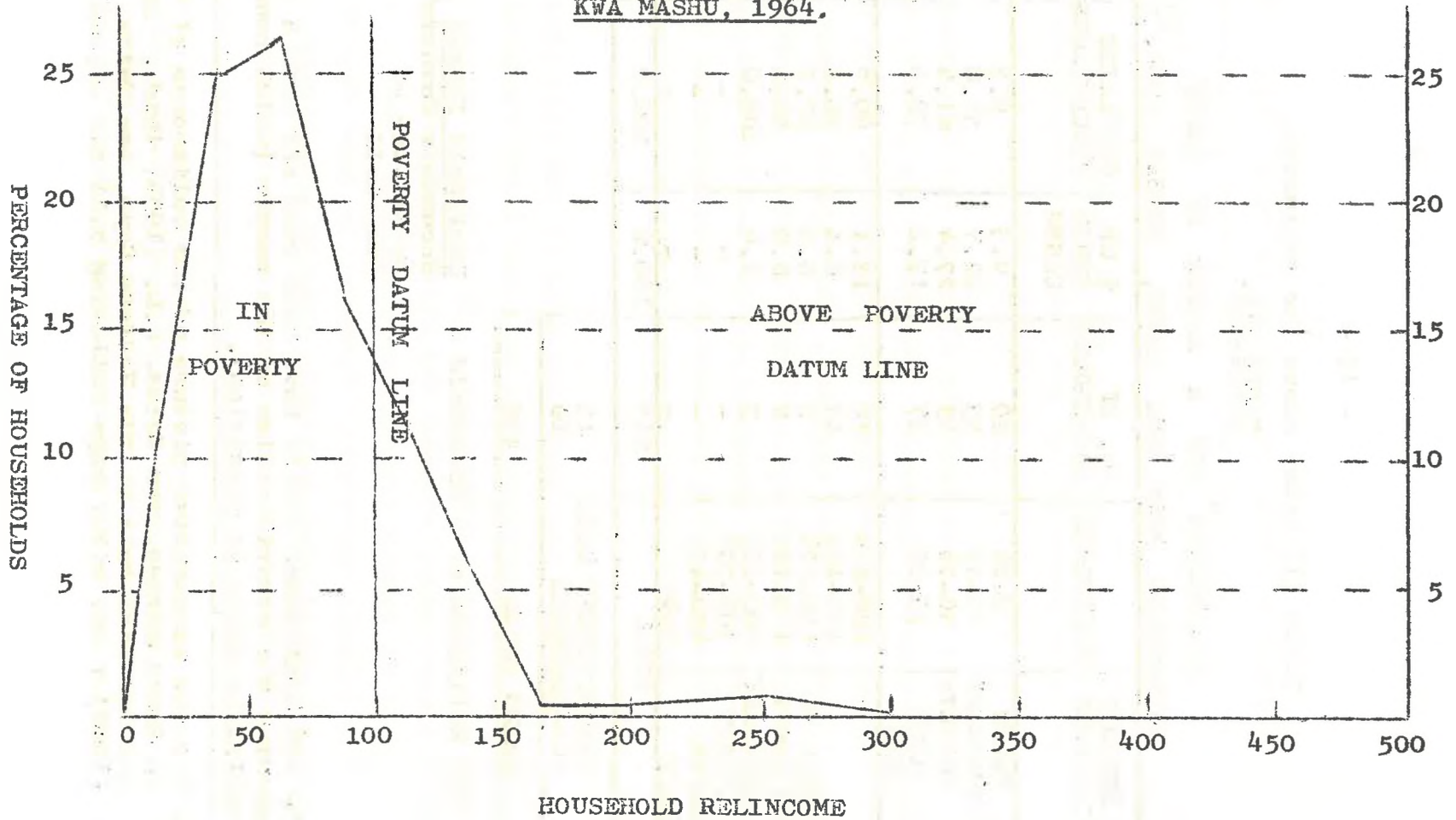


Figure I graphs the content of Table III. The figure stresses that the Bantu households with a satisfactory relative economic level are rare. The typical household is in poverty - nearly four-fifths of the sample are in poverty. From Table III it is calculated that, at the 95% confidence level, we be sure that at least about 72% of the Kwa Mashu households in 1964 were in poverty, and possibly as many as 83% were in this state^{1]}.

It is notable that the findings for Kwa Mashu, using the Department of Economics' scale for the poverty datum line for Durban, agree well with the findings of Young, quoted on page 7 above. Taken together, the figures suggest somewhere between about 7 to 8 out of every 10 Bantu households in Durban have a legal income insufficient to meet the basic needs for healthy survival. The reasonably close agreement between the various sets of figures presented lends strong support to this conclusion.

Reference has just been made to the fact that legal incomes were insufficient to meet the level required by the secondary poverty datum line. The C.S.I.R. survey concentrated legal income only, whereas the field study undertaken at Kwa Mashu attempted to obtain information on income from all sources, (including illicit earnings). However, as less than 5% of the cases reported any illegal earnings, this in effect means that only legal income was reported. The actual extent to which Bantu in Durban

1. Applying confidence limits to the sample estimate of 78.6% with the relincome of less than 100, and ignoring any gains introduced by the stratification of the sample. The limits quoted above were read off a nomograph.

supplement their income from illegal sources is unknown. In this regard, reference should be made to the finding of the Economics Department that actual income reported falls considerably below the reported expenditure.^{1]} The Department's survey covered Cato Manor, Kwa Mashu, Lamontville, and Umlazi Glebe. The average expenditure of households in these areas in 1958 was found to be R61, or R27.00 per month in excess of the average income of R34 a month. This gap between income and expenditure is most important. Commenting on it, the Economics Department's report suggests that this means the actual income of the Bantu population must be quite a good deal higher than the stated figures in order to maintain the level of expenditure reported. This would mean that the extent of poverty amongst the Bantu in Durban is not as great as the figures based on legal income, quoted above, would suggest. The possible explanation is that illegal and irregular earnings form an important part of the income of Bantu households, and that these are not disclosed during survey interviews.

There is no reason to doubt that there is some gap between the legal income of Bantu, and their expenditure. However, illegal sources of income are not desirable, so that it is valid to calculate the extent of poverty on the basis of stated legal income - on the grounds that a serious social problem exists if legal incomes are too small to support the average household. Secondly, it has been suggested by one of the Institute's Fellows that in her experience, Bantu tend to over-estimate their expenditure, so that the true gap between income and expenditure amongst the Bantu households may not be as great as the Economics Department's survey

1. Department of Economics (no date) : op. cit.

figures suggest.^{1]} There is also reason to believe (judging from the experience of the average Welfare Worker), that there is a genuine gap between income and expenditure as far as the average Bantu household is concerned.^{2]} This gap is made up from time to time by windfalls and other sources. It would explain why so many households tend to have trouble with rent payments, and fall into arrear more than once. Weighing all these factors, it is suggested that while poverty in Durban amongst the Bantu may not be as extensive as is suggested by the figures presented above, nevertheless there is no reason to doubt that a serious amount of poverty does exist, particularly when the standard of the household existing on its legal income alone, is taken as a standard. We can conclude that the problem of poverty is serious enough to produce a high incidence of malnutrition, ill-health, and a host of other problems associated with poverty. That this is in fact so is shown by the figures given in subsequent chapters of this report.

1.4. PER CAPITA DAILY INCOME. AFTER PAYMENT OF RENT AND TRANSPORT

The Kwa Mashu data for poverty can be presented in a slightly different form, which may have more meaning for the average person. We can present the household income in the form of a per capita daily income after rent and transport costs for workers, have been subtracted. This yields what has been called the "net rate per head per day" for a household (abbreviated to N.R.P.H.P.D.)^{3]}

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1. This idea was put forward in a discussion by Mrs. E. Preston-Whyte whose current research has taken her into Bantu homes in Durban and has included a limited study of expenditure patterns.
 2. This gap leads to a large amount of debt amongst the Bantu.
 3. Irving, J. (1958): Economic rent and household income among the African population of Grahamstown: Institute for Social and Economic Research, Rhodes University, Grahamstown. Occasional papers No. 2. (mimeographed), pp. 18 ff.

Table IV below gives the results of this method applied to the Kwa Mashu data.

TABLE IV
=====

THE DAILY PER CAPITA NET INCOME (AFTER RENT AND COST OF WORKERS' TRANSPORT HAVE BEEN PAID)^{1]}
OF A SAMPLE OF BANTU HOUSEHOLDS, KWA MASHU, DURBAN, 1964.

DAILY PER CAPITA NET INCOME	NO. OF HOUSEHOLDS	PERCENTAGE	CUMULATED PERCENTAGES	CONFIDENCE LIMITS FOR CUMULATED PERCENTAGES ^{2]}
NEGATIVE BALANCE	7	3.26	3.26	1% - 4%
0 - 2 cents	3	1.40	4.66	3 - 10
3 - 5	10	4.65	9.31	6 - 14
6 - 8	19	8.84	18.15	13 - 24
9 - 11	30	13.94	32.09	26 - 39
12 - 14	24	11.16	43.25	37 - 50
15 - 17	29	13.48	56.73	50 - 64
18 - 20	10	4.65	61.38	44 - 68
21 - 23	20	9.30	70.68	64 - 76
24 - 26	12	5.58	76.26	69 - 81
27 - 29	10	4.65	80.91	74 - 86
30 - 39	23	10.70	91.61	87 - 95
40 - 49	9	4.19	95.80	92 - 98
50 - 59	4	1.86	97.66	94 - 99
60 - 69	1	0.47	98.13	95 - 99
70 - 79	1	0.47	98.60	95 - 99½
80 - 89	2	0.93	99.53	97 - 100
90 - 99	1	0.47	100.00	98 - 100
TOTAL	215	100.0	100.0	
INSUFFICIENT DETAILS	13			
NON-RESPONSE	10			
GRAND TOTAL	238			

1. i.e. "Net Rate per Head per day".

2. The 95% confidence limits have been read off from a nomograph, ignoring the stratification of the sample, (which produced negligible gains in precision.)

NOTE: Tables AX and AXII in Appendix A show the distribution of the costs of rent and workers' transport, and the cost of single journeys from Kwa Mashu for casual workers such as chars and washerwomen.

The average (mean) per capita income for the primary poverty datum line for these households was 26½c. per day. This means on the average, a household needed 26½c. at least per head per day, after rent and workers' transport costs had been paid, to keep healthy and decent under short-term conditions. From the above table, it is evident that 76.26% (or three quarters,) of the sample of households had less than this. The depth of some of the poverty amongst the Bantu in Durban is shown by the fact that 32%, or a third, had less than 12c per head per day on which to live and almost one tenth had less than 6c per head daily. It needs little imagination, given present prices, to imagine how little in the way of food, clothing, fuel and lighting, soap and all the other necessities of life, can be purchased by a household with less than 6c per head daily after rent and transport have been paid. The depth of poverty amongst some of the Bantu in Durban appears most serious. While Kwa Mashu cannot be claimed to be completely representative of Bantu in the rest of Durban, it is not all that different, so that the figures suggest that some of the Bantu Poor in Durban are in a very serious position. These Poor, no doubt, are the families with the first call on welfare, and probably most or all of them are receiving relief. The scope of the problem is not small. If we assume that the Kwa Mashu figures roughly reflect the position in Durban as a whole, then roughly a tenth of all Bantu in Durban are in the same dire straits. If so, this involves to something of the order of 29,000 souls in a desperate position.

1.5. FACTORS ASSOCIATED WITH POVERTY :

It is important for us to gain some understanding of the factors underlying Bantu poverty in Durban. It is possible, by

analysing in greater detail the sample data from Kwa Mashu, to obtain clues. The following are the main findings which emerged from this analysis :-

The households with an income greater than their secondary poverty datum line contained an average of 3.8 persons. On the other hand, the households with an income which was not more than R5 below the secondary poverty datum line had an average of 4.1 persons, whereas the really poor households (with an income more than R5 below the line) contained an average of 6.9 persons. This means that on the average the very poor households were nearly double the size of those which were above the poverty line. The correlation between household size and poverty was 0.45.^{1]} This is a moderate correlation, showing that the larger households tend to be in poverty. The finding agrees with the results of previous poverty surveys undertaken in South Africa.^{2]} The evidence shows some individual variation, but the overall pattern is undoubtedly that poverty tends to be more a problem of the larger household than of the smaller one. A full table

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1. This is a point bi-serial correlation co-efficient, relating households above or below the secondary poverty datum line to the number of persons per household.
 2. Watts, H.L. (1962) : op. p.13, shows a correlation of 0.31 between a measure of poverty and household size amongst the Cape Coloureds; while Watts, H.L. (1959) op. cit., p.62 refers to correlations ranging from -.29 to -.36 for the relation between size of household and poverty amongst Urban Whites in South Africa; the same reference also refers to correlations ranging from -.11 to -.29 for Bantu households in various cities, when poverty is related to household size.

relating household size to poverty datum line category is shown in Table AII Appendix A.

It is true to say, for the Kwa Mashu sample at least, that the larger (poorer) households have more children. The mean number of children aged 15 years and less for households in poverty was 3.4 children, as against 1.2 for households above the secondary poverty datum line. Thus, in the Kwa Mashu sample, the households in poverty had almost three times as many children as those not in poverty. (Table AIII Appendix A gives further details.) While similar information is not available from other studies in South Africa, there is no reason to believe that this is not a common pattern. We have confidence in concluding that poverty tends to be more a problem of the larger household with more children than of the smaller household.

Because of this pattern, nine out of every ten in the total of 618 children aged 15 years or under in the Kwa Mashu sample were living in poverty. We can form a crude estimate of the overall pattern in Durban, by making the crude assumption that roughly the same pattern applies to the other Bantu townships. This being so, it seems reasonable to state that roughly nine-tenths, or the vast majority, of Bantu children in Durban are reared under conditions of poverty, or where poverty is only staved off by the family illegally augmenting their income from a variety of illicit sources. Either way, very serious problems of child health and welfare must be present, involving perhaps 74,000 Bantu children in Durban.^{1]} The problem of Bantu child-care in Durban emerges as a serious social problem facing the community.

1. Estimated on the basis of figures provided on pages 81-84 of Young, M. (1965) : op. cit.

An examination of the sample data shows that the main factor related to poverty is that of occupation. This is not unexpected, as previous poverty studies (including Rowntree's), have shown that this is generally the case. The poor households are the large households, where the breadwinners have lowly skilled occupations, which are poorly paid. While size of household, presence of broken families, and other less important factors do play a part in the incidence of poverty, the key one is occupation. This fits in with Rowntree's original findings in York 1899, where he concluded that the major single factor in poverty was regular work at low wages - i.e. poorly paid jobs.^{1]} Thus the main core of the poverty problem amongst Bantu in Durban seems to be the same as in Western Europe a half century and more ago - the problem of wages which are below the breadline, of lack of skill and education, and of low productivity. Likewise as in Europe, there are the associated factors of ignorance, financial mismanagement and the fact that the poor "pay for their poverty".^{2]} These associated factors make existing poverty worse, and also pull into poverty families whose incomes are above the secondary poverty datum line. Rowntree found this same phenomenon in York, and so distinguished between what he called "primary poverty" - which was due to insufficient income - and "secondary poverty" - which was due to ignorance and mismanagement resulting in the household's income not being used to the best advantage. While we have no

1. Rowntree, B.S. (1901) : Poverty, the study of townlife: London, MacMillan. (Fourth edition 1902, Ch. 5, p. 120.)

2. The poor have to buy in small quantities, usually from local shops, and so lose the economy of bulk buying, and/or buying from bazaars or large stores with lower prices. In a recent market research study, housewives remarked on the lower price of goods in town in contrast to the townships. (See B.M. Legwate (1965): Buying Behaviour among Africans in Durban, B.A.CC. Market Research Series No. 2, Boni's Advertising Consultants and Contractors, Durban.) (mimeographed). Also see figures for Johannesburg on the higher cost of goods in the townships - Sheila Suttner (1966): Cost of Living in Soweto: S.A. Institute of Race Relations, Johannesburg, p.16). Appendix B gives some brief comparisons in prices.

measure of the extent of secondary poverty in Durban - as it is extremely difficult to measure objectively, unlike primary poverty - social workers talk with despair of poverty of this type, and some from their experience, appear to rate it as a worse problem than primary poverty due to low income alone. Be that as it may, Durban exhibits both primary poverty, (which the bulk of our previous analysis refers to,) and secondary poverty due to mismanagement, ignorance, etc. Taking both types of poverty together, we are on safe grounds in concluding that Durban exhibits a very serious problem of Bantu poverty (even when the possibility of under-reporting of income is taken into account).

1.6. THE SOLUTIONS FOR WIDESPREAD POVERTY :

As the problem of poverty in Durban, (and in other urban areas in South Africa) appears to be fundamentally the same as the problem which faced Europe half a century and more ago, it means that we in South Africa can expect to find the same solutions which Europe achieved working successfully here. This is contrary to what many South Africans think, for they tend to see our problems as unique. Thus, we must learn from European experience - we must see how they tackled the problem of poverty, and apply the same measures here. This also means that the Welfare Worker can take heart - for if Europe could largely solve the problem of poverty, then we have a good chance of doing likewise. The problem seems, as in Europe, to follow on industrialisation and urbanisation. The attack on the problem must be on several fronts - pressing for a "living wage"; working for better training and education of the poor - especially the children who represent the new generation; raising productivity; the propagandisation of birth control to reduce the strain on large families with low income;

and the creation of social conditions which will help to stabilise the family and prevent broken homes.^{1]} There is a need for health and nutritional campaigns, in order to combat the widespread ignorance, and the misuse of limited financial resources. There is scope for co-operative buying schemes, to insure cheaper food-stuffs and clothes for the poor. These and other possible approaches are all elements in the solution of the problem of poverty. In fact, as in Europe, it means that every attempt must be made to work for social and economic development amongst an illiterate under developed people. The problem is not one of case work, but community engineering on a large scale. While in South Africa there are complicating factors which Europe did not have to face (such as, for instance, the problem of job reservation, which Europe did not have in the legal sense), there is no reason to doubt that the solutions of poverty in Europe will likewise prove to be the solutions of poverty in South Africa. From the foregoing analysis it follows that preventative rather than palliative measures are needed - and that programmes should be directed towards striking at the roots of poverty, and not merely attempting to deal with the after-effects. Present efforts are largely palliative at a case-work, group work, and institutional level - we must switch more and more to community engineering and organisation, aimed at eradicating poverty and its associated evils.

Further tables relating to the socio-economic characteristics of the sample of households from Kwa Mashu will be

1. Migratory labour is a factor in South Africa which creates social problems, particularly in the realm of broken families. The broken fatherless home is a factor in poverty and infant ill health.

found in Appendix A. They are appended for the reader who wishes to study the topic in greater detail.

The analysis and description of the socio-economic level of the Bantu in Durban forms a backdrop to the health and welfare problems described in the following part of the report. On the basis of the figures presented in this Chapter, we can expect to find that the extent of health and welfare problems amongst Bantu in Durban are serious.

CHAPTER 2

A DESCRIPTION OF THE NUTRITIONAL
HEALTH OF PRE-SCHOOL BANTU
CHILDREN IN DURBAN.

N.K. LAMOND.

2.1. INTRODUCTION :

In the previous chapter, it was estimated that more or less seven-tenths of the Bantu families living in the Durban region are in poverty. Because particularly the larger families with more children tend to be poor, perhaps as many as nine-tenths of the Bantu children in the region grow up in poverty. Poverty means poor feeding and malnutrition. This, in turn, means ill-health. Medical experts know from long experience that it is particularly the younger children who suffer under these conditions. Consequently one of the key health problems involved is the malnutrition and resulting ill-health of Bantu children. The present chapter concentrates on this problem, and analyses the nutritional health of pre-school Bantu children in Durban.

Probably, if the average White South African was asked to describe his impression of the Bantu child, he would in good faith, draw a graphic picture of a fat little piccaninny becomingly swathed in a band of gaily coloured beads and wearing a charming smile that shows his perfect set of beautiful teeth. Indeed, such children are to be seen in the areas that serve as tourist attractions, and there are many such children to be found in the Reserves that border the highways leading to the picnic spots and Game Reserves that abound in our land. These children, however, represent the ideal type in the White conception of the Bantu. Reality is in many instances very different, and it is in order to present the whole rather than merely a part of the picture that this chapter has been written.

In a survey of the incidence of malnutrition among the lower age group of the Bantu population in the Metropolitan area

of Durban, one of the major difficulties met with is the limited amount of information available. This will become obvious as the analysis proceeds.

2.2. DEFINITION OF MALNUTRITION:

Malnutrition must not be confused with under-nutrition. Undernutrition in its extreme form is seen as starvation, where there is an insufficiency of all the essential nutrients. These are water, roughage, mineral salts, vitamins, carbohydrates, proteins and fats - the latter three of which yield the necessary calories to keep the body functioning smoothly. It is not often that the first two nutrients are lacking, but the other five essential foodstuffs may not be found in THEIR CORRECT PROPORTIONS in the daily intake, mostly in the absence of a well-balanced nutritious diet. This state of affairs is bad feeding, or malnutrition.

Malnutrition can thus be understood as one of two things: Henry VIII for instance, was vastly malnourished because he ate far too much of certain foodstuffs - in present day understanding he would undoubtedly be a candidate for such conditions as coronary thrombosis and/or hypertension. On the other hand, the Bantu children who are the age group for consideration in this project, are malnourished because they have an insufficient intake of certain of these nutrients, with particular deficiency in the groups protein, vitamins and certain mineral salts, e.g. iron.

The younger babies who suffer from the condition known as marasmus (which will be discussed later) do not obtain sufficient of the calorie-yielding foodstuffs mentioned above. Marasmus



therefore, is a state of undernutrition verging on starvation, rather than necessarily MALNUTRITION. Figures for marasmus will be provided in this chapter.

Malnutrition is made clinically manifest in degrees of increasing severity. Many of the toddlers would 'get by', (and do in fact do so) if they did not fall prey to other disabling conditions as for instance, infectious diseases, constitutional diseases, or injury. Although they are in the first stage of malnutrition, this condition is not made manifest unless further such physical traumata are superimposed. One of the leading surgeons in Durban stated quite categorically that much of the sepsis seen following injury among the Bantu WOULD NOT OCCUR if only their general dietetic state of health were in balance.

Certainly the severer states of malnutrition are more promptly amenable to clinical diagnosis, and in this category can be included such diseases as kwashiorkor, anaemia and vitamin deficiency.

2.3. ABSENCE OF ADEQUATE STATISTICS :

Malnutrition as such is not a notifiable disease. Furthermore, its presence in less severe states is difficult to diagnose. Consequently no figures are available for the incidence and severity of this health problem. We do not know how much of it occurs amongst pre-school Bantu children in Durban.

Some limited idea of the extent of malnutrition can be obtained by studying figures for Kwashiorkor - a notifiable serious protein deficiency - and also by examining data for the

incidence of diseases such as tuberculosis, which are known to be closely related to malnutrition. This is done in the following sections. The figures presented have serious shortcomings, as will be indicated. However, the data are the best available.

2.4. THE INCIDENCE OF KWASHIORKOR - A SEVERE FORM OF MALNUTRITION :

When Kwashiorkor, a protein deficiency disease, was made notifiable throughout South Africa in September, 1962, a step was taken to bring one aspect of malnutrition to the attention of the authorities. Kwashiorkor is, however, only one manifestation of the gross syndrome of malnutrition. In the Bantu child this protein deficiency occurs between the time when the baby is deprived of his mother's breast milk (often because he has been replaced by the imminent arrival of another sibling), and the time when he is either old enough to fend for himself at the family meal time, or is considered of sufficient importance as a family unit to be given a reasonable share of the food available to the members of the family group.

It is common practice for the mother to wean her baby as soon as she realises that she is pregnant. The foodstuffs that are then given the child are frequently incorrect, either in quantity or quality. If some form of cow's milk is used, it is often diluted to such a degree as to be too weak to prevent starvation. The mother, in order to save money in her state of poverty, is satisfied with the mixture in the bottle so long as it looks like milk. On the other hand, she may not be able to obtain

milk, or she may believe that milk is not a suitable feed for her baby, so she will resort to a thin gruel made from mealie meal. Mealie meal to the Bantu represents the most perfect of foods.

Thus this manifestation of malnutrition is observed in the age group extending from approximately two months to four years. In a survey conducted on 688 cases of Kwashiorkor at King Edward Hospital in 1964, ^{1]} it was found that -

- 20% of cases were in the age group 6 - 12 months;
- 55% of cases were in the age group 13 - 24 months, with the peak period being at 22 months;
- 87% of cases were under the age of 4 years;
- 96% of cases were under the age of 6 years.

Table V gives details of the number of Kwashiorkor in-patient cases admitted to the King Edward VIII Hospital in Durban during the period 1955 - 1964. Unfortunately the records did not separate Bantu and Indian children. The proportion of Bantu to Indian cases is about 40 to 1, meaning that on the average about 2½% of the cases were Bantu :-

1] Figures obtained from Paediatric Department of the Medical Faculty attached to the University of Natal, Durban.

TABLE V.

FIGURES FOR INDIAN AND BANTU KWASHIORKOR CASES ADMITTED AS IN-PATIENTS TO THE PAEDIATRIC UNIT AT KING EDWARD VIII HOSPITAL. DURBAN. : 1955 - 1964

YEAR ^{1]}	NO. OF KWASHIORKOR ADMISSIONS ^{2]}	TOTAL NO. OF ADMISSIONS ALL CAUSES	KWASHIORKOR CASES AS % OF TOTAL ADMISSIONS	NO. OF KWASHIORKOR DEATHS	DEATH RATE PER 1,000 KWASHIORKOR ADMISSIONS
1955	731	4,944	15%	392	536
1956	834	5,287	16%	429	514
1957	1,203	+5,847	21%	408	339
1959	1,102	5,451	20%	392	356
1960	1,230	+5,152	24%	397	323
1961	1,139	+4,218	27%	367	322
1962	1,153	+5,241	22%	357	310
1963	1,160	+5,524	21%	340	293
1964	1,498	+6,355	24%	429	286
TOTAL FOR 9 YEARS	10,050	+48,019	21%	3,511	349

1] No data for the 1958 year are available.

2] Details for the number of cases aggravated by complications are available only for 1961 and 1962 - 590 and 761 cases in the two years suffered complications. Out of these 313 and 326 died.

In interpreting these figures, the following facts must be borne in mind :-

As yet there is no uniformity in medical circles with regard to the assessment of Kwashiorkor. According to the Annual Report for 1964 of the Assistant Medical Officer of Health for 'Greater' Johannesburg, pages 26/27,

"as large numbers of patients report to clinics in the first instance, as these clinic medical officers are well schooled in the criteria and diagnosis of Kwashiorkor, and as our medical organisation conducts a more extensive domiciliary service than others, it was surprising to find in a sample of 1,921 local cases notified that 1,639 (85.32%) were notified by Baragwanath Hospital, 206 (10.72%) by private practitioners in the area and 51 (2.65%) by our medical services. Following a suggestion by Dr. Albert Sæbi when he visited these areas that the true position in these situations can only be found by large-scale studies of controlled population sampling, study groups have completed during the last few months of 1964 the detailed structure of a field survey to determine more accurately the prevalence of Kwashiorkor in Soweto. The project is scheduled for 1965. After a further recent appeal to Baragwanath Hospital to ensure that only true cases of Kwashiorkor be notified and other malnutritional states may be separately listed for the additional feeding and care by the Health Visitor Service of this department, which is given to notified cases of Kwashiorkor, and following awareness of the pending survey, there has been a drop in the notification of Kwashiorkor by the hospital."

Likewise, any figures purporting to represent the situation in the Metropolitan area of Durban must be suspect for the following reasons :-

a) When medical officers make an attempt to assess place of residence of the victims, an arbitrary period of time of residence of one month is fixed. Thus visitors to the area, if they have been visiting for longer than one month, are counted for notification purposes as being residents of that area. It was estimated by the City Health Department of the Durban Municipality that in a survey conducted over one month, some 50% of the cases accredited to their metropolitan area were, in fact, 'outsiders'.^{1]} In Johannesburg the picture reported by the Assistant Medical Officer of Health in 1964, is as follows:

"The standard of health and nutrition of infants attending the child health clinic is good among the permanent residents here, but as a large portion of the population is continually on the move, many cases of malnutrition do not come within the orbit of the clinic. Thus, if a cross-section of the child population of Pimville be taken, malnutrition of varying degrees would appear to be rife".

b) A Bantu, aware of such laws as the influx control, migration etc., in his anxiety to obtain assistance for the child, often gives an address in Durban as his residential address, although he is an illegal immigrant. On follow-up by the health visitors from the Municipal Health Department, no trace of the child can be found at the false address. This is yet another

1] Annual Report from Medical Officer of Health for Durban for year ending 31.12.63, page 34.

instance of the 'outside' case of Kwashiorkor being notified as though it originated in the metropolitan area of Durban.

c) It may be that the father of the child does live in one of the locations in Durban, but that the mother and child live in a far distant area of Natal. When the baby falls ill, the mother seeks her husband in order to gain his permission to take the baby to the hospital, and thus once again an 'outsider' is notified as being a Metropolitan Durban case. ^{1]}

From Table V it will be noted that Kwashiorkor appears to be on the increase. The figures quoted by the largest Bantu Hospital in Durban (i.e. King Edward VIII Hospital) are rising steadily. Yet when surveys are periodically undertaken, it is revealed that an increasing percentage of these cases are coming from the outlying districts. The actual numbers from Durban itself are in a steady decline. We accept the evidence of these surveys:

1] One might wonder why the mother who lives in far distant places risks the very life of the sick baby by travelling so many miles to seek the necessary permission from the father for hospital treatment. There are many Provincial and Mission Hospitals spread throughout the region that could administer just as efficient care. The reason for this apparent waste of time and money is to be found in the section of the community who are still traditionalist in their outlook. The men with this cultural background prefer to keep their wives and children away from the 'polluting' influence of the town. Nevertheless they still control from a distance every decision that affects the family welfare. Hence the wife of a traditionalist is not in the legal or moral position to do what she thinks fit for her child. In the present time, it is not possible to even surmise how many children are made more ill or even lose their lives as a result of this delay in obtaining medical aid. (Information regarding the keeping of the wives at home obtained from Mrs. H. Sibisi, a Social Anthropologist at the Institute for Social Research, University of Natal.)

and conclude the rise shown in Table V is the result of more cases migrating in to Durban from other areas for treatment. The improvement is due probably both to improved housing conditions and municipal welfare centres at Kwa Mashu, and to improved hospital services which lead to better dietary and medical care and less cross infection of the already sick children. The increased percentage of in-patient Kwashiorkor cases when compared with the total admission case load may be due to the fact that once the condition was declared to be a notifiable one in September, 1962, the diagnosis was more readily applied. This fact too might account for the downward trend in the death rate of cases admitted, as the diagnosis would have been made more readily and earlier in the manifestation of the syndrome.

It must be stressed, however, that for every ONE child admitted, it is estimated conservatively by the paediatricians of the hospital that THIRTY children were treated as outpatients in the late 1950's. Once the condition became notifiable the proportion was possibly not so heavily weighted. For instance, in 1963 a total of 2,288 were notified from King Edward VIII Hospital, of which 1,160 were admitted for in-patient treatment. Also it could be postulated that with the improvement in preventive feeding schemes brought about by voluntary organisations and transmitted through such services as the Municipal Welfare Clinics, Durban Bantu Child Welfare Creches, Kupugani, Our Daily Bread, Cato Manor Welfare Huts, Non-European Play Groups and others, the condition in the urban areas - i.e. Metropolitan Durban - is indeed becoming arrested. This improvement is comparable to the probable state of affairs in Johannesburg.

Before we can readily accept such a pleasing finding,

however, it behoves us to observe the distribution of residence of the cases notified to the Durban Medical Officer of Health by King Edward VIII Hospital ONLY, in 1963 and 1964. See Table VI below.

TABLE VI.
AREA DISTRIBUTION OF ALL KWASHIORKOR CASES
NOTIFIED BY KING EDWARD VIII HOSPITAL IN
1963 AND 1964.

AREA	YEAR	
	1963	1964
DURBAN :	634	407
<u>OUTSIDE DURBAN :</u>		
Umbumbulu	472	531
Ndwedwe	209	234
Umzinto	113	130
Verulam	115	112
Pinetown	141	119
Camperdown	69	57
Mapumulo	70	79
Ixopo	42	50
Clermont	63	33
Eshowe	27	35
Inanda	30	35
Richmond	20	29
Harding	12	25
Port Shepstone	23	15
New Hanover	19	18
Nklandla	-	13
Stanger	25	17
Mtunzini	10	10
Kranskop	11	10
Bizana	18	10
Greytown	10	8
Umlazi	31	3
Msinga	10	-
Other Areas outside Durban	114	113
TOTAL FOR AREAS OUTSIDE DURBAN	1654	1686
GRAND TOTAL	2288	2093

Thus it will be appreciated that with all the extension of services available at the present time, the excellent work being done in the municipal area is, to a certain extent, relieving the most pressing stressful situation among the children. However, the state of malnutrition as it is made manifest by kwashiorkor in the Metropolitan area of Durban, or in the rural areas of Natal where the greater proportion of the Bantu population is located, is still a major problem.

There are hospitals and clinics in many of the areas listed in Table VI, and each institution has the same sorry tale to tell about its own population. It is indeed a reflection on the state of health of the Bantu population that the scourge of malnutrition is so rife that so many hospital beds, so far away from the place of residence of the patients are being filled, often because the beds closer to home are already occupied. It must be remembered though, that as already explained, many 'outsiders' do voluntarily make their way to the King Edward VIII hospital.

It is to be expected that as kwashiorkor becomes less prevalent, the remaining clinical manifestations of malnutrition will also decline. Protein yielding foods contain most of the other elements needed for a state of balanced nutrition. Protein is found in the most expensive foods, but as the population becomes more diet conscious, the other elements necessary in smaller quantities will be automatically provided. Kwashiorkor is easily preventable, given correct feeding.

2.5. OTHER DISEASES ASSOCIATED WITH MALNUTRITION.

Malnutrition is not only manifested as a protein deficiency (kwashiorkor). In the younger age group, where for many various reasons there is an insufficient supply of breast milk,

the smaller infant fails to thrive, and this more generalised result of poor feeding is made manifest in the condition known as marasmus. Here the age group affected is that of 0 - 12 months, and as this condition is not notifiable to the Public Health Authorities, we have no means of obtaining any more than impressionistic information with regard to its incidence. Once the condition of marasmus has reached a certain stage of severity, it appears that a point-of-no-return is reached. Despite every care, the child fails to respond and the reasons for this failure is not understood. Research is continuing into this problem.

As is already well-known, a child who has not received an adequate, well balanced diet in his early formative years, is far more likely to fall victim to other diseases that are concomitant with a poor economic background. Such a disease as tuberculosis is accepted by all authorities as being such an indicator. Because this is a notifiable disease, it is possible to gain a comparatively true picture of its incidence in the area under survey. On the other hand, such conditions as anaemia and vitamin deficiency diseases, most particularly pellegra, are endemic, but not reported on, as they are not notifiable condition. Lastly, such conditions as seasonal diarrhoea, (which assumes epidemic proportions in the hot summer months when flies and other vectors abound), are further facets of this sorry overall picture of malnutrition that do not warrant official notification to the Public Health Authorities. Yet it is an empirical fact that conditions caused by pathogenic micro-organisms such as gastro enteritis, bacilliary dysentery and tuberculosis, would not take such a ruthless annual toll of babies and young children if their nutritional state of health was at par. Tables VII to XI provide data for the number of inpatient paediatric cases admitted to King Edward VIII Hospital for diseases closely associated with

malnutrition. The figures are not complete as for certain years statistics are not available. However, the tables provide an indication of the position.

TABLE VII.

FIGURES FOR INDIAN & BANTU INPATIENTS IN
THE PAEDIATRIC UNIT, KING EDWARD VIII HOSPITAL
DURBAN, SUFFERING FROM MARASMUS. 1955-1964.

YEAR ^{1]}	NO. OF MARASMUS ADMISSIONS ^{2]}	CASES AS % OF ALL PAEDIATRIC ADMISSIONS ^{3]}	NO. OF DEATHS FROM MARASMUS	DEATH RATE PER 1000 MARASMUS ADMISSIONS
1955	283	6%	189	667
1956	175	3%	90	514
1957	668	11%	290	434
1959	530	10%	257	484
1960	540	11%	223	413
1961	478	11%	173	361
1962	636	12%	208	327
1963	1041	19%	342	329
1964	1914	30%	567	296
TOTAL FOR NINE YEARS	6265	13%	2339	373

1] No data for the year 1958 are available.

2] Details for the number of cases suffering complications are available only for 1960 (398 cases) and 1961 (571 cases). A total of 169 and 204 of these cases, respectively, died.

3] Percentaged to the base shown in Table V.

TABLE VIII

FIGURES FOR INDIAN & BANTU IN-PATIENTS, SUFFERING FROM TUBERCULOSIS, IN THE PAEDIATRIC UNIT, KING EDWARD VIII HOSPITAL, DURBAN, 1957 - 1962.^{1]}

YEAR	NO. OF TUBERCULOSIS ADMISSIONS 2]	CASES AS % OF ALL PAEDIATRIC ADMISSIONS	NO. OF DEATHS FROM TUBERCULOSIS 3]	DEATH RATE PER 1000 TUBERCULOSIS ADMISSIONS
1957	310	5%	?	?
1959	204	4%	?	?
1960	349	7%	?	?
1961	342	8%	73	213
1962	341	7%	70	205
TOTAL FOR FIVE YEARS	1546	6%	?	?

- 1] The data are only for the period 1957 - 1962, as figures for the other years are not available. Figures for the year 1958 are not available.
2. Details for cases suffering from complications could be obtained only for 1961 and 1962. In those years, 160 and 179 of the cases suffered from other complications, and 65 and 66, respectively, died.
- 3] Deaths were listed only for 1961 and 1962 in the available statistics.

TABLE IX

FIGURES FOR INDIAN AND BANTU IN-PATIENTS SUFFERING FROM VITAMIN DEFICIENCY DISEASES, IN THE PAEDIATRIC UNIT, KING EDWARD VIII HOSPITAL, DURBAN, 1961 - 1964^{1]}.

YEAR	NO. AND TYPE OF CASES SUFFERING FROM VITAMIN DEFICIENCIES				CASES AS % OF ALL PAEDIATRIC ADMISSIONS ^{2]}	NO. OF DEATHS	DEATH RATE PER 1,000 CASES ADMITTED
	RICKETS	PELLA-GRA	SCURVY	TOTAL			
1961	28	9	4	41	10%	5	122
1962	20	4	1	25	5%	4	160
1963	?	?	?	41	7%	5	122
1964	?	?	?	66	10%	7	106
TOTAL OVER FOUR YEARS	?	?	?	173	8%	21	121

- 1] Data were available only for 1961 to 1964, with no details for the type of deficiency in 1963 and 1964.
- 2] Percentaged to the base shown in Table V.

TABLE X

FIGURES FOR INDIAN AND BANTU IN-PATIENTS SUFFERING FROM BACILLARY DYSENTRY, IN THE PAEDIATRIC UNIT, KING EDWARD VIII HOSPITAL, DURBAN, 1961-1962 1].

YEAR	NO. AND TYPE OF BACILLARY DYSENTRY CASES			CASES AS % OF ALL PAEDIATRIC ADMISSIONS 2]	NO. OF DEATHS 3]	DEATH RATE PER 1,000 CASES
	UNCOMPLICATED	COMPLICATED	TOTAL			
1961	64	207	271	6%	87	321
1962	166	496	662	13%	169	255
TOTAL OVER TWO YEARS	230	703	933	10%	256	274

1] Data were available only for 1961 and 1962.

2] Percentaged to the base shown in Table V.

3] Of these deaths, 76 in 1961 and 142 in 1962 were from cases who suffered complications.

NOTE: In a communication to the author, Professor H. Pollak has suggested that the clearance of the Cato Manor slum, and the moving of the population to housing schemes with piped water and improved public sanitation has probably reduced the incidence of bacillary dysentery. More recent figures than the above are not available from King Edward VIII Hospital.

TABLE XI.

FIGURES FOR INDIAN AND BANTU IN-PATIENTS SUFFERING FROM GASTRO-ENTERITIS, IN THE PAEDIATRIC UNIT, KING EDWARD VIII HOSPITAL, DURBAN; 1961 - 1962 ^{1]}.

YEAR	NO. AND TYPE OF GASTRO-ENTERITIS CASES			CASES AS % OF ALL PAEDIATRIC ADMISSIONS ^{2]}	NO. OF DEATHS ^{3]}	DEATH RATE PER 1,000 CASES ADMITTED
	UNCOMPLICATED	COMPLICATED	TOTAL			
1961	629	211	840	20%	358	426
1962	866	421	1287	25%	484	376
TOTAL OVER TWO YEARS	1495	632	2127	22%	842	396

1] Data were available only for 1961 and 1962.

2] Percentaged to the base shown in Table V.

3] Of these deaths, 29 in 1961 and 74 in 1962 were from cases who had suffered complications.

It must be stressed that these tables do not separate Indian from Bantu cases. Unfortunately the official records do not provide such a breakdown. The bulk of the cases were Bantu, but the proportion is reported to have varied from 40 : 1 Bantu to Indian kwashiorkor cases, to 16 : 1 for tuberculosis cases. The actual numbers of Bantu cases are unknown, but in each instance the Bantu cases predominate.

When examining these tables it must be remembered that they refer only to hospitalised cases, i.e. the most serious cases, where the mother sought medical aid, and where hospitalisation was considered necessary. Consequently they do not reflect the actual incidence of these diseases in the pre-school population of Bantu children, in Durban. The data thus provide under-estimates of the incidence of these diseases associated with malnutrition.

As Kwashiorkor and Tuberculosis are the only diseases among those attributable to malnutrition that are notifiable to the local Medical Officer of Health by the medical profession, comparatively accurate records of their incidence are maintained at the hospitals and clinics where these cases were first seen. Thereafter, the correct treatment can be administered, and in many instances, these cases are followed up, and the disease process arrested.

If, however, the children are not brought to these institutions there is no record of the morbidity rate caused by these conditions available for the Bantu child population. Furthermore, no information apart from the mortality rate of the other deficiency diseases is available to the Medical Officer of Health. He has no knowledge of the incidence of these conditions in the population, and this may well be high, when one considers the

poverty line below which a large proportion of the Bantu population exist.

Numerous babies are brought into the hospitals. However, no reliable data are available as to the number of children who, although decidedly below par, never arrive at a hospital, nor for those children who were not sufficiently ill to be treated other than as out-patients. Bearing all these comments in mind, and also remembering that as with kwashiorkor, the figures are probably inflated by cases brought into Durban from outside, the tables nevertheless show a considerable amount of disease and deaths amongst Bantu children, which are directly or indirectly attributable to malnutrition.

Apart from the diseases discussed, it is also accepted by the medical fraternity that severe malnutrition in early childhood has a long-term aftermath in adulthood. The incidence of primary carcinoma of the liver is thought to be higher in the Bantu individual who was submitted to a period of kwashiorkor leading to liver involvement in his younger years.^{1]} Thus, malnutrition affects in this and other ways, to an unknown extent, the health of the older sections of the Bantu population in Durban. While the most noticeable effects occur amongst the pre-school child, health problems associated with malnutrition also affect the older child and adults too, often on a long-term basis. Statistics are not available.

Finally, a further comment on Tuberculosis is not out

1] Opinion expressed in a lecture by Dr. Gilman, Professor of Physiology at the University of Natal, to "Diploma of Nursing" students at the Medical School, 1956.

of place. Much research is being done into the condition of tuberculosis, its prevention, and its cure. Much public money is spent annually on the various measures undertaken to deal with this particular disease. At the King Edward VIII Hospital where many thousands of babies are born each year, each one is inoculated with the B.C.G. Vaccine. It has been found, however, that this Vaccine is only effective if the nutritional state of the child is reasonably adequately maintained.

The majority of the Mission Hospitals in Natal are able to continue their existence on the funds they receive from the Central Government for the tuberculosic patients that receive care in their wards and clinics. Naturally this is not their only source of income, but it does figure largely in the annual budgeting of their finances.

The Department of Bantu Affairs makes special provision for maintenance grants and food parcels for the sufferers from tuberculosis. The Department of Labour and the Municipal Chest Clinics work hand-in-hand in their efforts to locate, diagnose and refer for treatment all the persons seeking work who have this disease.

From these examples^{1]} it will be seen that much money time and man-power is tied up in the various aspects of the management of tuberculosis. Yet this condition is a comparative rarity among the White population where such factors as good nutrition, reasonable personal and community hygiene, and on the whole adequate socio-economic conditions, prevail. It is a tragedy that innocent young Non-white children are placed in a potentially harmful environment through no fault of their own, particularly

1. These examples are intended to be briefly illustrative of the scope of the problem. They do not represent a full record of the work involved with reference mainly to children.

when the excuse of ignorance of the harmful factors can no longer be the plea on the part of the authorities.

2.6. AN HISTORICAL REVIEW OF THE BANTU POPULATION IN NATAL:

As a background to the current health problems amongst Bantu in Durban, an understanding of the culture of the Bantu, and the historical development of the present problems, is of importance for this study. This section sketches the position.

Historically the Bantu people of Natal, almost entirely belonging to the Zulu nation, were a patriarchial, pastoral folk with a strong traditional cult of ancestor worship. As it affects the understanding of the present problem, stress must be laid on the importance of certain factors and the relative unimportance of others. Owing to the strength of belief in ancestor worship, it was necessary to produce many offspring so that the head of each family would be able to ensure the continuance of this traditional religion. Thus children for the sake of continuity of lineage were important. Similarly, the wealth of the nation was bound up in the number of cattle rather than in their condition, because more cattle meant more wealth, more bartering power, more prestige and more status. Because the areas of Natal were vast and highly fertile, and all the land belonged to the chief, there was little need for care and conservation, nor was there any special pride of personal ownership and individual thought for protection of the soil ^{1]}.

1] G.J. Krige (1955): The Social System of the Zulus: Shuter and Shooter, Pietermaritzburg, 2nd Edition, pp.166-7.

There was plenty of food available in the good years for the entire population, and very little thought was given to the future. It is often felt by the unenlightened that the lack of provision for the future or anxiety with regard to future problems, is a "bad" characteristic of Zulu culture. It is not realised that in the Zulu way of life there was no known way to preserve grain against the attack of rodents and other pests, and if one looked after one's neighbours in their times of need, this form of social insurance would protect one in one's own time of misfortune. The male in Zulu culture was paramount, and the head of the family made all the important decisions - his word in all respects was law.

Thus when the Zulu culture became penetrated by the industrialised culture of modern society, many inevitable anomalies resulted.

The males moved into the towns in large numbers as migratory labourers, thus depriving the families of their advice and counsel. The women in the rural areas remained the more simple, subservient types; often visiting their husbands in the townships only in order to conceive and have their babies, and then returning to the homelands so as to remain uncontaminated from urban influences; and yet not in the position to make their own decisions with regard to crops or cattle care.

Meanwhile the men, thus separated from their homes, shed the immediate responsibilities of fatherhood and families, and many sought solace in the shebeens and brothels of the town. The break-up in family care, and in the controlled family planning of tribal times, assisted by the prolonged periods of

lactation, caused further change in responsibility for child rearing. Many children, born legitimately or otherwise, being the victims of such changing circumstances, became the burden of the state or voluntary organisations, instead of the pride of the Zulu traditional extended family.

This social change, brought about by a system of migrant labour, is not peculiar to the Zulu or even to the Bantu. Stycos and Back report a similar finding in their study on the control of human fertility in Jamaica. They write: "Certainly much of what looks like irresponsibility is a product of such economic circumstances as the migratory labour force, high rates of underemployment and seasonal employment, and bare subsistence levels of income rather than some innate or historically based tendency toward promiscuity or virility-validating behaviour."^{1]}

With the increase of education in the upper echelons of Bantu society in the Metropolitan area, another sociological trend was being made manifest. Doctors, lawyers, teachers, ministers, clerks, nurses, etc. incorporated much of the 'good' of western culture. As they settled down to nuclear families - no longer the extended family of previous times - in their own homes in the earlier townships, they exerted a stabilising influence throughout these areas. They assisted markedly in the growth of a new way of life that is moulded to present circumstances, resulting in the production of smaller families with healthy children who should be the useful citizens of the future.

1] J. Mayone Stycos and Kurt W. Back (1964): The Control of Human Fertility in Jamaica : Cornell University Press, Ithica New York. p.280.

On the other hand, it was inevitable that with the break-up in the traditional way of life of the Zulu and the development of an urban population of the less fortunate in the socio-economic sense, (i.e. the labourer class), malnutrition would be found among the children of this stratum.

In the Bantu schools in Natal this fact was treated by the Provincial Authorities in a two-pronged method. The pupils were provided with a daily meal containing basically essential food-stuffs in sufficient amount. It was recognised that very often this was almost the only dietary intake of the child in twenty four hours. The second method of attack was the visit by the school health visitor, who referred the deficiency diseases to the proper authorities for treatment. At the commencement of each term it was observed by these qualified people how the minor ailments of septic sores, rashes, discharging ears etc., would be rampant following the long holidays; but how, as the children's nutritional state improved, these other ailments were not so prevalent. However, in 1955, when the Central Government took over the Bantu education from the Provincial Governments, the Bantu people were called upon to make an agonising decision. The monies that were to be spent on education were pegged in proportion to the revenues received from the Native Poll Tax. The Bantu people were asked to decide whether they would rather continue with school feeding schemes, or spend the money that could be saved by the discontinuation of feeding schemes on additional buildings and improvements to existing facilities.

They almost universally decided in favour of extending school facilities. The valuable school feeding schemes then fell away. Various interested associations made every effort to get voluntary feeding schemes under way, and to encourage the schools to grow their own crops for consumption on the premises. Apathy and

general disinterest did not help to get many of these schemes established on a more permanent basis.

During all these years of break-up in the traditional way of life, it was becomingly increasingly obvious that not only the school children were in a parlous state of nutritional health, but that the pre-school children were even worse off. The people brought their younger children in ever-increasing numbers to the hospitals and clinics. Malnutrition amongst pre-school children emerged as a serious health problem in Durban. The figures given in the preceding sections of this chapter give a very conservative estimate of the position that has developed.

2.7. THE PRESENT SIZE OF THE BANTU POPULATION IN THE DURBAN METROPOLITAN AREA :

The estimated number of pre-school Bantu children aged 0 - 4 years, in the Durban Metropolitan region are as follows :^{1]}

<u>YEAR</u>	<u>MALE</u>	<u>FEMALE</u>	<u>TOTAL</u>
1960	11,500	12,200	23,700
1965	22,200	21,400	43,600

Thus at the present time there are more or less 43,600 pre-school Bantu children in the Durban region to be protected from all the manifestations of malnutrition. By 1970 the figure will rise to about 45,800 children.^{2]}

For further details consult the first report on this project, written by Margaret Young.^{3]}

1] Young, M.A. (1965) : op. cit., pp. 81 - 82.

2] Ibid.

3] Ibid.

2.8. THE HEALTH AND WELFARE SERVICES AVAILABLE IN DURBAN TO FIGHT MALNUTRITION :

The services available are adequate at a basic level, provided use is made of them. The greater the public demand for these services, the further will be the increase in their scope. These services are as follows:

(i) Ante-Natal Clinics :

The Ante-Natal Clinics for Bantu are held at King Edward VIII Hospital; the Polyclinic at Kwa Mashu; and more recently at Umlazi; and at McCord Zulu Hospital.

The figures for attendance at the Clinic at King Edward VIII Hospital for the period 1962 - 1965 are shown in Table XII:

TABLE XII.
ATTENDANCES AT THE ANTE-NATAL CLINIC AT KING EDWARD VIII HOSPITAL. 1962 - 1965.

MONTH	NEW CASES AND TOTAL NUMBER OF CASES. BY YEAR							
	1962		1963		1964		1965	
	NEW CASES	TOTAL CASES	NEW CASES	TOTAL CASES	NEW CASES	TOTAL CASES	NEW CASES	TOTAL CASES
January	?	1,288	1,011	1,639	1,158	2,026	1,017	2,030
February	?	1,450	975	1,623	1,051	2,015	936	1,905
March	?	1,605	928	1,680	1,018	2,039	1,124	2,257
April	?	1,196	854	1,630	1,011	1,929	747	1,607
May	?	1,469	905	1,629	1,015	2,026	822	1,811
June	?	1,486	895	1,516	976	2,004	893	1,883
July	?	1,615	1,134	1,931	1,002	2,055	759	1,930
August	?	1,618	1,128	2,045	959	1,760	1,105	2,307
September	?	1,675	1,106	3,005	1,105	2,246	1,048	1,989
October	?	1,761	1,266	1,524	1,049	1,964	956	2,292
November	818	1,433	1,193	2,225	1,062	1,866	1,051	2,308
December	862	1,084	985	1,897	903	1,899	1,087	1,941

Examining the table, it is interesting to note the following:

The steady increase in numbers over the years has now appeared to reach a plateau. The reason for this is that as Kwa Mashu Polyclinic and the Umlazi Centre have started operations, the women do not have to travel the long distances to King Edward Hospital. Overall, the ante-natal attendances among the Bantu of the Metropolitan area are still increasing steadily, as the newer clinics play an increasingly important part.

The cost to each woman visiting the clinic is uniform - 40 cents for the first visit, made up to R1-00 for all ante-natal visits, and finally totalled to R3-00 for the entire confinement, (irrespective of number of visits to the ante-natal clinic, and the nature of the actual confinement, or length of stay thereafter in the hospital.) Eighty percent of these women pay the R3-00. The remaining 20% are assessed on their means by Bantu clerks in the hospital, and nobody is turned away on the score of indigency. Thus it is disappointing that the difference between the "total" and the "new" column is so very slight. It is well recognised that in order for these long-term aims of ante-natal care that affect the rearing of the baby to be effective, observations, treatment and advice must be available throughout the entire ante-natal period. It would appear from these figures that the number of 'return' visits being paid by each woman is too small to be practically effective. This in itself is probably a contributory factor to ill health among Bantu children in Durban.

As cost of transport may be a deterring agent, it is interesting to compare the 'return' visit rate of King Edward Hospital with that of Kwa Mashu Polyclinic, where the clinic is more readily accessible to the clients:-

TABLE XIII

ATTENDANCES AT THE ANTE-NATAL CLINIC AT KWA MASHU
POLYCLINIC, FROM 1964 - AUGUST 1966

MONTH	1964		1965		1966	
	NEW	TOTAL	NEW	TOTAL	NEW	TOTAL
January	341	984	411	977	427	1,727
February	345	1,011	485	1,264	376	1,469
March	370	918	497	1,325	447	1,760
April	315	873	378	924	360	1,181
May	336	829	388	971	415	1,549
June	322	815	427	1,092	443	1,581
July	354	811	422	1,255	417	1,400
August	375	837	456	1,450	537	2,064
September	393	934	448	1,418	---	---
October	367	903	371	1,173	---	---
November	353	797	373	1,354	---	---
December	335	791	372	1,419	---	---

It will be noted that at the Kwa Mashu Polyclinic, the real purpose of the ante-clinic seems to be much more readily achieved. There is a big difference between the 'new' cases and the total monthly attendances, showing that return visits are being made in increasing numbers. The latest figures for 1966 are particularly gratifying. The marked increase for the August work may well be an indication that at least this aspect of preventive medicine is being more readily accepted by the Bantu woman when it is rendered accessible to her. This is a useful hint for future recommendations. Instead of the tendency for the powers-that-be to condemn the 'lesser' folk as 'acceptors of

hand-outs' it might be more fruitful to work on the assumption that these folk are only too willing to be helped, once they understand the need for such help, and it is made more easily available.

A further examination of Table XII for King Edward Hospital shows that the highest attendance figures tend to be around the August - October period of the year. As most babies are born in this period, this means that the increase in attendance at ante-natal clinics is as a result of women turning to the clinic once their pregnancy draws near to its termination. At least this tendency has the advantage of giving the midwives and doctors a chance to detect and correct, or make allowances for, conditions that might affect the labour and immediate safety of mother and baby. As 80% of mothers who deliver at King Edward VIII Hospital have attended the ante-natal clinic at least for one visit, this factor is seen to be of great practical importance.

Nevertheless, in both 1964 and 1965 there were only 118 clinic sessions conducted for this vast number of attendances at the Hospital's clinic. Thus, at each session over 200 women were attended. With the limitations of time, space, and medical and nursing staff, it is suspected that only the bare essentials of ante-natal care can be carried out under such conditions. Therefore it is suggested that little education is in fact undertaken specifically by the Clinic for the prevention of malnutrition.

Altogether, it is felt that of all the thousands of Indian and Bantu babies born (18,306 in 1964 and 19,355 in 1965 at King Edward VIII Hospital), only a small proportion of them started life having had a necessary amount of preventive care in their foetal existence.

(ii) Child Health Clinics :

Child Health Clinics are held in all the Durban township under the auspices of the Durban City Health Department^{1]}. According to the Medical Officer of Health, in 1963 and 1964 attendances at the Durban Municipal Bantu Child Health Clinics were as shown in Table XIV.

TABLE XIV.

DETAILS OF ATTENDANCES AT THE DURBAN MUNICIPAL
BANTU CHILD HEALTH CLINICS.

TYPE OF CASE ATTENDING THE CLINIC	NO. OF ATTENDANCES	
	1963	1964
Infants	75,588	73,529
Toddlers and Pre-School Children	91,235	97,877
Nursing Mothers	67,099	65,835
TOTAL	233,922	237,241

During these visits in 1963, 35,607 mothers were instructed in treatment of minor ailments; 2,864 children were referred to the clinic doctor; and 10,354 health talks and demonstrations were given. In 1964, the numbers were 31,425 mothers instructed in the treatment of minor ailments; 3,206 children were referred to the clinic doctor; and 9,593 health talks and demonstrations were given.

1. Umlazi Township does not fall under the Durban Corporation - as a Bantu Administration Department Township it is catered for by the State Health Department. See page 66 below.

In many instances, however, it seems to have been 'forgotten' by the Bantu people that it was traditional for there to be an adequate 'spacing' of children if not a limitation in actual numbers, so that each mother had a time interval in which to rear her youngest child beyond the dangerous 22 month period, before a further sibling was born.

Also, in the past when the Zulu belonged to a rural tribe, there was extremely strict control of the nubile maidens until their wedding day, so that the present high rate of illegitimacy is a recent phenomenon. Males were trained in "birth control" during initiation ceremonies at puberty.^{1]} Thus almost all the children born were adequately cared for in the extended family structure. Nowadays many of the babies who are the victims of malnutrition do not have this secure background, and if the illegitimacy rate where children are thus deprived is to be controlled, it would appear that some practical scheme on Birth Control is essential.

Although the organizers of such a scheme find that the more enlightened Bantu accept the services offered by the Family Planning Clinics, they also find that there is some resistance to its use throughout the Bantu community. They find, firstly, that many men resist such a scheme for two very real reasons. If they cannot "father" a child sufficiently frequently, they become the laughing stock of their fellows for lack of manhood. Secondly, they sincerely believe that if their wives are thus protected from pregnancy by such means as "the pill" or "the loop", they will become promiscuous and no longer confer their favours on their

1] Krige, E.J. (1955) op. cit., p.93.

husband alone. Thirdly, the majority of women who should be the advocates of such a scheme owing to their understanding - particularly the midwives who themselves attend the clinic regularly - refuse to educate their patients, because they state "If not so many babies are born, we will be put out of work!" They have no breadth of vision beyond the four walls of the hospital to see that this eventuality is hardly likely to come to pass.

At the moment there are seven Family Planning Clinics operating in the Durban Metropolitan area, and in the wider area of Natal there is a clinic attached to almost every provincial hospital and many mission hospitals and clinics.

It is found by the clinic workers that it is necessary for the womenfolk to accept the responsibility of carrying out the instructions for family planning, as the menfolk are tending to lose their sense of duty in this matter, and are no longer so interested in the welfare of their children. Yet a field worker in anthropological research points out that this belief is in conflict with the 'image' of the strength of the man in controlling his family's affairs ^{1]}, and so a paradox exists.

It is estimated by the local organizer of this clinic work that in Durban 20% of the women attending the clinics in 1958 were Bantu - whereas now the proportion has reached 25%, and is steadily increasing. Approximate figures for Natal are 300 in 1958 (of whom 60 were Bantu); 7,000 in 1963; 28,600 in 1964; and 60,000 in 1965 (of whom 3,000 were Bantu). Even if this substantial increase is due to factors directly related to standard of

1] Comment made by Mrs. H. Sibisi, of the Institute for Social Research.

education and socio-economic class, so that it is those who can afford the service who are accepting it, it should nevertheless be viewed as a most encouraging adoption of an entirely new pattern of social organization.

(iv) Home Visits :

These visits are conducted by trained Bantu Health Visitors under the control of trained White supervisors in all the townships in Durban. This is done under the auspices of the Municipal Health Department. Their purpose is to visit all the mothers of neonates on return home from hospital, or soon after the termination of the services of the domiciliary midwife. Thereafter visits are made to the homes of babies who need mid-week checks between clinic attendances, and also periodic visits are made to non-clinic mothers. All the 'city' cases of notified kwashiorkor are also visited. Each visitor has her own area that she covers with unheralded 'spot' visits. She keeps her eyes open, and is on the lookout for any apparently non-thriving child. She also gives many informal talks on hygiene, food preparation, immunisation, budgeting, and other aspects of health education.

During 1963 a total of 10,403 such visits were paid to Bantu homes. In 1964, the number rose to 11,451.

(v) Nutritional Education :

(a) Municipal Health Education :

A team of male Bantu health educators under the control of White supervision, under the auspices of the Municipal Health Department, makes every effort to improve, among other factors, the Bantu

dietary habits. The biggest field in education is found to be among Bantu male factory workers interviewed at Municipal eating houses. Such methods as seminars, films, models, van and/or loudhailer groups are employed. In 1963, 1,033 such sessions were held, whereas in 1964, the numbers rose to 1,999 on nutrition and 4,186 sessions on tuberculosis.

"Not only is the importance of the wisest adult dietary habits stressed, but models to demonstrate kwashiorkor are also used chiefly to teach Bantu fathers the cause of this disease which attacks their infants and for which the slaughtering of a goat to appease their ancestors is frequently regarded as remedial. This is also an occasion to appeal to fathers to use their traditional authority over their wives in regard to feeding their children correctly." 1]

Bantu scholars and school teachers have been visited for many years by this Municipal health education team, and it is confidently believed that

"the very young mothers, including those of illegitimate children, are keenly aware of the need of adequate diet for children, and that they saw that the child health clinics are the answer to many of their problems. This results perhaps from years of steady teaching in schools where both kwashiorkor and nutrition models have been used for the young mothers of today who were the seniors in yesteryear school programmes." 2]

1] This quotation is taken from the Annual Report for the year ending December, 1963, by the Durban Municipal Medical Officer of Health.

2] Ibid.

In 1963, 96 demonstrations were given to 6,657 senior Bantu scholars.

The townships, hostels, compounds and shacks are also visited by this team on a loudhailer and loudspeaker van basis. In all in 1963, 2,406 such sessions were undertaken. In 1964, a wider appeal was made through the medium of Radio Bantu.

(b) Welfare Organizations Engaged In Nutritional Education :

Voluntary organisations are also notable for their efforts in the Durban region to promote health education from a nutritional aspect.

Kupugani, which is a registered welfare organization, provides basic essential nutritious food at cost to all under-privileged members of the South African population. It employs a team of three Bantu female educators, who visit the various townships. They stress the importance of a balanced diet which is within the reach of most of even the indigent pockets. Their approach is somewhat different from those of the Municipal health educators. They do not have the authoritative backing of a recognised organization, as have the Municipal health educators. Moreover, they go 'armed' with the basic foodstuffs, and act as selling agents with the ready availability of the material for which they are canvassing. Because they are felt to be more 'one of the people', they find that their best approach is through the formal and informal primary groups that abound in all communities. For formal contact they approach the school principals, the ministers of religion, and the Bantu Advisory Committees, the women's guilds, etc. Having obtained the 'ear' of the accepted leaders, they then

seek out the informal leaders of the face-to-face groups in the townships, and gain their support. For instance, a mother whose family has thrived on a product sold by Kupugani, which she has found cheap and reliable, is far more likely to spread the good news among her friends and neighbours. The educators work at odd hours - e.g. on Sundays, or in the evenings when they can get the family together as a whole entity, and expound the values in nutrition and economy of their products.

The Durban Bantu Child Welfare Society has one health educator who visits all foster mothers, creches, and cases referred by home workers.

(c) Provincial Health Personnel Give Informal Nutritional Education

The Provincial Authorities have no formal education programme as such. It is clearly understood, however, by all the medical and nursing personnel of the hospital teams that as much private on-the-spot tuition as possible is to be given in the ward, out-patients departments and clinics, on all matters relative to nutritional health.

(d) Other Sources of Nutritional Education:

There are health educators attached to the Maize, Dairy, and Egg Boards. They give lectures/demonstrations on all aspects of these products.

Private enterprise also deserves mention. Leading concerns such as "Dunlop's", "Hind Bros.", and "Putco", are some of the concerns that realise the importance of an adequate coverage of all aspects of health to their workers. They often go further than lecture/demonstrations, by encouraging such activities as schemes for subsidised meals and co-operative buying.

(vi) Health Services in the Umlazi Township^{1]}:

The previous figures refer to the Bantu townships served by the Durban Corporation. However, while the Umlazi township is de facto one of Durban's Bantu townships, it falls under the jurisdiction of the State's Bantu Administration Department^{2]}. The health services are provided by the State Health Department.

Umlazi is the only urban area run by the State Health Department. It has about 12,000 houses, and 75,000 people are registered as living there. The main emphasis of the work of the State Health Department amongst the people is on community health, with the aim of obtaining the active participation of the community in health promotion.

At the present time, an extensive campaign of health education is being carried out. One of the prime aims is to change, if possible, the basic concepts of the people as regards the cause of disease, and remove the idea that one human being can cause another to deteriorate physically through the use of evil power.

Two clinics are run by the State Health Department. The staff concerned have undergone a course in health education at the King George V Hospital (T.B. Hospital), under the direction of Dr. Molly Walker, who is a Health Education Officer for the Department, and also for S.A.N.T.A. From time to time two of Dr. Walker's staff of health educators are also used in Umlazi to assist with the health education campaign there.

It is notable that an effort is being made through the clinics to educate every patient about his disease, and the State Health Officer sees this as important as the cure of the patient -

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1. This section was provided by Miss L. Geils.
 2. The City Health Department has one "Mother and Baby Clinic" in Umlazi which cares for and advises mothers and checks babies' health, and provides immunisations.

because often a patient will not complete a course of treatment through ignorance, and thus become a dangerous reservoir of infection.

(a) The Work of the Clinics:

The main work being done by the clinics is the fighting of infectious diseases. A regular part of the routine work is child care. Their programme involves immunisation and the treatment and prevention of malnutrition. (The main deficiency diseases encountered are pellagra and kwashiorkor). The children are immunised against diphtheria, whooping cough, tetanus, poliomyelitis and smallpox. As each new family moves into the township, it is visited, and the mother is given a card and told to bring her children to the clinic for examination and care.

The nutrition of the children is supervised, and they are supplied with skimmed milk powder at 5 cents per pound. This is limited to those children who have malnutrition, and those with tuberculosis in the family. If a family is really destitute they are given the milk free of charge.

The most prevalent infectious disease, if adults are included, is tuberculosis. During the course of 1966, over 500 new tuberculosis cases were registered in the area. While our terms of reference limit us to the children, the fact of the matter is that illness amongst adults in a household certainly affects the children, especially when it is the male breadwinner who is affected. This point is taken up again later in the welfare chapter (Chapter 3).

(b) Health Education in Umlazi:

Health education is directed at key people in the community, of which the teaching profession forms a large part. (They are obviously very important, as they have the coming generation in their hands, and can play a part in moulding their thinking). Other key people who are given health education are priests, ministers, school board members, school committees, businessmen, all officials, policemen, and even clerks and 'inyangas' (medicine men in the tribal tradition).

Health education is partly through patients, who come for treatment. Each patient has an individual interview on admission and on discharge. There is one hospital (a mission hospital) in the area. Group discussions are held with the patients while they are in the hospital. This education ultimately should filter back into the homes, and have a bearing on the health of the children too.

Group discussions are held amongst key people in the community, and lectures are given with pathological specimens, microscopic slides, films and X-rays to demonstrate the points being made.

Two large scale health campaigns have been held in 1966.

One was a campaign against diptheria and tetanus at all of the schools in the township. A definite attempt was made to educate people as regards diptheria. A total of 11,000 children were inoculated against these two diseases. All school boards were also sent circulars, and the campaign was circularised throughout Umlazi. The team which visited the schools was accompanied by two health educators, and every classroom of children was visited. From our point of view it is important

to note that all children were requested to talk about immunisation at home, so that all pre-school children could be brought either to the school on the day of the immunisation, or to the clinic. Attendance at the clinic trebled as a result. Many children brought younger brothers and sisters with them to school to be inoculated.

The second health campaign concerned tuberculosis. Starting with a meeting of teachers, each classroom was then visited by health educators, and the children given talks. They were also given the Heaf test. Out of 11,000 children, no less than 4,000 were found to be positive. These cases were given pills for a year, to be administered by the school staff. The teachers will enter all the results on immunisation cards - despite the extra work involved, they are most eager to cooperate. All the children who reacted positively to the Heaf test were given a letter asking all contacts in the household to come for X-rays, B.C.G. vaccine, etc.

It is planned that the above type of campaign, working through community resources, will become an annual event.

2.9 THE SOURCES OF FOOD SUPPLY FOR BANTU PRE-SCHOOL CHILDREN AND THEIR FAMILIES:

In the townships, owing to such factors as inadequate fencing, freely roving fowls, the high frequency of both working adult males and females, the cost of a metered water supply, apathy through laziness, lassitude due to adult malnutrition (often manifested as pellagra), and ignorance, there is often little concerted effort to develop adequate vegetable gardens around each dwelling. Most inhabitants have to rely on purchase^{1]} or donation to provide food to prevent malnutrition in the toddler age group. Some - but not enough - homes have good vegetable gardens.

The following are the main sources of food:

(i) Bantu-Owned Grocery and Greengrocer Shops and Restaurants:

As each of these shops is privately owned, usually by an individual, the capital available is limited. Thus the prices charged in these shops is slightly higher for each commodity than it would be in the central shopping area in the larger stores in Durban. Also the vast majority of Bantu workers are paid on a daily basis for casual labour (for instance, a washerwoman), or a weekly basis, (as say, a building labourer). This means that at no one time does the average family have sufficient money to be able to budget adequately. Consequently they are usually unable to buy the basic staple foods in bulk, and suffer the increased costs caused by small frequent buying of items such as beans, samp, mealie meal, tea, sugar etc. This further helps to put up the cost of their living, and so reduce the quality of the diet purchased.

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1. There are no markets for fresh produce in the townships, which contributes to the cost for the Bantu when buying fruit and vegetables.

It is suggested that the Bantu-owned shops have a two-fold influence on the community. The shopowner is frequently more considerate of hardships, and might allow a family credit to purchase essential foodstuffs for some time during a period of destitution, which the larger stores in town would not do. On the other hand, it is suggested that a regrettable trait found in many shopkeepers is the manner in which he attaches unnecessarily high prices to the commodities, specially when these are bought in small amounts, thus gaining considerably as a result of the inability of the average Bantu family to buy in bulk. Furthermore, the rate of interest charged for credit is believed to be extortionately high.

(ii) Kupugani.

This welfare organization not only has a shop in central Durban, but also sells essential foodstuffs at cost in the townships by means of the visiting health educators armed with their wares.

When there is a glut of a certain fruit or vegetable on the city market, Kupugani agents buy up the surplus at a very reduced price, and then take this for quick re-sale at cost to the different townships.

In 1965, Kupugani started an industrial feeding kitchen. This supplies 1,700 mid-day nutritious meals at 10 cents per meal. The cost is subsidised by 95% of the employers of the firms concerned, who pay 50% of the cost incurred. The remaining cost is deducted from the labourer's pay packet. Although this scheme has little direct bearing on the problem under review, it is deserving of mention for the following reasons:

There is a definite rest time made available for the labourers for their mid-day meal. This results in an improved level of productivity due to the physical rest, improved state of health, and feeling of well-being of the workers. The food that the labourer does not consume himself is frequently taken home to increase the family food intake. As the man of the house is not hungry, there is thus more food available for the children.

Owing to the success of the scheme, two plans for expansion are under consideration, - one to the schools, and another in plastic containers for widespread delivery. Both these schemes will directly benefit the children of the toddler age group.

(iii) Milk-Feeding Schemes:

(a) Dried Skimmed Powdered Milk.

Dried skimmed milk powder is available from child health clinics in Durban. The Central Government pays one third, the Durban Municipality another third, and the final third of the cost of the milk is reclaimed from mothers who attend the child health clinics. The total cost of the scheme was R6,000 per annum in May 1962. This increased to R12,000 per annum in October 1962, and R24,000 per annum in May 1963. The state subsidy amounted, respectively, to R2,000, R4,000, and R8,000 in these three years.

The amount chargeable to mothers for powdered milk is not always reclaimed from the mothers, as approximately 11% are treated as welfare cases. This milk is distributed at the Municipal child health clinics, and it has the following effects :-

Only mothers who attend the clinics regularly are entitled to buy or obtain this milk. Thus both regularity and number of attendances to the clinics have increased.

The incidence of deaths from gastro-enteritis, as well as Kwashiorkor, in clinic-attending babies is showing a marked decrease.

The incidence of malnutrition in general among the clinic babies is also showing a steady decrease.

More babies are thus presented for immunisation programmes, and this should reduce the incidence of certain infectious diseases.

As the babies are kept healthier, the B.C.G. vaccine is more likely to prove effective, either in preventing, or minimising, an attack of tuberculosis. B.C.G. vaccine is ineffective in limiting this scourge if the child is in a state of advanced malnutrition.

Babies are referred to doctors or to other clinics for minor ailments, or more serious disorders, earlier in the course of the disease, so that the whole state of health of the child is more closely attended.

Mothers are given more talks and lectures on all aspects of health education. Thus preventive and promotive medicine is on the increase.

Mothers too, can be observed for signs of malnutrition

especially pellagra, and referred for effective treatment, before their depleted state of health cause them to neglect their children even further.

(b) Dried Powdered Milk:

Either full cream or skimmed powdered milk is available at a cost of 16 cents per lb. for skimmed milk from Kupugani. Full cream is 28.5 cents per lb. to all residents of the townships.

The Malnutrition Relief Fund obtains whole cream powdered milk in bulk (either Klim or Nespray). This is then distributed at the wholesale cost price to the individual Bantu purchaser, through the clinics of the City Health Department, and Feed the Babies Fund. The price works out at 34 cents per lb.

Thus, the dried powdered milk schemes are intended to allow Bantu to purchase milk (in a dried form) at reduced prices in view of their poverty.

(c) Fresh Milk Scheme:

The Malnutrition Relief Fund raises and administers funds for the provision of fresh whole milk to Bantu children, in order to provide some form of supplementary feeding. The money for this work is obtained from the Native Revenue Account of the Durban Corporation. In 1964 the Municipality granted an expenditure of R25,000-00 and voluntary organisations participating in the scheme contributed an equal amount of R25,000-00 per annum, so that a total of R50,000-00 was raised and spent on milk for Bantu children. The milk is purchased in bulk, and consumed "on-the-spot" at various centres in the townships. Schools, creches, and committees supervise the distribution of this milk, so that no unnecessary wastage is allowed. Only a small amount of the cost of the scheme is recovered from the Bantu families themselves.

A total of 8,095 gallons of milk monthly is supplied, (of this 1,204 gallons are 'maas' - i.e. thick sour milk). According to the Durban Corporation's Bantu Administration Department, this milk is made up of 1,456 gallons to Chesterville; 3,487 gallons to Kwa Mashu; 1,630 gallons of fresh milk, and 1,204 gallons of maas to Lamontville; and 206 gallons of milk to Umlazi Glebelands. (These totals leave 112 gallons apparently unaccounted for, which may be taken up by in practice slightly larger figures for each area than those quoted above).

Examining the milk amounts quoted above, and extracting the amounts given to pre-school children either through the creches, or the play groups or nursery schools, 5,055 gallons a month of the 'sweet' milk, and 5,147 gallons of all the fresh milk are given to pre-school children. This represents 74% of the total amount of fresh sweet milk distributed, and 64% of all fresh milk (including 'maas'). The amounts vary according to the township, depending on the actual schemes being run by voluntary organisations and schools. The figures are as follows, with percentages of the total amount of milk for each township being distributed to pre-school children shown in brackets:

Kwa Mashu	3,477 gallons (99.7%)
Chesterville	551 gallons (38%)
Lamontville	822 gallons sweet milk (50%) 92 gallons maas (7½%) (32% of all milk in area)
Umlazi Glebelands	206 gallons (100%)

Fuller details, including a comparison with the position at the end of 1959, is given in Appendix B.

No fresh milk is at present being distributed in the Umlazi township, which is under the Central State Health Department.

(iv) Creches, Nursery Schools and Play Groups:

An important element in helping to prevent malnutrition amongst the large numbers of poverty-stricken Bantu families in the Durban region is the feeding received by those children who attend either nursery schools, pre-school play groups, or creches. School feeding is also most important in this regard, but of course concerns the school-going child, who is not really our concern in this chapter. (Chapter 3, and Appendix B provide some information on school feeding in the Durban region).

The following list indicates Bantu nursery schools, play groups and creches in the Durban region, all of which to a greater or lesser extent feed the children attending them. The organisation responsible for each institution is shown in brackets after each name, using the following abbreviations:

- D.B.C.W. = Durban Bantu Child Welfare Society;
- D. Coll. = Durban Girls' College Old Girls' League
Nursery Schools;
- U.J.W. = Union of Jewish Women;
- I.R.R. = (South African) Institute of Race Relations
(Women's group of the Durban Branch);
- D.O.C.P. = Durban Organisation for the Care of Pre-
School African Children;
- C.N.S.A. = Chesterville Nursery School Association
(Bantu run);
- B.C.W.O. = Bantu Community Welfare Organisation;
- O.B. = An Organisation developed by the Bantu.

Where the number of children catered for was established, the number is shown in parenthesis.

CRECHES. PLAY GROUPS AND NURSERY SCHOOLS FOR PRE-SCHOOL
BANTU CHILDREN IN DURBAN AND ITS IMMEDIATE REGION.

CRECHES	PLAYGROUPS	NURSERY SCHOOLS
<p><u>KWA MASHU TOWNSHIP:</u></p> <p>1. Inkulisa (D.B.C.W.)* 2. Thembelihle (D.B.C.W.)* 3. Tokozane (D.B.C.W.)* 4. Thandakuhle (D.B.C.W.)* * [402 in all; average is + 100 each]</p> <p>[Plus one to be opened in January 1967] (D.B.C.W.)</p>	<p>[One to be started in 1967 by D.B.C.W.)</p>	<p>1. Ekujabuleni Nursery School (D.Coll) [120] 2. Ekuthuleni Nursery School (U.J.W.) [80]</p>
<p><u>NEWLANDS:</u></p> <p>1. One (by I.R.R.) [+ 80]</p>	<p>1. One by [D.O.C.P.] [80]</p>	
<p><u>LAMONTVILLE TOWNSHIP:</u></p> <p>1. Creche (D.O.C.P.) [50]</p>	<p>1. Mtshali's "Nursery School" (OB) [134] 2. Gijima Hut Play Group (D.O.C.P.) [58] 3. Lamontville Community Centre Play Group (D.O.C.P.) [70] 4. Thembelihle Play Group (D.O.C.P.) [72] 5. Place of Care runs a Play Group [130] 6. Bantu Infant's Home Play Group (D.B.C.W.) [+ 130]</p>	<p>1. Enkuliso Bantu Nursery School (D.Coll) [120]</p>

(Continued)

CRECHES	PLAY GROUPS	NURSERY SCHOOLS
<u>CHESTERVILLE TOWNSHIP:</u> 1. A.H. Zulu Creche (D.B.C.W.) [74]		1. Nabontwana Nursery School (C.N.S.A.) [70 - 100] 2. St. Barnabas Nursery School (C.N.S.A.) [110] 3. Good Hope Nursery School (B.C.W.O.) [60] 4. Zamakuhle Nursery School (B.C.W.O.) [121]
<u>UMLAZI GLEBE:</u> 1. Sizanina (D.B.C.W.) [71]	1. Umlazi/Glebeland Pre- School Play Group (D.O.C.P.) [78]	
<u>UMLAZI GOVERNMENT TOWNSHIP:</u> 1. Inkanyiso (B.C.W.O.) [50]	1. Mother Hubbard Christian Crusade (O.B.) [35-40] 2. Umlazi Government Village Play Group (D.O.C.P.) [50]	1. Sheshafike Nursery School (O.B.) [35-40]

The total number of children catered for by the above organisations is between 2,280 - 2,320. This compares with our estimate of about 52,000 pre-school Bantu children aged six years and under in the region. This means that only a very small fraction of the pre-school children, most of whom we have shown to be in poverty, are catered for, and receive some form of feeding from these organisations. While the voluntary organisations are doing a most important work, the scale of the problem is clearly much too large for voluntary organisations alone to cope.

The details of the feeding provided, and the charge to the parents, vary widely from one organisation to another. It is not our aim to describe the details of each and every organisation. The Durban Bantu Child Welfare Society is one of the largest and most important of the agencies dealing with child welfare in Durban. While it is not a health organisation, its work does have a considerable importance for the health of children who come under its care in one way or another. It runs most of the Bantu creches in Durban (see above). A detailed description of its creches and the Bantu Infants' Residential Home run at Lamontville will provide a good idea of the type of provision made for the children.

Under the auspices of the Durban Bantu Child Welfare Society, six creches are run in the various townships. The properties concerned belong to the Municipality. Altogether these six creches have a total of approximately 500 daily attendances from Mondays to Fridays, with the exclusion of Christmas Day and Good Friday. They are open from 7 a.m. to 5 p.m.

The monthly fee is R1-00 for the first child, 75 cents for the second, and 65 cents for the third child from a family. Children of working mothers, from the age of eight months (provided they are weaned and can take food by spoon), to those who are ready for school, are admitted. Each child receives care, attention, immunisation (by City Health Visitors), extra vitamins and a well balanced daily diet. In many instances they are given three meals a day.

The children are divided into three categories and cared for accordingly:

Infants from 8 months till \pm 18 months;

Toddlers from 18 months till $2\frac{1}{2}$ years;

Pre-school children from $2\frac{1}{2}$ years to 5 years.

The upper age limit in previous years was 6 years, and now that more places are available in the Bantu Primary Schools, the children are tending to leave the care of the creches at an earlier age. This is of great benefit, because the waiting list can be shortened more rapidly, and more children who otherwise would not have received this care, are taken into the creches.

The improvement in the general health of these children, once they receive a regular diet, is remarkable. Weekly checks are kept on the weight of the infants. The older children have their weights recorded at monthly intervals. By the time of the second weighing of all new admissions, a marked increase is almost always noted.

During the school holidays it is observed that the daily attendance rates always decrease. There are three reasons for

this: Firstly, if the older children are at home, some parents prefer not to pay the money to the creche, but leave the younger children to the tender mercies of their older siblings.

Secondly, the parents who do continue to pay the monthly fee, leave it to the older children to transport their younger siblings to the creche. In the parents' absence this is not always done. The third reason is that in the December/January school holidays more than at any other period of the year, the fathers, as labourers, tend to have their annual vacation, and there is a mass exodus of families to the rural areas. Thus it is noted that following the school holidays there is always a marked deterioration in the general nutritional state of these creche children. Once a good, well-balanced diet has been restored, the minor ailments diminish in number, and the weights of the children soon pick up.

The Bantu Infants' Residential Home at Lamontville is run under the auspices of the Durban Bantu Child Welfare Society. The building belongs to Durban Municipality. The home is registered for 72 occupants. However, due to the pressure of the need there are seldom less than 80 - 90 children resident in this establishment.

Children are placed in this home by Court Order, or brought as abandoned by such authorities as the South African Police, or are received from single parents - e.g. a widower - who pay privately for their maintenance.

In this home, likewise, a most marked improvement is noted in a very short space of time, in the children's nutritional state.

Most of the play groups organised for Bantu children in

the Durban region are under the auspices of the Durban Organisation for the Care of Pre-school African Children. Some information on the feeding provisions will give an idea of how the play groups help to maintain the health of the children. All the play groups under the Organisation total 543 children at the present time. Children from the ages of three to six to six-and-a-half years are accepted. The hours of operation are from 7 a.m. until 1 p.m. Thus the groups operate on a half-day basis. The numbers in each group are severely limited by the accommodation (which tends to vary in standard according to the building which could be obtained for the use of the group concerned). There are waiting lists for all groups. Parents pay a monthly sum of 40 or 50 cents (it varies from group to group). In really necessitous cases fees are reduced or waived.

The object of the play group programme is to ensure feeding of the children, and also the inculcation of habits of cleanliness and hygiene, child training, group play, and free play and co-operation. There is a close liaison with the clinics, and the children are visited from time to time by trained clinic staff for immunisation etc.

In the Lamontville groups, the feeding is undertaken by the Lamontville School Feeding Scheme. Each child gets one third of a pint of fresh milk per day, brown bread spread with some peanut butter, or some other spread. A hot midday meal is cooked at the Lamontville Community Centre, and distributed in large containers by a Durban Corporation vehicle. The menu may be samp and gravy one day, a thick soup another, a porridge a third, and once a week there is a stew. In the other groups, the cooking has to be done by the individual play groups themselves.

(v) Supplementary Feeding Schemes:

When one is dealing with a very poor population, such as the Bantu in the Durban region, then supplementary feeding, especially with high protein content foods, often makes all the difference between a child being reasonably healthy, or sick. Some of the forms of supplementary feeding organised in the region have already been described above under the milk feeding schemes (see Sections (a) and (b) of (iii) above). In addition to these schemes, there are other forms of supplementary feeding. "Feed the Babies", for instance, provides Pronutro as a supplement for children requiring it. Once a week at Newlands about 12 ounces are handed out to each child on the books. Similar work is undertaken once a week at Lamontville.

Fuller information is provided in the next chapter, which deals with social welfare aspects of Bantu children in the Durban region.

(vi) Foster Care:

The Bantu Child Welfare Society has a limited list of reputable foster mothers who reside in the various townships of the immediate Durban area. Each foster mother is allowed to care for not more than 6 babies, and the Child Welfare pays her R5-00 per month for each charge. In turn, the real mother of the baby pays the Child Welfare R5-00 per month. The Bantu Child Welfare Society has a case worker, whose duties include supervising the adequate care of each baby thus placed.

This supervisory and financial arrangement works very well indeed, because the foster mother is assured of immediate payment, and the baby is assured of adequate care. Meanwhile the real mother is relieved of her anxiety regarding her baby's welfare in her absence. The case worker maintains contact with both mothers. In addition the employer of the child's real mother has the regular

services of her employee, thus ensuring the best possible benefit to all parties concerned in cases where the home is broken.

(vii) Unauthorised Organisations:

It is known by the Child Welfare Authorities that in the Lamontville and Umlazi areas certain Bantu people have set up institutions similar to the daily creches. These are, however, regarded as "illegal" in that they have not been registered with the Authorities as required under the provisions of the Children's Act No. 33 of 1960. The matter is receiving attention, and registration will bring in its wake higher standards of care for the children. It will, however, cause an extra load to fall on the Municipal Health workers who are responsible for the inspection of these institutions.

These "illegal" organisations are far below the required standard regarding hygiene and necessary facilities, and in many cases will have to be closed down by the Authorities. Consequently it is feared that as more of these illegal concerns are found, there will come a time when the children of working mothers will be deprived of even this minimal supervision and care. By implication, it is probable that there are many pre-school children who are left in extremely unhappy physical, mental and social straits by the absence of any responsible adult control.

It would appear, therefore, that there is room for much expansion in creches, both as regards facilities and their supervisory care.

2.10 FINANCIAL ASPECTS OF THE PROBLEM OF MALNUTRITION:

Chapter 1 has described the socio-economic conditions of Bantu families in Durban. Several further aspects of the problem must be considered.

(i) Salaries and Emoluments:

As already mentioned, the majority of Bantu in Durban

are paid on a weekly basis (often calculated on a daily basis), or are actually paid daily. It is only the upper echelons of the white collar classes in employment as nurses, teachers, doctors, clerks etc., who have the security both of a regular monthly salary and an eventual pension.

Two problems immediately arise: Firstly, in many homes seldom is there a sufficiently large sum of money immediately available to do much planned budgeting, nor is it possible to do any monthly bulk buying (at a cheaper rate) of storable commodities for family feeding and cleanliness. The poor pay for their poverty by buying small quantities at prices that are consequently higher.

Investigations have been made to see whether any figures regarding an acceptable level of "saving" can be established. It was believed that in a non-welfare state such as South Africa it would follow that, as a sine qua non, people would have some goal as their aim for monthly saving. Yet despite extensive enquiry, it has not been possible to arrive at an estimate of the percentage of income that would satisfy this "saving" need. In fact, the breakdown of expenditure for the representative income of a South African Bantu family makes no provision for saving^{1]}.

This then, is the problem for the South African who

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1. See G.R. Feldman-Laschin (1964): Income and Expenditure Patterns of Urban Bantu Households : Cape Town Survey : Bureau of Market Research, University of South Africa, Research Report No. 8 : p.47, Table XXIX.

earns a sufficient income in order to have a surplus to save - what amount should be saved to meet the family's needs? In a survey conducted by the Department of Economics of the University of Natal among the Bantu people of Natal, it was found that this problem does not really exist for the Bantu - the Bantu does not appear to earn as much as he spends! 1]

Likewise, it has been shown that when one lives beneath the Poverty Datum Line, there are other more urgent calls to be met with one's income than saving, and even food intake has to be reduced to meet other important needs. 2]

All in all, it will be understood that often there is little possibility of saving for a "rainy day" on even a reasonable scale taking place. Savings would be seen in terms of cents rather than rand, and would be considered hardly worthwhile among many Zulu. In fact, a particularly common method of "saving" that is practised throughout the area is that of the "stokfel". In this system a group of wage earners band together and each contributes a fixed amount of money weekly. Each week, the entire proceeds of the "kitty" is donated to one

1] Unpublished report on a survey conducted in Durban Bantu Townships by the Department of Economics of the University of Natal. (op. cit.).

2] It has been suggested by Batson that a family needs an income $1\frac{1}{2}$ times the Poverty Datum Line before they are able to spend on food the minimum laid down by the Line. This is because they have to purchase articles other than those specified by the Line - e.g. medicine, doctor's bills, education, replacement of kitchenware and furniture, tobacco, sweets, etc. etc. Thus a family with an income equal to one below the Poverty Datum Line in practice cannot afford the minimum diet prescribed. See Young, M.A. (1965) : op. cit., p. 67.

member of the group, and with the weekly rotation, this "capital" is given to each member of the group in turn. Unfortunately, when this larger amount is regarded as a prize rather than an investment, it is disposed of lightheartedly without due regard for essential requirements. Where, however, it is valued as an investment, it often makes the initial down-payment on a comparatively expensive article to be bought under a hire purchase scheme.

The more cautious members of the society do invest their usually small savings in the Post Office, Building Society or Burial Insurance^{1]}.

(ii) Grants from the Bantu Welfare Department of the Central Government:

There are various grants described in this section, all of which either directly or indirectly assist in providing a source of income to prevent malnutrition among toddlers. Most of the grants are inadequate when seen in the perspective of the present day cost of living. For instance, a maintenance grant, irrespective of the family's size or state of fatherlessness, amounts to R10-50 per month as a maximum. Any earnings at all - for instance on the part of the mother - are deducted from this R10-50. ("earnings" for this purpose include not only money, but also the value of such items as food, clothing and transport, earned as payment in kind). Such a grant is seldom provided for a mother who has only one child. There is thus very little incentive for her to stay at home with her baby and breast feed it for at least the first 6 - 8 months of life, thereby preventing such conditions as marasmus and gastro-enteritis, let alone the kwashiorkor of the slightly older age group. Even a

1. See Natal Regional Survey: Report No. 6 (1959):
Baumanville: a Study of an Urban African Community:
Oxford University Press, Cape Town, pp. 50-1.

disability grant paid to an incapacitated father (where the mother is forced to go to work) is counted as family earnings and deducted from the maximum R10.50.

The grant paid for a foster baby amounts to R4.25 per month. This is inadequate, and so it is difficult to obtain conscientious, suitable foster mothers.

Both the above grants are reviewed annually. Other grants are also available. In an emergency, whilst the Bantu Affairs Commissioner is investigating the case to check whether the mother's legal guardian, living in an area other than Metropolitan Durban, will accept responsibility for the dependents, the issue of a food parcel containing very basic essentials is made once every two weeks. This 'poor relief' is grossly inadequate, particularly in its nutritional composition, and furthermore, its bulk is constant, irrespective of the size of the family eking an existence on it.

(iii) Effects of Inadequate Emoluments :

(a) Hire Purchase :

As the vast majority of the Bantu community live a hand-to-mouth existence, without much possibility of long term planning, many individuals fall too easy prey to the iniquities of the hire-purchase routine. To justify the bitterness of this statement, it is necessary to quote instances.

It is not altogether a rare occurrence to find a beautiful expensive radiogram installed in a home that possesses

no electricity, and where no money is available for provision of the necessary battery. More commonly, a matched lounge suite will occupy pride of place in the living room. Meanwhile, the children are frequently ill-clad, and if not actually hungry, are certainly under-nourished, as a penalty for complying with social "oneupmanship".

No big stores are permitted by law to establish trade in the townships, but it is extremely disheartening to social workers and such people who deal with the practical aspects of hardships to observe how their charges are influenced by large screens advertising Singer Sewing Machines and alcoholic beverages. Much re-thinking is needed by responsible people to curb the penetration of material values into basic philosophical ideology.

It is realised, however, that rehousing from a shack to a house does entail a greater financial outlay in reasonable furniture and equipment, and this is a serious drain on many a family's income.

(b) Unsatisfactory Budgeting :

According to health educators, although many husbands and fathers are anxious to ensure some sort of food supply for their children, and to this end, leave money with their wives, much of this money is deflected into clothing and other articles that the wives desire. In their guilt, the wives hide this from their husbands. On the other hand, due to the traditional background of a patriachial society, the head of the house in many cases satisfies his own food and beverage needs first, then those

of his wife, his school-going children, and finally only allows the leavings to go to the babies, toddlers and old aged folk dependent on him. This state of affairs is not always as selfi as it may appear. Although in some cases it may in fact be due to lack of thought for the helpless, it must be remembered that most of these men belong to the labourer class. If they do not maintain a reasonable state of physical strength, they will soon be laid off work, and then the whole family would have little or no income at all.

Due to transport difficulties experienced, particularly the long distances and overcrowding of vehicles, most township dwellers do not practice the advantage of "group clubbing together" and buying in bulk on the city markets or in the bigger stores where the commodities are cheaper.

Money is also spent in other ways not directly related to the family's welfare. For instance, the dry-cleaning trade has a most lucrative business in the housing areas, because the man of the house must be turned out smartly. This may assist him in obtaining work, and the facilities in the houses for washing and ironing clothing are a little antiquated. Nevertheless, it causes the Welfare Officers of the Municipal Bantu Administration Department much frustration to see valuable money spent thus unnecessarily.

School books and school uniforms are an essential cost to urban Bantu. The children are not admitted to school unless they are wearing the regulation uniform. In the more senior standards they are sent home if they do not buy the books that are required of them. Unlike the Whites for whom schooling

can be entirely free up to Standard Ten, the Bantu parents have a hard struggle financially to educate their offspring.

As there are no schools up to Matriculation level in Durban, the child who is worthy of education beyond Standard Eight, must be sent away to boarding school, at yet further cost to his parents.

All in all, by the time the family has included all the items of expenditure in the budget - if indeed, there seems to be any incentive to attempt a budget - it will be seen that food takes the place as a residual item. It often gives way to tobacco or alcohol, that at least have the advantage of blunting the physical pangs of hunger and the mental anguish of hopeless failure.

This finding is contrary to that of Irving who reports that "Families in primary need have minimum consumer's choice; the basic necessities must be purchased in strict priority of biological need. Food comes first." 1]

Yet reconciliation between these two opposing views is probably the crucial point of the whole problem of malnutrition. Food as a filling, hunger-relieving measure may indeed be bought, and so the people do not actually starve. The correct food, however, is beyond the pockets of the majority of this group of the population when it is "estimated that about 4/5ths of the households in the Bantu townships in the region fall below the secondary Poverty Datum Line." 2]

1] Irving, J. (1961): "The Provision of Primary Human Needs", in The Report of the Family Congress: Pretoria 4 - 7 April 1961 : Published by the Steering Committee of the Family Year and Family Congress, Pretoria : p.84.

2] See p. 15 above.

The population as a whole, therefore, is in most cases malnourished according to the definition used earlier in this chapter. Malnutrition is more evident in the younger children for the numerous reasons already mentioned. The foods that contain the essential nutrients in the proportions correct for human consumption are those that are more expensive, as milk, meat, dairy produce and fish. Needing to buy as cheaply as possible, and without refrigeration, the inevitable result of malnutrition follows. There is no doubt an extensive problem of malnutrition poses the largest health problem affecting the Bantu in Durban.

2.11. SOCIOLOGICAL FACTORS ASSOCIATED WITH THE PROBLEM OF MALNUTRITION.

(i) Socio-economic Structure of the Townships :

Of recent years a growing interest has been shown in sociological circles in the 'typical' Bantu who lives in township. Many studies have been undertaken in order to gain some knowledge in this sphere. The different pre-literate tribes have been observed, to see the impact that a Westernized industrial type of culture has made on the more traditional way of life. Mayer, for instance, wrote on the interaction or lack of it, between the illiterate pagan Xhosa and the more White-aculturated citizens of the same tribe. ^{1]} de Ridder has done a thematic apperception test study of the various tribes that make up the polyglot of the Bantu Urban population of greater Johannesburg. ^{2]} These and

1] Mayer, P. (1961): Townsmen and Tribesmen : Oxford University Press, Cape Town.

2] de Ridder, J.C. (1961) : The Personality of the Urban African in South Africa : Routledge and Kegan Paul, London.

other writers such as Wilson, Pauw and Longmore report findings from their scientific deliberations similar to those of the Welfare Officers who work in the townships belonging to Durban.

Durban's Welfare Officers, both White and Bantu, are of the opinion that the peoples of the townships at the present time can be divided into three broad categories. They are :-

(a) The more educated upper echelon that has accepted much of the Westernized industrial way of life. These people are those who, among other things, attend the health clinics regularly; make every effort to include the proper foods in their diet; keep a fair level of personal and environmental cleanliness in their homes; and cultivate their gardens. Thus they have absorbed the precepts of healthy living and act upon these ideals to the best of their ability.

(b) The labouring working class, that still has much of its way of life based in the traditional Zulu culture. These people, although resident in families in the townships, tend to migrate back and forth to the rural areas. As mentioned previously, they suffer not only physical deterioration, but also much psychological stress as a result of being the "in-betweens" - not quite secure in their knowledge of a state of permanence in either rural or urban life. Sociologically they are marginal to both ways of life, a true part of neither.

(c) The migrant and casual visitor, officially housed apart in the hostels for single men. Only families are housed permanently in the townships of the Durban Metropolitan area. Yet it is common knowledge, and well documented in such official

reports as those of the Municipal Medical Officer of Health, and the paediatricians of King Edward Hospital, that up to 30% of the children who are notified as kwashiorkor cases of the municipal area, do in fact belong to the rural areas. These children usually are brought to Durban because their fathers are here, as temporary migrants. So it is that these men - temporary residents, who are almost entirely rural in background and cultural belief - must be accepted as an important and quite sizeable category in the township population. The length of stay of such men in this category is not known, but their presence in Durban does bring severe malnutrition cases into the city.

Therefore, it will be seen that many facets are made manifest in a complicated society. Each of these aspects has a direct influence on the state of health of the whole community, let alone more specifically on the toddler age group under discussion.

(ii) Pattern of Parental Responsibility :

In the majority of cases, in the upper echelon where the nuclear family structure is more prevalent, both the father and mother accept that it is their responsibility to provide for all their children in the best way possible.

Thus they make the best use of all the health facilities available, with the result that these children are seldom those that are included in the figures for any of the manifestations of malnutrition.

In the other social classes, the approach to parental

responsibility has already been discussed - e.g. so many of the mothers are sent with their babies to the country, so as to prevent contamination of the womenfolk with urban Westernised ideas. The mother makes decisions only up to a point, and then in a crisis has to travel in to see the father.

Four other points are deserving of discussion:-

(a) Illegitimacy:

In this survey, several aspects of this problem must be mentioned.

Where legally the baby may have been born out of wedlock, he still has every reasonable chance of survival if his parents are living together. It was the policy of Durban that houses were rented to couples who maintain a stable union^{1]}. Many illegal unions are long lasting, and a "family" pattern of life is securely established. It is only where this union is terminated that hardship would be caused by this illegitimacy.

The babies who suffer so seriously are those that are born to the young girls - (many of whom according to the authorities are originally raped and then continue on the "downward path") - and to the women who consort in a loose relationship with the men. These are largely the victims of the migrant labour policy, which separates a man from his family. A field worker in Social Anthropology made a significant point. Among the Zulu people marriage is still a most desirable institution. All these unmarried mothers therefore aim to achieve this status. To this end they have to make the effort to make themselves gay,

1. Today the Durban Corporation requires proof of marriage before renting a house to a Bantu couple.

attractive and 'modern'. The money needed for this 'gilding of the lily' is spent at the expense of supplying adequate food for the baby^{1]}. One gains a greater understanding of the ambivalent attitudes these women must adopt toward their babies. The heart-rending choice may be between the satisfaction of the children's dietetic needs at the sacrifice of their more long term security.

A large number (possibly most) of the unmarried mothers are accepted by their own families. The mother most usually goes out to work, while her mother - the grandmother of the baby - cares for the child or children. There is some evidence to suggest that many unmarried mothers do eventually marry the father of the child. Initial payments of lobola are made, and the marriage finalised on the completion of the payments. At the same time it does happen that unmarried mothers not infrequently have no means of financial support if they are rejected by their own family of origin, or if their own family cannot assist for one reason or another. They are then driven either to put their babies to unsuitable foster care, or to abandon them altogether in the township. A proportion of these children are returned to their grandparents in the rural areas where their chances of healthy survival are not great.

Attention must be focussed on the problem that traditional factors in the situation have proved dysfunctional in the contemporary Western mode of life. Lobola has been generally transformed into cash payments. However, given the low wage structure for Bantu workers, and the limited opportunities to save, this has resulted in the postponement of the age of marriage, and has contributed to a rise in the number of unmarried mothers. In

1. Information from Mrs. H. Sibisi, Institute for Social Research

the words of a study of Baumanville in Durban:

"The present preoccupation with money has had two important effects. In the first place, it has undermined the traditional functional significance of lobola as a guarantee of good conduct and reciprocal rights and obligations on both sides; ... Secondly, the high rates tend to delay the time of marriage for both sexes, since intending bridegrooms must save for a long time to raise the required amount, and this may account for the increase in the number of unmarried mothers¹."

This delay in the age of marriage is contrary to Bantu tradition, and creates both the problems of pre-marital sexual intercourse amongst the "betrothed", and also of irregular sex activity. Both can result in illegitimate babies. In the former instance, the child virtually has the protection of the kin, and the grandmother's care and the father's support. It is the results of the second situation that create the particularly difficult social problem.

The influence of the Natal Bantu Code is also dysfunctional today in the age of a mobile society where women are increasingly becoming more emancipated from family and tradition. No marriage may be contracted on a customary or Christian basis without the Guardian's consent. In the case of girls who have moved from rural to urban areas, this consent is not always easy to obtain, particularly if the father of the woman is not alive. Furthermore, the Guardian will probably be absent from the rural home,

1. See Natal Regional Survey, Report No. 6: (1959):
Baumanville : A Study of an Urban African Community:
Oxford University Press, Cape Town; p. 33.

working elsewhere as a migrant. The end result is that a marriage is sometimes unable to take place because of these no longer appropriate requirements. In conjunction with this point, it must be also remarked on that there are no provisions for the civil marriage of Bantu.

These legal and traditional institutional forms play no small part in contributing to Bantu illegitimacy.

(b) Need for both parents to work:

When this state of affairs does exist, the parents have to make other arrangements for the care of their younger children.

Those who can find places for their babies in creches are fortunate, and where the foster mothers are under the control of the Durban Bantu Child Welfare Society the babes are safe. Such services offered are not sufficient for the needs. The baby is therefore either sent to the country to the "granny", or is left to the tender mercies of somebody in the township - sometimes suitable, but not always so.

(c) Ignorance of the facilities offered:

This, in the light of all the preceding discussion, would not be thought to be possible. However, due to the fact that much distrust and suspicion of strangers is built up in a community where one has no say as to who one's neighbours will be, or in which area in a township, let alone in which township one would like to live, it is understandable that each family keeps itself to itself to protect itself from attack and assault. This atmosphere is not conducive to the door-to-door spread of knowledge. Much has to be done by the educators to inform the population of the work that is being done to help the community to prevent malnutrition among the toddler age group.

(d) Distances to travel :

The aim of the Municipal Authorities is to establish sufficient child clinics in all the townships within reasonable walking distance of all the areas, so that the youngsters will be brought for supervisory control. There are two factors to be considered here, however. Often the person who is in charge of the baby is herself not in a fit state to transport the child even a "reasonable" distance. She, being apathetic with pellagra or another state of malnutrition herself, has not the energy nor willpower to bother about a "reasonably" healthy baby. Secondly, whilst the clinics are being built and established in each community, the distances from home to clinic in inclement weather are still very great. Right now many many babies and toddlers are just not getting to the clinics for the sadly needed attention. If these children were taken to the clinics, the health problems would certainly be alleviated.

2.12. THE COST OF MALNUTRITION TO SOUTH AFRICA :

It has been shown that malnutrition amongst the Bantu - especially the pre-school children - is the product of a complex network of inter-related social and economic factors. Poverty, ignorance, and waste, together with social change as it affects the Bantu living in Durban, and a host of other factors, combine to produce the large scale problem of malnutrition which faces Durban. This problem is shared by the other cities, towns, and villages in South Africa. Before proceeding to our recommendations, it is worth making a brief examination of the cost of malnutrition to South Africa.

(i) The Cost In Terms Of Actual Financial Involvement.

Under the present division of health services, the Central Government is responsible for preventive medicine. This aspect of health has long been accepted in the realisation of the need for immunisation and the notification and control of spread of infectious diseases. Subsidies are provided on such items of food as bread, wheat, maize, margarine and dairy products for the maintenance of health for the entire population, White and non-White. Nevertheless it should be recalled that the Bantu population is paid at lower rates, although they have to buy food at the same prices as the other groups. Totally inadequate wages, ignorance and above all, the concomitant problems of a migratory labour system, such as travel expenses from home to work, all contribute to the prevalence of malnutrition in the difficult and complex social structure of our country.

However, until 1961 it was the policy of the Central Government to look upon any feeding schemes as a matter of welfare rather than preventive health. Since 1961 the Central Government has generously subsidised one-third of the expenditures incurred on milk powder schemes, and has given aid to local authorities such as municipalities and district surgeons in Natal to continue with the issue of milk in some shape or form.

On the other hand, the Provincial Government of Natal has inflexibly adhered to the policy that it is responsible only for the curative aspect of health. Thus, in the provincial hospitals and the mission hospitals subsidised by the Province, much money was spent on treating children suffering from the condition of kwashiorkor, let alone all the other manifestations of malnutrition, whilst no support at all was given to any programme which would have been instrumental in preventing these conditions.

In 1956 at King Edward VIII Hospital it was found that the average length of stay in hospital per each child suffering from kwashiorkor was 30 days. It is accepted by the paediatricians that this figure is still valid.^{1]}

In 1956 the cost per patient per day at this hospital was R3-00. In 1963/64 the cost per patient per day at this hospital was R4-78. No allowance has been made for an intervening gradual rise in cost between these two periods abstracted.

1] Quoted on 8.9.1966 in a lecture given by Prof. H.L. Wallace of the Paediatric Dept., University of Natal, Durban.

Thus a conservative estimate of the annual cost to the Natal Provincial Administration of survivors of the in-patients of kwashiorkor only at one hospital for the 10 year period 1955 - 1964 is approximately R700,000-00. See Table XV.

TABLE XV
ANNUAL COST OF SURVIVING IN-PATIENTS SUFFERING
FROM KWASHIORKOR AT KING EDWARD VIII
HOSPITAL 1955 - 1964

YEAR	COST PER PATIENT PER DAY	COST FOR 30 DAYS AVERAGE LENGTH OF HOSPITALISATION	SURVIVING PATIENTS	TOTAL
	Rand	Rand		Rand
1955	3	90	339	30,510
1956	3	90	405	36,450
1957	3	90	?	?
1958	3	90	710	63,900
1959	3	90	795	71,550
1960	3	90	833	74,970
1961	3	90	772	69,480
1962	3	90	796	71,640
1963	4.78	143.40	820	117,588
1964	4.78	143.40	1069	153,294.60
TOTAL			6539 (+ 1957 figure?)	R689,382.60 (+ 1957 figure?)

R700,000-00 was spent in 10 years on curing a disease in approximately 7,000 victims - a disease that would have been prevented by the administration of $\frac{1}{2}$ pint of fresh milk per child per day.

In order to obtain an impression of the enormity of the cost to the taxpayer of Natal, this information can be presented in a further two forms :-

(a) CURATIVE cost of treatment per ONE surviving child for a 30 day period at R4.78 is R143.40.

PREVENTIVE cost for one child for the same period at the retail price of milk in 1963 of 5c per pint is 50 cents.

Thus, where ONE child was returned temporarily to a state of health, from which he may well have deteriorated once he left the hospital, two hundred and eighty six (286) children could have been protected from kwashiorkor and other diseases.

(b) Over the ten year period R700,000 was spent on only 7,000 victims, whereas each day for this ten year period, 11,666 children could have received their health-giving ration of milk.

Moreover, as has been stated, this very conservative estimate has been based on the figure of cost per patient per day - it is the policy of the Natal Provincial Administration not to include such items as capital expenditure, depreciation of property and other long-term items of expenditure when arriving at this basic figure. Since 1964, (the latest figure available), the salaries of most of the incumbents of posts at King Edward VIII Hospital have risen considerably. Salaries constitute almost 50% of the total running costs of a hospital, and it is always necessary to devote many more nursing hours of duty to children than to adult patients. For these two reasons alone, therefore, it is very probable that a much higher estimate of, say, R1,000,000 spent on 7,000 victims would be a more accurate reflection of the prevailing situation.

A further cost is that involved by the voluntary agencies participating in the work of combatting child ill-health amongst Bantu in the Durban region, and also the cost of the work of Local and Central Government authorities operating in the same field. It was not possible to obtain a complete picture of the costs involved, as some of the organisations (such as the Durban Bantu Child Welfare Society) provide a multiple service not purely in the field of health, so that the costs cannot be apportioned with certainty. In the case of other organisations, likewise there are some difficulties in establishing the amount spent on Bantu child health. However, some idea can be obtained from the fact that the combined appeal annually of the Durban Non-European Children's Fund has in the past raised something of the order of R30,000-00 or more. It must be borne in mind that this is only one group of voluntary organisations working mainly (although not entirely) in the field of Bantu child health. In 1964, the balance sheet reflected a total R49,300 allocated by the Fund to its individual charities. It is probably not unrealistic to double this figure, and say that somewhere around R100,000 or more is being spent on Bantu child health by voluntary organisations and statutory bodies working in the Durban region. In the whole of the Durban Metropolitan region, (which may be taken as stretching from Amanzimtoti in the south to Umhlanga Rocks in the north, and inland to Hillcrest), the figure would be much greater. This sum would not have been necessary if the Bantu were not so poor, and in need of health assistance and education.

The Annual Report for the year ending 31st December, 1964 of the City Medical Officer of Health of the City of Durban provides the number of deaths recorded from kwashiorkor and malnutrition in the under 5 years age group since 1958. These are set out in Table XVI and compared with the figure given for King Edward VIII Hospital :-

TABLE XVI

DEATHS AMONG INDIAN AND BANTU CHILDREN FROM
KWASHIORKOR AND MALNUTRITION IN THE UNDER
5 YEAR OLD AGE GROUP. 1958 - 1964.

YEAR	NO. OF DEATHS REPORTED BY:		
	DURBAN MEDICAL OFFICER 1]	KING EDWARD VIII HOSPITAL	DISCREPANCY 2]
1958	335	649	314
1959	151	698	547
1960	123	620	497
1961	126	540	414
1962	110	565	455
1963	87	682	595
1964	85	996	911

1] Vide Report of the Medical Officer of Health for Durban for the year ending 31.12.64, p.41.

2] These are apparently deaths of cases who came to the hospital from areas outside Durban.

As will be observed, not only is there a gradual decrease in the 'city' deaths, but there is also a marked discrepancy between the death figures quoted as being the "responsibility" of the City of Durban and those that in fact take place in Durban as a result of the inflow of the needy from the outlying districts. There are other hospitals in Durban whose figures have not been included, therefore the discrepancy is actually greater.

If, as is the case, every effort is being made in Durban by both official Central Government and Municipal Local Authority, and by voluntary support from the citizens of Durban, to shoulder the responsibility of preventive health measures in Durban itself, then it would appear that much of the distress that is seen in the hospitals in Durban is caused by an ineffectual preventive and promotive health service outside the area of Municipal Durban. This problem is the responsibility of the Central Government, and smaller Local Authorities. This ineffectual service is costing the country and the people dear.

(ii) Cost In Terms Of Loss Of Potential Man-power.

South Africa has entered on a phase of rapid industrial expansion. The authorities are embarking on long-term policies aimed at making South Africa take its place among the foremost countries of the world. These policies include the conservation and best use of water. Man-power is also being seriously considered, for this ultimately is our most valuable asset. Yet our outlook on the conservation of man-power is really akin to that of the more advanced of the emerging countries of the world - it is not yet in practice the outlook of the established

countries of the West. After all, the health of a nation is only as sound as that of the weaker members of its community. All the health measures adopted will not prevent the loss of man-hours if the workers are not up to par in the common endeavour. The malnourished children of today are the labour force of tomorrow. If they are not fit enough to manage a good daily work-load, they will act as a brake to the continued progress of our industrial expansion. In this sense, we still have a long way to go before we jealously safeguard and conserve the health of all our peoples. Malnutrition is one of the problems which can, and must, be wiped out.

Partial figures for the direct cost of malnutrition in Durban have been given. The indirect costs resulting from ill-health have been hinted at. In South Africa as a whole these costs must be multiplied many times over. No one knows the full cost - apart from the intangible costs of human suffering and wasted life - but in economic figures alone clearly they must run into millions of Rand every decade. Prevention is better than cure, to use a cliché, and it is also much cheaper. Can South Africa afford the cost it is paying for malnutrition?

2.13 RECOMMENDATIONS:

Recommendations based on the analysis made in this chapter, as well as those derived from other parts of the report, are grouped together in the concluding part, Chapter 5. The reader should consult this chapter.

* * * * *

CHAPTER 3.

SOCIAL WELFARE SERVICES FOR THE BANTU
POPULATION IN DURBAN AND
ITS IMMEDIATE REGION^{1]}

- 1] We are greatly indebted indeed to Professor Hansi Pollak for her very generous assistance with the form and detail of this chapter. Despite an extremely heavy programme of work she was kind enough to make available a considerable amount of time for discussing this chapter, and for making, on the basis of her expert knowledge, detailed suggestions. Without her help, this section of the report would have been very much the poorer. Nearly all the material for the chapter was collected by Professor Pollak, Mrs. M. Waldeck, Miss N. Lamond, and Miss L. Geils. The chapter was collated and written in its final form by H. L. Watts. Any imperfections or omissions in the text are his responsibility.

3.1 INTRODUCTION:

Chapter 2 described in some detail the health services available for the pre-school children in Durban. This chapter goes on to describe the social welfare services for the Bantu population in Durban and its immediate region. While the main emphasis is on the services provided for children, a sketch is given of services which cover the Bantu population at all ages. This is done in order to set within their context the services for children. An additional reason, is that in most instances services which are for older persons also indirectly affect the welfare of the children - this is particularly so in the case of services affecting parents.

It must be stressed that this chapter does not pretend to go into any detail on all the services mentioned. It is not a complete inventory of all the various welfare and health services in Durban for the Bantu population. Rather, it should be regarded as an illustrative list of the types of the services provided. In this regard, it is fairly complete, covering most of the organisations concerned. However, as anyone working in the welfare field in Durban knows, the range of programmes undertaken is so wide, and the number of agencies involved so extensive, that a complete and full description of the picture as it is at present (at the end of 1966), would be a special research project in its own right. The aim of the present research is somewhat different.

The services of five organisations are described in detail. These are - or were - the constituent members of the "Durban Non-European Children's Fund". This fund sponsored the present research, and one of the aims of the investigation was to obtain

a clear picture of the work of these organisations, and to provide an evaluation of their programmes. This is the reason why these organisations have been covered in greater detail than the others described. It does not imply that they are in any way superior, or for that matter, inferior, to the other agencies operating in the field. The particular emphasis given to the constituent bodies of the Durban Non-European Children's Organisation, is, to repeat, only due to the particular aims of the present study.

A final point should be stressed by way of introduction. The health and welfare services for the Bantu population are, in their effects, inextricably interwoven. It often becomes a matter of splitting hairs to decide whether the effects of a particular programme are in the welfare or the health field. It is only as a result of administrative differentiation that there is any point in making a distinction between health and welfare services. For example, feeding is undertaken by not a few of the voluntary welfare agencies. It could be argued with considerable force, that their feeding programmes are nothing more or less than programmes in the field of preventive medicine. This type of intermingling of health and welfare will be seen to run right through the full gamut of services for the Bantu in Durban. So it is that this chapter in sketching the services, covers both health and welfare services. While the health services were dealt with in some considerable detail in the preceding chapter, with great emphasis on the facilities for Bantu children, reference is made to them here to illustrate something of the totality of the present position. Readers who are interested in the details of various health facilities should consult chapter 2.

3.2 A NOTE ON THE PROBLEMS OF ADAPTION BY THE BANTU TO RAPID SOCIAL CHANGE:^{1]}

Before proceeding to a description of the type of welfare services which are available to Bantu in the City of Durban and its immediate region, it will be worth while to provide some idea of the sociological context within which these services are required. It has already been shown in chapter 1 that the bulk of the Bantu population are below the poverty datum line. The social changes which have brought this about are briefly referred to below:

Countries which have undergone rapid industrialisation have shown a very similar pattern of development. In moving from a predominantly agrarian to a highly diversified economy, they have a marked downward drift of their population. This has resulted in a depopulation of the rural areas, with a concentration of the population in industrial towns requiring workers. Despite expanding markets for labour, internal shifts in the industrial labour force have frequently given rise to job insecurity and unemployment. As a concomitant of the rapid growth in the urban populations, existing community services have been unable to keep pace with the ever-growing demand. Housing, education, sanitation, hospitals, recreational facilities, etc., have lagged behind the rapidly growing needs of the urban population.

Sir William Beveridge has considered that there are five social evils of an urban and industrial society. These evils seem to be particularly marked in the countries which have undergone a dramatic shift from an agrarian to an industrial economy. The evils, according to Beveridge, are:

1] The material for this section has been drawn from the paper by H. P. Pollak (1960): Social Development since Union: South African Institute of Race Relations, Johannesburg.

- (i) Squalor, poor living conditions, poor and inadequate housing, insufficient open spaces, and inadequate or insanitary surroundings;
- (ii) Idleness or unemployment due to industrial dislocations beyond the control of the individual worker;
- (iii) Ignorance - there is the evil of insufficient education to allow the individual to operate in a modern industrial society;
- (iv) Sickness - there is a need for medical care, which is complicated by costs of such care, which are beyond the resources of the individual;
- (v) Want - there is a problem of economic need (of poverty), and/or the need of the industrial worker to be protected against sudden loss of income from wages. He is far more vulnerable to a sudden cessation of his income than was the agrarian worker^{1]}.

It is evident that these problems abound in the South African urban environment. They are problems from which the urban Bantu suffer. They are, indeed, problems which are associated with the rapid development of an industrial economy producing a marked townward drift of a rural uneducated population. It is very often believed by so many in South Africa that these problems are unique. In fact, they were not only stressed in the Beveridge Report, but are reported frequently in the increasing literature which is becoming available from studies of rapid urbanisation in South America, Asia, and other parts of Africa. Such literature indicates that the problems elsewhere are extremely similar to our own.

Our problems are not only basically similar to those of many other countries; in the South African environment, we have added to the problems of industrialisation and urbanisation those associated with de-tribalisation, westernisation, and acculturation of a previously rural people. Furthermore, there are the plethora of rigidities imposed by administrative regulations, by the perpetua-
1] Royal Commission on Unemployment Insurance 1930-1, Great Britain.

tion and enforcement of influx control, and by the system of migratory labour. These add to the difficulties of adaption in our changing environment.

A famous American Social Anthropologist, Oscar Lewis, in a recent report on urbanisation in Mexico, gives a vivid description of the problems facing a rural peasantry subject to forces of urbanisation and industrialisation. He used a phrase which is becoming common in sociological literature - he speaks of "the culture of poverty". By this he means the matrix of poor living conditions, low literacy, irregular wages, earnings which have to be supplemented by the earnings of women and of children, and the overwhelming problems of poor health and bad nutrition, of ignorance of nutritional food in an entirely different environment, and family maladjustment and crime. Welfare workers in the Republic will have no difficulty in recognising the presence of the "culture of poverty" in our towns. One big difference in other countries is that the rural migrants elsewhere have the social and psychological protection of a common culture and a common religion. In South Africa, the townward shift of the Bantu population is associated with the migrants being subject to culture-conflict and westernisation, and uprooting from their rural tribal background (insofar as it has survived to the present time). So while our problems are fundamentally no different from the general problems facing developing countries elsewhere in the world, they are exacerbated by the traditional background of the Bantu, by westernisation, by de-tribalisation, and by the administrative rigidities imposed by legislative regulations which form a framework within which a flexible adjustment must be attempted.

Hobart Houghton in his book "South African Economy"^{1]} has

1] Houghton, D. Hobart (1964): The South African Economy: Oxford University Press, Cape Town.

pointed to the existence of a dual economy in the Republic. On the one hand, we have a highly structured capitalistic, progressive economy, with its banking, finance, highly developed industrial system, and rising standard of living. By contrast, on the other hand, we have the subsistence or sub-subsistence economy of the peasant Bantu farmer. This fact is well known, and needs no further comment. What should be emphasised, is that in addition to a dual economy, we in fact also have a dual social system in the Republic. There is the privileged White minority with a high level of education, and many economic opportunities. This group is western in terms of its societal structure, and is a mobile society with chances for the individual to climb vertically. The economic structure of the society is highly diversified, and is fairly fluid in terms of social class, placing no very great restrictions on the individual's use of his skill, and ambition^{1]}. Side by side with the western society of the small White population there is "the culture of poverty" of the non-Whites, particularly the Bantu. At present legislative restrictions impose artificial ceilings on the social and economic advancement of the population. The traditional colour-bar is re-inforced by job reservation, by provisions of the Industrial Conciliation Act, and by the lack of recognition of Bantu trade unions. The net result is that these restrictions have all operated to the maintenance of a significant disparity between skilled and unskilled wages. This has probably slowed down the climb of the Bantu out of poverty. Other develop-

1.] No detailed study of the social mobility in White society in the Republic has yet been made. There are several American and British studies of social mobility indicating that while the society in those countries allows for a considerable amount of upward social mobility, there appears to be a tendency for social class to become increasingly crystallised with a consequent lessening of the opportunities to "get to the top". How far this is true of South Africa is unknown - it must await a study comparable to the overseas ones.

ments have also had an impact on the Bantu - the steady increase in industrial automation, has produced job shifts, not all of which have been to the disadvantage of the Bantu. There have been movements from the unskilled to the semi-skilled ranks in the Bantu industrial population. At present though, there are little opportunities to advance to the skilled level, and openings for professional class workers are still relatively small. The end result can be summed up in the following words of Professor Pollak:-^{1]}

"African urban society has thus assumed an abnormal structure. A small but influential professional class - teachers, clergymen, nurses, social workers, doctors, lawyers - has emerged, as also a class of 'white collar worker'. In recent years there has been a significant increase of African traders, a few in control of substantial businesses. African urban society is thus today diverse and stratified - with a growing stable middle class, but a society deprived of a broadly-based skilled artisan class. Among the urban African it is the women of the middle-class, so active in the manifold Church and community activities - who exercise that essential stabilising influence upon a society in transition."

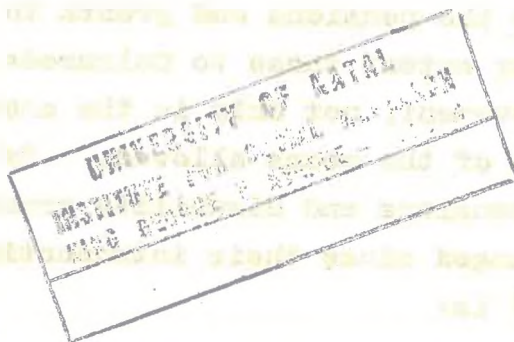
It has been said by Pollak^{2]} that the African lives in a straight jacket of control and prohibition. The law prescribes where and how he must live, what work he may or may not do, determines where, when, and how he may move. It controls very large facets of his and his family's daily existence. To the sociologist this appears to add to the problems of adaption by a rural non-western population to life in a rapidly growing industrial society.

1] Pollak, H.P. (1960): Op. cit., page 8.

2] Ibid.

There is evidence to show that the wages of Bantu workers have increased considerably in the last few years. However, as was pointed out in chapter 1, the available evidence suggests very strongly that in terms of real income there has been virtually no change in most of the occupations - and this would apply probably equally to those occupations affected by wage determination or industrial conciliation agreements. The rises in wages have been apparently completely cancelled out by the inflationary spiral in the cost of living. The net result is that the amount of poverty does not appear to have decreased significantly within the last decade to a decade-and-a-half.

We can describe the Bantu population of Durban in sociological terms, as a population living in a "culture of poverty". It is within the sociological context that the present welfare and health services to the Bantu operate, and in terms of which their contribution and significance must be assessed.



3.3 STATE SERVICES AVAILABLE TO THE BANTU:

The State provides the following welfare and health services for Bantu in the Durban region:-

(i) Pensions and Grants:

The State Social Welfare programme of the later 1930's and 1940's was progressive, and was directed towards a contributory social security system. Initially it was confined to the Whites, but old age pensions and blind pensions were extended to Asiatics and Bantu in 1944. All races were similarly included in the programme of disability pensions in the year 1946. All but the Bantu were provided for by family allowances in 1948. As far as grants are concerned, the State subsidisation of voluntary effort extended to all races. The present position is as follows:

(a) Old age and disability grants:

When the old age pension and disability grants were first introduced, the scales for the Bantu were lower than those for Coloureds and Indians. Over the years, particularly the pensions and grants to Whites, and also to a lesser extent those to Coloureds and Asiatics, have shown improvement, not only in the amount granted, but also in terms of the means allowed. By contrast, the Bantu old age pensions and disability grants have stayed relatively unchanged since their introduction. The current scale (in 1966) is:

Old age pensions may be granted to men aged 65 years or older, and women aged 60 years or older. The maximum pension per annum for Bantu is R44-40 per annum - or R3-70 per month. This is paid every second month, at a rate of R7-40. The maximum basic pension is payable plus the additional allowance (which was included

in the above figure), if an applicant's income or means do not exceed R21-00 per annum in the case of Bantu. The maximum private income plus pension, which a Bantu can have is R65-40 per annum. This amounts to R5-45 per month, and compares with a figure for Coloureds and Asians living in cities, of a maximum private income plus pension of R264-00 per annum, with a figure of R528-00 per annum for Whites^{1]}.

Disability grants can be awarded only upon production by the applicant of medical evidence that physical or medical disabilities of a permanent nature render him incapable of deriving from any employment or occupation the means required to enable him to provide adequately for his own maintenance. The qualifying age for both sexes is 16 years. The basis of assessment of the income and assets of the applicant, and the grant payable is exactly the same as for the old age pension just described above.

It would be most interesting to analyse the proportion of the various racial groups in receipt of old age pensions and disability grants, and to see how this has altered over the various years since the inception of the grants. Unfortunately, this would take us beyond the scope of a study with its main emphasis on the Bantu in Durban. The number of Bantu old age pensioners and

1] Fuller details of the old age pension regulations and scales can be obtained in the report by Suttner, S. (1966): Revised Social Pensions in South Africa: A Fact Paper No. 17 of 1966. South African Institute of Race Relations, Johannesburg. (Mimeographed): pp. 2 - 12.

adults in receipt of a disability grant in the Durban region could not be easily ascertained - these grants are organised on a central basis in Pretoria, where all the records are kept. If however, the national position is similar to that prevailing in Durban, then the vast majority of the pensions and grants would go to the Bantu population^{1]}.

It is a revealing exercise to compare these grants with the poverty datum line estimates of the theoretical minimum income necessary to support an adult person in health and decency, taking short-term considerations only into account. Table I (page 10), shows that for a sedentary male, the poverty datum line amounts to R1-97 per week, while the figure for females is R1-83. Multiplying these values by 4.3 to obtain monthly values, we find that the poverty datum line for a sedentary male is R8-47, while for a female it is R7-86. It must be stressed, that to this should be added the cost of any rent, or portion of rent which the individual has to bear, as well as a sum of 25 cents weekly to pay for

1] In January 1966 the total number of persons reported as being in receipt of old age pensions was 373,224. Of these 88,154 were Whites; 54,281 were Coloured; 8,194 were Asians and the vast majority amounting to 222,595 were Bantu. Thus 60% of the total number of old age pensions were paid to Bantu, while 2% went to Asians; 14% to Coloureds and 24% to Whites. We do not know what proportion of the population concerned was living in rural or urban areas as the case may be. Likewise, the number of persons in receipt of disability grants in January 1966 was 93,227. Of these 16,409 (or 18%) were Whites; 16,256 (or 17%) were Coloured; 3,817 (or 4%) were Asian and the majority amounting to 56,745 (or 61%) were Bantu. Again we do not know how many of these persons receiving disability grants were living in the cities and towns. (See Suttner, S. (1966): op. cit., pp. 12 and 20.

household fuel and lighting - if the person concerned is a member of a household, then a pro-rata portion of the 25 cents should be added in. The poverty datum line quoted is that based on the figures originally prepared by the Department of Economics of the University of Natal. These are somewhat more conservative values than those provided by the Council for Scientific and Industrial Research, (see the estimates given in Table AI (Appendix A(i))), Even taking these figures without the addition of rent or the household item of fuel and lighting, we see that the maximum possible income which an old age pensioner or a disability grantee may have is R5-45 per month. This is only 64% of the minimum figure laid down by the poverty datum line for men, and 69% of the minimum poverty datum line figure for women. We have taken the values for sedentary adults as being applicable to old age pensioners and persons suffering from a disability, on the grounds that neither of these two types of individuals are likely to be either moderately active, or very active. The position would be even worse if rent and fuel and lighting for the household were included in the calculations. The conclusion is unavoidable that unless old age pensioners and persons in receipt of a disability grant are able to have additional assistance from voluntary agencies, or some other source, it is impossible for them to remain healthy, living on the grants alone. The discrepancy between the poverty datum line and the grants and pensions is large enough to present a very serious health problem indeed. By contrast, the maximum private income plus pension of

Coloureds, Asians, and Whites is in each case considerably above the poverty datum line. For example, taking males only, the amount allowed to Asians is over twice the poverty datum line figure, while the Coloured figure is over two-and-a-half times the poverty datum line. The White figure is over five times the value of the poverty datum line. This is despite the fact that medical experts have never found any basis whatsoever for assuming that one racial group can maintain health and decency at a lower theoretical level than another racial group - we all have the same basic physiological equipment. This means that our needs are in theory at an absolutely minimum level, identical. The facts speak for themselves - something should be done about the old age pensions and disability grants for Bantu, and quickly. The disparity between the grants and pensions and the poverty datum line is such as to mean that ill-health must be a constant danger amongst this group of the population. It is far cheaper for the country to increase the pensions and maintain them in health, rather than try and cure them once they have become ill. On the one hand increasing the pensions would mean only a matter of a few rand a month for each individual, whereas no curative medicines or services amount to as little as a few rand per month once serious physical deterioration has set in. Such deterioration would seem inevitable in the case of individuals who are forced to live on these grants and pensions alone.

(b) Blind pensions:

A blind pension may be granted to a person aged 19 years or over, once the individual concerned has been certified as a blind person and registered as such in terms of the Act. Suttner's paper gives further details on the residential qualifications, and the means test applicable to this type of pension^{1]}. The pension payable is assessed on the same basis as in the case of old age pensions, with the exception that in determining the means or income, only one-half of the blind person's personal earnings is taken into account, and the pension is reduced by R2-00 per annum for every R2-00 per annum increase in income of the individual in excess of the amounts accepted.

Our comments on the fact that the disability grants and old age pensions were remarkably below the minimum level suggested by the poverty datum line, apply with equal force to pensions received by blind Bantu persons.

(c) Maintenance grants:

Maintenance grants are paid for the maintaining of a child, and when necessary the mother, or more rarely, the father or guardian, in cases where the family is

1] Suttner, S. (1966): op. cit., pp. 16 - 18. Suttner shows that in 1966, in January, the total number of blind pensions being paid amounted to 14,775. Nine hundred and thirty six or 6%, of the grants were paid to Whites; 1627 went to Coloureds (or 11% of the total); Asians received 161 pensions (or 1%); while 12,051 were paid to blind Bantu, (82% of the pensions). It would seem from these figures that the problem of blindness is most severe amongst the Bantu population, even allowing for the fact that they are the largest group in the Republic. We do not know how many of the cases referred to live in Durban areas.

facing serious financial difficulties. There is no qualifying age for the person to whom the grant is awarded. Children may be eligible for a grant to the end of the calendar year in which they reach the age of 16 years. In exceptional cases, where there is sufficient reason for a child to continue with his studies, payment of a maintenance grant to a child may continue until the end of the calendar year in which he or she attains the age of 18 years. The maintenance grant can only be paid if the applicant is either a foster parent or guardian; - a woman who is a widow or unmarried, or who has been deserted by her husband for a period of at least six months, and is not adequately maintained by him, or whose husband is in receipt of a social pension, or whose husband has been found medically unfit for a period of at least six months, or whose husband has been sentenced to imprisonment for a minimum period of six months, or to detention in a state or state-aided institution. An applicant may also be a widower, or a divorced or deserted father who is in receipt of a social pension, and who, had it not been for his means or residential qualifications, would have been qualified for such a pension, or on the other hand, who has been declared medically unfit for a period of six months.

The basis of assessment is the same as in the case of old age pensions. The maximum basic grant paid to a Bantu is R24-00 for a mother living in a city area. In such an area, she may receive a maximum of R1-25 per month for each of the first two children, and 75 cents per month for the third and every further child. The maximum income (means) that a family may have without affecting the amount of the grant is R24-00 per annum in a city for every adult (man

and wife), plus R6-00 per annum for every child per adult. The means of a family plus any state grant shall not exceed R10-00 per month. The maximum state grant including any social pension which may be paid to a family is R72-00 per annum in a city. No additional grant is paid for children in school^{1]}. From the above, it will be seen that the maximum grant which may be paid to a Bantu family living in a city is only R6-00 per month. The maximum means of a family plus the grant (whatever type of grant including maintenance grant, and by definition including the mother's earnings) may not exceed R10-00 per month. Let us compare these figures with the poverty datum line values.

From Table I, page 10, above, it is calculated that the monthly cost of an infant is R5-07. The infant is the cheapest child to rear, for taking a child of 13 to 15 years of age, (who is nearing the maximum age of 16 allowed by the grant) is R8-86 per month. The maximum sum of R1-25 per month for the first and second child in the cities is well below these figures. In the case of infants, it represents only 24%, or about one-quarter, of the minimum laid down by the poverty datum line. In the case of children aged 13 to 15 years, the position is much worse, for the grant amounts to only 14% of the theoretical minimum required. These calculations exclude rent, or fuel and lighting for the household. The discrepancy between the very modest poverty datum line figures (which it has been stressed more than once are not a human standard of living, and are an almost sub-minimum level), and the maintenance grant figures for children is so wide as to be almost unbelievable. The implications are shocking - in the case of Bantu families where the mother has

1] For further details see Suttner, S. (1966): op. cit., pp. 21 - 25.

to support her children on the basis of maintenance grant figures alone, then unless she was able to obtain supplementary feeding from other sources, her children would be ill or dead within a few months. There can be no question of even trying to maintain a rough standard of health and decency - the gap is too wide for even the most intelligent and the most competent housekeeper to even have the most remote chance of coping.

The position is equally bad in the case of the mother. It can be accepted that the principle of the maintenance grant is in part to maintain the family, and to allow the mother to look after her children. From this point of view, the mother with very young children should not work. In such a case of course, she would have no income other than that provided by the maintenance grant. As the maximum basic grant to a Bantu mother in a city area is R24-00 per annum, she would receive only R2-00 per month, provided she qualified for the maximum. By contrast, from Table I, page 10, above, we calculate that the poverty datum line figure for a moderately active women is R8-21 per month. The maximum maintenance grant for a mother is only 24% of the poverty datum line figures. Again it must be stressed that no allowance has been made whatsoever for any rent, or for fuel and lighting - the poverty datum line figure quoted is the primary poverty datum line, and not the secondary line which would be higher.

There is no need to pursue the matter further - we could for example, calculate what the position would be in the case of a theoretical average family, where there were more than two children, and the grants for the third

and subsequent children dropped to only 75 cents a month. Such a calculation would merely labour what has become painfully clear. It is quite impossible for a mother and her children to live on the maintenance grants. If she is to survive in health she has to obtain a considerable amount of help from elsewhere. The very low grants alone by themselves would explain why it is generally held that the infantile mortality rates amongst illegitimate babies is higher than amongst babies born to stable or legalised unions. If an unmarried mother gets only her maintenance grant, without any additional aid from any other source, then her plight is desperate, and ill health and death are very real possibilities for her child(ren).

It must be stressed in the strongest possible terms that the maintenance grants for Bantu families must be reviewed as soon as possible, and brought in line with the present cost of living.

(d) Foster care grants:

Grants to foster parents are paid in respect of children in need of care, placed by a Childrens' Court in the care of persons other than their parents or step-parents, and in respect of the maintenance of children by their guardians if inadequate assets were left for their maintenance by the parents. The incomes of foster parents or guardians do not affect the amount of the grant. The maximum basic grant in the case of Bantu foster parents is R51-00 per annum per child. This works out at R4-25 per month. Taking the minimum case of an infant to be supported by foster parents, we have previously estimated that the poverty datum line is R5-07 per month for an

infant. Thus the grant falls below the poverty datum line, amounting to only about 84% of the theoretical minimum necessary to support an infant. On the other hand, in the case of older children, the position is much worse. Thus, for example, in the case of a 13 year old child, the grant represents only 48%, or under half of the poverty datum line for this age group.

In terms of the above figures, there can be no doubt that the present level of the foster grants are so low, as to fail to cover the cost of rearing a child even at the barest theoretical minimum level. This explains why at the present time it is very difficult to find foster mothers. The foster care programme in fact implies that foster mothers must voluntarily make a contribution out of their own pocket to the cost of caring for foster children. This is contrary to the basic aim of the grants, and again there is no doubt that the grant should be up-graded. If they are to be more realistic, then a sliding scale should be adopted with more being allowed for older children than for infants. As a first step, reaching the poverty datum line should be aimed at. However, as this level is not a human standard of living, the aim should be to surpass it as soon as possible.

(e) Grants to Bantu in institutions:

The grant paid to Bantu children in institutions is R4-95 per month, which is slightly higher than the foster care grant, and amounts to about 98% of the theoretical minimum necessary to support an infant. Therefore the grants are at a level below the poverty datum line, and mean that the children cannot be supported in health

and decency without additional outside assistance. Any organisation running childrens' homes therefore, is in the position where, as far as Bantu children are concerned, it has to find additional income over and above the official grants, if it is to keep the children healthy and decently clad. Once again, there is a need to review the grants and to bring them in line with the present cost of living.

(f) Final note on State Pensions and Grants:

It is not within the scope of the present investigation to undertake a fuller analysis of, or historical description of, social pensions and grants in South Africa. Those wishing to pursue the matter further may examine both the paper by Suttner, previously referred to, and a fuller analysis by Draper^{1]}.

(ii) The Public Assistance Programme:

The Poor Relief Memorandum was published on the 1st of April, 1946. The document concerned is still used as the basis for poor relief for all races. It is understood, however, that at present it is being revised. Full details of the principles underlying this assistance will be found in the paper by Draper^{2]}.

Relief is given in kind, with rent very seldom being paid. Essentially the relief is regarded as a temporary measure, either

1] See Suttner, S. (1966): op. cit., and Draper, M. (1964): Social Pensions in South Africa, covering Old Age Pension, Blind Pensions, War Veterans' and Disability Grants - All Races. South African Institute of Race Relations, Johannesburg: A Fact Paper No. 15 of 1964. (mimeographed)

2] Draper, M. (1964): op. cit., p. 67.

until the family's immediate crisis is passed, or they have been granted some other type of State-aid such as an old age pension, disability grant, a maintenance grant, etc. The rations are very limited, but provision is made for free hospitalisation, medicines, spectacles, medical aids, and household requirements such as fuel, soap, candles, clothing and blankets. The general emphasis is to supply as little relief as possible. In the words of Waldeck, "throughout the schemes of public assistance in South Africa there is a reflection of the principle characteristic of the Elizabethan Poor Law as amended in 1834, namely, the principle of less eligibility. This principle entails administering the minimum subsistence needs of persons applying for relief; the aim of this principle is not to encourage beneficiaries to remain recipients of relief. Poor relief is regarded only as a temporary measure"^{1]}.

A person must be destitute in order to receive poor relief. The most usual form of relief is the issue of rations. This at present constitutes:

mealie meal - 9lbs 4 ozs., worth 25 cents.

3 lbs 3 ozs samp, worth 10 cents.

2 lbs of mixed beans, worth 10 cents.

3 lbs sugar, worth 17 cents.

$\frac{1}{2}$ lb margarine, worth 13 cents.

1 tin condensed milk worth 14 cents.

Total weekly value of rations: 89 cents.

1] Waldeck, M., in a section on Public Assistance in Draper, M., (1964): *ibid.*

The State Bantu Administration and Development Department issues these parcels to families in need. In the case of families with children, the Bantu Child Welfare Society in Durban draws up a list of families who are in need of poor relief, and this is sent to the Department. Each family on the list gets a food parcel every fortnight. However, if the family is a large one, one parcel per week is issued. Very needy families are provided with two parcels per week. In the case of a tuberculous, as soon as the breadwinner is found to be suffering from T.B., he and his family are put on poor relief, and receive a parcel once a fortnight.

Examining the food parcel, it will be seen that one of its main deficiencies is in terms of its protein contents. Taken by itself, this poor relief will stave off starvation, but will not maintain a family in health. The poor relief does not only fail to cover the food needs of a family on an adequate nutritional basis, but it does not cover the other minimal essentials defined by the poverty datum line, such as clothing, fuel and lighting, and cleansing materials. In the interests of the health, if not of the decency of the family, it is strongly recommended that the poor relief rations be carefully reviewed, and brought into line with modern knowledge of the minimum requirements of a family from the point of view of both health and decency. For example, in the case of a family where the breadwinner is found to have T.B., the rations are of such a nature as to greatly increase the risk of the rest of the family obtaining T.B. likewise. It is in the interests of the community itself to ensure that the needy are maintained in health. Their ill-health spreads the risk of infecting others. In the light of modern knowledge, this somewhat mediaeval concept of poor relief is no longer acceptable. The position should be reviewed by a panel of medical and social experts.

(iii) Welfare Services:

(a) Administration of the Childrens' Act:

The administration of the Childrens' Act used to be in the hands of the Commissioner for Child Welfare, who was responsible for all four racial groups. This fell under the department of Social Welfare. The administration of the Childrens' Act in the case of Bantu children has now been transferred to the Bantu Administration and Development Department. Bantu Commissioners for Child Welfare have been appointed. Under the control of such Commissioners falls the administration of the whole programme in all its details^{1]}. Maintenance grants, previously referred to, are administered by the Bantu Commissioners under the Act.

(b) General welfare services:

The general welfare services used to all fall under the Department of Social Welfare. Many national welfare organisations developed, and included non-Whites in their programmes. So it is that the Director of the South African Institute of Race Relations was able to say in his Annual Report for 1949:

"To-day, most national welfare organisations have taken non-Europeans within the scope of their work, and most of the welfare legislation of the country includes provision for non-Europeans. Discrimination exists on racial grounds, but what is important however, is that the principle of including non-Europeans has been accepted." 2]

1] For details, the Childrens' Act No. 31 of 1937, as amended, and the Childrens' Act No. 33 of 1960, may be consulted.

2] A Survey of Race Relations 1949 - 1950 (being the 21st Annual Report of the South African Institute of Race Relations): Twinbro Press (Pty) Ltd., Johannesburg.

From 1948 onwards, important changes have taken place. No family allowances have been provided for Bantu families. Indian families were excluded in 1948 from the allowances. Unskilled and semi-skilled workers were excluded from the unemployment insurance fund. Only those with annual earnings totalling R574-00 were eligible for this fund's assistance. In 1951, free milk was provided to school children, but did not apply to the Bantu. (The scheme was administered by the Social Welfare Department only for Whites, Indians, and Coloureds at school). In 1949, grants to Bantu school feeding schemes were reduced, and have now almost ceased since the Bantu Education Act came into force. Nursery schools for Bantu children no longer receive State aid. This has meant that almost all such nursery schools have had to close, and the training centres for nursery school teachers have been eliminated.

When re-training and sheltered employment schemes were provided in 1955 under the Rehabilitation Council, Bantu were not included. Again, subsidies previously enjoyed by Bantu women's hostels, youth groups, etc., have been withdrawn. No new subsidies have been granted to Bantu creches since 1956, despite a significant amount of inflation since then. The recent policy in regard to creches and the care they provide is that this essential service must be supported and subsidised by the Bantu Administration Department of local authorities, where the service is provided in White areas. It is only in the Bantu homelands that the State continues to make grants available to registered Bantu creches. As the bulk of the population needing creches is an urban one, this has thrown the cost of creche care entirely on local authorities.

Most of the Government Welfare subsidised programmes, which were once common in principle to all races, have now been withdrawn from Bantu recipients. The local Authorities have had to finance the needs of their local Bantu population. The Department of Bantu Administration and Development confines its welfare care only to the Homelands.

In Durban, we have the position where there is dual control as far as part of the Bantu population is concerned. The Umlazi Township lies within the Umlazi Mission Reserve, and as such is a Bantu Homeland. The control of this large and rapidly developing township is under the State Department of Bantu Administration and Development. The rest of the services for the Bantu population have to be supported from the Bantu revenue account of the Durban Corporation. In the case of Umlazi, some 75,000 odd Bantu are already residing there. The State Department has done outstanding work in the provision of recreational facilities, but as yet is slow in the development of the necessary chain of welfare services - especially children's services and creche care - in the townships. Details of the services provided both in Umlazi, and in other Durban townships are given in various sections below.

In passing, it is interesting to note that the evolution of an urban community in a Bantu Homeland (namely Umlazi township) has tremendous educational advantages. It has been the policy to allow no educational facilities beyond Junior Certificate in Bantu schools in White areas. This means that the newer Municipal townships in Durban suffer the great disability of not being able to provide schools up to the level of matriculation for the resident

population. If children in these municipal townships want to matriculate, they must go to a boarding school - with a consequent marked increase in the cost of their education for their parents. Umlazi serves Durban, but as a township in a Homeland will provide educational facilities up to matric. Furthermore, a large technical school is to be developed in Umlazi. This will make it easier for Durban residents to have higher education for their children beyond standard 8 level.

(iv) Health Services:

The health services for Bantu children, with particular emphasis on the pre-school group, have already been described in chapter 2. The position is summarised in this section, with added details about the services for other age groups amongst the Bantu population. The overall picture provides a background against which the particular position of children can be understood.

(a) Tuberculosis care:

The State is responsible for the care and provision of hospital care, and after care treatment of T.B. patients. In Durban, there are two hospitals for T.B. sufferers - the Springfield Hospital, and King George V Hospital.

As far as Durban is concerned, there is a chest clinic, which is run jointly by the State and the Durban Municipality.

Food parcels are provided to T.B. families. The State pays seven-eighths of the cost of these parcels. These parcels are intended for the T.B. patient himself, and are designed to meet his needs. They are not supposed to be for family use. In Durban, the parcels are not automatically given to every discharged patient, but only to those

certified by the doctors at the chest clinic as requiring this supplementary feeding after discharge from hospital. The parcel has to be personally fetched at the headquarters of the City Health Department. This sometimes involves the recipient in travelling expenses up to 20 cents. It appears that more than a few of those eligible for parcels do not collect them because they do not have the money to pay for the transport. The position as regard the administration of the parcels should, if possible, be simplified by possibly decentralising the distribution. In addition, the Durban City Health Department should go into the question of whether the scheme has been as fully utilised as it could be. Is the Durban Municipality making the fullest possible use of the State scheme?

During the last three to four years, the State has developed a very promising programme of health education against tuberculosis infection. The programme is still in its initial phases of development, but appears to be achieving promising results. Pictorial illustrations, flannel-graphs, and other techniques, are used by Bantu health educators, who tour the townships and also move into peri-urban and rural areas, trying to educate people about the possibilities of tuberculosis infection, and how it can be minimised. Despite the fact that the programme has not been in existence for very long, it appears to be successful.

(b) Interim period of activity in preventive and promotive health:

The Gluckman Commission^{1]} in 1944 made some sweeping

1] Gluckman, H. (1942-1944): Union of South Africa, National Health Services Commission: Report on the provision of an organised national health service for sections of the people of the Union of South Africa. Government Printer, Pretoria.

and radical recommendations regarding the levels of responsibility in the health field, between the government, the provincial authorities, and local authorities. It envisaged a unified health service under the central government, in which the emphasis would be on preventive and promotive health. In initiating this scheme, a pilot scheme had already been started in a rural area. This was the very well known Polela Health Centre, which proved the efficacy of the general programme of integrated health and welfare, under the personal direction of doctors, nurses, and social welfare workers. These workers were all well aware of traditional and cultural factors obtaining in traditional Bantu rural communities. After the Gluckman report had been released, the then Minister of Health embarked on an active programme of extending the health centres. A number of health centres were established and developed in Durban in Lamontville, Chesterville and Glebelands. The headquarters of the Institute of Family and Community Health was in Durban, on the premises of the former Clairwood British Military Hospital. This Institute trained public health nurses in the field of health education, covering such matters as environmental sanitation, and preventive and promotive health. It is a matter of great regret that this development was not allowed to extend, for in fact it was gradually curtailed. From 1948, the health centre programme slowly ground to a halt, with centre after centre closing down. Eventually the whole training scheme of the Institute was withdrawn. This constituted a sad setback in the field of promotive and preventive health in the Republic. The recommendations in the concluding chapter will pursue this point further, for if preventive and promotive health campaigns

are to be developed, then this early work in the field must be picked up again, and extended widely.

(c) Government subsidised powdered skimmed milk scheme:

By 1961, there was a mounting public campaign against the very high incidence of malnutrition and Kwashiorkor. People were concerned at the lack of participation in fighting the problem, on the part of the government and the provincial authorities. At this time too, there was a considerable surplus of dairy products. For example, South Africa was exporting butter at a loss. In 1961, the government announced the inauguration of a pilot scheme confined to some eight municipalities, whereby skimmed milk powder would be distributed from municipal health clinics. In that year, the scheme was inaugurated in Durban, and proved to be a noteworthy success. By 1962, the government scheme was well in operation, and included Durban. The present position is that the government is prepared to pay one-third of the cost of the distribution of skimmed milk powder to deserving cases, provided that the municipality itself contributes one-third, while the remaining one-third is secured from the recipient. The scheme is limited to children suffering from malnutrition, or those who on medical grounds could be classed as being threatened by malnutrition. Essentially the scheme is aimed at fighting kwashiorkor and other malnutritional diseases.

This scheme is not without its limitations; it is a pity that it is limited to children suffering from malnutrition or those who appear to be threatened by malnutrition. If the full value of the scheme from a preventive

health point of view was to be exploited, it would be an ideal for all children in the lower socio-economic groups to receive a supply of skimmed milk powder as a valuable form of protein supplement. This would help to maintain their health, and not wait until their health was already in jeopardy before treating them. Secondly, the scheme has certain administrative difficulties. The vote on the part of the local authority (who has to pay one-third of the cost of the scheme) has to be paid annually. This inevitably implies a certain amount of uncertainty as to the scale of the scheme in that particular area from one year to the next. In practice, the scheme has continued unbroken; in Durban the expenditure has mounted very steadily. For the financial year 1966/67 the City Health Department of the Durban Corporation will spend R30,000-00 on skimmed milk powder. Initially, R12,000-00 of this money is derived from the Bantu revenue account and R18,000-00 from the Borough Fund account, and of the total, R10,000-00 will be recovered from the Minister of Health, and R10,000-00 from the parents who purchase the skimmed milk powder at city health clinics.

(v) Bantu Education:

Until 1953, Bantu education fell under the province of Natal. The details of the transfer to the Bantu Education Department are well known, and adequately documented, so that there is no need to refer to them here. A sum of R13,000,000-00 per annum is pegged as the straight contribution to Bantu education. The balance of the contribution to education comes from four-fifths of Bantu taxation. The per capita costs on education have been declining, showing that less money is now being spent than previous

on educating the Bantu child^{1]}. The school feeding programmes were successively reduced from 1949 onwards. After 1953 they virtually fell away. Parents were faced with the difficult choice of either using scarce funds for teachers' salaries, or on the other hand for school feeding. In the earnest desire of Bantu parents for education for their children, they chose the former alternative, and consequently school feeding schemes dropped away. This loss has constituted a serious gap in Bantu feeding programmes. This is particularly so as the need has been stressed for many years to have feeding for the school children; it has been said more than once how valuable the school meal was.

It must be pointed out that at present the Bantu Education Department has no school health or dental service. From this point of view the Bantu school child is in a disadvantageous position. As long as the Bantu child is a toddler, his health is protected by the work of the Child Health Clinics. The creches and play groups have medical examinations and care which provide for at least some of the pre-school children, providing a modicum of protection. By contrast, the Bantu school going child has no regular sources of health inspection, or supervision, or remedial services. Such services would be particularly important when so very many of the Bantu parents at present are ignorant on health matters.

The existing policy of the Department of Bantu Education has produced declining opportunities for "higher" education of

1] Horrell, M. (1964): A Decade of Bantu Education: South African Institute of Race Relations, Johannesburg. p.197 reads "... whereas in 1953, R17.99 per pupil was spent on Bantu Education, by 1961 the figure had dropped to R12.46 per pupil."

Bantu children in the so-called White urban areas. As has been pointed out in section 3.3 (iii) (b) above, secondary schools only up to the level of J.C. are being provided in the White urban areas. Except for some of the older townships which previously had schools which went up to matric - and have consequently kept these schools - the vast majority of the townships have schools which cannot take the child beyond standard 8. The vast rehousing programmes have taken place mainly after 1950, and in these new townships the children cannot get higher education. If a child wants to matriculate, and subsequently take up a professional career, his parents have to send him to a school in one of the Bantu Homelands. As has previously been referred to, Umlazi township, as a township in the Umlazi Mission Reserve, has a high school, but none of the other Durban townships are in this fortunate position. In this sense, some of the children of today are far less favourably placed from the educational point of view than were their parents of a generation ago. If parents want their children to proceed to matric, they are compelled to send their children to boarding school, if the family is situated in a White urban area. It has been estimated that the costs of such boarding school, education, plus the costs of travelling to and from home, plus a very modest allowance for pocket money, would cost R100-00 to R110-00 per annum per child. From our analysis in chapter 1 of the socio-economic position of the urban Bantu families, it is quite obvious that such an expenditure is beyond the ability of the overwhelming majority of urban Bantu parents. Where a family does attempt to educate the child up to matric, unless they are in a particularly fortunate economic position, it is almost certain that food is one of the items that will be sacrificed in an attempt to educate the children. This has inevitable health repercussions.

Education of Bantu children to the level of J.C. is officially free. In practice, the parents have to contribute towards the cost of their children's education. For a start, in terms of government policy, the building of schools in new townships is financed at a rate of 20 cents per month added to the rent of every household. Thus, unlike the other sections of the South African population, especially the White community, the Bantu themselves have borne part of the cost of the schools, whatever the income of a particular family was or is. Secondly, school books are not uniformly provided on a free basis. Generally free books seem to be provided to about one child out of every four. This means that the parents very frequently have to pay for school books, stationery, as well as a school fee which might range from 15 cents to 30 cents per term. All children at school have to wear uniforms, and this is quite an additional item of expenditure, as any parent at the present time rather ruefully realises. All these various items add in total quite considerably to the cost of the items to be borne out of what is usually a very meagre household budget. These costs fall particularly heavy on mothers who are recipients of a maintenance grant (and it must be remembered that part of the condition of a maintenance grant is that the children concerned must attend school)^{1]}.

1] For corroboration of the above, and for additional information on the costs of schooling for Bantu children, see Appendix 'E' below. This appendix has been based on an information sheet prepared by Mary Draper of the South African Institute of Race Relations (Durban Regional Office). Of particular importance is the note in parenthesis in the 6th paragraph of the notes in the appendix. It has been a fairly common phenomenon in certain areas for parents to have to raise funds themselves to pay the salaries of additional teachers in schools where the number of official teaching posts is hopelessly inadequate.

3.4 THE PROVINCIAL SERVICES:

Since the provision of education has been taken away from the provinces, as far as Bantu education is concerned, their responsibilities towards the Bantu population have been confined to the provision of hospital and curative services. In Durban itself, there is the King Edward VIIIth Non-European Hospital, which is often referred to as the largest hospital in the southern hemisphere^{1]}.

Medical costs constitute a constantly increasing percentage of the provincial budget. It must be appreciated that with the steady growth of the Bantu population in Durban, demands for services at the hospitals have shown a proportionate sharp increase. This will be even more so in the future as the Bantu population continues to grow^{2]}. In addition, there appears to have been a significant change in the attitude of the Bantu towards hospitalisation. 20 - 25 years ago, they saw the hospital as a place where one went to die. Today, the hospital "culture" seems to have penetrated deep even into the reserves. For example, the number of births annually at King Edward Hospital as far as the Bantu is concerned, is considerably in excess of the Medical Officer of Health's figures for the number of babies born to people resident in Durban. This indicates that there is a demand for hospital services arising within the rural areas, and that people move into Durban to King Edward to receive hospital care.

1] King Edward VIIIth Hospital has 2,100 beds, and is estimated to cost R6,000,000-00 annually to run. (These figures indicate that slightly less than $\frac{1}{4}$ of the Province's vote of R26,000,000-00 is required for King Edward Hospital.)

2] Young, M.A., (1965): op.cit., pp. 81 - 83.

Part of this is due to the fact that many Bantu women have husbands working in Durban, and they come to town to deliver their babies.

King Edward Hospital has an enormous out-patient service in each of the many specialised departments of the hospital. The charges for such service is 40 cents per visit. This fee can be reduced for welfare cases.

Over and above the King Edward VIIIth Hospital in Durban, the Province has a polyclinic at Kwa Mashu and also at Umlazi.

The Government has indicated that it is desirous to have King Edward VIIIth Hospital removed from its present site, on the grounds that it is "wrongly sited" in a White urban area. The Province has plans for two very big hospitals - one in Umlazi and one on the periphery of Kwa Mashu. In future, therefore, hospital facilities will be provided in the major Bantu townships of Durban, and will be from the transport point of view, far more accessible to the people than King Edward is at the present. This hospital necessitates patients and relatives from Kwa Mashu in particular, having to travel a considerable distance from their homes to the hospital.

An important contribution to the care of the Bantu has been made by the many Mission Hospitals in Natal. These hospitals receive a Provincial subsidy, based on the nature of the service undertaken by a particular institution. A Government subsidy is provided, exclusively for the service of Mission Hospitals in the matter of providing beds for T.B. patients. In Durban, there is the McCord Zulu Hospital. This is at present sited in a White residential area. The hospital provides general, surgical and obstretical service. In addition, it has a large number of Bantu

nurses in training. In the Umlazi Mission Reserve, there is the Umlazi Mission Hospital. This has a medical, a surgical, and a large orthopaedic department. These two hospitals render a considerable service in helping to meet the medical needs of the Durban Bantu population.

For details of Provincial Health Services, for children, chapter 2 should be consulted.

3.5 MUNICIPAL SERVICES:

(i) Services rendered by the City Health Department:

Chapter 2 has described in some detail the work undertaken by the Municipal Child Health Clinics. (See Section 2.8, sub-section (ii)). The City Health Department is, in general, responsible for all aspects of environmental health sanitation. From the point of view of public health, it must be stressed that the new Bantu townships have waterborne sewerage, and each dwelling is provided with a shower outside, attached to the toilet. Running water is provided, and regular refuse collection is undertaken. These facilities have helped to reduce fly-borne diseases, including the sometimes serious scourge of enteritis. The Child Health Clinics at Kwa Mashu, Lamontville, Chesterville and Glebelands provide immunisation, pre-natal and post-natal care, and a domiciliary midwifery service (which is growing greatly, and will steadily ease the burden on King Edward VIIIth Hospital as far as confinements are concerned).

Since 1962, a considerable contribution towards health has been made by the participation of the Durban Municipality in the Government skimmed milk programme. Besides this programme, large

quantities of high protein content foodstuffs, and full cream powdered milk have been made available to the municipal clinics by various voluntary agencies. These foodstuffs have been intended for necessitous mothers and babies, and have been distributed under the control of the City Health Department. (The report on the Malnutrition Relief Fund, and Feed the Babies Fund alone in section 3.7, subsection (ii) below gives some details of this.) The effects of the improved public health sanitation and of the widely developed preventative child health programme referred to in the preceding paragraph, are seen in the decline of the Bantu infantile mortality rate. There has been a most gratifying reduction^{1]}.

However commendable the services provided by the City Health Department are, it is interesting to point out that a large proportion of the costs of such services are borne by the Bantu themselves. For example, the rents charged to Bantu householders represent a consolidated sum made up of both interest and redemption charges on the building, plus an amount repayable to the City Health Department for health services, as well as an amount to cover services such as sanitation, roads, lighting etc. It is as well to bear in mind that the Bantu bear in many instances either the entire cost or a major proportion of the cost, of services provided by the municipalities. For example, the Bantu Native Revenue account which is financed out of profits from the sale of liquor to the Bantu, is drawn on to provide a variety of services for the Bantu. This is an indirect form of making the Bantu pay for their services.

1] Young, M.A. (1965): op. cit. page 22. Whereas in 1951 the infantile mortality rate was 369 per 1,000 live births, it has dropped down to 109 per 1,000 live births in 1963.

(ii) Services provided by the Bantu Administration
Department of the Durban Corporation:

(a) Liquor Sales:

The brewing of kaffir beer (now known as Bantu beer) has been a municipal monopoly for many years. This position prevails throughout the Republic. Profits may be used only for the promotion of Bantu welfare, and the position is very strictly regulated by the Department of Bantu Administration and Development of the State. At the moment, one-third of the profits of the beer account go to welfare services. The other two-thirds may go into housing and other provisions

Bantu beer halls are provided mainly in the working areas and also in the residential areas. These are well patronised. In the last few years "White" liquor has been made available to the Bantu under certain circumstances. The municipality has established liquor distribution points in the townships, and has also provided pleasant bar lounges for those who wish to use them. (An interesting point is that the sales of Bantu beer have not declined as a result of the availability of White liquor). It has already been stressed above, that the principle of providing welfare services from the beer account is universally applied in South Africa by local authorities. It does seem to be a most curious anomaly that the more the Bantu spend on liquor, the greater the amount available for their welfare services. In fact, a crucial situation arose in 1962 for reasons which need not be discussed here. There was a widespread boycott of the beer halls, with a consequent large drop in the sales of Bantu beer. The profits dropped drastically. In that year, substantial cuts had to be made in the grants to the various welfare agencies providing services for the Bantu. One wonders what would happen if ever the position came about that

Temperance societies became very active in the townships, and had such success that the sales of Bantu beer dwindled away to almost nothing. Certainly, temperance workers are not likely to be very happy about the present position! Be that as it may, the Durban Corporation has been adamant in its demand that all Bantu welfare services must be paid for from the beer profits. The account for these profits must be self-liquidating. The Corporation has not been prepared in the past, to make money available from its Rate Account, to pay for general welfare services for the Bantu. However, it does make some grants available from this source, but the total figure involved is not large^{1]}. This is a policy which is not pursued by all other municipalities. Johannesburg, Cape Town, Port Elizabeth, and many other towns are willing to use part of their rate funds to finance the building and development of services in the Bantu townships. Johannesburg spends substantial sums out of its rate funds on the Bantu population^{2]}.

1] In 1966, from the Durban Borough Revenue Account R6325-26 was spent on grants-in-aid to Bantu Institutions; R2343-79 on "Bantu Sports Grounds", and R2150 was granted to the Natal Bantu Blind Society, yielding a total of R10,719-05 spent on Bantu recreation and welfare from this source. By contrast, the Durban Bantu Revenue Account yielded in 1966 an income of R6530,800-47, of which R5578,780-63 was spent. The expenditure included R236,311-47 on Bantu recreation and welfare (out of which R33,488-42 was on grants-in-aid). Source: City of Durban (1966): City Treasurer's Report and Abstract of Accounts for the year ended 31st July, 1966: Durban Corporation, Durban: pp. xxiii-xvi; 33-70; 130-5.

2] For instance, in the financial year ending 1966, the Johannesburg Municipality subsidised its Native Revenue Account with an estimated R702,866 from the Rate Fund. In 1962/63, R913,481, in 1963/64 R731,905 and in 1964/65 R474,520 from the Rate Fund was used to subsidise the Native Revenue Account for purposes connected with Bantu health and welfare. (See P.R.B. Lewis (1966): "An Examination of Johannesburg's Bantu Revenue Account as at 30th June, 1965". Johannesburg Municipality, (Lithographed), p. 11.)

(b) Recreation:

The Bantu Administration Department, mainly through the medium of its welfare subsection, has developed a most active recreational programme for the Bantu. It has provided playing fields in all the townships, and has made facilities available for games such as football, rugby, tennis, etc. There is a large stadium at the J.H. Smith Hostel, and a swimming pool is provided at Kwa Mashu. The recreational facilities have been amongst the most highly developed services provided by the department, and provide a healthy outlet for the urban Bantu. These services are well supported on a Sunday, which is the one day of the week when most Bantu are free.

(c) Welfare Section:

The Bantu Administration Department of the Durban Corporation has a welfare section, which is involved in developing group amenities for the population. It is working towards the object that each neighbourhood unit in the townships will have a community centre. The progress is very slow, due to a variety of factors. Kwa Mashu existed for four years before the first community centre was developed. These centres are intended to focus activities for group work - such as scouts, youth clubs, women's clubs, etc. In the evenings these centres are used for all manner of entertainments.

Further activities of the welfare section are referred to below.

(d) Bantu Youth Employment Scheme:

One of the most important recent developments in Durban has been the setting up of a Bantu youth employment scheme. Welfare workers had pointed out that one of the greatest difficulties in the townships, was the difficulty faced by school leavers in attempting to find employment. Whilst under the Industrial Conciliation Act, and the Wages Act, there is a differential rate of enumeration for a juvenile and an adult, the difference is so small (usually amounting to between 25 and 50 cents per week), that it is not worth an employer's while to employ the juvenile worker. In recent years, those who have been staying at school for longer periods up until, for example, the level of J.C., have experienced great difficulty in finding employment after completing their education. This gave rise to the problem of the Bantu school leaver being unoccupied. Tendencies were evident for anti-social gangs to form, and bad habits to be developed by the unoccupied youths. The initiative was taken by the Durban Bantu Child Welfare Society. This Society obtained the co-operation of the Durban Community Chest, the Chamber of Industries, and the South African Institute of Race Relations. Proposals for the development of a Bantu Youth Employment Scheme were submitted to the municipality. The suggestions were accepted, and put into operation in 1964. The service rendered is most valuable. The Corporation endeavours, through its employment exchange, to place these young people. In the interim between leaving school and obtaining employment, they are occupied in gainful activity. Training is provided, with recreational facilities, and a programme which develops the character of the individual inculcating

regularity of habits and discipline.

The Bantu Youth Employment Scheme is one of the newer, but certainly one of the more valuable, of the services that have been rendered to the Bantu community by the municipality.

(e) Personal investigations:

The welfare section of the Bantu Administration Department of the Durban Corporation is involved in innumerable investigations. Cases needing welfare assistance come to them, and are referred to the various proper channels. For example, cases which might be eligible for old age pension are referred to the Bantu Commissioner, while all cases involving children are referred to the Bantu Child Welfare Society. Considerable personal day-to-day contact with the Bantu community is involved. The welfare section has a realistic appreciation of the problems facing welfare cases. In really needy cases, the rent is either temporarily or even permanently remitted. The staff does all they can to assist cases, and undertake investigations, and verification of personal circumstances. This involves a considerable amount of the time of the welfare section. The service provided is valuable.

(f) Feeding programmes:

By far the most activity of the Department is its very widespread programme of feeding by means of the subsidised fresh milk scheme. This scheme is administered by the welfare section of the Durban Corporation Bantu Administration Welfare Department. The scheme has been in operation since 1939. Milk is bought in bulk by tender, and made

available to Bantu children at a very reduced price. The scheme used to be at first for various creches, the Bantu Child Welfare Infants' Home and organised school feeding groups, as well as for certain distribution points in the townships where women could purchase milk. The distribution proved to be costly, and time-consuming. There was also the problem of ensuring that only the poor obtained the subsidised milk. Thus, after a trial, the more extensive scheme was dropped, and a more limited programme substituted. Today, the scheme applies only to children in recognised groups, so that there can be complete control of the handling and distribution of the milk.

The subsidised milk scheme was administered entirely by the Bantu Administration Department until 1959. In 1960, the Malnutrition Relief Fund took over the entire supervision, direction, and control of the programme. The municipality still makes its annual grant towards this scheme. In 1964, the control of the programme was restored to the municipality.

It is interesting to note how this subsidised milk programme has formed the mainstay of the voluntary feeding programmes which will be discussed later in this section. In 1959, 80,000 gallons of fresh milk were supplied at a cost of R14,000-00. In 1966, some 195,000 gallons, or nearly two-and-a-half times as much, was supplied at about R48,000-00 cost. Appendix 'B' can be consulted for details of the distribution of the milk.

(g) Vegetable Clubs:

Many years ago, before the development of the Kwa Mashu and Umlazi townships, when the family areas occupied by the Bantu in Durban were still limited, one of the active programmes of the Corporation's Bantu Administration Department's Welfare section, was the assistance given to innumerable vegetable clubs. Groups of women, ranging in size from 4 women to 20 or more, clubbed together, each paying a monthly sum. The group then bought vegetables in bulk at the municipal market. However, transport and distribution of the vegetables proved to be a problem, so the welfare department of the municipality stepped in and helped with the organisation and administrative running of these clubs. There is no doubt whatsoever that they played a valuable part, and enabled the purchase and distribution of fresh vegetables in the township at a significantly lower price than obtained in the townships. Today, despite the large number of families living in a township as large as Kwa Mashu, there is no public market. The residents are compelled to make journeys to the City market, (in which case the costs of transport have to be added to that of their purchases), or else they have to buy inferior produce at higher prices in the local township stores.

It seems a great pity that this programme has fallen into disuse, and it would be well worth while organising a new scheme, if this was possible.

(h) Gardening:

Mention should be made of the effort of the Bantu Administration Department to encourage the township residents to garden, and to grow vegetables. However, with water being

metered, plus the lack of fencing, the widespread use of gardens has been somewhat deterred. The municipality provides trees, shrubs, and seeds at low cost from its municipal nurseries. There are not a few attractive gardens and vegetable gardens in the townships. Nevertheless, in general, the contribution to diet from such sources must be small. One cannot help wondering if a competition sponsored by Radio Bantu would not increase the amount of interest which people show in their gardens, particularly the vegetable gardens, which could help to supplement the diet of the family.

(i) Childrens' Services:

One of the most active fields of endeavour of the welfare section of the municipal Bantu Administration Department has been its extensive assistance to the voluntary societies providing care for Bantu children.

The municipality provides buildings for a variety of voluntary agencies. In the last few years, there has been an active building programme undertaken. For example, the Othandweni Infants Home of the Durban Bantu Child Welfare Society was built by the Durban Corporation, and made available to the Society. In Kwa Mashu, the Bantu Child Welfare Society has been provided with creche buildings by the Corporation. It has just taken possession of its fifth creche. In Glebelands, one creche was built by the Municipality, and again run by the Child Welfare Society. New buildings in the southern complex of townships are being built for play groups, with an average of two new buildings being completed every year. This part of the programme of the municipality

renders noteworthy assistance to the voluntary societies.

The Durban Corporation has a very substantial programme of grants-in-aid to voluntary societies for their operating programmes. By way of illustration, the Bantu Child Welfare Society receives R1,500-00 per annum for each of the creches that it operates. Other societies which provide only half-day programmes for their creches, receive commensurately less. In fact, virtually every voluntary agency working in the Bantu field in Durban, receives aid in the form of a grant or personal service from the Welfare Section of the Bantu Administration Department.

Finally, we must stress the liaison rendered by the Welfare section - in innumerable ways it renders aid to voluntary agencies, and its liaison with them is most valuable. This facet of their work constitutes an example of outstanding team-work and assistance by the Durban Corporation. The staff for the programmes - which consist of a small number of Whites, and an increasing number of trained and qualified Bantu workers - constitutes a team of devoted, loyal and indefatigable workers. Their co-operation has made the joint participation of the Durban Corporation with the voluntary societies as fruitful as it is today^{1]}.

1] Appendix 'F' provides a list of all grants-in-aid to welfare societies made by the Durban Corporation.

(j) Bursaries:

A number of bursaries are offered to the Bantu in Durban by the Bantu Administration Department of the Durban Corporation.

The Durban Municipal Advancement Bursaries are awarded to scholars of Bantu parentage who wish to further their education in such courses as in the opinion of the Selection Committee will be beneficial to the Bantu community.

There are three of these bursaries valued at R100-00 per annum and five valued at R85-00 per annum, tenable for two years at a recognised scholastic institution other than a university.

Two bursaries at R120-00 per annum tenable for one year at the University College of Zululand are offered to students who are reading or intend reading, for a degree course. In addition, four medical bursaries are offered to recipients selected by the Natal University Medical School, valued at R120-00, tenable for one year.

3.6 VOLUNTARY HEALTH AND WELFARE SERVICES -
GENERAL COMMENTS:

The contribution made to the provision of services for the Bantu by the voluntary effort in Durban is immense. The work undertaken comprises not only the activities of registered welfare organisations in the fields of health and welfare, but also the outstanding work of the churches, the service organisations, the Rotary, Round Table, Lions International, Women's organisations (especially the work of the Federation of Women's Institutes of East Griqualand and Natal), the many European schools which have programmes for assisting the Bantu, and last, but not least, the work of countless individuals who assist either by financial donations, or by rendering voluntary service themselves. Furthermore, amongst the Bantu community there are a number who assist with quite informal programmes of their own. Our brief review of the welfare and health services provided by voluntary workers unfortunately cannot extend to cover the work of all these many and varied bodies and individuals. We will have to restrict our description to the work of the registered welfare organisations, with only a passing reference to other types of bodies.

In the opening sections of this chapter, reference has already been made to the extension of services to Non-Europeans by most of the existing National Councils. Thus, for example, Child Welfare, Cripple Care, Mental Health, Blind, and S.A.N.T.A. National Councils, have all, over the years, developed quite considerable activities amongst the Non-Europeans, including the Bantu. Specialist services have become available to the urban Bantu. In more recent years, a number of new National Councils have arisen. These are, for example, the South African Marriage Guidance Council, the South African National Council of Alcoholism, and the South African National Council for the Care of the Aged. In most instances, these Councils have also included in their programmes work

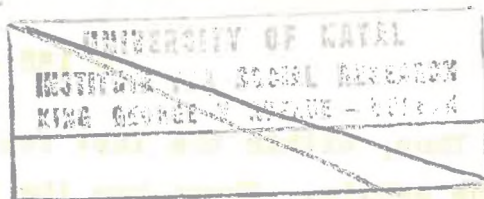
for the Bantu.

The brief survey which follows below gives only an outline of the major voluntary agencies working in the Bantu field in Durban. An attempt will be made to indicate to what extent the Bantu themselves are participating in the organisation and administration of these services. It must be stressed that the programmes to be described are portrayed in only the barest outline. An exception to this rule is the case of the constituent bodies of the Durban Non-European Childrens' Fund. These are described in far greater detail, on the grounds that one of the main aims of the investigation was evaluating the work of these latter societies, particularly in the field of combatting Bantu malnutrition. In order to undertake such an evaluation, it was necessary to go into some detail on the total services which they have developed. The fact that this detail is given for the Durban Non-European Childrens' Fund members, and not for other voluntary organisations, is no reflection of the programmes of the other societies.

Before discussing the programmes of the societies to be dealt with, there are two general aspects relating to the work of voluntary societies which should be mentioned, since they have universal applicability:

(i) Financing of Voluntary Welfare:

Durban pioneered the institution of a Community Chest. The Community Chest was launched in 1931 when 12 member societies were affiliated as full members of the Chest. In the first year of its activities, the appeal of the Chest raised R30,000-00. Since that date, the number of participating member societies has grown substantially. With more member societies, additional services being provided by the voluntary agencies, and rising costs



due to inflation, the appeals of the Chest have increased from year to year.

A large number of small societies have remained outside the activities of the Chest. They still seem to finance their own activities by means of direct appeals to the public, street collections, and fund-raising functions of various sorts. Most, if not all, of the larger societies have become affiliated to the Durban Community Chest.

In Cato Manor at its worst, some 80,000 Bantu lived under deplorable slum conditions. At that stage, the public-spirited citizens of Durban felt impelled to do something in a situation which initially was ignored by the Government, the Province, and the local authorities. Efforts of the voluntary workers were primarily devoted to providing free feeding schemes for the children, and developing child care services, health services, and also trying to bring order into a chaotic situation. Thus, in 1958 "Their Daily Bread" began its operation of providing meals to school children. In more recent times, the Lamontville feeding scheme and more recently the Umlazi feeding scheme came into existence. These three organisations have now amalgamated under the title of "Their Daily Bread". In 1958, the first Cato Manor Appeal was launched, largely under the auspices of Round Table. At that stage, it was thought that the appeal would be every two years. However, by 1959 it was obvious that the appeal would have to be an annual event. By then, the appeal covered not only "Their Daily Bread", but also the Cato Manor Community Welfare Huts, the "Durban Organisation for the Care of Pre-School Bantu Children" and "Feed the Babies" Fund. Once Cato Manor was cleared, the name of the appeal was changed from the "Cato Manor Appeal Fund" to the "Durban Non-European Children's Fund".

Thus, within the last few years two major appeals were made to the public. There was the appeal of the Durban Community Chest, and the smaller appeal for the agencies working under the auspices of the Durban Non-European Children's Fund. When Cato Manor was still in existence, the public conscience was stirred - possibly to an extent by guilt, and also by humanitarian feelings - and the Cato Manor appeal was well supported. In most years it attained its target without great difficulty. More and more as Cato Manor was cleared, the organisations followed their charges into the new township of Kwa Mashu, and also extended their activities to the southern complex. During the last two years of its drive, the Durban Non-European Children's Fund experienced considerable difficulty in attaining its target. (This was during 1964/65). It became obvious that the community was not giving support to these agencies to the same extent that it had done when Cato Manor was in existence. In the light of this, and also in the light of the clash between the appeal of the Durban Non-European Children's Fund and the Durban Community Chest, it was decided eventually that the societies of the Children's Fund would seek individual affiliation with the Durban Community Chest. It must be stressed that the Durban Non-European Children's Fund was nothing more than a consolidated fund raising agency. It did nothing to co-ordinate the individual programmes of the constituent bodies, and had no say in their activities. It was thus agreed by the Durban Community Chest that it would include the constituent bodies of the Durban Non-European Children's Fund in its 1966 appeal. As the "Lamontville School Feeding Scheme", the "Umlazi School Feeding Scheme" and "Their Daily Bread" had in the interim amalgamated, the five bodies from the Durban Non-European Children's Fund which have joined the Community Chest are: "Their Daily Bread" feeding scheme, Durban Organisation for the Care of Pre-School African Children, Feed the Babies Fund, the Malnutrition Relief Fund, and the Bantu Community

Welfare Organisation.

In 1966 the Chest appeal attempted to reach the unprecedented target of R365,000-00. This represented a great increase over previous appeals. (For example, the 1965 appeal amounted to only R250,000-00). Unfortunately, the appeal of the Chest has fallen short of its target, and by the end of 1966 the sum of R314,489-49 had been attained - indicating a shortfall of R50,510-51. It remains to be seen for the future whether the Chest will have similar difficulty in the next few years in obtaining sufficient support from the public to reach its target figure for its appeals

(ii) Government Policy Regarding Voluntary Services:

In 1951 the Government appointed a Commission of Enquiry into the financing of voluntary welfare organisations^{1]}. Its recommendations were released in 1953. We are only interested in those recommendations which apply to Non-European work. With regard to local authorities, the du Plessis Commission (as it was called)^{2]}, recommended that local authorities should not be authorised to perform any practical work for Europeans. As far as the Non-Europeans were concerned, assistance from local authorities in the welfare field was deemed necessary only as a "transitional phase". Wherever possible, voluntary organisations managed by the Non-Europeans themselves, should play an increasing role in the running of the organisation. The Commission made radical recommendations regarding the organisation of Non-European work. In place

1] Part of the material for this section has been taken from page 19 of the Paper by Pollak (see Pollak, H.P. (1960): op. cit.

2] Recommendations of the Committee of Enquiry into the Financing of Voluntary Welfare Organisations: 31st August, 1953 : Chairman, Mr. W. C. du Plessis. Government Printer, Pretoria

of one agency serving all racial groups, separate voluntary agencies should be set up for each separate racial group. In order to bring this about, separate sub-committees should, in the first instance, be set up for each racial group. Thus in a particular voluntary society, European leadership would be allowed purely as a transitional phase. Thereafter, the separate sub-committee of the race concerned would eventually be responsible for becoming the controlling committee and developing the separate welfare organisations for the race concerned.

At the time that these recommendations were published, they were regarded by those working in the field of Bantu welfare as unrealistic and impossible to attain. In practice, however, directions from above have brought about a gradual but forceful implementation of this policy. In the early 1950's, welfare organisations working in the townships were instructed that in future any resident European staff would not be permitted to live in the township. At that time, there were many Bantu homes - for example childrens' homes, homes for unmarried mothers, institutions for delinquents, etc. - which had a White resident staff in the form of matrons, home directors, and so on. In Durban, however, the position was not as difficult as in other areas. This is because the only organisations which had operated such institutions had already embarked upon a policy of rapid "Africanisation" of their staff.

In 1957 the Government's Bantu Administration and Development Department issued a circular announcing a new policy. The provision and control of social welfare and recreational activities in the townships, by a body of Europeans, or by a joint or mixed committee of Europeans and Non-Europeans, was contrary to policy, and would not be approved. This policy has been implemented in

successive stages over the years by the Government. It must be stressed that almost every organisation working in the Bantu field had originally either a European, or a mixed committee. The Government policy has involved a radical reorganisation of every society in the field of Bantu welfare. Within the last three years, the Bantu Administration and Development Department has insisted that no Bantu organisation working for the Bantu should be permitted to continue with mixed committees. It has therefore been necessary to have either a White Executive Committee with a Bantu Advisory Committee, or alternatively, a Bantu Executive Committee assisted by a White Advisory Committee. The days when all those who were vitally interested in the programme could sit down to develop it, to iron out difficulties, and to thrash out problems, has become a thing of the past. Constitutions of the organisations concerned have had to be redrafted. Often the organisations had to expand to develop a Bantu sub-committee. From this point of view, some societies were better equipped to deal with the changing situation than others. Some had already had it as their own target to develop increasing Bantu participation and had for many years worked towards it. They had been building up and strengthening the participation of Bantu members. Other organisations by contrast have been, until the policy changed, White affairs. All have had to pass increasing responsibility to Bantu committees. All have experienced difficulties in doing so. This is because Bantu society at present does not have a leisured middle class of any significant size. Consequently, it is extraordinarily difficult to find suitable volunteers who have both the time and the knowledge and the experience to render voluntary service to organisations. The persons most fitted to do this, are the professional groups of ministers, teachers, nurses and social workers. Almost all men and women in these groups are working, so that they have little time to give

as volunteers. Nevertheless, it is gratifying to see the number of capable women in particular, who have increasingly come forward from the Bantu community, and are taking an active part in the Child Welfare services. They have become active too, on the Parents' Committees and Advisory Committees. The greatest difficulty, is that of finding men and women who have had any experience in the field of financial control and organisation. It must be stressed that European societies, which have had generations of tradition of voluntary service, experience continual difficulties in finding treasurers - therefore it can be imagined how difficult it is in a society which is only now beginning to develop a trading class, and which has had virtually no training in the art of book-keeping, accountancy, and financial control.

Nevertheless, despite difficulties, the Bantu themselves are taking an increasingly active part in the control of welfare organisations working for the benefit of their population. There have not been only problems involved in the change-over, but benefits too have accrued. In the years to come, the experience being gained by the members of the Bantu community in administration and organisation will become increasingly important, and this policy is providing a training ground in such activities.

3.7 VOLUNTARY HEALTH AND WELFARE SERVICES - CHILDREN'S SERVICES:

(1) Durban Bantu Child Welfare Society:

The Durban Bantu Child Welfare Society was established in 1935 with a very modest field of operations. From these small beginnings, it has become the major organisation dealing with Bantu Child Welfare in the city of Durban. It should be stressed that while officially the society is a child welfare organisation, as

there is no Bantu family welfare society in Durban, and as it is virtually the only casework agency dealing with families, a considerable amount of its work is really in the field of family rather than purely child welfare.

Today, many of the specialist programmes undertaken by other societies - such as Cripple Care, Mental Health, S.A.N.T.A., etc. - depend to an extent on the co-operation and active assistance of the Bantu Child Welfare Society, which assists in the administration of such services.

(a) Work of the Bantu Child Welfare Society:

We can summarise the work of the Bantu Child Welfare Society as follows:-

1. Court enquiries:

The Society carries out investigations on behalf of the Child Welfare Commissioner, in terms of the Childrens' Act. In the last year, this involved 378 cases, which represented 1,163 court appearances. The Society does not deal only with the municipal area of Durban, but on the instruction of the Bantu Child Welfare Commissioner, has extended its activities to the regions surrounding Durban.

2. Maintenance grants and administration of poor relief:

In the 1965 Annual Report of the Society, it was reported that the number of maintenance grant families dealt with, increased to 552. The Society also administers poor relief supplied by the Bantu Administration and Development Department. In that year, poor relief was administered to 427 Bantu families.

3. Foster care programme:

The foster care programme of the Society is not a large one, mainly because of the gross inadequacy of the foster care grant, which has already been referred to in section 3.3, sub-section (i) section (d) above. As foster care involves the foster parents in being willing to partly support the child out of their own pocket, it is very difficult to obtain suitable foster parents. From the Society's point of view, the programme involves a lot of casework, with constant endeavours to obtain more foster home placements. Appeals have been lodged with churches, and various Bantu Women's Societies, in order to familiarise them with this programme. Last year, 357 children were placed in foster care.

4. Adoptions:

This programme is largely confined to finding adoption homes for children from the Othandweni Infant's Home. The number of adoptions is very small, but it must be remembered that this aspect of the Society's work is inordinately time-consuming. In terms of the Natal Bantu Code, the most exhaustive enquiries have to be made to trace any possible relatives in the rural areas. Only if none can be traced, then may adoption be arranged.

Last year, the programme was smaller than it had been for many years. Only 25 adoptions were organised.

5. Othandweni Infants' Home:

This home is the only residential home providing institutional care for Bantu children in Durban. It provides for from 90 to 100 infants, from birth until 6 years of age.

Large numbers of the children who are admitted come in an extremely poor condition. From many points of view, this home could be considered as an auxiliary children's hospital. Because of over-crowding in King Edward VIIIth Hospital, children are not admitted unless there is a free bed. This results in many of the children in the infant's home being in such a state that they should really receive hospitalisation, but no hospital facilities are available for them. As a consequence, it is imperative that this institution has not only a highly qualified trained matron, but also its complement of qualified nursing staff, and a large complement of nurse-aides.

It is significant that this institution is entirely staffed by Bantu workers, and the whole committee consists of Bantu members.

6. Creche programme:

The Durban Bantu Child Welfare Society operates four creches in Kwa Mashu. An average of between 90 to 100 children are in attendance. One creche is operated in Glebelands, while the A. K. Zulu Creche in Chesterville has been taken over by the Society. A seventh creche will be in operation from 1967, in Kwa Mashu. The creche programmes have been described in chapter 2. (Section 2.9, sub-section (iv)).

It must be stressed that these creches afford care to children from the hours of 7.30 in the morning to 5.30 in the evening. Their programme provides carefully supervised care for the health and psycho-socio development of the children.

7. Some statistics:

The following statistics, taken from page 5 of the 1966 Annual Report of the Bantu Child Welfare Society will give a further indication of the scope of its activities during the year 1965:-

Number of families dealt with during the year -	2,215
Number of children dealt with during the year -	6,244
Number of office interviews -	15,186
Number of home visits undertaken by social workers	5,566
Number of maintenance grants administered -	
520, involving 2,484 children;	
Poor relief - 441 families, involving 1,620 children;	
Othandweni Infants' Home - 29,616 'Child days';	
Number of meals served at the Othandweni Infants' Home -	88,848
Creches - 97,958 'Child days';	
Meals served at the creches -	293,964

The staff of the society has grown very substantially, the social workers are all qualified Bantu workers, as also are the heads of the creches and the Infants' Home. Out of a staff of 60, 6 are White, (the General Secretary, the Case Supervisor, the Creche Supervisor, and three persons dealing with finance, records and administration). The rest are all Bantu.

(b) Bantu committees:

From its inception, the Society has had on its executive, leading members of the Bantu community. These have been persons active in church, education, and social work. The society has encouraged the creation of Bantu sub-committees, and from the beginning each creche was organised with a Bantu Parents' Committee. Later, as the creches developed, a combined Creche Committee was set up consisting entirely of Bantu members. The Infants' Home has for the past four years been under a Bantu Home's Committee with a European Advisory Committee in attendance.

In terms of Government policy, the Society has set up a general Advisory Committee consisting of Bantu members. This Committee is increasingly assuming responsibility for many aspects of the programme. The society has consequently been able to adjust itself to changes in Government policy with facility.

(c) Finances:

In 1936, when the Society commenced activities, it received a modest grant of R200-00 from the Durban Community Chest, and R120-00 from the Durban Corporation. In 1966, the Community Chest gave R25,167-00, while the Durban Corporation gave from its Bantu Revenue account R14,200-00. In addition, the Corporation provided thousands of Rand worth of building accommodation for the creches and home of the Society.

It must be stressed that the creches do not fall under the Durban Community Chest, but raise their own finances to meet their costs. For example, the Students Rag of the

University of Natal, has for many years given a substantial grant towards this service.

During the last four years, the Society has been most fortunate in receiving several bequests, and many individual donations. At Christmas time, the Society has participated in the various Christmas Cheer programmes, which have made possible the wonderful Christmas distributions - particularly to all maintenance grant families. Rotary Ann's, some women's institutions, (especially the Federated Institute of East Griqualand and Natal Women's Institutions), make all sorts of contributions in kind, and also sew the many thousands of garments required.

Thus, there is a very active community-supported programme in operation. The programmes have shown flexibility in adjustment to constantly changing situations. The Society has maintained the highest standards of both individual and group care of children.

(ii) The Durban Non-European Children's Fund:

The Durban Non-European Children's Fund is concerned with the area covered by the city of Durban and its surrounding districts. This is an area somewhat larger than the municipal area of Durban, but is considerably smaller than the metropolitan region which may be regarded as stretching from Amanzimtoti to Umhlanga Rocks, and inland to Hillcrest. The fund originally grew out of the problems and distress associated with the terrible slums of old Cato Manor, within the municipal boundary of Durban. These slums were regarded by some experts as amongst the worst in South Africa.

In 1954, when conditions in Cato Manor were really bad, there were many welfare organisations trying on a voluntary basis, to alleviate the plight of the Bantu people living in these slums. All of the organisations were sorely hampered by lack of money. The Round Table, therefore, conducted an appeal under the name of the "Cato Manor Appeal Fund". The original intention was to have an appeal every two years, but after the second appeal, it was found to be essential that there should be an annual approach to the public for money. One or two appeals were conducted under the original name.

This time, towards the latter part of the '50's, Cato Manor was being gradually cleared. The inhabitants were being moved to newly constructed townships outside the boundaries of Durban - Kwa Mashu to the north, and Umlazi to the south. Thus the name "Cato Manor" no longer was entirely appropriate. Also, the name did not have very happy associations. Consequently, it was found desirable to change the name, and that of the "Durban Non-European Children's Fund" was adopted. The fund was registered as a welfare organisation, W. O. 2416.

Initially the fund consisted of the following first five organisations.

Their Daily Bread feeding scheme;

Cato Manor Community Welfare Huts;

Durban Organisation for the Care of Pre-School African
Children;

Feed the Babies fund;

Lamontville feeding scheme;

Umlazi school feeding scheme;

Mainnutrition Relief fund.

The last two organisations joined the fund slightly later than the previous ones.

The original committee of the fund was formed by Round Table. Each organisation was asked to send 2 to 3 representatives to a meeting. After registration as a welfare organisation, the position was formalised.

In all, eleven appeals were held by this fund, and every year an average of approximately R30,000-00 was raised. In the first year (1954) R25,000-00 was raised. The maximum amount ever raised was R35,000-00. A brochure was published with each appeal, 5,000 copies being distributed. In addition, as wide as possible press coverage was arranged when each appeal was made. Most of the money obtained came in as a direct result of the press publicity, but personal appeals were also made to large organisations for assistance.

The position has now altered. In 1965 negotiations were started between the committee of the Durban Community Chest and that of the Durban Non-European Children's Fund (hereafter referred to as D.N.C.F.), because the financial appeals launched by the two organisations were overlapping, even though they were held at different dates. As a result of these negotiations, the Durban Community Chest has agreed as from 1967 to take over the fund raising of the D.N.C.F.

At the present time all of the seven bodies listed above as constituent members of the fund are still in existence. Three of them have amalgamated - Lamontville school feeding scheme, the Umlazi school feeding scheme, and "Their Daily Bread" feeding scheme have now joined into one organisation to be known as "Their Daily Bread". The Cato Manor Community Welfare Huts has changed its name to the Bantu Community Welfare Organisation, on the grounds that Cato Manor

is no longer the area served by the agency. The organisations followed the move of their welfare cases from the old slums of Cato Manor to the new townships, and also to some of the older townships. It is in these townships that at present the voluntary work of the organisations concerned is being carried out.

A description of the activities of the constituent voluntary welfare agencies forming the D.N.C.F. is provided below. For the sake of the organisations themselves, a separate confidential evaluation of the work being undertaken is provided. However, as this does not concern the general work in welfare in Durban, this material is not included in the present report.

(a) "Their Daily Bread" feeding scheme:

"Their Daily Bread" feeding scheme is the name which is being given to the amalgamation of three feeding schemes namely the Umlazi feeding scheme, the Lamontville feeding scheme and the first, "Their Daily Bread" feeding scheme in Chesterville. The welfare organisation number of the latter (W. O. 1854) has been adopted by this group.

The finance for all three of these organisations was formerly obtained from the D.N.C.F. As this fund ceases to exist at the end of 1966, "Their Daily Bread" feeding scheme has applied to the Durban Community Chest for membership, and will join as from the 1st of January, 1967.

The new committee of the combined organisation has not yet been finally established. In all likelihood it will be composed of a combination of the committees of the previous schemes.

All together 11,300 children are fed by the scheme in the Bantu townships of Chesterville, Lamontville and Umlazi. The programme differs in each area, as a result of the separate townships originally being catered for by the three separate organisations. It is therefore appropriate to discuss each of the areas separately:

1. Chesterville and Cato Manor Area:

"Their Daily Bread" feeding scheme started in this area in 1954, and arose out of a letter to a Durban newspaper pointing out that the Chesterville school was the only school not being provided with feeding at that time. As a result of the letter, contributions from various people poured in, and a committee was formed. Once this scheme was started, the Round Table volunteered to raise the money. As we have already pointed out, it was not long before the voluntary organisation become part of the Durban Non-European Children's Fund appeal (originally known as the Cato Manor appeal).

In 1955, the year after the original commencement of the scheme, all government sponsored school meals came to an end. A school inspector of the Bantu Education Department who is a member of the present committee asked that the parents of school children be given the privilege of paying for the school feeding. The children paid 10 cents a month, as Chesterville was - and still is - a sub-economic housing area. With the change in the set-up, the work in the Chesterville area has grown from one school to twelve. These consist of primary schools only, and the age groups covered are from 7 to about 14 years. A total of about

1,300 children are fed in the schools in the township. Each child is given two slices of bread and jam every school day. Half-a-pint of milk is given to each child at the schools twice a week. The organisation does not utilise the powdered milk scheme, but their milk is subsidised to an extent of 50% by the Durban Corporation's Bantu Administration Department.

Today, each child pays 12 cents per month, which represents a fairly nominal increase since 1954. There is no remission made if a family has more than one child at a school. The amount paid by the children covers the price of the milk, but not the bread and jam. The school board collects the money and pays the Durban Corporation for the subsidised milk. Bread and jam are paid for by the funds collected by the D.N.C.F. Each school has its own Parents' Committee, elected by the school. The Committee is intended to keep an eye on the feeding scheme, and see that the children pay for their food. Their books are audited, and if a child does not pay he is in theory not supposed to receive any food. However, if a child comes from an indigent family, he is given the money to pay for his food - but this is only on the recommendation of the Bantu Child Welfare Society. It costs about R400-00 per annum to provide school feeding for indigent children in the township.

As has been pointed out, Bantu children originally paid 10 cents per month, which exactly paid the price of the milk under the subsidised milk scheme of the Durban Corporation. In 1964/65 financial year there

was an increase in the price of milk. The fees were then raised to 12 cents a month per child to meet the additional costs. An analysis of the financial position shows that the ratio of contributions from the parents of the children to the contributions from the feeding scheme remained very stable. Sixty per cent of the total costs of the food for the feeding scheme is provided by the scheme itself, and 40% from the contributions of the parents.

With the clearance of Cato Manor, a decline in the number of children being fed in the Chesterville and Cato Manor areas took place, leaving only the children in Chesterville. Whereas in 1961, 5,407 children were being fed, in 1962 there were 4,740 in 10 schools. By 1965 the figure had declined to 1,325 children at 3 schools - the Chesterville Junior School with 500 children, the Christopher Nxumalo School with 475 children, and the Umkhumbane School with 350 children. As the activities declined, the "Daily Bread" fund received smaller grants from the D.N.C.F. Whereas the Cato Manor appeal in 1961 contributed R6,000-00 to the school feeding schemes, in 1964 when the consolidated appealing body was the D.N.C.F., the contribution was only R2,500-00. No contribution was made in 1965. The society's reserves have been very greatly reduced, and would virtually be entirely absorbed if faced with a similar deficit as that of 1965. From 1967 the funds will come from the grant to the amalgamated group of three feeding schemes, provided from the Durban Community Chest.

It must be stressed that the entire expenditure since the inception of the fund has gone into food. All administrative expenses - both of the European Committee and the Bantu School Committee, as also the audit, has been rendered in an honorary capacity.

2. School feeding in Lamontville:

School feeding in Lamontville has always been run by the Durban South Rotary Club, and drew most of its funds from the Cato Manor Appeal Committee (later the D.N.C.F.) The schools being fed in this area have increased in number from one school to six, with a present total of 3,800 children being fed.

Lamontville is not regarded as a sub-economic area, so that each primary school child is expected to pay for the basic cost of the food. The parents pay 20 cents a month per child. On two days a week the children are provided with putu and milk, or amasi; on two days a week they receive samp and beans; and on one day a week they get pro nutro soup with meat extract added to it. They formerly had a stew with meat and vegetables, but the meat became too expensive for this to be continued. They also have two slices of bread on the day on which they receive soup. On three days of the week, the children are given one-third of a pint of milk or amasi - this amounts to half a gallon of milk per child per month.

The milk and bread are paid for directly by the School Board, which collects the monies from the children. The mealie meal, the samp, beans, pro nutro etc,

are paid for by money from the feeding scheme itself - that is at present the D.N.C.F.

There is one secondary school at Lamontville which takes part in the feeding scheme in addition to the primary schools. Furthermore, the pre-school groups which are widely dispersed throughout the township also participate in this scheme. In the case of the play groups, the parents contribute a monthly sum of 50 cents per child. Forty cents of this is paid to the Lamontville feeding scheme, and the children receive more feeding than the school children.

In the case of the play groups, the parents' contributions of 50 cents per child per month constituted some 53% of the total costs in 1964, and 45% of the total costs in 1965 (the change due to the rise in the price of milk). In the primary schools, the 20 cents paid per month per child by the parents constituted some 65% of the total costs of the feeding scheme for primary school children in 1964, and 61% in 1965. The secondary school parents contributed 62½% towards the total costs in 1964, and 67% in 1965.

As with the feeding scheme in Chesterville and Cato Manor, the one in Lamontville is also administered without any costs, all the services being voluntarily donated by the workers concerned. All the money thus is spent on food.

3. Umlazi School Feeding:

The Umlazi feeding scheme came into being under the Durban South Rotary Group, with the finances being drawn from the D.N.C.F. The Umlazi township is developing extremely rapidly, and this scheme will be by far the largest as far as school feeding is concerned. It already feeds 6,000 children in 35 schools, and will eventually attempt to feed the children in 70 schools - something of the order of more or less 12,000 children.

The township falls outside the jurisdiction of the Durban Corporation. It is controlled by the Central Government's Bantu Administration Department. Consequently the milk subsidisation scheme provided by the Durban Corporation which applies to the two previous feeding schemes, does not apply in this area. As a result, the voluntary workers approached a large commercial dairy in Durban with the request to reconstitute powdered milk and sour it, then supplying it at a reduced bulk rate. The milk is supplied at a cost of 30 cents per gallon. Each child receives one-third of a pint of milk three days a week. They also obtain two slices of bread a day without jam - this represents one-thirteenth of a loaf of bread. The bakery which supplies the bread slices it free of charge. Twice a week when the children are not given milk, they are provided with pro nutro soup powder.

The milk is paid for by the School Board which collects the children's contributions. The bread and soup powder is bought by the fund itself.

4. General:

The pro nutro soup powder is bought in bulk from the manufacturer by the feeding scheme at 13½ cents per lb., instead of the usual 15½ cents per lb. It is usually obtained in 50 lb. bags. The bread is supplied by a bakery at the wholesale price of 6¾ cents per loaf. The bakery slices the bread free of charge, and also obtains jam at wholesale prices for the organisation.

It will be seen that a considerable amount of the actual day-to-day administration of the scheme takes place in the schools themselves. The teachers do about one hour and twenty minutes work per day in connection with the feeding schemes. They do this entirely on a voluntary basis.

From 1967 the feeding scheme in its amalgamated form will come under the financial support of the Durban Community Chest. In 1966, six Bantu cooks were employed at R12-00 per month, but the actual proportioning out of the rations for the day in each school was done by the teachers, who also ladled out the food and collected and banked the money. Thus, even in the future the administrative costs will be negligible.

The feeding schemes have rendered an invaluable service to the Bantu school child. The principals have all stressed its value. This is particularly so where many - probably the overwhelming majority of the school children come to school without having had breakfast. This is not because of parental neglect, but because of the sheer force of poverty. Parents have played their part

in that they contribute towards the cost of the scheme, in the proportions that have been mentioned above. Tribute must be paid to the important part which the school principals and their staff have played in the success of the schemes by being responsible for the internal organisation and administration. The voluntary contributions of the community have indeed provided a solid investment in combatting both malnutrition and under-nutrition.

In 1951 an experiment was carried out at Lamontville to test scientifically the effectiveness of feeding schemes. Four hundred children all suffering badly from protein deficiency malnutrition were selected and examined by a doctor. One hundred of them were then used as an experimental group to receive one-half of a pint of milk every day. The second experimental group of 100 children were given one-quarter of a pint of milk a day. Finally a third experimental group of 100 children were given one cup of synthetic fruit juice a day. The remaining 100 children out of the total of 400 were used as a control group, and were not given anything at all.

After three months the children were all collected, and re-examined by the same doctor. It was found that all traces of protein deficiency had disappeared in the children who had been getting one-half of a pint of milk a day. The children who had been getting one-quarter of a pint of milk a day showed some slight improvement, whereas the other two groups had made no progress at all.

After six months, the 400 children were once again examined. It was found that after this period of time even the children who had been receiving only one-quarter of a pint of milk a day were completely recovered from their protein deficiency, whereas the children receiving only synthetic fruit juice (more or less equivalent to a cool-drink), or nothing at all, had shown no improvement. This proves objectively the value of even very limited school feeding in improving the health of the children, and combatting and preventing disease and malnutrition. At a somewhat less scientific level, it is said by the teachers that it is very easy to pick out the children that are new to the school - they are the children who have not had the benefit yet of school feeding, and at a glance their health looks markedly inferior to that of the children who have had the benefit of school feeding for some period of time.

School feeding schemes should be, in the nature of things, temporary measures, mere stop gaps. However, until on the one hand the Bantu parents are better educated about the value of diet, and on the other hand in view of their extreme poverty, even more important, receive higher incomes for their labour, the need for school feeding schemes is likely to remain. One hopes that the day will not be too far distant when such schemes will become redundant.

(b) Bantu Welfare Community Organisation:

This voluntary organisation was originally known as the Cato Manor Community Welfare Huts, and developed in response to the needs of the slum population of old Cato Manor. Subsequently, with the clearing of Cato Manor, the name changed to the present one. It was in 1949 that the organisation was officially registered as a Welfare Organisation - No. 1094.

At present the following are the activities carried out by the Bantu Community Welfare Organisation:

1. Nursery schools and school feeding at Chesterville:

Two nursery schools (or play groups rather than official nursery schools), are run in the Chesterville township, catering for children between the ages of 3 to 6 years. The nursery schools are open five days a week. The one known as the Good Hope Nursery School caters for 80 children, while the other known as the Zamokuhle Nursery School has 121 registered children. These two schools are really play groups, as they are staffed by untrained nursery school teachers. Good Hope is run by two teachers. The children receive a daily supply of milk, bread with either jam or margarine in rotation, plus a ration of pro nutro. Medicines are supplied for the medical care of minor disorders. At Zamokuhle, three teachers run the play group. The feeding is the same as at the previous school.

A third play group - St. Barnabas - is not controlled by the Bantu Community Welfare Organisation, but the

Organisation provides milk and food for the children, as the organisation controlling the school is unable to finance the feeding. During the financial year ending the 30th of June 1966, R332-00 was spent on this item.

The children have to pay 15 cents per child per month for attendance at the play groups. The total cost of running the two play groups controlled by the organisation was in the financial year ending 1966, not far short of R1,400-00. The contribution from the parents (which as mentioned previously, is at the rate of 15 cents per child per month), amounts to only about one-eighth of the total income necessary for running these two nursery groups. The cost of R332-00 referred to as being involved by the feeding scheme at St. Barnabas, was borne entirely by the Bantu Community Welfare Organisation, as it received no contribution in any form from the play group concerned. If we examine the 1966 financial position, the cost of milk and food for feeding the children at the two play groups run by the organisation, amounts to 41% of the total costs. Apart from a very small amount charged for water, the rest of the expenditure, amounting to almost 59%, goes for the wages of the five untrained nursery school teachers.

2. The Clinic at Kwa Mashu:

The Bantu Community Welfare Organisation runs the so-called "Tickey clinic" at Kwa Mashu. The name dates back to the days when a tickey (three pennies) was the cost of attendance at the clinic. During the year ending June 1966, the clinic saw 42,284 patients.

The clinic is held weekly on Thursdays, with an average of about 845 patients per week attending. This clinic has already been referred to in chapter 2, so that it will not be necessary to refer to it in great detail. As the Annual Report for 1966 points out, the clinic concentrates wherever possible on providing food in the form of skimmed dried milk and pro nutro rather than medicine. In this sense their work is in part, of a preventative nature. As far as possible, the parents who bring their children are educated in proper infant feeding and feeding habits, and in hygiene. Three doctors in an honorary capacity attend the clinic, and Bantu V.A.D.'s assist. Bad cases are referred to the Municipal poly-clinic in Kwa Mashu.

The patients attending the clinic are today charged three cents per visit. In 1966 this brought in 25% of the total finance required for running the clinic. On the expenditure side, milk and food (dried skimmed milk powder and pro nutro), provided to patients, cost 59% of the total expenditure on running the clinic, and medicines accounted for 31% of the costs. The remaining small proportion of expenditure (amounting to about 10%), went on wages. Thus, because of the honorary capacity of most of the staff concerned with organising the clinic, nearly all the expenditure is incurred on food supplements in the form of high protein content food, or medicines.

It is clear that as with the nursery schools and feeding at Chesterville, this clinic meets an important need. The number of attendances (amounting to over 42,000 during 1966), indicates that the work done can-

not be at a very detailed individual level, but the Municipal poly-clinic at Kwa Mashu provides the facilities for more intensive medical checks. When the bulk of the Bantu children are suffering simply from the effects of poverty, then something as simple as additional protein feeding, and checks at a fairly general level on the health of the children, do play a significant role in helping to reduce the incidence of ill-health.

3. The creche at Umlazi:

The Inkanyiso Creche at Umlazi represents a fairly new development in the activities of the Bantu Community Welfare Organisation. Sixty children and twelve babies are registered, between the ages of 6 months to 3 years. These children are in all day care under five paid Bantu workers.

This nursery creche charges R1-50 per child per month for the first child in the family. Where a second child attends the figure is R1-00 for the second child, and R0-75 in respect of a third child from a family attending. The children receive three meals a day. Breakfast consists of porridge with sugar, milk and pro nutro (the latter has already been referred to as a high-protein content powder.) For lunch, in rotation, the children receive meat, soup, vegetables, samp, maas, etc. Fresh fruit in season is provided, or dried fruit or pudding. In the afternoon, the children receive milk, bread, with jam or peanut butter.

The children undergo a daily medical inspection, and minor ailments and injuries are attended to. The State Health Department visits the creche and adminis-

ters the necessary immunisations. (It has already been mentioned that Umlazi township falls under the Central Government, and this is why it is not the Durban Corporation's Health Department which provides the clinic facilities of the creche).

The creche is administered in part by a Bantu sub-committee. It is the intention of the organisation that gradually more and more of the duties involved in supervising the official running of the creche will be taken over by the sub-committee.

During the 1966 financial year, the creche fees brought in just under R500-00. This represented 22% of the total cost of running the creche, the remainder of the finance being provided by the Bantu Community Welfare Organisation. On the expenditure side, 44% of the costs went on food for the children, and 54% on wages of the staff running the creche. Maintenance charges accounted for the remaining 2% of the costs.

4. General:

In addition to the above activities, the Bantu Community Welfare Organisation has a sewing class at Kwa Mashu township for Bantu women. This is held weekly, with an attendance of 18 women. Welfare work, mainly in the form of relief, is also undertaken in Kwa Mashu. Grocery parcels, supplemented by vegetables and pro nutro are distributed each week to about 40 people. These cases are people in need of particular help such as the sickly, handicapped, or families where the earning power of the breadwinner has been temporarily affected, etc. This work affects children

indirectly rather than directly.

Finally, there is a feeding scheme in the reserve in the Kloof area of Natal, which feeds children of school-going age. The feeding scheme known as Emolweni is financially autonomous, but acts under the delegated authority of the Bantu Community Welfare Organisation. Thus, we need not go into details as far as this scheme is concerned.

In total, during the financial year ending the 30th of June, 1966, the Organisation spent 27% of its total expenditure on wages, 48% on food, 14% on medicine, 8% on welfare, and the remaining 3% went for maintenance charges, water, and general administration. This means that the administrative overheads of the organisation are low, and the vast majority of its expenditure is directly incurred in doing the job.

The Bantu Community Welfare Organisation has had no direct measure of the effectiveness of its work. However, it is clear that its work in the form of the nursery schools is appreciated by the Bantu themselves, insofar as when Cato Manor was finally cleared, they received requests to undertake similar work elsewhere, and as a result moved to the areas described. Its work is clearly meeting a need. At the same time, if it was desired, the quality of the work could be improved. For instance, the nursery schools could be made into proper nursery schools under the care of trained nursery school teachers. The "tickey clinic" could if it was desired, improve the quality of its medical care, and keep records. At the same time, it is realised that it may well be felt that there is no

point in on the one hand completely duplicating the poly-clinic at Kwa Mashu, and on the other hand running full fledged nursery schools when there is so obviously a need for the play group type of organisation in the Bantu townships. These points are discussed further in the confidential report to the organisation itself.

(c) The Durban Organisation for the Care of Pre-School African Children:

1. Background, and general functions of the organisation:

This organisatoon commenced activities in 1959 at a time when Cato Manor was experiencing its manifold problems associated with shanty towns, lack of hygiene, and lack of most amenities for group living. Very large numbers of mothers engaged in either full-time or part-time work as chars, laundry women, etc. There were absolutely no community facilities for the care of the children of these working mothers. Most of the children were left unattended during the day. Spontaneous little groups arose in various places, where a few mothers paid some adult person to keep an eye on the children. Some of these groups were operating in the overcrowded and insanitary shanties, while others had obtained the use of church halls. The situation was most unsatisfactory, since there was no control of hygiene, and the contentration of children often constituted a health hazard. In addition, there was no feeding of the children in these groups, nor was there any organised activity to keep the children occupied.

At this time, the Durban Girls' College Old Girls Guild Nursery School at Lamontville was training nursery school teachers. Eight girls were undergoing training, and one of the citizens of Durban conceived of the idea that ensuring that some immediate assistance be given to the

existing small Bantu groups by providing them with trained nursery school teachers. His initial endeavours were confined to obtaining individual guarantees for monthly support for the salaries of the teachers. The response was encouraging, and the organisation started off with guarantees of R80 to R90 per month. From the outset, it was thought of providing a very simple sort of child care service. Nothing as ambitious or costly as a nursery school with its lavish buildings, equipment, etc., was envisaged. The object was to build on what the Bantu themselves had initiated, but to provide simple sanitary accommodation, trained teachers, and a basic simple diet. In this way it was hoped to ensure such type of care would become available to the largest number of children. This type of choice seemed to be a wider one than the alternative of providing a high standard of care with expensive staff, but for correspondingly far fewer children.

From the outset, the organisers of the play groups envisaged their responsibilities as being limited to finding the salaries of the teachers, providing general supervision, and providing food, and stimulating the parents' committees in giving them some training in organisation and administration. Contrary to most other societies providing creche or nursery school care, no centres were set up. Instead, existing Bantu groups were "taken over". No European staff has ever been employed in the groups, and the maximum control and responsibility has been left in the hands of the Bantu parents themselves. Thus, this organisation is in contrast to most of the other voluntary agencies working in the field of Bantu child care in Durban.

The first Cato Manor appeal had been launched in 1958, the the second appeal was to be made in 1959. Realising the enormous need for these play groups in the Bantu townships where so many mothers were working and the children were left unattended, it was appreciated that it was impossible to finance a widespread service by appeals and pledges from individual friends and well-wishers. Consequently, the play groups were accepted as one of the Cato Manor welfare organisations, and in 1959 the Durban Organisation for the Care of Pre-school Bantu Children was launched. Until the last appeal of the D.N.C.F. in 1964, the organisation was financed through this fund, (which was previously known as the Cato Manor Appeal Fund).

Originally the society concentrated its efforts in Cato Manor, where several play groups had spontaneously developed. Once it became apparent that the clearing of Cato Manor was proceeding apace, and that the population would be re-settled in Kwa Mashu and Umlazi, it was decided to extend services to the southern Bantu townships. In the early 'sixties, services for the care of children of working mothers in Lamontville were in the hands of the Bantu themselves, and assistance was badly needed. Several approaches were made to the organisation by representatives of parents. It was thus eventually decided to take over some of the Bantu groups in Lamontville and Glebelands. By 1963, some six groups had already come under the auspices of the organisation. The same pattern as had applied in Cato Manor was used in Lamontville - namely that the organisation provided trained teachers, while feeding was undertaken by another organisation (in the case of Cato Manor it had been undertaken by the Cato Manor Feeding Scheme). The

Rotary South, with its Lamontville School Feeding scheme was approached to undertake responsibility for feeding the play groups in Lamontville. The feeding scheme would receive part payment for this service from four-fifths of the fees collected from parents. So it is that the play groups were accepted by the Lamontville feeding scheme, and this pattern of shared responsibility continues to the present time. The third partner to this enterprise of caring for pre-school Bantu children is the Bantu Administration Department of the Durban City Council. In terms of the present Government policy, no subsidies are granted by the Central Government to nursery schools, creches, etc., operating in municipal areas. The onus has been thrown onto municipalities to make grants for such services. Until 1963, registered creches etc., were eligible for Government subsidy. Now, however, such subsidies apply only to services in the Bantu Homelands. Today, the Bantu Administration Department of the City of Durban makes a contribution. Initially no contribution was made from the Native Revenue account, but after the development of service programmes at Lamontville, an approach was made. Since 1963 concrete financial assistance has been rendered by the Department, when R1,000 was contributed. Over the years the assistance has increased, and in 1966 a sum of R4,000 was provided from the Native Revenue account. In addition to this financial help, immense assistance is rendered by the welfare department of the City Council's Bantu Administration Department in innumerable ways.

The accommodation of the play groups has varied enormously. Until about two years ago, none of the groups were housed in a building that had been designed for the task, or was really suitable for the use of small children.

Accommodation varied from utterly unsuitable tin shanties - one is still in use - to part of a community hall. Many of the structures used were poorly ventilated, overcrowded, and all but one lacked cooking facilities. Conditions, particularly on rainy days, were often extremely unsatisfactory. There has however, been a very considerable improvement within the past two years. This is since the Durban Bantu Administration Department has embarked on a building programme, and is gradually handing over newly constructed buildings to the play groups as they are completed. These buildings are suitable for the use of small children in play groups. Within the foreseeable future all play groups (except Glebelands) operating within the Council's areas of jurisdiction will be adequately housed. Unfortunately, the same cannot be said for the most unsuitable unit in old Umlazi village, which is a tin shanty. This latter area falls under the control of the Central Government, and its Department of Bantu Administration does not at present intend rebuilding in this area.

Present Government policy requires that all groups services to Bantu children - that is, nursery schools, creches, play groups - be registered, and certain minimum criteria have been laid down. Applications have been submitted for the registration of each of the units. Details of which units are at present registered are provided below.

Finally, it must be pointed out that many of the play groups receive either regular or irregular help from various religious organisations, White schools, and women's organisations. This varies from a supply of fruit and vegetables on one day a week, occasional gifts of clothing and old toys, to Christmas parties etc. The main organisations

involved in this form of help are Rotary Ann's, the Sisterhood of Temple David, the Parents Association of the Hillary Government School, etc.

2. Administration and organisation of the society:

The society obtained its welfare registration in 1959, as Welfare Organisation No. 2085. It has no open membership, and is in fact operated by some four or five persons. In its earlier days, its committee was considerably larger, and was of a multi-racial nature. It is an extremely tightly-knit group of devoted persons, who have from the inception of the organisation managed it. Over the years, the policies have been worked out, the operating difficulties solved, parents' committees developed, and to some extent trained, so that day to day operations continue smoothly. Consequently there is little decision making involved, and committee meetings are not frequently required. The administrative expenses are subsequently negligible.

3. The play group programme:

The society at present operates 7 play groups. Four of them are in Lamontville, one serves Glebelands, another Glebelands and Umlazi, while the last one is in the Umlazi Government Village. In addition, the women's section of the South African Institute of Race Relations runs a play group in Newlands, which comes partly under the care of the society. Finally, the organisation also runs a creche in Lamontville. The play groups accept children from the ages of 3 years until the school going age of 6 to 6½ years. The hours of operation are from 7 in the morning until 1 p.m. The play groups run on exactly the same basis as the schools, and the holidays co-incide.

This means that during the school holidays the older children care for the younger ones, while mother is away at work. (Most creches find that their attendances drop considerably during holiday periods). The numbers accepted in each play group are severely limited by the available accommodation, and there are waiting lists at all groups. Parents pay a monthly sum of 40 or 50 cents per month (varying with the play group concerned). If there are really necessitous cases, the fees are either reduced or waived.

The object of the programme is to ensure the feeding of the children, the inculcation of habits of cleanliness and hygiene, child training, the provision of group play and free play, and teaching the children co-operation. All the head teachers of the groups have been trained, and are assisted by women (many of whom are former school teachers), who over the years have become extremely efficient. In the smaller units, there is the head teacher, and an assistant, as well as a third worker employed for domestic duty. The larger units may have one or two additional assistants.

Where possible there is active liaison with the Municipal Child Health Department. In the areas which are served by the Durban Corporation, each of the play groups is visited from time to time by trained staff of the Municipal clinic. Immunisation and booster shots are provided. On arrival each day, each child is inspected for any signs of indisposition or illness. If it appears that the child is ill, he or she is sent home (accompanied by the domestic if there are adults at home), or taken to the Municipal clinic if necessary.

The play groups have had a remarkably clean bill of health - which is somewhat surprising considering the inadequate facilities they have enjoyed in the past, and the unsatisfactory condition of at least three of the groups at the time of writing. None of the play groups have had to close down for epidemics; there have been times when widespread cases of ringworm have occurred.

The following details are provided for the specific playgroups:-

Gijima Hut, Lamontville:

This hut is in the poor section of Lamontville. It at present has 58 children, with a staff of three. The quarters provided are most unsuitable. Only one room, with a tiny kitchen, and inadequate toilet facilities is available. This proves to be particularly difficult in inclement weather, when the room becomes grossly overcrowded. Although this hut has been condemned by the Health Authorities, it is still being used. The Durban Municipality has provided in the estimates for 1967, for the erection of a new 'L' shaped building to be used by this play group.

Thembelihle; Lamontville:

This play group caters for 72 children, with a staff of four. Until early 1966, the group met in a church hall, where the physical conditions were also entirely inadequate and unsuitable. There was no running water for the washing of hands before meals, etc. However, a new and very suitable building is to be occupied very shortly.

The Durban Corporation has built a play group unit for the organisation, and this will provide a kitchen with

stove, adequate toilet and sanitary facilities, and good accommodation for the children.

Official registration has been granted to this play group by the Government Bantu Administration Department.

Lamontville Community Centre Play Group:

This play group operates in the hall of the Community Centre at Lamontville. It has a staff of five (including a cook who is responsible for the centralised cooking for all the units in Lamontville except the play group 'Kwa Mtshali'). Seventy children attend the play group. The physical plant is large, but not entirely suited to play group needs, (as a community centre was obviously not built as a play group). Registration has not yet been received by this group.

Play group run by the Lamontville Creche:

The creche operates in the welfare building at the Bantu Administration Department at Lamontville. The accommodation is suitable, although somewhat overcrowded. This unit has a staff of five, and caters for 50 babies. Unlike the other play groups, it operates throughout the year. The hours during which the play group functions are also longer, being until 5 or 5.30 p.m. In practice however, the staff stays on until the last child has been fetched by the parents, but this is never beyond 6 p.m. Children are admitted from the ages of 8 months to 3 years, and the mother must be a working mother. The fee is R1-50 per month. Registration has been provided for this group.

'Kwa Mtshali' Nursery school:

This play group (not nursery school despite the name), is the biggest unit, and under the care of a Mr. Mtshali. It has a staff of seven, and caters for 134

children. Recently this group moved into a new building provided by the Municipality. Mr. Mtshali undertakes his own feeding scheme for the group. Registration has not yet been granted, but has been applied for. It is likely, in view of the most suitable new building being occupied, that registration will be forthcoming. (This play group has been included here, although it was not counted when it was stated that there were four play groups being operated by the organisation in Lamontville. This is because Mtshali's play group is really under the control of Mr. Mtshali himself, and therefore is not to the same extent under the Durban organisation for the Care of Pre-School African Children, as the other four are.

The Glebelands Pre-School Play Group:

This group operates in the hall of the Glebelands Community. It is run by a staff of four workers, and caters for 78 children. The building is unsuitable, but it has up to now proved impossible to obtain more suitable accommodation. Food is transported from the Lamontville Community Centre by means of simple porter transport. This play group has received official registration.^{1]}

The Umlazi/Glebelands Play Group:

While this play group does not fall directly under the control of the Durban organisation for the Care of Pre-School African Children, the society nevertheless pays the salary of one worker amounting to R10-00 per month. Thus this play group can be mentioned here. It is entirely Bantu run, and caters for some 90 to 100 children. The population served are in the Umlazi and Glebelands area. At present the society is not officially registered.

1] Because the future of Glebelands as a family township is uncertain, the Authorities are naturally unwilling to build any structures for play groups which might become redundant if the area is turned into a single persons residential area.

Umlazi Government Village Play Group:

This play group operates in a most unsuitable iron structure. It is staffed by 3 workers, and caters for 56 children. Every effort has been made to persuade the Central Government's Bantu Administration Department to provide better accommodation, but so far to no avail. It appears that the main building effort is being concentrated on the new part of Umlazi, which is being developed into a model township. Consequently no building has been taking place in the older areas.

Newlands Play Group:

This unit is run by the women's group of the South African Institute of Race Relations, but it falls under the play group scheme. A staff of three workers run the group, and 75 children are catered for. The scheme in Newlands offers both creche and play group service. An excellent and well balanced feeding scheme is provided by the women's group, which also supplies the Bantu staff with a bonus and uniforms, clothing for the children, and play equipment. The standard of this group is of a very much higher level than in the southern townships. The Clifton Boys School makes a financial contribution towards the group. Registration has not yet been granted.

4. Feeding of the children attending the play groups:

At present the Lamontville feeding scheme provides the food for four of the play groups in Lamontville. Kwa Mtshali undertakes its own feeding, and also sends by means of a simple porter system, food cooked in the play group's kitchen to the unit in old Umlazi.

The play group at Newlands is, as has been pointed out, sponsored by the Women's Group of the South African Institute of Race Relations. This group has accepted the responsibility for furnishing most of the food requirements. Both the Newlands group and also Kwa Mtshali's play group receive rations of pro nutro from "Feed the Babies Fund". The remaining play group in Umlazi which is Bantu run, and for which the society only pays the salary of one worker, provides its own food.

The food provided by the Lamontville school feeding scheme, supplies one-third of a pint of fresh milk per day to each child, and brown bread spread with jam. The midday meal is a hot meal, at present cooked in a central kitchen at the Lamontville Community Centre. The cooked food is then distributed in large containers by Durban Corporation vehicles. Thirty cents out of the fifty cents paid by the parents for each child per month for attendance at the play groups at Lamontville is paid to the Lamontville feeding scheme for the food provided. (This contribution from the parents works out at roughly 40% of the cost of the food supplied). The units fed by Mr. Mtshali use 40 out of the 50 cents per child for providing their own food (except milk). In the latter case, assistance is also rendered by the Sisterhood of Temple David, in the form of vegetables

and fruit, and also pro nutro is supplied by "Feed the Babies fund". Some other contributions in kind are received from traders etc.

The hot midday meal varies, and has been described in chapter 2. Briefly it may be said that samp and gravy are supplied one day, a thick soup another day, porridge a third day, and once a week there is a stew. The society itself also purchases some pro nutro, and sprinkles this on the hot meals as an additional protein supplement for the children.

5. Bantu supervisory committees:

In the southern townships (that is, Lamontville, Glebelands, and Umlazi), the operation of the play groups is dependent on the parents' committees. The entire control and supervision in these areas is undertaken by regular visits made by two of the key White voluntary workers in the organisation. (One of these is the Chairman). It has taken some considerable time for the society to develop effective parents' committees for each unit, and these are not all yet functioning in an entirely satisfactory manner. Naturally some committees are better than others, and the Thembelihle play group has an outstanding committee.

Initially each group was visited weekly. The present target is weekly supervisory visits, but this is not always achieved. While parents' committees have met from time to time, it is mainly the head teacher of each group who does most of the liaison and contact with the parents. Today, the collection of the school fees is left to the parents' committee of each group, who pay over with great regularity to the Bantu supervisor. As has been described

under "Their Daily Bread" feeding scheme above, 40 cents of the 50 cents collected are handed over to the latter organisation.

Parents' committees may decide on the expenditure of the remaining 10 cents out of each 50 cents paid by each child per month. Most of this remainder is used for margarine or jam for bread, and for cleaning materials. Occasionally money may be taken out of this source to pay the fees of a child whose parents are unable to pay.

At present endeavours are being made to train committees in proper bookkeeping and accounting, so that a suitable record could be kept of the expenditure they incurred. Bookkeeping records vary greatly in quality, and some further experience is obviously required before the committees reach a uniformly high standard.

6. Financial aspects:

It was in 1960 that the society received its first contribution from the Cato Manor Appeal Fund (later to be known as the Durban Non-European Childrens Fund). Two thousand six hundred and twenty rand (R2,620-00) was granted, mainly for the salaries of the teachers in the play groups. Until 1963 an annual allocation of some R2,500-00 was received from the fund, when it was increased to R3,000-00. Contributions from the fund have fluctuated depending on the success of the appeal. While no contribution was received from the fund in 1966, R4,000-00 was supplied in 1965, and only R1,350-00 provided in 1964.

The Durban Corporation's Bantu Administration Department instituted a grant to the play groups from the Native

Revenue account. This was started in 1963, and amounted to R100-00. In 1964 the grant was raised to R1,600-00, while in 1966 it amounted to R2,600-00. For the current financial year it is R4,100-00. In relation to the total expenditure, the Corporation's grant represents just under one-third of expenditure in 1966. (In 1965, the grant amounted to 42% of the total expenditure incurred, while in 1964 it amounted to 43%).

Contributions from the public have fluctuated, but averaged somewhere around about R370-00 per year.

The expenditure of the society has increased as its activities have expanded. Whereas in 1959 the total expenditure amounted to R3,834-00, by 1966 it was R5,663-00. The organisation's expenditure on salaries and food constitutes 98% of the total expenditure. Administrative costs are negligible - covering an absolutely nominal amount for travelling and general expenses. Minimal expenses are incurred on equipment. As the operations have expanded, the salaries have necessarily increased as more and more staff have been engaged. The staff salaries are extremely modest, and the society itself considers that some increases, particularly to the trained staff, are overdue. (The salaries certainly compare unfavourably with those paid by some other organisations to their Bantu staff undertaking similar duties). The total staff at present employed in the groups amounts to 35 Bantu, with a total of R4,385-00 out of a total expenditure of R5,663-00 in 1966. In 1952, salaries accounted for 92% of the total expenditure, while in 1965 the figure has dropped to 71%. The 1966 figure stands at 77% of the total expenditure being for salaries. The drop in the proportions spent on salaries is due to the

increase in revenue resulting from the Durban Corporation's grant, which has allowed more money to be spent on food.

It must be borne in mind that the major feeding costs are incurred by the former Lamontville Feeding scheme (now part of "Their Daily Bread"). The total costs of feeding provided by this latter scheme which covers five of the play groups, was R2,126-00 in 1964, and R2,215-00 in 1965. The re-imburements which are officially 40 cents per child per month out of the total of 50 cents per child per month paid by parents, as play group fee, amounted to 54% of the feeding costs in 1964, and 44% in 1965. The net cost incurred by the Lamontville Feeding scheme (that is, "Their Daily Bread") in feeding the play groups was R1,237-00 in 1965.

The main expenditure incurred on feeding by the Durban Organisation for the Care of Pre-School African Children itself, is for some foodstuffs for the Kwa Mtshali and Newlands play groups, and also for some pro nutro. In relation to the total expenditure incurred by the society, the percentage spent on food from the budget of the play groups increased from 3½% in 1962 to 7% in 1963, 15% in 1964, 16% in 1965, and 21% in 1966. This represents a satisfactory increase in the amount of money available for feeding the children.

It is unfortunately impossible to calculate the total cost of running the play groups. In addition to the expenditure of the society itself, and also of the Lamontville Feeding scheme, the "Feed the Babies" fund makes substantial contributions of pro nutro to three of the groups, which on their present allocations cost R273-00 per annum. The 10 cents per month per child retained by the parents' committees

(which is spent by them on margarine, jam, cleaning materials etc., should also be added in. This contributes approximately a further R250-00 per annum.) The Women's Group of the South African Institute of Race Relations bears the greater cost of the Newlands Feeding. However, on a conservative estimate, it is considered that the various play groups described above cost somewhere around R7,600-00 per annum to run. This leaves out of the calculation the substantial assistance rendered by Rotary Ann's, the Sisterhood of Temple David, the Hillary School, etc. This works out at a cost of roughly R13-30 per child per annum to the community, plus R4-50 to the parents (as no payment is made during school holidays). This suggests that it costs somewhere under R18-00 per annum per child to care for them in the play groups. If this figure is accurate, then it is indeed a modest cost both to the parents and the community for the important service provided. It must at the same time be stressed that the programme is definitely conducted on an austerity basis, but it seems wiser to care for as many children as possible, rather than raise the standards at this stage and help less.

7. General:

The Durban Girls' College Old Girls' Guild runs a nursery school in Lamontville, which duplicates some of the work of the play groups there, but at a nursery school level. This school, known as "Enkuliso", was the original training centre for all nursery school teachers in Durban. As it operates in a different area of Lamontville, there is a natural geographic distribution of the work, without overlap. Apart from liaison maintained with the school, no contacts are maintained on any systematic basis with other groups affording child care. No group discussions, or con-

ferences are held. As this report makes obvious, there are more than a few organisations operating in Durban for the purpose of providing child care for the Bantu population, and it would seem that there is scope for profitable liaison between these various organisations, particularly in the sphere of holding regular group discussions and conferences. This point is taken up in the concluding chapter of the report.

Despite the need for providing a number of additional play groups, the society at present does not contemplate expansion. In Lamontville, the township is already so congested that there are no additional sites that could be made available for a play group building. In the new part of Umlazi, the State Bantu Administration Department is setting up its own services with Bantu Committees. Finally, a further limiting factor to expansion is that today control of buildings and physical standards is far more rigorous than previously, so that it would be impossible to start in the improvised and somewhat primitive manner in which most of the existing play groups originally commenced. A final limiting factor is that the present supervisory force of the organisation is taxed to the limit, so that no expansion could occur unless additional voluntary honorary supervisors were forthcoming.

Now that two new units have been provided with kitchens, it is hoped by the organisation that in future increasingly the play groups will be able to take over their own feeding. This naturally involves financial negotiations with the other organisations concerned, as the society itself has no budget for food. The present plans include cooking for at least 3 play groups, and a distribution to a further 4

groups which are nearby. By 1967, 4 play groups could provide for the neighbouring 3. It is believed that if "Their Daily Bread" will continue to pay for milk and bread, the rest of the feeding could be paid for from the 40 cents previously paid for feeding. In 1966, the Durban Corporation grant was increased, and if it is renewed at the higher level, or increased further, the society considers that they will be able to bear most of the costs of the feeding, except for milk. For this last item, outside financial assistance would still be required.

The organisation has had practically no staff turnover, particularly as far as trained staff are concerned. The women who undertake the work are conscientious, devoted, efficient, and can be depended upon. However, what is urgently required is a refresher training course for the trained staff, as well as some form of training for new staff. This could be fruitfully explored by the organisation.

There is no doubt at all that the play group programme is filling a great need. It is heartening to see the steady improvement in buildings provided by the Durban Bantu Administration Department, as well as to note the greater financial contribution of the Durban Corporation to the programme. All this has enabled the standard of care to be improved over the years. At the same time, it is lamentable that some of the units will be forced to continue under most unsatisfactory conditions - for example, in the old Umlazi township - and also that such slow progress is being made in the new Umlazi township. (This is particularly important when it is remembered that the new Umlazi township is going to develop rapidly into a very large hous-

CHAPTER 1.

POVERTY AND PROGRESS^{1]}

H. L. WATTS

1.1 INTRODUCTION:

A key factor in the incidence of health and welfare problems amongst any population is that of the socio-economic status of the people concerned. It is a truism to say that the health and welfare of a people are inversely related to their socio-economic status and standard of living. Whatever problems the relatively well-off may have, they are not the problems which the Social Worker, or the Clinic, are likely to have to deal with. On the other hand, from at least the time of the industrial revolution onwards, the problems associated with poverty in towns have followed a common pattern, and are well known - poverty means bad housing and malnutrition, tuberculosis, ignorance, a high infant mortality rate, and problems of broken homes, illegitimacy, and child neglect. It is not necessary here to try and unravel which of these factors are symptoms, and which are causes - suffice to say that where extreme poverty in urban areas has been found - in whatever part

1] The title of this chapter "Poverty and Progress" is unashamedly copied from B.S. Rowntree's second classic study of poverty in York, published in 1941. (See Rowntree, B.S. (1941) Poverty and Progress: Longmans, London). The study of poverty and socio-economic conditions in South Africa follows closely in the steps of Rowntree, and his successor Bowley, so that it is as a tribute to their pioneering work (in England), during the early part of this century, that this chapter is named after one of Rowntree's books.

ing scheme). The Durban Organisation for the Care of Pre-School African Children operates on a "shoestring". It does not claim that its services can be considered anything but a play group, but it does claim, rightly so, that the somewhat spartan physical conditions have been imposed rather than created by the play groups. The supervised group and free play, the regular feeding, the liaison with health authorities have provided a standard of care that has protected the children against the graver hazards of life, and has helped considerably to maintain their health. It has also given them a most important training in socialisation, hygiene, and group adjustment. One of the strengths of the organisation lies in its dependence on the Bantu staff and committees, and the increasing responsibilities which are being handed over to, and accepted by, the parents.

From an organisational point of view, the programme is peculiar. In each of the play groups there are at least 2 registered welfare organisations, as well as often some other voluntary organisations, involved in providing care. The Organisation for the Care of Pre-school African Children is financially concerned almost exclusively with paying the salaries of the staff. Other registered welfare organisations and voluntary groups provide the feeding. Often a third and a fourth registered welfare organisation will regularly furnish some food supplies to one play group or another. Unless it was possible to obtain a detailed breakdown of expenditure of each of the contributing registered agencies, it is impossible to estimate what the total costs of the programme are. No one organisation has any idea of the overall costs.

As all of the supporting agencies are members of the Community Chest, it would obviously be far more logical for Chest allocations to be adjusted accordingly, and the costs of the feeding subtracted from the agencies providing the service, and added to the budget of the play groups. This would enable financial independence to be obtained, and would preclude the present dual and often triple financial participation. The costs to the community would remain the same of course, but both from a policy and an administrative point of view, the present system is undesirable. The suggested change would make it possible to keep an accurate check of the overall costs of the scheme.

At present a great operational weakness is the feeding from a central kitchen. This raises all sorts of problems, and also means that food cannot be served as hot as might be desired in winter. However, it is hoped that within the next few years this situation will be completely changed, and a system of two units being fed from one kitchen substituted. It seems unlikely that the goal of each play group having its own kitchen will ever be attained.

In addition to the possibility of greater decentralisation in feeding, the possibility of inter-agency co-operation on a local basis should be carefully explored. For example, the well equipped Bantu Child Welfare Creche next door to the play group in Glebelands could easily cook a midday meal for both units, and obviate the present system whereby food is transported by portorage from Lamontville to Glebelands. Obviously the two organisations cannot each cook separately in one kitchen, but it should not prove too difficult to work out a simple formula of re-imbursing the Bantu Child Welfare Society for cooking food for the play group. This

type of co-operation could possibly be arranged with mutual benefit. Further possibilities of this type of co-operation in other areas could be investigated.

While the society is desirous of requesting the absolute minimum financial support from the public, and would like as far as possible to be self-supporting, it is impossible to run a feeding programme on 40 or 50 cents per child per month. Furthermore, it is considered that some additional expenditure on trained health staff would be desirable. A mobile trained nurse, with a knowledge of nutrition, would be an invaluable addition once the group feeding scheme is given up. She could effect closer liaison with the Municipal Health Clinics, and ensure that the children were individually screened for tuberculosis^{1]}. While the quality of the nutrition, the equipment, the health promotive services provided, the standards of buildings, and cleanliness, of the many creches in Durban on the one hand, and of the play groups on the other, cannot be compared, despite its limitations the society has done an excellent job under extremely difficult conditions.

At the same time, it is urged that the society should in future extend its activities into a fuller programme of promotive and preventive health. Financial independence is

1] Individual screening in the Bantu Child Welfare creches has shown an alarming rate of positive but non-infective tuberculosis amongst the children. Immediate treatment has effected early and complete cures. It would seem likely that a similar programme amongst play groups would show the same pattern.

a commendable aim, but until such time as Bantu wages are substantially increased, and the Bantu is in a position to pay fully for his own services, it is unavoidable and imperative that a substantial part of the community's investment in welfare and health services must go to the Bantu pre-school child.

(d) Feed the Babies Fund:

1. Background and general functions:

The concept of creating a special "Feed the Babies" fund, came from two of the key medical practitioners associated with the Institute of Family and Community Health, which was part of the Department of Social, Preventative and Family Medicine of the Faculty of Medicine at the University of Natal. In the 1950's there was an extremely high infant mortality rate amongst Bantu babies, with figures standing at over 250 deaths per 1,000 infant births per annum. The originators of the idea were anxious to test out to what extent this high infant death rate could be reduced if there was a programme of supervised and balanced feeding for Bantu babies. It was felt that an experimental programme of supervised nutrition using about 50 selected babies would be worth pursuing. Consequently, the Union of Jewish Women was approached round about 1953, and asked whether they would sponsor a modest project of "adopting" some 50 babies. All that was asked was that R1-00 per month per child should be paid. The Union agreed to this suggestion.

It was from this modest beginning that the scheme developed. More "babies" were added until it became too big to be financed exclusively by the Union of Jewish Women. By 1956, it was, for administrative purposes, placed under the aegis of the National War Memorial Health Foundation.

The scheme operated under the latter's welfare organisation, but the control of the scheme was still exercised by the originators of the idea. Subsequently, the Cato Manor Appeal Fund, (later the D.N.C.F.), provided financial assistance, as also did individual donors. Income from these sources has varied year by year, but by 1959 the income of the scheme had already risen to some R6,000-00 per annum. In 1964, the D.N.C.F. made a grant of R7,600-00 to "Feed the Babies", while in 1965 the grant amounted to R8,000-00. No grant was made in 1966, as the D.N.C.F. did not hold an appeal. As from 1967, "Feed the Babies" fund will come under the Durban Community Chest.

2. Programme of the organisation -
feeding of the babies by the organisation itself:

In 1959, despite community support, the stage had been reached when "Feed the Babies" fund could not afford to help more than 400 babies annually. The minimum costs of effective food supplements (mainly milk), was at that time R15-00 per baby per annum. This was costing R6,000-00 per year. In 1960, a small pilot scheme was conducted to test the acceptability of pro nutro by the Bantu. This was at the stage when pro nutro was first being manufactured. The result was so encouraging that the committee decided to adopt pro nutro as its only food supplement for feeding the babies. This had the agreeable result that existing funds could cover the costs of supplementing the diet of 1200 children annually, instead of the 400 previously. The figure per child dropped to a cost of about R0-85 per month. Babies included in the scheme were carefully selected. Children who had not yet developed the symptoms of kwashiorkor, but who showed evidence of malnutrition (such as poor weight gains, growth failure, or

actual loss in weight, diminished skin lustre, enlarged follicles and increased reticulation of the skin, frequent changes of the mucous membranes of the eye or mouth), were selected. These children were all of the ages of 6 months to 3 years. Their mothers were supplied with a supplement of pro nutro, which was to be given to the child in three or four equally divided quantities, amounting to a total of 2 to 2½ ounces per day. It was felt that this food supplement in addition to the usual diet which the mother supplied for her baby, would play a key role in improving the health of the children.

The efficacy of the pro nutro programme was stressed in the annual reports of 1961, 1962 and 1963. It was stated that no deaths had occurred amongst the children in this scheme, that no kwashiorkor had been found, and that their growth rate had continued to rise above the average for their own ethnic groups. It is on the basis of these observations that "Feed the Babies" fund decided that pro nutro would continue to be used as the only supplement to the home diet of the children falling under this scheme.

In addition to the decision to supplement the diet of a selected number of babies with pro nutro, it was decided that the fund would concentrate on making pro nutro available to child health clinics, certain children's institutions, nursery schools, etc.

From its inception the scheme has been run by a very few voluntary workers. It has always had an extremely small committee, and no policy changes of any major import have been made in the last year. While there have been some changes in the allocation of pro nutro to existing

bodies, (one or two organisations being dropped from the scheme, and new institutions added,) the basic policy of supplementing the diet of the children in certain institutions, and also supplementing the diet of selected babies falling directly under the scheme, has been adhered to. At present this body functions as follows:

Once a week two women workers (an Indian and a Bantu worker), go to Newlands beyond the Municipal boundary, where they operate from the premises of the Newlands Creche, (run under the auspices of the Durban Branch of the South African Institute of Race Relations). Pro nutro is handed out to the "needy" cases. These cases come voluntarily, at the present time apparently either having been previously selected, or having heard via "the grapevine" from others of the feeding scheme. About 12 ounces of pro nutro per child is given, to last one week. This is measured out with a tea tin, as no scale is available. Apparently the children should be given a pound per week, but the tin does not measure a full pound of the pro nutro. It is often children who are already known to the workers who come to collect the pro nutro. All new children must be brought by the mother, and if they are thought by the workers to be in need, they are accepted for this form of supplementary feeding. Some type of social case history of the parents, and siblings of the children, is obtained. Details of the type of work, wages, etc., of wage earners in the family concerned, as well as the housing and the economic responsibility of the family, are collected.

Home visits are made to cases on the books, "as often as possible". Basic hygiene, (covering both personal and home hygiene), sanitation, refuse pits, gardens, etc., are

discussed in an attempt to informally educate the people. As the whole area lies beyond the Municipal boundary of Durban, there are at present no public health facilities in Newlands^{1]}. As part of the work at Newlands, the children are weighed on a bathroom scale at regular intervals of more or less one month to six weeks, to provide an idea of their growth trend. Really sick babies are referred to a doctor at a "Well Baby Clinic" some two or three miles distant at the centre run by the local Health Commission. The same is true for X-rays, and immunisation of babies. Some transport is usually provided to take children to the clinic for these purposes.

The Bantu worker involved in this programme has had no specific training. The Indian worker has had some auxiliary nursing training, and worked at the Family and Community Health Centre of Professor Kark, and so has had this background.

Similar feeding is also carried out at Lamontville township in the Durban borough. The premises used in this case for the dispensing of pro nutro are the Community Centre of the Durban Corporation's Bantu Affairs Department. Work is similar to that described for Newlands. Sick children, and those in need of medical attention or immunisation, are referred to one of the many "Well Baby Clinics" run by the Durban Municipal Health Department. Unfortunately, it appears that due to the reluctance of mothers to make use of these clinics, the babies do not always receive the medical attention they could and should obtain. (The

1] For example, drinking water is drawn from the polluted Umgeni River, or from one or two taps in the area supplied by the Durban Corporation. Both these taps belong to institutions in the area, who charge one cent per 4 gallon paraffin tin of water.

referrals to the clinic depend on the individual mother taking her baby as suggested by the workers of "Feed the Babies Fund". If the mother for one reason or another does not take the baby, nothing is done in the matter).

Somewhat similar work is done in one area amongst Indians, but this falls outside the scope of the report.

A doctor used to make the rounds, seeing the children from time to time. This was an informal arrangement, arising from the fact that one of the key figures at one stage in the organisation was a medical practitioner. However, as the doctor concerned has left the country, this no longer is done. All decisions in regard to referring the babies to the Health Clinic are now made by the Indian worker, who has had some auxiliary nurse training.

It should be pointed out that living conditions in Newlands, where about 81 mothers of infants aged 6 months to 6 years attend the sessions, are very primitive. The women in the area represent a rural group experiencing the first impact of urbanisation. Most of their husbands are unskilled workers in Durban. Need in the area is said to be great, and offers considerable opportunity for expansion. There is a Catholic Mission in the area, which also offers some care to babies, but there is no liaison between the Mission and "Feed the Babies" fund. The fund workers have no transport, and so home visiting in this dispersed semi-rural area is difficult.

While the pro nutro distributed at Newlands and Lamontville is given free of charge, the workers also sell Nespray at 34 cents per pound. This a full cream powdered milk suitable for infants under six months of age, and the

price represents cost price to "Feed the Babies" fund.

3. Distribution of pro nutro through municipal clinics:

"Feed the Babies" fund also distributes pro nutro through existing institutions. At the time when the Malnutrition Relief Committee took the decision that the distribution of its food programmes be undertaken through the Durban City Child Health Clinics, this same decision was taken by "Feed the Babies" fund. In both cases, this was to be without cost to the municipality - since there was an acceptance of the Durban Corporation's refusal to embark on an expenditure on food for children, on the grounds that this was beyond its competence. The decision taken involved part repayment from those who had some ability to pay, and free issues of food to those who could not pay.

"Feed the Babies" fund furnishes bulk supplies of pro nutro to the City Health Department. At present 34 bags of 25 lbs each are supplied^{1]}. This is then distributed through the clinics. At present the scheme is operated through 19 clinics, and has grown very substantially. Repayment was originally at the rate of 3 cents per lb., when the cost of pro nutro was much lower. It is now at 5 cents per lb - but costs the fund itself 13 cents per lb. At present an average of 895 lbs of pro nutro are distributed per week to mothers paying 5 cents per lb. The repayments average R44-75 per week. 102 lbs per week are distributed free. The fund thus makes available about 997 lbs of pro nutro per week to the Durban City Council^{2]}.

1] Weekly figure, quoted by the Society. At the end of 1966 more was distributed, suggesting the clinics were using stocks they had previously built up. (See Appendix 'C').

2] These averages are based on our calculations.

It appears that the proportion of repayments has increased. Nevertheless, the costs of this municipally distributed programme are very considerable indeed as far as the fund is concerned. The fund has not calculated the full cost of this part of their programme. Appendix 'C' provides details of the amount of pro nutro distributed by the fund through the municipal clinics over a period of five weeks from October to November, 1966.

4. Distribution of pro nutro to various agencies:

"Feed the Babies" fund also distributes pro nutro free to various agencies, in order to provide supplementary feeding for infants in the institutions concerned. The Bantu Child Welfare Society receives about 19 bags of pro nutro a month, to supplement the diet of 90 infants at the Othandweni Infants Home, and also for more or less 500 children cared for in the various creches of the welfare society. The Kwa Mtshali pre-school play group receives 5 bags of pro nutro a month, for 135 infants. The Newlands pre-school play group receives 4 bags a month for 75 infants, while Gaza nursery school at Umlazi receives 1 bag of pro nutro a month for 36 infants. This represents a total of 29 bags of pro nutro a month for 806 infants. In addition, it might be mentioned that about 11 bags of pro nutro are provided monthly to cater for 472 Indian children in various institutions, and 5 bags weekly are provided to a Coloured children's home. Addington Hospital also receives pro nutro, but on an irregular basis only when requested.

It should be pointed out that with the exception of Addington Hospital, the Gaza nursery school and one of the Indian nursery schools, all the recipients of this pro nutro

are registered welfare organisations. It is doubtful whether "Feed the Babies" fund has, in fact, appreciated that this very substantial and costly programme of theirs constitutes a subsidy to existing welfare organisations. There is no doubt that the supplement of pro nutro is immensely valuable to the diet of all the children in these institutions. There is also no doubt that the agencies - particularly some of the smaller ones - are very much dependent on the pro nutro. But, for example, in the case of the Durban Bantu Child Welfare Society, we have calculated that the contribution of "Feed the Babies" fund to the Othandweni Infants Home, constitutes an addition of only 19% to the costs of the food already provided by the Child Welfare Society. In the case of the 16 bags which go to the creches run by the Child Welfare Society, this pro nutro supplement amounts to only 4% of their total food expenditure. The programme of such free distributions is a costly one, and it is strongly recommended that this whole procedure be reviewed by the fund in conjunction with the recipient organisations. In general it is not considered to be a sound social welfare policy for an organisation appealing to the public for funds, to be using a very substantial proportion of its funds to supplement the activities of other organisations. As from 1967, "Feed the Babies" fund will be a member of the Durban Community Chest, as will be the majority of the institutions receiving the pro nutro from the fund. It is considered that if expenditure on pro nutro is essential, the better policy would be for each of the registered agencies to request an increase in its budget to cover the costs of the pro nutro, and thus obviate the "Feed the Babies" fund deflecting its activities away from feeding babies itself, to subsidising

other registered agencies. The costs to the public would be the same, but it would allow a rationalisation of activities. It is estimated that the distribution of pro nutro to the institutions costs "Feed the Babies" fund something in the vicinity of R2,300-00 per annum.

5. The distribution of pro nutro through private individuals:

In addition to the above schemes, two individuals conduct a small programme of their own, distributing pro nutro to needy families. One individual distributes four 25 lb. bags per month, at a total cost to the fund of R156-00 per annum, and the other distributes 24 one lb. bags per month, costing R37-44 per annum. The total cost of this part of the programme is R193-44 per annum.

6. Financial considerations:

Between 1960 and 1965 the fund's financial programme was relatively unchanged. It was financed mainly through the Cato Manor Appeal Fund, latterly the D.N.C.F. This latter organisation allocated R7,600-00 in 1964, and R8,000-00 in 1965, but retained all the monies received from "adoptions". This system of adoptions dates back to the early days of "Feed the Babies" fund, when organisations or individuals "adopted" a particular baby, and paid R1-00 per month for the baby's feeding. This practice has continued, despite the fact that today the pro nutro supplementary feeding does not cost as much as R1-00 per baby per month. Donations from the public were small, but the initial R300-00 per annum from the Union of Jewish Women has continued.

The total food purchases in 1964 amounted to R5,725-00 and R7,245-00 in 1965. In both years, the proportion of

repayments on pro nutro constituted 16% of the total costs. Salaries paid by the fund absorbed 13% of total expenditure in 1964. There were no administrative expenses apart from the audit fees.

7. General:

A careful analysis of the whole programme reveals that the operating scheme of "Feed the Babies" fund itself is confined to just under 400 children. Eighty-one of these are at Newlands, and one-hundred and thirty at Lamontville. One-hundred and eighty-seven Indian children are also included in this total figure. Only 16% of the total pro nutro purchased annually is used in a programme conducted by the fund itself. This is an effective programme, since it is individually administered. There is a certain amount of informal health education undertaken with the mothers, and there is medical liaison with the health clinics. The "adoption" scheme has provided a good and regular source of income, and has widened community awareness, and the participation of the outside community ensures that regular reports are made to the participants in this scheme, who have reports on the babies they have adopted.

The municipal programme utilises the greatest amount of pro nutro. As it is distributed to 19 municipal clinics, it ensures an enormous area of coverage. Distribution takes place under controlled conditions. Fifty eight percent of the total pro nutro bought by the fund is distributed through the municipal clinics. There can be no doubt that this is a most effective manner in which to combat malnutrition, and ensure that the food supplement is going into homes where it is required. However, it is most

doubtful whether it is indeed the function of a voluntary welfare organisation supported by public funds, to pay the entire costs of such a programme. It is conservatively estimated that this part of the programme costs the fund some R3,000-00 to R3,500-00 a year. It is a well known fact that other local authorities have not hesitated to spend out of their rate funds for essential food supplies to needy families, as part of an enlightened campaign to promote health. The Durban Corporation makes almost no contribution from its general rate fund for the health or welfare of the Bantu.^{1]} The services are paid from the rents of the Bantu (a proportion of the rent being calculated to pay for health services), and from the Bantu Revenue account. As a social policy this is probably unique, in that the poor group is expected to pay for its own services. However, it must be stressed that a very substantial proportion of the pro nutro is distributed to Indian and Coloured recipients, and the cost figure quoted above is not for the Bantu only. The Coloured and Indian communities contribute to the rate fund. Consequently, at least for the Indian and Coloured section the City Council should be prepared to make some contribution to the cost of the food supplements, on the grounds that they receive some income from rates.

It is most strongly urged that the whole principle of voluntary agencies paying for the cost of supplementary food distributed through municipal clinics should be reviewed. It is urged that the Durban City Council should shoulder the main burden of these services. In this connection, it is not out of place to stress that while the City Council does make grants-in-aid to agencies, and in-

1] The present small contribution from the Borough Rates Account mainly takes the form of some grants-in-aid. (see p. 146 above.)

directly assists in remission of service charges, or provides accommodation to some of the agencies, it is increasingly reluctant to shoulder any additional responsibility for welfare services. The services of "Feed the Babies" fund cannot be regarded as welfare, but rather distinctly as health services. It is a grave mistake to regard food supplements as welfare, when fundamentally nutrition is a health matter. There appears to be no reason why the Durban City Council should not make itself responsible for a larger portion of this expenditure. It is also illogical that those families that are helped by the fund itself, and who are in a position to pay, should now be paying 7 cents a lb for pro nutro, while the recipients through the municipal clinics pay 5 cents a lb.

It is urged that this programme of supplementary feeding through the municipal clinic should not be curtailed. However, the strongest representations should be made to the municipal authorities to the effect that they should make a substantial contribution to the costs of this programme. At the moment the Durban municipality makes absolutely no cash outlay on this part of the programme, the only costs being the indirect costs of administration.

With regard to the donations to existing welfare agencies and nursery schools, it is urged that the whole programme should be reviewed and drastically curtailed. Within the structure of the Community Chest, there should be re-allocation of grants to individual member agencies. The supply of pro nutro to the children should not be stopped, but the basis of administration and allocation revised.

At the conclusion, it is most strongly urged that the whole programme be reviewed. Priority should be given to the extension of the individual administered service of the fund itself. There is a tremendous need for developing such a service in the peri-urban areas, where at present the need is greatest, and the health services poorest. It would be possible to find additional distribution points in these areas. Such a scheme would both extend the present coverage of that part of the fund's programme which it administers itself, and would assist in the areas which most require health education and combatting malnutrition. Such a scheme would assist the fund to develop as an agency undertaking its own work, rather than be as it is today, distributor and donor to other organisations.

The municipal programme as such is a valuable one. It is urged that provided some satisfactory arrangements regarding financing could be made, and the local authorities in the metropolitan area be persuaded to bear part of the costs of the scheme, if not the entire costs, then it would be well to extend the scheme to other areas within metropolitan Durban. It is considered that the Clairmont township, and areas falling under the local Health Commission are those where the need is greatest, and where extension of supplementary feeding would be most useful.

(e) The Malnutrition Relief Fund:

1. Background to the development of the association:

The Malnutrition Relief Association originally developed in response to the efforts of the paediatrician of the Faculty of Medicine at the University of Natal, and

his colleagues, to bring to the public attention the steadily mounting incidence of malnutrition amongst Bantu children in Durban in the 'fifties. His initiative and efforts gained the support of the many welfare organisations dealing with the care of Bantu and other underprivileged children in Durban, of Women's Associations, and above all of the many churches. A public campaign was launched. The object was to make the community aware of the extent of the problem of malnutrition, and of what preventative and relatively inexpensive action could be taken through feeding schemes and health education^{1]}. The endeavours were directed at convincing the public, and through them forcing the Durban City Council, the Provincial Authorities, and the Central Government, to undertake a vigorous programme of preventative health care. It was recognised at the outset that this was a difficult task in a sphere of health and welfare, while each organ of government tended to pass on responsibility to the other, and while the Durban City Council had been adamant in its interpretation that preventative health was a governmental, and not a municipal, responsibility.

The Faculty of Medicine of the University of Natal, in association with the King Edward VIIIth Non-European Hospital, the Natal Paediatric sub-group of the South African Paediatric Association, the Durban Bantu Child

1] In King Edward VIIIth Hospital alone, in 1955 there were 731 cases of kwashiorkor, and 283 other types of malnutrition, yielding a total of 1,014 cases of young children being admitted as a result of malnutrition. In 1956, the total figure was 1,009, and in 1958/59 it was 1,632. (See Tables V and VII, pages 32 and 40).

Welfare Society, the Durban Round Table, the Durban South Rotary Group, the Durban Child Welfare Society, and the Durban Indian Child Welfare Society, released a memorandum setting out the problem, indicating what could be done to tackle it in a cheap preventative programme, and particularly outlined the responsibility accepted by other local authorities elsewhere in making financial contributions out of their rate revenue for milk and feeding distribution programmes for the children of all races. The churches had already initiated a Church Milk Appeal Fund, and the campaign was well supported by a daily newspaper in Durban. In response to the growing demand for remedial action, the mayor of Durban sponsored a public meeting on December the 9th, 1959. This was attended by 56 persons representing 41 churches, voluntary welfare organisations, service groups, and women's organisations, as well as the paediatric department of the University of Natal. To many attending this meeting, it proved to be a somewhat disappointing affair. It had been hoped that opportunities would be afforded to discuss the seriousness of the position, to plead for greater municipal support and participation in a co-ordinated programme, and that some considerable support would be lent to the inauguration of a vigorous programme by the municipal authorities. However, the mayor announced that the meeting had been called for the express purpose of creating machinery to co-ordinate and deal with the distribution of fresh milk to under-privileged children, and thereby to control the ravages of kwashiorkor amongst the Bantu community. At that time the municipality was itself distributing some 6,472 gallons of milk per month to welfare organisations in the various Bantu townships, at a subsidised rate of

2½ cents per pint - the full cost being 5.2 cents per pint. The entire costs of this activity was borne by the Native Revenue account of the Bantu Administration Department of the Durban Corporation. (That is, from the profits of the sale of beer in the Bantu townships). At this time, there also existed a very limited scheme subsidised by the Department of Social Welfare. Milk was made available to some Coloured and Indian children between the ages of three to seven years, for on the spot consumption at milk depots administered through voluntary welfare agencies. The limited terms of reference of the meeting, as announced by the mayor, precluded discussions on the whole subject of malnutrition. Considerable support was forthcoming from the meeting for the need to co-ordinate governmental, municipal, and private voluntary endeavour in the furnishing of milk to malnourished and needy children. The meeting elected a chairman, and some 22 persons representing churches, welfare and women's organisations to a general committee. A steering committee was also elected. Thus it is that the Malnutrition Relief Committee came into being on December, 9th, 1959.

The Municipal Authorities advised the Steering Committee that they were desirous of passing the entire programme of the Municipal Subsidised Milk Scheme to the newly created Malnutrition Relief Fund Committee, and that they (the Durban Corporation) would transfer to the Committee the R14,000-00 already voted for the programme in the 1961 estimates. In addition, the Durban Corporation indicated that it would be willing to make a further R10,000-00 available from the Bantu Revenue account. The Council promised a contribution of R10,000-00 from the

Borough (rate) Fund, provided that at least R70,000-00 could be raised by the Committee from provincial and governmental sources.

The Steering Committee called the meeting of the General Committee, and submitted the above proposal to them. This was the one and only occasion in the history of the organisation that the General Committee was convened. The proposal was accepted. In practice, this implied that instead of getting a substantial contribution from the municipality of Durban, a conditional offer was made by the Borough, on the basis of terms which it might be impossible to fulfil under the existing legislative conditions. Furthermore, the newly created committee found itself responsible for a very substantial milk distribution scheme, which had previously been administered and controlled by the Welfare Department of the Durban Corporation's Bantu Administration Department.

The Committee threw itself whole-heartedly into the task of attempting to obtain provincial and government support. A very carefully prepared memorandum was submitted to the Provincial Authorities, and a deputation, including the Mayor of Durban, the City Treasurer, the Medical Officer of Health, the Chairman and medical members of the Committee, met the Administrator-in-Executive Committee on the 27th of April, 1960. The memorandum put forward stressed the enormous cost to the province of furnishing curative care, in contrast to the far cheaper approach of preventative medicine whereby children could be supplied regularly with one-third of a pint of milk per day. Such preventative medicine would prevent the development of kwashiorkor and other manifestations of malnutri-

tion. The deputation received a sympathetic and courteous hearing, but the Administrator announced that it was not possible for the province to make a financial contribution. This was on the grounds that health education and preventative services were the responsibility of the Central Government and not the Province of Natal.

Many subsequent efforts were made through approaches to the Government, to obtain financial support. These met with no success, and the Government could not be induced to change the definition from the health point of view, of the responsibility of the Government, the Province, and the individual Local Authority. Since these efforts to obtain more favourable financial support, and a re-definition of the legislative position, all proved abortive, the conditional offer of R10,000-00 from the Borough Fund fell away. The Durban City Council has in fact, not made any contribution to the Malnutrition Relief Fund in the seven years of its existence, as far as contributing from the Borough Fund is concerned. The only contributions have come from the Native Revenue account, which represents profits derived from the Bantu people themselves.

It was in 1962 that the Malnutrition Relief Association was officially registered as a welfare organisation. Its objectives were widely based, and not merely confined to the co-ordination of the effort in the narrow field of milk distribution.

2. Programme of the Association:

From the outset, the Association decided that it would not embark itself upon any field distribution programme. It views its task mainly as a pressure group, and secondly as a co-ordinating channel for the supplies of milk to existing welfare organisations, municipal bodies and churches. Consequently, the Association has never had any administrative, technical or field staff. The City Treasurer has acted as the Treasurer of the Association, and secretarial work has been undertaken by the Chairman's personal secretary (who is not a member of the Executive). Although its constitution provides for membership, there are no members, and only one general meeting has been called (in November, 1961), at which an Executive of seven persons was elected. The office bearers then elected remained in office, except for those who have left Durban. Other office bearers have been co-opted to replace those who have left the Committee. The average attendance at the Executive meetings has been five, in addition to representatives of the Durban Medical Officer of Health's Department, the Durban Bantu Administration Department, the Chairman, the Medical Officer of Health, and the City Treasurer. The Association is virtually controlled by some five to six persons who have attended and made decisions at the Executive meetings. The day to day running of the organisation has been in the hands of the Chairman. No annual report is issued, but annual balance sheets are presented and approved by the Executive of the Association.

The programme of the Malnutrition Relief Fund includes the distribution of fresh milk, a dried powdered skimmed milk scheme, and thirdly, the distribution of whole

cream powdered milk (Klim, or Nespray). These are discussed in the following sections.

3. The fresh milk distribution scheme:

From its inception until 1964, the Association was a controlling body of the Durban City Council's subsidised fresh milk distribution scheme for Bantu. The City Council throughout has borne the entire cost of this operation, drawing on the Bantu Revenue account. The source of the funds has limited the distribution to Bantu children within the residential areas falling within the jurisdiction of the Durban City Council. In order to ensure adequate control, milk supplies were channelled through organised groups of children - i.e. nursery schools, creches, play groups, and schools where adequate control could be exercised for existing feeding programmes. All of the constituent members of the Durban Non-European Children's Fund - with the exception of "Feed the Babies" which had no group-oriented programme - were thus participants in the subsidised milk scheme. The practical administration of the scheme was undertaken, as previously, by the Welfare Department of the Durban Corporation's Bantu Administration Department. However, the Malnutrition Relief Fund could decide upon the amounts to be furnished to the various welfare organisations being supplied.

In its first year of operation, the fund succeeded in obtaining lower tenders for the supply of fresh milk than had previously been the case. (Heretofore, the milk had been supplied at normal commercial prices). In view of the later merger of the only two big commercial dairies in

Durban, and the fact that there were no other dairies in the City large enough to handle such a contract, the situation has developed into quasi-monopoly with only one tender being submitted each year. It is true that milk prices have risen quite considerably throughout the Republic. The Durban position indicates a price rise for the bulk contract of from 39 cents per gallon in 1961, to 43 cents in 1963, to 46 cents in 1965, and 50 cents in 1966. In 1961, the Durban City Council was re-imbursed by welfare agencies at the rate of 2½ cents per pint of milk, with the cost to the Durban Council being 19 cents per gallon. In 1963, the repayment was at the rate of 3 cents per pint, with the subsidy from the Durban Council remaining at 19 cents per gallon. With a gradual increase in the amount of milk being supplied, both costs have produced a very sharp increase in the overall costs of the programme. At the end of 1965 it was estimated that the milk being distributed would cost about R48,000-00 for some 195,000 gallons. By contrast, in 1959 it cost only R14,000-00 for 80,000 gallons of milk. During the period of the administration of the scheme by the Malnutrition Relief Fund, milk purchases have totalled R142,500-00, with repayments amounting to almost R71,000-00. It is thus obvious that the scheme has been a large-scale one.

In view of the fact that the issuing of the milk contract was an automatic procedure, and that the allocations of milk were made only to existing welfare organisations, the control and administration of the scheme became a mere formality. From 1965 onwards the Association divested itself of responsibility, and the authority for the programme once again fell entirely to the Durban

Municipal Authorities. What in fact happens now is that the Malnutrition Relief Fund obtains money from the Native Revenue account of the Durban Corporation. The fund then grants money from this source to various organisations, who purchase the fresh milk for feeding at a subsidised rate through the Durban Corporation. The requirement is that each organisation concerned must pay a sum equal to that granted towards the milk. Thus, for instance, from the Borough of Durban R25,000-00 was paid to the Malnutrition Relief Fund for fresh milk feeding in 1964/65. This in fact meant that the organisations which received this money had to raise another R25,000-00. Thus in all, during the 1964/65 financial year, R50,000-00 was spent on fresh milk feeding within the boundaries of the City of Durban.

Further details of the money provided by the Durban City Council from its Native Revenue account are as follows:

1960/61	R24,000-00
1961/62	R16,500-00
1962/63	R10,500-00
1963/64	R20,000-00
1964/65	R25,000-00.

For details of the distribution of fresh milk in 1966 and 1959 in Durban, Appendix 'B' should be consulted.

4. Dried powdered skim milk scheme:

The major effort of the Association in 1961 and 1962 was the initiation of a very ambitious and wide-spread programme for the distribution of dried skimmed

milk powder. This powder was at that time available at low rates in bulk supplies as a form of surplus product. The intention was to supplement the diet of infants and the many thousands of pre-school children in Durban who were not attending either a creche, play group, or a nursery school. In 1964 a survey was undertaken by Dr. Zelda Jacobsen, who estimated that the percentage of pre-school children in Durban attending various organised centres was only 20% in Chesterville, 10% in Lamontville, Glebelands and old Umlazi Township, 3.7% in Kwa Mashu, and 6% in Newlands^{1]}. Immensely valuable though the fresh milk scheme was, it must be admitted that it touched a mere fraction of the children requiring care. After full consideration of the possible methods of distribution, it was decided by the fund that the most effective machinery would be the existing services of the Durban Municipal Health Department. This Department operated Child Health Clinics for all racial groups, and covered the entire municipal area of Durban, as well as those townships that fell under the jurisdiction of the City. It was thus decided that the main field of activity would be to concentrate upon the distribution of this powdered milk to the Municipal Clinics. Particular emphasis would be placed on the vulnerable pre-school children, with controlled distribution to necessitous children through the many dispersed clinics. Similar arrangements were made with the local Health Commission for distribution through

1] . Zelda Jacobsen (1965): A Survey of Organised Group Facilities for African Children of Pre-School Age in Durban: Unpublished manuscript of the study. Medical School, University of Natal, Durban.

its clinic at Newlands. In addition, suitable rural outlets under adequate supervision were sought, and in 1961 and in 1962 some eleven distribution points on the north and south coasts, and also inland, were set up. These outlets were mainly controlled by missions.

The R10,000-00 made available from the Native Revenue account could be used exclusively for Bantu children within Municipal Durban. Fortunately, both in 1960 and 1961, very substantial contributions were made to the fund by the general public, particularly the churches. This additional source of revenue could be used for Coloured and Indian projects, and also for projects outside the City of Durban. A system of repayment was instituted, on the basis of approximately one-quarter of the costs being repaid. However, free distribution was given to those who could not afford to pay. By the end of 1962, some R2,000-00 per month was being spent on dried milk, of which some R840-00 was for Bantu children within Durban.

The results of this programme bore ample evidence of its efficacy. Infant mortality was declining, and there was a slight decline in the kwashiorkor cases from Durban, and at the same time much valuable work was being effected at the Health Clinics by means of health education to the mothers who came to receive the supplies of powdered milk.

In February 1961, the Central Government announced that it would initiate a pilot scheme to make powdered milk available to a selected number of municipalities on the basis of half of the cost being borne by the Government, and the other half being borne by the local authority. This pilot scheme was initiated in Durban in October, 1961.

The Central Government and the Municipality each contributed R2,000-00. As the pilot scheme applied only to Bantu, the Malnutrition Relief Fund concentrated more of its efforts upon the Coloured and Indian groups who were not being catered for. The pilot scheme was a success.

So it was that the official subsidised skimmed powdered milk scheme was introduced into the Republic in June, 1962. The Government and local authority each were to bear one-third of the cost, and the recipient was to bear the remaining one-third (which at that stage amounted to five cents per lb.) The City Council of Durban was involved in an expenditure of R2,000-00 per annum,^{1]} This provided for some 3,300 lbs of dried skimmed milk per month. One-half of the City contributions came from the Borough fund, and the other half from the Native Revenue account. By February 1963, this scheme had been extended considerably. The present contribution from the Durban Municipality amounts to R30,000-00. (R12,000-00 from the Bantu Revenue account and R18,000-00 from the Borough Fund account).

Introduction and expansion of the subsidised powdered milk scheme vitally affected the Malnutrition Relief Fund. It meant that it was no longer necessary for the Association to make any contribution to the provision of powdered skimmed milk within the area of jurisdiction of the municipality. (During 1961 and 1962 its main activity had been to finance the distribution of such powder). Once the Durban Corporation entered into the scheme, it discontinued its grant from the Bantu Revenue account to the Malnutrition Relief Fund. Since 1963, the Fund has consequently received no financial support whatsoever from the municipi-

1] Later in 1962 the amount was raised to R4,000-00. See the Medical Officer of Health's Annual Report for the City of Durban, 1962, p. 36.

pality for this scheme. On the other hand, the fund is now furnishing most of the supplies of full cream powdered milk which are being distributed at present through the various health clinics.

The shortcoming of the Government's subsidised powdered skimmed milk scheme was that it depended upon the initiative of the individual local authority. Despite the proved value of the scheme, and the fact that the Government has from year to year increased the amount of powdered milk to be made available, (and hence has increased its own financial responsibility), the full amount made available has never been used. This is because many of the local authorities have not been prepared to pay even their one-third share. The Malnutrition Relief Association has made some efforts to introduce adjoining smaller local authorities around Durban to the scheme. Limited success has been achieved. The Fund has also attempted to make the Durban Bantu Administration Department's contribution applicable to the dormitory Bantu townships, on the moral grounds that the fathers work in Durban, and contribute to the expansion of Durban, even if they do not live there. No success has been achieved with this argument. It is most significant that this scheme is not yet in operation in the Government-operated "model" Umlazi township situated in a "Bantu Homeland". Efforts by the Association to ensure the inclusion of Umlazi in the Government subsidised scheme have not succeeded.

5. Whole cream powdered milk (Klim and Nespray):

The other shortcoming of the Government's powdered skimmed milk scheme is the limitation of skimmed milk. Such powdered milk has not been found suitable for

babies under six months. The Malnutrition Relief Fund has therefore concentrated its Durban efforts on making full cream powdered milk available through the Municipal clinics. It has also added Lactogen to the supplies it makes available to the clinics. The Fund obtains whole powdered milk in bulk. It is distributed through the City Health Department, and "Feed the Babies" Fund, at cost price, to be paid by the Bantu purchaser. Thus the Fund ultimately acts as a large-scale bulk buyer to obtain price reductions, and gets its money back. The milk is sold at 34 cents per lb.

With the success of pro nutro, the Fund has also added the distribution of some pro nutro to its list of activities.

6. Proposed change in some of the activities of the Fund:

From 1963 onwards, the activities of the Malnutrition Relief Fund have declined greatly. This is partly as a result of the expansion of the Government's powdered skimmed milk scheme. In addition, public support for the Fund has declined very considerably (partly through the initiation of the Government scheme, but also due to the lack of publicity on the part of the Fund). The development of Kupugani with its great number of widely dispersed selling centres in Durban and the adjoining rural areas has also been partly responsible for curtailing the activities of the fund. Finally, the increasing difficulties which have been experienced with the distribution channels outside Durban have also played a part in the cutting back of the Fund's activities. Until 1964, substantial contributions of full cream powdered milk were

made to the City Health Clinics, but in 1964 and 1965 food purchases were extremely limited - the programme had almost ground to a standstill.

With effect from 1967 the fund has been accepted as part of the Durban Community Chest. As it still has some considerable reserves in hand, it was decided at its last meeting in June, 1966, that a more active programme should be resumed. Efforts would be directed towards making protein food supplies available to the following vulnerable groups:-

500 lbs of full cream powdered milk would be made available monthly to the City Health Department for distribution to mainly Coloured and Indian babies. 1]

Supplementary high protein foods would be made available to children receiving maintenance grants from the Durban Child Welfare Society, and the Bantu Child Welfare Society. In addition a small amount would be made available for skimmed milk in Umlazi.

Mainly butter and milk would be provided to pensioners in the Durban Corporation's housing schemes.

These commitments would absorb some R4,500-00 if continued for one year. Whether they will be continued indefinitely will obviously have to be reviewed in the light of subsequent developments.

7. Financial aspects:

It has been shown that prior to the establishment of the Government-aided powdered skimmed milk scheme, the Durban Corporation made contributions towards the Malnutrition Relief Fund. The Durban Corporation also makes a vote each year from the Bantu Revenue account

1] The decision was "up to 500 lbs" would be bought, so the figure is a maximum level.

for the supply of subsidised fresh milk. At present, the Municipality channels its contribution towards powdered milk into the Government sponsored skimmed milk scheme.

Despite all efforts, absolutely no financial support for the Malnutrition Relief Fund has been forthcoming directly from either the Durban Borough fund, or the Natal Provincial Council, or the Central Government. The Association is consequently entirely dependent upon the contributions of the public. Public support was magnificent in the first two years of the funds existence - almost R8,000-00 was contributed, of which the churches contributed R3,500-00. Contributions through the churches continue to be made though at a much lower rate. Today small sums are regularly received. The Women's Institutes have been regular donors, and substantial contributions were also initially made by Round Table. From the Durban Non-European Children's Fund appeal in 1964, the Malnutrition Relief Fund was allocated R2,000-00. In 1965 no allocation was made, and since then the Association has had to rely upon its accumulated reserves. This has inevitably curtailed its activities. The extent to which the Fund is supported in the future will depend of course on the Durban Community Chest, and at this stage no long-term predictions can be made. It would be a great pity if the valuable work which the Fund could do is seriously hampered in the future as a result of lack of community support. It is after all, as a result of public support initially, that this Fund undertook the very valuable work that it did in the early years of its existence, prior to the introduction of the Government subsidised schemes.

8. General:

The Association's activities have fluctuated over the years, depending upon two factors. These factors are on the one hand Government policy in the field of preventative health, and on the other hand, the factor of community support. These two factors are inevitably interdependent. The Association came into being in 1959, on a wave of concern and anger at the needless loss of life, and at the inactivity of the Government and Province, and the limited participation of local authorities in the field of nutrition and preventative health work and education. Since 1962, both the Government and the Durban Municipality are contributing as equal partners, to the subsidised skimmed milk programme. This activity together with the subsidised fresh milk scheme for Bantu children, as well as the efforts of other voluntary organisations such as "Feed the Babies" fund with its widespread distribution of pro nutro, Kupugani with its non-profit sales of protective foods etc., and also the efforts of extended health education programmes amongst mothers, have all contributed to bringing about a very marked improvement in the health of Durban infants and children. The initial wave of support for the Malnutrition Relief Fund has thus greatly declined. Much of its original programme has been taken over by Government and Municipality - this was, of course, precisely part of its objective. To that extent, the Association has succeeded.

Today its main activity has been to plug "gaps" in the Government programme by providing full cream milk to babies under the age of six months. Even this supportive work has been declining over the years. The fact that the Association has not employed field staff has ensured that

all expenditure has been on food, but on the other hand, this has inevitably placed limitations on its programme. However devoted its office bearers may be, they have not the time to engage in field operational activity. Once the Municipality participated in the Government skimmed milk scheme, the Association might well have concentrated its efforts in the areas where the scheme did not operate, and where the need was consequently greatest. The peri-urban areas, and the nearby reserves could have well been the target of its efforts. There is concrete evidence that kwashiorkor is well under control in Durban (see Chapter 2), but at the same time, the number of imported cases of this illness is increasing. Instead of tackling this problem, the activities of the Malnutrition Relief Fund have steadily declined.

1964 and 1965 were years of extremely limited operations by the Malnutrition Relief Fund. In the second half of 1966 activities were re-stimulated. However, the new extended programme to be adopted - namely the monthly purchase of up to 500 lbs of full cream powdered milk for distribution throughout the Municipal area by means of the Child Health clinics, the purchase of high protein foods for maintenance grant cases of the Durban Child Welfare Society and the Bantu Child Welfare Society, and milk and butter purchases for pensioners in housing schemes - appears to have been an impetuous rather than a carefully designed programme. Are these cases that are to receive additional help in future the most needy cases? Are they those most seriously threatened by malnutrition? Is it a sound policy to make further contributions to Child Welfare societies already making some provision for their cases?

And if so, why exclude the Indian child, when it is known that there is a considerable amount of poverty amongst the Indian community? Is it sound for one organisation within the Community Chest to use its resources to support the programme of another? In the long run, is it sound for voluntary effort to continue to make substantial subsidised and free issue of food to Municipally-operated clinics, and to make food supplies available to recipients of Government Social Pensions and Grants? These are questions which should be very carefully considered by the Committee. It would seem that the longer voluntary effort makes good the deficiencies of an inadequate Government pension and grant, the longer the authorities will desist from meeting their rightful obligations. It is not suggested that the recipients of inadequate pensions and grants should, under no circumstances be aided by the public. Rather it is urged that financial and food assistance should be viewed as an absolute emergency, and should be accompanied by ever-loud protests at the inadequacies of Government policies - particularly the grossly inadequate grants made to Bantu. (This point was discussed in some detail previously in this chapter. See pages 116-27 below). To supplement without demur, is to invite perpetuation of a system that is socially unsound. It is not suggested that for example, old age pensioners in Corporation's housing schemes, and children of maintenance grant mothers in Durban, do not require additional food. We know that they require this help. But is not the need of children in the peri-urban areas, in the Umlazi township, and in the nearby reserves, greater? If one weighs up what these children receive in contrast to what those in Durban are receiving at present, would it not be wiser to extend the Fund's activities to areas outside Durban? Would not

the resources of the Malnutrition Relief Fund also be better spent if the Association continues to act as a pressure group - if it continues to work to stimulate adjoining local authorities not yet participating in the Government's skimmed milk scheme, to do so? Would it not be better if the Association presses for an effective rural and peri-urban skimmed milk distribution scheme, and to prove by a private demonstration project how this could be done? After all, the Association pioneered the dried milk scheme programme in Durban in 1960 and 1961. It might well do the same in one or two selected peri-urban and rural areas today. This would, it is believed, be sounder policy than concentrating upon the supplementation of existing programmes that already meet to an extent at least, the needs of the children in Durban. The needs of the children who fall outside the existing scheme should be considered.

(iii) Durban Girls' College Old Girls' Guild:

The Old Girls' Guild of the Durban College took the initiative years ago, of providing the first fully trained nursery school for Bantu children. This was the Ekujabuleni, which was then situated in the old Bantu family location - the small location of Baumannville. Today, with the removal of Baumannville, Ekujabuleni is situated in Kwa Mashu. It caters for about 150 children. The fees are 75 cents per month for one child, R1-00 for two children, and R1-25 for three children from the same family. The school accepts children from the ages of 2 to 6 years. It is not necessarily working mothers who send their children to this school.

The children are given a midday meal, and this is balanced. An attempt is made to give the children the kind of diet to which they are accustomed, such as having mealie rice and beans. They also get meat and milk which is given to them three times a week.

If a child is found to be suffering from ringworm or any other disease, it is referred to a health clinic.

The Committee consists of an Executive Committee made up of Old Girls from the Durban Girls' College. In accordance with Government policy, a Bantu sub-committee is in the process of being formed.

A similar nursery school is run in Lamontville by the Guild - this is the Enkuliso nursery school. The fees for this school, the controlling committee, and the care provided for the children are identical with that at Ekujabuleni.

At the present time, Ekujabuleni houses one hundred and eight-five children, while Enkuliso is catering for one hundred and sixty children. In the strict sense of the word, these two schools are nursery schools. The two institutions comply with the standards set by the South African Nursery School Association. They may be regarded as the only two fully fledged nursery schools for the Bantu population in Durban. There are other nursery schools, as will have been evident from material presented in chapter 2, but they do not all comply in detail with the Association's requirements.

The Enkuliso nursery school in Lamontville has played a very valuable part by initiating training courses for Bantu nursery school teachers. It is significant that most of the heads of the present creches, and of many of the play groups,

were trained at Enkuliso. It was a matter of great regret to all those interested in the child care programme in Durban, when the training was closed down as a result of changes in Government policy.

(iv) Chesterville Nursery School Association:

The "Chesterville Nursery School Association" runs two nursery schools in Chesterville. These are the Nabontwana and the St. Barnabas nursery school. At the present time, Nabontwana caters for about seventy to one hundred children while St. Barnabas' has about one hundred and ten children.

The Association has applied for registration as a welfare organisation, but has not yet received its certificate of registration.

The schools were originally run by a Bantu organisation called the Chesterville Nursery School Association, under the Reverend Zulu. When he left in July 1955, the Bantu Committee got into financial difficulties, and the schools were not very well run. During the regime of the Reverend Zulu, the schools received a donation of jam and mealie meal from the F. C. Hollander Lodge. The Bantu Welfare Department approached the Lodge for assistance when the Reverend Zulu left Durban. Ten members of the Lodge decided to form a new Chesterville Bantu Nursery School Association. They applied for a Durban Corporation grant-in-aid, which was received after a period of time. The grant amounted to R1,450-00 a year.

The children at these two schools pay 20 cents a month. An auxiliary committee consisting of Bantu members is being formed, as this was one of the conditions of the grant. The executive consists of members of the Lodge. The ultimate intention is for the Bantu sub-committee to take over the running

of the schools.

The schools cater for children from the ages of 3 to 5 years. They are run on nursery school lines, and the children have breakfast and lunch, and a sleep, at school. The schools are supplied with milk as part of the Durban Corporation's subsidised milk scheme, and slightly damaged loaves of bread are donated by a bakery (which donates fifty loaves a day to each school). Other donations of food are also made to the schools from various persons.

Now that the Association has received an official grant-in-aid from the Durban Corporation, the Committee hopes to go into the feeding of the children on a more scientific basis. It is intended to work out a balanced diet for the children. It is also hoped to be able to provide health services.

The main difficulty facing the two schools is the lack of equipment and material, as well as the raising of sufficient funds. Until the Chesterville Nursery School Association becomes a registered welfare organisation, it cannot appeal to the public for money.

The facilities are far from ideal, especially St. Barnabas' which uses the Chesterville Community Centre - and this does not really lend itself to a nursery school.

Although the organisation gives itself the title of a nursery school association, it must be stressed that its institutions are not property constituted nursery schools, in terms of the requirements of the South African Nursery School Association. While in chapter 2 they were classified as nursery schools, and apparently regarded as such by the Bantu Administration Department of the Durban Corporation, in terms of strict

standards and definitions they should rather be regarded as play groups.

(v) Union of Jewish Women:

The Union of Jewish Women runs the Ekuthuleni Nursery school at Kwa Mashu. The building used has been supplied by the Durban Corporation's Bantu Administration Department. The Union has authority to admit sixty children, and this has now been extended to eighty-five. The average attendance at the school is about seventy children.

Fees of 75 cents per month are charged for each child. However, the Committee is always prepared to make concessions to those who are unable to pay in full. In addition to monies received from fees, an important source of income is a grant-in-aid received annually from the Bantu Administration Department of the Durban Corporation.

The nursery school operates from 8 in the morning until 2.30 in the afternoon. The time of closing is 3 p.m. The staff consists of a fully trained nursery school teacher from Orlando, with assistants and a cook. The programme for the children consists of the usual type of organised and free play, with mid-morning rests. Two small meals (one consisting of milk and biscuits, and the other one a substantial midday meal of soup and vegetables, etc.) are provided daily for the children.

At present there is no active Bantu committee, although the Union of Jewish Women did attempt to organise a parent-teachers committee. They have now been officially advised that they must set up a Advisory Bantu Committee, and that eventually the running of the school must be handed over to

them. They are at present only in the exploratory stages as far as setting up this committee is concerned.

(vi) Play Groups in Umlazi:

In addition to the play groups organised by the Durban Organisation for the Care of Pre-School African Children (which has been dealt with above), there are several play groups in Umlazi. There is the "Mother Hubbard Christian Youth Crusade", and the "Sheshafike Nursery School". Both of these two organisations cater for from 35 to 40 children each. Both of these organisations are run by Bantu committees, and are not at present registered welfare organisations. While the Sheshafike Nursery School again takes to itself the name of "nursery school", it should more strictly be regarded as a play group, along with Mother Hubbard.

The object of the Government programme at Umlazi is to set up one properly organised creche and play group in each of the neighbourhood units. This is still in its initial phases, and both the Mother Hubbard and Sheshafike organisations could be regarded as the first of more to be developed along similar lines in the township. These will be run and staffed completely by the Bantu themselves.

It might be mentioned here that the Government plans to build a place of safety for Bantu children in Umlazi, in 1967. This will cost R100,000-00, and will cater for children from the age of one day to eighteen years. It will house about two hundred children at a time. The institution will again be staffed entirely by Bantu. It will have a 24 hour service.

(vii) Meyrick-Bennett Children's Centre:

The Meyrick-Bennett Children's Centre is a specialised child guidance centre which is available to children of all races in Durban. It is partly financed by the University of Natal (which pays the salary of the Director, the Deputy Director, and the Secretary). The centre is associate member of the Durban Community Chest. The other major source of its finance is fees, membership dues, and donations.

A non-European section operates on the premises of the American Board Mission in Beatrix Street. At present the number of Bantu children referred to the centre is very small, but the agencies are aware of its services. Children suffering from acute behavioural problems and maladjustment may be referred to the centre for assistance. Needy cases receive either a reduction in fees, or can in really deserving cases, be treated free of charge.

This centre is the only child guidance centre in Natal. It renders excellent service to the children of Durban, but unfortunately is facing serious financial difficulties. It deserves the fullest support of the public of Durban.

3.8 VOLUNTARY AGENCIES IN THE SOCIO-MEDICAL FIELD:

There are a variety of agencies operating in the socio-medical field, which provide directly or indirectly care for Bantu children, or assist with family welfare. The following is not necessarily a complete list, but is illustrative of the organisations in existence:-

(i) Cripple Care:

The Cripple Care programme in Durban for all Bantu persons - both children and adults - is under the auspices of

the Natal Cripple Care Association. This holds special weekly clinics, and has an extensive orthopaedic service.

Within the past 18 months, there has been the development of a new society under the aegis of the Natal Cripple Care Association. This has moved into the special field of cripple children, and liaises closely with the orthopaedic section of the Umlazi Mission Hospital, despite the fact that it is not situated in Durban. It is an institute for the care of Bantu cripple children, to which all children in Natal may be sent. Situated in Edenvale, near Pietermaritzburg, it is known as "Kwa Hlengabantu".

(ii) Bantu Blind Society:

The Bantu Blind Society serves Durban and district. It deals with both adults and children requiring treatment and assistance. It operates a training centre and a workshop.

There are extremely great difficulties in the way of providing institutional placement for blind Bantu children. This is because there is no such institution in the area, the few institutions which exist have very long waiting lists. An important service would be rendered if an institution for blind Bantu children, for training and helping to develop them, could be provided in the Durban region. If there are difficulties in the way of locating it in an official White area, then it could either be located in the Umlazi Mission Reserve, or one of the reserves close to the city.

(iii) S.A.N.T.A. (South African National Tuberculosis Association), Natal Branch:

The Natal branch of S.A.N.T.A. carries out a very extensive programme against tuberculosis. Under its aegis

there are several T.B. settlements operating, and one for Bantu cases is in the Botha's Hill area, outside the municipal boundary of Durban, on the periphery of the Durban Metropolitan area. This settlement is sponsored by Toc H, and affiliated to S.A.N.T.A. There are also the Charles James S.A.N.T.A. centre at Amanzimtoti, and the Dunstan Farrel S.A.N.T.A. centre at Hibberdene.

S.A.N.T.A. carries out an extensive service of liaison with patients who have been discharged from T.B. hospitals. It has already been mentioned previously in this report that there is the Springfield and the King George Vth T.B. Hospitals in Durban. At present the demand for assistance from S.A.N.T.A. is so great, that it is only able to make a grant of R3-00 per month to cases that have been discharged from hospital. This is obviously only an amount which can assist patients during their recuperation, and is not something on which they can live alone (it has also been pointed out previously that the disability grants which can be paid to T.B. patients, are not sufficient to support a person in health). Consequently, both the aid from S.A.N.T.A. and also the disability grants, are unfortunately quite inadequate to meet the needs of the T.B. sufferer and his family during the intervening period that the person concerned is not able to work.

(iv) Mental Health:

The Durban Mental Health Society carries out an extensive service of preventive and promotive mental health for all races in Durban. It operates weekly clinics, at which the services of government psychiatrists from the Mental Hospital in Pietermaritzburg are made available. It undertakes a carefully supervised casework service with its clients. The Society has also developed occupational centres for handicapped

and retarded children.

At the present moment, one of the grave lacks in its programme is that there are no facilities for the care or education of mentally retarded Bantu children, nor are there adequate facilities throughout the whole of South Africa for the care of feeble-minded Bantu children who are not educable. However, it is only within recent times that voluntary effort has built up educational services for White retarded children, so that it can be hoped that in time similar services will be provided for the Bantu child. This is obviously an area in which voluntary effort can take the initiative, and try to fill this gap.

The field of mental health is one in which there is a tremendous amount of work to be done, and where not only in South Africa, but in most parts of the world, there is a tremendous amount of leeway that has to be made up. It is to be hoped that the services of this Society will continue to expand rapidly in the future, and grow both in scope and in depth.

(v) The Natal Association for Maternal and Family Welfare:

The Natal Association for Maternal and Family Welfare is an organisation providing family planning advice and facilities for that section of the population which is either unable for economic reasons, or for other reasons, unwilling, to consult a private medical practitioner. In 1958 the Association commenced activities for Indian, Coloured, and Bantu women. At that stage there was only one clinic in Durban, at which the total attendance amounted to 300 patients. Out of these, only about 90 were Bantu women.

By 1966, the number of clinics had increased. Clinics for Bantu women are held on five days a week in an office near the main non-European bus depot. Weekly clinics are held at King Edward VIIIth Hospital, at Kwa Mashu, and at the surgery of a factory at Reunion. A weekly clinic is also held at Springfield, at the Community Centre. The total number of Bantu women clients dealt with in 1966 amounted to 5,524.

The Association is endeavouring to obtain permission to open up a clinic at Umlazi. Together with Kwa Mashu, this township will be one of the two largest in Durban, so that the Association feels that it is important to extend its activities into this area of the Durban region.

The pill and the loop are the methods which are principally used by the Society. The clinics are open to any Bantu woman who is a mother. An attempt is made to educate the women about reproduction and family planning, by means of lectures. Each case is medically examined, before receiving contraceptive advice. Patients are charged cost price for the pills where they are used (i.e. 30 cents for one month's supply), but no charge is made for the medical consultation. The charge for the loop is 50 cents, which includes insertion by a doctor, as well as subsequent check-ups. Records are kept for each case.

It will be seen from the above figures that the work of the Association is expanding. There is no doubt that there is considerable scope for family planning amongst the Bantu, but due to the resistances engendered by their present value system, it seems unlikely that there will be a very rapid spread of family planning amongst the population, at least for some time

to come. The clinics cover both the townships and also the "White" part of Durban. In this latter regard, the clinic in town is important for the many thousands of women in domestic service, who live in with their employers, and consequently cannot easily get to the family planning clinics at the townships.

In view of the dire poverty of so many of the Bantu, and also in view of our finding in chapter 1 that there was significant correlation between the size of the family and being in poverty, the service of family planning for the Bantu is in principle an extremely valuable one. It is obvious that the vast majority of the Bantu population either know little or nothing about it at the moment, and/or are resistant to the idea of family planning. In view of the importance of the work for the welfare of the population, and in view of the fact that family planning will undoubtedly play a part in helping to alleviate the present distress of the poor, it is to be hoped that the services of the organisation will continue to develop rapidly as far as the Bantu are concerned. At the same time, we feel that if the best methods are to be used in approaching the Bantu population with the topic of family planning, then research undertaken by social scientists is needed to guide any programmes. Recommendations in this respect are provided in the final chapter to the report.

(vi) National Cancer Association:

The National Cancer Association has undertaken a unique developmental programme. In Durban, it has a Bantu

medical social worker who is attached to King Edward VIIIth Hospital. Her job is to follow up and report on all patients discharged after cancer treatment. While this programme does not affect directly, as many of the others do, the welfare of Bantu children, it is nevertheless of long-term importance for Bantu families. In view of the long-term nature of all cancer research, and work in the field of cancer, it is likely to be years before the full effects of this developmental programme are felt. Whatever effects are the outcome, they can only be to the good.

(vii) The Natal Blood Transfusion Service:

The Natal Blood Transfusion Service operates in the whole of Natal, and bleeds donors for the supply of blood to persons of all races. Its work has been of importance, not only for adults and families, but also in more than a few cases, for children themselves when they were in need of blood transfusions.

The Natal Blood Transfusion Service is experiencing an ever increasing demand for blood, particularly from the hospitals dealing with Bantu patients. This is partly because of new surgical techniques; partly because of the increasing awareness amongst the Bantu of the value of hospital care; partly because of the increasing size of the Bantu urban population, (it is more likely to be the urban population that has rapid access to hospitals and transfusions than the rural population); partly because of its very depressed socio-economic condition, the Bantu population has a high incidence of morbidity; and finally, partly because of the social disorganisation and maladjustment sometimes found in the Bantu townships, the incidence of assault cases and other injuries where

blood transfusions are required, are higher than amongst the Whites. The Transfusion Service has embarked on an active programme of educating the Bantu about the medical importance of blood transfusion, and is strenuously endeavouring to obtain more Bantu donors. At present it is working mainly through the Bantu high schools, and a variety of factories, as far as its bleeding programmes are concerned. The number of donors from the White group appears to be as large as can be achieved without considerable further efforts, so that in view of the fact that the Bantu population is the largest in Natal, any substantial increase in blood supply will have to come from the Bantu themselves. Hence the importance of the efforts of the Service to obtain more donors from amongst the Bantu, and to educate both the adults, and the rising generation about the need to give blood.

The King Edward VIIIth Hospital in Durban is the main one which makes heavy use of the Service's supply of blood as far as Bantu patients are concerned. It is not only for cases of illness and accident that transfusions are used, but also sometimes in the case of complications associated with pregnancies and confinements.

(viii) Society for the Bantu Deaf:

This Society provides some relief work, and assistance to deaf Bantu cases. It also provides testing facilities for the deaf, to determine the nature of their affliction, and whether anything can be done about it. The Bantu Child Welfare Society refers Bantu children to this Society, for testing, for possible commital to schools for the deaf, or for possible assistance with some type of aid.

The Society has no social workers, so that in cases where

some type of social case work or qualified social work investigation is required, they, (in common with the Bantu Blind Society), refer the cases back to the Bantu Child Welfare Society for attention.

3.9 VOLUNTARY AGENCIES DEALING WITH SPECIAL CATEGORIES:

(i) Social Services of South Africa (Durban Branch):

The Social Services of South Africa is an organisation catering for prisoners and their families from all racial groups. In addition to its national headquarters which are situated in Durban it also operates a Durban branch.

The Society undertakes relief work for short-term prisoners. Children from families of long-term prisoners, are referred to the Bantu Child Welfare Society for investigation and consideration for maintenance grants. The Society itself used to have a grant which it administered for the benefit of cases awaiting trial, or released prisoners who had not yet obtained employment. This fund has now fallen away, so that it has had to turn to Government Poor Relief for families and individuals in financial difficulties, as a result of either awaiting trial, or release after imprisonment. It has already been pointed out that the Poor Relief has the serious deficiency that it does not provide an adequate provision to maintain the health of the persons concerned. In some cases, the matter is also dealt with by the Bantu Child Welfare Society, and attempts are made between the two organisations to assist the family.

Social Services undertakes case work services concerning prisoners or awaiting trial cases, and families and dependents. It also provides some type of after care service, and attempts

to assist prisoners to obtain employment.

From the point of view of the children, which is our main concern in this report, the relief work of the organisation, and the attempts to obtain employment for released prisoners, are the two main aspects of importance for the family and the children. It is self-evident that in cases of destitution following on the arrest of the breadwinner, the children can face serious malnutrition unless something adequate is done in the matter. The Society does what it can to help. However, in the case of released prisoners, there are difficulties in the way of obtaining employment for ex-prisoners of all racial groups, including the Bantu. In this regard, if the Government set a lead to other employers by making greater use of released prisoners, it might gradually become easier to help to economically rehabilitate ex-prisoners.

Rehabilitation and supportive case work of prisoners and ex-prisoners is extremely expensive and time-consuming. In fact, a considerable amount of the work of the Society can at best be described as "emergency case work", with little time for supportive work. Ideally, supportive work should receive a tremendous amount of attention, and from the point of view of the children, it is important that the case work provides the necessary support before the family breaks up - not afterwards.

From the point of view of the Bantu population, the work of Social Services is most important. The number of Bantu prisoners serving sentences is extraordinarily high, including as it does not only the usual type of criminal sentences, but also the large number of sentences imposed for violation of various administrative regulations (such as Pass Laws, Influx Control Regulations, and so on), and more recently also a number of cases of sentence for what might loosely be described as

"political" activities associated with things such as sabotage and attempted sabotage, incitement, etc.

During the year 1965/66, a total of 1,615 new cases were dealt with by the Branch in Durban. Of these, 749 were Bantu cases. After-care services were concerned with 91 parole cases, 243 on probation, and 307 other types of ex-prisoners. Family-aid was provided to 43 Bantu families, while in 69 cases other types of assistance was provided. In 721 cases, counselling was provided, and actual treatment arranged for 16 cases. A total of 344 ex-prisoners were helped to find work, while 412 were assisted to obtain their necessary documents. Initial transport costs were met in regard to 684 cases, while accommodation was arranged for 77 cases.

There is extremely high mobility amongst ex-prisoners, so that quite frequently contact is lost with cases within a matter of months. This means that it is somewhat difficult to assess the success of the rehabilitative efforts of the organisation. Despite this, there is no doubt that the organisation is providing a most important service, which is significant for society.

(ii) The Aged:

There are no specific organisations dealing with the care of the aged. T.A.F.T.A. has not as yet extended its services to the Bantu. This particular sphere of work in the welfare and health field is rather specific, and somewhat directly removed from the problems of children. However, there is some relation in so far as a household has to support both young children and also aged persons, then if inadequate provision is available for the aged, it inevitably means that everyone in the household has to make do with less, and this

increases the risk of malnutrition and ill health amongst the children.

There are few aged Bantu in urban areas, because the rights of domicile are granted virtually only to workers. The Government Department of Bantu Administration and Development makes every effort to repatriate old Bantu to the rural areas, so that it is only a handful who are authorised to remain. In Durban, there is a small old age home - the Bantu Refuge - operating in Lamontville. The Association is run by a European Committee, with a Bantu Sub-Committee advising. A grant is received both from the Durban Community Chest, and also the Durban Corporation. For the rest, apart from the provision of old age pensions, (the inadequacy of which has already been discussed), the old persons have to be supported by whatever families they possess.

(iii) Alcoholism:

There is a Durban Branch of the South African National Council on Alcoholism. It has as yet no active programme for Bantu persons afflicted with this disease. However, the branch has an acute awareness of the need to extend its services to the other races, and it is hoped in the near future to extend its work to the Bantu alcoholic. Up until now the demand for treatment and educative services from the Bantu has been less than that from the Coloured and Indian communities. No doubt with an increasing awareness of health matters, the demand from the Bantu community will increase. The services of the Council are most important from the point of view of the child in a family with an alcoholic, as alcoholism has a disruptive effect both on the emotional life of the family, and on the economic well-being of the home. Inevitably children are affected, so that it is to be hoped that in future

the Durban Branch will be able to provide not only more facilities for Bantu alcoholics, but will be able to educate the Bantu public about the importance of treatment.

At present, when Bantu cases occur, they are dealt with at a clinical consultative level. If treatment is required, it is arranged either through a hospital, or through a non-European doctor who has a sympathetic approach to the problem of alcoholism.

Two years ago, the South African National Council on Alcoholism ran a course of lectures on alcoholism in Durban. This was for the benefit of those interested in the problem of alcoholism amongst the Indian, Coloured, and Bantu communities. The course was well attended by doctors, nurses, teachers, ministers of religion and other interested persons of the races concerned. No further lectures or seminars have been held recently.

It might be mentioned in passing that the Council considers that before much valuable service can be done amongst the Bantu, a considerable amount of research will have to be undertaken into the sociological problems which are peculiar to the Bantu alcoholic, and into the drinking patterns of the Bantu people generally.

3.10 AGENCIES DEALING WITH RECREATION AND CHARACTER BUILDING:

(1) Y.M.C.A.:

The Y.M.C.A. has an active Bantu programme. It is conducted from Bantu Social Service in Beatrix Street. There are also various activities organised in the different townships.

These take the form of the usual programmes of group activity, physical education, judo, discussion groups, choirs, singing, music, etc.

This is a valuable service which appears to be greatly appreciated by the Bantu community itself. It does not directly serve the children, but operates a valuable programme for the youth.

(ii) Y.W.C.A. :

The Y.W.C.A. (International), has developed programmes amongst the Bantu women. On its staff it has several Bantu fieldworkers who formed the well-known Zenzele Groups. Quite a number of these groups operate in Kwa Mashu, Lamontville, Glebelands, and Chesterville. The programmes are largely confined to health education, child education, and rearing. etc. In recent years, these groups have concentrated quite a lot of their activities on the discussions of the legal disability of Bantu women.

An Annual Conference of all Zenzele Clubs is held in Durban. Every two years a National Conference of all Y.W.C.A. programmes is held. Zenzele Groups have been fortunate in obtaining the active support of a large number of middle-class Bantu women as their leaders. The programme is an effective one, and has contributed considerably to the development of Bantu community leaders. Many of the women today, who are playing an active part in the voluntary associations such as the Bantu Child Welfare Society, the Parents' Committees of the various play groups, etc., have come from the Zenzele Groups, and received their initial impetus and experience from these groups.

(iii) Boy's and Girl's Clubs:

Boy's and Girl's Clubs are one of the most flourishing activities in the townships in the Transvaal, but they do not appear to have caught on to the same extent as yet in Durban.

The Scouting and Girl Guide movements are active in the Bantu townships, with in all several dozen companies and packs in existence. The Bantu Boy Scouts have their own constitution, whereas the Girl Guides have the same constitution as Indian, Coloured, and White Guides.

Although these organisations are not registered welfare organisations, they are important enough in their effect to be considered under the heading of recreational and character building organisations. The Scouting and Guide movements are showing some significant growth amongst the Bantu communities, and if they develop more, they can make a really noteworthy contribution to the development of the rising generations of Bantu children. The main difficulty appears to be to obtain suitable scout masters and guide mistresses, and similar instructors, but this is a problem which will possibly gradually solve itself in time as the young people pass through the ranks into adult groups. One hopes that at least some of those who have been in the Organisation as children, will, as adults, maintain a sufficient interest to be able to assist in running the organisations in the future.

3.11 ORGANISATIONS, OTHER THAN REGISTERED WELFARE ORGANISATIONS, WHICH ARE REGISTERED UNDER THE COMPANIES ACT AS NON-PROFIT COMPANIES:

(i) Kupugani:

Something has been said briefly in chapter 2 about Kupugani. (See section 2.9, sub-section (ii), page 71). The object of the organisation is to achieve the widest distribution at the lowest cost, to as many under-privileged persons as possible, of essential basic food supplies.

At the present moment, the programme is organised through a large number of distribution points in the Bantu townships, and fortunately also in the peri-urban areas and Bantu reserves, (which are often outside the scope of voluntary organisations). Kupugani makes available foodstuffs such as pro nutro, high protein soup powder, dried milk, nutritional foods, basic foods, dried beans, etc., at very low prices. In addition, the organisation also has a programme of health education. It has been fortunate in obtaining the services of some workers who were trained at the Institute of Family and Community Health (which has been previously referred to as an outstanding pilot effort in community health work.)

In Durban and Pietermaritzburg Kupugani has developed an industrial feeding unit, whereby after long negotiations with some of the larger firms, it has either advised them on the setting up and the planning of a low-cost nutritional diet for their canteens, or is itself providing such nutritious meals distributed to the canteens in suitable containers.

Kupugani has appreciated that it is essential to undertake health education among the fathers. This is because it is the male wage earner who controls the purse strings, and as a result the feeding of the family depends to a large extent on how

much he is prepared to make available to them out of his earnings. Furthermore, it is the practice of many of the migratory workers who are resident in the reserves, to go home for the weekends, and take home at the same time, the weekly food supplies with them. Therefore, the health education work amongst the industrial workers is of considerable importance, for it can effect not only directly, but also indirectly the health of the families.

Employers encourage their Bantu employees to partake of these nutritious midday meals supplied either by Kupugani or in the firms' own canteens, as they find that the health, and thus the labour output of their Bantu employees increases noticeably.

Kupugani distributes an average of 1,500 meals per day, at a cost of 12 cents per meal. These meals are completely balanced, and there is a choice of three types of meal every day.

(ii) South African Institute of Race Relations
(Durban Branch - Natal Region):

This organisation is not a case work agency. Its activities are mainly directed towards undertaking research in the field of race relations, and investigating problems in this area of inter-personal relations. It undertakes liaison with various groups, and attempts to stimulate programmes favourable to increasing interracial understanding.

In the Natal Regional Office, the Women's Group has undertaken to raise funds from its own resources in order to provide a supplementary programme to one of the play groups at Newlands. This service has helped to raise the standard of the play group concerned. In part the group also provides a creche for a num-

ber of children. Newlands is a peri-urban area outside the municipal boundary, where living conditions at the moment are extremely primitive. Thus this play group-cum-creche provides a useful service in the area.

In recent years, one of the major activities (which started in a very small way), was to raise some money from amongst its own members to grant bursaries to boys and girls desiring to complete high school education and matriculate. As has been indicated, in the case of children living in the newer Bantu townships, completing a high school education means having to go to one of the boarding schools in the reserves. This programme has been well supported by the members, and has grown tremendously over the last four years, owing to the generous support of members, Philanthropic Trusts and well-wishers. The number of pupils assisted has increased from 14 in 1963 to 72 in 1966. During 1966 an amount of R6,155-00 was received, and was disbursed as follows:

PAID OUT:

42 students @ R85 (full board & books)	R3570	
14 students @ R40 (part board & books)	560	
10 students @ R15 (books only)	150	
6 Emergency grants plus various supplementary grants/loans	<u>375</u>	
72 Students assisted	TOTAL PAID OUT	R4,655-00
Balance in fund as at November, 30th, 1966		R1,500-00

(The balance of R1,500-00 arose because moneys were received during the year after bursaries had been granted. The sum goes forward to the new financial year).

While this bursary programme^{1]} does not directly affect the health of Bantu children, it has an indirect effect, in that it relieves the strain of higher education on the budget of the relatively few families that are effected by the bursary scheme. Thus, the likelihood of malnutrition and ill health amongst the children concerned occurring as a result of the severe strain put on the family budget by educational costs, is somewhat diminished.

1] It can be noted that a number of bursaries are also offered to the Bantu in Durban by the Bantu Administration Department.

The Durban Municipal Advancement Bursaries are awarded to scholars of Bantu parentage who wish to further their education in such courses as in the opinion of the Selection Committee will be beneficial to the Bantu community.

There are three of these bursaries valued at R100 per annum and five valued at R85 per annum, tenable for two years at a recognised scholastic institution other than a university.

Two bursaries valued at R120 per annum tenable for one year at the University College of Zululand are offered to students who are reading, or intend reading, for a degree course. In addition, four medical bursaries are offered to recipients selected by the Natal University Medical School, valued at R120 per annum, tenable for one year.

3.12 SHORT-TERM SPECIFIC PROJECTS:

There are a number of organisations which do not furnish a regular continuing service to the Bantu community in Durban, but from time to time undertake specific projects. The following are very brief illustrations of the type of work undertaken:

In 1966, the World University Service Committee of the University of Natal embarked on a book collection, to make a large number of school books, encyclopaedias, and reference books available to Bantu schools in the region. Over 5,000 suitable books were obtained, and were distributed to Lamontville and Kwa Mashu secondary schools.

The Round Table, and the various branches of Rotary in Durban, and Lions International, have been active in various projects for Bantu welfare. In this we must include the wives of the members of the organisations - such as the Rotary Anns undertaking work in conjunction with Rotary. For instance, Rotary Anns have carried a continued interest in the various creches in the Bantu townships. The Durban North Rotary Anns "adopted" one of the Bantu Child Welfare Society creches. An interest is taken in the creche, and all sorts of additional assistance is provided. Likewise, several play groups receive considerable assistance from Rotary Anns of the Durban South Rotary branch.

The projects undertaken from time to time by such bodies are, while being short-term, nevertheless of importance in the life of the Bantu community.

3.13 THE CHURCHES:

All of the Christian churches undertake some aspect of welfare work for the Bantu. Most of them work with their counterpart Bantu congregations, and/or counterpart denominations. Liaison particularly as far as the Women's Associations and Youth Groups are concerned is very active.

It is quite impossible in a brief narrative of this nature to recount the many many types of church aid and assistance, and the innumerable ways in which the people of the Christian church are rendering service to the Bantu community. Some of the work is undertaken by youth in inter-denominational camps. Other Christians work on specific projects, with their own particular church groups. Some of the work is inter-denominational and ecumenical in nature. All that we can do is to stress the innumerable efforts penetrate to almost every sector of the Bantu community. For example, in about 1960 when there was so much concern in Durban about Bantu malnutrition, it was the churches who afforded the leadership, and launched the Church Milk Appeal. During the course of this appeal they raised some R6,000-00 within a few months. By way of illustration, there was the inter-denominational "hunger week" held in Natal during 1966. This was a week set aside for the Christian churches to think specifically of the needs of the hungry, and funds were collected to be distributed to various welfare organisations and groups working in the area of the needy. Most of the money collected went to the Bantu community.

The projects of the various church bodies are on-going, and change both in volume and emphasis at any particular time. However, the overall effort undoubtedly makes a significant contribution in many ways - both obvious and also hidden - to

the welfare and health of the Bantu community, not only in Durban, but in the rural areas.

3.14 CONCLUDING WORDS:

From the review presented in this chapter, (which it must again be emphasised is more illustrative than complete), it can be seen that State, Province, Municipality, the many voluntary associations, the service associations, the non-profit organisations, and the churches all make in their own various ways, a substantial contribution to the Bantu health and welfare programmes. While it is not only amongst the Bantu children that the efforts are organised, it is probably true to say that it is particularly at the care of the Bantu child that most of the effort is directed.

It would constitute an interesting and worthwhile research project to undertake a sustained investigation into the details of the various programmes outlined above, and also any which have been omitted^{1]}. Especially the total financial costs to the public bodies, to the general public, would be most revealing if they were ascertained. It can be seen that the total effort of the community is, by any standard, immense. But at the same time, the problems faced are also immense. It must be remembered that the widespread help comes from almost every sector of the community, and that it can be concluded that the community as a whole has accepted the challenge of serving its fellow citizens, and endeavouring to assuage the difficulties that they are experiencing both because of their depressed economic condition, and because of the difficulties facing them in adjusting to a rapidly changing situation.

1] A list of the social agencies in Durban can be obtained from the following roneo'd directory put out by the Social Workers Association of Durban:- (1966): A Handbook of Social Agencies in Durban.

CHAPTER 4.

CONCLUSIONS AND SOME GENERAL DISCUSSION^{1]}

This report has analysed the social circumstances of the Bantu in the City of Durban and its immediate region. Particular reference has been made to the children. The main emphasis has been on understanding present problems, with a view to providing a guide for preventive rather than curative health and welfare campaigns. As Tawney has very rightly said:

"Since half of the thought and money spent on relieving existing evils would probably have prevented many of them from coming into existence at all, it is, on a long view, more important to lay bare causes than to plan immediate remedies."^{2]}

This is a view we share, and which our conclusions stress. The main conclusions are presented below, with some additional discussion afterwards.

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- 1] This section was written by H. L. Watts, collating the findings of the previous chapters.
 - 2] R. H. Tawney, in an address at the London School of Economics, when inaugurating a training course for social workers, made this statement.

4.1 MAIN CONCLUSIONS OF THE STUDY:

The typical Bantu household in the Durban region is in poverty. Bantu households with a satisfactory economic level are rare. There is a close correspondence between the findings of a study undertaken in Kwa Mashu in 1964, Young's findings for Durban in 1964, the study undertaken in 1958 by the Department of Economics at the University of Natal, and the earlier C.S.I.R. study of Durban in 1953. Taken together, the overall figures suggest that somewhere between about seven to eight out of every ten Bantu households in Durban have a legal income insufficient to meet the basic needs for healthy survival. Rising wages appear to have been cancelled out by the rising cost of living. The close agreement between the various independent sets of figures obtained by different investigators lends strong support to this conclusion. The "culture of poverty" is widely evident amongst the Bantu in Durban.

There is a gap between income and expenditure. Part of this may be made up by illegal earnings which were not reported. If so, we have a most undesirable situation - a serious social problem exists if the household cannot exist on its legal income, and is driven to supplement it illegally. Our findings would also support the accuracy of the statement that is made more than once as to the great amount of debt into which many Bantu households get themselves.

The depth of some of the poverty amongst the Bantu in Durban is shown by the fact that an estimated one-third have less than twelve cents per head per day on which to live, and almost one-tenth have less than six cents per head per day, after the cost of workers' transport and rent have been deducted. These figures compare with an average requirement

for healthy and decent survival of 26½ cents per head per day for the typical household. Given present prices, it is not difficult to imagine how very little in the way of food, clothing, fuel and lighting, soap, and all the other necessities of life can be purchased by a household with less than 6 cents per head daily after rent and workers' transport have been paid. The depth of poverty amongst some of the Bantu in Durban appears appalling. The incidence of poverty is such that we would expect a correspondingly high incidence of malnutrition, ill health, and a host of other problems associated with poverty, occurring amongst the Bantu in Durban. That this is so, is borne out by the figures on health and malnutrition presented in the report.

The findings of the present study are in agreement with those undertaken elsewhere in South Africa, to the effect that the amount of poverty is correlated with the size of the household. The larger households tend to be faced with worse poverty than the smaller households. In particular, it appears that the poorer households have more children. This is not unexpected. For example, in the Kwa Mashu sample the average number of children of the households in poverty was nearly three times as many as the average number of children for households not in poverty. Because of this problem, nine out of every ten Bantu children in the region are likely to be living in poverty. This is a remarkable conclusion. It points to the large scale problem which must be solved. Perhaps 74,000 Bantu children in Durban and its immediate surroundings grow up under conditions of poverty. It is not an exaggeration to say that the problem of child care resulting from "the culture of poverty" is the largest single social problem facing the community of Durban. The

problem is too large to be tackled by voluntary organisations and voluntary community effort alone. It needs the full support of the government.

The main factor related to poverty is that of occupation, with poorly paid jobs. This has been found by previous poverty studies from the time of Rowntree onwards. The poor households on the average are the large households, where the breadwinners have lowly skilled, poorly paid occupations. In the last resort, the key factor in poverty (as Rowntree found in 1899), is poorly paid work. There are a multitude of other factors associated with the poverty of the Bantu, which aggravate the position, but they do not alter the fact that poorly paid work is the main cause. This stresses the urgent need for wage structures being raised to a level where workers can support their families in decency and in health. From this point of view, all the voluntary effort at the moment, which is trying to stop the gap between a family's needs and their income, is really subsidising commerce and industry. As long as the position continues, without any basic improvement in wage structures, there can be little hope for any great improvement in the living conditions and health and welfare of the Bantu people of the region. The same goes for the rest of the urban areas of the Republic.

It is necessary to stress how all pervasive the factor of poverty is, and to underline the fact that if we are to control the situation, and if our efforts are to be more than purely palliative, then any programmes which are to have long term benefits must strike at the very roots of poverty, rather than dealing with the problems and symptoms that it has produced.

While we do not know how much poverty is caused by financial mismanagement, waste, ignorance, which prevent the income of a household being used to best advantage, we do know that these factors in many homes make the position worse than our figures have suggested. After all, the poverty datum line assumes the maximisation of budgeting on the part of the family, and that what money is available is used to the best possible advantage. So many of the families have a rural tribal background, and are unable to squeeze the maximum nutritional value out of their income, because they have neither the education nor the background and opportunity to do this. This underlines the extent of poverty amongst the Bantu in Durban. Even by the most conservative estimates, the problem is appallingly large. To fail to admit this, is to close one's eyes to the established hard facts of the situation, and also to fail to appreciate the essential problem which requires solution.

While the basic elements of poverty in Europe a half century and more ago, and in developing countries at the present time - such as South America - and South Africa, appear on analysis to be fundamentally the same, there are at present certain additional factors operative in South Africa which complicate the issue. These have already been pointed out, but it is worthwhile summarising them here again so that our appreciation of the basic problem is adequate.

The present South African position allows very little opportunity for the Bantu to advance by vertical mobility - by rising from the unskilled level to the skilled level and upwards. In Europe for example as with the poor Whites in South Africa, part of the poverty problem was solved by some of the younger generation rising "through the ranks" to the

better paid jobs. In part the poverty problem solved itself. Until such opportunities substantially open up for the Bantu, the solution of the poverty problem in South Africa will be far more difficult, and the ability resources of the Bantu themselves cannot be fully tapped as an aid to solve the problem. This fact must be appreciated by all concerned. Ideas and policies are essential, but if they are to direct and control our efforts, they must be rooted and grounded in a realistic appreciation of the factual position. Again, if we are to learn from experience in Europe, and more recently in developing countries, then we must realise that upward mobility is one of the factors involved in helping to solve poverty, and consequently we in South Africa must try to provide for increasing opportunities for upward mobility amongst the Bantu. The size of the skilled and middle classes amongst the Bantu population must grow, and as rapidly as possible.

The Industrial Revolution in Europe last century, and earlier, was at a stage of technological development where a large unskilled labour force could be used. In South Africa today, technological advancement means that more and more unskilled tasks are being replaced by the machine. Automation is furthering this process. This means that the need to educate and train the Bantu for higher skilled jobs, and to make such jobs available, is going to become more and more urgent as South African industry progresses - and will be far more urgent than it ever was a century ago in Europe, or even during the early part of this century in America when large numbers of a predominantly rural population migrated from Europe to the north American continent.

Thirdly, the task of educating and training a rural peasant population which has been drawn into an urban society, is complicated in South Africa by the fact that in the case of the Bantu there is a different cultural background to be adjusted to westernisation. As has already been shown, in Europe and in present day developing countries, all belong to the same culture. We have far more knowledge today about the processes of acculturation than our forebearers did, and we also have techniques for the mass education of populations - these must be used intelligently, under the guidance of skilled social scientists, so that the process of helping the adaptation of our Bantu populations to western urban culture proceeds as rapidly and smoothly as possible. It is futile to suggest that we try to maintain them at their tribal level, where not only has the tribal society been dealt a death blow by the impact of an urbanised industrial economy, but also - and more important - such a tribal culture in no way fits the individuals for successful socio-psychological adaptation to modern South African conditions. Again in this matter we must be realistic, and start with the factual situation, and these are the facts and the processes with which we must work.

A further factor which for example, was operative in Europe in solving poverty, and which is scarcely operative in the Republic yet, was the development of more adequate social protection for vulnerable groups - for the disabled, the families in difficulties, the ill, the old, the indigent. South Africa at present is suffering from a time lag - our poor relief is, as has been shown in chapter 3, way below the poverty datum line. This applies equally to our social pensions and grants made by the State. In some ways, our social protection for the Bantu could be described as more

mediaeval than modern in concept and practice. We must catch up with modern developments in this sphere, and wipe out the present time lag. We have an excellent chance to learn both from the successes of our European forebears, and the experience of developing countries - particularly Latin America where under the guidance of skilled social scientists, great strides have been made in a matter of decades. As South Africa's economy develops, and as our Bantu population becomes better educated and better trained, and as better paid jobs are provided, it will become easier for our country to be able to afford to improve our social welfare protection of those in need. Even now, when the cost of poverty is so high, can we really afford not to tackle the question immediately? We think not - the true cost to us of poverty is higher than adequate social protection would be, and the costs of preventative health and welfare measures are cheaper than the costs of not only the suffering but the inefficiency and ill health in our midst, and the cost of the curative and rehabilitative measures which at present we have to pay for.

We conclude that the attack on poverty must be on several fronts at once. It must include pressing very strongly for a living wage, and for realistic social grants to the needy which allow them at the very least to reach a bread-line; must include working for better training and education of the poor (especially the children who represent the new generation); raising productivity; the increasing opportunities for the Bantu to get more skilled jobs and to advance socio-economically; propogandising birth control to reduce the strain on the large families with low incomes; and the creation of social conditions which will help to

stabilise the family, and reduce the number of broken homes. There is a need for health and nutritional campaigns to combat the widespread ignorance and misuse of limited financial resources of the Bantu. There is a scope for co-operative buying schemes to ensure cheaper foodstuffs and clothes for the poor - that is for most of the urban Bantu. In fact, every attempt must be made to work for social and economic advancement and development of the illiterate under-developed or semi-developed Bantu in our townships. It is clear that preventive rather than curative or palliative measures are needed. If success is to be achieved ultimately, then programmes should be directed towards striking at the roots of poverty, not attempting to deal solely with the after effects - and in this sense perpetuating the causes indefinitely.

A multi-pronged attack must include the under-developed rural peasant Bantu population, from which many of the urban Bantu are drawn - they come to the towns bringing their problems, their ignorance, and their problems of adjustment, with them.

Our broad conclusions are clear - there is no need to repeat some of the detailed and specific conclusions which have been given throughout the review. We proceed to a discussion of some of the aspects.

4.2 GENERAL DISCUSSION ON SOME RELEVANT TOPICS:

(i) Comparison of some vital statistics for Durban and Johannesburg:

It is obvious from our description of the health and welfare work being undertaken amongst the Bantu in Durban that a considerable amount of most valuable work is in progress. At this stage, we may pause and ask ourselves how effective on an overall basis the work has been. Ultimately the prob-

lem is one of the successful adaption of the Bantu population to urban industrial conditions in a western type civilisation. At the moment, it is clear that the problem is bad enough for it to be in its stark essentials a problem of health and survival. From this point of view, the best indicator of the adequacy of an environment for supporting human life is the infant mortality rate. The chances of a young baby to survive its first year of life, when exposed to the surrounding environment, are a very telling test of the adequacy of that environment. We have already shown how the Bantu infant mortality rate has been brought down in Durban. The latest available figures show a rate of 108.63 deaths per 1,000 live births, in 1963^{1]}. By contrast, in the largest city in the Republic - Johannesburg - in the same year the infant mortality rate amongst Bantu was only 66 per 1,000 live births^{2]}. This figure is substantially lower than that for Durban. This shows that the chances of the Bantu child surviving in Johannesburg are significantly better than those in Durban. If we have come a long way in tackling the health problems, and improving the socio-economic environment for Bantu children in Durban, it is evident that there is still a lot of work to be done. In this respect, Durban is clearly still behind Johannesburg. If we take the White infant mortality rate as our criterion, then there is a tremendous amount of work still to be done - in 1963 in Durban the White infant mortality rate

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- 1] City of Durban (1965): Annual Report of City Medical Officer of Health for the year ending 31st December, 1963: Durban Corporation, Durban: p. 4. The 1963 Annual Report was the most recent available at the time of writing.
- 2] City of Johannesburg (1964): Report on the Health of Johannesburg in 1963, by the Medical Officer of Health: City of Johannesburg, Johannesburg: P. 2.

was only 24.31 deaths per 1,000 live births^{1]}.

A further index of the state of health, and of the socio-economic environment, of the Bantu population in Durban is provided by the figures for tuberculosis. In 1963, the attack rate per 1,000 head of Bantu population was 7.04; This is for primary tuberculosis. The figure for Johannesburg including Bantu working in mining, was 6.06. This difference between the incidence rate for tuberculosis is not merely a chance one as it is shown by previous years too. For example, in 1961, whereas the incidence of primary tuberculosis amongst all Bantu in Johannesburg was 5.14 cases per 1,000 head of population, in the same year in Durban it was 8.82^{2]}. The 1963 death rate amongst Bantu in Durban from pulmonary tuberculosis was 0.67 deaths per 1,000 head of population. In Johannesburg in the same year, the figure for Bantu was 0.33, or half of the Durban rate. Again this difference is not merely a chance difference, because whereas in 1962 the Durban death rate was 0.70, it was only 0.30 in Johannesburg^{3]}. These figures again support the contention that the health and welfare of the Bantu in Johannesburg appear to be better cared for than those in Durban. This is not in any way to minimise the great value of the work already being done in Durban, but to suggest that the existing facili-

1] City of Durban (1965): Ibid.

2] City of Durban (1965): op. cit., p. 15; and City of Johannesburg (1964): op. cit., p. 9.

3] See City of Durban (1965): op. cit., p. 17; and City of Johannesburg (1964): op. cit., p. 9.

ties can be improved, as the death rates quoted above suggest that the environment and socio-economic conditions are not as good in Durban from the Bantu's point of view, as they are in Johannesburg.

We could continue the comparison by comparing Durban with other cities, but in a review of this nature this seems unnecessary. The point has been made that we must not rest on our laurels.

(ii) Brief details of an interesting feeding scheme in Johannesburg:

It is thought provoking to examine how the feeding of Bantu children is carried out for example by one organisation in Johannesburg. One of the societies in Johannesburg is known as "The African Children's Feeding Scheme". In 1965 the society was feeding roughly 43,000 children daily. This is a most impressive figure, especially if we bear in mind that it represents the activities of one organisation. To achieve this total, the organisation has streamlined its activities. In 1958 it took a decision to operate mobile food vans. It was found that it was far too difficult to find sufficiently well-situated feeding centres, and as it took only a few minutes to provide the food to the school children it was uneconomical to concentrate on indoor shelters. Nine mobile vans are in use. Six of these operate in Soweto (south-western Native townships), one in Krugersdorp, one in Benoni, and one in Roodepoort. In 1965, 10,500 children were fed daily from 17 feeding centres. In Hekpoort Valley 25 schools were catered for, involving a total of 5,500 children. Five to six thousand school children were fed in Soweto, as well as 48 creches caring for 4,400 children^{1]}

Each van is stocked up daily at a central point, and operates with a driver/organiser and 2 women assistants. Originally one driver plus a voluntary helper was used, but

1] These 1965 figures are included in the above total of 43,000 (mainly pre-school) children fed daily.

this was found to be unsatisfactory. Powdered milk is mixed at a central depot, and taken in enormous containers which each have a tap. The children receive two thick slices of whole wheat bread very generously spread with peanut butter, and one pint of powdered full cream milk. A charge is levied for the children, at one cent per meal. Welfare cases receive feeding free. (The welfare cases concerned have been referred either by Baragwaneth Hospital, the Johannesburg Municipality Welfare or Health Departments, or the Schools. Each one handles about 200 to 220 loaves of bread daily, and 160 gallons of milk. The service operates five days per week.

The operation of the service depends upon well trained and disciplined staff. Each van distributes at from five to nine points, and the times of arrival are so scheduled, that they must be adhered to accurately if the service is to be maintained. A considerable amount of administrative work at each stop is entailed, as returns have to be completed showing the number of children fed, the amount of cash collected, etc.

In addition to using the mobile vans, the African School Feeding Scheme has approached schools, and if these are capable and willing to undertake the feeding scheme themselves, the organisation undertakes the bulk purchasing of milk, peanut butter and bread for them, and organises about the deliveries. The actual feeding is then done by the schools themselves.

In the case of creches, the organisation pays three-quarters the cost of the foodstuffs supplied, and the creches pay only one-quarter. By contrast, the schools pay the full cost of any supplies furnished.

One of the main advantages of the mobile feeding scheme of the organisation is that it caters for the pre-school child-

ren out of creches. In the Johannesburg Municipality's Baby Clinics, children under the age of 2 years are catered for. Once the children are at school, they can receive school feeding. It has been found that the pre-school child from 2 to 5 years is badly neglected, except in the percentage of cases who are cared for by creches. The mobile scheme, with its great number of stopping points, makes it possible for a very large number of pre-school children to be reached. If the children are old enough, they come along on their own, whereas in other cases an older child will collect additional milk and bread to take home for his siblings. The mobile scheme could well be seriously considered as a possibility for Durban - and the fact that it can be organised to cater for the bulk of the pre-school population that is not in creches or play groups, commends the scheme greatly.

(iii) A discussion of specially vulnerable groups in the Bantu population:

It has been shown that there is widespread poverty amongst the Bantu population in Durban. Given this situation, there are nevertheless certain types of families which are particularly vulnerable. These are the families where the male head and breadwinner is temporarily precluded from wage earning - either because of unemployment, injury at work or sickness; secondly family units without a male head, where the woman is either a widow, divorced, or a deserted wife; and thirdly the unmarried mother with her child or children. Poverty is likely to be accentuated in cases such as these, where it is not merely a problem of regular employment by the breadwinner producing an income which is too low for the family to live on, but rather where due to some calamity the income of the family is seriously depleted by the absence or incapacitation of a male breadwinner. Consequently, these types of families need special care. It is

true that they are eligible for assistance from the State, either in the form of relief parcels, or disability, or maintenance grants. It has been graphically shown already that such aid is very much below the poverty datum line, so that unless it is supplemented in some way we cannot expect the family to stay healthy and decent. The circumstances surrounding the problems of such specially vulnerable families is briefly discussed below.

In the case of a normal family, where the male head and breadwinner is temporarily precluded from wage earning, the reason for this can either be unemployment, injury at work or sickness. Most of the Bantu wage earners fall below the lower limits of eligibility for the unemployment insurance fund. This point has already been made, and it has been suggested that the necessary amendments to the regulations be made to cushion the serious effect which unemployment can have on the income of a family already perilously close to the poverty datum line, or below it. As far as accidents are concerned, if they take place at work, all workers are covered by worker's compensation. These benefits cover immediate cases of hospitalisation, but where permanent injury has been sustained, there are long administrative delays until the benefit is paid. In the interim there is no income, and in the event that the worker recovers, there is no provision for sick pay during this period. Public relief has already been shown to be seriously deficient from the point of view of maintaining the health of a family in such a misfortune. With regard to the third hazard of sickness, the overwhelming number of Bantu adults are without any insurance coverage. The most serious and frequent effect of illness is in respect of tuberculosis. During the period of the breadwinner's hospitalisation, it is

possible for the wife and children to receive a maintenance grant. Not only is the administrative machinery slow - at present in an uncomplicated case it takes from six to eight weeks to organise - but as has been shown in chapter 3, the grants are so much below the poverty datum line that the threat of ill health must be imminent. When the T.B. father is finally discharged from hospital, he is in most cases not fit to attend to duty, or he is classified as fit only for "light duties". In the present economic system where Bantu workers are mainly unskilled, "light duties" are something which are almost unobtainable. While the former T.B. patient is recuperating at home - it must be stressed that with modern drugs his period of hospitalisation is very much shorter, but involves continuing the treatment at home by regularly taking pills supplied by the authorities - he is unemployed. Theoretically patients in this position are eligible to receive a T. B. food parcel furnished by the Municipal Health Department, on a subsidised basis whereby the Central Government pays seven-eighths of the cost, and the municipality pays one-eighth. The food furnished is based exclusively on the needs of the T.B. patient himself, and is not supposed to be for family use. Chapter 3 has referred to some of the disadvantages and limitations of this system, from the point of view of the recipient. The fact that the person is unemployed is serious. The T.B. patient may come back fit for work, and his previous firm naturally may or may not take him back - in most cases his position has already been filled, and he has to seek work afresh. He then goes to the labour exchange, and registers. For a period of two weeks he is registered with them. He is, however, one of several thousands who are seeking work, and the chances are that he will not easily find that work. He may then be endorsed out of Durban. In such a case he returns home and does not continue

his treatment. The end result in all probability according to one medical officer, was that dozens more people contact T.B. from him, because it is only a short while before he becomes active again.

The situation described above is one that requires urgent attention and revision of the present regulations. Not only is it serious from the point of view of the T.B. patient himself, but it also can be very serious from the point of view of the family, and especially the children. There is a real need for sheltered employment for T.B. patients once they come out of hospital, and in some cases, sheltered employment for the rest of their lives. There is also a need to provide realistic care for the family, at a level commensurate with the spiralling costs of living today. Unless programmes along these lines are worked out, and the State accepts the responsibility of the rehabilitation of such patients, plus the adequate care of their families, then again in the words of one of the medical officers interviewed, every one of these patients, will become a liability to the State. They will also spread the disease further, and increase the liability. It is possibly this state of affairs that is behind the alarming rise in the rate of tuberculosis amongst Bantu throughout the country.

In the case of broken homes, where the woman is either a widow, or has been divorced, or is deserted, the mother and children are eligible for a maintenance grant. This makes little contribution towards the needs of the family, and the woman is faced with the position of having an endless struggle to try and keep the children from the constant threat of ill health. In the urban area, she may have no kin to whom she could turn, and in any event, in most cases any kin would be of the labouring class, and consequently have their own battles

to make an income below the poverty datum line stretch as far as possible.

In the case of the unmarried mother or her children, it is obvious that each individual manifests a particular set of circumstances. However, in general it is possible to make the following three broad classifications:

There is the mother who is legally but not socially married. She is in the same position as those classified as "common law" wife, in other countries. There are two sub categories in this general classification. In the one case, the man is already paying lobola, and the union will only be legalised either by Christian rites, or by registration of the customary union, on completion of lobola. The man assumes full economic responsibility for his "wife" and for other children which ensue from such union. This little family group has all the features of a normal family except that it lacks the blessing of a church or state. While children ensuing from such a union are regarded as being illegitimate, they are not deprived of the benefits of a father's presence and influence. In this case, from a sociological point of view we should regard the family as a normal rather than a broken one. In the second situation, there are the couples who are in census terminology "living together". In Durban this is popularly known as the "kipita marriage", from "being kept". There may be quite a variety of situations with this type of family set up, but in general, the man and woman are living together temporarily. They may be unmarried, or as often happens, the man may originally have been a migratory worker with a wife and family in the reserve, who has established a relationship with a woman, and is now living with her. It must be stressed that the impossibility for women to rent homes often drives them to establish such relationships.

These "kipita" unions vary along a continuum of temporary relationships lasting maybe a year or two, to those which have a duration of over twenty years. Phillip Mayer in his study of East London, has given a brilliant picture of the subtle differences in both the economic and social responsibilities of the man to his "wife" and children^{1]}. No such detailed sociological investigation has been undertaken in Durban, but social workers familiar with conditions have indicated very similar trends. The children are regarded as belonging to the woman, and it is the mother who is considered mostly responsible for their maintenance. The father pays the rent and makes some contribution to food, but the mother more often than not has to bear the costs of clothing, schooling, etc. The man's contribution in food may be absolutely minimal. If he has his legitimate family in the reserves, his primary responsibility is to them. The result is that the children of these "kipita" marriages live under conditions of stark poverty, and are not necessarily eligible for maintenance grants. They are seriously exposed to the threat of under-nutrition and malnutrition.

The final class of broken home is that of the unmarried mother who has been completely deserted by the man. The incidence of pre-marital pregnancies amongst young Bantu girls in the towns is unfortunately fairly common. This is directly attributable to the conditions of transition and change. Social research has stressed the dangers in a society where there are thousands of virile migrant workers living under abnormal conditions of sex segregation. The stable urban family unit is also keenly aware of these dangers. Furthermore, the impact of westernisation and industrialisation has brought about great post-

1] Mayer, P. (1961): op. cit.

ponement in the age of marriage, particularly of the men. These factors have played their part in the risks to which the younger women are exposed. In the contemporary urban environment, the Bantu have adapted themselves to this change of the unmarried mother and her baby, and invariably she and her child are accepted by the family and remain in the parental home. The usual pattern is that the mother goes out to work, and leaves the child in the care of the grandmother - who herself may quite often be a full-time or a part-time worker. In many such cases, the baby is virtually looked after during the day by the younger children of the family. There is the usual pattern of insufficiency of income, and consequently poor nutrition. There are however, a number of cases where such babies are adequately cared for. Much depends upon the availability of the creche care. If the child can be admitted to the creche, all is well, and the baby is extremely well cared for. It has already been shown in chapter 3 that the bulk of the children in Durban do not have access to creche or play group care, so that only a small fraction of the children are catered for in this manner.

In the case of the unmarried mother whose family is in the country, the position is far more desperate than that described above for the girl with her family in the town. Such young women have no kin in the urban area to whom they can turn for help. Particularly if they are members of traditionalist families, the disgrace of her unmarried status may make her unacceptable at home. She therefore tries to continue and work, and make her own arrangements for the care of the child. She may pay anything from R3-00 to R5-00 per month, and only too often the care provided is utterly inadequate. There is no supervision, and the baby may be neglected. There are women in the

township who take in a number of such children, and make it a business to "look after them". These are the children who are not taken to Child Health Clinics, and who are not brought to the attention of child welfare societies - it is here that the very gravest conditions are found. It is in these pitiful circumstances that the infant mortality rate is so high. There are no children's institutions in which such babies can be placed, and the situation is one of the utmost gravity. It calls for serious thought as to the possibility of developing services which will try to alleviate the plight of such a mother. Not only is her income in all probability inadequate to maintain herself and her child or children in health and decency, but she may have to pay a relatively exorbitant price for having some older woman to look after her children while she is at work.

These types of families described above are the ones that are especially vulnerable. We have already shown how vulnerable most of the Bantu families in Durban are because of their depressed socio-economic conditions. In the families just described additional factors have made the situation even worse, and the provisions of poor relief and state pensions and grants are at such a level that they are completely inadequate (given present day prices) to keep the children of such families healthy. Over and above the services in health and welfare provided for the general Bantu population, more specific attention should be given to the needs of these particularly vulnerable groups.

CHAPTER 5

RECOMMENDATIONS

1. A MULTI-PRONGED ATTACK AT THE ROOTS OF POVERTY IS NEEDED:

It has been made abundantly clear that part of the problem of the ill health and welfare needs of Bantu - especially children - in the region around Durban, is associated with the movement to the town of a semi-westernised, largely illiterate, unskilled population. This problem is in some ways similar to the problem which followed on industrialisation in Europe after the Industrial Revolution, and which is being experienced by developing countries throughout the world. We recommend that attention be directed not only towards strengthening not only the existing pattern of case work and group work, and institutional care (along the lines which will be suggested below), but more particularly, that considerable attention must be given to the whole problem of striking at the roots of the problem. Some of the basic causes of poverty are as yet still untouched, and must be tackled.

Efforts must be made to turn the under-developed Bantu with their large-scale problem of poverty, into a prosperous working population. Unless this is achieved, we will continue indefinitely with the present evils. If this is to be achieved, a multi-pronged approach is necessary.

It is essential to push vigorously and continuously for a

living wage for the unskilled worker. The part that lowly paid work plays in causing poverty is crucial. The public must be convinced of this fact by extensive publicity (for often people believe the myth that all the Bantu poor are in poverty through their own fault). The Government appears, through its reluctance to give a lead in raising wages to the minimum level of the poverty datum line, possibly to be unconvinced of the urgent need to raise wages. Public pressure must be mobilised, and the Government persuaded to give its lead to the country by raising wages. However, with or without Government support, a target of a minimum wage, in the first instance equal to the poverty datum line for a family, must be set. Wages must not stop at this level, but at first they should at least reach it - and be adjusted as the cost of living increases. As long as the majority of the Bantu receive wages that are below the poverty datum line, so long will it be necessary for the community to subsidise commerce and industry, and contribute in the form of direct gifts of food and service to maintain the health of the population. At the moment it is true to say that it is largely voluntary effort that is being used to subsidise a sub-minimum wage.

Industry itself is keenly aware of the situation. Much valuable work has been done today by the Bantu Productivity Association. It is appreciated that it is impossible to raise Bantu wages unless there is some increase in productivity. This relates to training and education, about which more is said below. In the final analysis, the problem is a national one and not local in nature. It requires national consolidated action and representations at the very highest level. We recommend that such consolidated action be worked for, and that the ground be prepared for such representations.

2. URGENT NEED TO REVISE THE SCALE OF PUBLIC ASSISTANCE AND STATE SOCIAL PENSIONS AND GRANTS:

A second line of attack is imperative if the problem of the Bantu's poverty is to be tackled seriously. It is vitally necessary to bring the Government Social Grants and Pensions system, and the Public Relief system, onto a far more realistic basis. It has been shown that the old age pensions, the disability grants and maintenance grants, the grants to foster parents and institutions are all below the poverty datum line. Once they may have been sufficient to maintain a person or a family in health and decency, but with the present day high level - and increasing level - of prices, this is not possible. Again what is happening is that the public conscience will not allow men, women, and particularly children to starve. Consequently the final responsibility of maintaining a needy family is removed from the Government and placed on the community. In Durban, the Community Chest has been desirous for many years to reduce its budget and allocations to member societies for public assistance, and the supplementation of social relief and grants. The Chest has held to the point that the longer voluntary effort is prepared to supplement State grants and relief, the longer the Government will not be faced with the necessity to improve either its administration of relief, nor the level of such relief and assistance. From this point of view it must be stressed that some of the agencies operating in Durban - especially the Malnutrition Relief Fund and "Feed the Babies" fund - are virtually pouring their supplies in to fill the needs of such low income families that are unable to survive on State assistance. They are therefore in a permanent way, underwriting and subsidising an inadequate Government grant system.

It seems that it is only on the basis of mass representation that some changes may be brought about. It is impossible for an individual agency to do anything in this matter. For example, for the last 25 years or so, the question of the inadequacy of the Bantu grants has been raised in well documented memoranda by the South African National Council of Child Welfare. The problem is with us still. It may be that one of the difficulties in the way of persuading the Government to improve its level of assistance is the prevalence of the concept that the Bantu should maintain his traditional system of dependence on his kin. If this is so, then the modern facts of the matter should be stressed - as any social scientist and student of social change knows, throughout the world it has been found that the whole urbanisation process has greatly undermined the former structure and function of the family. The importance and function of kin has greatly decreased. This is as evident amongst our present day Bantu as it is in South America or elsewhere. Traditional Bantu society, and the value of the kinship structure, cannot be undermined by assisting those in dire need. Furthermore, when the amount of poverty amongst the Bantu is so widespread at the moment, it is completely unrealistic to expect the kin to be able to support relatives in need, when their own needs are so great, and their income in most cases already below the poverty datum line.

We recommend that every effort be made to improve this situation. Old age pensions, disability grants, maintenance grants, foster care grants, grants to institutions caring for children, public assistance, and government assistance to T. B. patients, should all be reviewed, and brought in line with our present socio-medical knowledge of the minimum needs of an individual in a family, and also brought into line with the present day cost of living. A panel of social scientists and medical

experts could, if need be, assist in this regard.

3. EDUCATION AND TRAINING OF THE BANTU MUST IMPROVE,
ALONG WITH OPPORTUNITIES TO ADVANCE ECONOMICALLY:

In conjunction with the pressure for a living wage, there must be a push for better education and increased training of the Bantu for urban industrial type of work. South Africa is a country undergoing rapid urbanisation and industrialisation. This is likely to continue, and all racial groups are being affected by the process. The education of the Bantu must be of such a nature that it fits and trains them for an urban industrial existence. It has been shown for many years that the rural areas cannot support at a satisfactory economic level the Bantu population. It is likely that in the Bantu homelands Bantu urbanisation too will proceed apace, given the opportunities. Thus the Bantu must be trained for living conditions in modern society.

Demands must be made for realistic opportunities for the Bantu to use the training and skills which they currently have, and which it is hoped they will improve on in the future. In this sense it is necessary to mobilise some of the resources of the Bantu themselves for the solution of the problem of poverty. The problem of poor Whites in South Africa was largely solved by training and educating the unskilled illiterate Whites. Today, their counterparts, sociologically speaking, are the poor Blacks. The same solutions of training and education, must be applied imaginatively. This calls for a co-ordination of planning and effort at far more than merely the level of the individual community. The problem is a national one calling for national imaginative action.

A strong plea must be made for greater expenditure on the whole programme of Bantu education, and the extension of training facilities both at a manual and a professional level for the Bantu population.

4. BANTU PRODUCTIVITY MUST IMPROVE:

Concurrent with the efforts to improve education and the level of training of the Bantu, can go (and from the point of view of the employer must go), demands for improved productivity. In fact, the Bantu must be trained and moulded into a more efficient industrial worker, and a more effective urban citizen. To repeat the point made previously, whether or not the Bantustans are extensively developed is beside the point - it is clear that increasingly as throughout the world, the rural peasant is becoming more and more drawn into the orbit of urban society. The Bantu must be encouraged and allowed to make a contribution towards his own welfare, and towards the welfare of the Republic. Wise revisions of job reservation rules will be needed if South Africa is not to continue to pay the dear price of not utilising to the full the resources of the Bantu population. If we keep the Bantu as an untrained, largely illiterate, unskilled or semi-skilled worker, restricted by legislation to the lowest wage levels, then the Republic will continue to pay the very high price of Bantu poverty in ill health and inefficiency. This is something which we cannot afford - it is too costly to perpetuate. If we think otherwise, then we are not facing the facts of the matter, and our attempted solutions of the problems of Bantu health and welfare will only scratch the surface.

5. SERIOUS CONSIDERATION MUST BE GIVEN TO
BANTU TRADE UNIONS:

Attempts to improve the economic position of the Bantu are fundamental to any attempts to improve the health and welfare of their people. Serious thought should be given as to whether or not attempts to improve the Bantu's economic position must not, in the nature of things, involve a rethinking of our attitudes towards Bantu Trade Unions, and the right to strike. It must be admitted that in Europe, historically the trade unions played an important part in helping to push up the wage structure to the level of "a living wage". Will the demand for a living wage in South Africa be successful without a healthy Bantu Trade Union movement? Is a healthy Trade Union movement essential under conditions of present day industrialisation, for the development of a mature, productive and healthy labour force? Honest thought must be given to these questions, and a true appraisal of the position sought if we are to progress. If Bantu trade unions are developed, then adequate training must be given to union officials for their task.

6. UNEMPLOYMENT INSURANCE:

It is strongly recommended that the provision of unemployment insurance for the economically most vulnerable group - the unskilled Bantu worker - must be made in one form or another. The majority of Bantu workers are still unskilled, and with the very low wage rates prevailing, they can afford less than anyone else to be unemployed. Loss of a job is, in such cases, a major crisis for the family. If need be the criterion, then this group of unskilled workers requires unemployment insurance far more than the workers who already have it.

7. SUBSIDISED HOUSING:

It has been shown that most Bantu in Durban are in poverty. This means that by virtue of being below the poverty datum line, they cannot afford economic rentals. That they do pay such rentals, means that food has to be cut. Thus, the community ultimately has to pay dearly in many ways for the resulting ill health.

We urge that public pressure be brought to bear on the State to introduce subsidised (sub-economic) housing for the Bantu until such time as wages have risen to a point where the Bantu can afford economic rentals. Our poverty datum line figures show beyond any doubt that most of the Bantu in the Durban region - and almost certainly in the other cities of South Africa - require subsidised housing. Rising costs appear in Durban at any rate to have cancelled increases in wages, and the position appears substantially the same as it was when the first survey into the rent-paying capacity of urban Natives in South Africa was undertaken^{1]}.

8. BANTU EDUCATION FACILITIES SHOULD BE EXTENDED TO ALLOW FOR INCREASING OPPORTUNITIES FOR A PROFESSIONAL CLASS TO EMERGE:

It is strongly recommended that the whole policy of limiting education to children in urban areas to a maximum of the J. C. level be reviewed. At present, children in urban areas who want to proceed to the level of matric have to go to boarding schools in the Bantu Homelands. It has been pointed out that this not only puts additional costs on families whose budgets are already limited, but it also means that with the

1] Committee on Socio-Economic Surveys for Bantu Housing Research (1960): op. cit.

limited number of schools taking pupils up to the matric level, the waiting lists are such that not all the applicants can be accepted. Under such conditions, it is extremely difficult for a Bantu professional group to develop unless this bottleneck in the educational facilities is removed. At present, the overwhelming number of children in the towns are blocked from making such contribution to Bantu advancement, insofar as this contribution is dependent upon higher education. A block has virtually been placed in the way of the development and evolution of a professional class. Where are the Bantu engineers, the accountants, more doctors, teachers, lawyers, architects, surveyors, etc., to come from if children in the urban areas are virtually unable to proceed beyond the level of Junior Certificate.

It is also strongly urged that greater provision for free school books be made available. Children are not admitted to schools unless they have their complete set of books - however capable the child may be. In many a family, the cost of these books takes precedence over food, with bad results on the health of the family.^{1]} Probably many Bantu families would have more money for food if Bantu education was made free in all respects, and not only as far as tuition is concerned. The costs of education which the families have to in reality pay, constitutes in many instances a limiting factor to the amount of education which a child is going to receive. This again constitutes a bottleneck to the progress and socio-economic development of the Bantu communi

9. FAMILY PLANNING:

It has been shown that the poor are the ones which have the large families. Further thought must be given to disseminating the knowledge and practice of family planning - smaller

1] Particularly in the case of maintenance grant cases where it is a condition of the grant that the children must go to school, education should be completely free, and include the costs of stationery and all school books.

families will help to alleviate the present problems of Bantu child care. We are of the opinion that careful research is needed to guide attempts to spread family planning amongst the Bantu. Well-meaning blundering can only do harm. It is necessary to propagate the concepts of family planning in such a way as to be acceptable to the Bantu themselves.

10. IT IS ESSENTIAL TO MAKE THE BANTU MORE DIET CONSCIOUS:

There is a great need to make the Bantu population more diet conscious, and to educate them about the food value of various foodstuffs. A large part of the problem is that they do not make the best use of their limited economic resources. The incidence of malnutrition would be reduced to an extent if the housewives were able to make better use of the money they have. We are of the opinion that extensive nutritional education amongst the Bantu is called for. This point is referred to in greater detail subsequently.

11. THE BANTU SHOULD BE PERSUADED TO MAKE FULLER USE OF EXISTING HEALTH SERVICES:

It was concluded in chapter 2 that the health services in the region were adequate at a basic level, provided use was made of them by the population. Efforts must be directed to encourage the population to make fuller use of these services. Continuing education in this field is required. Appendix 'D' gives details from the Kwa Mashu Sample Survey of the extent to which housewives reported using various clinics etc., for the more serious complaints in their families. While the majority reported seeking some form of medical assistance, it is evident that not all families by any means do so as yet. This would be even more true in the peri-urban and rural areas.

12. NEED FOR LONG-TERM PREVENTIVE WORK:

It is quite apparent that there are broadly speaking, two paths that can be followed in the continuance of the work to combat malnutrition amongst the Bantu pre-school children^{1]}. The first approach (which is already well understood by the various organisations, and is bearing some fruit), is to feed all babies and children who need feeding. This is a humanitarian approach, and is one that appeals to the heart of the generous well-wisher. Sadly, it is a mere stop-gap method. It only provides treatment for the results of the present situation, without expunging the causes. As such, it will in the long run achieve very little. The problem of malnutrition will never be removed from our midst as long as it continues to be attacked along the present lines of providing feeding schemes. The ultimate goal must be a Bantu population which can feed itself adequately and intelligently.

The alternative approach is to strike at the root causes of the problems of malnutrition. This is a long-term, very expensive approach. In the final cost accounting, it is cheaper than the curative approach. It is the approach that is the only one that is likely to have worthwhile lasting results. It is not being suggested that the voluntary organisations, municipal, provincial, and central government bodies are not already aware that this approach is the only answer to the problem ultimately. Nevertheless, it needs stressing. It would appear that the machinery necessary for providing such an overall creative scheme aimed at prevention rather than cure, is not yet available. The aims of the preventive approach

1] Recommendations nos. 12 - 19 and 23 & 24 were prepared by N. K. Lamond. The other recommendations were written up by H. L. Watts.

could be summarised in one sentence: to show the way to the Bantu people how to help themselves to achieve a better state of nutritional health in all economic levels in each age group. This presupposes a living wage. The problem is far wider than the malnutrition in the toddler group alone. Detailed recommendations are made below in regard to aspects of preventive work.

13. FOOD PRODUCTION AND RURAL NUTRITION
MUST BE IMPROVED:

It is recommended that attention be given to the improvement of food production. Although this survey deals with the Bantu living in the metropolitan area of Durban only, it is axiomatic that a town cannot receive an adequate food supply unless the rural areas can provide it. Secondly, it has been shown that much of the population which resides either officially or unofficially in the townships of Durban, spends a good deal of the year in the rural areas. Thus the nutritional state of the rural areas is directly of importance. Thirdly, the bulk of the notifications of kwashiorkor made from King Edward VIIIth Hospital, comes from rural areas throughout Natal. Hence the importance of improving food production.

14. MORE PROJECTS SIMILAR TO THE VALLEY TRUST
SCHEME SHOULD BE LAUNCHED:

The recommendation to improve food production is based entirely on observation made at a project embodying the application of the concepts mentioned above. This project is that of the Valley Trust at Botha's Hill, Natal^{1]}. The approach in this project is at the level of the people themselves. Instructions and advice are given (and frequently repeated) by specialists in such spheres as agriculture, diet, and the preparation and cooking of food. Education is also given in health.

1] Welfare Organisation No. 1736, established in 1953.

The specialists concerned have worked hard to acquire knowledge of the local customs and superstitions. They have obtained the confidence and trust of the people. Their lectures/demonstrations are given simply and informally, and within the setting of the community. Tuition is direct, through primary face-to-face groups. This fits in with the discoveries of group dynamics, which emphasise that attempts to produce change in individuals, (be it in patterns of diet or anything else), are often far more effective when these efforts are directed through groups rather than at the individual himself or herself. We recommend that this type of approach should be tried out in other areas as well as Botha's Hill.

In the case of the Valley Trust, the Bantu in the local community have their first contact with the medical team from the Trust, when they need some medical assistance of a curative nature. This means that the Bantu arrive at the Clinic full of anxiety, intermingled with trust. This frame of mind renders them far more receptive to advice than would normally be the case. Trying to communicate with the patients, every effort is made to utilise any aspect of traditional belief which can be turned into a positive and curative aid. In this way, as far as possible, nothing is done to undermine traditional beliefs. The aim is to ensure that the people retain confidence and a sense of security. Once sufficient contact with the people has been established, and their confidence won, the basic facts of malnutrition as a causative factor in disease is stressed. Thereafter, the agricultural demonstrators move in naturally to demonstrate and convince the community about the importance of such factors as laying out arable land, fencing, ploughing, digging, cultivation of crops, the utilisation of natural fertilisers, damming, fish-farming, etc. Not only does

this work prevent serious soil erosion, and help to restore the fertility of the land, but from the health point of view it is helping to strike at the roots of malnutrition.

The work demands patient, long, co-operative contact with the Bantu. Re-education is a slow process. Nevertheless, we recommend that the unique combination of medical and agricultural work, as combined in the efforts of the Valley Trust, should be repeated again and again at a similar simple basic level throughout the length and breadth of our country.

In recommending the above step, it is realised that there are difficulties involved. At present the Valley Trust project is a unique experiment. Its advantages are difficult to assess in the absence of control groups. Secondly, no one knows how many such projects should be established in the rural areas, nor do we know how big an area an individual project can effectively cover. Thirdly, it is difficult to establish such long-term preventive projects cheek by jowl with short-term relief and curative projects aimed at supplying food for the malnourished. The latter type of project would probably undermine the initiative and resourcefulness - the self-help of the populace - that the former is making every effort to foster. Be that as it may, we must feed the malnourished now, and we must also root out the causes of malnutrition. A final complication is that the personnel required for such projects must be suitable for the job. The work is demanding, requiring not only patience and a spirit of dedication, but appropriate personality traits, as well as initiative and far-sightedness to encourage further evolutionary experimentation. While the Valley Trust project is a private welfare organisation, the Central Government would have to accept fully the financial responsibility in both the medical and agricultural spheres of

large-scale projects of this type. This expenditure of public monies on preventive measures would, while appearing expensive in the short run, save South Africa much money. The money spent on prevention would achieve lasting results, whereas at the moment the amounts being spent annually on cures are absorbed without leaving any lasting trace in the curative desert of curative treatment.

15. WORK UNDERTAKEN BY THE DEFUNCT "INSTITUTE OF FAMILY AND COMMUNITY HEALTH" MUST BE CONTINUED:

In the late 1940's, the Institute of Family and Community Health was operating in the rural area near Polela in Natal. The workers found that the conditions of poor physical development amongst the Zulu children were appalling. Using an epidemiological approach, they determined the cultural and social factors which caused all the manifestations of poor nutrition. Much useful experience was gained in assessing the existing situation, and in the education of the local population. Careful progress was made with the introduction, in the first instance, of feeding practices that would not clash with the Bantu's culturally acceptable patterns of eating. Then as the confidence of the leaders of the society was gained, more drastic changes were introduced. The Institute workers displayed the utmost patience and understanding of the reluctance of the population to accept new ideas. Once valuable progress had been made with the primitive rural peoples, the Institute moved to Durban. There it became associated with the Department of Social, Preventive and Family Medicine, of the Medical Faculty of the University of Natal. It did much valuable work, and undertook the education of health demonstrators. The Institute is no longer in existence, and we believe that it was a brave venture, but that it was brought into life prematurely. White South African society was not yet prepared to

see the urgency of the need for such a branch of preventive medicine in South Africa. We recommend that very serious consideration be given to readopting the type of approach which the Institute followed, and pursuing it with vigour^{1]}.

Many of the people who were trained by the Institute are at present filling other positions, and not using their special talents and training. It is suggested therefore, that these health educators should be traced, and utilised to form the nucleus from which will grow a useful team to further the work of health education in Durban. The existing health educators should be co-ordinated into a larger strategically-organised team. This again calls for pooling resources, and co-ordination of efforts at a level above that of the individual welfare organisation. Concerted action is required to make much impression on the problem.

16. NEED FOR EXTENSIVE HEALTH AND DIETARY EDUCATION OF THE BANTU:2]

One of the most urgent needs at the present time is that of dietary and health education of the Bantu population. This education must start by utilising the basic cultural values and beliefs that the Zulu population has. On this foundation must be built and incorporated the scientific knowledge that we have concerning the essentials of good nutrition. Periodic assess-

1] See Kark, S.L. & G.W. Stuart: (1962): A Practice of Social Medicine: Livingstone Ltd., Edinburgh and London.

2] See Food and Agricultural Organisation : (1962): Education and Training in Nutrition: Basic Study No. 6 in the "Freedom from Hunger Campaign" series, Food and Agricultural Organisation of the United Nations, Rome.

ments must be conducted in an objective scientific fashion, to observe the best of the various experiments in the rural life situation.

The recommendation that health education is a basic requirement is not a new suggestion. It is something already being undertaken in practice. However, its importance must be re-emphasised. Communities other than Durban are engaged in health education, and it is suggested that regular annual or biennial conferences of health educators should be held, so that research and experience gleaned by workers in different parts of the country can be pooled, and the best results obtained by accumulating knowledge and experience. Within the Durban region seminars and group discussions on health education could be held amongst workers in the field several times a year. This would help both to stimulate and co-ordinate health education work, and maximize the amount of ideas available. It would also pool experience of the local problems.

Education of the population about health and malnutrition must be continued at all levels, not only in the rural areas (as in the case of the Valley Trust Organisation), but also in the urban areas. Education must be conscientiously and effectively incorporated into the work of the ante-natal clinics, well-baby clinics, schools, factories, church guilds, mother's meetings, etc. In addition, use should be made on a regular basis, of Radio Bantu which has a great impact on the Bantu population. Bantu newspapers and weeklies, should also be regularly utilised as a mass communication medium for disseminating knowledge about health matters, and the importance of nutrition. The correct procedures of hygiene, of nutrition, and the best use of one's financial resources, must be continuously inculcated into the Bantu population. In fact, a programme of mass education about

health and ill health, about the causation of disease, and about foodstuffs, must be undertaken on a co-ordinated and carefully planned basis.

Experience in Johannesburg has suggested that it is often the men who are the stumbling blocks, nullifying the attempts of the health educators^{1]}. Attention must be paid to this point.

Educators must be well trained, and must be the best persons that can be found for the job. It is all too easy to under-estimate the complexities and difficulties of effective education. We must not make this mistake. Educators must be thoroughly trained, and understand the cultural background of their people, so that they can make contact at a primary level to get their ideas accepted. This calls for research to reveal motivations for, and resistances to, changing dietary patterns. We strongly urge that such research be sponsored. This leads to a further recommendation: training for health educators must be provided on a continuing basis. This training should be co-ordinated, and centralised. The type of training commenced years ago under the auspices of the Department of Preventive Medicine at the Medical school of the University of Natal, must be planned and brought into being again.

1] Information reported by Professor H. Pollak, and gained by her in an interview with a group of health educators working in Johannesburg, February, 1966.

17. CONTROL AND CO-ORDINATION OF HEALTH EDUCATORS:

The controlling authority of health educators within a town should be the municipality. This would allow co-ordination and centralisation of the effort. The municipality should have a grant for this purpose from the Central Government. The health educators should be responsible ultimately to the local authority, whether or not they work for voluntary agencies or other bodies in the town concerned.

In the rural areas, health educators should be answerable to a section of the Central Government - probably of the Department of Bantu Administration and Development. In the case of rural areas, transport is particularly a problem, so that bases would have to be established in the medical-agricultural projects proposed above, and the educators could then radiate out from these base camps. Where no roads exist, they could undertake long distance travel on horseback.

All aspects of health and dietary education should be under the control of a centralised organisation. This is essential if duplication of effort and waste of resources is to be avoided. The authority should be financed by the Central Government. It is essential that the authority be streamlined for action - the control is not to be a model of superstructure with grand buildings supported by red tape, but a small section for the bringing together of new ideas, co-ordinating efforts, and roaming free in the field of preventive medical education.

18. EDUCATION ABOUT HOUSEHOLD BUDGETING:

It must be stressed that education must include teaching about household budgeting. The problem of poverty amongst the Bantu makes the need to use their money to the best advantage

even more urgent than it would otherwise have been. In the advisory services to mothers, far greater attention should be bestowed on education about budgeting. This can be tackled in two ways. In health education courses, information about food values, and the best expenditure on food, as well as education about expenditure on all items of household needs, could be conducted. Secondly, it is strongly urged that budgeting constitute a part of the normal procedures of case work services. Social workers should spend some time on this aspect with most of their families. From this point of view, the training of Bantu social workers should pay far greater attention in the case work course, to some study of lower income expenditures, and how best to advise families on proper budgeting procedures (in the United Kingdom, most of the family case work agencies have one or two family budget experts attached to them, and the services of such experts are used for selected clients). Time should be spent in discussion with the cases of the implications of hire purchase agreements, how and where best to buy, and what the various implications for the family are of various types of purchases. This is not a service which can be done in one interview, and requires regular repetitive, consistent instruction. From this point of view it must be appreciated that a very large number of Bantu women are completely unaccustomed to a system where all expenditure is on a cash basis - for them it is a big change from the traditional system where so much of the requirements of the household were either picked or collected from the gardens, the fields, the veld.

19. NEED FOR MEDICAL AND DENTAL SERVICES
OPERATING THROUGH THE BANTU SCHOOLS:

One of the shortcomings of the Bantu education system at present is that there is no provision for the medical and dental supervision of the children. (The Child Health Clinics of the

Durban City Council accept children only up to the age of 3 years, but from 3 years onwards there is no organised medical service for the Bantu child). Preventive and promotive work through the schools is required. Such a school medical service would be an extremely sound investment, and it is strongly urged that representation be made to the authorities to the effect that such a programme be introduced at the earliest possible moment.

20. URBAN BANTU SHOULD BE ENCOURAGED TO GROW FOOD ON THEIR PLOTS:

The best utilisation of the limited ground facilities which urban Bantu have for food production on their plots should be encouraged. If seeds were issued at cost price, loans were available for adequate fencing, and water was made more freely available, people might be more interested in growing their own vegetables. As has been indicated, the Durban Corporation is prepared to make plants and seeds available at a reasonable price from the municipal nurseries. Programmes of competitions for the best vegetable garden - and less important, the best flower garden - should be organised, and given a very wide publicity, including by means of the local service of Radio Bantu. This might stimulate gardening. Vegetables and fruit grown at home would provide a valuable source of vitamins. The soil of certain of the township lands was some of the most arable farming land in the area before the townships were built, and it would definitely help the individual householders if they could grow even a small fraction of their food.

21. ALL SCHEMES MUST BE STAFFED BY CAREFULLY SELECTED TRAINED WORKERS:

None of our recommendations which imply the use of trained staff will be practical unless they are not only planned and

financed, but are carried out by personnel of the correct type. Essentially, the schemes require carefully selected trained workers. The jobs are beyond the scope of the well-meaning but untrained "do-gooder". The problem is partly one of manning - getting the right people to do the job. Hence scientific personnel selection procedures are absolutely essential. The use of trained personnel consultants would be of benefit in selecting staff. It goes without saying, that if the best possible staff are to be obtained, then the salaries offered in cases where the work is not honorary, should be commensurate with the qualifications and skills demanded. In this we are not suggesting pipe dreams. If the programmes suggested are costly, it must be remembered that the ill health that South Africa has amongst its Bantu is far more costly to the nation. This is no less true if the cost is often hidden. We must be completely realistic about this fact.

22. MUNICIPAL MARKET IN THE TOWNSHIPS:

Provision should be made for the running of a municipal market type of project in each of the townships. The bus fares into town are too high for the average housewife to undertake the journey frequently for shopping. Moreover, the bus is usually so crowded that she might not be able to find room for her purchases. A municipal market on a non-profit making basis would meet an important need, and will allow housewives to purchase fresh produce at lower prices than is possible from the trading centres in the townships.

23. A SUGGESTION THAT THE LARGE BAZAARS BE ALLOWED TO SERVE FOOD IN THE TOWNSHIPS:

Big stores such as Woolworths, or the O.K. Bazaars, should be allowed to sell wholesome food and groceries at cheaper rates in the townships, if they so desire. While this does clash with

the official policy of allowing only Bantu enterprise in the townships, the fact must be faced that the individual small Bantu trader with limited capital has to buy on a small scale, and sell his goods at far higher prices than a chain store bazaar with their large-scale economy^{1]}.

24. SOME ALTERATIONS TO CERTAIN LAWS ARE SUGGESTED:

It is recommended that efforts be made to obtain alterations to some of the laws which have a bearing on the problem of malnutrition, ill health and poverty. The Hire Purchase Act should be altered, so that expensive luxury articles cannot be bought by those who cannot afford to pay without seriously threatening their health through cutting down on foodstuff. If it is possible, the poor should be protected against putting a millstone around their necks.

Legislation should be brought in to allow the bigger stores (such as a chain store bazaar) to sell goods (especially groceries) in the townships, with the proviso that all the employees must be Bantu. At present the poor suffer, because if they buy in the townships they can only buy from the small-scale traders who have to charge them higher prices, whereas if they buy in town, they have to pay extra in the way of transport over a considerable distance.

25. PREVENTIVE AND CURATIVE SERVICES MUST BE CO-ORDINATED AND UNIFIED:

At the moment the Provincial authorities are responsible for the curative aspects of the treatment of malnutrition, but

1] Suttner, S. (1966): Cost of Living in Soweto in 1966: South African Institute of Race Relations, Johannesburg. See page 16.

not the preventive aspects. This artificial cleavage could be considered ludicrous if it were not made manifest in the tragic loss of life that continues annually. It is high time that the passing of responsibility from one authority to another ceased. All Central Government authorities, Provincial Hospital authorities, Local and Municipal Health authorities dealing with health matters should be co-ordinated and run side-by-side. Thus greater efficiency can be achieved to tackle the problems, and to try and carry out the recommendations made in this report. The fragmentation of our efforts, both at the voluntary worker level and more particularly in this case, at the level of the various health authorities, is inefficient. As a result the efforts made are rather less effective than they could be.

The unnatural, uneconomic, and impractical cleavage between preventive and curative health services should be abolished, with the proviso that although there may be one central controlling authority in Pretoria, there should be established simultaneously decentralised regional authorities, which could provide a rapid liaison with the head office. The legal changes necessary for such co-ordination would no doubt take some time to bring about. In the final analysis, there is no good reason whatsoever, why there should not be a more practicable and embracing public health approach to the problem of malnutrition and health education, than there is at present. Representations must be made to the various authorities in this matter, and must continue to be made until progress is achieved.

26. A PLEA SHOULD BE MADE FOR THE RESTORATION OF
GREATER EXPENDITURE ON BANTU EDUCATION, AND
PARTICULARLY FROM THE HEALTH POINT OF VIEW,
FOR THE RE-INTRODUCTION OF THE SCHOOL MEALS:

The value of the school feeding schemes has been proved many times over. The Umlazi and Lamontville school feeding

schemes show that parents are paying, and are willing to pay a small fee per month for this service. It is not a case of giving complete charity. There is no reason at all why the Bantu Education Department should not, in principle, pay at least something towards the contribution of school feeding, and the rest of the costs could be recovered from the parents. This would then make such a scheme a service supported by the Bantu themselves with Government subsidy. If this was done, it would free voluntary effort from school feeding schemes for other constructive service - they would not have to act as agencies subsidising Bantu feeding.

27. REPRESENTATION SHOULD BE MADE TO DURBAN CORPORATION CONCERNING THE SUPPORT OF BANTU WELFARE AND HEALTH SERVICES FROM THE RATE FUND:

It is urged that combined representations should be made to the Durban City Council concerning its attitude that all Bantu services must be paid for from the Bantu Revenue Account - at the present time, the only contribution from the Borough Rates Account to Bantu health and welfare, is a few grants-in-aid and grants to a few specific recreational projects.

It must be emphasised that although the Child Health Clinics of the Municipality are doing outstandingly good service, the number of such clinics must be increased. In Kwa Mashu at the present time, there are some 124,500 persons. Despite this, there are only 2 such child health clinics serving the whole area. If the Corporation was willing to pay for additional health and welfare services for the Bantu from the sources other than the Bantu Revenue Account, then a very necessary extension of these and other services could be achieved.

28. SUGGESTION THAT THE DURBAN CORPORATION MIGHT CONSIDER SOME REVISION OF ITS HEALTH SERVICES:

It is urged that Durban might very well follow the example of Johannesburg, where provision is now being made for a complete revision of the Bantu health services. These are being planned on the basis of units which are very similar to the former health centres. It seems to the observer that the work is being planned in Johannesburg rather along the lines of the former Institute of Family and Community Health. It should be urged that health centres rather than clinics alone be re-introduced, and programmes planned around such centres vastly extended. The health centre work was invaluable, combining as it did medical programmes with concentration on environmental sanitation, health education, and with emphasis upon the sound medical and social development of the people. The Health Centres were the finest investment that the Government has made in health. It is considered a great tragedy that this movement should have been stopped when it was rendering such magnificent service. The Durban Corporation could very well consider itself re-introducing such a scheme, possibly with the long-term aim of obtaining Government support for it as well.

The new health services being planned in Johannesburg, which it has been said are more or less along the lines of the former health centres, will use new buildings consisting in each case of 2 wings separated by an administrative office. The one wing will be for a T.B. treatment centre where preventive work will also be carried out, while the other wing will contain a mother and child clinic. Attached to each of these community health centres will be teams of trained health workers with public health training - each centre will serve a radius of $1\frac{1}{2}$ miles, and the team will be responsible for not more than 2,500 families. The whole scheme of the distribution of foodstuffs,

and family visiting will centre on these new buildings which are to be located throughout the Johannesburg Bantu townships. An arrangement has already been made whereby ultimately all the curative services of the Johannesburg Municipality will pass over to the Transvaal Provincial Administration, and the Municipality itself will have a health programme that is entirely preventive and promotive in character.

At the beginning of 1966 when the Johannesburg Municipal Health Programme for the Bantu townships was observed, the most interesting feature was the free supplies of important supplementary foodstuffs given to all mothers attending the mother and baby clinic. All mothers attending the clinics were given, without charge, regular supplies of the following immediately upon weaning a baby: One pound of skimmed milk powder per week, 1 lb of full cream milk powder every two weeks. If the baby is over one year of age, 1 jar of peanut butter is supplied every two weeks, and the mother is advised that this should be mixed with pumpkin or other vegetables. If the woman is breast feeding, she is issued with yeast tablets, milk of magnesia, and Kaolin, gentian blue, etc., when necessary. Upon medical recommendation, bottles of vitamins 'D' and 'E' are supplied according to need. Malnourished children and ex-kwashiorkor cases receive free every two weeks a supply of casilan, which is a 90% protein content supplement. The requirements in all the above categories are assessed by the health visitors. To the very poor, there is a free distribution of mabella. In the year 1963/64 the cost of this supplementary feeding to the Child Health Department was in Bantu areas R114,066-00. This figure does not include the skimmed milk programme which is operated as in Durban, on the basis of the Government subsidy.

In contrast to the above example which was given by way of

illustration, the Durban Corporation makes no free issues of foodstuffs through its clinics to mothers and children, except in necessitous cases, excluding the Government subsidised skimmed milk powder scheme. It is true that in Durban there is a very substantial programme making pro nutro and full cream powdered milk available to mothers of children under the age of 3 years, but these programmes are entirely paid for by the voluntary societies - by "Feed the Babies" fund, and the Malnutrition Relief fund. This whole policy whereby voluntary agencies are prepared to make very substantial issues of supplementary foods available for distribution through the municipal clinics is in need of considerable review. Is it sound policy for the local authority to absolve itself from any financial responsibilities in this matter, and not to make any of these foodstuffs available out of its own budget, but to depend entirely on voluntary effort? Does it not invite the local authority to perpetuate its present policy? Would it not be essential for the agencies themselves to expect some form of growing independence from the municipality, and for the municipality to gradually take over the whole programme? We urge that this whole matter be considered very carefully and very thoroughly.

It is interesting that the Durban Corporation is reluctant to add to its present programme of grants-in-aid to registered welfare organisations, on the grounds that the Borkenhagen Commission has recommended that welfare is the responsibility of the Government and not of the local authority. Yet, these food programmes are not welfare - they are nothing if not a very important preventive health programme. It is entirely fallacious to make an arbitrary and artificial distinction between health and welfare in this matter. Finally, it is very important to appreciate that the various agencies pouring their resources into the municipal food distribution through the clinics

are themselves not the recipients of any municipal grants.

If the municipality took over its rightful role, it would release the voluntary effort to develop and institute preventive and promotive programmes in other areas, particularly in the peri-urban areas where there is a great need at the present time. These voluntary associations could set up pilot schemes, and experiment with the introduction of supplementary feeding in the peri-urban areas. Once these schemes were under way, they could endeavour to get the local health commission to take them over. This is really the way in which the government's skimmed milk programme was started, by voluntary agencies undertaking it, and proving its value. It was then taken over by the authorities. The same should happen with the feeding programmes. It seems a tragic diversion of scarce resources for a wealthy municipality like Durban not to be prepared to spend of its funds on supplementary feeding - that is, from funds other than the Native Revenue Account. Here again, it must be stressed that the voluntary agencies which make pro nutro and other supplementary foodstuffs available through the municipal clinics, make them available for all races. This means that a substantial part of their feeding goes to the Coloured and Indian communities. There can be absolutely no justification whatsoever for the municipality not being prepared to pay for at least these latter services from the Borough fund, because some rates are received from both the Coloured and the Indian communities.

29. NEW GROUPS BY MEANS OF WHICH HEALTH EDUCATION CAN BE PROPAGATED, SHOULD BE EXPLORED:

Far greater emphasis should be placed on health education via groups which have not been actively exploited until now. There is a completely untapped field in the form of existing groups such as creches, the play groups, which have their parents

committees, or supervisory committees, the Zenzele groups, and the many Bantu committees attached to the various welfare organisations. It is recommended that an effective health programme through these avenues should be mounted. Every avenue should be explored whereby the Bantu can be educated in regard to health, nutrition, and hygiene.

30. NEED FOR SOCIAL RESEARCH, AND SOCIAL SCIENCE EXPERTS,
TO GUIDE HEALTH EDUCATION AND FAMILY PLANNING PROGRAMMES
AND TRAINING COURSES:

We strongly urge that social research is necessary to test the effectiveness of existing forms of nutritional and hygiene education, and of health education generally, as also of family planning education. Research is also necessary to guide future programmes, and devise more effective approaches to the Bantu population. It is very strongly recommended that health education (including family planning) and public health training should make more use of sociologists and social anthropologists. All the work must be based on a recognition of the existing cultural practices and values of the Bantu. We must build on these, not destroy. It must be clearly recognised that the health education programmes are nothing more or less than attempts to bring about a change in the social way of life of a people. Such a change is more an exercise for the social scientist and community development officer than for medical specialists. Doctors and public health nurses know what they want to achieve - they know what information they wish to impart - but it is for trained social scientists to help devise how this can best be achieved. The complexity and delicacy of the task of inducing cultural change must never be under-estimated. To repeat what has been stressed previously, well-meaning blundering will only do harm. Teamwork alone will not suffice - this would be merely pouring new wine into old bottles. Instead, an approach based on expert

social scientist leadership is required. Health education is not like immunisation campaigns, where some element of compulsion can be used without changing people's attitudes or beliefs significantly. While it is fully realised that good work is being done by existing health education schemes and programmes, far better results would be achieved if experts in the field of acculturation and changing social behaviour were called in. It is highly desirable that the public health authorities should set a lead in this.

Research is needed to give social scientists a more accurate picture of what is going on, and to guide future efforts. Such research into fields of nutritional and hygiene education, and family planning, is urgently needed in South Africa. While the National Nutritional Research Institute of the South African Council for Scientific and Industrial Research is setting a lead in the field of nutrition research in the Republic, most of its work up to the present has been more in the field of laboratory analysis, than field studies directed to give an understanding of food practices and taboos of the various racial groups in our midst. Research oriented to guiding practical programmes is essential.

In this regard, we can learn from the experience of certain developing areas. In Latin America, for instance, social scientists have played an important role in guiding social and health programmes designed to uplift the people. The use of experts has played a key role in their efforts. In the medical field we do not hesitate to use specialists, and would not think of using lay guidance in important matters. Why should we believe that any other approach would work in the social sphere of changing people's habits of behaviour? Just as a medical expert has his part to play in programmes of improving the health

and welfare of the Bantu, likewise, the social scientist must contribute his share.

While at first sight it might sound strange, we are firmly convinced that in the long run our voluntary bodies would achieve far better results if they spent slightly less on feeding, and diverted money thus saved into a group-employment of a skilled trained consultant sociologist or social anthropologist, to act as adviser on certain aspects of their programmes. Likewise, it is high time that our official health bodies employed trained social scientists to guide their campaigns. To re-emphasise, the difficulties involved by cultural adaptations are often underestimated by the average person. Our programmes cannot be static, and in order to make them as effective as possible in order to meet changing situations, we must make the fullest possible use of the skills that are required for the task in hand, and this means including the social scientist in our efforts.

31. A FOUNDATION SHOULD BE APPROACHED TO SPONSOR THE VISIT OF A SOUTH AFRICAN SOCIAL SCIENTIST, TO STUDY THE USE OVERSEAS OF SOCIAL SCIENTISTS IN PUBLIC HEALTH TEAMS:

In furtherance of part of the previous recommendation, we urge that an approach be made to a foundation or benefactor to sponsor the visit of a South African social scientist to other developing countries, in order to gain personal first-hand experience of the use of sociologists and social anthropologists as members of public health teams. The person chosen must, on his return to the Republic, spread his experience and knowledge throughout the land by means of conferences and group discussions in the main centres. Thus, as wide as possible a dissemination of his overseas experience should be provided.

32. NEED FOR A VOLUNTARY PLANNING AND CO-ORDINATING COUNCIL FOR BANTU HEALTH AND WELFARE:

Our review has shown that many agencies provide health and welfare services for the Bantu in the Durban region, particularly in the fields of child care and health. It is considered that there is a very real need for far greater co-ordination, and for greater rationalisation in the field of the division of responsibilities. At present, there is extraordinarily little consultation between these organisations. One is unaware of what is being done by others. It is possible that the amount of overlap of services is negligible, but probably overlap does occur. It is imperative that some radical change in this position takes place.

Consequently, it is suggested that there be created a Bantu Health and Welfare Planning and Co-ordinating Council. It is suggested that this be an independent body, not functioning to start with under the Regional Welfare Board. We are aware of the fact that the agencies are fiercely jealous of their autonomy, and that previous efforts to bring about such a co-ordinating body have met with no success. However, it is hoped that the agencies will co-operate if a new attempt is made to form such a council. Publicity about the proposal should stress that there is no desire at all to undermine the identity of the various individual voluntary agencies, or to eliminate their organisations. To the contrary, it should be stressed that there is a deep need for an effective health and welfare planning body, and that it is in the interests of all that such a council come into being. It could be stressed that this idea is similar to that of the Non-European Welfare Co-ordinating Council in Johannesburg, which renders valuable service.

It is recommended that the proposed Council be a voluntary,

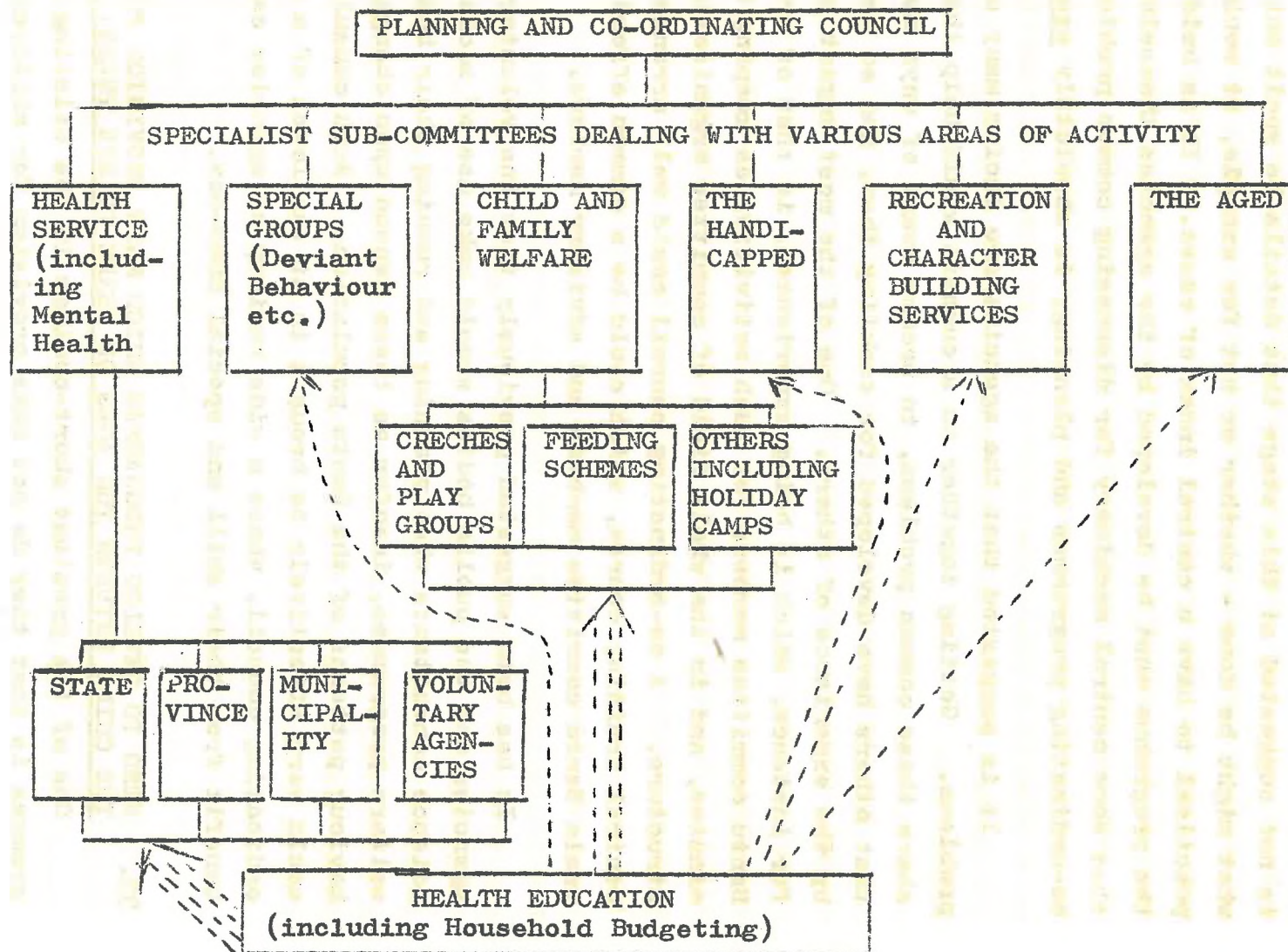
and not a statutory body. Its membership should consist not only of voluntary societies, but also of representatives of government, provincial, and local authority departments which are active in the provision of services to the Bantu community. Each of the contributing bodies must be aware of the total range of services which are provided, and that the full picture of the needs of the Bantu community can best be considered, and more effective programmes developed, if ideas and suggestions are pooled in the light of common information of what is already being done.

The diagram below indicates in graphic form the types of organisation for the voluntary Planning Council envisaged. Under the Council there could be the following specialist sub-committees: A sub-committee for the care of health services (including mental health); one for special groups, including deviant behaviour; one for child welfare, one for the care of the handicapped, one for recreational, and character-building services, and one for dealing with the aged. The child welfare one could probably well be expanded into one dealing with family welfare of which the child would form part. Health education would link with each and all of these various sub-groups, and particularly with the health services and family welfare, and the handicapped. Despite this, if the health education is to be as broadly based as possible, then it would be worth attempting to bring such education into all sections of the Council.

It is stressed that the value of such a co-ordinating and planning council, with its co-ordinating and planning sub-committees, would be very great. It would lead to the various organisations in the field of Bantu health and welfare voluntarily undertaking a rationalisation of their programmes.

DIAGRAM NO. 1

VOLUNTARY BANTU HEALTH AND WELFARE PLANNING AND CO-ORDINATING COUNCIL.



Dovetailing in of the various efforts could be achieved. It is not suggested at this stage that details be spelt out of what might be done - whether or not for example, it would be practical to have a central index of cases. It is held that the programme must be developed by the agencies themselves, and that some central machinery for discussing common problems, and co-ordinating programmes and planning, is absolutely essential.

It is suggested that the agencies are facing many common problems. Getting together on a council would help them to share these common problems, to become aware of ways and means that others have developed for tackling them, and so benefit by the experience of others. One of the most urgent problems, for instance, which is being experienced, is that of training Bantu committee members for such activities as keeping books, minutes, and in the whole field of committee organisation and structure. A co-ordinating council could well arrange a central training course, which could be a common effort to train Bantu committee members and advisory members.

It has been suggested previously that the voluntary agencies and the public bodies should make use of social science consultants when planning and running their health and welfare programmes, insofar as these depend upon changing behaviour patterns of the Bantu population. Such consultants could very effectively be brought in at the level of a co-ordinating council, where a wide variety of agencies could benefit from their skill and special know-how.

33. NEED TO DEVELOP PROGRAMMES WHICH MAKE PROVISION FOR THE CHILD BETWEEN THE AGES OF THREE TO SIX YEARS:

One of the greatest short-comings in the existing programmes is that they do not make provision for children between

the ages of three to six years, except for the handful of children who are at creches, nursery schools, and play groups. This is a vulnerable age group, and its omission from an existing programme on any large scale is serious. It is urged that societies get together, and investigate the possibility of initiating a pilot scheme for children in this age group. This could be based on the experience of the Johannesburg feeding scheme referred to in chapter 4. An experiment could be undertaken with the use of mobile vans, in order to make this service available to thousands of children at scattered distribution points. It is suggested that an identical pilot scheme be put into operation in Durban. We suggest that this be done in Kwa Mashu, because it is considered that the ready co-operation of the Durban Corporation will be given for this activity. A scheme based on contributions from the parents, such as the Johannesburg programme (where one cent is charged for an amount of ready-mixed powdered milk, and two slices of bread spread with peanut butter), and intended to reach a very wide number of children, should be planned on a trial basis. Such a scheme would fill a glaring gap in the existing service being provided. An additional advantage is that such a scheme would lend itself to the development of distribution points in the peri-urban areas around Durban. One of the difficulties of the present schemes was finding suitable halls or venues in order to develop both clinics and feeding schemes. The use of mobile vans circumvents this problem, and great potential for the development of such a programme exists in areas where no services are provided at present.

34. THE FINANCIAL INTERLOCKING OF VOLUNTARY AGENCIES SHOULD BE REMOVED:

There is no doubt that the multiplicity of organisations operating in the child welfare field, and the financial inter-

locking whereby two or three agencies are financially responsible for aspects of one programme is not a sound policy which should be perpetuated. Examples of this type of interlocking were shown in chapter 3. Now that the five organisations which previously belonged to the Durban Non-European Children's Fund are all in the Chest, it would be a far more logical procedure to re-allocate grants. It is better for one agency to be entirely responsible for a particular operation. The Durban Community Chest should increase allocations to certain societies so that they could buy food for themselves, and reduce allocations to other societies which were merely acting as buying organisations rather than spending all of their funds on operational programmes undertaken by themselves. For example, it has been shown that there is the system whereby the "Feed the Babies" fund feeding programme was not undertaken by the fund itself. This is true likewise of the Malnutrition Relief fund. It has meant that virtually both of these organisations were miniature community chests, collecting monies from the public, and in part redistributing them to other organisations. Admittedly, the redistribution took the form of food rather than cash, but as the prices paid by the purchasing organisations were no cheaper than if the foodstuffs had been bought by the organisations undertaking the distribution, nothing was saved. This type of interlocking and complicated financial interdependence is not a good idea. It would be far sounder to change the whole basis so that one agency was responsible for all its programmes, including the financing thereof. This is particularly so as operating agencies can buy the foodstuffs at exactly the same prices as any other agency. A situation which has arisen seems to be a duplication of effort rather than of activity.

35. VARIOUS TYPES OF CO-OPERATIVE BUYING SHOULD BE ORGANISED:

The vegetable clubs should be re-activated and stimulated. Likewise, there are endless opportunities for considerable savings by means of co-operative buying in this sphere of other purchases. Even if only a small group of neighbours banded together to buy in bulk, either fresh vegetables from the market, or a bulk supply of groceries from one of the cheapest supermarkets, the saving for the individual households would be noteworthy. It is expensive to buy in small quantities, particularly in the townships. Any form of co-operative purchasing should be encouraged and assisted.

Under this recommendation can be considered the encouragement and assistance of the more widespread development of Kupugani and its work, so that it is possible through this means to reach more and more individual households.

36. NEED FOR A CONSIDERABLE EXPANSION OF PLAY GROUP AND CRECHE FACILITIES:

It was shown in chapter 3 that only a very small proportion of the Bantu children are able to receive care through creches, or play groups or nursery schools. At the present time when so many of the Bantu are in poverty, these organisations serve a very real need, and it is recommended that effort be devoted towards extending these services throughout the Bantu townships. The creches in particular are really part of a child welfare and family welfare programme. Their importance can scarcely be over-emphasised.

37. FACILITIES FOR THE CARE OF FEEBLE-MINDED BANTU CHILDREN, AND FOR THE CARE AND EDUCATION OF MENTALLY RETARDED CHILDREN SHOULD BE PROVIDED:

There is a serious gap in the services being provided in the Durban region from the point of view of the feeble-minded Bantu child, and also the mentally retarded child. There is an urgent need for local facilities for the care of the feeble-minded child. In the case of the mentally retarded child, facilities both for the care of the child, and education and training as far as possible, are required. It is recommended that attention be given to this need.

38. A NEED FOR CO-ORDINATION OF EFFORT IN THE WHOLE OF THE DURBAN METROPOLITAN REGION:

The Durban Metropolitan Region is a socio-economic unit. It stretches roughly from Umhlanga Rocks in the north to Amanzimtoti in the south, and inland as far as Hill Crest. However, administratively, it is broken up into over a score of local authorities. This means fragmentation and duplication of effort, both at a voluntary welfare level, and also at a more official level, within one region. The suggested co-ordinating council could render good service by attempting to unify the effort in the metropolitan region, and by pinpointing various geographical areas where as yet, few if any services are provided, and consequently developmental work should proceed.

39. TRAINING COURSES FOR CRECHE AND PLAY GROUP WORKERS SHOULD BE INSTITUTED:

It is recommended that training courses for creche and play group workers should be drawn up and instituted. This should also apply to nursery school teachers, as the training scheme which the Durban Girl's College Old Girl's Guild originally organised, has now had to fall away. The Bantu workers

who are to serve in these various organisations must receive adequate training for their task. It is possible that one way of achieving such training is by persuading the Bantu Education Authorities to include this as part of the concepts of vocational schools to be developed in Umlazi township. More immediately, there is an urgent need for persons already in the creches, play groups, and nursery schools, to receive refresher courses, and in cases where they have not had training, to be given some training for their tasks.

40. DYSFUNCTIONAL ASPECT OF LOBOLA AND NATAL
NATIVE CODE SHOULD BE ALTERED:

It has already been shown in chapter 2 how the system of lobola, and the functioning of the Natal Native Code, is dysfunctional in the environment of an industrial type urban society. In the Bantu townships, it is the women and their children who are in difficulties in this matter, and not the men. Welfare workers, particularly those from the Bantu Child Welfare Society, are only too well aware of the problems which are caused in broken families by these no longer entirely applicable regulations. Due to changes associated with the development and westernisation of the Bantu, it is now high time that these legal regulations be reviewed and archaic elements cut out. We earnestly recommend that this point be taken up and pursued.

41. NEED FOR SOMEBODY OR BODIES TO FOLLOW UP THE
RECOMMENDATIONS OF THIS REPORT, INSOFAR AS
THEY CALL FOR COMMUNITY PRESSURES TO INDUCE CHANGE:

Throughout this chapter, recommendations have been made which call for public pressures to induce change - to persuade the authorities or the existing bodies to undertake some line of action. Likewise, the suggestions are made which apply to

various fields of welfare and health services catered for by voluntary agencies. With the dissolution of the Durban Non-European Children's Fund as a fund-raising body, it would be a tragedy if the recommendations were never carried out because no one takes a lead. The constituent bodies of this fund are still in existence. It is urged that as this report was originally commissioned by the fund, the various ex-members of the fund get together and plan a co-ordinated campaign with other bodies to mobilise support for the recommendations which call for public action and change. We suggest that they also work to get support for those recommendations which involve a co-ordination of effort, and a co-operative planning, by various voluntary agencies. Effective pressure groups must be formed and maintained, as it will take a long time to carry out some of the recommendations.

Somebody, or bodies, must take the lead if our recommendations are not to be forgotten. It must not be a case of leaving the task to someone else, so that in the end no one does anything, and we go on in the same old way as before, just as if this piece of research had never been undertaken. At all costs, this is something which must not be allowed to happen. The researcher does his task, but the time comes eventually when he has to hand over to those for whom the research was intended to provide guidance. May this report be used, and not be yet another book gathering dust on a few office shelves in Durban. We as researchers, ask you, the readers, to see that this does not occur.

For the benefit of the organisations which previously belonged to the Durban Non-European Children's Fund, a separate confidential brief report is being submitted, providing some evaluations of the programme of each organisation, and making some suggestions which have not been included in this report. If these confidential evaluations are taken together with what has been published about the various organisations concerned, in chapter 3, then it is hoped that some guidance and assistance will be provided for the five agencies involved.

ACKNOWLEDGEMENT

A very grateful acknowledgement must be made of the tremendous help rendered by Professor Pollak in connection with the preparation of the recommendations for this report. Her wide experience in the field of both local and international welfare work, proved most invaluable, while her keen insight into the implications of the material in this report proved extremely useful. We would like to pay tribute to the way in which she gave very freely of her time in order to discuss the recommendations, and this despite very heavy commitments of her own. This chapter would have been considerably poorer without her assistance, and any imperfections which remain are not the result of her assistance, but of our own work.

APPENDIX A.

**FURTHER STATISTICAL TABLES REVEALING
THE SOCIO-ECONOMIC CHARACTERISTICS
OF A SAMPLE OF BANTU HOUSEHOLDS
FROM KWA MASHU, DURBAN, 1964.**

TABLE AI

ESTIMATED POVERTY DATUM LINE FOR DURBAN, OCTOBER 1964*

(Derived from the C.S.I.R. Scales)

AGE AND SEX OF PERSON	WEEKLY PRIMARY POVERTY DATUM LINE ALL ITEMS (excluding Rent and Transport)	MONTHLY VALUES
0-4 years	R1.34	R5.76
5-9 years	1.70	7.31
10-15 years	2.40	10.32
16-64 years <u>male</u>	3.13	13.46
16-59 years <u>female</u>	2.54	10.92
65+ years <u>male</u>	2.04	8.77
60+ years <u>female</u>	1.86	8.00
household	0.68	2.92

* These figures are estimates based on a revision of the figures given in Watts, H.L. (1962): Survey of the Housing Requirements of Coloureds in Towns of the Western Cape Province: National Institute for Personnel Research, C.S.I.R., Johannesburg. (mimeographed): Appendix 'C'. The figures were revised in terms of the Consumer Price Index for October, 1964 (Bureau of Statistics: Monthly Bulletin of Statistics: January, 1965): XLIV. No. 1.p.98. Table L-2: Government Printer, Pretoria.)

TABLE A II

HOUSEHOLD SIZE IN RELATION TO THE SOCIO-
ECONOMIC LEVEL OF A HOUSEHOLD,
KWA MASHU SAMPLE. DURBAN. 1964.

NO. OF PERSONS IN HOUSEHOLD	SOCIO-ECONOMIC LEVEL: HOUSEHOLD INCOME IS :				INSUFFICIENT DATA	TOTAL
	MORE THAN R5 BELOW S.P.D.L.*	UP TO R5 BELOW S.P.D.L.	UP TO R5 ABOVE S.P.D.L.	MORE THAN R5 ABOVE S.P.D.L.		
1	1	-	1	1	2	5
2	1	1	3	6	-	11
3	10	3	4	10	1	28
4	12	6	1	8	4	31
5	22	4	2	3	1	32
6	23	-	1	3	-	27
7	22	1	2	2	-	27
8	24	-	-	1	3	28
9	16	-	-	-	1	17
10	7	-	-	-	-	7
11	6	-	-	-	-	6
12	5	-	-	-	-	5
13	2	-	-	-	-	2
14	1	-	-	-	-	1
15	-	-	-	-	1	1
TOTAL	152	15	14	34	13	228
MEAN. NO. PER HOUSEHOLD	6.9	4.1	3.8	3.8	-	
NON-RESPONSE						10
GRAND TOTAL						238

* S.P.D.L. = Secondary Poverty Datum Line.

TABLE A III

NUMBER OF CHILDREN AGED 15 YEARS AND UNDER,

PER HOUSEHOLD BY SOCIO-ECONOMIC LEVEL,

KWA MASHU SAMPLE, DURBAN, 1964.

NO. OF CHILDREN PER HOUSEHOLD	SOCIO-ECONOMIC LEVEL: HOUSEHOLD INCOME IS:				INSUFFICIENT DATA	TOTAL
	MORE THAN R5 BELOW S.P.D.L.*	UP TO R5 BELOW S.P.D.L.	UP TO R5 ABOVE S.P.D.L.	MORE THAN R5 ABOVE S.P.D.L.		
0	13	2	5	15	4	39
1	15	5	5	7	3	35
2	26	4	2	6	2	40
3	25	3	1	4	1	34
4	27	-	1	1	2	31
5	21	1	-	1	1	24
6	12	-	-	-	-	12
7	4	-	-	-	-	4
8	4	-	-	-	-	4
9	2	-	-	-	-	2
10	3	-	-	-	-	3
TOTAL	152	15	14	34	13	228
MEAN NO. PER HOUSEHOLD	3.5	1.8	1.1	1.2	-	
NON-RESPONSE						10
GRAND TOTAL						238

* S.P.D.L. = Secondary Poverty Datum Line.

TABLE A IV.

REPORTED ANNUAL INCOME OF MALE HEADS OF
HOUSEHOLDS (HUSBANDS). KWA MASHU.1964.

INCOME IN RAND PER ANNUM	NO. OF CASES (HUSBANDS)	% OF KNOWN CASES
NO INCOME	23	11.1
UNDER R120	6	2.9
R120 - 239	7	3.4
240 - 359	19	9.1
360 - 479	93	44.7
480 - 599	39	18.7
600 - 719	15	7.2
720 +	6	2.9
SUB-TOTAL	208	100.0
NO INFORMATION	6	
NOT APPLICABLE	16	
NON RESPONSE	8	
TOTAL	238	

NOTES:

- (1) Not all the male heads of households are husbands - 14 cases are men without a living wife present in the house, and 21 are sons of the female head.
- (2) "Not Applicable" represents households with no male head in any form.

TABLE A V.REPORTED ANNUAL INCOME OF WIVESIN KWA MASHU SAMPLE

INCOME IN RAND PER ANNUM	NO. OF WIVES	% OF KNOWN CASES
NO INCOME	150	68.5%
UNDER R60	7	3.2
60 - 119	24	11.0
120 - 239	30	13.7
240 - 359	7	3.2
360 - 479	0	0
480 - 599	1	0.4
600 +	0	0
SUB-TOTAL	219	100.0
NOT APPLICABLE	14	
NON-RESPONSE	5	
TOTAL	238	

NOTES:

(1) This table includes female household heads, and females who share the headship of the household with a son. There are 16 such cases, or 7% of all households where household composition was established. Thus strictly speaking, the table is not for "wives" only but for the wives of household heads or female heads.

(2) "Not applicable" refers to 14 households with male heads without wives.

TABLE A VI.

REPORTED ANNUAL INCOME EARNED BY CHILDREN
OF THE HOUSEHOLD HEAD. PER HOUSEHOLD.

TOTAL INCOME IN RAND PER ANNUM PER HOUSEHOLD	NO. OF HOUSEHOLDS WITH EARNING CHILDREN	% OF KNOWN CASES
NO INCOME	167	78.1
UNDER R36	6	2.8
36 - 71	6	2.8
72 - 143	17	7.9
144 - 215	6	2.8
216 - 287	5	2.3
288 - 359	1	0.5
360 +	6	2.8
SUB -TOTAL	214	100.0
NOT APPLICABLE	14	
NON-RESPONSE	10	
TOTAL	238	

NOTE: "Not applicable" refers to 14 households without children.

TABLE A VII.
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HOUSEHOLD INCOME REPORTED AS ADDITIONAL TO
HUSBAND'S AND WIFE'S EARNINGS (INCLUDES
EARNINGS OF WORKING CHILDREN).

INCOME IN RAND PER ANNUM	NO. OF HOUSEHOLDS	% OF KNOWN CASES
NONE	122	65.7
UNDER R36	4	2.1
36 - 71	15	8.1
72 - 143	19	10.2
144 - 215	13	7.0
216 - 287	6	3.2
288 - 359	1	0.5
360 +	6	3.2
SUB-TOTAL	186	100.0
NO INFORMATION	48	
NON-RESPONSE	4	
TOTAL	238	

NOTE:

The 48 "No information" cases include households with partial information, where it was evident not all the additional information was reported. (This also explains why Table VIII has a higher number of known cases, as reported sources of income are listed even if incomplete.)

TABLE A VIII.

REPORTED SOURCES OF HOUSEHOLD INCOME OTHER
THAN HEAD'S AND WIFE'S INCOME.

SOURCE OF INCOME REPORTED *	NO. OF HOUSEHOLDS WITH SOURCE	EACH SOURCE AS % OF 225 KNOWN CASES
NO ADDITIONAL SOURCE	122	54.2
CHILDREN'S EARNINGS	52	23.1
RENT FROM LODGERS	22	9.8
ILLICIT SOURCES	12	5.3
HANDICRAFTS	12	5.3
TRADING AND HAWKING	8	3.6
WELFARE	5	2.2
OTHER	11	4.9

* A household may have several additional sources of income.

TABLE A IX.

TOTAL ANNUAL INCOME OF HOUSEHOLDS.
ALL REPORTED SOURCES COMBINED.

TOTAL INCOME IN RAND PER ANNUM	NO. OF HOUSEHOLDS	% DISTRIBUTION
UNDER R240	36	16.9
240 - 479	90	42.3
480 - 719	68	31.9
720 - 959	17	8.0
960 - 1199	2	0.9
1200 +	0	0
SUB-TOTAL	213	100.0
NO INFORMATION	6	
NON-RESPONSE	19	
TOTAL	238	

Mean Annual Income per household = R409.20, or R34.10 per month.

Some of the non-response includes partial non-response so the complete income was not known.

TABLE A X.

ANNUAL EXPENDITURE OF HOUSEHOLD

HEAD ON RENT.

ANNUAL RENT	NO. OF HOUSEHOLDS	% OF KNOWN CASES
RENT FREE (paid by a Welfare Agency)	1	0.4
UNDER R24	0	0
24 - 35	1	0.4
36 - 47	51	22.4
48 - 59	0	0
60 - 71	34	14.9
72 - 83	116	51.0
84 - 95	14	6.1
96 - 107	8	3.5
108 +	3	1.3
SUB-TOTAL	228	100.0
NO INFORMATION	1	
NON-RESPONSE	9	
TOTAL	238	

Mean expenditure on rent = R69.96 p.a., or R5.83 per month.

TABLE A XI.

ANNUAL EXPENDITURE OF HOUSEHOLD ON FUEL AND LIGHT.

ANNUAL EXPENDITURE IN RAND	NO. OF HOUSEHOLDS	% OF KNOWN CASES
UNDER R12	25	11.8
12 - 23	135	64.0
24 - 35	20	9.5
36 +	31	14.7
SUB-TOTAL	211	100.0
NO INFORMATION	17	
NON-RESPONSE	10	
TOTAL	238	

TABLE A XII.

ANNUAL EXPENDITURE OF HOUSEHOLD ON WORKERS' TRANSPORT.

ANNUAL AMOUNT IN RAND	NO. OF HOUSEHOLDS	% OF KNOWN CASES
FREE	2	1.0
NONE	8	4.0
UNDER R20	18	9.0
20 - 39	111	55.1
40 - 59	30	14.8
60 - 79	17	8.6
80 - 99	9	4.5
100 +	6	3.0
SUB-TOTAL	201	100.0
NO INFORMATION	28	
NON-RESPONSE	9	
TOTAL	238	

Mean expenditure on fuel and light = R21.24 p.a., or R1.77 per month.

Mean expenditure on workers' transport = R40.16 p.a., or R3.34 per month.

Occasional workers, such as chars, have to pay 15 cents per return trip by bus from Kwa Mashu to Durban, or 14 cents by train

TABLE A XIII.
=====

REPORTED TOTAL ANNUAL EXPENDITURE
OF HOUSEHOLD.

ANNUAL AMOUNT IN RAND	NO. OF HOUSEHOLDS	% OF KNOWN CASES
0 - 49	3	1.3
50 - 99	27	11.8
100 - 149	50	21.9
150 - 199	59	26.0
200 - 249	37	16.2
250 - 299	31	13.6
300 - 399	16	7.0
400 - 499	4	1.8
500 - 599	0	0
600 +	1	0.4
SUB-TOTAL	228	100.0
NO INFORMATION	4	
NON-RESPONSE	6	
TOTAL	238	

Mean expenditure of household = R191.12 p.a., or R15.92 per month.

APPENDIX B.

SOME DETAILS OF FRESH MILK
FEEDING SCHEMES FOR BANTU CHILDREN
IN THE DURBAN REGION

(Appendix B (i))

FRESH MILK FEEDING SCHEMES IN THE VARIOUS TOWNSHIPS.

(a) THE POSITION IN 1966:

Most of the feeding listed below is done in the various play centres and nursery schools. The amount of milk which each school obtains under the subsidised milk scheme per month, through the Durban Corporation/Malnutrition Relief Funds Scheme is shown.

CHESTERVILLE TOWNSHIP:

1. The Bantu Community Welfare Organisation runs three places of care to which they provide food and milk. These places of care are called Huts 7, 9 and 11: Hut 7 gets 135 gallons of milk per month, Hut 9 gets 60 gallons, and Hut 11 gets 130 gallons.
2. Chesterville Nursery Schools provide food and milk, and one of these schools gets 88 gallons a month from the scheme.
3. Bantu Child Welfare "Place of Care" (i.e. creche) provides food and milk - they get 138 gallons of milk.
4. Round Table supplies 140 gallons of milk to one secondary school.
5. "Their Daily Bread" supplies 430 gallons of milk to Chesterville Junior School, 135 gallons to Umkumbane Junior School, and 200 gallons to the Christopher Nxumalo Primary School.

TOTAL: 1.456 gallons

KWA MASHU TOWNSHIP:

1. The Bantu Child Welfare Society runs four places of care (creches), and provides the children with both food and milk. The names of these are Inkuliso, Thembihle, Tokozane and Tandakuhle, and each one of these receives 138 gallons of milk per month.
2. The Department of Bantu Administration run a youth employment scheme. The youths are given one meal a day, and on Fridays they are given milk. The scheme orders 10 gallons of milk per month.
3. The City Health Department runs two clinics - Goodwin which uses 1,400 gallons of milk per month, and Rydalvale which uses 1,250 gallons. The milk is given to children who are regular clinic patients, and only to children who have a clinic card. (The powdered milk used by the clinics is paid for by the Bantu Commissioner's Office. The clinics receive 150 lbs. powdered milk a month).
4. The Durban Girls' College Old Girls' Guild runs the Ekujabuleni Nursery School. This provides food and milk, and the milk consumption is 200 gallons a month.
5. The Union of Jewish Women runs the Ekuthuleni Nursery School - which supplies food and milk and uses 75 gallons per month.

TOTAL: 3,487 gallons

UMLAZI GLEBELANDS:

1. Umlazi Glebelands Play Group - 68 gallons.
 2. Durban Bantu Child Welfare Creche - 138 gallons.
- The above are also supplied with meals.

LAMONTVILLE:

1. Under the Lamont Schools' Feeding Scheme fall the following schools, all of which get milk and maas:-

<u>School</u>	<u>Milk per month</u>	<u>Maas per month</u>
Fika phambile	114 gallons	213 gallons
Bantu Vukani	166 gallons	213 gallons
Ekuthuleni	146 gallons	146 gallons
Entuthukweni	127 gallons	166 gallons
Gijima	123 gallons	268 gallons
Lamont Secondary	132 gallons	106 gallons

2. Places of Care:

Gijima Hut Play Group	50 gallons	
Lamont Health Play Group	75 gallons	72 gallons
Lamont Creche (Nylon)	52 gallons	20 gallons
Inkoliso (D.G. College)	200 gallons	
Mtshali's Nursery School	105 gallons	
Durban Child Welfare Infants' Home	340 gallons	
TOTAL:	<u>1630 gallons</u>	<u>1204 gallons</u>

The places of care also provide meals.

There is also a Bantu refuge home in Lamontville run by the Bantu Administration Department, and the indigent men and women who live there are supplied with all their food, including milk.

The total number of gallons of milk supplied by the Durban Bantu Administration Department is 8,095 gallons monthly (which is 112 gallons more than the total of the previous figures). Some distributing points may receive slightly more milk than their figures show.

(Appendix B (iv))

(b) THE POSITION AS AT THE END OF 1959:

SUBSIDISED MILK

Milk supplied to Welfare Organisations in the various townships at the subsidised rate of 3d. per pint. ("At present" (then) "undertaken by the Municipal Bantu Administration Department, out of profits of the 'kaffir beer' account"):-

BAUMANVILLE:

	<u>Monthly</u>
Their Daily Bread Fund	208 gallons
Durban Bantu Child Welfare Society	<u>233</u> gallons
	<u>441</u>

CATO MANOR:

Their Daily Bread Fund	1416 gallons
Durban Bantu Child Welfare Society	116 gallons
Cato Manor Community Welfare Huts	344 gallons
Zenzele Nursery School	30 gallons
	<u>1906</u>

CHESTERVILLE:

Their Daily Bread Fund	716 gallons
Round Table	120 gallons
Chesterville Child Care Association	<u>115</u> gallons
	<u>951</u>

KWA MASHU:

Durban Girl's College Old Girl's Guild	137 gallons
Durban Bantu Child Welfare Society	240 gallons
City Health Department (Clinic)	<u>660</u> gallons
	<u>1037</u>

LAMONTVILLE:

Lamontville Schools Feeding Scheme	1541 gallons
Durban Girl's College Old Girl's Guild	150 gallons
Evans Mtshali (Nursery Schools)	113 gallons
Feed the Babies Fund	<u>278</u> gallons
	<u>2082</u>

UMLAZI GLEBE:

Lamontville Schools Feeding Scheme	<u>55</u> gallons
--	-------------------

Average monthly milk supplied: TOTAL: 6,472 gallons.

(Appendix B (v))

Comparing the position in 1966 with the former position in 1959, it will be seen that fresh milk feeding has expanded by 1623 gallons of milk a month, or a 25% increase, which is noteworthy.

The following are details of the distribution of pro nutro through the Municipal Child Health Clinics on the 18th of November, 1966. As each mother receives one pound, the figures represent both the number of lbs. of pro nutro distributed, and the number of children for whom the supplement is intended:-

<u>Municipal Child Health Clinic</u>	<u>No. paying for pro nutro</u>	<u>No. receiving pro nutro free</u>	<u>Repay-ments^{1]} R. C.</u>
Austerville	46	-	2-30
Cato Manor	7	-	-35
Chatsworth	60	12	3-00
Chesterville	47	2	2-35
Clairwood	58	17	2-90
Clair Estate	3	-	-15
David Landau	11	-	-55
Gail Street (Coloured)	31	3	1-55
Goodwins Cottage	51	13	2-55
Lamontville	53	1	2-65
Lancers Road	112	8	5-60
Mayville (Asians)	50	6	2-50
Mayville (Coloured)	30	1	1-50
Redhill (Coloured)	50	-	2-50
Merebank	43	3	2-15
Rydalvale	114	37	5-70
Sparks Estate	42	-	2-10
Umlazi Glebelands	66	4	3-30
Wentworth Government Village (Coloured)	53	-	2-65
Total:	927	107	46-35

Corresponding figures for the preceding four weeks are as follows, providing the totals only:-

1] Repayments are at 5 cents per pound, by those paying for the pro nutro.

11th November, 1966, 811 lbs were paid for, 88 were distributed free, and the cost was R40-55. On the 4th of November 1966, 951 lbs were paid for, 100 lbs were distributed free, and the cost was R47-55. On the 28th of October, 869 lbs were paid for, 118 were distributed free, and the cost was R43-45. Finally, on the 21st of October, 1966, 919 lbs were paid for, 95 lbs were given away free, and the cost was R45-95. (In all cases, "cost" refers to the cost at 5 cents per pound, for those who paid for their pro nutro).

APPENDIX "D"

SOME DATA FROM THE KWA MASHU
SAMPLE SURVEY RELATING TO
THE HEALTH PRACTICES OF
THE BANTU FAMILIES.

TABLE DI

FIRST STEP TAKEN BY BANTU HOUSEWIVES.
IN REPORTED CASES OF ILLNESS.
KWA MASHU. DURBAN 1964.

FIRST STEP	NO. OF REPORTED CASES OF ILLNESS	%	SUB-TOTAL %'S
Visited Clinic	100	14.7	76.0
Visited Polyclinic	149	21.9	
Visited Hospital	157	23.2	
Visited Doctor	110	16.2	
Visited Chemist	37	5.4	5.4
Visited Inyanga or Isangoma	52	7.6	13.3
Joined Zionist or other Church	19	2.8	
Other	20	2.9	
No Information/ Uncertain	36	5.3	5.3
TOTAL	680	100.0	100.0

NOTE: This information is based on a sample of 238 cases from Kwa Mashu, and refers to an average of nearly 3 cases of illness per household. The illnesses reported were only those regarded by the informants as serious enough to warrant help outside the household.

TABLE DII.

TOTAL NO. OF DEATHS OF CHILDREN UP TO THE
AGE OF 15 YEARS. SUFFERED BY EACH
HOUSEHOLD. KWA MASHU SAMPLE.
DURBAN 1964.

TOTAL NO. OF CHILD DEATHS SUFFERED BY EACH HOUSEHOLD	NO. OF HOUSEHOLDS	% KNOWN CASES	DESCENDING CUMULATIVE %'S
0	116	50.8	100.0
1	53	23.2	49.2
2	26	11.4	26.0
3	17	7.5	14.6
4	10	4.4	7.1
5	3	1.4	2.7
6	2	0.9	1.3
7	1	0.4	0.4
NO INFORMATION	10	-	-
TOTAL	238	100.0	

Total No. of deaths = 230 cases. (In 112 households with deaths).
 Mean No. of deaths per household with deaths = 2.1 deaths.
 Overall mean per known cases = 1.0 deaths.

Out of these 230 cases of death, in only 10, or 4.3 % of the cases, the woman reported visiting a hospital or clinic with the sick child.

The cause of death was asked - most women replied in terms of rational symptoms. Diarrhoea (enteritis) seemed the most common single symptom mentioned.

TABLE DIII.
TOTAL NO. OF STILLBIRTHS REPORTED PER FAMILY,
KWA MASHU SAMPLE, DURBAN 1964.

TOTAL NO. OF STILLBIRTHS PER HOUSEHOLD	NO. OF FAMILIES	% KNOWN
0	209	91.7
1	16	7.0
2	2	0.9
3	1	0.4
No Information	10	-
TOTAL	238	100.0

Total No. of stillbirths = 23

TABLE DIV
TOTAL NO. OF MISCARRIAGES EVER. PER FAMILY,
KWA MASHU SAMPLE, DURBAN 1964.

NO. OF MISCARRIAGES	NO. OF FAMILIES	% KNOWN
0	208	91.3
1	12	5.2
2	2	0.9
3	4	1.7
4	-	-
5	2	0.9
No Information	10	-
TOTAL	238	100.0

Total No. of miscarriages = 38

SOUTH AFRICAN INSTITUTE OF RACE
RELATIONS : Natal Region.

NR.123/1965.
12.10.65

SCHOOL COSTS - AFRICAN PUPILS - NATAL.
(PER ANNUM)

INFORMATION SHEET

	CLASS	TEXT BOOKS	EXER- CISE BOOKS & EXTRAS	SCHOOL FEES/ LEVIES	BOARD- ING FEES	EXAM- INA- TION FEES	TOTAL
LOWER	(Sub A	-	0.30	0.20	-	-	0.50
	Sub B	-	0.50	0.20	-	-	0.70
PRIMARY	(Std 1	1.50	0.50	0.20	-	-	2.20
	Std 2	1.60	0.50	0.20	-	-	2.30
HIGHER PRIMARY	(Std 3	2.50	0.60	0.80	-	-	3.90
	Std 4	3.00	0.60	0.80	-	-	4.40
	Std 5	4.30	0.70	0.80	-	-	5.80
	Std 6	4.50	0.70	0.80	-	-	6.00
SECOND- ARY (TO JUNIOR CERTI- FICATE)	(Form I	9.00	1.50	4.00	-	-	14.50
	Form II	16.00	1.50	4.00	-	-	21.50
	Form III	4.00	1.50	4.00	-	4.00	13.50
	Re- peaters	9.00	1.50	4.00	-	4.00	18.50
SECOND- ARY (TO MATRIC)	(Form IV	35.00	2.50	4.00	60.00	-	101.50
	Form V	12.50	3.00	4.00	60.00	6.00	85.50
TOTAL:		R102.90	R15.90	R28.00	R120.00	R14.00	R280.80

FOR NOTES ON ABOVE FIGURES.

SEE FOLLOWING PAGE

" NOTES

1) Source.

The foregoing figures are compiled from information obtained from the Bantu Education Department and are conservatively estimated. In some cases, the costs may be greater, e.g. cost of books for Form IV may be as high as R40, depending on the particular subjects, and Matriculation examination fees may be as high as R8,

2) Items Not Included in Estimate of Schooling Costs.

Omitted from the figures are :

- (i) the cost of school uniforms/sports equipment/satchels/suitcases, etc.
- (ii) extra levies or contributions, e.g. sports funds, medical funds, etc.
- (iii) bus fares to and from day schools.
- (iv) train fares to boarding schools in rural areas.
- (v) maintenance during school holidays.

3) School Fees/Levies.

School fees from Lower Primary to Junior Certificate Level are paid by pupils in the majority of cases, but are not actually compulsory. Technically, they are termed "voluntary levies", but in fact, pupils are expected to pay fees if they can afford the money. In cases of extreme indigency or special hardship, fees may be waived in the discretion of School Boards or Committees.

School fees (or levies) for Lower Primary Schools have been shown as 20 cents per annum, and for Higher Primary as 80 cents per annum. However, it should be noted that the fee (or levy) may be increased (in the discretion of the School Boards and Committees) to 40 cents per annum for Lower Primary and R1.20 for Higher Primary. However, in the majority of schools the lower rate still applies.

4) Boarding Fees.

It should be noted that there are no day schools in Natal for for Matriculation pupils. Thus all pupils proceeding to Matriculation must attend a boarding establishment which entails considerable cost to a family, in relation to average African earnings. (A minority of Matriculation pupils are assisted by various bursary funds.)"

"5) Financing of Lower Primary Schools ("Site" Levy of 20 cents per month).

A site levy of 20 cents is added to the monthly rents of family-type housing in municipal areas. This money is utilised for building costs, servicing and maintenance of Lower Primary Schools only. It may not be used for any other purpose.

6) Financing of All Other Schools.

The African communities in various Municipal townships, through their local School Boards and Committees, are required to raise half the building and maintenance costs for all other types of schools, i.e. Higher Primary and Secondary Schools. The other half of the capital cost and maintenance is met by the Government on a R for R basis (funds permitting). The raising of the necessary money for the addition of new classrooms, the building of new schools, and the maintenance of existing schools, places a very considerable burden on African communities and extreme difficulty is experienced in raising this money. (In some cases, School Boards and Committees also pay the salaries of extra teachers, where there is no allocation in the Bantu Education budget for this purpose). "

8th October. 1965.

Mary Draper (Miss)
Research Officer : Natal Region

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APPENDIX "F"

PROVISIONAL

SCHEDULE OF GRANTS-IN-AID 1966/67.

CITY OF DURBAN

(Vote 49/8/2/19.)

DETAILS	1966/67 Estimate
Bantu Bursaries - University of Natal Medical and Other Faculties	600
Bantu Child Welfare - Cash	5,000
do. - Lamont Infants Home	1,200
do. - Rent of Offices	300
do. - Kwa Mashu Creches - Running Expenses	7,750
do. - Kwa Mashu Creches - Equipment	1,000
do. - Nurse's Salary	480
do. - Umlazi Glebe Creches - Running Expenses	1,550
do. - Chesterville Creche - Running Expenses	1,550
Bantu Ladies' Hospital Society	250
Bantu Refuge Home	3,000
Beatrice Street Y.M.C.A.	1,000
Bursaries - School Books	1,000
do. - Teachers' Certificates	1,610
Creche and Day Nursery - Chesterville	-
Chesterville Bantu Nursery School Association	1,300
D. and D. Bantu Athletic and Cycling Association	300
D. and D. Institute for Deaf - Running Expenses	500
do. - Xmas Party	50
D. and D. Road Safety Organisation	1,000
Durban Girls' College Old Girls' Guild - Day Nurseries	4,000
Durban Group of Schools for Bantu Adults	1,300
Durban Organisation for the Care of Pre School African Children	4,100
Emergency Relief	100
General	2,500

continued on next page

continued from previous page.

Institute of Race Relations (Subs. $\frac{1}{2}$ Cost)	20
Joint Council of Europeans and Bantu (Subs. $\frac{1}{2}$ Cost)	20
Lamont Creche - Running Expenses	1,100
Malnutrition Relief Committee	-
McCord Zulu Hospital - Electricity Charges	-
do. - Midwifery Services	-
do. - Chesterville Clinic Rent	-
Bantu Community Welfare Organisation	500
Natal Family Planning Clinics	1,000
St. Johns Ambulance Brigade - Equipment	300
S.A. Bureau of Racial Affairs ($\frac{1}{2}$ Cost)	20
S.A. Council for Scientific and Industrial Research	-
S.A. Red Cross Association	-
Temporary Employment - Students	100
Union of Jewish Women	600
Y.W.C.A. Bantu Women's Club (Zenzele)	400
	<hr/>
	R45,500
LESS Contributions from Borough Fund	7,390
	<hr/>
	R38,110
	<hr/> <hr/>

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