HEALTH & DISEASE

GENERAL

1975 - Jan 1977
Medically-trained Bantu serving in homelands

A. Mr. L. F. Wood asked the Minister of Bantu Administration and Development:

How many trained Bantu (a) doctors, (b) dentists, (c) chemists and druggists, (d) veterinarians and (e) nurses are serving the Bantu people in the Bantu homelands.

The Deputy Minister of Bantu Development:

(a) Doctors—72.
(b) Dentists—0.
(c) Chemists—19.
(d) Veterinarians—0.
(e) Nurses—16,510.
Closing gap in salaries paid to White and non-White doctors and nurses in State employment

Mr. R. M. DE VILLIERS asked the Minister of the Interior:

What progress has been made in closing the gap in salaries paid to White and non-White doctors and nurses, respectively, in State employment.

Mr. DE VILLIERS answered:

The DEPUTY MINISTER OF THE INTERIOR:

The Government's policy in regard to the narrowing of the gap has been clearly stated on various occasions in the recent past. Apart from the salary improvements which were granted to non-White officials over the past few years - the most recent of which became effective as from 1 July 1974 - the matter is continuously receiving the attention of the Government with a view to implementing its policy.
Closing gap in salaries paid to White and non-White doctors and nurses in State employment

*29. Mr. R. M. DE VILLIERS asked the Minister of the Interior:

What progress has been made in closing the gap in salaries paid to White and non-White doctors and nurses, respectively, in State employment.

The DEPUTY MINISTER OF THE INTERIOR:

The Government's policy in regard to the narrowing of the gap has been clearly stated on various occasions in the recent past. Apart from the salary improvements which were granted to non-White officials over the past few years—the most recent of which became effective as from 1 July 1974—the matter is continuously receiving the attention of the Government with a view to implementing its policy.
Salary scales for doctors/dentists/pharmacists

Mrs. L. F. WOOD asked the Minister of the Interior:

What are the salary scales laid down for (a) White, (b) Coloured, (c) Indian and (d) Hindu (d) doctors, (e) dentists and (f) pharmacists in State and provincial hospital services?

The MINISTER OF THE INTERIOR:

The salary scales are as follows:

<table>
<thead>
<tr>
<th>Rank</th>
<th>White</th>
<th>Coloured/Indian</th>
<th>Hindu</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professor/Chief Specialist</td>
<td>15,600</td>
<td>13,200</td>
<td>9,500</td>
</tr>
<tr>
<td>Principal Specialist</td>
<td>14,400</td>
<td>12,100</td>
<td>9,500</td>
</tr>
<tr>
<td>Senior Specialist</td>
<td>13,200</td>
<td>10,900</td>
<td>9,500</td>
</tr>
<tr>
<td>Specialist</td>
<td>12,000</td>
<td>10,600</td>
<td>9,500</td>
</tr>
</tbody>
</table>

Government Medical Officers

<table>
<thead>
<tr>
<th>Rank</th>
<th>White</th>
<th>Coloured/Indian</th>
<th>Hindu</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Government Medical Officer</td>
<td>13,700</td>
<td>11,200</td>
<td>9,500</td>
</tr>
<tr>
<td>Principal Government Medical Officer</td>
<td>12,600</td>
<td>10,100</td>
<td>9,500</td>
</tr>
<tr>
<td>Government Medical Officer</td>
<td>7,500</td>
<td>6,000</td>
<td>5,500</td>
</tr>
<tr>
<td>Junior</td>
<td>5,000</td>
<td>4,000</td>
<td>3,500</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Dentists: As in respect of Government Medical Officers</th>
</tr>
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<tbody>
<tr>
<td>Rank and salary scale (r per annum)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>White</th>
<th>Coloured/Indian</th>
<th>Hindu</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Pharmacist</td>
<td>9,000</td>
<td>5,000</td>
</tr>
<tr>
<td>Principal Pharmacist</td>
<td>6,000</td>
<td>4,500</td>
</tr>
<tr>
<td>Senior Pharmacist</td>
<td>5,000</td>
<td>3,500</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>4,000</td>
<td>3,000</td>
</tr>
<tr>
<td>Pharmacist (Pharmaceutical)</td>
<td>2,500</td>
<td>2,000</td>
</tr>
<tr>
<td>Trainee Pharmacist (Male)</td>
<td>2,000</td>
<td>1,500</td>
</tr>
<tr>
<td>Trainee Pharmacist (Female)</td>
<td>2,500</td>
<td>2,000</td>
</tr>
</tbody>
</table>

(See Table for details)
Medical and dental students

81. Mr. L. F. WOOD asked the Minister of National Education:

(1) What is the present enrolment of each university in respect of (a) White, (b) Coloured, (c) Indian and (d) Bantu medical and (ii) dental students;

(2) (a) whether he intends to extend the training facilities for medical and dental students, if so, in what manner;

(3) what is the projected output of trained (a) White, (b) Coloured, (c) Indian and (d) Bantu (i) medical practitioners and (ii) dentists for 1980, 1985 and 1990, respectively.

The MINISTER OF NATIONAL EDUCATION:

<table>
<thead>
<tr>
<th></th>
<th>(a) (i) and (ii)</th>
<th>(b) (i) and (ii)</th>
<th>(c) (i) and (ii)</th>
<th>(d) (i) and (ii)</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.O.F.S.</td>
<td>222</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>U.P.</td>
<td>1 203</td>
<td>404</td>
<td></td>
<td></td>
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<tr>
<td>U.S.</td>
<td>617</td>
<td>115</td>
<td></td>
<td></td>
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<tr>
<td>U.C.T.</td>
<td>850</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Wits</td>
<td>946</td>
<td>258</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natal</td>
<td></td>
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</table>

(2) (a) no;

(3) (a) (i)* and (ii)* (b) (i)* and (ii)† (c) (i)* and (ii)† (d) (i)† and (ii)†

<table>
<thead>
<tr>
<th></th>
<th>(a) (i)* and (ii)*</th>
<th>(b) (i)* and (ii)†</th>
<th>(c) (i)* and (ii)†</th>
<th>(d) (i)† and (ii)†</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>587</td>
<td>68</td>
<td>19</td>
<td>54</td>
</tr>
<tr>
<td>1985</td>
<td>685</td>
<td>75</td>
<td>21</td>
<td>63</td>
</tr>
<tr>
<td>1990</td>
<td>783</td>
<td>83</td>
<td>24</td>
<td>73</td>
</tr>
</tbody>
</table>

Notes: *Calculations based on five year trend since 1960.
†No projection could be made since there is no trend.

Names submitted for consideration in appointment of committees in terms of Publications Act

85. Mr. J. D. DU P. BASSON asked the Minister of the Interior:

What (a) bodies submitted names of persons or (b) persons submitted their own names to him in response to his request in the public last year to submit names to him for consideration in the appointment of committees in terms of the Publications Act, 1974.

The MINISTER OF THE INTERIOR:

(a) See the attached schedule.

(b) It is not in the interest of the persons concerned that their names be made known.

SCHEDULE

S.A. Association of Theatrical Managements.
Praedestem Gemeente Kerk.
St. Andrews Presbyterian Church.
Akte Morale Standaarde.
Federale van Bond van Jongeledereverenings en Gereformeerd Grondslag in Suid-Afrika.
South African Theatre Union.
Vroueshulp van die N.G. Kerk.
33. Mr. L. F. WOOD asked the Minister of Health:

How many inspections were carried out by his Department during 1974 on (a) doctors, (b) dentists and (c) chemists and druggists in connection with their responsibilities as defined in sections 65 and 186, respectively, of the Medical, Dental and Pharmacy Act and the regulations promulgated thereunder.

The MINISTER OF HEALTH:

(a) 379.
(b) 28.
(c) 1,404.
Medically trained non Whites

90. Mr. L. F. WOOD asked the Minister of Health:

How many (a) Bantu, (b) Indians and (c) Coloureds have been registered as (i) midwives, (ii) health visitors, (iii) radiographers and (iv) sister tutors in each year since 1970.

The MINISTER OF HEALTH:

(i) Midwives as at 31 December of each year:

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<tbody>
<tr>
<td>(a)</td>
<td>9096</td>
<td>9681</td>
<td>10371</td>
<td>11188</td>
<td>12014</td>
</tr>
<tr>
<td>(b)</td>
<td>103</td>
<td>104</td>
<td>103</td>
<td>103</td>
<td>103</td>
</tr>
<tr>
<td>(c)</td>
<td>263</td>
<td>263</td>
<td>263</td>
<td>263</td>
<td>263</td>
</tr>
</tbody>
</table>

The particulars for the period since 1972 are as follows:

Indians: 1973 - 198, 1974 - 263,

(ii) Health visitors as at 31 December of each year:

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<tr>
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</thead>
<tbody>
<tr>
<td>(a)</td>
<td>371</td>
<td>374</td>
<td>450</td>
<td>545</td>
<td>666</td>
</tr>
<tr>
<td>(b)</td>
<td>103</td>
<td>104</td>
<td>103</td>
<td>103</td>
<td>103</td>
</tr>
<tr>
<td>(c)</td>
<td>39</td>
<td>51</td>
<td>52</td>
<td>52</td>
<td>52</td>
</tr>
</tbody>
</table>

(iii) Radiographers are not registered according to racial groups.

(iv) Sister tutors as at 31 December of each year:

<table>
<thead>
<tr>
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<th></th>
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<tbody>
<tr>
<td>(a)</td>
<td>48</td>
<td>51</td>
<td>65</td>
<td>89</td>
<td>106</td>
</tr>
<tr>
<td>(b)</td>
<td>103</td>
<td>104</td>
<td>103</td>
<td>103</td>
<td>103</td>
</tr>
<tr>
<td>(c)</td>
<td>39</td>
<td>51</td>
<td>56</td>
<td>63</td>
<td>66</td>
</tr>
</tbody>
</table>
HANSARD 32nd PARLIAMENT, 2nd SESSION.
Q. 342-3.
14 MARCH, 1945.

Mr. R. M. FADMAN asked the Minister of Bantu Administration and Development:

(1) How many (a) mission hospitals, (b) other hospitals and (c) clinic centres are there in the Bantustan in (i) the Republic and (ii) South West Africa?

(2) How many hospital beds are there in hospitals in the Bantustan in (i) the Republic and (ii) South West Africa?

(3) How many (a) White and (b) Bantu (i) medical practitioners, (ii) nurses and midwives, (iii) dentists, (iv) chemists and druggists, (v) physical therapists, (vi) radiographers, (vii) health inspectors, (viii) health assistants and (ix) pharmaceutical assistants are serving in the Bantustan in the Republic and South West Africa, respectively.

The DEPUTY MINISTER OF BANTU DEVELOPMENT:

1. (a) Republic South West Africa
   (i) 595 54
   (ii) 340 18
   (iii) 7 7
   (iv) 38 7
   (v) 25 3
   (vi) 41 6
   (vii) 2 11
   (viii) - 19
   (ix) 7 1

2. (a) Republic South West Africa
   (ii) 72 1
   (iii) 710 732
   (iv) 1 (Student)
   (v) 10 (10 Students)
   (vi) 34 -
   (vii) 58 -
   (viii) 20 3
   (ix) 16 -

2/101
Full aid for new Black varsity

Political Staff

The University of Pretoria and the University of the Witwatersrand medical, dental and veterinary faculties will be closely associated with the new Black medical university to be established at Ga-Rankua near Pretoria.

This is clear from a statement issued by the Minister of Bantu Administration and Development, Mr M C Botha, following inquiries about the university.

The decision to build was announced earlier this week.

In his statement, Mr Botha said the University of Pretoria's three faculties would be asked to assist in the preparation of syllabuses and to provide lecturers, on loan if necessary. The University of the Witwatersrand would be involved in the same way. The two universities would be represented on the council of the new institution.

HOMELANDS

In addition, the three existing Black universities would serve on the new council and would assist with the training of first-year students.

The various homeland governments would also have representation on the council to ensure that the interests of all homelands were provided for.

Mr Botha also revealed that the new university would be a statutory institution. Empowering legislation would have to be introduced in Parliament.

INDEPENDENT

"In other words, it will be an independent institution with three faculties and will not be a branch of any other university," Mr Botha said.

Medical pupils would also serve as part-time lecturers as was the case in similar faculties.
Science Editor

Present-day medical education is not designed to provide optimum health service to a changing society and far-reaching changes are necessary if the situation is to improve.

This is the view of overseas health experts who are to be guest speakers at the Wits Medical Students’ Congress this week.

They are Professor J D E Knox, head of the department of general practice, University of Dundee, and Professor Moshe Prywes, on authority on medical education, of Jerusalem.

There was a new world emphasis on community and preventive health as opposed to hospital-based curative medicine, but up to now the knowledge and attitudes which students acquired were less appropriate for the provision of health care and preventive medicine within a community.

DEFECTS

Students were aware of the defects in their training and thus the reason for the conference which was entitled “The GP Dilemma,” Professor Knox said.

The specialist emphasis in student teaching sometimes “played hell” with diagnosis, he added.

For example, his students would probably not regard a stomach ache in the same light if asked to make a diagnosis by a psychiatrist and a gastroenterologist in turn.

DECLINE

Professor Knox said the explosion of medical knowledge in recent years had caused universities to abandon turning out one-all-rounders — the general practitioners — who were the most important members of the team providing primary health care.

The decline in general practitioners was further aggravated. They were paid less than specialists. The GP was also being increasingly excluded from hospital practice.

Therefore, doctors went into general practice, “by default rather than by intent.”

But with the new curricula and departments of community and family medicine being formed at many universities (both have been established at Wits), Professor Knox saw the GP of the future as a doctor prepared by his education for a tough job.

He would find professional satisfaction as an essential part of the total health team, including hospital doctors.
It was not the policy of the Department of Health or the Government to introduce a State-controlled national health service in South Africa, Dr James Gilliland said in Johannesburg yesterday.

Dr Gilliland, the co-ordinating director of health services in the department, was addressing the Wits medical students' conference.

He said health services would continue to be provided by two separate, but interrelated modes — private practitioners and the various health authorities.

Where these two modes existed side by side, the patient could decide which he wished to use.

"But I must also emphasise that the health authorities must organise their services in such a fashion that, on account of their presence and availability, no one shall be significantly financially embarrassed as a result of illness."

While a national health service was not envisaged, there was an increasing awareness that co-ordination of health services was long overdue. This could be done without diminution of the functions and responsibilities of each authority.

This had, in fact, been achieved by sharing physical facilities so that State, provincial and local authority provided a "one-stop" health service with each sector retaining its identity.

**HOMELANDS**

Outlining the development of health services in the homelands, Dr Gilliland said responsibility for comprehensive health services would gradually be transferred to the Black governments.

The first of these Homelands Departments of Health and Welfare was established in the Transkei in 1973 and in Bophuthatwana last month.

The Ciskei would follow in September, Lebowa, Gazankulu and Venda next year and kwaZulu in 1977.

Regular liaison between the South African and the homeland governments in health matters had been assured and highly technical services would be provided on request through such bodies as the Medical and Dental Council.

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**Science Editor**

A Black doctor outlined the frustrations he experienced practising in Soweto when he addressed the Wits medical students' conference in Johannesburg yesterday.

He said the Black patients could not afford to pay for treatment or medicines, private GPs could do little but provide "first aid" or refer them to Baragwanath Hospital.

Attempts by the private doctors to help provide total health care in Soweto in association with the hospital authorities had failed. They had been told there was no place for them.

The doctor said he had been asked by a Bantu Affairs official when he was going to leave town. He was not welcome in Soweto, although he had practised there for 18 years.

Asked where he should go, the official said: "Where you came from." (He was born near Pretoria).

The GP deplored recent moves by "orthodox" medicine to gain the co-operation of the witch doctor in the treatment of disease. It was because of the witch doctor's hold over the people that doctors often saw a patient only when his illness was far advanced.
The Body

5. Leave about six lines for the introduction. Write your three main points down leaving a few lines in between each.

4. Write your aim at the top of a clean sheet of paper.

3. What do these words say to you? What specifically do you want your audience to think and do at the end of your talk? Now, write the aim of your talk in one short sentence.

2. Working on a 5 minute talk, ring the three words you think are the most important on your list.

1. Take a piece of paper. Think about your subject. Jot down 20 to 30 words associated with it.

Horizontal Plan

- Final Arkham
- The Rocky Horror Picture Show
- The Blues Brothers
- Star Wars
- The Matrix
- The Da Vinci Code
- The Godfather
- The Godfather: Part II
- The Godfather: Part III
- The Godfather: Part IV

John Howard 17 23/2/17

Minister of Education
Bikitsa: Fight illness with food

UMTATA — Agriculture should be treated as a branch of medicine, the medical superintendent of the Butterworth Hospital, Dr C. L. Bikitsa, told students at the Tsolo College of Agriculture yesterday.

"With antibiotics and drugs I can only patch up sick people," Dr Bikitsa said. "But if you give me milk and meat I will wipe out tuberculosis in the Transkei."

Dr Bikitsa, who was guest speaker at the college diploma day, said he looked forward to the day when the beds in his hospital would be empty because diseases like tuberculosis, kwashiorkor, malnutrition and sepsis had been wiped out not by drugs but by good food.

He mentioned one disease, cancer of the gut, of which the Transkei had the highest incidence in the world. It had been shown that the cause was deficiency in certain trace elements, which resulted in diseased crops.

"Using fertiliser laced with trace elements we shall be able to produce maize which will not poison us."

Dr Bikitsa, himself a farmer, said land in the Transkei was static and unproductive, while the population was growing, although the Transkei had a wonderful climate and plentiful water. It should become the granary of Africa, exporting a massive surplus every year.

"The concept of an agricultural country which works three months of the year during the rainy season and rests back for the rest is so ludicrous I cannot imagine why we have allowed it to go on so long."

"This pattern will have to be changed. We will have to train agriculturists who will go out and motivate people to see the importance of agriculture."

The 31 final-year students at the college were all given their diplomas yesterday.

Mr Parnell said in his address, plans were afoot for expansion and complete rebuilding of the college. New classrooms were to be built soon, as well as a workshop.

The college would also have a soil-testing laboratory which would serve the whole Transkei.

Rainfall for the past season had been low, Mr Parnell said, and Tsolo had had only 385 mm, compared with the average 650 mm. As a result, the maize crop was down by about a third and grazing was scarce. — DDR.
About 5,000 extra hospital beds would be needed every year and another 6,000 doctors would have to be trained within the next 10 years if existing standards were to be maintained, Dr Johan de Beer, Secretary for Health, said in Johannesburg today.

At the jubilee congress of the Medical Association on "Health services of the future," he said that 4,000 of these doctors would be needed for hospitals. The other 2,000 were unlikely to fill the additional need outside hospitals. This lent greater urgency to the extension of medical training facilities, particularly for Blacks.

"UNFORTUNATE"

Dr de Beer called for a new, rationalised relationship between his department and the hospitals and health departments of the provinces and homelands.

The object was co-operation in the national interest, in contrast to the present "unfortunate situation which authority sought to gain as much as possible in terms of sectional interests and autonomy."

The rationalisation he sought would not affect the autonomy of the homelands' departments of health.

Dr de Beer stressed that he was not seeking unification of the different health and hospitals authorities, but co-operation between them.

"AN EPIDEMIC"

There were, however, some aspects which so closely overlapped or were so delicate that a centralised structure and control was indicated.

Additional medical training facilities were urgently needed, particularly in respect of the Black population, said Dr de Beer, who outlined specific health areas in which targets had to be set and programmes devised. These included:

- Tuberculosis, which was running at epidemic rates;
- Malnutrition, in which milk powder schemes and enrichment of meals were called for;
- Family planning, in which big thinking and effective action were needed to create a national network of services;
- Psychiatric services, in which outpatient and community services would reduce the number of inpatients.

A medical look ahead

Science Editor

Professor Phillip Tobias today gave a prediction of man, society and medicine 50 years from now.

In summary, he said, the goal of medicine of 2028 would be survival of the whole species of man, not only as an individual, or as a society.

Professor Tobias, Witwatersrand anatomist and physical anthropologist, was addressing the opening session of the 50th congress of the Medical Association of South Africa in Johannesburg.

SCHOOLS

This is how he sees mankind and medicine of the future:

- If present trends continue, the world population will be 10,000 million, and 5,000 medical schools will be needed. Africa alone will need 750, as against the present 41.

- South Africa — already lagging behind international optimum standards with only six medical schools — will need 45.

- It may be assumed that inadequate standards, will still be a feature of the less-developed world, as they are today.

- The world will still be carrying an enormous burden of preventable disease in the "inade-
Medical care in South Africa is at a 'crisis point' and fundamental changes to the entire system are imperative if the needs of society are to be met, says the President of the Medical Association, Dr Jonathan Gluckman.

In his presidential address at the official opening of the association's jubilee congress in Johannesburg last night he said: "I believe that we as a profession have failed to play an adequate role in the health service to the people as a whole."

Dr Gluckman said it was difficult to see how a tremendous shortage of doctors and paramedics could be met in the next 20 years. To meet it, the patterns of medical education should be reconsidered. Preventive and promotive health and nutrition problems must come much more to the fore.

PERSPECTIVES

Present teaching tended to emphasise specialisation, the esoteric rather than a direct, positive involvement in health. Doctors must also acquire proper perspectives of their function and responsibility in society - an aspect to which students, with rare exceptions, were not being exposed.

Dr Gluckman said doctors would have to accept compromises in the face of the shortage of staff "no matter what our historic attitudes have been."

At present they routinely performed many tasks which could be handled better by people trained less broadly but more intensively.

He referred to the training of anaesthetists' assistants and said he believed this development inevitable. "We have no hope of providing sufficient doctors in the short time available to us to put our medical services on a better footing. I believe it inevitable that we shall have to use partly trained people - watchmen, or so-called 'barefoot doctors' - to serve large sections of our population, and I believe this is of pressing urgency."

With few exceptions, To Page 2, Col 5
Havemann's call on equal pay

PIETERMARITZBURG—The Administrator of Natal, Mr. Ben Havemann, has asked the Minister of the Interior, Dr. Connie Mulder, to bridge the wage gap between Black and White medical staff.

And Natal’s MEC in charge of hospitals, Mr. Frank Martin said yesterday: "If the Government gave us the money we would give Black medical staff equal pay now."

And the Minister of Health, Dr. Schalk van der Merwe said in a telephone interview last night that the Cabinet was committed to narrowing the wage gap for Black medical workers. "Parity in wages will eventually be reached," he said, but he would not expand.

In a letter to Dr. Mulder, the Administrator, acting on instructions from Exco, said Natal supported the elimination of the wage gap and he asked for Dr. Mulder's comments.

Natal has for years fought the other provinces represented on the Medical Co-ordinating Council for higher pay for Black medical staff.

The council considers wage recommendations for civil servants made by the Public Service Commission. "There is nothing legally stopping us from paying equal salaries. It would mean breaking the council agreement on wages, and we would do this if we had the money," Mr. Martin said.

"We just haven’t the revenue to start paying them equal salaries. Our provincial subsidy is calculated from the salary recommendations made by the Public Service Commission and there is nothing we can do about it."

"We believe that people with equal qualifications and responsibilities should be paid the same," he said.

The Durban City Council recently reversed a decision on Black doctors’ wages and agreed to pay equal salaries.
Sex clinics plan in city

Science Editor
The establishment of clinics to help people with sexual problems at Johannesburg hospitals, particularly the General and the Strijdom, is being considered.

This was announced today by Professor L. A. Hurst, head of the department of psychiatry at the University of Witwatersrand, at a sex therapy "workshop" conducted as part of the jubilee congress of the South African Medical Association.

The lecturer was Dr. Doreena C. Renshaw, University of Cape Town graduate, director of the sexual dysfunction clinic and associate professor of psychiatry at Loyola University of Chicago. The object of the proposed clinic, Professor Hurst said, would be to enhance marital happiness. The advice of Dr. Renshaw was being sought in their introduction.

Dr. Renshaw said it had been estimated that half of the married couples in the United States suffered from some form of sexual dysfunction, and from her experience many in South Africa were similarly affected.

"Anyone who expects to find Hollywood, Playboy type of sex in marriage will be disappointed. Sexual harmony has to be worked for," said Dr. Renshaw.
'Disease of human relations'

Cape Times Correspondent

GENEVA. — An open attack on apartheid and public health in South Africa has been made in a publication of the World Health Organization.

The article is entitled "The disease of human relations." It was written by Thomas J. Gray, who is described by the WHO as a South African writer living in Europe.

The article says: "South Africa today has one White doctor for every 400 Whites, one Indian doctor for every 500 Indians, one Coloured doctor for every 6,200 Coloureds, and one African doctor for every 44,000 Africans."

"Given the shortage of Black doctors, medical training facilities for non-Whites should, logically, be extended. In reality, Africans find it difficult to study medicine and are effectively barred from all but one medical school."

ETHNIC ORIGINS

"Health professionals with identical qualifications and skills receive differing rates of pay, based on their ethnic origins:"

"When the country's Medical Association protested, it was given official assurances that the salary gaps between Black and White would be reduced. In fact, they have increased."

"Low incomes and living standards for Blacks, who form 70 percent of all South Africans, leave them vulnerable to disease. More than 68,000 died from tuberculosis in one year compared to 324 Whites — who form about 15 percent of the population. Because malnutrition is a major problem for the Black majority, babies in the African homeland reserves are reported to have only a 50 percent chance of reaching the age of five."
Too much sickness among Africans—

Professor

Staff Reporter

PROFESSOR H. Sefef, professor of African Medicine at the University of the Witwatersrand, said yesterday there was far too much sickness among Africans.

He was speaking at the jubilee congress of the South African Society of Physiotherapy at the Institute for Medical Research in Johannesburg.

He said there was no precise figures for disease among Africans, but there was no doubt a good deal of sickness. He pointed out that in the rural homeland areas the infant mortality was 146 in every thousand people. The figure for the rest of South Africa was 20 in every thousand.

**SURVEY**

Prof Sefef said one survey in the Transkei showed that eight per cent of adults X-rayed showed some evidence of tuberculosis.

In the urban areas hygiene among Africans was higher, but the incidence of malnutrition and other infections was still too high.

Even in the cities the incidence of diseases among Africans was still four times that of Whites.

Africans in cities were plagued by disorders associated with the Western way of life, "or better, the Western way of death".

In some cases Africans suffered more from these diseases than Whites. These included high blood pressure and strokes, and heart and kidney failures.

Hypertension was the principal cause of death among Africans in Johannesburg, he said.

The deplorable lack of amenities and outlets for Africans left two avenues open to them—sex and drink. Sex resulted in the spreading of gonorrhea and illegitimate babies.

Tobacco and alcohol swelled the major proportion of the city African's income, he said. The consequences were that the worker's family suffered poverty, especially among migrant labourers.

**FACTORS**

Social and economic factors were the root cause of disease, including the maladministration and inequality of income, schooling and housing.

The bulk of the suffering was among Africans, but the medical services were concentrated on Whites. Most of the disease was in rural areas, while most of the doctors lived in the cities.

In the homelands, with a population of about eight million there was only one doctor for every 14,000 people, said Prof Sefef. Compared to this there was one doctor for every 400, Whites.
National health ‘to be major issue’

Staff Reporter

THE major issue of the next general election will be the introduction of a national health service, predicted Professor C. Searle, head of the Department of Nursing at Pretoria University, yesterday.

Professor Searle was speaking at the jubilee congress of the South African Society of Physiotherapy which opened at the Institute for Medical Research in Johannesburg yesterday.

Professor Searle said leading figures in the medical profession were pointing to failure in health services, and that State intervention would soon be necessary.

“An average citizen has to go to the private sector for his medical needs, and cannot enjoy the state services which he pays taxes for.

“Health is rapidly becoming a luxury for White citizens, and their demands will make the introduction of a national health scheme a burning issue at the next election.

Professor Searle said a comprehensive health service for Blacks was already a “fait accompli”, but that the needs of Whites were not being looked after. She stressed the need for combining private services with a comprehensive State health service which would improve the quantity and quality of health services and suit the pocket of the middle class.”
Patients 'in the wrong hospitals'

Science Editor

Many patients being treated in general hospitals should not be there at all but should be in rehabilitation hospitals where they could be treated more efficiently and economically, an orthopaedic surgeon said at the physiotherapy congress in Johannesburg yesterday.

The trouble was that the number of rehabilitation programmes worthy of the name could be counted on the fingers of one hand, he said. Many more were urgently needed.

The establishment of separate rehabilitation centres was economically sound. At present the chronic sick requiring rehabilitation received highly skilled nursing care and attention in acute diseases hospitals — "five-star breakfast-in-bed service" — which, apart from wasting skilled nursing, denied the patient the opportunity to become independent.

The number of patients who required rehabilitation was enormous. Also enormous in terms of time and money was the cost of not providing care.

What was needed was effective legislation. Rehabilitation was to become really effective, the surgeon said. On any rehabilitation programme today it might be necessary to deal with as many as seven different government departments, each with an apparent interest in the patient’s welfare.

This "nursing intensive oxwagon" was inherited by the present government and it was high time that it was replaced by a "1975 model" with an intern combustion engine.

The solution appeared to be that rehabilitation should be handled by single portfolio, only then would it prosper.
The Argus Correspondent

PRETORIA. — The Minister of Health, Dr S. W. van der Merwe, has suggested that the South African Medical and Dental Council conducts an inquiry into professional malpractices.

Addressing the first meeting of the council in its newly constituted form, the Minister warned that:
- The medical profession was becoming increasingly materialistic.
- The number of cases of malpractice was rising out of proportion to the numerical increase in doctors.
- Relations between doctors and pharmacists needed urgent attention.

Dr van der Merwe said the composition of the council had been changed to meet changing demands, but the council itself had been evenly divided on whether it should be increased or reduced in size.

GOING WRONG

A problem of primary concern was the image of the profession. The traditional doctor-patient relationship was being eroded, and in the eyes of the public, the profession was becoming more and more materialistic.

The Minister said the increasing number of disciplinary investigations was becoming a source of concern. It appeared that the number of cases of malpractice was rising disproportionately and that somewhere something is going wrong.

"I am forced to ask myself whether this time has not come to use the disciplinary powers of the council," the Minister said.
Doctors seen as too greedy, says Minister

Staff Reporter

THE Minister of Health, Dr Schalk van der Merwe, warned doctors and dentists yesterday that the public believed they were becoming "more and more" materialistic.

Addressing the first meeting of the newly elected South African Medical and Dental Council in Pretoria, the Minister said the image of the profession in the eyes of the community had become a problem of primary concern.

"In this matter we will have to be entirely realistic. In South Africa the medical and dental professions have developed in a way which in the scientific field deserves admiration nationally and internationally."

In the process of this development, however, "something somehow got lost" and this was damaging the image and status of the profession.

The traditional doctor-patient relationship was in the process of serious erosion.

The council, Dr Van der Merwe said, would have to give increasing attention to the profession's materialistic image.

Dr Van der Merwe said another serious problem was discipline.

The increasing number of disciplinary investigations was becoming a source of concern. It appeared that the number of cases of malpractice investigated was rising out of proportion to the numerical increase of practitioners.

The only conclusion is that somewhere something is going wrong.

"I am forced to ask myself whether the time has not come for the council to undertake an inquiry to determine the causes of this phenomenon."

The medical association was doing its utmost to maintain self discipline in its own ranks. The association however had no statutory powers.

The new Act made provision for people outside the council to be involved in its work, and it was now possible to establish a more active co-operation with the association.

Another aspect demanding urgent attention, Dr Van der Merwe said, was the relationship between the different professions and the maximum utilisation of all registered persons.

The pharmacetical profession was dissatisfied because doctors dispensed in competition with chemists and even entered the marketing field, and doctors were dissatisfied with the so-called "courier prescribing" by chemists.

Chemists were particularly dissatisfied with the control exercised by doctors over the medicines they handled.

Dr Van der Merwe pointed out that the two professions were supposed to work together in the interests of the patient.

They should act jointly to encourage a more harmonious relationship between the doctor and the pharmacist, the Minister said.

Professor H. W. Snyman, Dean of the Medical Faculty of the University of Pretoria, was yesterday re-elected president of the South African Medical and Dental Council.
Munnik calls for Coloured birth control

THE Coloured population of the Cape would have to co-operate with the Provincial Administration by practising family planning if they hoped to have facilities equal to those given to Whites, the Administrator, Dr L. A. P. A. Munnik, said today.

Speaking in the Budget debate in the Provincial Council, he said the myth that the Government encouraged family planning to depopulate Black populations was the biggest nonsense ever.

The Government was concerned with the welfare of the Coloured people, but if it could not afford to cater for the population explosion, he said, He called on Coloured leaders to encourage birth control among their own people. Only in this way could the shanty-towns of the Cape be eliminated.

Referring to an Opposition call for the elimination of influx control, Dr Munnik said the Coloured migration to the Peninsula showed what could happen without this sort of control.

Influx control was not an ideology but an economic necessity. People poured into the Peninsula area to live in shanties without jobs or income, and this had to be curbed.

Referring to a call for equal wages for Black and White teachers and medical staff, he said this was not a new idea and the principle had been accepted by the Administration.

**SALARIES**

However, it could not be put into effect overnight. If you say we must put everyone on equal salaries tomorrow, South Africa could not afford it.

"Attack us if you think we are not doing it fast enough," but realise that we cannot do it overnight. The Whites, the Coloured and the Africans know this," he said.

Coloured nurses in South Africa received higher wages than White nurses in Britain and African nurses received higher wages than nurses anywhere else in Africa.

The effect of equal wages on inflation should also be considered, Dr Munnik said.

A top-level Cabinet committee had been appointed to look into the financial problems of small municipalities following discussions he had had with the Government.

However, all South African municipalities would have to be prepared to tighten their belts in view of the expenditure...
Dental chief slams the Minister

SUNDAY TIMES REPORTER

THE PRESIDENT of the Dental Association of South Africa, Dr H. van Rensburg, has sharply attacked the Minister of Health for his call this week for an urgent inquiry into gross misconduct in the medical profession.

"I cannot allow these incredible unsubstantiated Press statements to pass without comment," he said.

"These statements refer to greediness, dishonesty and materialistic and un-disciplined behaviour by members of my profession."

Only two disciplinary inquiries relating to dentists had been held by the Medical and Dental Council in the past year. One of these inquiries had related to a dentist of 80 who had moved premises and had failed to inform his patients of the right address.

Dr Van Rensburg said that if these two cases were related to the services rendered by the 1,800 dentists in South Africa then the call for an inquiry was totally unjustifiable.

At the inaugural meeting of the new Medical and Dental Council in Pretoria this week the Minister of Health, Dr Schalk van der Merwe, said that instances of misconduct in the medical profession were increasing disproportionately to the numbers of those qualifying.

"The only conclusion that can be reached is that something serious is happening in the medical profession," said Dr Van der Merwe.

On the question of tariffs, Dr Van Rensburg said that the dentists had opted out of the medical aid schemes because these had allowed for an increase of only 12 per cent over seven years. A system of tariffs had been devised by the Medical and Dental Council and agreed to by his association.

This system included measures to hold practitioners responsible for "unrealistic charges in excess of this tariff". In cases where these had not been discussed beforehand with patients.

Dr Van Rensburg said that the only guarantee of payment by medical aid societies was payment of the restricted amounts up to the amount of benefit allowed by the societies.
Soweto heart disease rate ‘formidable’

The Argus Bureau

LONDON.—An extraordinarily high rate of heart disease among schoolchildren in Soweto has been blamed chiefly on overcrowding and poverty there, in a survey published in the latest issue of the British Medical Journal.

The survey found that in one age group about 20% out of every 1000 children suffered from rheumatic heart disease. The researchers conclude: ‘The socio-economic status of the community must be improved if optimal prevention is to be achieved.’

Yet, they say, the survey figures do not represent the full extent of the problem in the Black townships near Johannesburg. The survey was conducted among schoolchildren, a relatively privileged group, and rheumatic heart disease would be more prevalent in poorer children who do not attend school.

Widespread rheumatic heart disease is usually associated with impoverished communities. The incidence of the disease has been declining throughout the world with the emergence of wealthier societies.

**FORMIDABLE**

The researchers say the disease remains a formidable health challenge in South Africa in spite of the declining incidence in other economically advanced countries.

It would take a long time for conditions in Soweto to improve sufficiently and so the survey calls for a comprehensive preventative campaign.

The cost of instituting and maintaining such a campaign, it claims, would be less than the cost of treating sufferers in hospitals.

In all, 12,000 children from 2 to 18 years were tested between May and September 1972. The disease was found in 5.9% out of every 1000.

The rate is much higher in older children. The incidence in the group from 6 to 18 years old was 7.1 in every 1000.

The highest figure in a comparable survey was a rate of 5.3 in 1000 in the Rocky Mountains in the United States. That survey, however, was conducted between 1956 and 1961 among predominantly 15-year-olds.

Other comparisons given reveal an incidence of 3.8 in 1000 in Japan nine years ago; 1.4 in Northern India; 1.7 in Denver, U.S.; and 1.0 in Barbados.

A survey five years ago among 500 children in one school in Teheran, Iran, showed a rate of 22 in 1000.

The Soweto rate of 19.2 in 1000 was found in children in the seventh school grade. The age group of highest occurrence was 15 to 18 years, and girls were slightly more susceptible than boys.

Of all the children found to be suffering from rheumatic heart disease, 82.5 percent it was the first diagnosis.

The most prevalent contributing factor to the high rate of the disease in Soweto, in the view of the researchers, was overcrowding. Families of eight children recorded an incidence of nearly 15 in 1000.

The survey was conducted by 10 senior cardiologists representing several medical institutions in South Africa, including the Department of Medicine at the University of the Witwatersrand and the Johannesburg General Hospital.

CHRISTIEAN
The pesky mosquito has got man licked. A full-scale war lasting 20 years has failed to eradicate the menace of the flying carrier of disease.

The World Health Organisation, in a frank admission, says that every little gain that has been made will be lost for ever unless man makes a greater effort immediately.

This year, in Africa alone, one million children will die of malaria, the W.H.O. estimates.

Underestimated

Despairingly, a survey made at the end of the 20-year campaign says: "W.H.O. was under the illusion that eradication was possible in practice. But this way to underestimate such major stumbling blocks as the impracticability of an international organisation acting as a substitute for the absence of a national medical infrastructure."

Which means, in simple language, that if a country's own health organisations don't fight the war against mosquitoes, nobody will.

W.H.O., as an unknown and untrusted foreign body, found it hard to get anything done in underdeveloped countries.

They couldn't convince the natives of the need to move their furniture out of their homes while the walls were sprayed, for example.

That is one of the basic essentials of the mosquito war, because the mosquitoes, after tanking up with blood from a sleeping human, settle on these walls.

Down drain

It has cost about R105-million to take on the mosquito in its serious battle, and it looks like R105-million down the drain.

Malaria is on the upsurge again in Africa, India, Pakistan, Sri Lanka and Thailand, for a start.

W.H.O.'s survey highlighted another lamentable aspect of the losing battle by pointing out that it was the small of victory that, paradoxically, contributed to failure.

"All too often the marked progress that had been made in mosquito eradication hulled national health authorities into a false sense of security," it said.

"They have relaxed their efforts ... and malaria has re-established itself."

So be on guard. Do your bit, little as it might be. Next time you see a skeeter, donder him!
Focus on dental health

EAST LONDON — The Dental Association of South Africa is aiming to reach every single primary school teacher in the Republic and South West Africa during their annual dentistry health week which begins next week.

Their motto will be "plaque, the tooth enemy," and their aim will be to discipline children in the correct and regular ways of brushing teeth.

The South African Medical Journal points out that dental diseases could be eliminated if teeth were brushed regularly and in the correct way, and if dental floss was used to clean between the teeth where the brush could not penetrate.

According to a dental surgeon in East London, 90 per cent of school children were in need of dental care.

"If they were taught self-discipline in caring for their teeth, the percentage of tooth decay would most certainly drop," he said.

The doctor said the programme would explain that it took 24 hours for bacteria to organise in plaque to produce acids and toxins which were responsible for two major dental problems, caries and periodontal disease, and that the aim of all dentistry was to remove the plaque.—DDR.
A poolside risk of cancer

Science Correspondent

SWIMMING pool owners who use the chemical known as OT for testing the chlorine in the water are exposing themselves to the risk of developing bladder cancer in later years.

Local experts — they included a professor at the University of Natal Medical School, a consulting chemist and a manufacturer of pool chemicals — were unanimous in their recommendations.

OT should be treated with caution; a glove or some other protection should be worn when shaking the tube and clear labelling is desirable, they said.

A recent report from the U.K. Government's Health and Safety Executive said that OT — its full name is ortho tolidine — is linked with bladder cancer, with an interval of as long as 40 years before the disease develops after exposure.

In the very few British factories licensed to use OT, strict regulations are enforced, with compulsory urine tests twice a year.

The U.K. concern arises from the fact that factory regulations do not apply to pool owners.

The Durban experts were all agreed that the fact that OT was very dilute by the time pool owners used it did not necessarily make it any safer to use.

OT kits used in this country sometimes have a cancer warning printed on them, but many do not.

The pool chemical manufacturer said that an alternative was available called DPD, which carried no cancer risk.

"But it would cost the pool-owner about R60 a kit instead of R4 that the OT outfit costs him," he said.
Black medical varsity planned

Mercury Correspondent

PRETORIA—Draft legislation is being prepared for the establishment of a university at Garankuwa for the training of African doctors, dentists and veterinary surgeons, the Minister of Bantu Education, Mr. M. C. Botha, said in Pretoria yesterday.

Attention would also be given to training for certain auxiliary health services.

The Minister said the university would be an autonomous institution, and it was intended to work closely with the universities of Pretoria and the Witwatersrand.

For training, the university would make use of the Garankuwa Hospital which would form an integral part of the university in which its control would be vested.

In this respect the Minister said the university would be unique in South Africa.

Mr. Botha said because the purpose was to train students from the ranks of all the African population groups, and the specialised nature of the training, it was essential that the proposed medical university should have the cooperation of all State departments concerned, the homelands Governments, the three existing African universities as well as the neighbouring universities of Pretoria and the Witwatersrand.

"It goes without saying that the homeland Governments would have to be involved in the university."

The Minister said arrangements had been made with the University of Pretoria to obtain the expert assistance of Professor H. W. Snijman, Dean of the Faculty of Medicine. He would act as chief adviser in setting up the medical university.

Mr. Botha said Prof. Snijman had extensive knowledge and experience and as an acknowledged expert had served in various commissions of inquiry. He
African medical university planned

Staff Reporter

Draft legislation is being prepared for the establishment of a university at Ga Rankuwa, near Pretoria, for the training of African doctors, dentists and veterinary surgeons, the Minister of Bantu Education, Mr M. C. Botha, said in Pretoria yesterday.

Attention would also be given to training for certain auxiliary health services.

The Minister said the university would be an autonomous institution and to ensure academic standards it was intended it would work closely with the universities of Pretoria and the Witwatersrand.

The university would make use of the Ga Rankuwa Hospital which would form an integral part of the university.

In this respect the Minister said the university would be unique in South Africa.

Mr Botha said because the purpose was to train African students and because of the specialised nature of the training, it was essential that the university should have the cooperation of all State departments concerned, the homeland governments, the three existing African universities as well as the neighbouring universities of Pretoria and the Witwatersrand.

"It goes without saying that the homelands governments will have to be involved in the university."

It was intended that first-year training would initially be undertaken at the three universities for Africans and that the medical university would provide training from the second year.
No race bias in SA Red Cross—report

Own Correspondent

GENEVA — There is no evidence that the Red Cross Society of South Africa practices racial discrimination, according to a report by the deputy secretary general of the League of Red Cross Societies.

The report, by Mr Bertil Pettersson, is the 18th item on the agenda of the annual meeting of the league’s board of governors, being held in Geneva from tomorrow to Saturday, November 1.

Mr Pettersson, Swedish-born but now a Mexican national, based his report on a personal visit to South Africa.

He was instructed to go as the personal representative of league secretary general Mr Jose Barros, as part of the programme adopted in 1973 “against racism and racial discrimination.”

His report to the board of governors is expected by officials of the league, which has 90 member Red Cross, Red Crescent and Red Lion societies, to remove pressure from some of them for the expulsion of the South African Red Cross.

The league also made it clear that it firmly opposes any expulsion action by moving the board of governors meeting to Geneva from Rabat. The Moroccan Government said it would refuse visas to South African Red Cross officials and the league promptly stated that this would violate its fundamental principle of universality.

Mr Pettersson’s report said in part:

“I made a study of the (South African) society’s constitutional documents, i.e., their memorandum (mandates) and articles of association. In neither of these documents could I find any reference to race or colour.

“It is quite clear that any member of any race, and for that matter of any age, sex, religion or political conviction, may legally become a full member of the society and will thereupon be entitled to full participation in its affairs.

“The society owns 78 ambulances and one aircraft which is used exclusively for ambulance purposes. These services are available to all races and are provided free of charge. Donations in reimbursement are accepted from those who can afford them.

“The society provides bursaries from an established fund for the postgraduate training of nurses. During the past five years 36 of the 40 bursaries granted were to Blacks.

“The Geneva Conventions, printed in English and Afrikaans, are used in schools for all races. To promote teaching, the society has now translated this pamphlet into Xhosa and Zulu, the languages of the two main Black ethnic groups in South Africa.”
City's new MOH

ARGUS 31/0/75

DR R. J. COOGAN, Cape Town's new Medical Officer of Health, believes in the face of 'a daunting challenge' - 'that we will succeed in developing in South Africa a comprehensive community health service second to none in the world today.

The Minister of Health, Dr S. W. van der Merwe, has approved Dr Coogan's appointment. He takes over as MOH at the end of November when Dr R. M. Langerman retires. Dr Coogan has been Deputy MOH since 1972.

He said yesterday the city's health services were undergoing complete reorganisation to meet present challenges.

DISEASES

This included consolidating advanced in the control of killer child diseases, controlling food, water and sanitation services and maintaining maternal and child welfare services 'to the point where infant mortality and maternal mortality are reduced to the minimum.'

Cape Town provided an 'interesting and challenging' microcosm of world health.

'We have both a developed society and an under-developed society.'

On one hand, said Dr Coogan, there was an increasing death rate due to heart and circulatory diseases, cancer and the 'stress syndromes.'

On the other hand were the old socio-economic enemies of malnutrition, tuberculosis and the population explosion. Venereal disease was also on the upsurge in all groups.

POLUTION

But there was another facet: 'Modern life poses a new awareness of environmental pollution, air pollution, noise pollution, and the possibility, in the not too distant future of pollution by nuclear radiation.'

Dr Coogan said the city's health service would aim at closer cooperation with the Provincial Hospital Service and the Day Hospital Commission.

'This is necessary to provide a cohesion between our preventive services, the curative services of the hospitals and a rehabilitative service which has still, largely, to be developed.'

Dr Coogan qualified at the Royal College of Surgeons in Ireland in 1944 while serving with the Army Medical Corps, and served for eight years in the merchant navy.

In the early 1950s he developed a hospital and a series of casualty clearing stations in an Arabian oil field being developed by American magnate Jean Paul Getty. He also looked after the oil multimillionaire in America and Europe.

HOSPITAL

He was appointed Medical Officer of Health to the Government of Jamaica in the mid-1950s and came to South Africa in 1960 as senior medical officer at the Chamber of Mines Chest Hospital near Johannesburg.

Dr Coogan came to Cape Town in 1967 as medical superintendent of the Brooklyn Chest Hospital, and in 1970 became superintendent of the City Hospital.

At the same time he was senior lecturer in infectious diseases at the University of Cape Town. He became Deputy MOH in the city in 1972 and in May this year was admitted a Fellow of the Royal Society of Health.

Dr Coogan is married and has four children. He has been a keen boxer and fencer, and is three times a national sabre champion and finalist for the British and Empire Open title.

He gave up rugby after a game on stony Kenyan ground at the age of 34.

'I spent the following 10 days treating the other members of the team, and myself, for multiple injuries,' he said.
Health crisis hits Durban

 Own Correspondent

DURBAN — Durban's municipal health service is nearing breakdown point with the city paying some of the lowest salaries in South Africa and smaller authorities in Natal attracting away staff with offers of better pay.

Astounding figures released today by the chairman of Durban City Council's health and housing committee, Mr. Clive Herron, show that the third largest city in South Africa is at the bottom of the money ladder, resulting in a critical shortage of medical officers, health inspectors and community nurses.

Of the 31 health inspectors trained by the city last year, more than half have already left for better paid posts.

The shock figures have been released a few days after a special council meeting to consider the situation. Members heard a report by Durban's medical officer of health, Dr. Colin MacKenzie, that the critical manpower shortage would leave the city unable to cope with an outbreak of epidemic disease.

A Government circular instructing local authorities to cut back on spending and putting a freeze on employing more staff has dashed hopes of relieving the crisis.

Mr. Herron said today: "This has caught us at a time when we have the most vacancies."

Among the vacancies are two for assistant medical officers of health, one senior clinical medical officer and four clinical medical officers.

R3,000 LESS

There are 11 vacancies for health inspectors. At present the maximum number of these posts is 67, but Mr. Herron believes that the figure should be 158, as Durban is a large industrial, residential and holiday area.

A chief health inspector in Durban is getting R3,000 less than his opposite number in Johannesburg, R3,000 down on Pretoria and R1,000 lower than in Bloemfontein.

But many inspectors did not have to go so far afield for better money. Smaller local authorities in Natal, such as Stanger, Greytown and New Germany, have attracted away staff with offers of R100 a month more plus fringe benefits.

Another section of the service to suffer is the community nursing. At the moment there are 66 community nurses working in Durban — one for every 12,000 of the population.

Mr. Herron reckons the city should employ about 200 of these nurses. Home visits over the last four years have dropped from 83,000 to 43,000.
Change of life-style could beat disease

Own Correspondent
CAPE TOWN — Some diseases caused by modern man's life habits could be prevented "by radical changes in our way of life such as altering our eating habits, and by withdrawing ourselves from the environment of city life and occupational exposure," according to Professor A. J. Brink, president of the South African Medical Research Council.

He said research had shown in part that such changes could prevent some diseases, but "the practice of this knowledge might make life hardly worth living." Medical research today must fight disease by defining its cause and removing this if feasible. Research must furthermore provide in-depth knowledge so that in cases where it was not feasible to remove the cause researchers could change or defeat its effects.

"We are more and more in need of in-depth knowledge in order that we may enjoy life," Professor Brink said.

"Therefore it is likely that research in all fields would become more sophisticated and require more trained researchers," 89.
Marburg: SA woman’s role

Science Editor

The top role a Johannesburg woman doctor played in containing the serious outbreak of Marburg disease in Zaire in October was disclosed today.

Another strictly kept secret, now also revealed, is that she contracted a disease similar to Marburg virus disease and was, in fact, in the Johannesburg Fever Hospital until recently.

She is Dr. Margaret Isaacson, head of the epidemiology department of the South African Institute for Medical Research, and a world expert on epidemic diseases.

Dr. Isaacson was a prominent member of the team which dealt with the Marburg cases in Johannesburg last year. When the outbreak in Zaire occurred, she was asked to go there with serum — the only form of specific treatment — taken from the two Johannesburg patients who recovered.

DEATH TOLL

The disease broke out in the north of Zaire and exacted a heavy death toll.

When Dr. Isaacson arrived there, she found a frightening situation. Practically everyone, who had been handling or nursing the patients in hospital, was dying of the disease, which has a mortality rate of some 95 percent.

Without thought for her own safety, she began treating the patients and teaching the staff how to handle them without getting the disease themselves.

"We tried to locate the contacts of patients in an effort to bring the epidemic under control," she said today. "If the disease had spread beyond the hospital into this city, 1 million people. I don't know what we would have done."

Dr. Isaacson was a member of a 50-member inter-
Medicine: Blacks lose school

Own Correspondent

DURBAN.—White medical students will be admitted to Durban’s Black medical school within the next few years following the Cabinet’s decision to phase out African—and later Indian and Coloured—students at the school.

A new medical school for Africans is being built by the Government at Groote Schuur Hospital near Pretoria and Indian and Coloured medical schools are likely to be established at the Durban Westville and Western Cape universities.

These facts emerge from the Cabinet’s announcement last week to Natal University’s Medical Faculty not to admit last-year African students as from next year.

The Dean of the Faculty, Professor P. H. C. Bollom, has issued a statement condemning the decision and opposing the institution in its present form.

And last night Dr. Batchelor, president of the Natal Coastal Branch of the Medical Association of South Africa, said:

“There is little doubt that in the next few years Whites will be admitted to the Durban medical school—but at a price.

‘The price will be the phasing out of Black students in line with the Government’s policy of separate development.’

Dr. Batchelor said the Cabinet’s instruction to close the school to African first-year students in 1977 and second-year students in 1978 meant the end of the only Black medical school in the country at present.

‘The Cabinet’s decision has come as a great disappointment to most of the staff of this medical school who enjoy a good reputation both here and overseas,’ he said.

He added that there had been indications for about a year that Blacks would be phased out of the school.
TOESPRAAK GELEWER DEUR SY EDELE DR. SCHALK VAN DER MERWE, MINISTER VAN GESONDHEID, TYDENS DIE JAARLIKE DINEE VAN DIE WORCESTER AFDELING VAN DIE KAAPSE WESTELIKE TAK VAN DIE MEDIENSE VERENIGING VAN SUID-AFRIKA IN DIE KERKSAAL VAN DIE WORCESTER OOS N.G.-GEMEENDE, WORCESTER OP VRYDAG 28 NOVEMBER 1975 OM 21H00.

EMBARGO VRYDAG 28 NOVEMBER 1975 OM 21H00.

MR. PRESIDENT, COLLEAGUES, LADIES AND GENTLEMEN, AS REQUESTED BY YOU, I GLADLY ACCED TO YOUR WISH TO EXCHANGE SOME THOUGHTS ON THE SUBJECT "PRESENT PRIORITIES IN HOSPITAL AND MEDICAL CARE FOR THE COLOURED PEOPLE OF SOUTH AFRICA."

VIR MY AS GENEESHEER EN MINISTER VAN GESONDHEID EN VAN KLEURLINGBETREKKINGE, IS DIT DUIDELIK, UIT HIERDIE ONDERWERP WAT U GEKIES HET, DAT DIE MEDIENSE PROFESIE EN IN BESONDER HIERDIE TAK VAN DIE MEDIENSE VERENIGING, INTIEM EN DIEPGAANDE BELANGSTEL IN DIE WEL EN WEE VAN ONS BEVOLKING, IN AL SY SKAKERINGS EN OP ALLE VLAKKE.

SUID-AFRIKA IS 'N DINAMIESE LAND MET 'N GROEIENDE EKONOMIE EN ALHOEWEL DAAR TANS 'N INFLASIE PROBLEEM IS, IS EK OORTUIG DAARVAN DAT MET ALMAL SE HULP EN SAMEWERKING DIT SLEGS TYDELIK VAN AARD IS, OMDAT ONS GROOTSTE BATE IN DIE GEHALTE VAN ONS BEVOLKING AS 'N GEHEEL LÊ.

DIE VERSKILLENDE BEVOLKINGSGROEPE, BLANK, KLEURLING, ASIËR EN SWART, IS IN STAAT OM HULLE PROBLEME, VAN WATTER AARD OOKAL, AFSONDERLIK EN OF GESAMENLIJK OP TE LOS, IN DIE GROEPSBELANG, ASOK IN DIE BELANG VAN DIE LAND AS 'N GEHEEL.

DIT SYNDE SO, IS DIT VAN OORHEIDSWEË NOODSAAKLIK DAT DIE MEGANISME, DIE INSTRUMENTE EN DIE FASILITEITE GESKEP WORD OM AAN ELKE BEVOLKINGSGROEP DIE GELEENTHEID TE BIED OM SY GEHALTE STEEDS TE VERBETER EN DAARDEUR HOMSELF TE DIEN EN

DEUR/....
DEUR SY DIE BEDIEN TE WORD OP SOVEEL VLAKKE AS MOONTLIK.
DIT VORM IMMERS DIE HOEKSTEUN VAN DIE BELEID VAN AFSONDERLIKE
ONTWIKKELING. DEUR HIERDIE BELEID SO TOE TE PAS, SAL ONS
TOEKOMSTIG STERKER BEVOLKINGSGROEPE VERSEKER, WAT VIR SUID-
AFRIKA VAN ONSKATBARE NASIONALE EN INTERNASIONALE BETEKENIS
SAL WEES.

OM HIERDIE IDEAAL TE VERWESENLIJK, IS DIT NODIG OM OP BAIE
TERREINE VAN DIE VOLKSHUISSHOUING, GELEENHEDE EN DIE NODIGE
FASILITEITEE DAARVOOR TE SKEP. SULKE GELEENHEDE EN FASILITEITE
MOET TEN VOLLE DEUR DIE MENSE VIR WIE HULLE GESKEP IS, BENUT
WORD. OPLEIDING OM DIENS TE KAN VERSKAF IS 'N BASIESE NOOD-
SAAKLICHEID. EERS WANNEER OPLEIDING OP 'N HOË PEIL, WERKERS
EN AKADEMIEK GEHALTE LEWER, KAN Kwaliteitsdiensstare VERWAG
WORD. DIT IS DAN OOK ONS STREME TEN ONSGTE VAN DIE KLEURLIJK-
BEVOLKING EN HTERAAN KAN ONS ALMAL SAAMWERK OM DIT TE VERWESENLIK.

LAAT MY TOE OM 'N PAAR ASPEKTE WAARIN U BELANG SAL STEL, NADER
TOE TE LIG.

'N GEMEENSKAPSGESONDHEIDSDIENST WAAROP DIE DEPARTEMENT VAN
GESONDHEID GROOT KLEM LAE EN WAARAAN JARLIJKS R9 MILJOEN
SPANDEER WORD, IS DIE ALGEMEENARTENDE BUISEPASiëNTE-DIENS
WAT AS 'N GESUBSIDIEERDE DIENS, DEUR PLAASLIKE OWERHEDE, AAN
AL DIE INWONERS IN HULLE RESGEOGEDE GELEWER WORD.

HIERDIE DIENS WAT BEKEND STAAN AS 'N APRIKEL 17 DIENS EN
WAT GELEWER WORD INGEVOLGE DAARDE ARTIKEL VAN WET 51 VAN
1946, MAAK VOORSIKING VIR 'N 7/STE SUBSIDIE OP SEKERE
KAPITALE EN BEDRIFSWIGAWES DEUR 'N PLAASLIKE OWERHEID
AANGEGAAN OM DIE DIENSTE TE KAN LEWER.

DIE OPRIGTING VAN KLINIKGORDIJN MET MEUBLEMENT EN
INSTRUMENTASIE, SOWEL AS SEKERE KATEGORIË VAN MEDISYNE,
KWALIFISEER VIR HIERDIE SUBSIDIE. GROTER WERKE VAN OOR
DIE R25 000,00 SOWEL AS KLEINER WERKE ONDER HIERDIE BEDRAG,
KOM IN AANMERKING VIR DIE SUBSIDIE. AFSONDERLIKE GERIEWE VIR DIE VERSKILLENDE RASSEGROEPSE WORD OPGERIG, AFHANGENDE VAN HULLE BEHOEFTES. SO WORD DAAR TANS 'N GROOT EKONOMIESE BEHUISINGSKEMA OP DIE KAAPSE VLAKTE VIR KLEURLINGE GEBOU, WAAR 'N KLINIEK IN DIE BURGERSENTRUMKOMPLEKS INGESLUIT SAL WEES TEEN 'N BEDRAG VAN R180 000,00.

DIENSTE WAT HIER GELEWER SAL WORD IS ONDER ANDERE KRAAMVERPLEEGDIENSTE, VOOR-EN-NAGEBOORTE SORG, KINDERSORG, BUITEPSIHMTEBEHANDELING VAN TUBERKULOSE EN VENERIESE SIKTE GEVALLE, IMMUNISERINGS- EN GESINSBEPLANNINGSDIENSTE, SOWEL AS DIE BEHANDELING VAN KLEINER ONGESTELDHEDE.

TERWILLE VAN EKONOMIESE OORWEINGE EN VIR DIE WELSYN VAN DIE GEMEENSKAP, IS DIT NOODSAAKLIK DAT HIERDIE DIENSTE BINNE MAKLIGE BEREIK VAN ELKE INDIWUDE IN DIE GEMEENSKAP SAL WEES.

MISTER PRESIDENT, IN ACCORDANCE WITH THIS POLICY, THE LOCAL AUTHORITIES OF WORCESTER, CAPE TOWN, CALEDON, CERES, TULBAGH, CLAN WILLIAM, FRASERBURG, KUILESRIVER, STELENBOSCH, GEORGE, GRABOUW, HEIDELBERG AND KYNSNA, ALL RECEIVED SUBSIDIES, IN THE RECENT PAST, TO ENABLE THEM TO ERECT THE NECESSARY CLINIC BUILDINGS WHERE THESE SERVICES COULD BE RENDERED TO THE COLOURED POPULATION GROUPS WITHIN THEIR COMMUNITIES.

AS INDICATED EARLIER ON, A SERVICE CANNOT BE RENDERED WITHOUT SUITABLY TRAINED PERSONNEL. MY DEPARTMENT, THEREFORE, SUBSIDISES POSTS ON THE ESTABLISHMENT OF LOCAL AUTHORITIES, WHICH ENABLE THEM TO RENDER SUCH SERVICES AS ARE NEEDED BY THE COMMUNITY, WITHIN THE SCOPE OF THE ESTABLISHED POLICY. THIS MAKES IT POSSIBLE FOR LOCAL AUTHORITIES TO APPOINT: MEDICAL OFFICERS, HEALTH INSPECTORS, NURSES AND SUCH OTHER CATEGORIES, OF WORKERS, PROVIDED FOR UNDER EXISTING HEALTH LEGISLATION.

BEARING IN MIND THE SPARSELY POPULATED RURAL AREAS OF OUR COUNTRY/...
COUNTRY, WHERE PEOPLE ARE ALSO IN NEED OF BASIC MEDICAL, NURSING AND OTHER SERVICES, SUPPLIED UNDER THE COMPREHENSIVE OUTPATIENT SCHEME, MY DEPARTMENT MAKES MOBILE CLINICS, COMPLETE WITH PERSONNEL, AVAILABLE TO SUCH LOCAL AUTHORITIES AND ALSO UNDER THE 7/8 THIS SUBSIDISED SCHEME.

DURING THE FINANCIAL YEAR 1976/77 A NUMBER OF BURSARIES HAVE BEEN EAR-MARKED BY THE DEPARTMENT OF HEALTH TO BE MADE AVAILABLE TO SUITABLY QUALIFIED COLOURED NURSES TO OBTAIN POST-BASIC TRAINING FOR THE DIPLOMA IN PUBLIC HEALTH, THUS ENABLING THEM TO PROVIDE A BETTER QUALITY SERVICE TO THE COMMUNITIES WHICH THEY WILL SERVE.

IT SHOULD NOW BE APPARENT, THAT AT ALL GOVERNMENT LEVELS I.E. CENTRAL, PROVINCIAL AND LOCAL, EVERY EFFORT IS BEING MADE TO PROVIDE SUCH HEALTH SERVICES TO THE NATION AS A WHOLE. THE PARTICULAR NEEDS OF ALL SECTIONS OF THE COMMUNITY ARE ALWAYS CONSIDERED IN DETAIL AND GREAT STRIDES HAVE BEEN MADE RECENTLY, TO SATISFY DEMANDS FOR BETTER SERVICES, WITH PARTICULAR EMPHASIS ON OUR COLOURED POPULATION, COUNTRY WIDE.

MENEER DIE PRESIDENT, BENEWESTE AL HIERDIE ASPEKTE, WAT VOORUITGANG BETEKEN, WAS EN IS DAAR NOG ALTYD DIE HUNKERING NA 'N EIE MEDISE FAKULTEIT VIR DIE UNIVERSITEIT VAN WES-KAAPLAND MET 'N AKADEMISE HOSPITAAL WAAR KLEURLING MEDISE STUDENTE OPGELEI KAN WORD. HIERDIE WAS NOG ALTYD ONS STREWJE EN DAARVOOR IS HARD GEWERK.

VANAAND KAN UKU DIE GOEIE NUUS, IN HIERDIE VERBAND MEDEBEL. DIE KABINET HET SO PAS BESLUIT, DAT 'N MEDISE FAKULTEIT VIR DIE UNIVERSITEIT VAN WES-KAAPLAND, EN DIE GEPAAARDEGAANDE OPLEIDINGSHOSPITAAL AS 'N GEINTEGREGERDE EENHEID BEPLAN EN OPPERIG MOET WORD. DIE AKADEMISE HOSPITAAL SAL OP DIE TERREIN VAN DIE UNIVERSITEIT WEES, ONS NA AS MOONTLIK DAARNAAN.

HIERDIE/...
HIERDIE BESLUIT HOU GROOT EN BELANGRIKE VOORDELE VIR DIE HELE KLEURLINGBEVOLKING IN EN IS WEER EENS 'N BEWYS, DAT VAN OwerHEIDSWEI, ELKE BEVOLKINGSGROEP IN ONS LAND SY REGMATIGE DEEL SAL KRY ASOOK SY PLEKKIE IN DIE SON.

HOSPITALE IN DIE BOLAND, SOOS DIE WAT U HIER IN WORCESTER HET, SAL MOONTLIK KAN INSKAKEL BY DIE FAKULTEIT VAN GENEESKUNDE VAN HIERDIE UNIVERSITEIT. SULKE HOSPITALE SAL KAN DIEN AS SATELLIETE OM KLINIESE OPLEIDING TE VERSKAF AAN STUDENTE IN HUL KLINIESE JARE. EKONOMIES SAL DIE OOK GEREGRVIGIG WEES OM STUDENTE NA DIE KLINIESE MATERIAAL EN DIE PASIENTE TE BRING LIEFERER AS OM PASIENTE NA DIE STUDENTE TE BRING. 'N ANDER ASPEK VAN GROOT SIËLKUNDIGE WAARDE HET, IS DAT PASIENTE IN HUL TUISOMGEWING HOSPITALISEER KAN WORD, WAT DIE MINIMUM ONTWIRTING VAN HUISHOUDINGS-, GESINS- EN FAMILIEBANDE SAL MEEBRING.

WAT VIR U, DIE PRAKTISERINGE GENEESHERE MET AANSTELLINGS BY HIERDIE TIEP HOSPITALE VAN BELANG IS, IS DAT U GEWILLIG SAL MOET WEES OM IN U EIE DISCIPLINES AS LEKTORE EN LEERMEESTERS VIR DIE STUDENTE OP TE TREE.

IT IS MY CONSIDERED OPINION, THAT AMONGST OUR COLLEAGUES IN CITIES AND TOWNS, THERE ARE SOME OF OUR BEST TUTORS IN THE MEDICAL PROFESSION. PEOPLE, WHO BY EXPERIENCE AND TOIL, HAVE MASTERED THE PRACTICAL ASPECTS OF MEDICAL PRACTICE. THEY ARE ADMIRABLY SUITED TO TEACH THE PRACTICAL, BASIC AND OTHER ALL IMPORTANT ASPECTS OF PREVENTIVE, PROMOTIVE AND CURATIVE COMMUNITY MEDICINE AND HEALTH SERVICES TO DOCTORS IN THE MAKING. IT IS ESSENTIAL TO HAVE THIS BASIC KNOWLEDGE AND KNOW HOW, BEFORE BRANCHING OFF INTO A SPECIALISED FIELD.

MAY I APPEAL TO COLLEAGUES, BOTH GENERAL PRACTITIONERS AND SPECIALISTS, THAT SHOULD THE POSSIBILITY BECOME A REALITY, YOU WOULD BE WILLING TO ASSIST IN THIS PROJECT AND MAKE IT A TREMENDOUS SUCCESS, IN THE INTEREST OF OUR COUNTRY AS A WHOLE. I THANK YOU.

VRYGESTEL DEUR DIE DEPARTEMENT VAN INLIGTING OF VERSOEK VAN DIE MINISTER VAN GESONDHEID EN VAN KLEURLING-, REHOBOTH- EN NAMABETREKKINGE.
EAST LONDON — A scuffle broke out in the magistrate's court here yesterday when a man awaiting trial for possession of dagga made a dive for the prosecutor's table and swallowed a dagga roll there as a court exhibit.

Although the man, Mr. Dries Long, 33, could not be forced to cough up the roll, despite the efforts of four policemen who struggled with him for about five minutes, he had not destroyed the evidence against him — the roll was to have been used as evidence against a 16-year-old youth, also charged with possession of dagga.

The whole incident happened so fast that the magistrate, Mr. P. C. J. Smith, who immediately adjourned the court for a few minutes, said afterwards he thought the man was suffering from a tic as he was struggling violently.

Mr. Long was charged with obstructing the course of justice.

The magistrate ruled that he could not hear the charge of obstruction and ordered that it should be heard in another court.

Mr. Long, a casual labourer, was allowed to bail and warned to appear again on February 16.

The youth, who pleaded guilty, pleaded that he had given him the dagga for a chest ailment.

The magistrate remarked that it was strange that "so many of you people" (referring to the youth) had chest problems for which they took dagga.

The youth was found guilty and sentenced to three months' imprisonment, suspended for three years. — DNR.
Apartheid lunacy

Another piece of apartheid madness will be set in motion this year.

SA's Black medical education, centering on Natal University's Black medical school, is on the point of being phased out and replaced by a system which will see Africans graduating from the Medical University of Southern Africa (Medunsa) at Ga Rankuwa, about 22km from Pretoria, and Coloureds and Indians graduating from schools attached to the universities of the Western Cape and Durban-Westville respectively.

As from 1976 first-year African students will attend African universities before going on as sophomores to Medunsa, while as from 1978 Natal University will be altogether debarred from taking in any more new African students in second-year and beyond. Coloureds and Indians are to be phased out at the discretion of the Ministers concerned.

The plan seems to be based on the report of the Committee of Inquiry into Medical Education. Though government appointed the committee in the late Sixties, its report has never been tabled, so many medical academics are still completely ignorant of its contents.

More recently, Natal University's medical school authorities have pressed, to no avail, for a clear answer from Pretoria about the school's future. Having lately seen R1.4m of extensions almost completed and authority granted for extensions to African students' hostel accommodation, the school hoped and expected it would be allowed to remain as it is and that the only debate would be over its size.

Natal University's argument is that the school should be expanded to allow an intake of 160 new students a year (now 120, with about 50-50 Africans and Indians and a smattering of Coloureds) of which 100 should be Africans.

That would help cope with the significant increase in the last five years of Africans matriculating with mathematics. This development has pushed up first-year applications to Natal University medical school (from 70 in 1970 to around 200 last year).

Natal University believes once there's a 160 intake a second Black medical school would be justified. Moreover, it's reckoned it would cost a mere R430 000 to provide for its extra intake.

Instead, Pretoria has now disclosed it is to spend R30m over six years on establishing Medunsa. At the same time it will be busily destroying a well-established Black school, which not only has an excellent academic record, but whose celebrated atmosphere of racial accord has drawn a host of dedicated teachers.

It's not as if Medunsa is going to turn out a great many more African doctors than Natal University. It's projected intake is 160 a year. Yet expectations are that by 1980, only two years after Medunsa's start-up, there'll be around 320 applications. So it'll be saturated almost from its inception.

Pretoria, apparently, aims to transform the Natal University into a White institution. Undoubtedly there's a good case for another such school in the country. But that's still no reason for closing Natal University down for Blacks.

As Professor John Reid, Dean of Natal's Faculty of Medicine, points out, Natal University could easily run two medical schools with the same staff: the existing Black school attached to King Edward as at present, and a White school attached to Addington.

Certainly Pretoria's latest lunacy can hardly improve SA's standing in the outside medical world. Recently, the World Medical Association wanted SA out of that body because of apartheid.
Black protest at N.U.

Mercury Reporter

BLACK medical students at the University of Natal are planning a series of meetings to protest against the Government's decision to bar Africans from the university.

The students are also against a move to bar Coloureds and Indian medical students later in a phasing-out programme.

Students spoken to yesterday said that the Medical School Council, in conjunction with the Students Representative Council (Blacks) has arranged for a number of meetings to decide what actions to take.

"We are not going to let the matter rest there," said a student member of the Medical School Council.

Professor J. V. O. Reid, acting Dean of the Medical School, said yesterday that he was not aware of any student meetings.

Professor Reid added that he was pleased that the Government had a second look into its previous decision.

"We have written to the Minister of National Education and still awaiting a reply," he said, adding that they hope to have an interview with the Minister in the "very near future".

In the meanwhile work has started on the first phase of the massive R30-million Medical University for Southern Africa at Ga Rankuwa near Pretoria. The first phase
University fights for its Blacks

Science Correspondent

An appeal has been made to doctors throughout South Africa to help persuade the Government to change its mind and allow all non-White students to continue to attend the University of Natal Medical School.

The appeal takes the form of a letter published in the S.A. Medical Journal which has been signed by the professors of every department in the University's Faculty of Medicine.

Beginning this year, Africans are being phased out over a two-year period and the University has been informed that it must be prepared to phase out Indian and Coloured students some time in the future.

The Government plan is that all African medical students will in future be trained at the Medical University of South Africa, near Pretoria, which still has to be completed.

The letter reads in part: "This decision means the destruction in its present form of an institution which we and our colleagues have so patiently built up over the past 25 years, believing that we were making a contribution of national importance.

"While we certainly welcome the establishment of another medical school in South Africa, charged with the task of training African doctors who are at present in desperately short supply, we question the wisdom of simultaneously excluding Africans from entry to a well-established and reputable institution such as ours."
Cases of notifiable diseases

63. Dr. A. L. BORAIME asked the Minister of Health:

1) How many cases of each notifiable disease were notified in respect of (a) Whites, (b) Asians, (c) Coloureds and (d) Bantu in 1974 and 1975, respectively.

2) How many deaths from each disease occurred in each race group during 1974 and 1975, respectively.

The MINISTER OF HEALTH:

(1) Cases notified—1974:

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<th>Coloured</th>
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Grand Total: 70,896

Cases notified—1975:

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Grand Total: 70,572

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Grand Total: 2986

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Burns backs new medical school

EAST LONDON — The leader of the Ciskei National Unionist Party, Chief S. M. Burns-Nemashe has come out in support of the proposed establishment of a medical school near Pretoria where black students will be given medical, dental and veterinary training.

Beginning this year, blacks are being phased out over a two-year period from the University of Natal medical school.

The present government plan is that all black medical students will in future be trained at the medical school in Pretoria, still to be completed.

In a statement Chief Nemashe said: "The more urgent issue is the sound and adequate training of black students as medical practitioners, as dentists and as veterinary surgeons.

We highly appreciate the fact that at this varsity institution all black South Africans will gain admission irrespective of their ethnic origin.

"We hope the medium of instruction will be the universal language for higher learning, English, and that the tone of the varsity will be correspondingly cosmopolitan," Chief Nemashe said.

Chief Nemashe said it would be more appreciated if lecturers and professors were not only drawn from inside the Republic but also from abroad.

"We entertain the fear that if such a varsity institution were to be staffed almost entirely by products of South African universities the teaching and research in the specified fields might be in danger of being limited by racial bias or ethnocentrism," Chief Nemashe said.

Chief Nemashe said the black people of South Africa were now marching forward along the road towards independence and self-sufficiency and all training should of necessity take this fact into account.

"Our youth should on no account be trained for subordinate roles but specifically for full responsibility in their future independent country.

"It would therefore be to the discredit of the Republican government if expenditure is incurred on a project viewed by its sponsor as being no more than an institution for producing 'kaffir' doctors, all of whom are to be treated as members of a subordinate caste in contrast to those of the ruling caste," Chief Nemashe said. — DDB
Spending on health

R182-m

THE Cape Provincial Administration will have spent an estimated R182-million on hospital services and public health during the year ending on March 31 1976. This is the highest single amount shown on a statement published this week.

The original estimate for the hospital services vote was R176-million. The additional sum is included in the additional appropriation passed by the recent sitting of the Provincial Council.

The revised total amount to be spent on roads and bridges in the province is about R187.3-million, almost R18-million more than the original estimate.

ESTIMATE

The estimate of expenditure on education remains unchanged at R134-million.

One of the unforeseen amounts that had to be paid by the Provincial Administration during the current financial year was the sum of R320,000 for disaster damage following the floods in the north-eastern Cape.
Black students in protest

MORE than 200 Black medical students with raised fists symbolising Black power (above) assembled outside the Durban Medical School yesterday to protest against the Government's decision to phase out Black students from the school.

Mr. R. E. Mkhangwa, president of the Black medical students representative council, hit out at the Government's decision.

"We have every right to study at this medical school as it was built on the sweat and blood of our forebears."

He said that it was a pity that, while South Africa was making every attempt to improve relationships with neighbour- ing states, very little was being done to 'build bridges' between Whites and Blacks in South Africa.

He said a series of meetings were being planned for each African township "to make our parents aware of our problems."

Mr. San Maloza said the removal of Blacks from one place to another was nothing new.

"As Blacks of this country we should not be allowed to study at the institution we choose."

Time was running out for Whites in
No limit on research
Transkei society told

EAST LONDON — Medical and other types of research should have no boundaries when lands such as the Transkei and Ciskei gained their independence.

This was what Prof A. J. Brink, the president of the South African Medical Research Council, told delegates at the opening of the biennial meeting of the Transkei and Ciskei Research Society here yesterday.

Medical research in South Africa was peculiar because the country had a different environment to other countries, physically, geographically and medically. We also had a multi-national structure.

Prof Brink said: "No two cases of a disease are exactly alike. Multiply this from the individual to the group, from the group to the community, from the community to the race and from the race to the nation and you have one of the most challenging anomalies the mind of man can encounter."

He said the types of disease most prevalent in each race group varied widely.

"Ischaemic heart disease has become virtually the largest single killing disease among South Africa's whites. It is a part of our way of living and working and is related to the technological environment of the day."

"The blacks — or more correctly the rural or recently urbanised blacks — hardly suffer from this disease at all until they come to the cities and adopt a Western way of life — and death," Prof Brink said.

The blacks, however, suffer from different heart diseases called cardio-myopathies.

Prof Brink pointed out differences other than heart diseases, and these included the greater longevity of black people, their virtual immunity to cancer of the bowel and the high incidence of cancer of the oesophagus which is found among Transkei blacks, where it had reached the highest incidence in the world.

He said the view that "the mind is capable of graduating any disease" was hopelessly incorrect.
Apartheid blamed for poor health

Pretoria Bureau

The United and Progressive Reform Parties in the Transvaal agree that health care implies not only hospital services for the sick, but a full re-appraisal of community conditions to prevent people from falling ill in the first place.

Their views are contained in separate articles published in the university of the Witwatersrand medical students' journal, "Auricle".

The United Party's contribution was prepared by Mr Dave Epstein MPC, and the PRP one by Dr Selma Browne, MPC and Dr Alex Boraine, MP.

Although their views were worded differently, both parties agreed that:

- Social conditions attributable to apartheid were responsible for malnutrition, which was a big cause of ill health.
- Health care was hampered by the fragmentation of responsibility between State, provincial and municipal institutions and functions.
- Apartheid in even the curative sector caused wasteful duplication of manpower and expense.
- Medical posts in hospitals and other institutions had to be more attractive.
- And equal pay and opportunities for non-White doctors and nurses, and the right for nurses to work in White hospitals and medical students to study at all medical schools, was needed to meet the demand.

The UP wanted free hospitalisation, and free health care as an ultimate objective, encouraging the body to heal itself.

Both underscored the importance of popular health within the means...
Look after black workers, warns professor

Finance Reporter

The South African system of black migrant labour has been attacked on medical grounds by Professor A. Solomon, professor of diagnostic radiology at Johannesburg’s Baragwanath Hospital.

He said migrant labour pools defeated any hope of industrial health control, and added: “Permanency in registered employment, inducements to encourage permanency, protective legislation and central medical monitoring together with continuously improving working conditions will safeguard an economy which leans heavily on black workers.”

He said black workers, particularly those in high-risk industries like asbestos mining and manufacture, should be registered and regularly checked for such industrial diseases.

Professor Solomon pointed out that 90 percent of the 21,000 workers employed on asbestos mines are black.

He said the high turnover of labour in the asbestos industry and the absence of a central records establishment for blacks made it impossible to keep an accurate long-term follow up on the health hazards.

He also called for trained medical officers to be appointed to factory inspectorates.

“The factory inspector is no longer sufficiently competent or able to recognise the ‘insidious undermining of the workers’ well-being.’”

He suggested in addition that the Workmen’s Compensation Act be enlarged to include inhalants as a cause of injury.
SA quits world medical body.

The Medical council had decided to withdraw for two reasons: one of which was political. He said the council had no “guarantee” that the world body would shortly be completely dissolved. “It would be the end of the world,” he said. While some principles applied to the council’s rules and regulations that were common to all countries, he said the world body’s financial situation was one of the situations that had to be considered. The second reason was the association’s financial situation. He said the council had no “guarantee” that the world body would shortly be completely dissolved. “It would be the end of the world,” he said.
‘No health care in industry’

22/11/76

The Erasmus commission on occupational health found there was a lack of awareness of occupational health and hygiene in industry, industrialists have been told.

Addressing a National Occupational Safety Association (Nosa) seminar on the commission in Kempton Park, Mr Bunny Matthey, general manager of Nosa, said the commission had found management did not care enough about health in the factory.

NO CONTROL

No one in a firm was responsible of occupational health. Those who were doing something were not properly trained. There was no control knowledge or responsibility in the use of toxic materials.

There were no statistics. The majority of the inspectorate was not trained or fully qualified.

The commission found 12 Government departments responsible for occupational health. These included the departments of Health, Labour, Mines, Water Affairs, Agriculture, Community Development and Forestry.

It suggested that the Department of Health bridged the activities of the inspectorate and the recommendations.

Safety in factories would fall under the Department of Labour and safety underground would fall under the Department of Mines. Municipal employees would carry out the inspectorate functions.
MEDICAL aid schemes will in future be allowed to pay doctors' fees in full for their 800,000 members. At present schemes may pay only 80 per cent of fees.

A spokesman for the Department of Health confirmed this week that the law had been amended to allow medical aid schemes to pay doctors in full from the beginning of next year. The 80 per cent maximum has been in operation since 1979.

The spokesman said that another important change was that in future medical aid schemes would be able to pay in full doctors who have opted out of medical aid schemes. At present medical schemes paid to their members only a portion of the fee of doctors who had opted out.

Restricted

"The present Act applies only to doctors who are members of the scheme and who charge prescribed tariffs. It does not apply to doctors who have opted out," the spokesman said.

The Medical Association made representations to the Minister of Health for the present arrangement to be amended.

"The aim of amending the present legislation is to see if more patients will now go to doctors who have opted out, even if they are charging more than the prescribed medical aid tariffs.

By NEIL HOOVER

"It will not be up to each of the 250 medical aid schemes in the Republic to decide whether they wish to pay the additional fees."

Another important change in the Act was that maternity fees would become part of a member's general fees. At present medical schemes have a prescribed fee for confinements.

One of the few controversial aspects of the new regulations in the ruling that medical aid schemes are not obliged to pay for drug addiction.

"Some South African municipalities recognise alcoholism as a disease, but the State does not, and therefore cannot allow medical aid schemes to pay for treatment for alcoholism. Nor can it agree to pay for sick leave to people suffering as a result of alcoholism," the spokesman said.
Donors urged to give holiday blood

Science Editor

Blood donors have an important duty to see to before taking off for the Christmas and New Year holidays.

Those due for a bleed are asked by the South African Blood Transfusion Service in Johannesburg to give their regular donation.

"We are not short of blood at present but we must be prepared for the 10-day period when little bleeding is done," Mr Frank A Browne, secretary of the service, says.

"There may be a disaster or a spate of accidents where blood is needed in large quantities.

"Over the holidays surgeons usually confine their activities to emergencies. But the normal programmes get under way again after the New Year and then there is usually a heavy call on the blood bank. We must have enough in stock."

There are also a substantial number of patients suffering from leukaemia and other disorders who need a constant supply of fresh blood, said Mr Browne.
Drop in ‘natural deaths’ in 10 years

Chief Reporter Cape Times 28/12/76

While violence and accidents are displacing certain diseases as major causes of death in the Cape Town municipal area, the latest report of the City’s Medical Officer of Health reflects a marked decrease in the death-rate from natural causes over a 10-year period.

In the period 1965 to 1975 the death-rate dropped from 10,20 to 8,44 for every 1000 Whites and from 10,61 to 7,18 for every 1000 members of other race groups.

In 1975 the overall death-rate fell to 7,56 for every 1000 people from 8,31 in the previous year, which represents a decrease of seven percent for all races — 6,7 percent among Whites and nine percent among other races.

The MOH, Dr R J Coogan, says in his report that the White death-rate decrease has been “fairly general” and that among other races the decrease has been most pronounced in the senility gastro-enteritis and “ill-defined causes” categories.

The report shows that cardiovascular (heart) diseases continue to head the list of principal causes of death among all race groups. Among Whites, accidents and violence have displaced “other respiratory diseases”, and diseases of the nervous system have displaced diseases of the genito-urinary system. Among people of other races accidents and violence have displaced bronchitis and pneumonia as principal causes of death.

In a classification of causes of death among Black and Coloured people in 1975 — the year under review in Dr Coogan’s annual report — accidents and violence are shown as the third-biggest cause, after heart diseases and cancer. Among Whites, accidents and violence are shown as the sixth biggest killer, after heart diseases, cancer, senility, arterial diseases and bronchitis and pneumonia.

Suicide up

Home accidents, as a cause of death, increased from 56 in 1974 to 67 in 1975, and the suicide rate increased from 0,04 in every 1000 people of all races in 1974 to 0,06 in 1975. Dr Coogan notes that males continue to predominate in each racial group, while 39 percent of all suicides “occurred among persons in the prime of life — that is in the age-group of 25 to 44 years”.

The MOH says the infant mortality rate is of special significance because it is regarded as one of the most sensitive indexes of health conditions of the general population. In 1975, he adds, infant deaths fell by 191, or 22 percent, compared with the previous year.
Ambulances are for all, councils told

Pretoria Bureau

The Government has again reminded municipalities that there should be no racial discrimination in ambulance services and official conferences.

At a management committee meeting of the Pretoria City Council last night, a circular from Mr. Eric Uys, Transvaal Director for Local Government, was tabled.

Mr. Uys said it was Government policy that there should be no racial discrimination in ambulance services during emergencies.

In accidents or disasters the first available ambulance should be used to transport patients, irrespective of whether the ambulance is manned by whites or blacks.

He also reminded that there should be no racial discrimination at congresses, meetings or symposiums at academic level.

ACCOMMODATION

Mr. Uys said local authorities should also help organisers obtain accommodation for people of other races attending such meetings.

A Pretoria City Council spokesman said today that it had been the practice for years to put injured people into the first available ambulance at accidents.
Blacks are worst hit by cancer

The occurrence of different cancers among non-whites varies throughout the United States, says the study, which was based on death certificate figures for 35 types of cancer compiled by the National Centre for Health Statistics from 1980 to 1988.

The latest report written by National Cancer Institute scientists said the geographical studies bolstered medical theories that a relationship existed between environmental factors and cancer risks.

LOCAL FACTORS

The reasons for the varying rates and distribution of cancer were unknown. But the geographical differences should spur investigators to look for local factors that might contribute to the disease, the scientists said.

The non-white study of more than a half-million deaths included blacks, Ameri cans, Indians, Chinese and Japanese, with blacks forming 92 percent of the group.

The scientists said the combined death rate for all forms of cancer was slightly higher than for whites.

Compared to other racial groups, blacks have proportionately higher rates for cancers of the mouth and throat, esophagus, stomach, pancreas, larynx, lung, bladder, cervix and a kind of bone marrow cancer called multiple myeloma.

Whites have higher mortality rates than blacks for cancer of the colon and rectum, breast, ovary, uterus, kidney, skin, brain and lymph system, as well as leukemia.

Sapa-AP
Anti-rape dart man optimistic

Own Correspondent

DURBAN — The Durban inventor of the dart-firing anti-rape device, Feme-protect, is expecting a decision from the Department of Health and Justice this week following a call for the total banning of the product by Mr Horace van Rensburg, Progressive Reform Party spokesman on health.

Mr Jac Coetzeesaid today that he had left 20 samples of the device with the departments for their inspection. He had been promised a decision early this week.

Mr Coetzee accused Mr van Rensburg of trying to torpedo his invention without taking the trouble to examine a production sample.

Mr Coetzee said he was still very optimistic that his product would be accepted. It would not be put on the market until the safety, legal and health aspects had been fully investigated and approved.

Mr Coetzee said the controversy over his advertisements had generated much talk and made it impossible to gauge how the product had been received by the average woman.
Caught in the middle on medical care

Pretoria Bureau

People in the middle-income groups in South Africa are hardest hit when it comes to medical expenses.

Households with an annual income of between R4,000 and R10,000 will be most seriously affected by increasing medical tariffs.

This is shown in recently published findings of the Department of Statistics on household expenditure of whites in 1975.

Households in this income bracket are paying 3.5 percent of their average annual expenditure on medical services and requirements for each person, as opposed to 2.7 percent at the bottom end of the scale, and 2.4 percent at the top.

Correspondence from the Department of Comprehensive and Community Medicine at the University of Cape Town and Groote Schuur Hospital in the latest issue of the South African Medical Journal emphasises the need to review income criteria on medical care.

The correspondence points out that while middle-income people may not benefit from provincial medical care, those in lower-income groups have expenses kept low by subsidised services, and upper income groups are better able to absorb increasing medical costs.
Squatter lands hazard party

The Department of Health on Monday held a meeting at the offices of the Chief Medical Officer of Health. Dr. van de Merwe, who reached a decision to advise the Premier and the Cabinet to take action on the squatter lands. The Premier has been advised of the situation and a meeting will be held to discuss the matter.

Dr. van de Merwe said that the situation was a serious one and that immediate action was required. The Premier has been advised of the matter and a meeting will be held to discuss the situation.

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Black toilets a city problem

The lack of toilet facilities for blacks in Johannesburg is giving city health officials grey hairs and causing health problems.

But, they claim, nothing can be done about the situation until the council provides more money.

One problem area is Wolhuter Street, Jeppe. CARE continually receives complaints about the filth on the pavements from people living and working on what one resident, Mr M Devabhail, calls "sewage street."

Opposite Mr Devabhail's house is a black hostel and a beerhall, but the drinking goes on long after the beerhall has closed, he told CARE, and because the drinkers have no place to relieve themselves they use the pavements.

"I know the area is heavily fouled," Mr J A Oxenham of the City Health Department told CARE, "but when the West Rand Administration Board took over the hostel and beerhall they closed down a public convenience nearby."

Mr M Wilserag of the board assured CARE they had "at no time closed down any toilets."
THE ASSEMBLY
Miners have a lack of faith in the Bureau for Occupational Disease and this is causing considerable concern.

In the Bureau's report for 1973/74, just tabled in Parliament, this is described as an unhealthy state of affairs, both for the Bureau and the miners.

While having existed for a considerable time, the situation persists partly because of exaggerated stories and propaganda which have so moulded public opinion that many miners regard the Bureau as an entity and partly because of the Bureau's failure to disseminate information.

COMPENSATION

Many miners, probably most of those with long service, believe they are entitled to medical compensation if they do not receive it they think it is due to incompetence of the Bureau staff or even deliberate obstruction.

One of the main misconceptions, accepted as responsible for lack of faith in the Bureau is that conditions underground are such that miners with more than 25 years service must suffer from a disease caused by their work.
Talks on medical fees

Representatives from medical aid societies and private hospitals met today to discuss the proposed 16 percent increase in fees.

Subcommittee of the Representative Association of Medical Aid Schemes and the Representative Association of Private Hospitals were formed in January to consider the issue.

The results of their studies was discussed at a meeting of the two bodies today.

The increase in fees at private hospitals for medical aid patients could rise by 16 percent which would mean a rise in the standard surgical tariff from R17 to R20.
CANCER LINKS FOUND

Johannesburg Correspondent

JOHANNESBURG — An important breakthrough in cancer research by two Johannesburg doctors has shown a definite link between primary cancer of the liver, a form of the disease with a high incidence in South Africa, and a virus which causes serum hepatitis, a serious liver disease.

Following research by Dr. Gwen Macnab, head of the serology laboratory of the S.A. Institute of Medical Research, Dr. Jennifer Alexander, cell biologist of the S.A. Institute of Virology, has established that liver cancer cells produce a large quantity of Australia Antigen, a type of virus particle found in many patients suffering from hepatitis.

Dr. Alexander was successful in keeping alive liver cancer cells in tissue cultures in test tubes and has been able to isolate a pure form of the cells. Her findings have opened the way for further research into both serum hepatitis and liver cancer, and will greatly assist scientists experimenting with new drugs against both diseases.

Instead of trying new drugs on patients one at a time without knowing side effects, doctors will be able to carry out multiple experiments in the laboratory.

Dr. James Gear, consultant in virology to the State Health Department, said yesterday that the discovery was of particular importance in South Africa, where there was a high incidence of liver cancer, especially among non-Whites.

He said: "Serum hepatitis is known to be transmitted through inoculations which contain human blood, a serious problem in blood transfusion."

Dr. Gear said Dr. Macnab had undertaken a study of patients suffering from liver cancer and had found that about 90 percent showed signs of Australia Antigen virus in the blood.

Dr. Alexander will be going to a New York congress soon to deliver a paper on the subject.
Cancer breakthrough in SA

Maraais Malan, Science Editor

A suspected link between a virus and primary cancer of the liver has been confirmed through a finding of world significance by a Johannesburg medical research worker.

This has opened new horizons, not only in cancer research, but also in the study of an important and potentially lethal disease in Africa, serum hepatitis.

The scientist is Dr Jennifer Alexander, cell biologist at the SA Institute of Virology.

The discovery has already evoked world-wide scientific and medical interest and she has been invited to read a paper on the subject at a congress in New York next month.

The Nobel Prize winner for medicine in 1976, Dr B S Blumberg, discovered the virus or virus particle causing serum hepatitis, the so-called Australia antigen, has been invited to Johannesburg to study the work at first hand.

FIRST TIME:

And Professor O W Proskov, director of the institute, comments: "This ranks as a scientific advance which merits international recognition."

Dr Alexander's research involves a cell culture of liver cancer cells which she obtained from a patient about three years ago. Although the patient died long ago, she achieved the "almost impossible" of growing the cells in culture and keeping them alive.

Now she has shown, for the first time in the world, that the cancer cells produce large quantities of Australia antigen, thereby establishing direct evidence of an association.

© Cancer find stays at home. — Page 23.
What do you do about snakebite?

EAST LONDON — Last week a Steynsburg woman, Mrs Barendina Vorster, died after being bitten by a cobra. With this in mind many are asking, “What action should be taken when someone is bitten by a snake?”

This is the question I posed to an East London doctor who is a recognised expert on snakebites and their treatment:

“Get the patient to a doctor,” was the crux of his reply.

But there are certain steps which can be taken to increase the patient’s chances of survival and there are some of the do’s and don’ts of treating snakebites.

Do try and find out what type of snake it was by killing or capturing it. This will help the doctor.

If you are reasonably sure the snake was some type of adder don’t apply a tourniquet as this will only cause irritation.

Do apply a tourniquet if the bite was from a cobra or ringhals or if you are uncertain what type of snake it was.

Don’t leave the tourniquet on for longer than 55 minutes without loosening it for five minutes. This could cause the limb to go gangrenous.

Do apply the tourniquet to the top of the limb, not the arm. On the bottom half of either it will fail to stop the circulation.

Do inject snakebite serum. If you have more than one ampoule use it. The required dosage is three to four ampoules in the case of an adder bite and nine in the case of a cobra bite.

Don’t think that by injecting serum you have cured the patient. The normal snakebite kit contains only one or two ampoules of serum and this is not enough, especially if injected into the muscle by a layman.

Do insist on getting the patient to a doctor, who will give serum intravenously if necessary.

Don’t cut the victim to bleed the bite or try to suck the venom from the bite. Don’t rub potassium permanganate (Condy’s Crystals) into the bite. This will only cause a burn.

Once you have observed these do’s and don’ts what are the snakebite victim’s chances of survival?

It appears they are excellent. In the case of 100 consecutive snakebite cases treated at the Frere Hospital over a period of two years not one died and only two suffered a serious reaction.

“Only half the bites were from venomous snakes, and half of these needed treatment,” the doctor who treated the snakebites told me. Snakebites were only treated if the symptoms appeared serious enough.

The venomous snakes are divided into two distinct classes, adders and the cobra—ringhals type.

Adder bites cause intense pain and local irritation, but though they could cause the loss of a limb they were not likely to seriously endanger life. Cobra or ringhals bites caused nervous paralysis, which caused the muscles to relax and could result in respiratory failure and death. The symptoms become visible in about half an hour and are drooping eyelids and a lolling head.

The doctor said it was easy to tell the difference between adders and types of cobras as the adders were short, fat and slow, while cobras were long, thin and fast.

There are two exceptions to the above groups, the berg adder which causes nervous paralysis like the cobra group and for which there is no known effective serum, and the boomslang, which causes excessive bleeding and eventual death. Boomslang serum is available in Johannesburg and can be flown to East London to treat a boomslang victim.

Though boomslangs are common, there was not one boomslang bite recorded among the 100 cases treated and the doctor told me it was probably because of the shy nature of this snake and the fact its fangs were situated far back and it could only bite a human on an extremity such as a finger or the side of the hand.

The polyvalent serum in the common snakebite kit is effective against all snakes found in this area with the exception of the boomslang and berg adder.

And something else to set your mind at rest is the fact the non-poisonous snakes are usually the more aggressive.

In addition to this if you are bitten by a poisonous snake it may not inject venom. How much venom it injects, if any, depends on how angry or excited it is. — DDR.
Cancer breakthrough

Dr Alexander's research involves a cell culture of liver cancer cells obtained from a patient three years ago. Although the patient died long ago, Dr Alexander achieved the “almost impossible” of growing the cells in culture and keeping them alive.

Now she has shown that the cancer cells produce large quantities of Australia Antigen, thereby establishing direct evidence of an association.

The director of the Institute of Virology, Prof. O. Prozesky, said scientists could now try to establish whether the material coming from this line of cancer caused serum hepatitis and whether the cell stopped being cancerous if it was cured of the virus.

He said the discovery gave doctors a chance to evaluate drugs against both serum hepatitis and liver cancer without having to expose humans to the drugs.

“What is important is that for the first time one can study the association between a virus and a cancer cell in a laboratory — what the virus does to the cancer and what happens if you clear the cell of the virus.”

It also was now possible to “culture the hepatitis virus in the laboratory.”

Several scientists in various parts of the world have already asked Dr Alexander for specimens of her liver cancer line.

But as her own investigations are at a crucial stage, she will not be able to comply until later this year.

Some overseas scientists have already indicated their desire to work at the institute.
The important point to note is that while the number of matriculants shows a strong rising trend, the number of A.P. passes, particularly at the higher levels, is extremely small. The principal minds wishing to indenture an Indian is the Native Apprenticeship Committee to be indentured.

F. W. Johnson in lone's Cape Town, and L. C. Elliott in Kimberley and Bethelsdorp. Which will offer courses leading to the first time in 1977, as

<table>
<thead>
<tr>
<th>Incidence excluding Apprentices</th>
<th>138</th>
<th>159</th>
<th>177</th>
<th>483</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time students at the Peninsula</td>
<td>262</td>
<td>302</td>
<td>383</td>
<td>531</td>
</tr>
</tbody>
</table>

Med Affairs, Annual Reports. In 1972 figures are mainly the jump in the number of technical courses only. The potential number of students is not available.

Price of Food

The "price of food" to in the previous table is that while the number of matriculants shows a strong rising trend, the number of A.P. passes, particularly at the higher levels, is extremely small. The principal minds wishing to indenture an Indian is the Native Apprenticeship Committee to be indentured.
HEALTH
and
DISEASE
GENERAL

APRIL 1977 - 1978
Trained Bantu medical staff and veterinarians in homelands

2. Mr. L. F. WOOD asked the Minister of Bantu Administration and Development:

   How many trained Bantu (a) doctors, (b) dentists, (c) chemists and druggists, (d) veterinarians and (e) nurses are serving the Bantu people in the Bantu homelands at present.

   The MINISTER OF BANTU ADMINISTRATION AND DEVELOPMENT:

   (a) Doctors ....................... 19
   (b) Dentists ....................... 0
   (c) Chemists ....................... 0
   (d) Veterinarians .................. 0
   (e) Nurses ......................... 3,518

   The above figures are applicable in respect of those Homeland Governments who have not yet taken over health services. Figures in respect of the Homeland Governments who have already taken over health services are not readily available.
Salary scales for staff in State/provincial hospital services

14. Mr. L. F. WOOD asked the Minister of the Interior:

What are the salary scales laid down for (a) White, (b) Coloured, (c) Indian and (d) Bantu (i) doctors, (ii) dentists and (iii) pharmacists in State and provincial hospital services.

The MINISTER OF THE INTERIOR:

(a) to (d).

<table>
<thead>
<tr>
<th>(i) Rank</th>
<th>Salary scale (R per annum)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td>Specialists</td>
<td></td>
</tr>
<tr>
<td>Professor/Chief Specialist</td>
<td>15 600 (fixed)</td>
</tr>
<tr>
<td>Principal Specialist</td>
<td>14 400 (fixed)</td>
</tr>
<tr>
<td>Senior Specialist</td>
<td>13 200 (fixed)</td>
</tr>
</tbody>
</table>

| (ii) Dentists: As in respect of Medical Officers |
| Rank | White | Coloured/Indian | Bantu |
| Chief Pharmacist | 9 900 × 450 | 8 100 × 360 | 6 060 × 240–6 300 |
| – 11 700 | – 9 540 | × 360–7 380 |
| St. Pharmacist | 7 740 × 360 | 6 060 × 240–6 300 | 4 740 × 180–5 100 |
| – 9 540 | × 360–7 740 | × 240–5 820 |
| Pharmacist | 5 340 × 240–6 300 | 4 380 × 180–5 100 | 3 450 × 150–4 200 |
| × 360–7 380 | × 240–5 820 | × 180–4 560 |
| Tr. Pharmacist | 4 020 (fixed) | 3 150 (fixed) | Male: 2 100 |
| | | | (fixed) |
| | | | Female: 1 980 |
| | | | (fixed) |

The above-mentioned scales do not include allowances payable to the personnel.
Bantu Homelands Constitution Act: Health matters

Mr. L. F. WOOD asked the Minister of Bantu Administration and Development:

Whether health matters have since 31 March 1975 been transferred to any Bantu homelands in terms of the provisions of the Bantu Homelands Constitution Act, 1971, if so, (a) to which homelands and (b) when did such transfers become operative.

The MINISTER OF BANTU ADMINISTRATION AND DEVELOPMENT:

Yes.

(a) and (b)

Bophuthatswana .... 1 April 1975
Ciskei ............... 1 September 1975
Lebowa ............ 1 April 1976
Garankulu ........ 1 September 1976
Venda ............ 1 September 1976
Medical staff in Homelands

Dr. F. VAN Z. SLABBERT asked the Minister of Bantu Administration and Development:

How many (a) White and (b) Black (i) doctors, (ii) dentists, (iii) nurses and (iv) chemists were practising in each Bantu homeland as at 30 June 1976.

The MINISTER OF BANTU ADMINISTRATION AND DEVELOPMENT:

It cannot be readily ascertained how many White and Black doctors, dentists, nurses, etc., are practising in each Homeland. The particulars given below are only applicable in respect of the persons in the categories concerned who are employed in the Homelands who have not taken over health services as yet. Figures in respect of the Homeland Governments who have already taken over health services, are not readily available.

<table>
<thead>
<tr>
<th>(a)</th>
<th>(i)</th>
<th>QwaQwa</th>
<th>Swazi</th>
<th>KwaZulu</th>
<th>Garankuwa</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>17</td>
<td>169</td>
<td>93</td>
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<td>(ii)</td>
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<td>3</td>
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<tr>
<td>(iii)</td>
<td></td>
<td>3</td>
<td>10</td>
<td>89</td>
<td>2</td>
</tr>
<tr>
<td>(iv)</td>
<td></td>
<td>0</td>
<td>2</td>
<td>9</td>
<td>7</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>(b)</th>
<th>(i)</th>
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<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>11</td>
<td>5</td>
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<tr>
<td>(iii)</td>
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<td>55</td>
<td>320</td>
<td>2 679</td>
<td>464</td>
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<tr>
<td>(iv)</td>
<td></td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
This question was asked:

1. How many cases of each notifiable disease were notified in respect of each race group in 1976?

2. How many deaths from each disease occurred in each race group during that year.

The Minister of Health:

Class 1: Notifiable diseases 1975

Mr. H. E. J. Van Rensburg asked the Minister of Health:

1. What are the results at the end of the year?

2. The results be answered on the special sheet of paper with your name and number on that sheet.

---

1. The Minister of Health:

Cases notified—1976:

<table>
<thead>
<tr>
<th>Disease</th>
<th>Whites</th>
<th>Asians</th>
<th>Coloureds</th>
<th>Bantu</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthrax</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Asiatic cholera</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brucellosis</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria</td>
<td>10</td>
<td>1</td>
<td>24</td>
<td>303</td>
<td></td>
</tr>
<tr>
<td>Encephalitis</td>
<td>183</td>
<td>7</td>
<td>9</td>
<td>92</td>
<td>1</td>
</tr>
<tr>
<td>Erysipelas</td>
<td>15</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gluconia</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Leprosy</td>
<td>3</td>
<td>1</td>
<td>8</td>
<td>124</td>
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<tr>
<td>Malaria</td>
<td>136</td>
<td>6</td>
<td>1</td>
<td>1 1 6 0 1</td>
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<tr>
<td>Meningococcal inf.</td>
<td>142</td>
<td>6</td>
<td>339</td>
<td>739</td>
<td>1</td>
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<tr>
<td>Plague</td>
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<td></td>
<td>6</td>
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<tr>
<td>Poliomyelitis</td>
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<td>2</td>
<td>60</td>
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<td>Poisoning, lead</td>
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<td>Poisoning, pesticidal</td>
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<td>2</td>
<td>25</td>
<td>71</td>
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<tr>
<td>Puerperal sepsis</td>
<td>6</td>
<td></td>
<td>4</td>
<td>71</td>
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<tr>
<td>Rabies in man</td>
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<tr>
<td>Relapsing fever</td>
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<tr>
<td>Scarlet fever</td>
<td>625</td>
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<td>23</td>
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<td>Smallpox</td>
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<td>Tetanus</td>
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<td>36</td>
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<td>Trachoma</td>
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<td>Typhus fever</td>
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<td>Typhus fever</td>
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<td>Venereal disease gen. ophthalma</td>
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<tr>
<td>Viral hepatitis</td>
<td>696</td>
<td>216</td>
<td>166</td>
<td>643</td>
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<td>Yellow fever</td>
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2. Notified Deaths:

<table>
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<tr>
<th>Disease</th>
<th>Whites</th>
<th>Asians</th>
<th>Coloureds</th>
<th>Bantu</th>
<th>Other</th>
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<tbody>
<tr>
<td>Anthrax</td>
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<td>Brucellosis</td>
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<td>Diphtheria</td>
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<td>Encephalitis</td>
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<td>Erysipelas</td>
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<td>Hepatitis</td>
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<td>Leprosy</td>
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<td>Malaria</td>
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<td>Plague</td>
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<tr>
<td>Poisoning, pesticidal</td>
<td>2</td>
<td></td>
<td>1</td>
<td>4</td>
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<tr>
<td>Puerperal sepsis</td>
<td></td>
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<tr>
<td>Rabies</td>
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<tr>
<td>Scarlet Fever</td>
<td></td>
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<tr>
<td>Smallpox</td>
<td></td>
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</tr>
<tr>
<td>Tetanus</td>
<td>1</td>
<td></td>
<td>7</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Trachoma</td>
<td></td>
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<tr>
<td>Trypanosomiasis</td>
<td></td>
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Cases notified—1976:

<table>
<thead>
<tr>
<th>Disease</th>
<th>Whites</th>
<th>Asians</th>
<th>Coloureds</th>
<th>Bantu</th>
<th>Other</th>
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<tbody>
<tr>
<td>Tuberculosis</td>
<td>38</td>
<td>21</td>
<td>566</td>
<td>1 6 1 4</td>
<td>5</td>
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<td>2</td>
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<td>2</td>
<td>33</td>
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<tr>
<td>Typhus Fever</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Venereal disease gen. ophthalma</td>
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</table>
Zambia has embarked on a scheme to incorporate traditional medicine into modern medical practice.

The scheme has received support from university lecturers and doctors who feel that herbalists have a vital role to play in the treatment of certain diseases.

The move follows thorough research by the National Council for Scientific Research, which has analysed certain herbs and found them to have medical properties.

Research employees toured the countryside and collected roots from herbalists for examination in laboratories. Scientists were able to determine their structures and write up a pharmacopoeia for various herbs.

One herb which interested the medical profession is being used in the treatment of bilharzia with good results. In fact, it was this herb which attracted the National Council for Scientific Research to study traditional medicine.

Two pure alkaloids were isolated from the plant used by villagers and these were tested chemically and found valuable. The other herb which interested researchers was one used for fertility by women. The concoctions were collected and analysed by chemists and doctors.

Zambian herbalists have given the scheme encouraging support. The research has been found to be of tremendous importance because it looks at new compounds to cure disease.

According to the late Dr Dawson Nkunika, who was secretary-general of the National Council for Scientific Research, penicillin has lost its miracle cure reputation as some strains of bacteria are now resistant to it.

Dr. Nkunika, who initiated the scheme, was of the opinion that some of the herbs could replace penicillin. Dr Dewan Mohinder Nath Nair, former head of the department of botany at Zambia University, has strongly defended herbalists and medicinal plants.

He said there was no truth in claims that plant medicine administered to people suffering from certain diseases made them worse.

No matter what some people may say, Dr Nair has personal proof of the effectiveness of plant medicine. His wife, who suffers from asthma, "sleeps like a log" when she takes certain plant medicine powders and he says her difficulty in breathing is instantly relieved.

To enhance the programme, the Ministry of Health has been organising workshops for doctors and traditional healers. Soon there will be special training programmes for traditional midwives throughout the country.

The programmes are enabling the herbalists to express themselves freely. It is not certain everyday that a medical scientist in Africa has good things to say about African medicine men. Call them herbalists or what you will, they have a vital role to play. — GNS

Tim Chikando
FACT

FACT

FACT

FACT

FACT
Inspectors appointed in terms of legislation.

17. Mr. L. F. WOOD asked the Minister of Health:

How many inspectors are appointed in terms of legislation administered by his Department.

The MINISTER OF HEALTH:

Approximately: 446,
Medical training for Bantu

908. Mr. N. J. J. OLIVIER asked the Minister of Bantu Education:

How many Bantu students (a) were enrolled during March 1976 in each of the years of study for training as and (b) passed their final examinations during 1976 in each of the years of study for (i) health assistants, (ii) health inspectors, (iii) public health nurses, (iv) medical laboratory technologists, (v) dental therapists, (vi) radiographers, (vii) physiotherapists and (viii) other para-medical personnel with specification of each type of course.

The MINISTER OF BANTU EDUCATION:

<table>
<thead>
<tr>
<th>(a) Year of study</th>
<th>(b) Year of study</th>
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<tbody>
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<td>1</td>
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<tr>
<td>2</td>
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<tr>
<td>3</td>
<td>3</td>
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</tbody>
</table>

(i) .................. 48 33
(ii) .................. 31 23 21 21
(iii) ................. 47 30
(iv) ................. 23 13
(v) .................. 15 13 12 12
(vi) ................. 4 6 4 5
(vii) ............... 8 8 4 3 4
(viii) Occupational Therapy 6 = 5 =
(viii) Dietetics 3 = 3 =
Medical facilities/staff in homelands

Mr. R. M. CADIO asked the Minister of Bantu Administration and Development:

1. How many (a) mission hospitals, (b) other hospitals and (c) health centres are there in each of the homelands in (i) the Republic and (ii) South West Africa;

2. How many hospital beds are there in each of the homelands in South West Africa;

3. How many (a) White and (b) Bantu (i) medical practitioners, (ii) nurses and midwives, (iii) dentists, (iv) chemical and druggists, (v) physiotherapists, (vi) radiographers, (vii) health inspectors, (viii) health assistants and (ix) pharmaceutical assistants are working in each of the homelands in South West Africa;

4. How many (a) White and (b) Bantu (i) physiotherapists, (ii) radiographers, (iii) health inspectors, (iv) health assistants and (v) pharmaceutical assistants are working in each of the homelands in the Republic.

The MINISTER OF BANTU ADMINISTRATION AND DEVELOPMENT:

The particulars given below in respect of the homelands, are only applicable in respect of those homelands who have not yet taken over health services. Figures in respect of the homelands who have already taken over health services are not readily available.

<table>
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<td>142</td>
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<td>Kavango</td>
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<td>0</td>
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<tr>
<td>Damaraland</td>
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<td>75</td>
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</tr>
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<td>0</td>
<td>0</td>
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<td>Kavango</td>
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<td>0</td>
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<tr>
<td>Damaraland</td>
<td>0</td>
<td>0</td>
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<thead>
<tr>
<th>Homeland</th>
<th>(a)</th>
<th>(b)</th>
</tr>
</thead>
<tbody>
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<td>Kaokoland</td>
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<td>0</td>
</tr>
<tr>
<td>Hereroland</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Kavango</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Damaraland</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Homeland</th>
<th>(a)</th>
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<tbody>
<tr>
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<td>Damaraland</td>
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<thead>
<tr>
<th>Homeland</th>
<th>(a)</th>
<th>(b)</th>
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<tbody>
<tr>
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<td>6</td>
</tr>
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<td>4</td>
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<tr>
<td>Kavango</td>
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<td>13</td>
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<tr>
<td>Damaraland</td>
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<thead>
<tr>
<th>Homeland</th>
<th>(a)</th>
<th>(b)</th>
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</thead>
<tbody>
<tr>
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<td>6</td>
</tr>
<tr>
<td>Hereroland</td>
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<td>6</td>
</tr>
<tr>
<td>Kavango</td>
<td>1</td>
<td>28</td>
</tr>
</tbody>
</table>

In addition 9 Army Doctors are rendering services to the general public as and when necessary in Kavango (5), Kaokoland (2), Hereroland (1) and Damaraland (1).

4. How many (a) White and (b) Bantu (i) physiotherapists, (ii) radiographers, (iii) health inspectors, (iv) health assistants and (v) pharmaceutical assistants are working in each of the homelands in the Republic.

4. How many (a) White and (b) Bantu (i) physiotherapists, (ii) radiographers, (iii) health inspectors, (iv) health assistants and (v) pharmaceutical assistants are working in each of the homelands in the Republic.
12. Which of the following is most likely to have a high price elasticity of demand?

1. Cigarettes.
3. Chocolate ice cream.
4. Food.
5. Shoelaces.

13. Given two straight line demand schedules, the coefficient of price elasticity of demand at point B (on the same horizontal line as A) is

Cancer check on cured meat

WASHINGTON — A senior Agricultural Department official said it was time for a closer look at the potential cancer risks of using sodium nitrite to cure meat.

Bacon, hams, hot dogs and many other meat and poultry products are treated with nitrite to prevent the growth of bacteria that can cause botulism, a deadly food poison. It also is added to give the products an appetizing rosy colour.

But under certain conditions, such as in frying bacon with high heat or in the normal human digestive process, nitrite can combine with other substances to form a nitrosamine, which some authorities say is among the more potent of cancer-causing agents.

A panel of experts originated by the Agriculture Department nearly three years ago will meet on Monday to examine evidence relating to nitrites and cancer.

Assistant Agriculture Secretary, Mrs. Carol Tucker Foreman, heads the panel.

Mrs. Foreman said she expected "some clashes" among panel members regarding nitrite and cancer.

"It's very hard. The industry people are upset and the consumers — if you start saying to them 'eat bacon and you're going to get cancer' are going to be upset," she said.

Up to now the panel had not faced the cancer issue squarely. It had focussed on benefits of nitrite in preventing botulism.

Even if the panel made a firm recommendation on use of nitrites, it would be months before the department made a decision on reducing or eliminating the chemical in meat and poultry. — (Spa-AF.)

5. None of the above.

16. A rise in the price of refrigerator components would probably lead to

1. A fall in the demand for refrigerators.
2. A rise in the supply of refrigerators.
3. A leftward shift in the supply curve of refrigerators.
4. A rightward shift in the demand curve of refrigerators.
5. A leftward shift in the demand curve of refrigerators.

17. Income elasticity of demand is defined as

1. $\frac{\Delta Q}{Q} \times \frac{\Delta Y}{Y}$
2. $\frac{\Delta Q}{Q} \times \frac{\Delta Y}{Y}$
3. $\frac{\Delta Q}{Q} \times \frac{\Delta Y}{Y}$
4. $\frac{\Delta Q}{Q} \times \frac{\Delta Y}{Y}$
5. $\frac{\Delta Q}{Q} \times \frac{\Delta Y}{Y}$
6. The law of increasing (relative) cost is incompatible with

1. A p
2. A p
3. The
4. A p
5. A p

7. Choose Special

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4. Can
do
5. Woul

8. Which one a produc-

1. Total
2. Quani
3. Money
4. Prices
5. Alloca

9. The law of more and m -
amount of 

1. Total p: variab
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2. A dimi
order to
3. Increase ex tra u
4. The rela
the tot
5. Increas

10. In an economy of resources, 

1. To increase increase
2. To decreases decrease
3. To increase increase
4. To increase increase
5. None of the above

11. Price elasticity of demand is

1. Measured by the slope of the demand curve.
2. A measure of the responsiveness of the quantity demand to changes in price.
3. The ratio of the change in price over the change in income.
4. None of the above.
5. Two of the above.
Jeans can make you ill.

BONN — The fad of wearing tight jeans is believed responsible for an increase in skin disease, the West German Health Ministry said yesterday.

The Ministry secretary, Mr Fred Zander, said the tight jeans caused heat and moisture to build up on the wearer's legs, creating what one German official called "jeansitis."

— SAPA-AP.
**Medical fees going up?**

JOHANNESBURG — Higher doctors' fees are expected to come into effect in early October following the report of the Remuneration Commission handed to the Department of Health this week.

The commission's chairman, Mr Justice Erasmus, has completed a three-month investigation into doctors' and physiotherapists' tariffs at the request of the Medical Association and the Central Council for Medical Schemes.

His confidential report, to be placed before the Minister of Health, Dr Van der Merwe, lays down the new scale of fees which must be implemented within three months.

The last determination of fees was stipulated in January 1973. — DDC.
A JAB AT POCKET

Mercury Correspondent 27/6/77

EAST LONDON—As from August 1 yellow fever and cholera injections for international health certificates will cost £3 each.

This was announced yesterday by the Regional Director for Health in the eastern Cape, Dr. J. D. Kry.

Previously, he said, South Africa had been the only country in the world to have provided free immunisation for yellow fever and cholera.

These new charges will apply to all mean stationed at the Royal Free Hospital and will be introduced immediately.
CAPE TOWN — A remuneration commission under the chairmanship of Mr. Justice R. P. B. Erasmus has submitted a report on doctors’ fees to the Minister of Health, Dr. S. W. van der Merwe.

A Department of Health spokesman confirmed this yesterday and said the minister would give his decision on the report before October 15.

Any alterations to present schedules of fees would affect medical-aid tariffs only, including physiotherapists’ tariffs.

A new unit system on which to base the tariffs is expected to be introduced similar to that already in operation for anaesthetists.

In this system certain procedures would be valued according to the degree of expertise, the scope of the service and risks involved.
3.

The importance of a community’s health and well-being cannot be overstated. In recent years, the Department of Health has implemented several measures to improve vaccination rates in rural areas, which have historically had lower coverage due to logistical challenges.

Vaccination fee

PRETORIA — Cholera, yellow fever vaccinations will cost R5 each from August 1. The Department of Health announced yesterday that smallpox and polio vaccinations will still be free of charge. (Sapa.)


Kenny, P.: "A Spanish Tapestry.

Meertens, G.: "People of the Sierra.

The 'Two Sicilies': South Italy and Malta.


Block E.: "The Politics of a Turbulent Region.

Patronage in Sicily.


Special Issue: "The Sicilian Mafia: An Institutionalized Crime Network.


It's a strange world we live in. No wonder the Mafia has such a strong presence.


Schneider, H.: "Comparing the Italian Mafia to Other Criminal Organizations Worldwide.

The Sakan Area: Yugoslavia, Albania, and Georgia.


Friese, G.: "Comparing the Italian Mafia to Other Criminal Organizations Worldwide.

Half the people in the Mafia are dead, and the other half are about to be.

Hasluck, J.: "The Mafia and Its Impact on Modern Italy.

Kazantzi, R.: "The Mafia and International Relations.


Simic, P.: "The Mafia and Its Impact on Modern Italy.

Whitaker, I.: "The Mafia and Its Impact on Modern Italy.

The Tribal Structure and National Economic Development, ASA 77.
EAST LONDON — The East London Cripple Care Society made an all-time record profit of R6 796 at their annual fete last month.

This was announced by the Mayoress, Mrs J. A. Yazbek, when she cut the ribbon officially to open a gift shop at the Margaret and Harry Fuller cripple centre at 7 St Luke's Road.

Mrs Yazbek said the fact that the society had recently acquired the house next door to add to the existing premises was a tribute to the inspiration of two devoted and dedicated people. — DDR
Clearly, both firms are best off if both increase prices. But suppose you were firm A; would you do it? Remember that you would thereby run the risk of losing $50,000 if your opponent stood pat. There are two circumstances under which you would not increase your price: (1) if you were a conservative manager for whom the hope of gaining $100,000 wasn't worth the risk and worry of possibly losing $50,000; and (2) if you believed that firm B was under conservative management and would not assume the risks of a price increase. Indeed, there is a third circumstance that leads to the same decision, and that suggests how subtly one has to reason when money is at stake. It is (3) if you believe that firm B believed that you were a conservative firm and would therefore not raise your price. So it is far from certain that the firms would make mutually advantageous decisions when allowed to communicate.

These two trivial games the strategic internal oligopolists play are contended with the act and each will have a product design, merchant of only a single dichotomy of business make it in have done.

Bilharzia may create vitality
Science Correspondent

BILHARZIA, far from making children lethargic, may make them more energetic.

This is a preliminary conclusion drawn by Mrs. J. Kvalsing of the Department of Psychology at the University of Natal.

She was speaking at a biological symposium held in Durban yesterday.

Fifty children from schools at Adam's Mission, near Durban, were studied in both classroom and playground situations.

Although the full results have not yet been analysed, it has emerged that the children with bilharzia were more energetic.

Mrs. Kvalsing, however, said it was possible that more energetic children explored more and thus exposed themselves to bilharzia.
<table>
<thead>
<tr>
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<td>No.</td>
<td>Area</td>
<td>No.</td>
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<td>T0</td>
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<td>8</td>
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<tr>
<td>2 - 4.9</td>
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<td>32</td>
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<td>5 - 9.9</td>
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<tr>
<td>Milnerton Munic (farm labourers, Kilarney area), Stable 'boys' M</td>
<td>4,315</td>
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<td>Retreat to Kalk</td>
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**'Bonding' urged to retain SA doctors**

The Argus Correspondent

JOHANNESBURG. — Bonding medical graduates immediately after qualification for 10 years’ service in health care should be introduced to curb South Africa’s alarming brain drain, a Wits University medical professor said in Johannesburg today.

Professor H. Seftel, Professor of African medicine at the University of the Witwatersrand, was speaking at a seminar at the university’s medical school.

He said medical students were privileged people who were committed to serving the community suffering. The community paid for the students to study at a medical school. 'There is no hesitation in calling for a system of bonding for graduate students to a period of 10 years' service in health care,' Professor Seftel added.

'Students might be the best way of selecting medical students who are really cared,' he said.

Dr. George Baston, director of the division of continuing medical education at the university, said two surveys were conducted in 1973 and 1978 to find out how many Wits medical graduates had remained in South Africa.

The survey showed that about 46 percent of students who graduated between 1960 and 1975 had left South Africa and South West Africa.

Most had gone to the United States, Australia, New Zealand, Israel and Britain.

Since last December when the second survey was carried out, the brain drain had worsened.
The older blacks best 'survivors'

Science Editor

Middle-aged South African blacks have a better chance of reaching old age than South African whites and both whites and blacks in the United States.

This little known fact emerged from a lecture last night by Dr Alex Walker, head of the Medical Research Council's biochemistry research unit at the South African Institute for Medical Research.

He was speaking at a meeting of the Institute for the Study of Man in Africa on "Colour and health - contrasts in nutrition and health patterns in South African blacks and Indians."

Dr Walker said calculations had shown that 39.3 of South African blacks who were 50 in 1951 were alive 20 years later.

But for US Negroes the figure was 34.8, for US whites 37.4, for South African whites 32.7, and for South African Indians 21.6.

INDIANS

The higher values for South African blacks was due to their lower mortality after middle age from degenerative diseases - coronary heart disease, cancer and diabetes.

The surprisingly low survival figure for Indians, he attributed partly to the principle of "programming."

It was believed, Dr Walker said, that Indians were destined or "programmed" to have shorter lives than some other races which neither improvements in living standards nor in medical services were likely to change significantly.

Mortality figures of black children under five tell a different story, however. In rural and urban areas figures of between nine and 19 percent have been obtained.

The figure for Indians in Durban is eight and in rural India, 10 to 20. White South Africans have a figure of 2.5 percent.
The CYL, showing negro influence, determined their own future. S.A.’s borders towards part of all Africans in establishing from colonialism. Reports of the appointment of Africa’s first black South African press, was in direct contradiction. The CYL was suspicious of a white evolved doctrine were oppressed because of their race. 

The CYL did not reject the CP out of hand. In fact, they found themselves drawn together because of a common radicalism of method in creating a mass movement.

The ANC’s interracial policy reached its climax in the meeting of the Congress of the People (COP) in 1955. The COP was supported by the ANC, the South African Indian Congress, the South African Congress of Democrats, the Coloured People’s Organization and the South African Congress of Trade Unions. The COP drew up a Freedom Charter in which it was stated that “S.A. belongs to all who live in it, Black and White.” It advocated the establishment of a multi-racial democratic state based on the principle of sharing power. Such declarations were an affront to the Africanists, denying the concept of “Africa for the Africans.” Interracial ideology, the interracial composition of the COP and the influence of non-African leadership constituted, to the Africanists, a betrayal of African nationalism. After the failure of the Western areas and Bantu Education Campaigns, the ANC lost a great deal of prestige. Africanists seceded in 1958 and formed the Pan-African Congress under Sobukwe in 1959.

The Pan-Africanist Congress (PAC) was an extension of the CYL outside the ANC. The PAC, like the CYL in the 1940's, maintained that it was returning to the ANC’s original nationalism. It censured the ANC.

(13) Walsh, pp. 335-336  
(14) Wilson & Thompson, p.459  
(15) Wilson & Thompson, p.464.
Call to promote health

TWENTY-TWO professors at the University of Cape Town Medical School have called on members of the medical profession to use their influence to promote a healthier community life.

"Our responsibility for human welfare insists that we draw attention to the dangers of social disorganisation, inadequate housing and disruption of the family unit," the professors say in a letter in the South African Medical Journal.

The letter says that medicine has turned its back on treating diseases only. The emphasis is now on diagnosis and therapy.

"Students are taught to pay attention to the total background of the patient — his home circumstances, economic considerations and cultural and hereditary factors.

"Comprehensive medicine is taught in every medical school in the Republic and community care, with its emphasis on preventive medicine, is highlighted.

"Surely it is time for members of the medical profession to use their influence collectively to promote a healthier community life throughout South Africa."
The Minister of Health, Dr van der Merwe, announced today the appointment of the first Health Matters Advisory Committee in terms of the Health Act passed earlier this year.

The 12-member committee, under the chairmanship of the Secretary for Health, Dr J de Beer, will meet for the first time in Pretoria on November 2 and 3.

Dr van der Merwe said today the realisation of the Health Act had been an exceptional event in the field of health, but the constitution of the advisory committee was equally important.

The committee has to investigate, consider and make recommendations on all, and also on particular, health matters.

Decisions taken on the recommendations would be applied as health policy and would be implemented on a national basis.

For the first time, health matters pertaining to State, provincial and local authorities, would be co-ordinated by a single body.

DIRECTORS

"I trust, and believe, health services will be rationalised and the overlapping and confusion which at times arose will now be eliminated," he said.

Besides Dr de Beer, the committee includes three directors in the department of health, four directors of provincial hospital services, two representatives of urban local authorities, one representative of a local authority in a rural area, and a representative of the Defence Force.

Department of Health representatives on the committee are Dr J Gilliland, Dr J P Roux and Dr H P Botha. Those from the Provincial services are Dr H Grove (Transvaal), Dr W K Botha (Natal), Dr J Kruger (Free State) and Dr E L Kotze (Cape).

Urban local authority representatives are Dr J P A Venter, of Pretoria, and Dr R J Coogan of Cape Town and the rural representative is Dr J Allen of Stellenbosch.

The Surgeon-General, Major-General N J Niewoudt, represents the Defence Force.

The committee's secretary is Deputy-Secretary in the Department of Health, Mr M H Raath.
Carbohydrate diet - easiest to follow

THE low carbohydrate diet was from a practical point of view the easiest diet to follow and doctors and patients would find it was the most effective way of losing weight healthily and possibly permanently, a doctor writes in the latest issue of the South African Medical Journal.

The doctor says slimming diets had value only when they were nutritionally adequate to maintain health, calorically deficient to reduce weight, socially acceptable to ensure that boredom did not destroy the continuity of the diet, economically feasible and potentially permanent.

He says the reduction of carbohydrates reduced the nutritional value of the diet little, if at all. It had the advantage that once the patient had learnt the approximate carbohydrate content of the foods he was allowed, he did not have to worry about the amounts of the wide range of foods available to him.

These foods included lean meat, white poultry, eggs, most fish, fat-free cheese, milk and most leafy vegetables.

Archaeology III was introduced for the first time in 1976, changing the Archaeology major from two years to three. The course is offered in both the Arts and Science faculties and focuses on the investigative techniques of the archaeologist in the field, in the laboratory, and in writing prehistory. The course includes some practical training in museum methods, photography, mapping, and the like, but has a heavy emphasis on the applied science techniques employed by archaeologists. Fieldwork is required.

In Additional Archaeology (taken simultaneously with or subsequent to Course III) students with exceptional aptitude and interest pursue individual original research projects involving scientific applications in the analysis of archaeological materials, and participate in a research seminar. Laboratory and fieldwork are carried out as each project requires.

COMPARATIVE AFRICAN GOVERNMENT AND LAW I:

The material for this course is derived largely from Southern Africa with comparative reference to case studies in the political systems of East and Central Africa. The course includes an introduction to the comparative study of the politics of race, class, and ethnicity.

Comparative African Government and Law I may not be taken in the first year and Political Science I must be completed beforehand. It is suggested that the following course or courses should be taken prior to or concurrently with Comparative African Government and Law I. The suggested courses and their times of meeting are given below:

- Political Science I meets at 9.25 a.m.
- Economics I meets at 10.20 a.m.
- Sociology I meets at 11.15 a.m.
- African History I meets at 8.30 a.m. (this course cannot be taken by a first year student)
- Social Anthropology I meets at 8.30 a.m.
New health committee is chosen

Staff Reporter

HEALTH matters concerning State, provincial and local authorities would for the first time be coordinated by a single body, the Minister of Health, Dr. Schalk van der Merwe, said in Pretoria yesterday.

Announcing the constitution of the first Health Matters Advisory Committee, he said the committee would investigate health matters and make recommendations.

The members of the committee, which will meet in Pretoria on November 2 and 3 are: Dr. J. de Beer, the Secretary for Health, chairman; and Dr. J. Gilliland, Dr. J. P. Roux and Dr. H. P. Botha, who are directors in the Department of Health.

Representing provincial administrations will be the Directors of Health Services in the four provinces.

Representatives of local authorities in urban areas are: Dr. J. P. A. Venter of Pretoria and Dr. R. J. Cougan of Cape Town; Dr. J. Allen of Stellenbosch and the Surgeon-General of the Army. Major-General N. J. Nieuwoudt, are also members. Mr. M. H. Raath, deputy secretary in the Department of Health, is the committee's secretary.
Brain drain to Dallas

Now a dead letter

Medical schemes not ON COLLISION COURSE

MEDICINE AND STATE
The medics’ bill  

J J van Rensburg, Pretoria:
It was with interest that I read “The doctors’ dilemma” (FM December 2) with your article on “Doctors’ fees — How big an increase?” (Current affairs, October 14) and the subsequent letter from “Sick of it” still in mind.

Surely it would be the utmost “medical-aid bureaucracy” if your statement that the Bill aims, inter alia, at “giving power to the Medical Schemes Council” to determine a tariff of fees were correct. In fact the Bill proposes that a tariff of fees will be determined by the Medical and Dental Council appointed under the Medical, Dental and Supplementary Health Service Professions Act, 1974, comprising the following members:

- The Secretary of Health;
- Ten persons appointed by the Minister, of whom four shall be medical practitioners; one shall be a dentist; one shall be attached to a faculty of medicine or dentistry; three shall be persons who are not registered under the Act; and one shall be a chairman of a professional board;
- One medical practitioner who is a director of hospital services;
- Four medical practitioners representing the universities;
- Nine medical practitioners and four dentists;
- One person designated by the SA Nursing Council; and
- One person designated by the SA Pharmacy Board.

It is clear from the above that the medical profession will have all possible control over the determination of tariffs.

The question should, however, be asked whether it could be expected that medical schemes would continue guaranteeing payment to doctors if they have no say in the “agreement” according to which they guarantee payment in exchange for lower tariffs for their members.

Should the Bill become enforced, surely the doctors would be in a position to determine their own fees without giving medical schemes any chance of objecting — since medical schemes are not allowed to contract out? This must be the juicy carrot referred to in your article, which should leave all doctors happy to forget about contracting out for the rest of their lives.

Despite this most favourable proposal (made by the Minister of Health), Professor De Klerk and the rest of the Medical Association (the doctors’ and dentists’ trade union as you have called them) still have an incomprehensible, arrogant approach. The question still remains whether or not their views are shared by a majority of doctors and dentists.
Children die in malaria outbreak

Two black children have died of malaria and 27 other people are being treated for the disease at Pongola on the Transvaal-Natal border.

It is believed most patients came from across the Swaziland border where they presumably contracted the infection.

The Department of Health is waiting for further information from its regional office in the area.

Apparently local health authorities are concerned about an increase in the numbers of malaria-carrying mosquitoes in the region. Spraying is in progress on both sides of the border.

The Health Department was told of 2,909 malaria cases in South Africa last year. Most were in the Northern Transvaal, with only 147 in the Southern Transvaal and Natal.
Gross national product

28. Mr. N. B. WOOD asked the Minister of Statistics:

(a) What was the gross national product for the latest year for which figures are available;

(b) what was the (a) percentage and (b) amount allocated to (i) health in the Republic and the homelands, respectively, and (ii) social welfare services;

(c) what was the (a) percentage and (b) amount allocated to (i) education and (ii) housing in respect of each race group.

The MINISTER OF STATISTICS:

(1) R27729 million for the calendar year 1976 and estimated at R28668 million for the 12 months ended 31 March 1977.

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<th>(a) Percentage of Gross National Product</th>
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<td>(i) Health:</td>
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In the case of (3)(ii) separate figures in respect of Whites, Coloureds and Asians are not available. Transkei is excluded.
Plastic food packages cancer scare over

By Tony Spencer-Smith

20/4/78 55

Scare van der...
Hansard 12 28 April 1978
Question 13 Col. 715-716

(4) What is the position of applicants for medical service of the KwaZulu Government, in particular;

(a) in KwaZulu Natal;

(b) in the area of the Black community;

(c) in the area of the white community;

(d) in the area of the coloured community;

(e) in the area of the Indian community.

Mr. A. K. MANTSHI asked the
Minister of Public Security and Home Affairs:

Whether he proposed to employ the applicants to medical posts in the medical service of the KwaZulu Government, in particular.

The Minister of Public Security and Home Affairs answered the question as follows:

Yes.

No.

To be continued.
Hawker's says city health inspector can't control these bad-meal sicknesses.

By Mervin Cox

Legitimate readers resent the activities of these meal sellers as they can get away with

unhygienic methods and generally unclean. Copy three.

Every day African hawkers set up business in Dalton Road, near the abattoir, selling offal from filthy hardboard tables supported by crates and wrapping the fly-blown and often rotting meat in newspaper or used potato bags.

"The health hazards are obvious," said Dr Neville Becker, Durban city medical officer of health. "No checks are made on the fitness of the meat for human consumption and the practice is illegal. We would like to clean up the area but as fast as we catch one set of traders another crowd replace them."

**Difficult**

Brigadier Hennie de Witt, police commissioner for Port Natal, said the police had difficulty stamping out the hawking but he intended to take up the matter personally.

"This practice cannot be allowed to continue," he said, "I intend taking the matter up with the chief magistrate and the town clerk in an effort to eradicate this illegal trading. We must try to get increased fines — at present offenders get away with paying a R10 admission-of-guilt fine, which is absurd."

By-laws make it an offence to sell raw meat without a licence. Licensed traders have to comply with regulations on refrigeration, storage, wrapping, staff facilities and hygiene. Dalton Street's illegal traders do not.

"You can imagine how much the registered trader resents these hawkers who are getting away with filthy practices for the price of an occasional fine," said a spokesman for the health department.

The source of the meat and offal sold by the hawkers is not known, but because the abattoir is only a few metres away the meat is probably bought from offal dealers there.

There is nothing to stop the hawkers buying offal from the abattoir and reselling it but, although the offal is probably uncontaminated when they buy it, storage in the open in filthy dustbins can make it dangerous to humans in a few hours.

Because the source of the meat is not checked, it could be from the carcasses of diseased animals and full of parasites such as tapeworms, liver flukes and TB-carrying organisms.

"Even abattoir-bought meat, when sold in the unhygienic conditions of the Dalton Street traders, can soon give the buyer food poisoning," said Dr Becker.

City health inspectors say they are afraid to go to Dalton Street alone and need police protection when on a raid.
Alcohol: hope for damaged brain cells

WASHINGTON — Brain damage suffered by chronic alcoholics, long thought to be permanent, may be partially reversible with abstention from liquor, Canadian researchers report.

The new findings, according to Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好 however, Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好 however, Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好 however, Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好 however, Dr. PETER M.又好又快 Dr. PETER M.又好又快 Dr. PETER M.又好 however, Dr. PETER M.又好又快 Dr. PETER M.又好又快 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It should be noted that the term 'technical' is misleading when referring to the above institutions, since they do in fact offer a wide range of courses, and are one of the number of commercial and academic pretensions and little else. "How," asked Pimstone, "can we expect the bourgeoisie we create at university to physically work in the desolate areas where doctors are needed? Must we teach hospitals be more physically integrated into the community? We should also consider the question of doctor substitutes — why not have the "barefoot doctor" system in SA? Why not make extended use of medical auxiliaries to bring medical care to rural areas?"

Professor Alan Sorkin, Professor of Economics at the University of International Health at Johns Hopkins University, Baltimore, perceives four major advantages in broadening the base of allocating health care funds:
- Increased manhours by the workforce;
- Increased productivity;
- Increased habitability of the land area by overcoming diseases such as malaria;
- Changes in the attitudes of people to their own destiny (healthy people are less fatalistic, docile, more self-confident).

Sorkin showed there was a close correlation between health care and development, in which the latter would not move without the former. His experiences while working with the World Health Organization had shown that, while improvement in the general standard of health care was inevitably followed by a short-run population explosion, a substantial fall in the birth rate invariably followed a drop in the death rate after a lag of 10-15 years.

The question many delegates were asking after digesting evidence produced by Third World health economists like Sorkin was: as a major food exporter with a persistently high rate of malnutrition can SA afford space-age hospitals like the new Johannesburg Hospital, put up at a capital cost of R150m (R52 500 per bed) and which will cost R30m-R50m a year to run?

<table>
<thead>
<tr>
<th>Year</th>
<th>NTC</th>
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<tbody>
<tr>
<td>1970</td>
<td>2 39</td>
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<td>1971</td>
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<td>1972</td>
<td>3 10</td>
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<td>1973</td>
<td>3 52</td>
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<td>1974</td>
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**Table 2. NTC 1 - V p**

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**HEALTH**

**Plenty wrong**

The little-explored, possibly neglected, field of the economics of health care in developing countries, such as SA, came under scrutiny in Cape Town this week at an international conference organised by UCT's Labour and Development Research Unit and the SA Medical Scholarships Trust.

In an uncommon get-together of economists, medics and sociologists, 140 delegates pondered and discussed 75 papers and concluded that SA, for all its wealth and economic leadership in Africa, did not have the highest standard of health.

Opening the conference, Professor Marius Barnard said that after numerous visits abroad, even those behind the iron curtain, he had come to the conclusion that although SA had modern hospitals and sophisticated medical facilities, the Republic came off second best after comparing the medical infrastructure with the incidence of malnutrition, infant mortality and diseases related to poverty and deprivation.

Professor Bernard Pimstone of UCT medical school, who has gained international recognition for his research work into "man's biological adaptation to nutritional deprivation" in the Western Cape said: "I have often been disturbed by the recurring question: would my research funding not have been better channeled into preventing rather than studying malnutrition?"

Other speakers concluded that there is nothing wrong with the allocation of resources within medicine, and in the community it is supposed to serve, because the prevalence of malnutrition and other preventable diseases remains unacceptably high.

Pimstone says the problem goes deeper than the provision of medical facilities or the pursuit of health statistics. It involves social and dietary mores and adaptations to urbanisation. One example is the abandonment of breast-feeding at an early stage of a child's life, leaving it indoors with surrogate parents while the mother tries to boost family income. This sets in motion the vicious circles of rickets, marasmus and kwashiorkor. "The problem can't be controlled by diet replenishment alone — it is part of a devastating social phenomenon of wider implications, and the cure has to be seen in a broader perspective," says Pimstone.

SA delegates at the conference agreed there was a need for a wide overview of health requirements in the country.

Referring to possible distortions in the allocation of resources for health care, it was suggested that a start could be made by examining medical faculties at SA universities — such as the system of admitting medical students exclusively on their...
Shocking details of rural health care revealed

By Barry Streek
CAPE TOWN — Alarming, indeed shocking, details of the inadequacies of health care in South Africa, particularly in the rural areas, were given at an international conference in Cape Town last week.

And a radically different medical system — which could be implemented in terms of the 1977 Health Act — is urgently needed, one which takes cures and prevention to the people rather than the people on expensive hospital beds, once people are sick.

Central to the new approach is the concept of a medically trained assistant in those areas where the health indices are at their lowest.

The medical assistant system is already functioning in neighbouring states — in Rhodesia, Mozambique, Botswana, Lesotho and Swaziland — but not in South Africa, possibly on a limited scale.

In the so-called Westernised, hospital-based system, based on the needs of developed countries, it follows, with some effect in the Durban areas but with disastrous results outside the cities and towns.

A delegate at the conference from Gazankulu said that R10 a year for even one person could be adequate for health care in some poor countries, but this was totally inadequate in areas, like Gazankulu, where expensive structures had been imported. Even the health laws prevented the introduction of new methods.

The need for a new health care system was summed up by one of the international delegates who said: "The statistics in the rural areas in South Africa have not surprised me. We know there is a problem, but what is your health policies. They are, so out of date.

They are ten years behind Botswana."

At the conference, which was sponsored by the Southern Africa Labour and Development Research Unit (Saldur) and the South African Medical Scholars Trust (Samet), it was paper-making papers and discussion that:

"Malnutrition and other diseases in the rural areas were more extensive than in the Crossroads squatter camp in Cape Town — the incidence of protein calorie malnutrition in Crossroads was 1.6 per cent while at Ngutu in KwaZulu it was 7.3 per cent.

A sample survey of children under the age of five in Transkei has revealed an infant mortality rate of 820 per 1,000 compared to figures of 12 per 1,000 for whites, 38.1 per 1,000 for Coloureds, 29.1 per 1,000 for Asians, and 68.7 per 1,000 for urban black people.

"For four, 4,822 births in the rural areas of the Ciskei, there were 3.84 children alive — 263 out of 1,155 children lived, and 3,277 children were alive for every 4,285 born in the urban areas of the city."

"Malnutrition is still extremely common in South Africa, tuberculosis is still rampant despite the apparent slight decrease in incidence recently and malaria seems to have escaped from the rural areas."

"In 1977, businesses in the greater Cape Town area lost an estimated R38 million due to the problem drinking among their employees," according to Dr W. Wynne Louw, of the University of the Western Cape.

"While there is one doctor for every 999 people in the 13 principal areas, the ratio is 7.62 per 1,000 in the rest of the country. The average in the principal areas was 2,087 people per doctor (Mr Mike McGrath, of the University of Natal).

South Africa spent 3.6 per cent of its gross national product of health expenditure in 1974/5, a decline from 4.2 per cent in 1965/6. In 1960 this proportion was lower in South Africa than for some countries with lower per capita incomes. This placed South Africa below Western countries below Czechoslovakia, Hungary and Poland but above Italy, Bulgaria and Romania.

"With medical graduates leaving South Africa in increasing numbers — 80 per cent of the University of Witwatersrand's medical graduates over the last five years are now overseas — the increasing need for doctors in military service and they have returned expatriate doctors to their countries of origin, health facilities are likely to suffer, particularly in the rural areas.

"In the South African pharmaceutical industry spends about four times as much on promotion of research," according to Mr Jonathan Brodie, the figure spent by the industry in promoting their products was almost as large as the entire cost of manufacturing.

This depressing picture of the state of South African health care was improved somewhat by the "proof of success at a higher level of projects in Southern Africa where health workers, clinics and doctors appear to have had a marked impact.

The senior medical superintendent of the day hospital in Pretoria said: "The programme in the greater Cape Town area, Dr. J. A. Smith, said: "Unless there is a sound primary level of health care, the rest of the system will be wasted, expensive and inefficient, no matter how skilled or how expert or highly specialised it is."

With the introduction of trained health care teams in 1968 in areas of the Cape where people were concentrated, had shown "a drastic improvement in health standards."

Although the day hospitals have been introduced in 1968, one and a half million items of service are being handled a year (all of which would have been handled in more expensive hospitals previously) at 16 centres.

Only two per cent of the patients were referred to established hospitals at a cost of four per cent of the Cape hospitals budget — and the high birth rate has dropped to 23 per 1,000.

In South Africa, according to Professor Lucy Wagerstaff, 45,000, as well as 30,000 of the country's nurses have dealt with over 130,000 patients since the late 1960s, and the doctor has a new role as "consultant, evaluator and monitor."

And a pioneering health care centre at Pholela in Natal reduced infant mortality from 10.7 per cent in 1962 to 10.06 per cent in 1955, but the experiment was, regretfully, not extended to other areas for a number of reasons.

Clearly, projects which have taken health and preventive care to the people have met with some success although clearly, social and economic (especially political) processes have a significant bearing on the level of health. This point was confirmed in a number of the research projects discussed.

As UCT's Michael Savage said: "If medicine is to be effective it must be based on stable family life, adequate wages, promote educational and employment opportunities, better agriculture and more active participation by communities in decision-making processes, the bulk of specific medical resources are devoted to health services which are curative rather than to those which are preventative and inhibit the occurrence of illness or in some way remove the situation in which illnesses are likely to occur."

With a new health policy, given lighter priority by all sections of the government, Britain, the new medical assistant and community programmes in all areas of South Africa, a much happier situation could be created.

But, while 200 delegates from 15 nations, including from South Africa, grappled with this serious problem, the South African Government was noticeably absent for its absence. The Department of Health did not send a representative to even listen, let alone explain and elaborate on its views.

One trusts that its absence was a bureaucratic oversight.

For must people like Professor Ralph Kirk, continue to say, a little pathetically, "I work in a university where many academicians including myself, wake up too late, and criticise actions when they could possibly have used their influence to prevent these, but didn't because they believe policies should be kept out of medicine. This despite the fact that health development is a political and social process."
Clean food prevents disease

GASTRO-ENTERITIS is an infection of the intestinal tract (gut). The symptoms are soft watery stools which may contain blood or slime, cramping pains in the stomach, vomiting and sometimes a fever. The younger the child with gastro-enteritis, the more serious is the disease. It is also more serious in underfed children.

The child loses water and body salts in the vomit and loose, watery stools. If this fluid is not replaced the child may become very ill and may die. When these symptoms develop, especially if the eyes look sunken, the child must be taken to the hospital immediately.

The doctor may have to give special fluids into the blood if the vomiting continues. Diarrhoea (many watery stools) and vomiting are seen with other illnesses such as kwashiorkor (badly fed children), measles, and infections of different parts of the body.

The child should always be taken to the hospital when these symptoms occur, so that the doctor or nurse can find out what is the cause.

Gastro-enteritis is caused by germs which are eaten with dirty food. The germs are spread by flies, dirty hands, dirty water and dirty feeding bottles or teats. The infection can be spread to babies by other children or adults.

To prevent this disease the house must be kept clean and insects kept off the food. Hands must be washed after visiting the toilet, after changing nappies and before making or giving food to the family.

Gastro-enteritis is uncommon in breast fed babies because breast milk is the best food and is germ free. Therefore all babies should be breast fed for as long as possible.

If the baby is bottle fed the feeds must be prepared with boiled water and all the equipment kept clean.

By keeping the food clean a mother can reduce the risk of gastroenteritis in her family.

Next week the subject will be Tuberculosis Part 1.

A child being treated for gastro-enteritis in hospital

Safety tips

Accidents do not happen — they are caused.

Matches must never be left within the reach of children. Playing with matches has caused fires from which many children have been badly burned and sometimes died.

Never leave a young child playing on a bed near an open window. Children like to see what is going on outside. They have been seriously hurt or even killed by falling out of an open window.

Occasionally it is necessary to bring tools into the house to repair broken things. Take great care to see that dangerous tools such as saws and screwdrivers are NEVER allowed to become toys.

WORD MEANINGS:

- SERIOUSLY: Badly.
- OCCASIONALLY: Not often.
- REPAIR: Make good or mend.
The paper has argued that Botswana can afford and would benefit from a more organic, more experimental, more locally determined approach to rural development than the apparent inappropriate drive for greater precision. The two proposals used as examples of such an approach, the upgrading of communal land company concept and a regular employment guarantee scheme, are both wonderful laboratory models, but they require adequate institutional and support. At the same time they are critical for the management of common assets and for the promotion of local government and initiative, and for the management of common structure.
committees and were employing 16,625 employees in the following sectors of the economy:

**TABLE 3**

| Sector       | Number of| \n|--------------|----------|
| Manufacturing| 6,945    |
| Services     | 5,637    |
| Commerce     | 3,030    |

A STRAIN of malaria resistant to a drug used to control the disease for 30 years—Chloroquine—has been found in areas of Africa, but has not made its appearance in South Africa.

The United States Centre for Disease Control (CDC) said three travellers are known to have contracted the chloroquine-resistant malaria strain in Africa. All three had been cured with other drugs.

The Tropical Medicine Consultancy in Virology to the South African Department of Health, Dr. James Gear, said yesterday that experts in South Africa had so far found no cases of the new strain.

Dr. Gear said he knew about the three patients who had contracted the resistant malaria to allow a report that they might be the first cases of the disease in South Africa. The two other victims were Americans who contracted the disease in East Africa in the first half of the year.

The new strain is resistant to chloroquine, the main treatment for malaria in Africa, and has been treated successfully with quinine. The drug is expensive but the Department of Health has kept the prices down under control, and there is no danger in the future.

82% of the respondents reported that their works committees had a period of one year. In most instances, 68%, regular monthly meetings were held, while a further 9% met weekly and 6% at intervals.

The most frequently mentioned reasons for choosing a works committee were that they were more effective than liaison committees, that they were more representative and acceptable to African workers, and that the workers preferred them.

In 1973 only three co-ordinating works committees had been established.

**Recognition of African Trade Unions**

The Verster investigation indicated that while the majority of participating organisations with liaison committees (56%) were opposed to the recognition of African trade unions, the majority of those with works committees (68%) were in favour of recognising them.

how your clinic can help you

MANY people do not know what a clinic can do for them. We hope to give them some idea of the clinic's functions.

Large areas will have one or more fixed clinics, while smaller towns may have a mobile clinic (a travelling van) which visits them on particular days of the week.

Some villagers in the country may have to travel to the clinic in a nearby village.

It is the duty of each person in the community to find out where the clinic is, when it is open, who works at the clinic and what services they supply.

Information about clinics can be obtained from the local authority or from the hospital in the area.

The clinic may usually be reached by public transport. Many clinics provide transport for patients from nearby villages.

Clinics give treatment for minor ailments and injuries and treat or follow up patients with TB and veneral diseases.

Some clinics give dental care and the nurses give advice about other health problems. Many clinics provide advice about family planning.

An important service is the "mother-and-child" clinics. Pregnant women are cared for and taught about breast-feeding and child care. Young children are weighed and measured often to make sure that they are developing well, physically and mentally.

Immunisation (vaccination) protects the children from "killer" diseases like diphtheria, measles and TB.

Some clinics have maternity nurses who help with births at home. For those women who want to plan their families and have healthy, well-formed children, the clinics give advice on family planning.

A Department of Health mobile clinic. A nurse is questioning a patient.
Lesotho may soon become abortion refuge for SA women

Weekend Argus Correspondent

JOHANNESBURG. — South African women might soon be able to drive to Lesotho for a legal abortion, according to the country's Medical Association.

The association is campaigning for a revision of Lesotho's abortion laws and wants to introduce abortion on demand during the first three months of pregnancy.

If the plan succeeds — and the indications are that it will — it will create serious problems for the country's small medical service if hundreds of South Africans flock to Lesotho for abortions.

And doctors registered in South Africa will not be able to go to Lesotho to do operations which are illegal in this country, said a local authority.

The secretary of the Lesotho Medical Association, Dr Mercy Molony, said: "We have taken the matter to heart. We are to discuss the matter in January.

If the majority of doctors agrees with our plan, we will try to have the law changed," she said.

The association plans to introduce a system with three categories.

During the first three months, abortion will be obtainable on demand. From the third to the sixth month of pregnancy, abortion will only be possible if the mental or physical health of the mother is endangered.

Abortion will not be allowed during the last three months of pregnancy unless the physical health of the mother is in danger or if it is likely a deformed child will be born unless the abortion is performed.

It is understood the new plan has the support of many Lesotho doctors and leading members of the Lesotho Medical Council."
AGENDA for the AGM/SAKELYS vir die Algemene Jaarvergadering

1. Personalia
2. Minutes of the AGM held on 7th September 1977/Notule van die Jaarvergadering van 7 September.
3. Chairman's report/Verslag van die Voorsitter.
5. Financial statement for the year ended 10th September 1978/Finansiële verslag vir die jaar geëindig 10 September.
6. Motion: The Western Cape Branch requests the chairman of the Classical Association to transmit to the biennial conference of the Association the proposal that the portion of the subscription remitted to the local branches for each registered member should be increased from 50 cents to R1.

Proposed: J.E. Atkinson; Seconded: Mr. J. Sang.


Huidige lede: Voorsitter/Chairman: John E. Atkinson
Sekretaris/Tesourier//Secretary/Treasurer: Mr. J. Sang
(Vice: Miss P. le Roux)

Sekretarisse vir die Skole/ Schools' Secretary: Miss B. Keeson
(not available for re-election)

Committee members: Dr. S. Bruwer, Mrs. M. Mezzabotta, Mr. Thom
Mr. P. Collins, Miss S. Armstrong, Dr. R. van Stekelenberg.


8. Any other business/Algemeen.

J. Sang.
Department of Classics, U.C.T.
Phone: 698331 Extn. 213.
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<th>79</th>
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8. Mr. N. B. WOOD asked the Minister of Health:

(1) How many persons (a) died and (b) were admitted to hospital as a result of poisoning by poisons used for agricultural purposes during the last 12 months for which figures are available;

(2) in respect of what dates are these figures given.

The MINISTER OF HEALTH:

(1) (a) 21.
    (b) 73.

(2) 1 January 1978 to 31 December 1978.
What are the salary scales laid down for (a) White, (b) Coloured, (c) Indian and (d) Black (i) doctors, (ii) dentists and (iii) pharmacists in State and provincial hospital services.

The MINISTER OF THE INTERIOR AND IMMIGRATION:

Salary scale (R per annum)

<table>
<thead>
<tr>
<th>Rank</th>
<th>White</th>
<th>Coloured/Indian</th>
<th>Black</th>
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<tbody>
<tr>
<td>(a) to (d)</td>
<td>17 490 (fixed)</td>
<td>14 850 (fixed)</td>
<td>12 870 (fixed)</td>
</tr>
<tr>
<td>Chief Specialist/Professor</td>
<td>16 170 (fixed)</td>
<td>13 530 (fixed)</td>
<td>11 910 (fixed)</td>
</tr>
<tr>
<td>Principal Specialist</td>
<td>14 850 (fixed)</td>
<td>12 390 (fixed)</td>
<td>10 950 (fixed)</td>
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<tr>
<td>Specialist</td>
<td>14 190 (fixed)</td>
<td>11 910 (fixed)</td>
<td>10 560 (fixed)</td>
</tr>
<tr>
<td>(ii) Medical Officers</td>
<td>14 850 (fixed)</td>
<td>12 390 (fixed)</td>
<td>10 950 (fixed)</td>
</tr>
<tr>
<td>Chief Medical Officer</td>
<td>14 190 (fixed)</td>
<td>11 910 (fixed)</td>
<td>10 560 (fixed)</td>
</tr>
<tr>
<td>Principal Medical Officer</td>
<td>8 610 × 390</td>
<td>7 440 × 390</td>
<td>6 630 × 270</td>
</tr>
<tr>
<td>Medical Officer</td>
<td>10 950 × 480</td>
<td>10 950–11 430</td>
<td>7 440 × 390</td>
</tr>
<tr>
<td>12 870</td>
<td>10 170</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Dentists: As in respect of Medical Officers.</td>
<td></td>
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<tr>
<td>(iv) Pharmacists</td>
<td>10 950 × 480</td>
<td>9 390 × 390</td>
<td>7 830 × 390</td>
</tr>
<tr>
<td>Chief Pharmacist</td>
<td>12 870</td>
<td>10 950</td>
<td>9 390</td>
</tr>
<tr>
<td>Senior Pharmacist</td>
<td>8 610 × 390</td>
<td>7 170–7 440</td>
<td>6 050 × 270</td>
</tr>
<tr>
<td>10 560</td>
<td>390–9 000</td>
<td>7 440</td>
<td></td>
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<tr>
<td>Pharmacist</td>
<td>6 090 × 270</td>
<td>5 010 × 270</td>
<td>4 110 × 180</td>
</tr>
<tr>
<td>7 440 × 390</td>
<td>6 900</td>
<td>5 010 × 270</td>
<td></td>
</tr>
<tr>
<td>8 220</td>
<td>5 820</td>
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The above-mentioned scales do not include allowances payable to the personnel.
A sick society

The problems of disease are inseparable from those of society. Nowhere is this more true than in SA — Harry Sefol, Professor of African Diseases, University of the Witwatersrand.

Indeed, as a close look at the vital statistics reveals, the relationship between ways of living and ways of dying in SA is stark. While medical technology churns out intricate and expensive cures, the real solution may lie in improved socio-economic conditions.

The link between health and wealth is most striking when infant mortality rates are compared. There were 18.5 deaths per 1,000 white infants under the age of one in 1976. This compares well with the best figures in the world — the US recorded 16.4 infant deaths per 1,000 that year.

For black babies, life is far more hazardous. Infant mortality among coloured people, according to Department of Statistics figures, was 112.2 per 1,000 in 1976, more than six times that of whites.

African figures are just as high. In the 1970 census, the African infant mortality rate was 123.9 per 1,000. This actually represents an increase from 101.2 in 1960. More recent figures are problematic, accurate data are only kept for selected magisterial districts, covering 3.4m Africans in 1976, when the figure was down to 100.2.

Department of Health epidemiologist Horst Kuster puts the African infant mortality rate somewhere in a wide range between 80 and 120. He adds, however, that it is deceiving to compare white and black figures, since although all African infants must be registered, not all births are.

Peter Bundred, senior lecturer in Community Medicine at UCT, estimated recently that 720 were mortality rates among rural Khoesan in Transkei is a shocking 282 per 1,000. (India’s was 122 in 1975, Thailand’s as low as 26.)

Whatever the exact figure, the discrepancy between white and black infant mortality rates is undeniable. The causes are clear. Census data show that over half of African infant deaths in 1970 were caused by enteritis and pneumonia, neither of which represents a grave danger for a well-nourished baby. But to a child whose resistance has been corroded by poor diet and living conditions, both are highly likely to prove fatal.

Surprising killer

Nor have conditions changed significantly over the past four decades. The Department of Statistics’ Report on Deaths points out that there has been no improvement in mortality figures from enteritis and diarrhoea for coloured people since 1937.

One surprising and totally avoidable killer is measles. Even among white children, says paediatrician Max Klein, the risk of dying from measles is 30 times greater than in the US. The solution is fairly simple — a measles vaccine. In the US, measles vaccination sliced mortality from 40,000 deaths in 1960 to a mere 30 in 1976. The campaign in SA has been less effective; doctors and the authorities disagree on why.

Better living standards have protected whites from many disease hazards facing the poorer classes. But the good life has its own risks, chiefly heart disease.

In 1976, over 25% of all white deaths were caused by coronary thrombosis. Most alarming is the incidence of heart disease in young white males. Epidemiologist Cyril Wyndham pointed out recently in the SA Medical Journal that SA white males between the ages of 25 and 34 are seven times more likely to suffer from heart disease than their Swedish counterparts. The danger to South Africans is 2.5 times greater than even their fast-living American co-

cvals.

The flood of joggers on to the streets may be having an effect. Wyndham shows that the incidence has dipped slightly since 1970.

Many medical authorities attribute the high incidence of heart disease to Western lifestyles, in particular smoking, obesity, hypertension, and a sedentary way of life. Sefol refers to Western man’s “unnatural gastronomic extravaganza,” and his “dietary intoxication.” Also on the upsurge is cancer, which caused 15.6% of all white deaths in 1976.

An interesting side-effect of better health among whites is that the percentage of whites over 65 has nearly doubled over the past 50 years, reaching 6.7% in 1970. In a number of countries, people over 65 account for over half the requirements of hospital bed and long term care facilities.

The disease pattern emerging from the statistics is clear. But health planning scarcely tallies. The Secretary for Health, with the best figures in the world — the US recorded 16.4 infant deaths per 1,000 that year.

For black babies, life is far more hazardous. Infant mortality among coloured people, according to Department of Statistics figures, was 112.2 per 1,000 in 1976, more than six times that of whites.

The old General Hospital was to be sure, in poor condition. But neighbouring Soweto, with less than 1.5 500-bed Baragwanath Hospital, plus a trickle of patients treated in the 233 beds of Johannesburg’s Non-European Hospital. In deciding to build the new Hospital on the Transvaal administration motivated purely by medical considerations, or did it want to emulate the Cape’s medical showpiece at Tygerberg?

Worse off

Rural areas are even worse off. Hundred points out that while urban areas have one general practitioner to every 2,000 people, in rural areas the doctor/population ratio is one to 10,000.

“Many deaths in rural areas could be prevented at low cost, yet 98% of the medical budget is spent on curative services, usually supplied to the urban elite at high cost.”

There were 58,9 registered nurses per 10,000 whites in 1975, against 9,2 for Africans and only 5,8 for Asians.

More hospitals and doctors would, however, go only some of the way towards solving the problems. Hundreds of malnourished babies are helped back to health at Baragwanath Hospital only to go home to the same conditions that precipitated their malnutrition.

The key, community health doctors point out, lies in the old adage that prevention is better than cure. Better education and adequate inoculation are essential. Studies have shown that many illnesses begin to disappear even before new therapies are introduced to remedy them, simply because of improved standard of living.

Health planning should be better balanced with the incidence of disease. Some medical establishments are equipped with expensive treatment of uncommon, and sometimes almost incurable diseases, while little is spent on highly preventable diseases widespread among blacks.

Another proposed solution is the Chinese precedent of “barefoot doctors,” villagers trained to meet rudimentary health needs of rural Chinese. The SA version would involve highly skilled nurses, trained to examine patients, treat common conditions, and refer serious cases to doctors. About 80% of all patients can be handled by primary health care nurses alone. The idea has been implemented to a limited extent in Soweto.

The focus of National Health Year is on greater public involvement in promoting health. De Beer has spoken of the need for a better balance between hospital and community-based services, and his department has taken tentative steps in that direction. But health authorities need to go much further if they are really to ensure a healthy society.
Further study on sewer plan urged

Municipal Reporter

The proposal to build a sewer outfall at Green Point Common was discussed at the recent meeting of the Sea Point Ratepayers' and Residents' Association. The association has decided to conduct further investigations before any decision is made.

In an interview, Mr. Chris Joubert, the chairman of the association, said:

"The association has been examining the feasibility of building a sewer outfall at Green Point Common. However, we require further investigation before we make a final decision."

Mr. Joubert added that the association will hold a special meeting to discuss the issue further.

ENGINEER'S VIEW

Cape Town's City Engineer, Mr. J. G. Brand, said today that raw sewage has been dumped into the sea at Green Point for the past 300 years.

This would be put to the association at its annual meeting, when members would decide whether to support the proposal.

HEALTH FACTOR

Mr. Joubert said he had been very concerned to read in The Argus that authorities at the University of Cape Town thought the new outfall was a potential health hazard.

It was also a fact that some local residents were worried about losing sportsfields and possibly part of the golf course if a sewer works was built.

This is a very serious decision which the city fathers are called on to make, he said.

There are many factors to be taken into consideration, including the position suggested by authorities at the University of Cape Town, that the council may be spending a great deal of the ratepayers' money to create a health hazard.

TO GO AHEAD

The City Council decided at last week's meeting to go ahead with the scheme.

The matter came up late in the afternoon, when a third of the council members had already left the meeting. Voting was 11 in favour of going ahead with the scheme, and 11 in favour of carry-
Research on accumulation of lead in animal/human tissues

919. Mr. N. E. Wood asked the Minister of Health:

Whether there has been any research in the Republic on the accumulation of lead in animal and human tissues; if so, what are the results.

†The MINISTER OF HEALTH:

No research per se has been undertaken in the Republic. Dr. E. B. Staphorst wrote a scientific review on the problem. The National Research Institute for Occupational Diseases performed a very limited survey of the lead content in the blood of children at the Baragwanath and Coram Gums in order to obtain data about the normal levels of lead in blood. The Institute also renders a monitoring service to industry which incorporates the determination of the lead content in the blood of exposed employees in order to enable industry to take the necessary steps to safeguard the health of such employees.
231. Mr. N. B. WOOD asked the Minister of Health:

(a) How many cases of malaria were reported in the Republic in the last 12 months for which figures are available and

(b) how does this figure compare with that for the previous period of 12 months.

The MINISTER OF HEALTH:

(a) 6,125.

(b) 3,512.
were not abated by the various politico-economic crises which forced down real wages in Rhodesia in the 1906-09 period; e.g. the agricultural product price slump in 1923-4 and the agrarian labour supply crisis in 1924-28, the Great Depression of 1929-33, the effect of the Malice Control Act (1931) on peasant production and a continuous process of involution in the peasant economy throughout the period. 3/ By 1933 the R.N.L.B. ceased to function. The inflow of workers was sufficient to meet most employer demands at pre-Depression wages. In 1934, however, W.N.L.A. nego-
tiated the establishment of a depot in Salisbury for the purpose of recruitment in its non-Southern Rhodesian 'tropical' colonies. Another Agreement in 1939 gave W.N.L.A. facilities for roads, stations and rest camps in exchange for an undertaking not to attract contractees from Southern Rhodesia. Manager of W.N.L.A. and his staff (W. Gommill) were stationed at Wankie and Inyazura. The Rhodesian railway network was to transport recruits in and out of South Africa and again this arrangement continued until the end of the war. At the outbreak of war, the recruitment activity of W.N.L.A. was stopped.

Despite having to acquire access to a 'labour market share' primarily founded upon the political power of Southern Rhodesia in excluding W.N.L.A. from their domain - W.N.L.A. was substantially its recruitment of 'tropicals' (those who were born north of latitude 22°S.), from 3,000 (1.1 percent of the total labour force) in 1936 to 32,000 (10.6 percent) in 1939. At this stage (circa 1936) W.N.L.A.'s preoccupation was with recruitment in Barotseland and Nyasaland, a large part of which was occupied by the latter which by 1939 all take-off of 10,000 contractees. 2/ In this area Southern Rhodesia and W.N.L.A. interests clashed strongly and were 'resolved' through open competition. The Southern Province of Nyasaland was a prime source of 'free flow' labour to Rhodesia. In a challenge to W.N.L.A. / intrusion .......

NOTES

2/ Data for the period up to 1933 are drawn from Charles van Onselen, op. cit.


Spinal injection
kills pain during childbirth

By Marks Hall, Senior Editor

The Baracwanda Maternity Hospital in South Africa has built up a controversial signal reputation for the controversial spinal injection for childbirth. The method, which was introduced by the hospital's obstetrician, Dr. John Bleeding, has been the subject of much debate. It is being used in South Africa and other parts of Africa.

The method involves the administration of a spinal injection to induce anaesthesia. The procedure is performed with the patient lying on their back with their knees bent. The injection is administered through a needle inserted into the patient's spine. The injection contains a local anaesthetic and a sedative, and is designed to block pain sensation and reduce the need for pain relief medication.

The obstetrician said he was impressed with the method and found that it allowed the patient to remain conscious during the operation. He said that the injection made the patient feel relaxed and helped with the process of childbirth.

The method has been controversial, with many doctors and patients expressing concerns about its safety and effectiveness. Some have raised concerns about the potential for complications, including dizziness and respiratory depression.

Despite these concerns, the method continues to be used in South Africa and other parts of the world. It has been shown to be effective in reducing pain during childbirth and can be administered safely when performed by a skilled obstetrician.

17/ Roger Leys, op. cit.
18/ ....
The thousand rounds as us and yet they only hit one horse. The going away and so fled. We estimated that they fled over 
when the weathering party moved off they thought we were all 
watered patiently hoping that we would try to take the next. The carniblers got down to water their horses. The boys 
we soon learned that the firing was caused by two troops of 

the power of discipline to see the men so obedient under such 
when they were walking across. It was a good instance of 
heard the Sergeant-Major roar out, dress back on the left!, 
By this time, so we could watch them. To our amusement we 
them to walk, the carniblers and I were safe behind rocks 
young Seymour, who was in command of the squadron, ordered 
started at a trot 

the Minister of Health;

<table>
<thead>
<tr>
<th>727. Mr. H. E. J. VAN RENSBURG asked</th>
</tr>
</thead>
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1. How many abortions in accordance 
with the provisions of section 3 of the 
Abortion and Sterilisation Act were 
carried out during the period 1 
January to 31 December 1977 and 
1978, respectively, on (a) married and 
b) unmarried women in each race 
group who were (i) under 14 years, 
(ii) 14 to 15 years, (iii) 15 to 16 years, 
(iv) 16 to 17 years, (v) 17 to 18 years, 
(vi) 18 to 25 years, 
(vii) 25 to 29 years, 
(viii) 30 to 35 years, 
(ix) over 35 years of 
age;

2. how many of these abortions in each 
case were procured in terms of para-
graphs (a), (b), (c), and (d), respecti-
vely, of section 3 (1) of the Act.

The MINISTER OF HEALTH;

(1) and (2) See annexures 7 and 8 of the 
Department's annual reports for 1977 
and 1978, respectively.

not faced it. We had a hot, flat, though 
we had not mastered the koppie 

so to the front. The only course was to retire to the
Millions wasted as medicines go down the drain

Bevis Fairbrother

AT LEAST R66-million worth of prescribed medicines are washed down the drain annually in South Africa, a Mercury investigation has revealed.

The White population was responsible for almost half of this figure in spite of there being 13,070,000 more Blacks than Whites in South Africa, according to the latest population figures released by the Department of Statistics.

The majority of a cross-section of the public interviewed over the past few weeks admitted to wasting a third of the medicines prescribed to them.

Medical aid societies estimated the average family spent about R8 a month on medicines.

From these facts, coupled with a survey by the Johannesburg General Hospital that 70 percent of their patients did not "comply sufficiently as per instructions" on prescriptions, and a White population figure of 13,070,000, the Mercury estimates Whites wasted almost R66-million worth of medicines.

Inquiry

The Steenkamp Commission of Inquiry into the pharmaceutical industry released its findings in January 1978. It claimed the consumer spent R240-million on prescribed medicines annually.

Professor Harry Grant-Whyte, a Durban expert on drugs, said medical practitioners were largely to blame for the situation as they prescribed more than was needed.

Professor Grant-Whyte suggested that prescriptions be in triplicate to control the situation.

One copy would be for the pharmacist, one retained by the doctor and the third posted to a central department to be processed.

Control

"This will be the first step in controlling irrational, gratuitous prescribing of excessive quantities of drugs, especially sedatives and tranquilisers."

"Certain patients should be counselled and given placebos and be monitored rather than subjected to vast amounts of medicines," said Professor Grant-Whyte.

Other doctors blamed patients for "the staggering" wastage figure:

"Patients sometimes feel better prematurely and do not complete a prescribed course of medicine. A large amount is thrown away and then they return shortly afterwards for more medication for the same complaint," said one doctor.
CONCERN at the high black and coloured infant mortality rate in South Africa — but with the promise of a steadily improving situation — has been expressed by the State Health Department and child health authorities.

Figures just published show the rate for coloured and black to be seven times higher than that of whites in the birth-to-one-year age group, and 47 times higher in the one-to-four-year group.

Dr Howard Botha, Director of Strategic Planning for the Health Department, said it was accepted that many of these deaths were preventable. That was why the department was concentrating on community medicine — bringing primary health care to as large a section of the population as possible.

"As yet primary health care and our health education programmes do not reach everyone. But this is in the direction in which we are working within the limitations of available funds."

"Adequate immunisation against some of the infectious diseases will already make a great difference. For example measles predisposes towards gastro enteritis and pneumonia — some of the main baby killers."

"Subcommittees of community leaders already exist to deal with various aspects of child health, including infant mortality."

"We are also reviewing our hospital building programme, with the possibility that there will be fewer new hospital beds but more mobile health services, clinics and day hospitals which can bring health care to the people where they are."

"This could also be an extension of the role of the primary health care nurse who is proving such a success in Soweto."

Professor Harry Stein, head of the Paediatric Department at Baragwanath Hospital, said the infant mortality figure of 112 per 1000 live births for coloured and black (white rate 15) given in an article in the latest SA Medical Journal, did not apply to Soweto.

In 1956 it was 150 in Soweto — in 1977 it had dropped to 42.

In 1956 (population of Soweto estimated at 300 000) 2 400 children were treated at the hospital for gastro enteritis. In 1978 it was 3 261 (population 425 000). The low mortality rate was due to: 25.3% of 1 000 live births. In addition, the proportion of people in Cape Town had better housing, clean water and received higher wages.

The infant mortality rate for black babies is 13 times higher than for whites in the one-to-four-year-old group, reported MARAIS MALAN. But the black infant death rate is decreasing.

The association between the incidence of gastro enteritis and poverty. Through co-ordination of provincial and local health services the infant mortality rate among the coloured in the area was down to 25.3 per 1000 live births. In addition, coloured people in Cape Town had better housing, clean water and received higher wages.

He advocated the following measures to curb the high infant mortality rate among coloured and black elsewhere.

- Good ante- and postnatal care.
- Greater support of breast feeding and family spacing. So that the small child can get better maternal care.
- A comprehensive investigation into the problems of the working mother. Maternity allowances should be paid for at least three months after the birth of a baby so that it can receive a good start in life. At present mothers usually take off two months before and one month after the birth.
- There should be more creches for the babies of working mothers and child-minders should be adequately trained.
- The rural mother should be cared for while her husband is working in the city.
- There is a need for more pre-school clinics. Subsidies are available but local authorities often do not make use of them.
Young blacks to get vaccine for liver virus

Science Editor

A new vaccine against a virus causing a potentially serious liver disease will soon be used in South Africa on black children in the hope of preventing the development of liver cancer in later life.

This was announced in Johannesburg last night by Professor Michael Kew of the department of medicine at the University of the Witwatersrand, during his inaugural lecture. He specializes in diseases of the liver.

The so-called hepatitis-B virus, which causes an infection of the liver, is now believed to be associated with primary liver cancer. Blacks from certain regions are particularly prone to this form of cancer, which is nearly always fatal within six weeks of diagnosis.

The results of treatment of liver cancer in South African blacks had been dismal, Professor Kew said.

"Clearly when a tumour runs such a rapid course and the results of treatment are so poor, one must direct one's attention to prevention."

Liver cancer had a peculiar geographical distribution which suggested that one or more environmental agent was responsible.

There were two possible culprits. One was a poison, aflatoxin, produced by a mould growing on grain products stored in warm, moist conditions. Studies had shown a direct association between aflatoxin intake and the incidence of liver cancer.

The second was the hepatitis-B virus, which usually caused infection in early life and often persisted in the blood, thus leading to a chronic carrier state.

Southern African blacks had a high incidence of chronic infection with the virus and virtually every liver cancer patient was also a carrier.

If a clinical trial showed that a vaccine against the virus protected against liver cancer it would be proof that the virus was the cause, Professor Kew said.
group could have hived off, and, each group had the potential to act as a nucleus for further expansion, the present model can account for divergent lines of evolution within a tradition.

In the description of the two models used in the present study, it was pointed out that group fission could have resulted from two different processes: (1) social stress as a result of overcrowding, and (2) increased mortality and lowered reproductive fitness due to the scarcity of a particular resource.

Group fission would appear to have been associated with social conflict (Legassick, 1969; Honig, 1967; Turner, 1954). This association

The State was not directing enough resources towards preventive health care. Dr. T. McCorry, regional manager of the Urban Foundation, the Western Cape, said yesterday.

Another project was the dissemination of community health by means of the training of community health workers. Dr. T. McCorry said, "Every health worker is going to train other workers and help them in the community."

If the Health Ministry took their knowledge into community health workers should be paid by the State, even if it were only 10% a month. The State should also save by prevention. The analysis of the bevelled complex dispersed rapidly although individual cultures showed a slower rate of spread. A number of problems are associated with the analysis and the results cannot be used as an absolute confirmation of the validity of the discontinuous spread model.

The major problem with the radiocarbon chronology is the small sample size. Only four Silver Leaves sites have been dated and one of these Eiland is a specialised activity area (Evers, 1975). Kwale and Urewa have more dated sites but only samples are very small. In the discontinuous spread model it was suggested that the overall rate of spread would have been faster than the expansion of an individual culture. Therefore, the regression for the overall rate of spread was calculated from the earliest known dates for each culture and this reduced the sample size. It is possible that the sample size problem an independent evaluation of the two mechanisms of dispersal is necessary.

The data used in the present study were derived from only one tradition, the flint-tipped and bevelled complex, and therefore the analysis would seem to be tied to the validity of a particular culture-historical reconstruction.

While this is true, the rapidity of spread associated with the simulation of the discontinuous spread model seems to indicate that this is the most likely mechanism of dispersal.

ACKNOWLEDGEMENTS

I would like to thank Professor T.R. Huffman for reading and commenting on the numerous drafts of the paper. Miss C.S. Harcourt helped edit the manuscript and Mrs. J. Howard-Tripp typed the final drafts.

I would like to express my special thanks to Dr. D.S. Wilson who introduced me to evolutionary ecology and helped to debug the program.
Being ill may also cost more soon

Science Editor

By the end of the month another cost-of-living blow is expected to fall when the South African Medical and Dental Council meets in Johannesburg to determine a new medical aid tariff for doctors and dentists.

Whatever the outcome, the public covered by medical aid are not likely to have much to rejoice over:

- A higher tariff may entice some contracted-out doctors back into the medical schemes' fold, but it will have to be substantially higher to have this effect. The result—probably increased medical aid subscriptions.

- If the tariff is not high enough, more doctors may contract out, so more patients will have to pay the difference between their medical scheme benefits and the doctors' private tariff.

In either instance health services will cost more.

In spite of beliefs to the contrary, the percentage of contracted-out doctors is not high at the moment. In December the figure was 3,800 out of about 15,000 on the medical register.

Of the 3,800 the medical aid tariff applies only to about 2,800 doctors in private practice. Medical schemes in South Africa deal with 5,000 to 7,000 practices. Some are solo but many are partnerships, so the number of contracted-out doctors form a clear minority.

The allegations that contracted-out doctors charge up to 100 percent more than the medical aid tariff has been denied by both the Medical Association of South Africa and the manager of a large privately run medical scheme.

The true figure has been placed at five to 10 percent, with an overall average of about 25 percent.

Informed sources believe the entire medical aid movement is due for a major rethink. The total cost of health care is still lower here than in most developed countries, but costs are escalating and the public will have to prepare itself for devoting a larger percentage of their income to medical expenses.
DEPARTEMENT VAN GESONDHEID
No. R. 1802 24 Augustus 1979
VERKLARING VAN MEDIESE TOESTANDE AS
AANMELDBARE MEDIESE TOESTANDE KRAG-
TENS ARTIKEL 45 VAN DIE WET OP GESOND-
HEID, 1977 (WET 63 VAN 1977), OOR DIE HELE
REPUBLIC VAN SUID-AFRIKA

Kragtens die bevoegdheid my verleen by artikel 45
van die Wet op Gesondheid, 1977 (Wet 63 van 1977),
verklaar ek, Schalk Willem van der Merwe, Minister
van Gesondheid, hierby die ondergenoemde mediese
toestande as aanmeldbare mediese toestande oor die
hele Republiek van Suid-Afrika, met ingang van die
datum van publikasie van hierdie kennisgewing:

Antrakts.
Brucellose.
Choler.
Differie.
Geelkoors.
Hemoragiése Koorsiektes van Afrika (Denguekoors,
Ebolaakoois, Kongokoors, Lassaakoois, Marburgkoors,
Slenkalkoors).
Hondsdoelde.
Lepra.
Leptospirose.
Loodvergiftiging.
Malaria.
Masels.
Meningokokkale meningitis (insluitende meningok-
kemie).
Paratifoïde koors.
Pes.
Pokke (alle vorms).
Poliomielitis.
Primêre maligniteit van die brongus, long en pleura.
Psittakose (insluitende Ornitose).
Tetanus.
Tiffioïde koors.
Tifuskoors (epidemiese luistiftuskoors, endemiese rot-
vlootifikuskoors).
Toxoplasmose.
Tragoom.
Tripanosomiase.
Tuberkulose (alle vorms van tuberkulose is aan-
meldbaar, behalwe gevalle gediagnostiseer slegs op grond
van kliniese teken en simptome en/of 'n positiewe
tuberkulientoets).

Vergiftiging weens enige landbou- of veemiddel wat
kragtens die Wet op Misstowwe, Veevoedsel, Landbou-
middels en Vee middels, 1947 (Wet 36 van 1947), soos
gewysig, geregistreer is.

Virus Hepatitis A en B en ongedifferentieerd.

S. W. VAN DER MERWE, Minister van Gesondheid.

DEPARTMENT OF HEALTH
No. R. 1802 24 August 1979
DECLARATION OF MEDICAL CONDITIONS AS
NOTIFIABLE MEDICAL CONDITIONS IN TERMS
OF SECTION 45 OF THE HEALTH ACT, 1977,
(Act 63 of 1977), THROUGHOUT THE REPUB-
LIC OF SOUTH AFRICA

Under and by virtue of the powers conferred upon
me by section 45 of the Health Act, 1977 (Act 63 of 1977),
y, Schalk Willem van der Merwe, Minister of Health,
hereby declare the aforementioned medical
conditions as notifiable medical conditions throughout
the Republic of South Africa, with effect from the date
of publication of this notice:

Anthrax.
Brucellosis.
Cholera.
Diphtheria.
Haemorrhagic Fevers of Africa (Congo Fever, Dengue
Fever, Ebola Fever, Lassa Fever, Marburg Fever, Rift
Valley Fever).
Lead Poisoning.
Leprosy.
Leptospirosis.
Malaria.
Measles.
Meningococcal meningitis (including meningococ-
aemia).
Paratyphoid Fever.
Plague.
Poisoning from any agricultural or stock remedy
registered in terms of the Fertilizers, Farm Feeds,
Agricultural Remedies and Stock Remedies Act, 1947
(Act 36 of 1947), as amended.
Polioymelitis.
Primary malignancy of the bronchus, lung and pleura.
Pneumococis (including Ornithosis).
Rabies.
Smallpox (all forms).
Tetanus.
Toxoplasmosis.
Trachoma.
Trypanosomiases.
Tuberculosis (all forms of tuberculosis are notifiable,
except cases diagnosed solely on the basis of clinical
signs and symptoms and/or a positive tuberculin test).
Typhoid Fever.
Typhus Fever (epidemic lice typhus fever, endemic
rattie typhus fever).
Viral Hepatitis A and B and undifferentiated.
Yellow Fever.

S. W. VAN DER MERWE, Minister of Health.
JOHANNESBURG — Massive increases in doctors' and dentists' fees were announced yesterday.

Hard-hit South Africans will have to pay a shock overall increase of 52.4 per cent in doctors' fees and 33.5 per cent in dentists' fees from November 1.

The increases were granted by the South African Medical and Dental Council at a special meeting in Johannesburg yesterday and will be gazetted in November.

Yesterday, the Secretary of Health, Dr. J. de Heer, said it was the largest increase ever granted by the council.

The increases mean:

1. Doctors will be paid out R6.5 million more by medical aid schemes. The patient's share of the account is added doctors will receive about R7.5 million more a year.

South Africa's 1.978.297 members of medical aid schemes will have to pay an average of nearly R7.5 million more per month on subscription fees.

Each doctor will collect an estimated R12.436 more a year from medical aid societies.

The new minimum statutory fees mean that:

The GP consultation fees will rise from R4 to R6.80, and specialist consultation fees from R16 to R23.10.

Fees for a doctor's visit to a private home, hospital or nursing home will increase from R6.88 to R13.20.

An adult tonsillectomy performed by a surgeon will increase from R36.40 to R52.80.

Removal of the appendix by a surgeon will increase from R72 to R99.

The council defended its decision to grant the increases by accepting a submission from the South African Medical Association that the costs of running a medical practice had escalated while statutory tariffs did not compensate doctors for the general increase in the cost of living.

The 80-page report submitted to the council stated: "From verified statistics it is clear that the financial position of doctors has, over the past few years, lagged behind the consumer price index and inflation rate."

The 84.4 per cent increase in statutory tariffs granted to general practitioners is seen as a move to narrow the gap between statutory and private tariffs.

Statistics show that contracted out doctors charge an average of 19 per cent more than fees laid down in the statutory tariff.

The representative association of Medical Aid Schemes said in objection to the doctors' remuneration increases: "Increases in earnings of this magnitude could never be justified to the man in the street who has had his income eroded by inflation and enormous increases in prices of all commodities in recent times."

The president of the Border Coastal Branch of the Medical Association of South Africa, Dr. D. Kayser, said: "We expected the increase because our fees have hardly gone up in five years."

Labour leaders last night expressed shock and dismay at the "appalling and unreasonable increases doctors propose to grant themselves."

Claims were made that the South African Medical and Dental Council had recklessly used its powers and that the council should be rapped by the government.

The general secretary of the Trade Union Council of South Africa, Mr. Arthur Grobbelaar, said last night: "There's no use appealing to the government to curb these increases. The government has shown itself to be ineffectual in similar situations in the past.

"The time has come for us, the general public, to take up the fight."

"These ridiculously excessive demands by the Medical Council must be stopped, and it is us who must oppose them."
New Act will have adverse effect on welfare work

By Elizabeth Wilson

The massive bureaucracy set up to implement the new National Welfare Act could severely hamper welfare organisations and treble their costs.

Mr Lage Vitus, acting director of the National Council for Mental Health, said welfare organisations could not afford the fragmentation into many regional and racially-segregated boards envisaged by the Government from this month.

"The need of spreading resources to the people who need them, this legislation will put an impossible strain on welfare services," said Mr Vitus.

The National Welfare Act requires all welfare organisations to be re-registered.

First, they must register as fund-raising organisations. Then, if they wish to operate as welfare organisations and qualify for Government subsidies, they must also register as welfare organisations.

The new Act allows a two-year registration period.

It requires that welfare activities be dealt with by four different departments: Social Welfare and Pensions, Coloured Relations, Co-operation and Development and Indian Affairs.

Each of these departments must now set up their own welfare boards on a regional basis.

TEN REGIONS

"The Department of Social Welfare has indicated that it will have ten different regions; other departments could have more," said Mr Vitus.

This could mean that a national council could have to correspond and deal with 40 different regional welfare boards all working independently and with their own policies and processes.

"Twelve people will be required to work on each board which makes for a lot of people and a lot of time.

"In addition to this, social welfare organisations will have to split into four racial groups and divide their services. Some national councils have more than 100 branches.

"If we are to do justice to each group this will treble our expenses. At the moment we are sharing facilities and staff."

Mr Vitus predicted the new system could also cause national councils to lose their international affiliations.

CONFUSION

Mrs Geraldine Schoeman, director of the South African Epilepsy League commented: "This Act was intended to promote better control of welfare agencies, but the way it has been drawn up it is going to cause tremendous confusion. There are going to be serious problems in implementing it. Already there is confusion even among Government departments as to how the Act will be put into practice."
Dying is the great leveller.

Vestiges of apartheid still exist in the Reef’s ambulance services, but fall away in emergencies.

“When someone is dying, we do not worry about the colour of the person’s skin,” seems to be the general feeling among fire officers canvassed.

Mr R Hansen, fire officer, said Krugersdorp ambulances served the town as well as parts of Pretoria, Rustenburg and Hartbeespoort Dam.

The black locations in the area, Kasigo and Munseeville, are served by the West Rand Administration Board.

Ambulance services for all Reef townships are run separately by the boards.

Krugersdorp station has five ambulances for whites and three for blacks all similarly equipped. Only the white staff, however, are qualified as paramedics, and are sent out to emergencies involving all races.

“In emergencies, no notice is taken of the colour of the patient’s skin, and white staff can be sent to blacks, or vice versa,” Mr Hansen said.

Mr A F Cloete, Bonn platoon officer, said his station had separate ambulances for blacks and whites but, depending on what ambulances were available, a non-racial emergency service would be provided.

ONE SERVICE

Mr C Emery, of the Johannesburg Fire Station, said Johannesburg’s 42 ambulances were fully integrated as one service, but where possible staff of one race were sent to serve patients of the same race.

Station officers on the Rand generally agree: blacks serve blacks and whites, but when a woman is in labour and time is short, the nearest ambulance must help.

INTENSIVE

Sandton is served by six ambulances and an intensive care unit.

To upgrade the service, Sandton would also soon be aided by voluntary civil defence units, staffed by trained people. Mr R F Schmidt, chief officer, said.

The white patients are taken to white hospitals and blacks to black hospitals, regardless of which hospital is closest in the emergency.

This man was knocked over by a car. In the emergency, a white team came by ambulance to the rescue.
The Popular Proft Who Cares

Awards Winner

Better Living

Story and photo by Penny Swift
LETTERS
It's a question of medical priorities

THE ARTICLES, "Government seeks compromise in medical fees" and "Unions slam medical fees" (RDMM, Oct. 13, 16) confuse the "Medical Council" with the doctors. Although the Medical Council is the public's watchdog to check overcharging, it now seems the Council are accused of overcharging for the doctors!

Legislation was not passed by the government to give doctors full authority to determine their own fees. It was passed by the Medical Council against their will, and it states the Council will be only too glad if "legislation is passed during the 1980 Parliamentary session to strip it of all fee fixing powers" and they apparently now ask for such a measure.

When the Medical Schemes Act became law in 1989, the first general rule was that the tariff was that the Medical Association (the doctors' trade union) had drawn up. At the time, the Schemes members were individuals in the lower income bracket who normally qualified as hospital cases. Therefore, there was no income ceiling for members of these societies and the tariffs had no general authority of normal fees. These societies were worried about saving industry many man hours that would otherwise have been wasted. Their employees being sent to public hospitals for treatment, the large amounts meant the loss of a whole day's work.

Medical Aid Societies represented a small percentage of the population. To aid and protect the same anomalous, there were also various general rules. Thus overtime fees (night visits) were chargeable only for calls received on or before 6 am and after 6 pm. (This was altered some years ago to 7 am and after 8 pm.) Thus if a doctor received half-call/AD call between 5.30 and 5.59 pm, but could not get around to the last case of the night, no fee was charged. It was still a day call: or a surgery might see a case at 5 pm but have to wait and treat the case until 11.15 pm before operating. It was also a day call. What do Mr Arthur Grobbelaar of the Trade Union Council, Senator A Scheepers of the Garment Workers' Union and Mr John van Wyk, say to those hours?

Another general rule was that if two operations were done by the same surgeon under the same anaesthetic but not through the same incision, eg double rupture, the fee that was charged for the second operation was the same as the first. When the fee was R15 for the fee for the second operation. R15. This is why, since been increased to R15.

The so-called 5.5% increase for 1987 did not mean that the fee could be increased by 5.5% on the fee for the second operation. It could mean an increase in the fee for the second operation and the patient in the case of the second operation. The fee for the second operation would then be R15. This has since been increased to R15. The fee for a corneal grafting operation, the surgeon would have to pay the patient the cost of the graft and be paid a minimum R15 extra.

This Medical Aid Tariff with all its general rules was in one swoop adopted by the Government and applied to the Medical Schemes where there was one room ceiling to membership. There was thus already a 33.3% reduction on standard fees for those doctors who contracted out. Fortunately, doctors could contract out if they wished, but many doctors did not because the regulations made the scheme pay the patient's share of any fee if the doctor was not contracted out, even if he charged higher tariffs. And of course some patients would pocket the money and go to a doctor.

The original Act provided for the tariff to be reviewed every two years. This was done by the Remunerations Committee presided over by Mr Justice Erasmus of the High Court.

He found that the period was excessive to every three years and on one occasion he notified doctors that they should not ask for an increase in fees but should increase their productivity if they wished to earn more.

So, from 1987 to 1979, the tariff fees were gradually increasing 10% and 15% and some have even decreased, but never making up the 33.3% that had costs in 1979. Not taking into account the increase in Col and the expenses of starting and running a practice, the general price of inflation.

The Government also had a few rules, especially in itself. Thus members of the Police Force and other categories of Government employees were at Medical Scheme rates less 10%. This had not been increased since 1984. The Government has not been increased since 1984. The Government has not been increased since 1984.

Under Government, one also increases hospital, the doctors who do part-time work in the hospitals (and part-time workers form the majority), receive no paid leave and no pension. Thus, for 30 years, I have given hospital services equivalent to 1/2 of the time of a full-time employee.

The Editor, Rand Daily Mail
Box 1138, Johannesburg 2000

1979, this figure had increased to 15.71%, indicating that the child had an additional year of life.

62. Proportional representation of selected RESULTS
For Africa, the proportional representation was the only index calculated.

63. Expectation of life, this was calculated both as birth order and at 5 years of age. For both males and females, it is expected to live beyond birth and 45 years.

64. If a 4-year-old during the period 1941 to 1945, the number of mortality and at 5 years of age.

65. It should be noted that the difference in specific death rates is smaller than the difference in the number of live births whilst the numerator is the number of children born in the corresponding period.
CONSUMER MAIL

Medical Aid—succour or sucker schemes?

By PAM KLEINOT

IT'S A multimillion rand industry, financed by nearly 2-million people and run on a "non-profit basis"—but its books are not open for scrutiny to its members.

This is South Africa's network of medical aid schemes which has been under the spotlight in recent weeks.

Old antagonisms between the medical profession and medical schemes were sparked off by the 52% increase in medical tariffs—described by medical schemes as "unjustified." Doctors said they had complaints about medical schemes.

Is it against this background that Consumer Mail investigated medical schemes and found:

- It costs the public an estimated R10-million a year to run, averaging out at R1.08 for each member every month.
- Of the subscription income paid to these schemes, 25% is set aside in a reserve fund and about 10% is used for administrative costs.

And as more and more doctors and dentists opt out of medical aid schemes, the consumer loses out. While the benefits remain the same, members have to pay in substantial sums.

Earlier this year one of the country's 38 entrepreneur schemes was in the news when more than R200,000 went missing.

The event focused attention on the entire industry and the claims and counter claims that revolve around it.

But just what safeguards are built into these schemes to prevent misuse or misappropriation of public money?

Members of the medical profession claim that entrepreneur schemes are a "high-powered business game" and accuse the administrators of the schemes of "profiteering."

These allegations are denied by spokesmen from medical schemes who claim that medical aid is run on a non-profit basis.

Mr J Ernstzen, vice-chairman of the Representative Association of Medical Aid Schemes (RAMAS), denies that funds are being misused or mismanaged.

Asked why the books are not open for public scrutiny, he said: "It's utterly ridiculous to suggest that they should be. No one walks into the OK Bazaars to look at their books."

He said members were supplied with audited balance sheets annually.

"Medical aid funds are strictly controlled and there is adequate legislation to ensure this," he said.

He said safeguards included:

- Subscription income may only be used for benefits and administration costs.
- The registrar of medical aid schemes investigates into administrative costs and controls the amount allowed.
- Reactions to the doctors' call for medical aids to throw open their books, Mr Ernstzen slammed them for "interfering" and compared the members/medical aid scheme relationship to that of the patient/doctor — which was considered to be sacrosanct.

"This sort of statement is made to divert attention from their own association and the recent increase."

Commenting on the missing R121,000 from one medical aid scheme, Mr Ernstzen said: "They cannot be legislated against."

In recent weeks Professor J N de Klerk, chairman of the federal council of the Medical Association of South Africa, has expressed concern about the large profits made by entrepreneur medical aids, claiming to be more than R1-million a year in some instances.

"Anyone who tells you these schemes are not in it for the money is talking nonsense," he said.

During a month-long investigation Consumer Mail established that:

- South Africa's 210 medical aid schemes — 38 of which are entrepreneurial — are ostensibly run on a nonprofit basis, but critics claim that administrative allowances make them the "finest business enterprise in the world."
- Substantially more than half the country's dentists and about 32% of the doctors have opted out of medical aid because they feel they are not earning a reasonable income from the lower medical tariffs.
- Of the total annual subscriptions received by medical schemes, 25% is set aside in a reserve fund and about 10% is used on administrative expenses.
- Dr Ralph Stocker, an authority on medical aid schemes, said while medical aid was initially welcomed when it was first introduced, it had subsequently deviated from its original role as a "debt collecting agency" and "assumed the role of dictator of what doctors should earn."
- "Gradually entrepreneurial interest filtered into the schemes and today there are few medical aids not controlled by a (Pty) Management Company," he said.

Mr Stocker said only 6% of a member's subscription money "can work for him" because 25% is set aside in reserve fund and about 10% for administrative expenses.

Mr Stocker said that for maximum efficiency the present medical aid schemes should be rationalized.

"This could be done by administrative costs — and there are too many of them to be a viable proposition," he said.

Doctors interviewed by Consumer Mail said they resented the fact that their earnings were being dictated to them by a group of businessmen with vested interests.

Other gripes about medical aid schemes include:

- The absolute way in which medical aid pick and choose what they cover. For example, while some cover remedial education hardy any cover for infertility and contraception.
- Members benefits are reduced corresponding with the drift by medics to opt out of medical aids.
- Patients often have to fork out large amounts because medical aids in some cases pay as little as 60% of fees of members of the medical profession who have opted out. There are many more dentists who have opted out than have opted in.
- Many doctors contracted out of medical aid last year following a recommendation by the federal council of the Medical Association of South Africa because of dissatisfaction with the findings and tariffs laid down by the fifth remuneration commission.
- Although there is a low debt rate for doctors contracted into medical aids, they are not paid out for up to three months.
- Many doctors who have opted out claim that there is no guarantee they will be paid once their patients have been paid out by their medical aid scheme.

They also said the increase in medical aid tariffs in the past decade had not kept up with the cost of living.

While their gross profits have remained more or less the same in the past few years, their net profits have lagged miserably behind because of increased expenses.

A breakdown of medical aid schemes shows:

- 31.7% of medical aid members belong to 100% medical aids.
- 47% belong to schemes giving between 80% and 100% cover.
- 20.6% belong to schemes giving only 60%.
- There are 172 in-house medical aid schemes which cover 80% for all services except surgical procedures, hospitalisation, theatre fees and medicine supplied in hospitals — for which they give 100% cover.
- There are 39 entrepreneur schemes. Members opt for higher subscriptions but get 100% cover.

RAND DAILY MAIL, Wednesday, November 28, 1979
Unhealthy state of affairs

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The challenge to Health: adapt
To amend the Anatomical Donations and Post-Mortem Examinations Act, 1970, relating to definitions; to provide for control over the importation and exportation of tissue; relating to the powers of the Minister of Health to make regulations; and to provide for incidental matters.

BE IT ENACTED by the State President, the Senate and the House of Assembly of the Republic of South Africa, as follows:

1. Section 1 of the Anatomical Donations and Post-Mortem Examinations Act, 1970 (hereinafter referred to as the principal Act) is hereby amended—

(a) by the substitution for the definition of "dentist" of the following definition:

"dentist" means a [person] dentist registered or deemed to be registered as such under the Medical, Dental and [Pharmacy] Supplementary Health Service Professions Act, [1928] 1974 (Act No. [13] 56 of [1928] 1974);";

(b) by the insertion after the definition of "dentist" of the following definition:

"'export' means to export from the Republic by any means;";

(c) by the insertion after the definition of "hospital" of the following definitions:

"'import' means to import into the Republic by any means; and "importation" has a corresponding meaning;";

"'importer' includes any person who, whether as owner, consignor, consignee, agent or broker, is in possession of or is in any way entitled to the custody or control of any tissue imported;";

(d) by the substitution for the definition of "medical practitioner" of the following definition:

"'medical practitioner' means a [person] medical practitioner registered or deemed to be registered as such under the Medical, Dental and [Pharmacy] Supplementary Health Service Professions Act, [1928] 1974;";

(e) by the insertion after the definition of "regulation" of the following definitions:

"'Secretary' means the Secretary for Health;";

"this Act" includes any regulation made thereunder;";
Commission of inquiry into medical schemes

PRETORIA — A commission of inquiry would investigate all aspects of medical aid schemes, as part of a full inquiry into health services, the Minister of Health, Dr L. A. P. A. Munnik, said yesterday.

The Hon Sir J. W. Haak has been appointed chairman of the commission, which will issue an interim report on medical schemes within three months of its appointment.

As an interim measure, until the commission reported, draft legislation will be gazetted today, concerning the present tariff of fees for services, as the SA Medical and Dental Council has decided to review tariffs.

Dr Munnik said he hoped the commission would be able to remove the unpleasantness that has accompanied the determination of tariffs.

"I hope they will be able to find an acceptable formula to calculate the cost of health services, so that suppliers receive reasonable incomes and patients were assured that they were paying reasonable fees."

The commission will make recommendations regarding the scope and cost structure of health services in both public and private sectors.

"This is with a view to rationalising services and making them more effective, as well as placing costs on a sound and firm basis," Dr Munnik said.

He said the tariff of fees for services by medical practitioners and dentists, to members of medical schemes, had made it an appropriate time to appoint such a commission.

Some of the terms of reference of the commission are:

- The rationalisation of medical schemes. An investigation of their administrative costs, assets and reserves, profits and/or compensation of entrepreneurs, use of manpower, the extent of coverage.
- The investigation into the extent to which the recommendations of a previous commission of inquiry into the pharmaceutical industry, have been implemented.
- To determine what influence pharmaceutical manufacturers have had on the cost of medicine.
- To investigate the implementation of the recommendations of a previous commission of inquiry into private hospitals and unattached operating theatres.
- To investigate the provision of medical services by state, provincial and local authorities.
- The incomes and fringe benefits of medical practitioners, dentists and supplementary health service personnel.
- Excessive use by patients of medical services.

The commission will publish an interim report of medical schemes three months after its appointment. It will issue interim reports on various facets of its terms of reference and will appoint committees to investigate these various facets.

Professor J. N. de Klerk, chairman of the Federal Council of the Medical Association of South Africa, MASA, said last night he welcomed the appointment of the commission "with open arms."

"We have stated all along we would support a commission and are only too happy it has been appointed." — DQC.
GENERAL EXPLANATORY NOTE

[ ] Words in bold type in square brackets indicate omissions proposed by Minister on introduction.

[ ] Words underlined with solid line indicate insertions proposed by Minister on introduction.

BILL

To amend the Medical, Dental and Supplementary Health Service Professions Act, 1974, so as to do away with the prescribing of qualifications obtained by virtue of examinations conducted by any examining authority situated outside the Republic, entitling any holder thereof to registration under the said Act as a psychologist; to provide for the temporary registration, for training purposes, in respect of supplementary health service professions, of persons not permanently resident within the Republic; to make new provision for the registration with the said Council of persons practicing supplementary health service professions; to prohibit the use of certain names by certain unregistered persons; to bring certain expressions of the said Act into line with others; to further regulate the effect of tariffs of fees for medical practitioners, dentists and psychologists and in respect of supplementary health service professions; to effect a change in relation to the power to make regulations; and to further define the powers of the Minister of Health; and to provide for matters connected therewith.

BE IT ENACTED by the State President, the Senate and the House of Assembly of the Republic of South Africa, as follows:

1. Section 11 of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (hereinafter referred to as the principal Act), is hereby amended by the deletion of paragraph (b) of subsection (2A).

Amendment of section 11 of Act 56 of 1974, as amended by section 3 of Act 52 of 1978.

2. Section 24 of the principal Act is hereby amended by the substitution for subsection (2) of the following subsection:

"(2) No qualification obtained by virtue of examinations conducted by a university, or other examining authority, situated outside the Republic shall be prescribed under this section unless—

(a) such qualification entitles the holder thereof to practise as a medical practitioner or dentist [or psychologist], as the case may be, in the country or state in which such university or other examining authority is situated;

(b) by the laws of that country or state, persons holding qualifications granted after examinations in the Republic and entitling them to practise in the Republic as medical practitioners or dentists [or psychologists], as
Govt to probe medical costs

By WILLIAM SAUNDERS-MEYER
Pretoria Bureau

A COMMISSION of Inquiry would investigate all aspects of medical aid schemes, as part of a full inquiry into health services, the Minister of Health, Dr L A P A Munnik, said yesterday.

Mr J W Haak, former Minister of Economic Affairs, has been appointed chairman of the commission, which will issue an interim report on medical schemes within three months of its appointment.

Because the SA Medical and Dental Council had decided to review tariffs of fees for services, and the commission's report would not be ready for the next Parliamentary session, an interim measure draft legislation on the present tariffs would be Gazetted today.

Dr Munnik said that he hoped the commission would be able to remove the unpleasantness that has accompanied the determination of tariffs.

The commission will make recommendations about the scope and costs of health services in both public and private sectors.

This is with a view to rationalising services and making them more effective, as well as placing costs on a sound and firm basis, Dr Munnik said.

The commission will also investigate:

- How far the recommendations of a previous commission of inquiry, into the pharmaceutical industry have been implemented;
- What influence pharmaceutical manufacturers have had on the cost of medicines to the consumer and on the supply prices to retailers, wholesalers and doctors;
- The implementation of the recommendations of a previous commission of inquiry into private hospitals and unattached operating theatres;
- The provision of medical services by State, Provincial and local authorities;
- The costs of conducting a pharmaceutical practice, profit margins on dispensing and on other commodities and prescription patterns, and
- The incomes and fringe benefits of doctors, dentists and other health service personnel, patient loads, private practices and their running expenses.
HEALTH & DISEASE - General
1-1-80 - 31-12-80
Minister's plan to control medical fees 'monstrous'

The Minister of Health's plan to control medical fees by setting the power to amend or set aside decisions of the Medical and Dental Council has been described as "monstrous" by a professor of forensic medicine.

Professor H Shapiro of Unisa was speaking at a special Johannesburg meeting of the council called to discuss draft legislation which gives the Minister extensive powers to control medical fees.

The meeting was requested by at least six members of the council.

Two Bills which are to amend the Medical, Dental and Supplementary Health Service Professions Act and the Medical Schemes Act are being discussed.

In terms of the draft law, the Minister will be empowered to amend or set aside any decision by the Medical Council and substitute new tariffs.

Professor Shapiro also strongly objected to another amendment which gave the Minister powers, after consultation with the executive committee of the council, to amend or set aside any decision or determination by the council.

The amending legislation makes it clear that any amended or new decision or determination "shall be deemed to be the decision or determination of the council," Professor Shapiro said the proposed amendment by the Minister to the Medical, Dental and Supplementary Health Service Professions Act was unnecessary and undesirable.

He asked for the amendment to be rejected. He said the amendment was in conflict with the charter of the council in all respects and it rendered the statutory authority of the council nominal and superfluous.

The amendment thus undermined the exercise of that authority.

A motion that the Minister be advised not to proceed with the amendment was seconded.

Professor Shapiro described the amendment as a "kiss of death; the kiss of a deadly mamba. This is a monstrous amendment to the Act."

He said that the effect of the amendment was that the Minister could do no wrong and "we (the medical profession) can do no right."

Professor A J Brink, Dean of the faculty of Medicine at Stellenbosch, dissociated himself from the tirade made by Professor Shapiro against the Minister, but said he had sympathy for the motion itself.

Professor H Snyman, president of the council, said the amendment which gave the Minister powers to veto the decision of the council was unacceptable and he would not be associated with it.

Professor Shapiro's motion, condemning the amendment, was carried by a vote of 25 to one with four abstentions.

Quant il oï Guîllelme ledeñier,
Molt fu dolanz, n'i ot que corocio.
Isielen es avale le planchier,
Vint a Guîllelme, sil eszi par l'estri
Et par la resce de son corant destrier.
"Sire, dist il, molt es buens chevaliers
Mes el pañes ne vaus tu un denier.
- Qui dit ce donques? dit Guîllelmes:
- Sire, dit il, ge nol vos do roier:
Foi que doy vos, ç'a fet Aymon le vie:
Envers en roi vos pense d'empirier."
Et dit Guîllelmes: "Il le comparra ch
Lors se regarde dans Guîllelmes arrie
En mi la sale choisi Aymon le vieit.
Quant il le vit, sel prist a ledeñier
"He! glox, lechiere, Dieus confende t
Por qui te paines de tran home jugi
Quant en ma vie ne te forfis ge rien;
Et si te paines de moi molt empirier?
Par saint Denis a qui l'en vet proier,
Ainz que t'en partes le te cuitt vendre chier."
Il passe avant quant il fu recrabiez,
Le poing senestre li a molle el chef,
Hauce le destre, enz el col li asiet,
L'os de la gueule li a par mi froissié;
Mort le trebuche devant lui a ses piez...
"Looy's sire, dit Guîllelmes li fiers,
Ne creeze ja glouton ne losengier,
Que vostre poré n'en ot onques un chier.
Ge m'en irai en Espaigne estrai;
Vostre iert la terre, sire se la conquier."
Henry 1903
Mr. N. B. WOOD asked the Minister of Health, Welfare and Pensions:

What are the respective qualifications of the members of the Commission of Inquiry into Health Services?

The MINISTER OF HEALTH, WELFARE AND PENSIONS:

Mr. G. W. G. Browne—Former Secretary for Finance.
Prof. H. S. Breytenbach—B.Ch.D., M.Ch.D., Ph.D.: Head: Clinical Dental Training: University Stellenbosch.
Mr. W. M. C. Davidson—F.C.I.S.: Managing Director of a group of medical schemes.

Dr. J. N. du Plessis—M.B.B.Ch.: Deputy Director of the Department of Health, Welfare and Pensions.
Mrs. H. M. Lessing—Member of the S.A. Consumer Council.
Prof. N. S. Louw—M.B.Ch.B., M.Med.: Professor of Gynaecology and Obstetrics: University Stellenbosch.
Prof. G. Marais—Ph.D. (Economics), B.Com., M.Com.: Director of the Management School: Unisa.
Mr. J. J. van der Spuy—B.A., LL.B.: President of the Transvaal Municipal Association.
Mr. D. J. de Villiers—B.A., LL.B.: Chairman of the Central Council for Medical Schemes.
514. Mr. H. E. J. VAN RENSBURG asked the Minister of Health, Welfare and Pensions:

How many cases of each notifiable disease occurred among (a) Whites and (b) Blacks in (i) Randburg and (ii) Sandton during 1977, 1978 and 1979, respectively?

The MINISTER OF HEALTH, WELFARE AND PENSIONS:

<table>
<thead>
<tr>
<th>Disease</th>
<th>1977</th>
<th>1978</th>
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<tbody>
<tr>
<td>(a) Tuberculosis</td>
<td></td>
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<td>(i) Typhoid Fever</td>
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<td>(ii) Tuberculosis</td>
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<td>Meningococcal Infection</td>
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<td>Viral Hepatitis</td>
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<td>Encephalitis</td>
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<tr>
<td>(b) Typhoid Fever</td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Viral Hepatitis</td>
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</tbody>
</table>

508. Mr. H. E. J. VAN RENSBURG asked the Minister of Health, Welfare and Pensions:

What was the national average per capita expenditure on (a) White, (b) Asian, (c) Coloured and (d) African (i) in-patients and (ii) out-patients in the Republic during 1977, 1978 and 1979, respectively?

The MINISTER OF HEALTH, WELFARE AND PENSIONS:

(a), (b), (c), (d), (i) and (ii) this information is not available, as all Provincial Administrations do not keep separate figures for in and out-patients and for the different population groups.
23/4/80

Medical Scheme amendment Bill

See 3 Hansard 5 cols 1044 - 1130
Anatomical Omaleness + Post mortem examination amendment Bill

See 5. Gram and 5 cols 1058 - 1064

Homeopathy, naturopathy, osteopathy + Naturopaths amendment Bill

See 5. Gram and 5 cols 1064 - 1073
21/4/80

Medical Dental & supplementary health service provisions
Amendment Bill 3rd reading

See Hansard 10 Colon 4412 - 4424
Medical, Dental + supplementary  
Health Service - professions  
an amendment Bill  
(Committee Stage).

See Hansard 9 Question Cos
4298 - 4351
76. Mr. N. B. Wood asked the Minister of Health:

(1) How many applications for the registration of drugs were dealt with during 1979 in terms of the Medicines and Related Substances Control Act, 1965?

(2) How many applications (a) were approved, (b) were rejected and (c) are pending?

(3) What amount was collected during 1979 in respect of (a) registration fees and (b) renewal fees?

The MINISTER OF HEALTH:

(1) 471

(2) (a) 227
    (b) 11
    (c) 666

(3) (a) R31 020
    (b) R8 500
6. NUTRITIONAL STATUS AND POLICY

Two papers dealt with nutritional status indicators in South Africa - those of Du Plessis et al. (Vol.1) and Neil White (Vol.2). In addition, a condensation of statistics on child nutrition in various parts of the country was provided as background and material. These studies show that there is a far greater proportion of children who are malnourished in rural areas than in urban ones, even among children in urban squatter areas. White shows that, using the arm circumference test, the proportion of malnourished children aged 1-5 years was 1.8% in Crossroads compared with 7.4% in Nqutu in Kwazulu, and he quotes other studies which find an incidence of 12% in Tsolo, Transkei, and 13.8% in the Muldersdrift farming area near Johannesburg. (The arm circumference method is an extremely conservative measure of malnutrition. In Tsolo, over 30% were malnourished by reference to the

For more information, please refer to the original documents or contact the authors directly.
The unwanted child

The unwanted pregnancy

REPORT BY
SHEILA STEVENS

Pregnancy

unwanted

of an

and guilt

traumas

The

AND DAILY MAIL, Thursday, January 28, 1999
Doctors reject Minister’s fees prescription

By Bob Kennaugh

Doctors have rejected draft legislation that would give the Minister of Health extensive powers to control medical fees and veto decisions of the Medical and Dental Council.

The Bills were gazetted last month. In terms of the draft legislation, any tariffs or fees will not be effective until approved by the Minister. The tariff, once approved by the Minister, will be a maximum tariff binding on all medical practitioners.

At a special Johannesburg meeting of the council members decided that the draft law was unnecessary and undesirable because it was in conflict with the spirit and the statutory objects of the council. The amendment usurped the functions of the council in all respects and rendered the statutory authority of the council nominal and superfluous.

TARIFTS

Doctors also approved a motion that the amendment was prejudicial to the good order and conduct of the business of the council. The council advised the Minister not to proceed with the proposed amendment.

Members also opposed an amendment which seeks to prevent doctors from contracting out of the Medical Schemes Act.

A four-man delegation from the council, headed by Professor H. Snyman, the president, is to meet the Minister to discuss the draft legislation.

Professor J N de Klerk of Stellenbosch University, chairman of the Federal Council of the Medical Association, proposed that tariff changes should be submitted to the Minister after the council had approved the recommendation.
**DEPARTMENT OF HEALTH**

No. R. 156

1 February 1980

**AMENDMENT OF THE ANATOMICAL DONATIONS AND POST-MORTEM EXAMINATIONS REGULATIONS**


<table>
<thead>
<tr>
<th>Kolom I</th>
<th>Kolom II</th>
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<tr>
<td>Voor-</td>
<td>Voorgeskrewe gemagtigde</td>
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<td>Niere...</td>
<td>Wentworth-hospitaal, Durban</td>
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<td>Greys-hospitaal, Pietermaritzburg</td>
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<tr>
<td>Niere...</td>
<td>Northdale-hospitaal, Pietermaritzburg</td>
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<th>Column I</th>
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<tr>
<td>Prescribed tissue</td>
<td>Prescribed authorised institution</td>
<td>Prescribed purpose</td>
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<tr>
<td>Kidneys...</td>
<td>Wentworth Hospital, Durban</td>
<td>Transplantation.</td>
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<tr>
<td>Kidneys...</td>
<td>Grey's Hospital, Pietermaritzburg</td>
<td>Transplantation.</td>
</tr>
<tr>
<td>Kidneys...</td>
<td>Northdale Hospital, Pietermaritzburg</td>
<td>Transplantation.</td>
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</table>
No. R. 157

1 Februari 1980

WYSIGING VAN DIE REGULASIES BETREFFENDE ANATOMIESE SKENKINGS EN NADOEDE ONDERSOEK

Krachtens die bewegings my verleen by artikel 13
(1) (4A) van die Wet op Anatomise Skenkings en Nadoede Ondersoek, 1970 (Wet 24 van 1970), wysig ek, Lourens Albertus Petrus Anderson Munnik, Minister van Gesondheid, hierby die regulasies afgekonking

RyLab

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<thead>
<tr>
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<td>Hart.....</td>
<td>Groote Schuur-hospi, Obser, Kap</td>
<td>Oorplanting</td>
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No. R. 158

1 Februari 1980

REGULASIES BETREFFENDE PRIVATE HOSPITAAL EN LOSSTAANDE OPERASIE-TEATEREENHEID

Die Minister van Gesondheid het krags my verleen by artikel 44 van die Wet op Gesondheid, 1977 (Wet 63 van 1977), die volgende regulasies uitgevaardig:

WOORDOMSKRYING

1. Vir die toepassing van hierdie regulasies, tensy uit die samehang anders bllyk, beteken—

"afgebakende area" die steriele gebied wat deur 'n skielike geskei van die nie-steriele gebied;

"behandeling" 'n diagnostiese of therapeutiese procedure wat uitgevoer word vir chirurgiese, mediese, verloskundige of tandheelkundige doeleindes, met inagri van die verslaap van die nodige verpleegdienste, akkommodasie, toerusting en aanvullende faciliteite, en het "behandel" en "behandele" 'n ooreenstemmende betekenis;

"Dienaar" die Direkteur van Hospitaaldienste van die provinsiale administrasie van 'n provinsiale woon- binne 'n bepaalde private hospitaal of losstaande operasie-teatereenheid, desgewen is of gaan teen;

"eenheid" die persoon, of die benoemde in die geval van 'n maatskappy of vereniging van persone (met of sonder regpersoonlikheid), wat 'n private hospitaal of losstaande operasie-teatereenheid instel, uithy di of onderholl. Indien meerdere verskyn, moet di enkele die hoëstê en die ander sekondêer of beleidwees; en het "geveel" 'n vertrek, dat sodanig vertrek geventileer word deur 'n doeltreffende kunsmatige ventilasietelsel of deur een of meer venti-
sters wat regstreks na die buiteling opmaak, en wat heeltemal of gedeeltelik oogmaklik kan word en so geplaas is dat di 'n doeltreffende deurtoek of kruis-ventilasie bewerkstellig:

No. R. 157

1 Februari 1980

AMENDMENT OF THE ANATOMICAL DONATIONS AND POST-MORTEM EXAMINATIONS REGULATIONS


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<td>purpose</td>
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<tr>
<td>Heart.....</td>
<td>Groote Schuur Hospital, Obser, Cap</td>
<td>Transplantation</td>
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No. R. 157

1 Februari 1980

REGULATIONS GOVERNING PRIVATE HOSPITAALS AND UNATTACHED OPERATING-THEATRE UNITS

The Minister of Health has, by virtue of the powers vested in him by section 44 of the Health Act, 1977 (Act 63 of 1977), made the following regulations:

DEFINITIONS

1. For the purposes of these regulations, unless the context otherwise indicates—

"approved" means approved by the Secretary;

"central sterile supply department" means a room or rooms in which instruments, dressings, lavs, contents, water and other items which are required to be sterile for the treatment of patients are sterilised, and are for such purpose received, cleaned, packed, sterilised and stored;

"designated area" means an area which devils sterile from non-sterile areas;

"Director" means the Director of Hospital Services of the provincial administration of a province within which a particular private hospital or unattached operating-theatre unit is or is to be situated;

"Inspecting officer" means a Government officer as defined in section 1 of the Public Servants Act, 1957 (Act 54 of 1957), authorised in writing by the Secretary to carry out an inspection;

"lighted", in relation to any room, means that such room is effectively lighted by means of an approved artificial lighting system or that the total unobstructed window area is equal to or less than 15 per cent of the floor area of such room;

"operating-theatre" means a room in which a registered medical practitioner or dentist carries out operations;
"verpleegkamer" dezer首席verpleegkamer;
"operatiekamer of -ruimte" daardie gedeelte van 'n
operatiesterrasteenheid wat speciaal gehou word en ten
volle toegesig is vir onmiddellijke na-operatiewe her-
stel, ressussitering, verpleging en spesiale versorging van
pasiënte tot tyd en wyl sodanige pasiënte geag word
geenensige herstel dat hulle met veiligheid vanuit
voormelde gedeelte verwyder kan word;
"inspectiebeëmping" 'n beambte omskrif in artikel
1 van die Staatshiedendaet, 1957 (Wet 54 van 1957), wat
deur die Sekretaris skriflik daartoe gemagtig is om 'n
inspectie uit te voer;
"losstende operatiesterrasteenheid" 'n operatiesterr-
esteenheid wat nie in besit is van of bestuur word deur
die Staat, 'n provinsiale administrasie, 'n plaaslike
bestuur, 'n private hospitalaaloverheid, 'n hospitaatraad
of enige ander openbare liggaam nie, wat nie verbonden
is aan 'n hospitaal of verpleeg- of kraaminnigting nie,
en waar 'n pasiënt wat in sodanige operatiesterrasteen-
heid geneer word, hoogstens 12 uur mag vertrek,
bereken vanaf die tydspan waarop hy die eenheid binne-
gaan ommedelend voordat hy geneer word;
"oorbevloed", in verband met 'n vertrek: of akkom-
modasie, dat daar minder as 4 m² vloeroppervlakte
een of minder as 12 m³ liggemte is vir elke persoon wat
in sodanige vertrek of akkommodasie werk of gebruik
worf, of dat daar minder as die helfte van hier-
de oppervlakte en ruimte vir elke sodanige persoon
van jonger as 10 jaar is; Met die verstande dat die
vloeroppervlakte en die liggemte van 'n enkelkamer
nie kleiner mag wees as ondersteeklik 10 m² en 30
m³ nie;
"operatiesenter" 'n vertrek waarin 'n geregistreerde
geneesheer of tandarts operasies uitvoer;
"operatiesterrasteenheid" 'n plek waar chirurgiese
werkzaamhede uitgevoer word en waarin voorstieni
gemak is vir die facilitiete toos in hierdie regulasies
uitgegeste;
"private hospital" enige hospitaal of enig ander
inrigting, gebou of plek waar voorstienig gemak is
vir die behandeling en versorging van gewillige
geneeskundige of chirurgiese behandeling en verpleeg-
sorg nodig het, maar met uitsluiting van—
(a) 'n hospitaal of enige sodanige inrigting, gebou of
plek wat bedryf word deur die Staat, 'n provin-
siale administrasie, 'n plaaslike bestuur, 'n private
hospitalaaloverheid, 'n hospitaatraad of enige ander
openbare liggaam;
(b) 'n spreekkamer, operatiesenter of aptek
van 'n geneesheer of tandarts wat nie bedaksinessi-
liese vertek nie;
(c) 'n losstende operatiesterrasteenheid; en
(d) in hospitaal of ander inrigting wat peliseiser
is vir die oppening en aanheffing van gesonder-
gestelde persone ingevolge artikel 46 van die Wet
op Gesondheidsoorloot, 1973 (Wet 18 van 1973);
"sentrale sterieleveringsafdelingsdepartement" 'n vertrek
of vertekere waarin instrumente, verbande, komune,
homers, water en ander items wat vir die behandeling
van pasiënte steriel moet wees, geselleiser word, en
vir hie die doel om aanvull, skoneman, verpak, gestel-
nerisser en gegete word;
"spreekkamer" 'n vertrek waar bedpanne, urinale, spu-
tumbeakers en soortgelyke hommers by geborg word en gele-
dig, uitgespoel en ontstoot kan word en waar van bed-
lime, verbande en dergelijke artikels geplaa kan word
voor verwyding;
"verlig", in verband met 'n vertrek, dat sodanige vertrek afdoende verlig word deur 'n kunsmatige verligtingstelsel of dat die totale onversierde venstreoppervlakte gelykstande is met minstens 15 persent van die vloersoppervlakte van sodanige vertrek;

voorgeskrewe procedures" die chirurgske operasies en mediese procedures wat in Aanhangsel A gelyk word.

Finie ander uitdrukking wat in hierdie regulasies gebruik word, het, teny uit die samehang duidelik anders beteken, die betekenis as die wat daarvan gebruik word in die Wet op Gesondheid, 1977 (Wet 63 van 1977).

REGISTRASIE

2. Behoudens die bepaling van regulasie 8, mag niemand 'n private hospitaal of 'n losstaande operasie- tenesseentheid oprig, instel, uitbrei, bedryf, onderhou, bestuur of beheer of 'n dien daarin lever of die verskaffing van behandeling daarin toelaat of reël nie, teny sodanige private hospitaal of losstaande operasieteneentheid of benoemde private hospitaal of losstaande operasieteneentheid geregistrereer is ooreenkomstig die bepaling van hierdie regulasies en die daarmee in bestaan is van 'n geldige registrasiesertifikaat wat die uiteindelike opsigte daarvan aan hom uitgereik het.

3. Elke sodanige registrasiesertifikaat wat ingevolge regulasie 14 (1) of 14 (3) uitgereik word, is van 1 Januarie 1979 van die datum van uitreiking tot en met die 31ste dag van die eerstvolgende December van die jaar van uitreiking vanaf die datum van inskrywing van sodanige registrasiesertifikaat toeval. Alleen met die aanvraag van die registrasiesertifikaat se goedkeuring, mag 'n hospitaal of benoemde hospitaal of losstaande operasieteneentheid geregistrereer word.

4. 'n Private hospitaal of losstaande operasieteneentheid word nie as sodanig geregistrereer nie en geen registrasiesertifikaat word ten opsigte daarvan uitgereik nie, teny—

1 die perseel vanop die private hospitaal of losstaande operasieteneentheid bedryf word of geënt wou, en die toestanding wat in sodanige private hospitaal of losstaande operasieteneentheid oorgehou word of geënt wou, alhoewel bestem is, geneeskundig, en teenregderyk is vir die doelwande van geneesderne private hospitaal of losstaande operasieteneentheid;

2 die private hospitaal of losstaande operasieteneentheid nie bestuur word of bestuur sal word op 'n wyse wat vir die geneeskundige, geneeskundige of regulerende sake van die perseel of personeel nodig is of sal wees nie;

3 die personeel van die private hospitaal of losstaande operasieteneentheid voltooi of voltooi aan aanvaarde norme vir die doelwande van sodanige hospitaal of onderskeid; en

4 die persoon in beheer van 'n losstaande private hospitaal of losstaande operasieteneentheid as 'n geneeskundige, of, in die geval van 'n uitstekende tandheelkundige diens, as 'n tandarts geregister is of sal wees ingevolge die bepaling van die Wet op Geneesliere, Tandarte en Anwylende Geneesliere-beroep, 1974 (Wet 56 van 1974), of, in die geval van 'n algemene mediese verpleegdiaens of 'n verpleegkundige diens, as onderskeidlik of verpleegkundige of 'n vroedsent diens geregister is of sal wees ingevolge die bepaling van die Wet op Verpleging, 1978 (Wet 50 van 1978);

"ventilated", in relation to any room, means that such room is ventilated by an effective artificial ventilation system or by one or more windows, opening direct to the outer air and capable of opening wholly or partly, and so placed as to make possible an effective through draught or cross-ventilation.

Any other expression in these regulations has the same meaning, unless the context clearly indicates otherwise, as that assigned to it in the Health Act, 1977 (Act 63 of 1977).

REGISTRATION

2. Subject to the provisions of regulation 8, no person shall erect, establish, extend, conduct, maintain, manage, control or render any service in a private hospital or an unattached operating-theatre unit or permit or arrange for treatment to be provided therein unless such private hospital or unattached operating-theatre unit or proposed private hospital or unattached operating-theatre unit has been registered in accordance with the provisions of these regulations and the proprietor is in possession of a valid certificate of registration issued to him in respect thereof by the Secretary.

3. Each such certificate of registration issued in terms of regulation 14 (1) or 14 (3) shall be effective from the date of issue up to and including the next succeeding 31st day of December, when it shall lapse, or for such portion of the said period as may be specified in the certificate of registration. An application for the renewal of such certificate of registration shall be made in accordance with regulation 11, not less than 90 days before the date of expiry. Provided that whenever such registration certificate is issued after 30 September, such registration certificate shall be issued for a period up to 31 December of the following year.

4. A private hospital or unattached operating-theatre unit shall not be registered as such and no certificate of registration shall be issued in respect thereof, unless—

1 the premises on which a private hospital or unattached operating-theatre unit is or is to be conducted and the equipment which is used or is intended for use in such private hospital or unattached operating-theatre unit is suitable and adequate for the purposes of the said private hospital or unattached operating-theatre unit;

2 the private hospital or unattached operating-theatre unit is not managed or will not be managed in a manner which will be detrimental to the physical, mental or moral welfare of the patients or staff;

3 the staff of the private hospital or unattached operating-theatre unit comply with, or will comply with, accepted standards for the purposes of such hospital or unit;

4 the person in charge of such private hospital or unattached operating-theatre unit or is or will be registered as a medical practitioner or, in the case of an including dental service, a dentist, in terms of the Medical, Dental and Supplementary Health Service Protection Act, 1974 (Act 56 of 1974), or in the case of a general medical nursing service or a midwifery service, is or will be registered in terms of the Nursing Act, 1978 (Act 50 of 1978), as a registered nurse or midwife, respectively;
(5) a nurse registered in terms of the Nursing Act, 1978 (Act 50 of 1978), is in charge of the nursing service if the person in charge is a registered medical practitioner or dentist as described in subparagraph (4); and

(6) such registration is in the public interest.

5. (1) In his application the proprietor shall give a description of the premises and also furnish particulars regarding their location, the nature of the treatment to be rendered there, the population groups of the staff attached to the private hospital or unattached operating-theatre unit and the population groups that will make use of the private hospital or unattached operating-theatre unit, and shall furnish any further information required by the Secretary in order to consider the application.

(2) The proprietor shall immediately report to the Secretary in writing any change in the particulars furnished by him in terms of subparagraph (1) or indicated on the current certificate of registration issued in terms of regulation 11 of these regulations.

6. The proprietor of a registered private hospital shall not less than three months prior to writing to the internal affairs of each hospital to the Secretary, the Director, when and shall provide that, in exceptional circumstances, the Secretary, in consultation with the Director, may authorize a shorter period of notice.

ESTABLISHMENT OF PRIVATE HOSPITALS AND UNATTACHED OPERATING-THEATRE UNITS

2. (1) No person shall erect, alter, equip or in any other way prepare any premises for use as a private hospital or unattached operating-theatre unit without the prior approval in writing of the Secretary.

(2) Any person intending to establish a private hospital or an unattached operating-theatre unit shall first obtain a permit in writing from the Secretary, who, in consultation with the Director, shall satisfy himself as to the necessity or otherwise for such a private hospital or unattached operating-theatre unit before granting or refusing permission.

(3) Having obtained such permission, the applicant shall comply with Form 1 (Section B) and submit plans for approval by the Secretary, together with the necessary information, and shall supply any additional information which the Secretary may require.

(4) Permission and approval in terms of regulation 7 are not transferable.

3. In the case of a private hospital or an attached operating-theatre unit to which the buildings are still to be erected or converted, plans of the buildings or proposed building, shall accompany the application for registration. The plans should show clearly the nature and construction of the buildings, or proposed buildings, or the nature of the conversion, as the case may be. Room names, dimensions and square measurements shall be attached to the plans in the form of a schedule.

9. A sufficient number of lifts or ramps shall be provided where patients are housed in a multi-storey building. Provided that adequate provision shall be made for lifts suitable for taking a patient bed or trolley and for the separate removal of solid linen, waste and refuse.
10. Alle plannen moet op 'n skaal van 1:100 getekent en in tweevoud ingedien word.

11. Die aanweker moet aan die Sekretaris skriftelike bewys lever wat nie enige staatsdepartement nie die betrokke plaaslike bestuur beswaar daarteen het dat die privaat hospitaal of losstaande operasie-eenheid op die betrokke paaie vir bedryf word. In die geval van 'n gebou wat nog ongeërg of omgebou staan te word, moet die aansoekers skriftelike bewys lever dat die plan deur die betrokke plaaslike bestuur goedgekome is.

**AANSEKOM HERNIURING VAN REGISTRASIE**

12. Minstens 90 dae voor die datum waarop 'n registrasiesertifikaat verval, moet die eieaar aansoek doen om die herniuring van sodanige registrasie.

13. Elke aansoek om herniuring van die registrasie van 'n private hospitaal of losstaande operasie-eenheid moet aan die Sekretaris gerig word veeleer in die vorm van Vorm I in Anhang A1.

**HANTERING VAN AANSEKES**

14. By ontvang van 'n aansoek besluit die Sekretaris in oordeel met die Direkteur-

(1) om die behoeftige private hospitaal of losstaande operasie-eenheid te registreer en 'n registrasiesertifikaat ten opsigte daarvan uit te reik; behoudens sodanige voorwaarden as wat hy goeddink; of

(2) om registrasie te weier, in welke geval hy geen registrasiesertifikaat uitreik nie; of

(3) om die registrasie van die private hospitaal of losstaande operasie-eenheid te herni en 'n registrasiesertifikaat ten opsigte daarvan uit te reik behoudens sodanige voorwaarden as wat hy goeddink; of

(4) om herniuring van die registrasie te weier, in welke geval hy geen registrasiesertifikaat uitreik nie.

15. Die Sekretaris kan vir die doel van regsula 14 die paaie waarop die aansoek, betrekking het, inspecteer of deur 'n inspektionsbestemming laat inspecteer en die aanweker moet ten opsigte van sodanige inspeksie aan die Ontvanger van Intake bendel as R30 betal, wat verreweg insluit.

**HERAANSEKOM OM REGISTRASIE**

16. Enige eieaar wat om die registrasie van 'n private hospitaal of losstaande operasie-eenheid aansoek, gedoen het en wie as aansoek geweier is, of enige eieaar wat so aansoek om herniuring van registrasie geweier is of so registrasiesertifikaat ingevolge regsula 18 gekensel is, of enige eieaar wat verskuif het om te verander aan die herniuring van registrasie aansoek te doen en wie so registrasiesertifikaat verwerp het, of enige eieaar of voornamende eieaar wat ingevolge regsula 55 aangepak is, teen die verskuif deur die Sekretaris van regsula 11 of 12 of teen die konselering deur die Sekretaris van 'n registrasiesertifikaat en wie so aangepak is, kan te ongerd herd ondersoek doen om die registrasie of herniuring van registrasie van dieselde private hospitaal of losstaande operasie-eenheid. Met die voorwaarde dat indien registrasie of herniuring van registrasie geweier is of die registrasiesertifikaat gekensel is onmoei verskuif deur die aansoekers om aan die voorwaardes en die vereistes te voldoen wat die Sekretaris ingevolge regsula 14 (1) of 14 (3) gestel het, sodanige verdere aansoek nie gedoen kan word nie totdat en lensys daar aan al sodanige voorwaardes en vereistes voldoen is.

10. All plans shall be drawn to the scale of 1:100 and submitted in duplicate.

11. The applicant shall furnish the Secretary with proof, in writing, that neither the Government departments concerned nor the local authority concerned have any objection to the private hospital or unattached operating-theatre unit being conducted on the premises concerned. In the case of a building still to be erected or erected, the applicant shall furnish proof, in writing, that the plan has been passed by the local authority concerned.

**APPLICATION FOR RENEWAL OF REGISTRATION**

12. Not less than 90 days before the date on which a certificate of registration expires, the proprietor shall apply for the renewal of such registration.

13. Every application for renewal of registration of a private hospital or unattached operating-theatre unit shall be made to the Secretary substantially in the form of Vorm I in Anhang A1.

**HANDLING OF APPLICATIONS**

14. Upon the receipt of an application the Secretary shall, in consultation with the Director, decide-

(1) to register the proposed private hospital or unattached operating-theatre unit and issue a certificate of registration in respect thereof, subject to such conditions as he may deem fit; or

(2) to refuse registration, in which event he shall not issue any certificate of registration; or

(3) to renew the registration of the private hospital or unattached operating-theatre unit and issue a certificate of registration in respect thereof, subject to such conditions as he may deem fit; or

(4) to refuse the renewal of registration, in which event no certificate of registration shall be issued.

15. The Secretary may for the purposes of regulation 14 carry out or cause to be carried out by a inspecting officer an inspection of the premises in respect of which the application was made and the applicant shall pay to the Secretary of Finance in respect of such inspection an inspection fee of R30, which shall include transport fees.

**RE-APPLICATION FOR REGISTRATION**

16. Any proprietor who has applied for registration of a private hospital or unattached operating-theatre unit and whose application has been refused or any proprietor whose application for renewal of registration has been refused or whose certificate of registration has been cancelled in terms of regulation 18 or any proprietor who failed to comply timely for renewal of registration and whose certificate of registration has expired or any proprietor or prospective proprietor who failed in terms of regulation 55 against the refusal by the Secretary of registration or renewal of registration or against the cancellation by the Secretary of a certificate of registration and whose appeal has been dismissed may at any time reapply for registration or renewal of registration of the same private hospital or unattached operating-theatre unit: Provided that, if registration or renewal of registration has been refused or the certificate of registration has been cancelled because of failure by the applicant to comply with all the conditions and requirements imposed by the Secretary in terms of regulation 18 (1) or 18 (3), such further application shall not be made until and unless all such conditions and requirements have been complied with.
17. Die Sekretaris kan te eniger tyd, op die voorwaardes en vir die tydperk wat hy in ooreek met die Direkteur bepaal, aan 'n eienaar vrystelling verleen van enige vereistes ten opsigte van registrasie ingeoefen hierdie regulasies.

KANSELERING VAN REGISTRASIE-
SERTIFICAAT

18. 'n Registrasiesertifikaat kan te eniger tyd gekanse-
selfe word—

(1) deur die Sekretaris indien die eienaar—

(i) versuim om aan enige voorwaardes en vereis-

tes te voldoen wat in geoefte regulasie 14 (1) of 14

(3) gestel is; of

(ii) versuim om die opgewisse moneed of

inligting te verstreek wat in geoefte regulasie 28

moet verstrekk; of

(iii) skuldig bevind word aan 'n van die bovengenoemde

hepligtes van hierdie regulasie.

(2) deur die Sekretaris of die Minister, indien hy

dit in die openbare belang as dat die

private hospitaal of losstaande operasie- en-

theater eenheid ten opsigte waarvan sodanige registrasiesertifikaat uitgekiw is,

gevalt word.

19. Indien die Sekretaris of die Minister, ten belange van die genee, kragtens regulasie 18, verval die registrasiesertifikaat van die private hospitaal of losstaande operasie- en-theater eenheid ten opsigte waarvan sodanige registrasiesertifikaat uitgekiw is, op die datum vermeld in die straflike kennis-

gewing boedel in regulasie 19.

BOUVERFESTES VIR LOSSTE ANDER OPPERASIE- EN THEATER EENHEID

21. Die vertrekte van 'n losstaande operasie- en-

theater eenheid moet aan die volgende vereistes te-

vind—

(1) Behalwe waar daar in hierdie opstel verder ver-

vier gestel word, moet alle mure minstens 2,6 m

hoog wees, gemeten van die vloer tot die plafond, en

gebon wees van haksteen, kliip, beton of ander onder-

lating materiaal en, teny anders geegekeur, moet die

binnemure minstens 225 mm dik en die buitenmure

minstens 89 mm dik wees.

(2) In die operasie- en-theaters, die spoela-

kamer, die toilette en slukplekke moet die vuil tussen die muur en die

vloer gerond wees.

(3) Alle gange wat vir pasiëntetrolley's bedoel is,

moet minstens 2 m wyd wees.

(4) Alle deure wat toegang verleen tot vertrekte waar

pasiënte gehuisves sal word, moet minstens 2 m hoog en

minstens 1 m wyd wees.

(5) Alle vertrekte moet beheerlik geverifieer en

verlig wees en ruim genoeg om te verseker dat hulle

nie oorheuwel is wanneer die maksimum getal persone wat gewoonlik op enige tydspan daarin sou wees, teen-

woordig is nie.

(6) Alle vertrekte, gange en teaters moet voorriek

wees van 'n gladde, stoligte plin.}

EXEMPTION FROM REQUIREMENTS IN
RESPECT OF REGISTRATION

17. The Secretary may at any time, on such condi-
tions and for such period as he may determine in
consultation with the Director, grant a proprietor
exemption from any requirements in respect of regis-
tration in terms of these regulations.

CANCELLATION OF CERTIFICATE OF
REGISTRATION

18. A certificate of registration may at any time be
cancelled—

(1) by the Secretary if the proprietor—

(ii) fails to comply with any conditions and

requirements imposed in terms of regulatien 14 (1)

or 14 (3); or

(ii) fails to furnish the returns, particulars or in-

formation which he is required to furnish in terms of

regulation 28; or

(iii) is found guilty of an offence in terms of the

provisions of these regulations;

(2) by the Secretary or the Minister if he deems

t it to be in the public interest that the private

hospital or unattached operating-theatre unit in respect of

which such certificate of registration has been

issued be closed.

19. Whenever the Secretary or the Minister, as the

case may be, cancels a certificate of registration in

terms of regulation 18 he shall give notice in writing to

the proprietor that he is so cancelling the certificate

of registration and that the private hospital or un-

attached operating-theatre unit in respect of which it

was issued shall be closed down on or before a

date specified in such notice.

20. Upon the cancellation of a certificate of regis-

tration in terms of regulation 18, the registration of

the private hospital or unattached operating-theatre unit in

respect of which such certificate of registration was

issued shall lapse on the date specified in the written

notice referred to in regulation 19.

BUILDING REQUIREMENTS FOR UN-
ATTACHED OPERATING-THEATRE UNITS

21. The rooms of an unattached operating-theatre

unit shall comply with the following requirements:

(1) Save where otherwise required in these regula-
tions, all walls shall not be less than 2.6 m high,

measured from the floor to the ceiling, and shall be con-

structed of burnt brick, stone, concrete or some other

imperious material and unless otherwise approved,

the external walls shall not less than 225 mm thick

and the internal walls not less than 89 mm thick.

(2) In the operating-theatre, nurses' room, toilettes

and other cubicles, the joint between the walls and

the floor shall be rounded.

(3) All corridors taking patient trolleys shall be not

less than 2 m wide.

(4) All doors giving access to rooms in which

patients are to be accommodated shall be not less

than 2 m high and 1 m wide.

(5) All rooms shall be satisfactorily ventilated and

lighted and spacious enough to ensure that they are

not overcrowded when the maximum number of per-

sons that would normally be in them at any time are

present.

(6) All rooms, corridors and theatres shall be pro-

vided with a smooth, dustproof ceiling.
(7) De vloere van alle vertrekken en gangen moet van goedgekeurde materiaal wees en bedek wees met 'n wasbare, onderdukbare materiaal. Behalve wat waar vlambare materiaal gebruik, gehob of gebreide wees, die vloer van die operatiekamer en van die vertrekken waar sodanige vlambare materiaal gebruik, gehob of gebreide word, asook alle vloere binne 'n afstand van 1 m van die deure van die operatiekamer en van sodanige vertrekke waar vlambare materiaal gebruik, gehob of gebreide word, bedek moet wees met 'n onderdukbare, wasbare, anti-statisieke type materiaal en dat 'n oppervlak waarstanswillingsmengsioen 'n vereiste is hierdie vloer nie anti-statisie is nie.

(8) Die oppervlakte van die muur moet glad geglaster wees en moet, behalwe waar hierdie reguliere anders bepaal, met 'n ligdukbare wasbare verf geneem wees of met 'n wasbare, onderdukbare materiaal bedek wees. Met dien verstande dat in die geval van spoelkamers, toilette, stortkolkies, operatiesuite, centrale sterilisatiedepartementen en sterilisatieraams, die muur tot 'n hoogte van minstens 2,1 m van die vloer af, in plaas daarvan om met 'n ligdukbare wasbare verf gevoet te word, bedek kan word met vitaligdukbare glasstukke of met 'n ander wasbare, onderdukbare materiaal. Met dien verstande, verder, dat die muur agter alle handewendebake tot 'n hoogte van 500 mm bekants en 500 mm aan weerstaande van sodanige handewendebake bedek moet word met vitaligdukbare glasstukke of ander wasbare, onderdukbare materiaal.

(9) Beheerlik geplaste en toeeknede brandbrane, brandslange, brandlamsers, branduitgangs en nooduitgang moet verflaat word en bevleegd word en stof gevoet word.

(10) Indien die operatiekamer nie op die grondverdieping van 'n meerdiepingsgebou is nie, moet die gebou voorziens wees van 'n brandtrap gereg as van die grootte wat groot genoeg is om 'n passierende draagbaar te neem.

(11) Genoegsame water moet aangeleed word en as 'n kraan, storie, spoelapparaat en sanitaire enkele in die operatiekamer en alle vuilwater van die handewendebake, spoelkamers, spoelkamers en toiletapparaat moet dieftreffend deur die 'n goedgekeurde radektelsel.

(12) 'n Goedgekeurde verbrandingsmond of ander geskikte stelsel moet verflaat word vir die deeltreffend verbranding van weghouden van vuil verbande en chirurgies verwyderde weefsel sonder om enige oorde te veroorsaak.

VERTRIEKKE WAT NODIG IS

22. 'n Loostandaard operatiekamer moet bedryf word in akkommodasie waarvoor voorsiening gemaak is vir—

(1) 'n Operatiekamer met 'n aanwezende steriliserkamer, herstelruimte en saakakkommodasie wat so beplaan of bedryf moet word dat die muurlike en die vloerlike pastoer deeltreffend geplakte is en deur Met dien verstande dat indien sodanige herstelruimte nie in beslag geneem word nie, kan die vloer en die gedeelte van die kamer wat die operatiekamer bestaan, met behulp van die saakakkommodasie teen brand en die res van die rest van die gedeelte van die kamer moet word dek.

(2) 'n Saakakkommodasie buite die operatiekamer. Met dien verstande dat indien die operatiekamer eenige genoeg daarvoor is, sodanige saakakkommodasie verskaf kan word op enige geskatte plek binne die operatiekamer; en

(3) 'n Spoelkamer, spoelfasilitéte, dienkkamerfase- fasiéte vir verpleegkundiges, 'n lasekamer of 'n slaapkamer, spesiale vir skoon huishoude, oplossingsvir vlambare materi al, voldoende kleedkamer- en toiletfasilite te vir

(7) The floors of all rooms and corridors shall be of approved material and covered with impervious washable material: Save that where flammable materials are used, kept or stored, the floor of the operating-theatre and the rooms where such flammable materials are used, kept or stored, as well as all floors within a distance of 1 m of the doors of the operating-theatre and of such rooms where flammable materials are used, kept or stored, shall be covered with anti-statische material of a washable impervious type and that a conspicuous extinguisher notice is a requirement if the floor is not anti-statische.

(8) The surfaces of the walls shall be smoothly plastered and, save where otherwise provided in this regulation, be painted with washable paint of a light colour or clad with a washable impervious material: Provided that in the case of sluice rooms, toilets, shower cubicles, operating-theatres, central steril supply departments or sterilising rooms, the walls up to a height of not less than 2,1 m from the floor may, instead of being painted with washable paint of a light colour, be covered with white or light-coloured glazed tiles or other washable, impervious material: Provided further that the walls behind all wash-hand basins shall, up to a height of 500 mm above and 700 mm on either side of such wash-hand basins, be covered with white or light-coloured glazed tiles or other washable, impervious material.

(9) Properly placed and adequate fire-hydrants, fire-hoses, fire-extinguishers, fire-escapes and emergency exits shall be provided and satisfactorily maintained.

(10) If the operating-theatre unit is in a multi-storied building and not on the ground floor, the building shall be equipped with fire-escape stairs as well as a lift of sufficient size to take a patient stretcher.

(11) Sufficient water shall be laid on to all taps, showers, sluice apparatus and sanitary conveniences in the operating-theatre unit and all waste water from wash-hand basins, sluice rooms, sluice pools and toilet pans shall effectively drain into an approved sewerage system.

(12) An incinerator or other suitable system shall be provided for the effective incineration or disposal of surgical dressings and surgically removed tissues, without causing any nuisance.

ROOMS REQUIRED

22. An unattached operating-theatre unit shall be conducted in accommodation in which provisions is made for—

(1) an operating-theatre with adjoining sterilising room and recovery room and ward accommodation so arranged or conducted that male and female patients shall be effectively separated: Provided that if such recovery area is so arranged as to provide adequate substitute ward accommodation, no such separate ward accommodation shall be required;

(2) a scrubbing-up area outside the operating-theatre: Provided that if the operating-theatre is sufficiently spacious for the purpose, such scrubbing-up area may be provided at a suitable place within the operating-theatre; and

(3) a sluice room, sluice facilities, nurses' duty-room facilities, a linen room or cupboard for clean linen, storage space for flammable material, adequate change-room and toilet facilities for staff and
23. Die vertrekke wat in regulasie 22 bedoel word, moet aan die volgende vereistes voldoen:

(1) Die wastokamer moet 'n vloeroppervlakte hê van minstens 12 m², met 'n minimum muurlengte van 3 m. Met dien verstande dat indien daar binne die wastokamer vooroorlogse uitkyk vir die kantoornuimte gemaak word, die vloer van die wastokamer in oppervlakte moet hê van minstens 18 m², met 'n minimum muurlengte van 3,6 m.

(2) Die kantoornuimte moet—

(i) minstens 6 m³ vloeroppervlakte beslaan indien 'n gedeelte van die wastokamer vir hierdie doel ingebruik neem; of

(ii) verskaf word in die vorm van 'n afsonderlike vertrek met 'n vloeroppervlakte van minstens 10 m² en met 'n minimum muurlengte van 2,4 m.

(3) Die spoekamer moet, indien dit verskaf word, buite die operasievertrekken wees en moet 'n vloeroppervlakte hê van minstens 12 m², met 'n minimum muurlengte van 3 m, en moet toegang wees met minstens een handewasbank met voldoende warm en koue water aangele.

(4) Die operasievertrek moet 'n vloeroppervlakte hê van minstens 20 m², met 'n minimum muurlengte van 3,6 m. Die muur moet minstens 2,6 m hoog wees, gemens van die vloer tot by die plafon, en moet 'n aanvul die oppervlakte: die vloer is bedek met harde glans-opskik of 'n soorten wonder of met 'n ander geskikte wasbaar, eenvoudige mate, die plafon moet met 'n lijmstof of metaal gevase. Die muur, die vloer en die plafon moet bestand wees teen herhaalde reiniging en ontsmetting.

(5) Warm en koue water moet aangele word na elke gebruik, nie langs een been beheer word nie. Die spoekamer moet aansluit bovenhandwassers of iets.

(6) Die operasievertrek moet doeltreffend gevoelsvast en verlig wees. Met dien verstande dat vensters as daar is, stoffig moet wees. Die minimum vereistes vir benutting is dat 'n kantoornuimte inheems met 'n 10-mikron-rooi reiniging sou moet wees.

(7) Die operasievertrek moet aan elektriese krag voorsoek wees, wat aangele is na minstens drie voertuie muurprofiel, en geskikte elektriese apparatuur wat van die plafon of van 'n vandieplasing aan die muur hang, voedende faciliteite vir noodverlig in geval van 'n vragonderbreking, 'n geskikte bediening van die spoekapparaat wat van die plafon inheems is in die Tendaal-vloer van die spoekapparaat, en wat toeganklik, ook in ander posisies, in geval van die operasie wat nie-voortgaan gaan word.

(8) Die operasievertrek moet toegang wees met 'n geskikte spoekapparaat (vir gebruik deur die chirurg en die medisch onderwyser) wat minstens twee stigtinge het en wat in staat is om elke en bloed teplyfterligstede te verwys. Daar moet ook voorsoek gemaak word vir ninoelapparaat van hierdie aard en wat gebruik kan word in geval van die spoekapparaat wat gewoonlik gebruik word, buite werking kry. (9) Die operasievertrek moet voorsoek wees van geskikte spoekapparaat om suurstof en luggas van 'n gasbank te leef, ten spyte van geskikte spoekapparaat om suurstof en luggas van 'n gasbank te leef, ten spyte van geskikte spoekapparaat om suurstof en luggas van 'n gasbank te leef.

patients separately (toilets, independent from change-rooms may be provided, for males and females separately), a waiting-room for patients and their visitors, office space and, where applicable, a consulting room.

23. The rooms referred to in regulation 22 shall comply with the following requirements:

(1) The waiting-room shall have a floor area of not less than 12 m² with a minimum wall length of 3 m. Provided that if the office space in to be provided inside the waiting-room the floor of the waiting-room shall have an area of not less than 18 m² and a minimum wall length of 3,6 m.

(2) The office space shall—

(i) have a floor area of not less than 6 m² if a portion of the waiting-room is set aside for this purpose; or

(ii) be provided in the form of a separate room, with a floor area of not less than 10 m² and a minimum wall length of 2,8 m.

(3) The operating room, if provided, shall be outside the operating theatre area and shall have a floor area of not less than 20 m² and a minimum wall length of 3,6 m. The walls shall be not less than 2,6 m high, covered from the floor to the ceiling, and shall have a continuous, smooth surface and be painted with hard plastic epoxy paint or a similar paint or covered with any other suitable washable, impermeable material; the ceiling shall be painted with a light-colored enamel paint. The walls, the floor and the ceiling shall be capable of withstanding repeated cleaning and disinfection.

(4) The operating theatre shall have a floor area of not less than 20 m² and a minimum wall length of 3,6 m. The walls shall be not less than 2,6 m high, covered from the floor to the ceiling, and shall have a continuous, smooth surface and be painted with hard plastic epoxy paint or a similar paint or covered with any other suitable washable, impermeable material; the ceiling shall be painted with a light-colored enamel paint. The walls, the floor and the ceiling shall be capable of withstanding repeated cleaning and disinfection.

(5) In the scrubbing-up area, hot and cold water shall be laid on to effect operated tips over two wash-hand basins or troughs.

(6) The operating theatre shall be effectively ventilated and lit. Provided that windows, if any, shall be dustproof. The minimum requirement for air conditioning shall be the installation of an office type condensing unit with a 10 micron dust filter.

(7) The operating theatre shall be provided with electric power to at least three airproof wall plugs. Suitable electric operating theatre lamps suspended from the ceiling or counterbalanced from the wall, approved facilities for emergency lighting in the event of a power failure and an approved operating table capable of placing the patient at least in the Trendelenburg position, and where applicable, in other positions as well, depending on the operations to be carried out.

(8) The operating theatre shall be provided with suitable suction apparatus (for use by the surgeon and the anaesthetist separate) with at least two suction points capable of effecting removing blood and vapour simultaneously. Provision shall also be made for emergency facilities of this kind which can be used if the apparatus is normally used fails.

(9) The operating theatre shall be provided with suitable piping for conducting oxygen and nitrogen oxide from a gas bank, unless such gases are supplied in cylinders. A Boyle’s apparatus or other suitable type of
narkoseapparatuur met al die noodzakelijke aanspraken vir die pasiënt se aswes moet verskaf word. 'n Gas-
absorberingsapparatuur is verpligend.

(10) Die steriliseerkamer moet 'n vloeroppervlakte van minstens 9 m² hê, met 'n minimum muurhoek van 3 m. Behalwe dat daar 'n losstaande operasie-
teaterenheid vir die afkoeling van hierdie regularies op diezelfde perkse bedryf is en 'n sterilise-
kerrooster in die kleinste vloeroppervlakte het alhoewel hierdie doel gebruik is, sodanige steriliseerkamer ver-
der gebruik kan word.

(11) Die instrumente. Komme, verbande, verband-
strommel/pakke, holers, water, ens., moet in die ster-
iliseerkamer gesteriliseer word in 'n goedgekuierde ster-
iliseerapparatuur, wat van een of meer van die volgende methode gebruik kan maak:
(i) Stoom onder druk;
(ii) kookwater;
(iii) droë hitte;
(iv) 'n steriliseergas;
(v) enige ander goedgekuierde methode.

Met dien verstande dat indien 'n stoomontlaagerkraal gebruik word, moet die apparaat gemonteer word in 'n soortgelyk geïsoleerde ruimte, met die steriliseerkamer, maar direk langs, die steriliseerkamer en die auto-
klaf in die steriliseerkamer moet in ruwe. Met dien ver-
stande, verder, dat indien gebruik gemaak word van 'n proses wat stoom, warmwater of ander gasse voer-
bring, in geklippe apparaat vir die verwondering daarom verskaf moet word.

(12) In plas van 'n ingeboude steriliseerapparatuur kan gestikte reëlle geteel word dat 'n goedgekuierde centrale steriliseringsafdeling voldoen: sterilisaties, verbande, handtoukies, kome, balke, instrumente, spuit en sterilisaties water verskaf vir alle operasies.

(13) (1) Die herstelkamer of ruimte moet minstens die afgewerkte area wees, met 'n vloeroppervlakte van minstens 12 m² en 'n minimum muurhoek van 3 m. Dit moet toegryer wees met minstens een handwaskom met warm en loue water, en 'n klein spuitbraakbeheerde latras en die handwaskom aangeslote; minstens een water- na muurprop; 'n lampiegat reg na elke bed geneem kan word; 'n stroomapparatuur met lamp en stroomset vir elke bed gehanteer kan word en gestikte reëlle steriliseer- en verbrand. Verder moet daar faciliteite wees om, indien nodig, die pasiënt af te skerms.

(2) 'n Stoomregter en opwaapskuit moet in 'n geskiede area verskaf word.

(14) Die kleedkamer moet 'n vloeroppervlakte hê van minstens 7 m² met 'n minimum muurhoek van 2,1 m en moet toegryer wees met vloer- en muurprop en met minstens een handwaskom met warm en loue water. Daar moet in elke kleedkamer 'n spuierlêer verskaf word op die gevorderde van elke
ter programme van die pasiënt se geneem kan word. Die kleedkamer moet een deur hê wat binne de
agbeheerde area opmaak, en moet 'n aparte ingang van buiten die agbeheerde area hê.

(15) Die saal moet 'n vloeroppervlakte hê van min-
stens 8 m² vir 'n kamer wat minstens een vloer-
muurprop en een handwaskom, met warm en loue water aangelope na elke kamer.

(16) Die operasie- en steriliseerapparatuur dien as anaesthesieapparatuur met alle die noodzaklike aanspraken vir die volledige blootstelling van die pasiënt se amputasie moet verskaf word. 'n Gas-
absorberingsapparatuur is verpligend.

(10) Die sterilisaasie- en sterilisaasie-apparatuur moet 'n vloeroppervlakte van minstens 9 m² hê, met 'n minimum muurhoek van 3 m. Behalwe dat daar 'n losstaande operasie-
teleenheid vir die afkoeling van hierdie regularies op diezelfde perc beperkt is en 'n sterilisaasie-
rooster in die kleinste vloeroppervlakte het alhoewel hierdie doel gebruik is, sodanige sterilisaasie-ruimtes vir die verwondering daarom verskaf moet word.

(11) Die instrumente, komme, verbande, verband-
strommel/pakke, holers, water, ens., moet in die ster-
iliseerkamer gesteriliseer word in 'n goedgekuierde ster-
iliseerapparatuur, wat van 'n of meer van die volgende methode gebruik kan maak:
(i) Stoom onder druk;
(ii) kookwater;
(iii) droë hitte;
(iv) 'n steriliseergas;
(v) enige ander goedgekuierde methode.

Met dien verstande dat indien 'n stoomontlaagerkraal gebruik word, moet die apparaat gestalte in 'n soortgelyk geïsoleerde ruimte, met die sterilisaasie-ruimte, maar direkt langs, die sterilisaasie-ruimte en die auto-
klaf in die sterilisaasie-ruimte moet in ruwe. Met dien ver-
stande, verder, dat indien gebruik gemaak word van 'n proses wat stoom, warmwater of ander gasse voer-
bring, in geklippe apparaat vir die verwondering daarom verskaf moet word.

(12) In plas van 'n ingeboude sterilisaasie- 
arraatuur kan gestikte reëlle geteel word dat 'n goedgekuierde centrale steriliseringsafdeling voldoen: sterilisaasie-ruimte, verbande, handtoukies, kome, balke, instrumente, spuit en sterilisaasie- water verskaf vir alle operasies.

(13) (1) Die herstelkamer of ruimte moet minstens die afgewerkte area wees, met 'n vloeroppervlakte van minstens 12 m² en 'n minimum muurhoek van 3 m. Dit moet toegryer wees met minstens een handwaskom met warm en loue water, en 'n klein spuitbraakbeheerde latras en die handwaskom aangeslote; minstens een water- na muurprop; 'n lampiegat reg na elke bed geneem kan word; 'n stroomapparatuur met lamp en stroomset vir elke bed gehanteer kan word en gestikte reëlle steriliseer- en verbrand. Verder moet daar faciliteite wees om, indien nodig, die pasiënt af te skerms.

(2) 'n Stoomregter en opwaapskuit moet in 'n geskiede area verskaf word.

(14) Die operasie- en sterilisaasie-apparatuur dien as anaesthesieapparatuur met alle die noodzaklike aanspraken vir die volledige blootstelling van die pasiënt se amputasie moet verskaf word. 'n Gas-
absorberingsapparatuur is verpligend.

(10) The sterilising room shall have a floor area of not less than 9 m² and a minimum wall length of 3 m. Save that where an unattached operating-theatre unit was conducted on the same premises prior to the promulgation of these regulations and a sterilising room with a smaller floor area was used for this purpose, such room may continue to be so used.

(11) The instruments, basins, dressings, dressing drums/packs, containers, water, etc., shall be sterilised in the sterilising room in an approved sterilising apparatus which may use one or more of the following methods:
(i) Steam under pressure;
(ii) boiling water;
(iii) dry heat;
(iv) a sterilising gas;
(v) any other approved method.

Provided that if a steam autoclave is used, the apparatus shall be mounted in an adequately ventilated machine room outside but immediately next to the sterilising room, with the autoclave facing into the sterilising room. Provided further that if the process used involves the introduction of steam, water vapour or other gases, a suitable apparatus for the effective removal thereof shall be provided.

(12) Instead of built-in sterilising apparatus, suitable arrangements may be made for an approved central sterile supply department to provide sufficient sterile dressings, towels, bowls, basins, instruments, syringes and sterile water for all operations.

(15) (1) The recovery room or area shall be in the demarcated area and shall have a floor area of not less than 13 m² and a minimum wall length of 3 m. It shall be fitted with a minimum of one wash-hand basin to which hot and cold water shall be laid on to elbow-operated taps over the wash-hand basin; at least one handwasher will plug a portable lamp that can be taken to every bed; a suction apparatus which can effectively draw off blood and pus and can reach every bed; a supply of oxygen to be laid on to every bed; and suitable resuscitation apparatus. In addition, facilities shall be provided for the screening-off of patients if necessary.

(2) A step ladder and sink shall be provided in a suitable area.

(14) The change room shall have a floor area of not less than 7 m² and a minimum wall length of 2,1 m and shall be fitted with washproof wall plug and at least one wash-hand basin to which hot and cold water is laid on. Their fittings shall be provided in each change room on the back of one for every eight persons, and such fitting sets shall be partitioned off from the rest of the change room. Each change room shall have one door which opens inside the demarcated area and a separate entrance from outside the demarcated area.

(15) The ward shall have a floor area of not less than 8 m² for every bed. It shall be fitted with at least one washproof wall plug and a wash-hand basin to which hot and cold water is laid on to elbow-operated taps. 
(16) The sluice room shall have a floor area of not less than 5 m² and a minimum wall length of 2.1 m. Sufficient cold water shall be laid on to a sluice pan. The sluice room shall be fitted with suitable shelves of impervious material for clean and disinfected bed pans and urine containers, as well as receptacles of impervious material, with tight-fitting lids, for soiled linen.

(17) (i) The storage area for flammable material shall have a floor covered with a washable, impervious material.
(ii) a suitable linen room or cupboard for clean linen shall be provided, and
(iii) facilities for sterile storage shall be provided.

(18) The duty room shall have a floor area of not less than 10 m² and a minimum wall length of 2.4 m. It shall be next to the recovery room or area and between the latter and the ward. If any with a window in the wall between the duty room and the recovery room or area and one in the wall between the duty room and the ward, it shall be equipped with hot and cold water laid on to all wash-basins with a tap with a top of impervious material, a refrigerator, and, unless provided elsewhere in the building, a sink, towel and sufficient shelves and lockers for keeping dresses, shoes and rolled gowns separately. Provided that instead of a duty room, a duty station may be provided for the nurse given the recovery room or area or the ward, and such station shall be equipped with such facilities as may be necessary for this purpose. An alarm system shall be installed to alert all staff of any emergency cases.

FURNITURE AND EQUIPMENT

24. (1) In accommodation in which an unattached operating-theatre unit is being conducted the following facilities shall be provided in addition to the furniture and equipment:

(i) Facilities for the administration of intravenous fluids and blood;
(ii) splint, acupuncture needles;
(iii) scalpel and forceps;
(iv) scissors and needles;
(v) a separate locker or cupboard for Schedule 7 substances;
(vi) a separate locker or cupboard for all other Schedule 1-6 unscheduled medicines;
(vii) an instrument cupboard for the operating-theatre.

(2) In addition the operating-theatre unit shall contain sufficient suitable apparatus and instruments, including but not being two Luerlorps, Mc-Gill-ripes clamps for vulvar necesities and kinders, dissecting endoarticular knife with the nodules verifications, tongueklam, bevelled, 'tigartekstil, 't imvassingstel and defibrillator, amon stethoscope for the patient to ventilate himself the one and forever, red, and under stethoscope and medical in the tydins 'n noodestand nodig vir eg mon.

PLIJE VAN EIGENAAR

25. Die eienaar moet sorg dat—

(1) die akkommodasie waarin hy sy losstaande operasieeenheid bedryf, altyd in 'n skoon en netjies toestand is;
(2) alle toestelle en instrumente altyd skoon en in 'n goeie en veilig werkende toestand is en, wanneer dit nie in gebruik is nie, netjies in die toepaslike bereik of kas gehou word.

(16) Die spoelkamer moet 'n vloerkoppervlakte hé van minstens 5 m² met 'n minimum muurlegte van 2.1 m. Daar moet voldoende koue water aangegaan wees met 'n spoelpot. Die spoelkamer moet toegang wees met geskeide ruimte van ondieplaatse materiaal vir skoon en ontsmette bedehome en urinewas, asook met houers van ondieplaatse materiaal met digshulende dels vir vull linnengoed.

(17) (i) Die openbarstnie is vlambare materiaal moet 'n vloer hé wat met 'n wasbare, ondieplaatse materiaal bedek is;
(ii) vorsing moet gemaak word vir 'n geskei deel van die spoelkamer of linnengoed vir skoon linnengooi; en
(iii) faciliteite vir steriele openbarst nie moet verskaf word.

(18) Die dienstkamer moet 'n vloerkoppervlakte hé van minstens 10 m² met 'n minimum muurlegte van 2.4 m. Dit moet langs saam die herstelkamer of -ruimte en tussen laaggelegen en die saal (as daarin saal is), met 'n venster in die muur tussen die dienstkamer en die herstelkamer of -ruimte en 'n venster in die muur tussen die dienstkamer en die saal. Dit moet toegang wees met warm en koue water aan u in elke kamer die kamer oor 'n handwaskom, so dat 'n tafel met 'n blad van ondieplaatse materiaal, 'n koe, en teeny dikorth in die kamer geset word, ook 'n spoelkroet en genoegsame ruimte en kasse van klei, stekiel en uil vordere afsonderlike behoeftes van daar word. Met die vereiste dat in plaas van 'n dienstkamer, daar binne die herstelkamer of -ruimte of die saal 'n dienstsetjie vir die verpleegkundige verskui word, waar die dienstsetjie toegang moet wees met sodanige faciliteite as wat vir hierdie doel nodig is. 'n Alarmsetjie moet geïnstalleer wees om die personeel in geval van noodgeloof te waarsku.

MEUBELS EN TOERUSTING

24. (1) In akkommodasies waarin 'n losstaande operasieeenheid bedryf word, moet daar benodigings vir meubels en toerusting ook die volgende faciliteite verskaf word:

(i) Faciliteite vir die toevoering van binne-anne veg en bloed;
(ii) bloeddrukmeters;
(iii) 'n stethoskop;
(iv) spuit en naald;
(v) 'n afsonderlike skuitkas vir Bylae 7-stowwee;
(vi) 'n afsonderlike skuitkas vir alle ander Bylae 1-6 ongekkeulseerde middywe;
(vii) 'n afsonderlike skuitkas vir gewaardevende stowwe;
(viii) 'n instrumentkas vir die operasieeenheid.

(2) Verder moet die operasieeenheid apparaat en instrumente bevat, met inbegrip van minstens twee laingeklope, Mc-Gill-ripes klampie vir vulvar necesities en kinders, dissectie endoartikulare knieën met die nodige verbindings, tongklam, bevelde, 'tigarteksten, 't imvassingstel en defibrillator, aan die skoonheidsraad om die patiënt te ventilate hyself die enkele en altyd, en onder toestelle en middels wat tydens 'n noodestand nodig vir eg mon.

DUTIES OF PROPRIETOR

25. Die eienaar moet sorg dat—

(1) die akkommodasie waarin hy sy losstaande operasieeenheid bedryf, altyd in 'n skoon en netjies toestand is;
(2) alle toestelle en instrumente altyd skoon en in 'n goeie en veilig werkende toestand is en, wanneer dit nie in gebruik is nie, netjies in die toepaslike bereik of kas gehou word.
(3) die sterilisierapparaat of -toestuing vir geen ander doel as sterilisering gebruik word nie, dat ander gebruik van die apparaat of toestuing gerealiseer getoeis word, met die ooreenkoms van enige ander doel ook nie toegelaat word nie, en dat sodanige apparaat of toestuing gereeld getoeis word vir doeltreffendheid en dat die bevinding aangeteken word in 'n register wat by hierdie doel moet byhou.

(4) die operatiewezer vir geen ander doel as die van 'n operatiewezer gebruik word nie en dat die gebruik daarvan vir enige ander doel ook nie toelaat word nie.

(5) 'n Register bygehou word van alle skynkundige ingepe wat uitgevoer word en van alle monsters wat vir pathologiese onderzoek weggestuur word.

(6) in gevalle van ingeswinge die Wet op die Beheer van Medicinale en Verwante Stowwe, 1955 (Wet 101 van 1965), en in gevalle van ingeswinge die Wet op Gevaarhebbende Stowwe, 1973 (Wet 15 van 1973), gekobre word slegs in skiltkaste wat vir dié doel aangewend word;

(7) geen gereelde in die operatiewezer of sterilisierkamer opgevang word nie;

(8) geen tapete of enige lens bedekkingsmaterial op die vloer van die operatiewezer of die sterilisierkamer van enige soort of dienrë deur pasiënte en bediener is of geplaas word nie, en dat geen planapparaat teen muur van pasiënte of beeldinheids-installasies gebruik word nie; en verder dat sodanige muur of vloer van schemerplekten of met skynkundige materiaal bekleed grondig is deurgestruik en bekeken;

(9) geen Kamers waarin die muur, vloer of plafon teken van klimaatbeleid toon, as pasiëntehoofdop- basis gebruik word nie;

(10) instrumente en toestuwing in alle tyd schoon, netjes en in goeie en veilig werklik toestand is en, wanneer dit vir die behandeling van pasiënte gebruik word, vóór gebruik behoorlik, soos wat nodig is, ontsmet of gesteriliseer word;

(11) aar in pasiënt in die operatiewezer-enheid is, geen deur wat toegang tot die eenheid verleen, geslot word nie;

(12) die spoelkamer nie gebruik word of die gebruik daarvan toegelaat word vir enige ander doel nie behalwe dat die bewaring en skoonhoud van bedpanne, urinebottels en spoelkamerlike houers, en die afvoer en opbreking van vuil linnage, verbande en ander afval, totdat dit verwys dus, en dat geen ander plek behalwe die spoelkamer vir die opname en skoonhoud van sodanige houers of plastiek use toegelaat worde nie en dat die gebruik van enige randuiders ander plek vir sodanige doel toegelaat word nie;

(13) deur in elke spoelkamer op basis behoorlike houers van ononderbrokke materiaal en met digiteitende dekels beskikbaar is vir vuil linnage, verbande en ander afval;

(14) die inhouder van houers vir vuil verbinding en effeekweës minstens twee keer per dag verwys en dwarre kleding word;

(15) alle bedpanne en urinehouers, na dié gebruik is, sonder verduur te wassen, skoon nie-sneuken en dan ontsmet word;

(16) 'n toerusting aantal vuilgoedhouers van ononderbrokke materiaal en met digiteitende dekels in goeie toestand beskikbaar is; dat hulle regop staan nie; dat die inhouder van sodanige houers minstens een keer per dag digiteitend weggereën word sonder om in oord te veroorloë; en dat die houers nadat hulle leeggemaak is, behoorlik gewas en ontsmet word;

(3) any sterilising apparatus or equipment is not used or permitted to be used for any other purpose than sterilisation and that it is regularly tested for effectiveness and the results recorded in a register which he shall maintain for this purpose;

(4) the operating-theatre is not used or permitted to be used for any other purpose than as an operating-theatre;

(5) a register is kept of all surgical operations performed and all specimens forwarded for pathological examination;

(6) any scheduled substance in terms of the Medicines and Related Substances Control Act, 1965 (Act 101 of 1965), and any hazardous substance in terms of the Hazardous Substances Act, 1973 (Act 15 of 1973), shall be stored only in lockable cupboards kept for the purpose;

(7) no curtains are hung in the operating-theatre or the sterilising room;

(8) no carpets or any loose covering materials are on or are laid on the floor of the operating-theatre or the sterilising room or any ward or duty room or patient area; that there is no paper wall against the walls of patient or treatment areas and further that all walls are kept free from soiled posters and paper or similar material which impedes cleaning;

(9) the walls showing dampness in the walls, floor or ceiling is not used for patient accommodation;

(10) instruments and equipment shall at all times be kept clean, tidy and in good and safe working condition and, if used in the treatment of patients, shall be effectively disinfected or sterilised, as may be required, prior to use;

(11) while there is a patient in the operating-theatre unit, no doors affording admission to the unit are locked;

(12) the sterile room is not used or permitted to be used for any purpose other than the storage and cleaning of sterile plain, urine bottles and similar containers, and the rinsing and depositing of soiled linen, dressings and other waste, until their removal, and that no other other than the sterile room is used for the storage and cleaning of soiled items;

(13) in each sterile room proper receptacles of impervious material, suitable to fitting lids, are always available for soiled linen, dressings and other waste;

(14) the contents of receptacles for soiled dressings and waste frames are removed at least twice a day and effectively disposed of;

(15) after use, all bed pans and urine containers are immediately emptied, rinsed clean and then disinfected;

(16) an adequate number of refuse receptacles of impervious material, with tight-fitting lids in good condition, are available; that they are never left open; that the contents of such containers are effectively disposed of at least once daily, without causing a nuisance, and that such containers are properly washed and disinfected after they have been emptied;
(17) die vloere van die vertrekke wat vir die losstaande operasieweestruimhede gebruik word, minstens een keer per dag skoningswerk en dat alle vuilgoed in vuilgoedbehouders geplaas word;

(18) ingeval die vloere nie antistaties is nie, 'n toegestans dierewaarsop op 'n opvalende plek verwoon word;

(19) benodigheidslyne seep, 'n geskiede handborzel en handafwysendapparatuur aktief beskikbaar is by elke handwaskom in die losstaande operasieweestruimhede;

(20) 'n geregistreerde verpleegkundige of geneesheer of tandarts aktief teenwoordig is (afge aan die geregistreerde verpleegkundige of geneesheer of tandarts in die operasieweestruimhede) skakend daer in die herstelkamer of ruimte 'n pasiënt is wat nie by sy volle bewusynis is nie;

(21) solank daar 'n bedpasiënt binne die gebied van die losstaande operasieweestruimhede is, dien die diens van ten minste 'n ingeskryw verpleegkundige gedeeldeel beskikbaar is;

(22) dat die onderskeie kamers of ruimtes gebruik word vir steds die doelens waarvoor hulle goedgekeur is;

(23) dat alle diens en materiaal wat oor die algemeen vir die toerekenende liggend en die veiligheid van die pasiënt nodig is, geleen en behou word;

(24) aspekte betreklik tot 'n volle naslag word by die behandeling van pasiënte;

(25) alle handwaskomme vir pasiënte, personeel en beskikers bevordering toegentaal is met skoonmaatskappelike en afvoerfaciliteite;

(26) doeltreffende plafondbelysing toegestaan word;

(27) die rookstel en die stormwaterverneersel ondergelig word in ooreenstemming met die vereistes van die betrokke plaaslike bestuur;

(28) die konsel waarop die persone gebande, gehou, opgehou en berein word in ooreenstemming met openbare gesondheidsstandaard en die regulasies van die betrokke plaaslike bestuur;

(29) genoemde noodfaciliteite vir verligting en vir die instandhouding van essensiële toestoeing en diens vir die beslaan en onderhoud van pasiënte;

(30) geen ongewenste persone toegang het tot die pasiënterkamers nie en dat die privaatrecht en belange van die pasiënt beviel word;

(31) dat by die ooreenstemmings en 'n "Geen toegang"-teken aangebring word; en dat

(32) 'n asfalt of liggemvloei in 'n losbare toestand, en behoort bygehou, op die persel beskikbaar gehou word.

26. Die dienaar moet ondergenoemde afsonderlike registers, waar toegelig, byvoeg of laat byvoeg:

(a) 'n Register, weens in die vorm van Aanhangsel D, van die algemene medische en chirurgiese pasiënte wat toegelaat word;

(b) 'n register, weens in die vorm van Aanhangsel E, van die bevallingspaasi, wat toegelaat word en van die geboorte; en

(c) 'n register, weens in die vorm van Aanhangsel F, van alle pasiënte wat in ene operasieweestruimhede behandeld word;

(d) 'n register, weens in die vorm van Aanhangsel G, van alle buitepasiënte of ongevalspaasi wat behandel word; en

(e) 'n register, soos die Sekretaris verlang, van alle pasiënte met enige klanklike siccoes en van enige ander spesialepasiënt;

(17) the floors of the rooms used for the unattached operating-theater unit are cleaned at least once a day and that all refuse is emptied into refuse receptacles;

(18) in the event of the floors not being antistatic, an appropriate warning is prominently displayed;

(19) all rooms and facilities available at every hospital bed in the unattached operating-theater unit;

(20) A registered nurse or medical practitioner or dentist (apart from the registered nurses, medical practitioners, or dentists in the operating-theater) is always present as long as there is a patient not fully conscious in the recovery room or area;

(21) whenever there is a bed patient on the premises of an unattached operating-theater unit, the services of at least an enrolled nurse is readily available;

(22) the various rooms, or areas, are used only for the purposes for which they have been approved;

(23) all services and measures generally necessary for adequate care and safety of patients are maintained and observed;

(24) aseptic principles are fully observed in the treatment of patients;

(25) all wash-hand basins for patients, staff and visitors are satisfactorily provided with cleaning materials and drying facilities;

(26) effective pest control is exercised;

(27) sanitary and storm-water drainage systems are maintained in accordance with the requirements of the local authority concerned;

(28) foodstuffs are handled, kept, stored and prepared on the premises in conformity with public health standards and the regulations of the local authority concerned;

(29) adequate supply facilities for lighting and for the maintenance of vital equipment and services are provided and maintained;

(30) no unauthorized person has access to patient records and that the privacy and interests of patients are safeguarded;

(31) a "No Tater" sign is affixed to the operating-theater unit; and

(32) a copy of these regulations, in a legible condition and up to date, is kept available on the premises.

26. The proprietors shall keep or cause to be kept in the following separate registers, where applicable:

(a) A register of general medical and surgical patients admitted, substantially in the form of Annexure D;

(b) a register of maternity patients admitted and of deliveries substantially in the form of Annexure E;

(c) a register of all patients treated in any operating-theater, substantially in the form of Annexure F;

(d) a register of out-patients or casualty patients treated, substantially in the form of Annexure G; and

(e) a register, as required by the Secretary, of patients with infectious diseases, or any other special class of patient; and
27. No proprietor shall admit to or treat in or allow to be admitted to or treated in any private hospital more patients than the number authorised by the certificate of registration. The Secretary may give permission for more patients to be admitted or treated in emergencies or if he is satisfied that no other hospital facilities are available.

28. Every proprietor shall within 15 days of the end of each month furnish or cause to be furnished to the Secretary a return showing the number of patients exceeding daily during the month the number authorised by the certificate of registration and the reasons for such excess in each case.

29. Every proprietor shall without delay furnish to the Secretary such returns and information as the Secretary may from time to time require in relation to the control and management of the private hospital concerning the facilities, stores or staff at its disposal, the services rendered therein and the patients receiving treatment or nursing care therein.

PRIVATE HOSPITALS

30. Accommodation and facilities.

A private hospital shall be conducted on premises where adequate and satisfactory provision has been made for—

(a) one or more nursing units, including—

(i) beds in wards or rooms for the treatment of patients;

(ii) a duty room or duty station for nurses so placed that quick access to any patient requiring medical treatment is not unduly delayed;

(iii) laundries and laundry facilities for patients;

(iv) a dressing and daytime room;

(v) separate provision for linen, pharmaceutical, surgical equipment, patients' belongings and such stores as may be necessary for the management of the nursing unit;

(vi) a canteen room;

(vii) facilities for the cleansing and storage of clean or equipment and materials;

(viii) a ward kitchen and

(ix) reception corridors;

(x) a room or rooms, adequate for administrative control, covering admission of patients and storage of records, which shall be separate from the duty room of any nursing unit and accessible to the staff where their duty lies to pass through the patient areas;

(xi) a main kitchen;

(xii) a store-room for bulk storage;

(xiii) a room and toilet facilities for staff;

(xiv) a waiting area and toilet facilities for visitors;

(xv) medical supplies;

(xvi) facilities for the immediate supply of all necessary pharmaceutical products;

(xvii) a laundry or a supply of clean linen;

(xviii) a mortuary or for the immediate removal of any dead body; and

(f) a register of the nursing staff, substantially in the form of Annexure H;
31. Additional facilities.

Depending on the requirements of the patients admitted or treated at such hospitals, any or all of the following facilities may be provided, in accordance with these regulations, and, where deemed indispensable or required by the Secretary, shall be thus provided:

(a) an operating-theatre unit;
(b) a separate maternity unit;
(c) reception and treatment facilities for out-patients and/or casualties;
(d) central sterilising facilities;
(e) accommodation and facilities for employees;
(f) facilities for
   - radiology and allied diagnostic purposes;
   - physiotherapy;
   - occupational therapy;
   - electro-convulsive treatment;
   - psychotherapy;
   - any special investigation or treatment;
   - the training of nurses, medical practitioners and members of supplementary health service professions;
   - the medical examination of employees;
   - the training of employees in first aid;

(g) any other approved facilities.

32. General structural requirements.

Save where otherwise required in these regulations, the following structural requirements shall apply to all private hospitals:

(1) The walls of the operating-theatre unit and of the labour unit shall be not less than 2.6 m high, measured from the floor to the ceiling and constructed of approved imperious material.

(2) In the operating-theatre unit, the labour unit, all toilets, bathrooms and store rooms, and wherever necessary, the joint between the floor and the walls shall be so arranged as to permit effective cleaning.

(3) Each corridor or passageway used for patients shall be not less than 2.5 m wide and where patients are moved within the operating-theatre unit or labour unit the corridor shall be at least 2.5 m wide.

(4) All rooms shall be satisfactorily lighted and ventilated.

(5) Dustproof ceilings of smooth, imperious material, painted with a white or light-coloured suitable washable paint, shall be provided throughout all patient accommodation and treatment areas.

(6) The floors of all rooms and corridors shall be of concrete or a similar imperious material brought to a smooth finish and, except where otherwise provided in these regulations, covered with a washable, imperious material.

(7) All interior wall surfaces shall be given a smooth, hard plaster finish with rounded corners, painted with a light-coloured durable washable paint or alternatively satisfactorily covered with a similar washable, imperious material. Provided that, where walls have been painted, the walls behind washing-basins shall be especially clad to a height of at least 500 mm above, and to a distance of at least 500 mm beyond the sub-
wees tot 'n hoogte van ten minste 500 mm boven, en 'n afstand van ten minste 500 mm aan weerskante van sodanige handewashakke, sodat op hierdie wyse 'n ononderbroken afwerking verkry word wat met die verwerk aansienlik word.

(5) Doeltreffend geplaseerde en toereikende brandkraan, brandblusser, brandtrappe en nooduitgang moet verskaf en beveiligend onderhou word.

(9) Handewashakke moet in die onmiddellijke nabijheid van elke toilet, urinaal en spoelfasilité verskaf word.

(10) Die vertrek waarin medisyne geberg word moet toegeres wees met 'n liggend materiaal en is met konstante kamertemperatuur versier.

33. Pasiente-akkommodasie.

(1) In hierdie regulasie word elke vaste toebehorsel vir die doeleinden van die bepaling van die minimum afmetings, gerekend as 'n muur of gedeelte van 'n muur van 'n kamer waarin 'n pasiente geenakkommodeer word.

(2) Geen pasiënt mag gebruik van elke ruimte met minder as 10 m² nie, of in 'n enkelevertrek waar daar nie die volgende minimum ruimte nie:

(a) 0,9 m tussen elke sykant van die bed en die naaste muur aan sodanige sykant; en

(b) 1,2 m tussen elke voetend van die bed en die teenoorgestelde muur.

(3) Geen pasiënt mag gebruik van elke kamer met meer as 'n bed nie, teny daar voorziene gemaak is vir 'n minimum ruimte van—

(a) 0,75 m tussen elke sykant van elke bed en die naaste muur; en

(b) 0,9 m tussen elke sykant van alle aangrensende beddens; en

(c) 1,2 m tussen elke voetend van die bed en die teenoorgestelde muur of 'n minimum van 1,5 m tussen elke voetend van 'n bed en die teenoorgestelde bed.

(4) Geen kind mag in 'n kinderkamer gebruik van nie, teny daar 'n minimum ruimte van—

(a) 0,75 m tussen alle aangrensende bababeddens; en

(b) 0,6 m tussen elke sykant van elke babahalde en die naaste muur; en

(c) 0,9 m tussen elke voetend van elke babahalde en die teenoorgestelde muur.

(5) Geen pasiëntkamer mag gebruik van nie, teny die akkommodasie van sowel manlike as vroulike pasiënte nie, teny al die pasiënte is van 'n leeftyd van hoogstens 10 jaar. Met dié verstaan dat die pasiëntkamer gebruik van die akkommodasie van 'n man en sy vrou.

(6) Uitgesonderd die geval van 'n moeder en kind, moet kinders en volwassenes altijd in asonderlike kamers geakkommodeer word. Met dié verstaan dat waar asonderlike akkommodasie van volwassenes en kinders onder 10 jaar ompraktes is met die oog op behandeling, daar voldoende tussenkotfasilitéte beskikbaar moet wees.

34. Pasiëntkamers.

(1) Elke pasiëntkamer in 'n private hospitaal moet direk verbind wees met 'n gang of deurgang.

(2) Deur die toegang verleen tot kamers waarin pasiënte gebruik van nie, moet minstens 1,2 m wyd wees.

of such wash-and basins in placed tiling or a special washable, impervious material so as to form an impervious finish continuous with the paintwork.

(8) Effectively placed and adequate fire-hydrants, fire-hoses, fire-extinguishers, fire-escapes and emergency exits shall be provided and satisfactorily maintained.

(9) Wash-hand basins shall be provided in the immediate vicinity of all toilets, urinals and sinks.

(10) An airconditioning system shall be installed in the room provided for the storage of medicine in order to ensure a constant room temperature.

33. Patient accommodation.

(1) In this regulation any fixture shall, for purposes of determining minimum measurements, be regarded as a wall or part of a wall of a room in which a patient is accommodated.

(2) No patient shall be accommodated in any room with a floor area of less than 10 m² or in a single room where there is not a minimum space of—

(a) 0,9 m between any side of any bed and the nearest wall on that side; and

(b) 1,2 m between the foot of any bed and the opposite wall.

(3) No patient shall be accommodated in a room with more than one bed unless provision is made for a minimum space of—

(a) 0,75 m between any side of any bed and the nearest wall; and

(b) 0,6 m between the sides of any adjacent beds; and

(c) 1,2 m between the foot of any bed and the opposite wall or a minimum of 1,5 m between the foot of any bed and the opposite bed.

(4) No infant shall be accommodated in a nursery unless there is a minimum space of—

(a) 0,75 m between adjacent cots; and

(b) 0,6 m between any side of any cot and the nearest wall; and

(c) 0,9 m between the foot of any cot and the opposite wall.

(5) No patient room shall be used for the accommodation of both male and female patients, except when all patients are children not older than 10 years: Provided that a patient room may be used for the simultaneous accommodation of a husband and wife.

(6) Except in the case of a mother and child, children and adults, shall always be accommodated in separate rooms: Provided that, where separate accommodation for adults and children under the age of 10 years is impractical for reasons of treatment, proper screening facilities shall be available.

34. Patient rooms.

(1) Each patient room in a private hospital shall communicate directly with a corridor or passageway.

(2) Doors giving access to rooms in which patients are or are to be accommodated shall be at least 1,2 m wide.
(3) Elke patiëntenkamer moet voorsien wees van 'n handewasbak toegerus met elmboog-beheerde kraan met warm en koue water aangele.

(4) Elke patiëntenkamer moet geïdentificeer word deur die volgende by die ingang aan te bring:
(a) Die nommer van die patiëntenkamer; en
(b) die getal goedgekeurde bedden daarin.

35. Bykomende faciliteite.

(1) (a) Waar verskui Sởesiepatiëntekamers toiletfasiliteite deel of waar 'n patiëntenkamer met sy eie fasilitiete meer as agt beddens bevat, moet die volgende verskaf word:
(i) Ten minste een bad of stort per 12 patiënte of gedeelte van sodanige gedaal: Met dien verstaande dat die gedaalverhouding van die hiedens tot die storte in oor- eenstemming moet wees met die wieke van die verpleegkundige;
(ii) ten minste een toilet per agt patiënte of gedeelte van sodanige gedaal, maar in kunslike kan elke derde toilet vervang word deur een urinaat; en
(iii) ten minste een handewasbak per agt patiënt of gedeelte van sodanige gedaal.

(b) Vir babas moet toegekende spesiale handfasilitiete verskaf word in directe aansluiting met die kinderkamers.

(2) (a) Die groote en toerusting van die saalkomhuis moet voldoende wees vir die groote en wieke van die verpleegkundige en vir die stelsel waarvolgens voedsel verskaf word.

(b) Die saalkomhuis moet so geplaas wees dat dit geen oorvoorsaak nie.

(3) (a) Na gelang van die stelsel waarvolgens voedsel verskaf word, moet voldoende verskafing gemaak word vir—

(i) fasilitiete vir die ontvang van aflaverings, vir die opberging en bereiding van warm en koue voedsel en die bediening daarvan aan patiënt en personeel; 
(ii) fasilitiete vir die verwering, opwaak en opberging van breekgoed en messegoed; en
(iii) fasilitiete vir die effektiewe uitlaat van stoom, rook, damp en hitte.

(b) Voldoende en geskikte voorsiening moet gemaak word vir—

(i) vullisdromme wat behoorlik keeg- en skoonmaak kan worden en toegankel is met digiteelde deksels; en
(ii) handewasbakke vir kombuispersoneel.

(4) Geskikte plekkamer-, rustkamer- en toiletfasilitiete moet vir die werknemers verskaf word en sodanige fasilitiete moet wees volgens die standaard soos dit bepaal is in die Wet op Fabriek, Masjien en Bouwerk, 1941 (Wet 22 van 1941) sowos gewysig.

(5) Geskikte en afdoende wasplamers, toelute en handewasbakke moet vir besoekers verskaf word.

OPERASIETEATERVEREENHID IN 'N PRIVATE HOSPITAL.

36. Algemene vereistes.

'n Operasieentheater moet die volgende inhalt:

(a) Een of meer operasieenteaters met teqang sleps deur 'n kamer, area, deurgang of gang wat duidelik hierna dat die gebeurende area is en wat so beplan en ingereg is dat toereikende hekke uitgeeke kan word oor alle persone en materiaal wat sodanige kamer, area, deurgang of gang binnegaan;

(b) Adequate and suitable provisions shall be made for—

(i) garbage bins which can be properly emptied and cleaned and which are provided with close-fitting lids; and
(ii) wash-hand basins for kitchen staff.

(4) Suitable change room, rest room and toilet facilities for employees shall be provided and such facilities shall be of the standard laid down in the Factories, Machinery and Building Works Act, 1941 (Act 22 of 1941), as amended.

(5) Suitable and adequate waiting rooms, toilets and wash-hand basins shall be provided for visitors.

OPERATING-THEATRE UNIT IN A PRIVATE HOSPITAL.

36. General requirements.

An operating-theatre unit shall include the following:

(a) One or more operating-theatres with access only through a room, area, passageway or corridor which is clearly within the demarcated area and so planned and equipped that adequate control can be exercised over all persons and materials which enter such room, area, passageway or corridor;
(b) en verder binne die afgabekende area—

(i) toereikende kamers vir steriele pakke en stell-
kamers;
(ii) 'n skroop-area houtekant die operasieteater
maar aangrensend daarvan en met bevordering toe-
gang daartoe: Met dien verstande dat, behoudens
die aangewenning van die Directeur met betrekking
tot spesifieke diens in die operasieteater, die Sekretaris
toevoeging kan verleen dat sodanige skroop-area
binne die operasieteater geleë kan wees;
(iii) 'n herstellkamer of -ruimte waar pasiënte toe-
reikend gevalkomeent kan word vir na-operatiewe
verpleegwaarneming, wat onmiddellik toeganklik is
vir 'n geneëheer en wat beskik oor voldoende
resusiter- en noodfasilitate;
(iv) 'n stelieverslaingsenheid: Met dien ver-
stande dat 'n gevolg van die fasilitate van sodanige
eenheid so afgeskort kan word dat dit buite die
afgebakende area is;
(v) 'n spoelkamer wat slegs die operasieteater of
operasieteaters bedien: Met dien verstande dat, indien
's spesiale gang ingerig is waarvan die operasie-
teater of -teaters skonegang kan word, sodoende
spoelkamer nie binne die afgabekende area nie, maar
maar so geleë moet wees dat dit 'n toegangsdour
slegs vanuit sodanige gang het;
(vi) voldoende verkleefkamerfasilitate, met direkte
toegang tot die afgabekende area, vir geneëheer,
verpleegkundiges en huishoudelijk personeel: Met
dien verstande dat daar vir pasiënte wat nie gebruik
maak van skoonkommediasie nie, bykomende ver-
kleeffasilitate verskaf moet word;
(vii) 'n oorloopasarea, vir die oorplasing van
pasiënte vanaf sani-trolleys na teatertrolleys, oorkant
die afgabekende area;
(viii) 'n dienkkamer vir verpleegkundiges of 'n
dienstatistie van verpleegkundiges wat so gepl. geno-
men en toegestaan is dat dit vir die verpleegkundige
personeel moontlik is om die pasiënte regstrooms waar
te neem en om, waar nodig, bystand aan die
pasiënte te verleen;
(ix) indien ligte versierings voorgesit gaan word,
voldoende fasilitate vir die opbou, bereiding en
bediening van sodanige versierings;
(x) skoonmakeerfasilitate en
(xi) afsonderlike operasiekamers, of voldoende
geskikte bergingskast in die plek daarvan, vir die
opbou en skoonhoud van skoon linie, medisyn, teevang
en diverse items.

37. Afmetings.

'n Operasieteater moet beskik oor—

(a) 'n vloeroppervlakte van minstens 30 m²;
(b) 'n muurhoogte van minstens 3 m;
(c) 'n breedte van mindstens 5.1 m; en
(d) 'n area, direk by die operasieteater, waar die
instrumente gestel kan word.

38. Vloer.

(1) Die vloer van enige operasieteater moet van 'n
onderuitlatende materieel wees, geleë soos oor tussen-
uitrustings en met alle voës opgeval ten einde 'n aaneen-
lopende, onderuitlatende bedekking te verskaf, en so
afgewerk dat die muurbedekking en vloerbedekking
saamgevoeg is in 'n aaneenlopende gladde oppervlak
sonder tussenruimtes.
(2) Tensy daar 'n antistatiese vloerbedekking gele-
a is en in stand gehou word in ooreenstemming met die
spesifikasies van die Suid-Afrikaanse Byro vir Stan-
daard, moet daar by die ingang van 'n operasieteater
(b) en verder within the demarcated area—

(i) adequate sterile pack and setting rooms;
(ii) a scrubbing-up area outside but adjacent to
the operating-theatre, with satisfactory access to such
operating-theatre: Provided that, subject to the
recommendation of the Director with regard to any
special services offered in the operating-theatre, the
Secretary may permit such scrubbing-up area to be
situated within the operating-theatre;
(iii) a recovery room or area where patients can
be adequately accommodated for post-operative
nursing surveillance, which is immediately accessible
to a medical practitioner and which has sufficient
resuscitation and emergency facilities;
(iv) a sterile supply unit: Provided that a portion
of the facilities of such unit may be screened off so
as to fall outside the demarcated area;
(v) a sluice room to serve the operating-theatre or
operating-theatre: only: Provided that, where a
special corridor is provided from which cleaning of the
operating-theatre or operating-theatres can be effected
such sluice room shall not be situated within the
demarcated area, but shall be so situated as to
have an access door from such corridor only;
(vi) suitable change-room facilities, with direct
access to the demarcated area, for medical practi-
tioners, nursing and domestic staff: Provided that
additional change facilities shall be provided for
patients not utilizing ward accommodation;
(vii) a transfer area, for the transfer of patients
from ward trolleys to theatre trolleys, across the
demarcated area;
(viii) a nurses' duty room or duty station which
is so situated, constructed and equipped that it is
possible for the nursing staff to observe patients
directly and render assistance to patients where
necessary;
(ix) if light refreshments are to be served, suitable
facilities for storing, preparing and serving such
refreshments;
(x) cleaners' facilities; and
(xi) separate store-rooms, or sufficient suitable
storage cupboards in lieu thereof, for the storage of
clean linen, medicines, equipment and sundry
items.

37. Dimensions.

Any operating-theatre shall have—

(a) a floor area of not less than 30 m²;
(b) a wall height of not less than 3 m;
(c) a width of not less than 5.1 m; and
(d) an instrument setting area immediately off the
operating-theatre.

38. Floor.

(1) The floor of any operating-theatre shall be of
impeccable material, laid without open interstices and
with jointing filled in so as to provide a continuous
impeccable covering, and so finished that the wall
covering and the floor covering are joined in a continu-
sious smooth surface without interstices.

(2) In an operating-theatre, unless anti-static floor-
ing has been laid and maintained in conformity with the
specifications of the South African Bureau of Stan-
daards, there shall be fixed and prominently dis-
played at the entrance to such theatre a cautionary
39. Installations.

By elke teater moet daar die volgende verskaf word:
(a) 'n Toeekennende pypleidingstoevoer van suurstof en distiksfosfoeksië;
(b) 'n voldoende verligtingstelsel;
(c) 'n inglygingsstelsel toegewees met filters wat deeltreffend is vir deeltjies met 'n grootte van vyf mikron en wat 'n toeekennende vermeide het om 'n temperatuur van ten minste 10 °C asook 'n relatiewe voeghede van ten minste 45 persent te handhaaf;
(d) 'n toeekennende en beveiligende meganiëse suigstelsel met ten minste twee suigpane;
(e) toeekennende fasiliteit vir 'n noodtoevoer van suurstof en distiksfosfoeksië, noodverligting en nood-suiging in die geval van 'n meganiëse, elektriese of ander onderbreking tydens 'n operasie;
(f) elektriese krag by ten minste drie sonkryke mun-

35. Gange binne operasieentreehede.

Onbelemmende wydte van minstens 2,5 m moet vir die pasiëntetrollies gehandhaaf word in die gange en deurgang van 'n operasieentreehede.

41. Skrap-areas binne operasieentreehede.

(1) Enige skrap-area moet minstens 2,5 m wyd wees en moet so toegewees wees dat dit ten minste twee perse-

42. Herstelareas binne operasieentreehede.

(1) Die herstelkamer of -ruimte moet binne die afgebakende area wees en met 'n vloeroppervlakte van minstens 12 m² en 'n muurlengte van minstens 3 m ha en moet voldoende spase verskaf vir die elke pasiënt met 'n gemaklike betrekking van 'n basis van 9 m² onbelemmende vloer-opervlakte per pasiënt.

43. Notice to the effect that the floor of such theatre is not anti-static and that explosive anaesthetic gases or cleaning agents are not to be used inside such theatre.

39. Installations.

At every theatre there shall be provided—

(a) an adequate piped pass supply of oxygen and nitrous oxide;
(b) an adequate lighting system;
(c) an air-conditioning system fitted with filters effective for fine micron particles and with sufficient capacity to maintain a temperature of at least 10 °C and a relative humidity of at least 45 percent;
(d) an adequate and satisfactory mechanical suction system with at least two suction points;
(e) adequate facilities for an emergency supply of oxygen and nitrous oxide, emergency lighting and emergency suction in the event of mechanical, electrical or other failure during an operation;
(f) electric power to at least three flash-proof wall plugs with an earth leakage device at a minimum height of 1.5 m;
(g) an approved operating table on which the patient can be positioned according to the requirements of the operation to be performed.

40. Corridors within operating-theatre units.

An unobstructed width of not less than 2.5 m shall be maintained for patient trolleys in corridors and passageways within any operating-theatre unit.

41. Scrubbing-up areas within operating-theatre units.

(1) Any scrubbing-up area shall have a width of not less than 2.1 m and shall be so equipped as to permit both unhindered and simultaneous scrubbing-up by at least two persons under hot and cold running water from elbow-operating taps over splash-limiting basins or a drain-out trough, and grooming prior to entering the operating-theatre.

(2) Where the use of the operating-theatre is limited to the procedures listed in Annexure A, satisfactory provision for simultaneous separate scrubbing-up by two persons only will be deemed sufficient for the purposes of this regulation.

42. Recovery areas within operating-theatre units.

(1) The recovery room or area shall be inside the demarcated area and shall have a floor area of not less than 12 m² and a wall length of not less than 3 m, and shall provide sufficient space for at least one patient from each operating-theatre which it serves, calculated on the basis of 9 m² of unobstructed floor area per patient.

(2) The recovery room or area shall be fitted with—

(a) a wash-hand basin to which hot and cold water is laid on to elbow-operating taps;
(b) a sufficient supply of oxygen for each patient to be accommodated;
(c) a sufficiently adjustable fixed or portable lamp for every recovery bed or trolley;
(d) an adequate and satisfactory mechanical suction system with one suction point for every recovery bed or trolley;
(e) two electric power outlets for every recovery bed or trolley; and
(f) facilities for screening off patients.
43. Sterieleverskaffingseenheid.

(1) Die vloeroppervlakte van die sterieleverskaffingseenheid moet minstens 12 m² wees, die muurlengte daarvan minstens 3 m, en dit moet 'n toereikende vrye vloerruimte he. 

(2) Die sterieleverskaffingseenheid moet toereikend toegangs wees om die instrumente, materiale, verbandpakke, bakke, houers, water en diverse items vry te gebruik in verband met die behandeling wat verskat word, afsonderlik of samengestel, te verpak of te onpak en op te bewaar. 

(3) Indien 'n stomontolokaal gebruik word, moet dit gemonter wees in 'n toereikend geventileerde en toeganglike magjienkamer buitekant die sterieleverskaffingsarea en onmiddellik aangrensdaar af en moet die ontolokaal in sowat 30 sm. op afstand van die magjienkamer self gevestig word. Indien die toestand dit toelaat, moet dit in 'n toereikend geventileerde en toeganglike magjienkamer buitekant die sterieleverskaffingsarea op die 'n toereikend geventileerde en toeganglike magjienkamer buitekant die sterieleverskaffingsarea of die toestand vir die magjienkamer, hoe konvenant of skoon vir die doel met 'n magjienkamer van sowat 30 sm. op afstand van die magjienkamer self. 

44. Dienkamers binne operatiewetenskappe.

(1) Die vloeroppervlakte van die teaterdienkamer moet minstens 10 m² wees met 'n minimum muurlengte van 2,4 m en moet so geleg en gebou word dat die doelvriendelike bewaking van die pasiente toegestaan is. Indien dit verstaan word dat in die plang van 'n dienkamer 'n toereikende dienststasie verskaf kan word. 

(2) Die teaterdienkamer of -stasie moet toereikend wees met sodanige faciliteite as nodig is vir die doel waarvoor sodanige dienkamers of -stasie gebruik word. 

45. Spoelkamers van operatiebehandelings.

Die vloeroppervlakte van 'n teaterspoelkamer moet minstens 5 m² wees met 'n muurlengte van minstens 2,1 m en moet genoeg wees met—

(a) 'n spoelpan; 

(b) toereikende rakke vir die opberging van skoon houers; 

(c) 'n vleisvrye staal-opwasbak met warm en koue water; en 

(d) 'n handewasbak met warm en koue water. 

46. Kleedkamers van operatiewetenskappe.

'N Teaterkleedkamer moet van toereikende grootte wees, met 'n vloeroppervlakte van minstens 9 m² en 'n muurlengte van minstens 2,1 m en moet genoeg wees met—

(a) 'n handewasbak met warm en koue water; 

(b) geskikte toilettelui op die basis van 'n toilet vir elke seve lede van die teaterpersoneel of gedeelte van sodanige getal; 

(c) toereikende faciliteite vir die afsonderlike bewaring van persoonlike kleres en besittings, skoon en gebruikte teaterdrag en 

(d) 'n stortbakjie met 'n droë aaneenkarea. 

43. Sterile supply unit.

(1) The sterile supply unit shall have a floor area of not less than 12 m², a wall length of not less than 3 m and adequate free floor space.

(2) The sterile supply unit shall be adequately equipped separately to receive, clean, pack, sterilise and store instruments, materials, dressings, basins, containers, water and sundry items used in connection with the treatment provided.

(3) If a steam autoclave is used, it shall be mounted in an adequately ventilated and accessible machine room outside and immediately adjacent to the sterilising area, with the autoclave opening into such area. Provided that, if any sterilising process involves the production of steam, water vapour or any other gases, a suitable means for the effective removal thereof shall be provided.

(4) The provisions of this regulation shall not preclude any proprietor from establishing and maintaining, with the consent of the Secretary, and subject to such conditions as the Secretary may impose, an approved central sterile supply department in order to provide adequate sterile supplies to all patient accommodation and treatment areas of the hospital.

44. Duty rooms within operating-theatre units.

(1) The theatre duty room shall have a floor area of not less than 10 m² and a minimum wall length of 2,4 m and shall be so situated and constructed to make effective patient surveillance possible; Provided that an adequate duty station may be provided instead of a duty room.

(2) The theatre duty room or station shall be equipped with such facilities as may be necessary for the purpose for which such theatre duty room is used.

45. Sink rooms of operating-theatre units.

A theatre sink room shall have a floor area of not less than 5 m² and a minimum wall length of 2,1 m and shall be fitted with—

(a) a sink; 

(b) adequate shelving for storing clean containers; 

(c) a stainless steel wash-up basin with hot and cold water; and 

(d) a wash-hand basin with hot and cold water.

46. Change rooms of operating-theatre units.

A theatre change room shall be of adequate size and have a floor area of not less than 9 m² and a minimum wall length of 2,1 m and shall be provided with—

(a) a wash-hand basin to which hot and cold water is supplied; 

(b) suitably partitioned off toilets on the basis of one toilet for every seven members of the staff or part of such number; 

(c) adequate facilities for the separate storage personal clothing and effects, clean and used clothing; and 

(d) a shower cubicle with a dry change area.
VERLOSKUNDIGE EENHID

47. Algemene vereistes.

'ren Verloskundige eenheid sluit in—

(a) een of meer verpleegkamers, overeenkomstig hierdie regulasies;
(b) toereikende babakamerfasiliteit, insluitende—
(i) 'n afsonderlike kamer waar voorsiening gemaak is vir spesiale versorgingsfasiliteit, insluitende—
(ii) ten minste een broeikas;
(iii) resusinteringvoorsiening met suigstof en suurstof; en

(c) suurstof- en suigingvoorsiening in die hoofeenheid;

(ii) resusinteringvoorsiening in die bevallingskamer, insluitende—

(a) 'n tafel van geskikte hoogte; met
(b) oorhoofs verhitting; en
(c) voorsiening vir suurstof en suigstof;

(d) 'n melkkoosnurs, indien meer as 15 beddens vir meeders verskaf word;

(e) 'n kramkamer bestaande uit—
(i) 'n bevallingskamer of -kamers volgens die basis van 'n bevallingskamer vir elke 10 beddens vir meeders, of 'n bevallingskamer plus 'n kamer vir pasiënt in die eerste stadium van bevalling vir elke 15 beddens vir meeders;

(ii) bykomende dienste, met inbegrip van—

(a) 'n spoelkamer met voorsiening vir die bevalling, onderzoek en weggeloen van placentas en
(b) afsonderlike ophogingsfasiliteit vir steriele pakke en instrumente, linne, medisyne en diverse toestel;

(f) waar meer as 15 beddens vir meeders verskaf word en geen operasieteensfasiliteit geskikbaar is nie, voorsiening vir 'n operasieteens- eenheid wat voldoende geskikte tafelfasiliteit bied.


(1) Die vloeroppervlakte van elke bevallingskamer moet minstens 16 m² wees met 'n wyde van minstens 3,7 m.

(2) 'n Bevallingskamer moet ook beskik oor—

(a) toereikende skoepfasiliteit;

(b) 'n geskikte, versnijbare lamp, vas of draagbaar;

(c) 'n anti-statische vloer indien ploflatbare verdoving-gasse gebruik word;

(d) toereikende voorsiening vir suurstof; en

(e) toereikende fasiliteit vir die resusintering van babies.

VERANDERINGS

49. Geen gebou van 'n private hospitaal of losstaande operasieteensheid of gedeelte van sodanige gebou mag uitgebrei, gesloep of andersins struktuur of funksioneel verander word sonder die skriftelike goedkeuring van die Sekretaris in aorlog met die Direkteur nie. 'n Eiendom wat sodanige goedkeuring verlang, moet skriftelik daarom aanvra doen en elke sodanige aanvra moet—

(1) vergeel gaan van gedetailleerde planne en specifikasies; en

(2) die redes vir die beoogde uitbreiding, sloping of verandering volledig uitset.

MATERNITY UNIT

47. General requirements.

A maternity unit shall include—

(a) one or more nursing units, in accordance with these regulations;

(b) adequate nursery facilities which shall include—

(i) a separate room where facilities for special care shall be provided, including—

(ii) at least one incubator;

(iii) resusitation equipment with suction and oxygen; and

(iv) oxygen and suction supply in the main nursery;

(ii) resusitation equipment in the delivery room shall include—

(i) a table of a suitable height; with

(ii) overhead heating and

(iii) oxygen and suction supply;

(c) a milk kitchen, if more than 15 mother beds are provided;

(d) a patients' preparation room, if more than 15 mother beds are provided;

(e) a labour unit consisting of—

(f) a delivery room or rooms on the basis of one delivery room for every 10 mother beds, or one delivery room plus a room for patients in the first stage of labour for every 15 mother beds;

(ii) ancillary services, including—

(aa) a sluice room with provision for storing, examining and disposing of placentas; and

(bb) separate storage facilities for sterile packs and instruments, linen, medicines and sundry equipment;

(c) where more than 15 mother beds are provided and no operating-theatre facilities are readily available, provision shall be made for an operating-theatre unit with sufficient suitable theatre facilities.

48. Delivery rooms.

(1) Each delivery room shall have a floor area of not less than 16 m² and a minimum width of 3,7 m.

(2) Each delivery room shall also contain—

(a) adequate scrubbing-up facilities;

(b) a suitable adjustable lamp, fixed or mobile,

(c) an anti-static floor if explosive anaesthetic gases are used;

(d) adequate provision for oxygen; and

(e) adequate baby resusitation facilities.

ALTERATIONS

49. No building of any private hospital or unattached operating-theatre unit or any portion of such building shall be extended, demolished or otherwise structurally or functionally altered without the written approval of the Secretary in consultation with the Director. Any proprietor wishing to obtain such approval shall apply in writing and every such application shall—

(1) be accompanied by detailed plans and specifications; and

(2) set out in full the reasons for the proposed extension, demolition or alteration.
VERTONING VAN REGISTRASIESERTIFICAAT BY PRIVATE HOSPITAL EN LOSSTAANDE OPERASIETHEATERENHEED

50. Die houer van 'n geldige registrasiesertifikaat moet sodanige registrasiesertifikaat wat in regulasie 14 (1) of 14 (3) vermeld word, op 'n opvallende plek op die personeel waarop dit betrekking het, vertoon of laat vertoon.

INSPEKIES

51. Die Sekretaris kan 'n private hospitaal of losstaande operasieteaterenheid te eniger tyd en so dikwels as wat hy dit nodig ag, inspekteer of deur 'n inspeкterende beampte laat inspekeer.

52. Die eienaar van 'n private hospitaal of losstaande operasieteaterenheid of 'n ander persoon wat vir die bestuur daarvan of beheer daarvan verantwoordelik is of wat in bevel van die vergelykingsdienste daarvan is, moet aan die persoon wat ingevolge hierdie regulasie as inspeкterende beampte optree, alle inligting verstreek wat sodanige beampte verlang betreffende die organisasie en bestuur van sodanige private hospitaal of losstaande operasieteaterenheid en betreffende die akkersie, vergelyking en behandeling van persone. Al die registers, kliese rekords en ander rekords in verband met persone en personeel moet vir die doel van sodanige inspeksie beskikbaar gestel word.

53. Niemand mag 'n inspeкterende beampte in enige opsig in die uitvoering van sy inspeksie dwarsboom nie; of weier om inligting wat deur sodanige beampte gevra word, na sy beste wete te verstreek nie; of weier om enige apparaat of plek of ding te wys om enige las oop te sluit nie.

54. Die Sekretaris kan te eniger tyd die eienaar van sodanige private hospitaal of losstaande operasieteaterenheid by skriftelike kennisgeving aanvra om, binni 'n redelike tyd wat in die kennisgeving gemeld word, sodanige structurele veranderinge of sodanige verbeterings in verband met die organisasie of bestuur van voorheen private hospitaal of losstaande operasieteaterenheid aan te bring of sodanige voorsiening van te skaf of te vervang of sodanige geboue reg te stel as wat in die bedoelde kennisgeving gemeld word.

APPRI

55. Die eienaar van eenmalige eienaars van 'n private hospitaal of losstaande operasieteaterenheid kan skriftelik by die Minister appelleer teen enige besluit wat die Sekretaris ingevolge 'n bepaling van hierdie regulasies geneem het met betrekking tot sodanige eienaars of voorheen eienaars, na gelang van die geval, van 'n private hospitaal of losstaande operasieteaterenheid.

56. 'n Appel ingevolge regulasie 55 moet aangeteken word binnen twee dae nadat die besluit waaroor geappelleer word, onder die aandag van die eienaars of voorheen eienaars, na gelang van die geval, gekoos het en moet duidelik vermeld—

(1) teen watter besluit sodanige appel aangeteken word; en

(2) op watter gronde sodanige appel aangeteken word.

57. 'n Appel ingevolge hierdie regulasies word ingelewer by die Sekretaris, wat dit, tesame met sy redes vir die besluit waaroor daar geappelleer word, aan die Minister voerlê.

DISPLAYING OF CERTIFICATE OF REGISTRATION AT PRIVATE HOSPITALS AND UNATTACHED OPERATING-THEATRE UNITS

50. The holder of a valid certificate of registration shall display or cause to be displayed in a conspicuous place on the premises to which such certificate relates, the certificate of registration mentioned in relation 14 (1) or 14 (3).

INSPECTIONS

51. The Secretary may at any time, and as often as he may deem necessary, inspect or have inspected by an inspecting officer any private hospital or unattached operating-theatre unit.

52. The proprietor of a private hospital or unattached operating-theatre unit or any other person responsible for the management or control thereof, who is in charge of the nursing services thereof, shall render to the inspecting officer in terms of these regulations all information the said officer may require regarding the organisation and management of such private hospital or unattached operating-theatre unit and the accommodation, nursing and treatment of patients. All registers, clinical records and any other records in connection with patients and staff shall also be available for inspection.

53. No person shall in any way obstruct any inspecting officer carrying out his inspection or refuse to give to the best of his knowledge any information requested by such officer or to show any apparatus or place or thing or to unlock any cupboard.

54. The Secretary may at any time direct the proprietor of such private hospital or unattached operating-theatre unit by notice in writing to effect, within a reasonable period stated in the notice, such structural alterations or such improvements in respect of the organisation or management of the said private hospital or unattached operating-theatre unit or acquire or replace such equipment or to remedy defects as may be specified in the said notice.

APPEALS

55. The proprietor or prospective proprietor of a private hospital or unattached operating-theatre may appeal in writing to the Minister against any decision made by the Secretary in terms of any provision of these regulations in respect of such proprietor or prospective proprietor, as the case may be, of a private hospital or unattached operating-theatre unit.

56. An appeal in terms of regulation 55 shall be lodged within seven days of the decision appealed against having come to the knowledge of the proprietor or prospective proprietor, as the case may be, and is a clear state—

(1) against which decision such appeal is lodged and

(2) the grounds on which such appeal is lodged.

57. Any appeal in terms of these regulations shall be lodged with the Secretary, who shall submit the Minister together with his reasons for the decision against which the appeal is being lodged.
58. Die Minister kan die besluit wat die Sekretaris ingevolge die bepaling van hierdie regulasie geneem het, bekrachtig, wysig of herroep, en moet die eienaars of voornemende eienaars van 'n private hospitaal of losstaande operasie-eenheid skriflik van sy besluit in kennis stel.

MISDRYWE EN STRAFBEPALINGS

59. 'n Persoon wat—

(1) 'n private hospitaal of losstaande operasie-eenheid instel, uitbrei, bedryf, onderhoud, bedryf of beheer of 'n diens daarin lever terwyl sodanige private hospitaal of losstaande operasie-eenheid nie in megdom van hierdie regulasies geregtig is nie; of

(2) die bestaande geboue van 'n private hospitaal of losstaande operasie-eenheid of 'n gedeelte van sodanige geboue uitbri, sloop of struktuur verander of gebruik daarvan wysig sonder die voorafgeloop skriflike goedkeuring van die Sekretaris; of

(3) die eienaars is van, of in diens is by, 'n private hospitaal of losstaande operasie-eenheid en wat—

(i) versuim of weier om aan die Sekretaris, of aan 'n persoon wat namens hom handel, toegang tot sodanige hospitaal of losstaande operasie-eenheid te verleen vir die doel van 'n inspeksie ingevolge regulasie 52; of

(ii) versuim om aan die bepaling van regulasie 54 te voldoen; of

(iii) die Sekretaris, of 'n persoon wat namens hom handel, in die uitvoering van sy pligte ingevolge regulasie 53 dwarsboom van of versuim om aan sodanige bepaling te voldoen, of in stryd met sodanige bepaling optree.

is aan 'n misdryf skuldig en straafbaar—

(a) by 'n eerste skuldigbewing, met 'n boete van hoogstens R500 of met gevangenisstraf vir 'n tydperk van hoogstens ses maande of met sowel daardie boete as daardie gevangenisstraf;

(b) by 'n tweede skuldigbewing aan 'n soortgoede misdryf, met 'n boete van hoogstens R1 000 of met gevangenisstraf vir 'n tydperk van hoogstens een jaar of met sowel daardie boete as daardie gevangenisstraf; en

(c) by 'n derde of daaropvolgende skuldigbewing aan 'n soortgoede misdryf, met 'n boete van hoogstens R1 500 of met gevangenisstraf vir 'n tydperk van hoogstens twee jaar of met sowel daardie boete as daardie gevangenisstraf.

60. Alle provinsiaal ondersteunde hospitaal is uitgesluit van hierdie regulasies.

61. Vorme.

Voor doeleinde van die Wet op Gesondheid, 1977 (Wet 63 van 1977), en die regulasies daaropgestel van uitvaardigings, moet gebruik gemaak word van vorms wat weslike ooreenstem met die wat in die aanhangsels hiervan gespesifieer word.

HERROEPING VAN REGULASIE R. 1071 VAN 25 JUNIE 1971

62. (1) Die bepaling van die regulasies vir losstaande operasie-eenhede (Regulasi R. 1071 van 25 Junie 1971) word hierby herroep vir sover dit van toepassing is op losstaande operasie-eenhede of daarop betrekking het.

OFFENCES AND PENALTIES

59. Any person who—

(1) establishes, extends, conducts, maintains, manages, controls or renders a service in any private hospital or unattached operating-theatre unit which is not registered in terms of the provisions of these regulations; or

(2) extends, demolishes or makes structural alterations to the existing buildings of a private hospital or unattached operating-theatre unit, or any portion of such buildings, or alters the purpose for which such buildings are used without the prior approval in writing of the Secretary; or

(3) is the proprietor of or is employed at a private hospital or unattached operating-theatre unit and who—

(i) fails or refuses to allow the Secretary, or any person acting on his behalf, access to such hospital or unit for the purpose of an inspection in terms of regulation 52; or

(ii) fails to comply with the provisions of regulation 54; or

(iii) obstructs or hinders the Secretary or any person acting on his behalf in the performance of his duties in terms of regulation 53, or who contravenes or fails to comply with such provisions, shall be guilty of an offence and liable—

(a) upon a first conviction, to a fine not exceeding R500 or to a term of imprisonment not exceeding six months or to both such fine and such term of imprisonment;

(b) upon a second conviction for a similar offence, to a fine not exceeding R1 000 or to a term of imprisonment not exceeding one year or to both such fine and such term of imprisonment; and

(c) upon a third or subsequent conviction for a similar offence, to a fine not exceeding R1 500 or to a term of imprisonment not exceeding two years or to both such fine and such term of imprisonment.

60. All provincial-aided hospitals are excluded from these regulations.

61. Forms.

Forms essentially as specified in the annexures here-to shall be used for the purposes of the Health Act, 1977 (Act 63 of 1977), and the regulations made under the Act.

REPEAL OF REGULATION R. 1071 OF 25 JUNIE 1971

62. (1) The provisions of the regulations in respect of unattached operating-theatre units (Regulation R. 1071 of 25 June 1971), are hereby repealed in so far as they apply or relate to unattached operating-theatre units.
(2) 'n Kernigieweg, bevel, besluit, goedkeuring, toestemming, magtiging, inligting of dokument uitgeer, geneem, verleen of verstrek en 'n ander handeling wat ingevolge 'n bepaling van hierdie regulasies uitgeoer is of by hierdie regulasies betrek is, moet, indien dit nie teenstrydig is met die bepaling van hierdie regulasies nie, eggaardig uitgeer, geneem, verleen, verstrek of uitgeoer te geheue het ingevolge die ooreenstemmende bepaling van hierdie regulasies.

63. Hierdie regulasies treed in werking op 1 April 1980.

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### ANNEXURE A

**SCOPE OF PRESCRIBED PROCEDURE CARRIED OUT IN UNATTACHED OPERATING THEATRE UNITS**

In unattached operating-theatre units no prescribed procedures shall be carried out unless the necessary facilities, equipment and assistance are available for such procedures, for resuscitation and for post-operative care.

### A. DENTISTRY

1. Restorative dentistry.
2. Removal of teeth.
3. Minor oral procedures.

### B. GENERAL SURGERY

1. Warts.
2. Circumcision.
3. Stitching of wounds and tendons.
4. Incision of superficial abscesses.
5. Excavation of haematoma.
7. Removal of superficial foreign bodies, but where methods for accurate localisation are available for surgical removal.
8. Thyroidectomy and colonoscopy.
10. Injection of haemorrhoids and varicose veins.
11. Abdominal paracentesis.
15. Treatment of fissure in ano.
16. Lateral sphincterotomy.
C. PSIGIATRIE
(1) Elektrokonvulsieve terapie.
(2) Narkoanalys.
(3) Electrostimulatie.
(4) Lumbale en siernele punksie.

D. ORTOPEDIE
(1) Reduksi van eenzijdige fraktuur.
(2) Reduksi van eenzijdige onwrijving.
(3) Manipulaties.
(4) Aspiratie van gewricht.
(5) Injekties in gewricht.
(6) Arteriografie.
(7) Karpo-tunnelverlysting.
(8) Peksheging.
(9) Seminewheging.
(10) Ganglionverwydering.

F. OOR, NEUS EN KEEL
(1) Laringoskopie.
(2) Pfoepunskie en sinuspoeling.
(3) Parasentrese, met inbegrip van die installering van plastiekbuisies en die skoonmaak van ore onder algemene narkose.
(4) Kouterisering.
(5) Verwydering van vreemde voorwerpe en poliepe.
(6) Reduksi van neusfraktuur.
(7) Tonsillektomie en adenoidectomie.

F. GINEKOLOGIE EN OBSTETRIE
(1) Onderzoek onder narkose.
(2) Insnyding van Bartholinse kieste.
(3) Uitwendinge kering.
(4) Insit van intrauteriene-voorbehoedmiddel.
(5) Kouterisering van serviks.
(6) Endometriumbiopzie.
(7) Hysterosalpingogram.
(8) Verwydering van servikale poliepe.
(9) Vulvarbiopzie.
(10) Hemoekтомie.
(11) Sterilisering.
(12) Dilutie en curettage.
(13) Diagnostiese laparoskopie.
(14) Sterilisering.
(15) Shirodkar-operasie.
(16) Radioelektrische ondersoek opsondaries wat algemene narkose vereis.
(17) Ander kleinere procedures wat nie binne 12 uur 'n X-straalonderzoek binne die eenheid sal vereis nie.

G. OOGDEELKUNDE
(1) Onderzoek van kinders onder narkose.
(2) Verwydering van vreemde voorwerpe in korne.
(3) Sondering van traanbuie.
(4) Insnyding van Melbooms-kieste.
(5) Verwydering van Pterigium.

H. VELSIKTES
(1) Diatermie en kurettoskopie van vratte.
(2) Diatermie en kurettasie van soelvatte.
(3) Diatermie en kurettasie van verrucous acuminate.
(4) Biopzie van vel of slymvlaas deur middel van 'n insnyding of met behulp van 'n pons.
(5) Verwydering van goedaardige oppervlakkige letse.
(6) Verwydering van kwaadaardige oppervlakkige letse.
(7) Insnyding en dreining van oppervlakkige abses.

C. PSYCHIATRY
(1) Electroconvulsive therapy.
(2) Narcoanalysis.
(3) Electrostimulation.
(4) Lumbar and cisternal puncture.

D. ORTHOPAEDICS
(1) Reduction of simple fractures.
(2) Reduction of simple dislocations.
(3) Manipulations.
(4) Aspiration of joints.
(5) Injections into joints.
(6) Arthrography.
(7) Cardiac-tunnel release.
(8) Tendon surgery.
(9) Nerve surgery.
(10) Ganglion removal.

E. EAR, NOSE AND THROAT
(1) Laryngoscopy.
(2) Proof puncture and sinus irrigation.
(3) Paracentesis, including insertion of grommets and toilet of ears under general anaesthetic.
(4) Curettage.
(5) Removal of foreign bodies and polyps.
(6) Reduction of fractured nose.
(7) Tonsillectomy and adenoidectomy.

F. GYNAECOLOGY AND OBSTETRICS
(1) Examination under anaesthetic.
(2) Incision of Bartholin's cyst.
(3) External version.
(4) Incision of intrauterine contraceptive device.
(5) Curettage of cervix.
(6) Endometrial biopsy.
(7) Hysterosalpingogram.
(8) Excision of cervical polyp.
(9) Vulpal biopsy.
(10) Hormone implantation.
(11) Hysterectomy.
(12) Dilatation and curettage.
(13) Diagnostic laparoscopy.
(14) Sterilisation.
(15) Shirodkar operation.
(16) Investigative radiological procedures requiring general anaesthetics.
(17) Other minor procedures which will not necessitate an X-ray within the unit within a period of 12 hours.

G. OPHTHALMOLOGY
(1) Examination of children under anaesthetic.
(2) Removal of corneal foreign bodies.
(3) Probing of tear ducts.
(4) Incision of Meibomian cysts.
(5) Removal of Pterygium.

H. DERMATOLOGY
(1) Diathermy and curettage of warts.
(2) Diathermy and curettage of plantar warts.
(3) Diathermy and curettage of verrucous acuminate.
(4) Biopsy of skin or mucous membrane by means of incision or punch.
(5) Removal of benign superficial lesions.
(6) Removal of malignant superficial lesions.
(7) Incision and drainage of superficial abscess.
I. UROLOGIE

(1) Sistoskopie.
(2) Ureterendilatatie.
(3) Vasectomy.
(4) Testisbiopsie.
(5) Meatoamie.
(6) Besnyding.
(7) Verwydering van uretra-karunkels.
(8) Verwydering van spermatocele.

I. TORAKSCHIRURGIE

(1) Plurale-aspirasie en naaldbiopsie van plura en long.
(2) Interkostale blok.
(3) Verwydering van oppervlakkige gewasse.
(4) Brongoskopie met of sonder verwydering.
(5) Esofageeskopie van vreemde voorwerp.
(6) Dilatatie van esofagus.

K. NEUROCHIRURGIE

Soos by B, plus, waar van toepassing:

(1) Onderzoek onder narcose.
(2) Lumibale punktie en gepaardgaande procedures soos intratekale fenol- of alcoholtoediening, spinele wortelblokking, lumbale spino-ligam, mielogram, meddas toediening en spinele dreining.
(3) Senuwebeblakkering soos Gasser-ganglion, oksipitale sentwwe, enz.
(4) Angiografie deur middel van naald of kateter.
(5) Traktonomie.
(6) Aapt van ventrikel deur bestaande heengat (boorgat) of fontanellle of beenpuntie vir deel van dreining of toediening van kontrasmedia of geneesmiddel.

L. PLASTIESE CHIRURGIE

Soos by B, plus, waar van toepassing:

(1) Plastiese reparasie van klein wonde.
(2) Manipulase van neusfraktuur (onder plaatslike verilonding).
(3) Klein veltransplantatie.
(4) Uitsny en herstel van littekens (onder plaatslike verilonding).

M. INTERNE GENEESKUNDE

(1) Gastroendoskopie en duodenoskopie.
(2) Sigmoiidoskopie.
(3) Rectale biopsie.
(4) Sternaal punktie.
(5) Diagnostiese paracentese van plura en peritoneum.
(6) Inspilting in senuweverbonds en ganglion.
(7) Lumbaal punktie.

AANHANGSEL B

Departement van Gesondheid

Aanvraag om registrasie as 'n "private hospitaal/losstaande operasie-eenhed"" volgens Regulaas R. 158 van 1 Februarie 1980.

Die Secretary van Gesondheid

Privatsak X38
PRETORIA 0001

Hierby word aanvraag gedaan om die registrasie van 'n "private hospitaal/losstaande operasie-eenhed"" volgens Regulaas R. 158 van 1 Februarie 1980, hieronder verstrekom:

1. Naam van "private hospitaal/losstaande operasie-eenhed"

2. Ligging van persoon (straat, lokaliteit, dorp)

3. Naam en postadres van geregistreerde eenduid van die eiendom (persoon)
4. Naam en adres van cliënt (in de geval van 'n manskappy of vereniging van persone, sy benoemde vertrouwensvoogd) wat die "private hospital/losstaaende operasieeenheid sal bedryf:"  

5. Naam en adres van die geneesheer of geregistreerde verpleegkundige en vroedvrou wat in beheer sal wees:

6. Indien 'n geneesheer in beheer sal wees, die naam en kwalifikasie van die geregistreerde verpleegkundige en vroedvrou wat in beheer van die persone diens sal wees:

7. Getaal en toestemming van die bekibare bidders vir patiënte (sien notas hieronder):

<table>
<thead>
<tr>
<th>Algemeen</th>
<th>Verpleegkundige</th>
<th>Aanbedelinge</th>
<th>Ander</th>
<th>Totaal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Volwassenes</td>
<td>Kinders</td>
<td>Mannies</td>
<td>Blywe</td>
</tr>
<tr>
<td>Blankes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nie-Blankes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Getaal:
(a) Operasieteaters:
(b) Besluitingkamers:

9. Verandering (as daar is) in beskikbare personeel: a) kamer/beddiens gesedeender dat geneesheer nep (specifieer):

10. Getaal geregistreerde personeel in diens op datum van aanvoer/vat in diens sal wees op datum van nuwe registrasie voor aansoek:

<table>
<thead>
<tr>
<th>Praktisiere</th>
<th>Verpleegkundiges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geneeskene</td>
<td>Tandkliniek</td>
</tr>
<tr>
<td>Blank</td>
<td></td>
</tr>
<tr>
<td>Nie-Blank</td>
<td></td>
</tr>
</tbody>
</table>

| Deeltiess | Blank | Nie-Blank |

11. Getaal vollyse ingeskrewe verpleegkundige personeel in diens op datum van aanvoer/vat in diens sal wees op datum van nuwe registrasie waarom aansoek:

<table>
<thead>
<tr>
<th>Ingeskrewe verpleegkundiges</th>
<th>Ingeskrewe student-verpleegkundiges</th>
<th>Ingeskrewe verpleeg-assiste</th>
<th>Ingeskrewe lêting-verpleeg-assiste</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voltyds</td>
<td>Blank</td>
<td>Nie-Blank</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>General</th>
<th>Maternity</th>
<th>Infectious</th>
<th>Other (Specify)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>Children</td>
<td>Mothers</td>
<td>Babies</td>
<td></td>
</tr>
<tr>
<td>Whites</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Whites</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Number of:
(a) Operating-theatres:
(b) Delivery rooms:

9. Changes in the patient accommodation/beds available during the current year, if any (specify):

10. Numbers of registered staff employed at date of application/in be employed at date of new registration applied for:

<table>
<thead>
<tr>
<th>Practitioners</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Denial</td>
</tr>
<tr>
<td>Full-time</td>
<td>White</td>
</tr>
<tr>
<td>Part-time</td>
<td>White</td>
</tr>
</tbody>
</table>
11. Number of full-time enrolled nurses employed at date of application/to be employed at date of new registration applied for:

<table>
<thead>
<tr>
<th>Full-time</th>
<th>Enrolled nurses</th>
<th>Enrolled student nurses</th>
<th>Enrolled nursing assistants</th>
<th>Enrolled pupil nurse assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-White</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

12. Ander voltydige geregistreerde personeel in diens (as daar is) (specificeer)

13. Ander deeltydige geregistreerde personeel in diens (as daar is) (specificeer)

14. Indien die Suid-Afrikaanse Raad op Voopleging die hospitaal erkenn as 'n goedgekeurde opleidingskool vir verpleegkundiges, vreemdouer of ingeskrywde verpleegkundiges of ingeskrywde verpleegassistente:

(a) Algemene verpleegkundiges | Vreemdouer | Ingeskrywde verpleegkundiges | Ingeskrywde verpleegassistente

(b) Indien die hospitaal erkenn as 'n goedgekeurde opleidingskool vir een of meer van die kategorieën van personeel in (a) hierbo vermeld, moet ondergaanwee inligting ook verstrekk word:

<table>
<thead>
<tr>
<th>Kategorie</th>
<th>Nommer van registrasie of inskrywingssertifikaat by die S.A.R.V.</th>
<th>Datum van uitreiking</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Student algemene verpleegkundiges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Studentvreemdouer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Ingelatingverpleegkundiges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Ingelatingverpleegassistente</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Registrasie by die S.A.R.V. (specificeer):

<table>
<thead>
<tr>
<th>Jaarlikse registrasie</th>
<th>Datum van uitreiking</th>
<th>Kwalifisa</th>
<th>Datum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algemeen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vreemdouer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ander</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(c) Ander opgeleide personeel, met uitsluiting van die personeel in beheer:

(i) Geregistreerde verpleegkundiges/vreemdouer:

<table>
<thead>
<tr>
<th>Naam</th>
<th>Kwalifisa</th>
<th>Nommer van oorspronklike certificaat</th>
<th>Datum van uitreiking</th>
<th>Jaarlikse registrasie</th>
<th>Kwalifisa</th>
<th>Datum</th>
</tr>
</thead>
</table>

(ii) Ingeskrywde verpleegkundiges

| Totaal | | |

(iii) Ingeskrywde verpleegassistente

| Totaal | | |

12. Other full-time registered staff employed (if any) (specify)

13. Other part-time registered staff employed (if any) (specify)

14. If the hospital is recognised by the South African NAC Council as an approved training school for nurses, midwives or enrolled nurses or enrolled nursing assistants:

(a) General nurses | Midwives | Enrolled nurses | Enrolled nurse assistant

(b) If the hospital is recognised as an approved training school for one or more of the categories of nursing referred to in subsection (ii), the following information should also be given:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of registration or registration certificate issued by the S.A.N.C.</th>
<th>Date of issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Student general nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Student midwives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Pupil nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Pupil nursing assistants</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Registration with the S.A. Nursing Council (specify):

<table>
<thead>
<tr>
<th>Name</th>
<th>Qualifications</th>
<th>Number of original certificate</th>
<th>Date of issue</th>
<th>Annual registration receipt number</th>
</tr>
</thead>
</table>

(ii) Enrolled nurses

| Total | | |

(iii) Enrolled nursing assistants

| Total | | |

(c) Other trained staff, excluding person in control:

(i) Registered nurses/midwives:

<table>
<thead>
<tr>
<th>Name</th>
<th>Qualifications</th>
<th>Number of original certificate</th>
<th>Date of issue</th>
<th>Annual registration receipt number</th>
</tr>
</thead>
</table>

(ii) Enrolled nurses

| Total | | |

(iii) Enrolled nursing assistants

| Total | | |
15. Reclame vir die opleiding en onderrig van elk van onder-
genomeerde kategorie, soos toegestaan:
   (i) Studentverpleegkundiges
   (ii) Studentverpleegkundige
   (iii) Leerlingverpleegkundige
   (iv) Leerlingverpleegkundige

   Elke verklaring hierby dat bestaande gegevens waar en korrek is.

Datum.................................................................
L.P.——Indien die bedoelde nuwe opleiding is, leg 'n
skedule daaraan.

Nota:
(a) *Woords wat met 'n sterretjie aangedui word, moet deurge-
  bye word indien hulle nie van toepassing is nie.
(b) Hierdie vorm moet gebruik word vir die eerste en elke daar-
onvolgende aanvraag van registrasie.
(c) Item 7: Die getal bedeels, buubehoefes en wieëëës wat verryst
  word, maar sluit die volgende uit:
  - alle trolley's
  - alle wank, voorbereidings-, eerstekudlum- en bevallings-
  kamerbeddens en buubehoefes in die verloskundige
  kamer;
  - die hospitallie en herstelbeddens van 'n operasieentee-
  enheid van 'n private hospitaal waar nie die van 'n
  looskundige operasieenteeenheid nie.

AANHANGSEL C
Vorm II
Sertifikaat No. ...................................................
Urvuying No. ....................................................

DEPARTEMENT VAN GESONDHEID
REGISTRASIE-SERTIFIKAT

Hierby word geswure dat die
geleen is as 'n private hospitaal/kostaa rende operasieentee-
enheid in opriënging de bepaling van Regulasie R. 150 van
1 Februarie 1980 vir 'n tydperk van .................................
maande geldig is.

Naam van eienaar of bestormende liggaam...........................................
Adres van eienaar of bestormende liggaam ...........................................

Naam van persoon in beheer...........................................

Maximum getal pasiente wat tegelykertyd geneekhmodeler kan
word:

<table>
<thead>
<tr>
<th>Pasiente wat tegelykertyd geneekhmodeler kan word</th>
<th>Maksimum getal geneekhmodeler</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Geneeskundige en chirurges: (a) Volwassenes</td>
<td>BLANK</td>
</tr>
<tr>
<td>(b) Kinderne</td>
<td>Ne-Blank</td>
</tr>
<tr>
<td>Bevallings: (a) Moeilers</td>
<td></td>
</tr>
<tr>
<td>(b) Babys</td>
<td></td>
</tr>
<tr>
<td>Aansteeklike siektes</td>
<td></td>
</tr>
<tr>
<td>Ander (specifieer)</td>
<td></td>
</tr>
</tbody>
</table>

Met nisnitting van bovengenoemde aktiviteite, word die verlies-
hedefe van bovengenoemde private hospitaal/kostaa rende opera-
seenteeenheid soos volg bepaal:

Geteken te..........................................................
.................................................................
Sekretaris van Gesondheid

Hierdie sertifikaat is nie verenrigbaar nie en moet jaarliks herne-
wend word.

* Skrap indien nie van toepassing is nie.

15. Arrangement for the training and teaching of each of the
   following categories, as applicable:
   (i) Student nurses
   (ii) Student midwives
   (iii) Pupil nurses
   (iv) Pupil nursing assistant

I hereby certify that the above particulars are true and correct.

Place.................................................................
Date.................................................................

N.B.—If available space is insufficient, attach separate schedule.

Notes:
(a) *Words designated by an asterisk to be deleted if not applic-
   able.
(b) Item 7 is to be used for the first and every subsequent
   application for registration.
(c) Item 7: The numbers of beds, cribs/cots actually available for
   accommodating patients are to be stated, but these
   exclude all trolley:
   — all waiting, preparation, first stage and labour room
   beds and cots in maternity units;
   — the recovery trolleys and recovery beds of an operating-
   theatre unit of a private hospital, but not those of an
   attached operating-theatre unit.

ANNEXURE C
Vorm II
Certificate No....................................................
Reference No.....................................................

DEPARTEMENT OF HEALTH
CERTIFICATE OF REGISTRATION

It is hereby certified that the

situated at ............................................................

is registered as a private hospital/unattached operating-theatre
unit in terms of Regulations R. 150 of 1 February 1980
for a period of ..........................................................

Name of proprietor or managing body...........................................
Address of proprietor or managing body ......................................

Name of person in charge...........................................

Maximum number of patients who may be accommodated at the
same time:

<table>
<thead>
<tr>
<th>Patients that can be accommodated simultaneously</th>
<th>Maximum number accommodated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td>*Medical and surgical: (a) Adults</td>
<td></td>
</tr>
<tr>
<td>(b) Children</td>
<td></td>
</tr>
<tr>
<td>Maternity: (a) Mothers</td>
<td></td>
</tr>
<tr>
<td>(b) Babies</td>
<td></td>
</tr>
<tr>
<td>Infectious diseases</td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
</tr>
</tbody>
</table>

With the exception of the above-mentioned activities, the
activities of the above-mentioned private hospital/unattached
operating-theatre unit are restricted as follows:

Signed at..........................................................
this..........................................................

Day of..........................................................

Secretary for Health

This certificate is not transferable and must be renewed annually.

* Delete if not applicable.
# Aanhangsel

**Registre van patiënten opgenomen**

<table>
<thead>
<tr>
<th>Reeks No.</th>
<th>Patiëntregistratie No.</th>
<th>Datum opgenomen</th>
<th>Volle naam van patiënt</th>
<th>Ouder/ God</th>
<th>Geboortedatum</th>
<th>Woonadres</th>
<th>Diagnose/ Hoofdverwekkende aandoening</th>
<th>Nummer genummer van patiënt behandel</th>
<th>Plaats registratie</th>
<th>Datum van Onafhankelijk aansprakelijk</th>
<th>In geval van dood</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>Deur als geregistreerd</td>
</tr>
<tr>
<td>Serial No.</td>
<td>Patient registration No.</td>
<td>Date of admission</td>
<td>Full name of patient</td>
<td>Age</td>
<td>Sex</td>
<td>Residential address</td>
<td>Diagnosis/reason for admission</td>
<td>Name of medical practitioner treating the patient</td>
<td>Final diagnosis</td>
<td>Date of discharge</td>
<td>Date of death</td>
</tr>
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</tbody>
</table>
AANHANGSEL E

BEVALLINGSREGISTER

Reeksnummer van geval
Datum opgeweken
Naam van patiënt
Ouderdom
Bevolkingsgroep
Adres

(a) Getal vorige bevallings
(b) Getal vorige mislukte bevalling
(c) Datum van bevalling
(d) Datum van mislukte bevalling
Volledige naam, vroeggeboorte of mislukte bevalling? Indien mislukte bevalling, vermeld benaderde getal maanen.
Liggings
Duur van bevalling
Geslag van baby
Dood of lewend geboorte
Complicaties (as daar is) gedurende of na die bevalling

Naam van geneesheer (block letters)
Handtekening
Naam van vrou en (as daar is)
Datum van vreemde se laatste besoek of datum van ontslag
Toestand van moeder op daardie tydspan
Toestand van kind op daardie tydspan

Handtekening

AANHANGSEL E

OPERASIETHEATERREGISTER

Reeksnummer
Datum
Naam
Toelatingsregister No.
Geslag
Ouderdom
Sani
Verkooi
Naam van marktieter
Naam van chirurg
Naam van assistent-chirurg
Operasie
Duur van operasie:
Die en, etc.
Teater
Handtekening van verpleegkundige by operasie
Handtekening van pasiënt
Complicaties (komplikasies, ongelukke, etc., en).

ANNEXURE E

MATERNITY REGISTER

Serial number of case
Date admitted
Name of patient
Age
Population group
Address

(a) Number of previous childbirths
(b) Number of previous miscarriages
(c) Date of confinement
(d) Date of miscarriage
Full term, premature or miscarriage? If miscarriage, state number of months
Presentation
Duration of labour
Sex of infant
Born alive or dead
Complications (any) during or after labour

Name of medical practitioner (block letters)
Signature
Name of midwife (if any)
Date of midwife's last visit or date of discharge
Condition of patient then
Condition of child then

Signature

ANNEXURE E

OPERATING-THEATRE REGISTER

Serial number
Date
First
Anesthesia register No.
Sex
Age
Word
Anaesthesia
Name of anesthetist
Name of surgeon
Name of assistant surgeon
Operation
Duration of operation: From to
Diuresis, etc.
Excreta

Signature of nurse taking operation
Signature of cross-checker
Reports (complications, accidents, etc.)

ANNEXURE G

ONGEVALLE- EN BUITEPASIENTEREGISTER

Reeks No.
Serial No.
Datum
Register No.
Tyd
Naam
Ouderdom
Geslag
Adres
Klasse/Beperking
Onslag
Nige No.

ANNEXURE G

CASUALTY AND OUTPATIENTS REGISTER

Serial No.
Register No.
Date
Time
Name
Age
Sex
Address
Complaint
Injury
Discharge

ANNEXURE E

REGISTRER VAN VERPLEEGKUNDIGE PERSONEEL

Volle naam
Pseudonym (in die toepaslik)
Identitatsnummer
Geslag
Geboortedatum
Bevolkingsgroep
Naationaliteit

ANNEXURE E

REGISTER OF NURSING STAFF

Full name
Middle name (if applicable)
Identity number
Sex
Date of birth
Population group
Nationality
AMENDMENT OF THE ANATOMICAL DONATIONS AND POST-MORTEM EXAMINATIONS REGULATIONS

No. R. 165                                      1 February 1980

It is hereby notified for general information that the Minister of Health, in the exercise of the powers vested in him by section 13 (1) (dA) of the Anatomical Donations and Post-Mortem Examinations Act, 1970 (Act 24 of 1970), intends to further amend the regulations promulgated under Government Notice R. 889 of 24 May 1974, as amended, by inserting the prescribed tissue, the prescribed authorised institution and the prescribed purposes named in the Schedule hereto, in column I, column II and column III, respectively, of Schedule II.

Interested parties are hereby invited to submit substantiated comments to the Secretary for Health, Private Bag X88, Pretoria, 0001 (for attention: Mr. L. A. du Pisanie), within three months of the date of this notice.

SCHEDULE

<table>
<thead>
<tr>
<th>Column I</th>
<th>Column II</th>
<th>Column III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presented tissue</td>
<td>Prescribed authorised institution</td>
<td>Prescribed purpose</td>
</tr>
<tr>
<td>Auditory nerve</td>
<td>Department of Neurosurgery, University of Pretoria</td>
<td>Research</td>
</tr>
</tbody>
</table>
Warning on medical control

The writer stated that the Dental Council should not allow themselves to be treated like "idols," and that it should ever reach realization it calls for the resignation of the whole Medical and Dental Council.

The writer held that the Dental Council should not follow their colleagues' example of rigidity, but should be ready to resign if necessary.

The writer warned against the danger of a call to the medical profession to stand together against "the disregard and ill-will of mine," and to form a "solid body from the 'other circles.'" He also warned against the "only weakness" and "dreadful weakness" of the profession.

The writer firmly believed that the profession must not fight "in strength," but must "settle disputes," and that "even the most sickly or feeble" of the profession must not be neglected.

The writer strongly advised against the "only weakness," and that "even the most sickly or feeble" of the profession must not be neglected.

The writer feared that the profession would become "tired and discouraged," and that it should not fight "in strength," but must "settle disputes," and that "even the most sickly or feeble" of the profession must not be neglected.

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KENNISGEWING 98 VAN 1980
WYSIGING VAN REGULASIES BETREFFENDE
ANATOMIESE SKENKINGS EN NADOODSE
ONDERSOEKE

Hierby word vir algemene inligting bekendgemaak
dat die Minister van Gesondheid kragtens die bevoegd-
heid hom verleen by artikel 13 (1) (dA) van die Wet
op Anatomiese Skenkings en Nadooodse Ondersoek,
1970 (Wet 24 van 1970), voornemens is om die regu-
lasies uitgevaardigd by Goewermentskennisgewing R. 889
van 24 Mei 1974, soos gewysig, verder te wysig deur
die voorgeskrewe weefsel, die voorgeskrewe gemagtigde
inrigting en die voorgeskrewe doel vermeld in die
Blye hiervan, in onderskeidelik kolom I, kolom II
en kolom III van Blye II in te voeg.

Belanghebbendes word hierby versoek om binne drie
maande na die datum van hierdie kennisgewing gemotia-
veerde kommentaar in te dien by die Sekretaris van
Gesondheid, Privaatsak X88, Pretoria, 0001 (vir aan-

BYLAE

<table>
<thead>
<tr>
<th>Kolom I Voorgeskrewe weefsel</th>
<th>Kolom II Voorgeskrewe gemagtigde inrigting</th>
<th>Kolom III Voorgeskrewe doel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hart</td>
<td>Tygerberg hospital</td>
<td>Oorplanting,</td>
</tr>
<tr>
<td>Temporale bene</td>
<td>Tygerberg hospital</td>
<td>Opleiding en navorsing</td>
</tr>
<tr>
<td>Larynx</td>
<td>Tygerberg hospital</td>
<td>Opleiding en navorsing</td>
</tr>
<tr>
<td>Liver</td>
<td>Tygerberg hospital</td>
<td>Navorsing</td>
</tr>
<tr>
<td>Spleen</td>
<td>Tygerberg hospital</td>
<td>Weefseltering</td>
</tr>
</tbody>
</table>

(8 Februarie 1980)

NOTICE 98 OF 1980
AMENDMENT OF THE ANATOMICAL DONATIONS AND POST-MORTEM EXAMINATION REGULATIONS

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<th>Column II Prescribed authorised institution</th>
<th>Column III Prescribed purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart</td>
<td>Tygerberg Hospital</td>
<td>Transplantation.</td>
</tr>
<tr>
<td>Temporale bones</td>
<td>Tygerberg Hospital</td>
<td>Training and research</td>
</tr>
<tr>
<td>Larynx</td>
<td>Tygerberg Hospital</td>
<td>Training and research</td>
</tr>
<tr>
<td>Liver</td>
<td>Tygerberg Hospital</td>
<td>Research.</td>
</tr>
<tr>
<td>Spleen</td>
<td>Tygerberg Hospital</td>
<td>Tissue typing.</td>
</tr>
</tbody>
</table>

(8 February 1980)

GG 6840
Don't light up!

If you're a smoking addict take a long, hard look at these facts provided by the Southern Africa Council on Smoking and Health. The statistics are based on 1976 figures and exclude blacks:
The risk of lung cancer in heavy smokers is 15 to 30 times greater than that of non-smokers.
The World Health Organisation says the control of cigarette smoking would contribute more to improving health and prolonging life than any other single action in the field of preventive medicine;
The rate of coronary heart disease, of which cigarette smoking is a main cause, is the highest in the world among white South African men and women;
One in four white South African children are smokers before they reach the age of 15 and many are regular smokers at the age of 11;
In Britain it is estimated cigarette smoking is responsible for 50 000 premature deaths a year and that more than 30 million working days a year are lost due to smoking-related diseases;
Babies born to women who smoke during pregnancy tend to have a lower birth weight and be more susceptible to infection than babies born to non-smokers;
Deaths from cardio-vascular diseases resulting from smoking are more than three times higher than the number of fatal car accidents in South Africa.
Considering those facts I'm not surprised South Africa is to hold a "National Smokeless Day" on April 2 as part of a worldwide anti-smoking thrust emanating from the World Health Organisation in Geneva.
Smokers throughout the country will be asked to abstain from smoking on April 2, but the main purpose of the campaign will be to alert the public to how seriously smoking has been and is affecting the health of South Africans.
The Council on Smoking and Health is hoping the entire South African population — smokers and non-smokers — will actively support this promotion and help build up a healthy nation of all race groups.
Mr. N. S. WOOD asked the Minister of Statistics:

(1) How many (a) Whites, (b) Coloureds, (c) Indians and (d) Blacks in the different professions associated with health services emigrated from South Africa during the last 12 months for which figures are available?

(2) What is the number of each race group in each such profession?

The MINISTER OF STATISTICS:

<table>
<thead>
<tr>
<th>Profession</th>
<th>(a)</th>
<th>(b), (c) and (d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical doctors</td>
<td>103</td>
<td>3</td>
</tr>
<tr>
<td>Dentists</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Pharmacists</td>
<td>30</td>
<td>1</td>
</tr>
<tr>
<td>Professional nurses</td>
<td>150</td>
<td>9</td>
</tr>
<tr>
<td>Other nursing personnel</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Optometrists and opticians</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Physiotherapists, etc.</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Radiographers</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>Osteopaths, chiropractors, etc.</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>358</td>
<td>15</td>
</tr>
</tbody>
</table>

(b), (c) and (d) 15 (separate figures not available).

Figures are for the period December 1978 to November 1979.
Political Staff
THE ASSEMBLY — Mrs Helen Suzman (FFP, Houghton) lashed out in the Assembly yesterday at Government attitudes to abortion in South Africa.

Speaking in the second-reading debate on the Abortion and Sterilisation Amendment Bill, she said the abortion legislation had been debated by men with narrow minds who knew nothing of the agony of women.

Referring to arguments put forward by a speaker on the Government side, Mrs Suzman said: “He might take a different attitude if his own 16-year-old daughter became pregnant.”

This was something that could happen to anybody’s daughter.

One of the manifold difficulties of women — pregnancy after rape — was made a little easier by the proposed legislation.

The Bill, among other things, empowers a magistrate to grant consent in certain circumstances for the sterilisation of persons who cannot themselves consent to it.

The second reading of the Bill was supported by all parties in the Assembly.

Mr H. J. van Rensburg (FFP, Bryanston) said exaggerated restrictions in the existing law were causing much misery.

Experts had said that victims reported to the police in only five percent of rape cases.

A large percentage of illegitimate births, especially among the coloured people, occurred as a result of rape.

The Minister of Health, Dr L A P A Munnik, said South Africa’s abortion law was based on Christian principles and these would be maintained.

Dr Munnik said he was prepared to consider proposals for improvements from Mr van Rensburg, but abortion on demand would never be accepted.
Commission of Inquiry into Fluoridation

*16. Mr. A. B. WIDMAN asked the Minister of Health:

Whether he intends to introduce legislation to give effect to the recommendations of the Commission of Inquiry into Fluoridation; if so, when; if not, why not?

The MINISTER OF HEALTH:

No, not at this stage.
The Department of Health has been receiving additional information from various sources which is being evaluated. When this has been finalized, a decision shall be taken.
never been the intention of the association to imply that the draft Bills had any political connotations.

After thorough consideration of all the representations I decided to amend certain provisions in the Bills to be introduced in Parliament. These amendments will have the following effect—

1. As regards the right of contracting in and contracting out in terms of section 29 of the Medical Schemes Act, 1967, the status quo will be preserved, but it shall be provided that if, after consultation with the S.A. Medical and Dental Council and the profession concerned, it is deemed to be desirable in the public interest, the right of contracting in and contracting out may be rescinded, or that it may only be allowed under certain specific circumstances, which will be prescribed by regulation.

2. The draft provision by means of which the Minister may set aside any decision of the S.A. Medical and Dental Council will be restricted to tariffs of fees applicable to services rendered to members and dependants of members of medical schemes, after the Minister has consulted with the executive committee of the council.

3. The tariffs of fees will have to be approved by the Minister prior to publication, and shall relate only to services rendered to members and dependants of members of medical schemes.

4. The tariffs of fees so published shall be maximum fees only in respect of services rendered by providers of services to members and dependants of medical schemes who have contracted in.

5. As regards the constitution of the tariffs committees, the status quo will be maintained for the present.

The professions will in this way, at their request, be afforded an opportunity of adopting measures and applying self-discipline to ensure that the right of contracting out will be in the public interest and will not be abused. Every possible malpractice with regard to the application of the tariff of fees will also be
Has anyone seen Jovani?

Jovani Sibanda (5) is lost. He was last seen playing outside his home in Mbabane on January 17. If anyone has seen him, they should contact his parents at 2232 Patrick Street, Mbabane (phone 672-3770) or the nearest police station.

Dr. Bob Komen in

The Department of Health is calling for a ban on skin lightening creams containing mercury or more than two percent of the chemical hydroquinone.

This was disclosed by Dr. Peter Mabunda, the department's medical director, who was marshalling the findings that skin lighting creams are responsible for an epidemic of skin blackening among the skin black women in the country.

The findings of Prof. G.H. Findlay and Dr. H.A. de Beer of the dermatology division at the University of Pretoria were published in the S.A. Medical Journal. They found that there were widespread use of skin lighting creams, particularly in black women, and that these creams were responsible for the epidemic of skin blackening that had been reported.

New legislation has been passed in Parliament to make it illegal to manufacture, import, sell or use skin lighting creams.

"We will be coming down very hard on anyone who violates this law," said Mabunda.

Agenda for today:

1. A meeting of the South African Council of Sports (SACOS) on sports facilities.
2. A meeting of the Women's Rights Commission on gender equality.
3. A meeting of the National Council of Churches on social issues.
4. A meeting of the National Education Panel on curriculum development.
5. A meeting of the National Arts Council on cultural events.

Published by Comm-Comm.
Printed by S.R.C. Press, U.C.T.
SA may rejoin world group

By PETER BAYER.

There is a strong likelihood that the Medical Association of South Africa will return to the World Medical Association (WMA) later this year.

South Africa resigned in 1976 from the organisation it helped to found in 1948.

The resignation was prompted by the fact that the WMA was becoming an anti-apartheid platform for its increasing Third World members.

The Secretary-General of the WMA, Dr Andre Wynen, said yesterday that after touring the country, visiting hospitals and meeting with top officials, he felt it necessary for South Africa to return to the WMA.

He said he had succeeded in amending the WMA’s constitution two years ago and that Third World nations now wielded less power in the association.

Dr Wynen said what he had seen showed that South Africa had a great deal to contribute to world medicine and had the most sophisticated medical care on the continent.

Secretary-General of MASA, Dr Marius Viljoen, who invited Dr Wynen to the country, agreed that South Africa should rejoin the WMA as an exchange of ideas was necessary to maintain a high standard.

"This does not mean we have already agreed to rejoin WMA," Dr Viljoen said.

"However, after Dr Wynen has presented his report, MASA will reconsider rejoining. At this stage, I see no reason why we should not go back."

The American Medical Association, which resigned from the WMA shortly before South Africa, for the same reason, has rejoined since the amendment.

Canada, which also resigned, has also rejoined and the Rhodesian delegation is apparently reconsidering rejoining. However, the Scandinavian delegation resigned after the amendment was made.
### Notifiable Diseases

44. Mr. H. E. J. VAN RENSBURG asked the Minister of Health:

How many cases of each notifiable disease were notified in respect of each race group in 1979?

<table>
<thead>
<tr>
<th>Disease</th>
<th>White</th>
<th>Coloured</th>
<th>Asian</th>
<th>Black</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthrax</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Amebic Cholera</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Brucellosis</td>
<td>12</td>
<td>16</td>
<td>2</td>
<td>59</td>
<td>6</td>
<td>125</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>99</td>
<td>3</td>
<td>8</td>
<td>15</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Encephalitis</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Erysipelas</td>
<td>0</td>
<td>0</td>
<td>103</td>
<td>0</td>
<td>0</td>
<td>132</td>
</tr>
<tr>
<td>Glanders</td>
<td>2</td>
<td>25</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Gonorrhoeal ophthalmia</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>123</td>
<td>2</td>
<td>132</td>
</tr>
<tr>
<td>Lead poisoning</td>
<td>1</td>
<td>1</td>
<td>11</td>
<td>1648</td>
<td>2</td>
<td>1771</td>
</tr>
<tr>
<td>Leprosy</td>
<td>101</td>
<td>788</td>
<td>9</td>
<td>315</td>
<td>0</td>
<td>1227</td>
</tr>
<tr>
<td>Malaria</td>
<td>115</td>
<td>26</td>
<td>1</td>
<td>59</td>
<td>0</td>
<td>134</td>
</tr>
<tr>
<td>Meningoencephalitis</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>59</td>
<td>0</td>
<td>69</td>
</tr>
<tr>
<td>Pesticidal poisoning</td>
<td>0</td>
<td>0</td>
<td>80</td>
<td>0</td>
<td>0</td>
<td>80</td>
</tr>
<tr>
<td>Plague</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>53</td>
<td>0</td>
<td>59</td>
</tr>
<tr>
<td>Poliomyelitis</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Puerperal fever</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Rabies in man</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Relapsing fever</td>
<td>81</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>82</td>
</tr>
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<td>Scarlet fever</td>
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**Total**
THURSDAY 28 FEBRUARY 1930

200

The Minister of Health

(3) Is anyone object of your case more than

(4) (a) 13.

(4) (b) 12.

(4) 1 January until 31 December 1929

(5) Enclosed you send the report

(6) What are the

(7) In the event of your case more than
The new slogan is ‘breast is best’

South African manufacturers of baby foods say they have stopped advertising breast milk substitutes in the non-medical Press.

The practice of advertising these products to the general public has been condemned by doctors and nutritionists.

They say there is a danger that mothers, through ignorance or poverty, will over-dilute these products to the detriment of their babies’ health. As in most cases, they say, “breast is best.”

In Washington, a House of Representatives subcommittee on international policy and trade is investigating the marketing practices of American Home Products Corporation and Nestle Incorporated, both of which have subsidiaries in South Africa.

The investigation follows claims by an American organization called the International Nestle Boycott Committee, which alleges the marketing practices of multi-national giants contribute to massive infant mortality in the developing world.

It was revealed at the subcommittee hearing that American Home Products Corporation had ordered its South African subsidiary to stop using a particular baby food advertisement.

An executive of the subsidiary company, Wyeth Laboratories, said it was given this instruction by its parent company about the middle of last year.

Since then, all advertising to the public had been discontinued. While the company continued to advertise in the medical press, its last advertisement directed at consumers (an advertisement in the magazine “Loving and Loving” for 26 dollars) appeared about September last year.

A spokesman for Nestle said they had not advertised any baby formula products to the general public for over two years. Now they advertised only in medical journals, which were directed at doctors who knew what was best for mothers and their babies, he said.

A spokesman for the Department of Health said the department held a meeting with all baby food manufacturers about two years ago, at which they agreed on a code of practice.

He said Wyeth Laboratories’ advertising to the public last year had not constituted an infringement of this agreement because it was not “aggressive” advertising.

Wyeth’s spokesman said the code of practice did not prohibit advertising to the public, but his company had decided, on its own, to limit its advertisements to the professional Press only.

Professor H. Stein, chief paediatrician at Baragwanath Hospital, said Baragwanath had been receiving very hard for many years now to promote breastfeeding. He said it was only in very few cases that mothers could not breastfeed.

He said that in the past many of the cases of malnutrition in baby brought to the hospital were the result of over-diluting of formula fed by mothers.
Tar and nicotine laws possible soon

By BRUCE STEPHENSON

Dr John de Beer, said in his annual report, tabled in Parliament yesterday, that legislation would be introduced soon as part of a comprehensive programme to curtail smoking.

He is aiming for January 1, 1982, as the date for this legislation to be effected.

The Government wants cigarette manufacturers to disclose the tar and nicotine contents of cigarettes on each packet from January 1, 1982.

Cigarette manufacturers said they were strongly opposed this.

The Government is also planning an education programme, aimed mainly at schoolchildren, to warn of the dangers associated with high tar content in cigarettes.

Adults will be encouraged to moderate their smoking.

Dr De Beer said from Cape Town yesterday that he was consulting manufacturers on the form of the warning that would appear on each packet.

"We have looked at what America and Britain are doing in this regard and I am not sure that their methods have had any effect.

"But we are learning from their campaigns and I am sure that we will find some sort of solution."

Arch anti-smoking campaigner Mr Alf Widman, MP for Hillbrow, has welcomed the move and wants the Minister of Health to ban smoking in "any public place".

Mr Widman said he was "delighted" at the department's plans.

This was "covered completely" by his Smoking Control Bill, which proposes that:

- Tar and nicotine content, plus a warning "Smoking is dangerous to your health", be displayed on every cigarette packet.
To the Rescue

Tankers to help in relief

of typhoon-stricken island

LAUNCHER and other accomodation ship Eni, whenever the weather permits — only from

THREE OF OIL WELL field.

LAUNCHER and other accomodation ship Eni, whenever the weather permits — only from

THREE OF OIL WELL field.

'Not too soon came, however,' my friend 2000 people were rescued on

THREE OF OIL WELL field.

'These results shows the reception gave notice that, since when we were washing

THREE OF OIL WELL field.

whenever the weather permits — only from

THREE OF OIL WELL field.

LAUNCHER and other accomodation ship Eni, whenever the weather permits — only from

THREE OF OIL WELL field.
Medical secrecy: Doctors blamed

Staff Reporter

DOCTORS were "very greatly to blame" for surrounding their profession with a medi- 
eval mystique and an air of unapproachability, the 
president of the World Heal- 
ing Federation, Dr Iain 
Pearce, said yesterday. 

Addressing the Medical Stu- 
dents Council at Groote 
Schuur Hospital, Dr Pearce 
said true communication be- 
tween doctor and patient was 
distressing in its rarity. 

The prime need was to con- 
vince the general public that 
self-healing was an inherent 
property of the human being. 
This should be believed in, 
strengthened and trusted. 

Dr Pearce, who is visiting 
South Africa from England, 
said that the present genera- 
tion of orthodox doctors was 
handicapped by the barriers 
of their own training, which was 
heavily over-biased to- 
wards drugs and surgery. 

The health establishment itself 
also emphasized acute, high- 
cost, hospital-orientated and 
drug-oriented medicine. 

This "interventionist" concept 
of therapy was further 
strengthened by the influence 
of the pharmaceutical indus- 
try which was more con- 
cerned with selling its drugs 
than keeping people healthy. 

"Disease service"

Three quarters of the physical 
disease which he himself had 
seen was due to faulty pat- 
terns of emotion and wrong 
atitudes of mind. 

Not recognizing this, the West- 
era medical system was 
dealing only with a fraction 
of health and its problems, 
and becoming less and less 
effective. The system itself 
frequently produced disease. 

The whole system—research, 
education, medical schools 
and universities, and the way 
hospitals were run—was in 
fact not a health system at 
all, but a "disease service". 

Not only did the system only 
recognize a few of the phys- 
iological factors influencing 
health and ignore the rest, 
but it used destructive tech- 
niques such as drugs, surgery 
and radiation as its main 
methods."
FRESH water! That's all it needs to bring out the biggest smiles in Inanda where typhoid recently reached epidemic proportions.

Twelve water tanks went into operation yesterday, for the first time and hundreds of happy residents queued up with containers of all shapes and sizes at various points in the township.

According to Mr Charles Pervis, District Magistrate of Verulam, who has been appointed head of the operation to get fresh water to Inanda, the residents may receive 25c of water a day.

Officials have been appointed at the base depot in Inanda to ensure the conservation of as much fresh water as possible.

Most of the water tanks were installed in the north of Inanda where the typhoid epidemic seems to be at its worst.
Inanda helped because it made people take notice

Mercury Reporter

The potentially explosive situation at Inanda was now being defined but not only because its seriousness and the health threat to Durban had caused the authorities to "sit up and take notice", the regional Director of State Health, Dr Johan van Rensburg, said yesterday.

He said departmental records showed that typhoid in Inanda had in fact shown a marginal improvement over recent years but that it nevertheless had presented a "continuous health problem".

Contaminated

He said: "A recent survey showed that without exception, every natural source of water in Inanda is contaminated with human waste, which is no good at all."

A proper water system, a refuse removal scheme, better roads — Inanda has been crying out for these for years but nothing could be done because there was no local authority to take charge."

Gravity

Now, however, the authorities had been forced to realize the gravity of the situation and were looking into effecting a long-term solution of Inanda's problems.

One area to be improved soon is the health service in the area, for years hopelessly inadequate.

The Department of Cooperation and Development has granted us funds to establish a permanent clinic there. Until now we have been able to run only a basic service from a mobile clinic based at Kwa Dukela," Dr van Rensburg said.

New clinic

Discussions were presently underway with community leaders to decide the best site for the new clinic.

"We hope to extend the service to health education," Dr van Rensburg said.

"The recent rain also gave cause for concern, as it caused a run-off from polluted sources which in turn contaminated reservoirs and boreholes that were not properly sealed.

"But the people know now that there is fresh water freely available and I doubt they will be getting supplies from elsewhere."
How to check for typhoid symptoms

WITH 30 cases of typhoid already reported in Inanda this year doctors say that women at home can play an important part in assisting in the arrest of the disease by keeping an eye out for symptoms of the disease among their domestic workers and by telling them how to spot signs of the disease among their children.

The symptoms to watch for, according to a spokesman for the Durban Medical Association (DMA), are:

* Fever.
* Excessive perspiration.
* Explosive diarrhoea
* Pea-soup stools.
* Abdominal pains due to infection. These can be continuous or spasmodic.
* Dehydration — thirst, dry mouth and tongue.
* Mental confusion.

Because of the high mortality rate of typhoid, it is important to get the patient to a doctor or a hospital as soon as possible. The disease can only be treated successfully by the administration of antibiotics or intravenous rehydration.

There are, however, a few things that can be done to ease things for the patient until she can be taken to a doctor.

* Give fluids since rehydration can to some extent be done orally.
* Keep the patient lying down — walking around can spread the toxin more rapidly through the body.
* Sponge the patient down when she is feeling hot or perspiring.

The DMA warns that typhoid is a highly infectious disease. People could be infected before it becomes visible and to prevent the disease from spreading, it will be wise to follow the following precautions.

* Keep domestic workers out of the kitchen.
* Prevent them from handling any food for consumption by other members of the household, without washing their hands with an anti-septic soap.
* Care should be taken not to wash their dishes with those of the rest of the household. The best precaution would be to boil their dishes and cutlery.

It would be wise to use a disinfectant in the toilet but even more importantly to supply domestic workers with disinfectants to use in their homes if water-carrying sewage systems are not in use.
Best schools

Settled for more than 100 years, the area boasts some of the best African schools in the Durban area, a number of shops and other local businesses, a police station and a new post office.

The land ownership of the area is complex. There are perhaps 400 black private landowners and 200 Indian landowners, while a certain amount of land is owned by the S A Development Trust.

Because it is so-called released land, it may be sold only to blacks. However, should it be necessary, the Department of Co-operation and Development could buy it back.

The whole area apparently is earmarked to be incorporated into KwaZulu in terms of the proposed Homelands Consolidation Bill.

When asked who the local authority responsible for Inanda was the Chief Commissioner of the Department for Co-operation and Development for Natal, Mr It N Bluinct, said there was none.

Health matters

Asked why, he said as far as health matters were concerned, the Department of Health assumed responsibility for the area. However, the Regional Director of State Health, Dr Johann van Rensburg, said yesterday the Department of Co-operation and Development had already assumed its responsibility for Inanda by supplying funds for the emergency relief of the area.

'The released area lies outside the area served by Inanda. The Department of Co-operation and Development supplies the funds and we act merely as their agents,' he said.

The department now has to make a decision whether it is going to act as a local authority in the area or not.'

Dr van Rensburg said his department had no power to collect taxes, lay sewerage, build roads or houses in Inanda, and therefore there was a desperate need for a bona fide local authority in the area.

PROF Ian Spencer

issued a form to 1 200 members asking for volunteers for one month's service to the desperately pressed hospitals and clinics of KwaZulu. Two replied,' he said.

The King Edward VIII Hospital in Durban was grossly overloaded because of the lack of primary health care in the rural areas.

'The education of a single doctor costs South Africa approximately R30 000. It should become law that doctors take a stipulated period of service among those communities such as KwaZulu which are in great need of medical attention.'
The unwanted

Mercury Reporter

The tragedy of Inanda's situation was that no one was prepared to take the responsibility of being the local authority for the area, the Regional Director of the Urban Foundation, Mr. Alan Mountain, said yesterday.

Although action had been taken to remedy Inanda's immediate problems, 'a long look' needed to be taken at the long-term solutions.

'No upgrading of the area can take place until a local authority assumes control,' he said.

The Urban Foundation, prompted by Inanda's lack of water and proper sanitation facilities, had investigated laying a reticulated water system in Inanda as early as March last year, and after its completion had submitted a report to various departments, including the Department of Co-operation and Development, for consideration.

However, nothing was done.

This was because there was no local authority to which money for the scheme could be loaned. The cost of the scheme, taking inflation into consideration, would be about R2.5 million, he said.

According to Mr. James Rivett-Carnac, who conducted the feasibility study for the foundation, the operating costs of supplying Inanda with water by tanker would be in the region of R144,000 a year.
Rand pumps will soon switch to gasohol

By Harvey Thomas, Motor Editor

Premium pumps on the Rand will switch over to gasohol — 10 percent alcohol, 90 percent petrol — in July or August.

And in Johannesburg today, the Automobile Association said that its tests of the mix had been "positive."

The new blend is a direct result of Sasol 2 coming on stream and will initially be sold on the Rand. But further gasohol areas will be designated, and gradually introduced.

The 10 percent blend is a combination of ethanol (a light alcohol) and other heavier alcohols. When gasohol is freely available in different parts of the country, the saving to South Africa in foreign exchange will lie upwards of R500-million.

The AA's tests proved that vehicles tuned to optimum economy with exhaust CO levels of less than 1.5 percent actually used 1.7 percent more fuel when filled up with gasohol.

"But the change in power output at maximum throttle opening was negligible," said Mr Fred Botham, the Association's Technical Services executive. He added that a recent survey had established that fewer than two percent of the vehicles on the Rand were tuned to such optimum economy.

When vehicles tuned to optimum economy were detuned by fitting larger jets to the carburettors the switch to an alcohol blend had improved consumption marginally. The move to gasohol does, however, bring new implications for the motor trade.

Special care will be needed by service station operators to keep water out of tanks, filler caps and dipsticks will have to be closed meticulously, and repair checks run.
Officer blasts dagga dealers

KIMBERLEY. — Dagga dealers who sold to military servicemen in their camps were affecting South Africa's defense, Mr P B Eekhout was told in the Kimberley Magistrate's Court yesterday.

The magistrate was told that servicemen who smoked dagga were unable to go to the operational area.

Lieut H Bosshof, of 11 Commando, giving evidence against two Kimberley men on a charge of selling dagga to two servicemen, said that he was in charge of a company of about 400 medically unfit servicemen and these men were a target for dagga dealers.

He said that since 1978 many servicemen had appeared in court on possession charges and that dagga smoking was a great problem in the army as it meant that soldiers who smoked dagga were sent to rehabilitation centres instead of operational areas.

Klaas Riet, 18, of the Bontfontein district in Kimberley, and Joost Knaas, 38, of Saviera Street, Galeshewe, were found guilty of selling dagga to two servicemen and sentenced to five years in jail. They denied the charges.

Mr J de Lange and Mr L van der Walt, two servicemen, giving evidence for the State, said that on February 6 they were approached by Riet and Knaas in their camp and asked if they wished to buy dagga.

They told the court that they agreed to meet Riet and Knaas the next day at a certain place for the transaction. They (Mr De Lange and Mr Van der Walt) said they went to report the incident to Lieut Bosshof immediately and the three of them worked out a plan to trap the men.

Mr Van der Walt said Lieut Bosshof gave Mr De Lange a marked R2 note to pay for the dagga and gave him a set of brown — army pants and shirt — to use in his part of the transaction.

Corporal G Miller of the Military Police said that on February 7 he and other MPs, on instruction from Lieut Bosshof, grouped themselves where the transaction was to take place.

He said he saw Riet take R2 from Mr De Lange and hand him a matchbox full of pure dagga.

Although Riet had no previous convictions, the magistrate said that because they were involved in this serious crime together, he should receive the same sentence. He wished to make an example of them. — Sapa.
Bureau to aid child welfare

Staff Reporter

The Child Care Information Centre at the University of Cape Town's Child Health Unit is to establish a voluntary and bureau to co-ordinate the efforts of individuals and service organizations involved in child welfare throughout the Peninsula.

The Urban Federation has granted the university £9,000 over the next two years for a co-ordinator to run the bureau.

Professor Maurice Kibet, professor of child health, said the bureau would play an important part in child welfare. This was because many individuals and separate bodies were doing valuable work among the underprivileged and there were many gaps and duplication. This wasted time, money and effort in work that was largely unco-ordinated.

Impetus for the establishment of the bureau had come from Dr Isabel Robertson, former head of the Child Welfare Society in the Peninsula and part-time lecturer in pediatrics at UCT.
Black workers retire earlier.

BLACK employees in an oil company contributed to the incidence of early retirement through ill-health in a ratio of proportion to the number employed. A doctor told the general practitioners' congress in Cape Town.

In a paper based on figures issued by a Cape-based oil company, Dr A Spentt said blacks formed 33 percent of all early retirements, while they made up only 32 percent of the workforce. Second were coloured employees then whites, with Indians in the lowest group.

Labourers formed the largest grouping among the prematurely-retired, accounting for 37 percent. Average age on retirement was 53 and the main cause was hypertension (23 percent) followed by chronic lung disease (13 percent) and heart disease (10 percent).
Health Dept's new assault on smoking

By MARILYN ELLIOTT

The South African Government collects R240-million annually in tax on the R1000-million tobacco industry, a spokesman from the Department of Health said in Johannesburg yesterday.

But while the Treasury collects money from the cigarette industry, another section of the Government — the Department of Health — is spending money on campaigns to halt smoking.

The Department's latest campaign, beginning with a "Smokeless Day" on April 2, is aimed at both smokers and non-smokers.

The campaign was born from a policy statement by the Minister of Health in Parliament last year. It is aimed at educating the public about the dangers of smoking by means of posters, pamphlets, films and media coverage. The department hopes to dissuade teenagers from smoking and persuade smokers to smoke less or smoke cigarettes of low tar and nicotine content.

At a press conference in Johannesburg yesterday, the deputy secretary for the Department of Health, Mr. Martin Gratz, said the campaign was designed to inform South Africans of the hazards of smoking and to try and halt beginner smokers.

Surveys in SA and the UK show that more than 80% of smokers want to stop and 87% do not want their children to smoke," he said.

Mr. Gratz said negotiations are well under way between the Department of Health and cigarette manufacturers to introduce compulsory tar and nicotine content statements on cigarette packs. He said it appeared to him that manufacturers were not particularly concerned about the nation's health — "they want to sell as many cigarettes as they can. It's business."

The Department of Health has also launched a counter-propaganda programme to offset the effects of cigarette advertising in the country — a R17 100 000 a year business.

A hard-hitting film, directed at youngsters, has been compiled by the Department in a fresh attempt to discourage smoking. The film — entitled "Smoking — An Illusion of Maturity" — attacks the main appeal of the advertising: that smoking will improve your image.

The slide and sound show presents a horrifying medley of dirty ashtrays, nicotine-stained fingers, halts dropping from mouths and blackened lungs as the real results of dedicated smoking.

Professor Harry Seftel, chairman of the Council on Smoking and Health, yesterday hailed the film as the most effective stop-smoking message he has seen.

"This is a film all South Africans should see. Our country has the highest number of heart attacks in the world. We also manufacture cigarettes with the highest tar and nicotine content in the world. While no association has been proved, it's an interesting point."

So far, public response to the "Smokeless Day" has been tremendous, Mr. Gratz says. "Factories, business houses and private individuals have stuck up our posters. The Council on Smoking and Health gets a huge mailbag everyday from concerned people. We hope that April 2 will be the beginning of a much stronger attack on smoking," he said.

This is the second "Smokeless Day," held in South Africa. The first, in November 1978, was organised by the SA Cancer Association.
A constant battle against virulent disease.

BY JEAN LE MAY

Pictures: LeMay

Field officer B. W. McLean: 'If the meat is positive, the patient is given further treatment.'
Below Piece disannihilation: two lines were nearby.

The area PDEG is part of the construction surplus. The revenue generated by price disannihilation introduces output in the area APE which is screened by output to two long ears D and E. Revenue will be produced by two distributional areas. Revenue will also be produced by two distributional areas.

The revenue generated by price disannihilation introduces output in the area APE which is screened by output to two long ears D and E. Revenue will be produced by two distributional areas. Revenue will also be produced by two distributional areas.
SA to produce new cancer drug

Owen Correspondent

DURBAN. - Durban will start producing by the end of the month a rare anti-viral drug which could be used against some forms of cancer.

The medical director of the Natal Blood Transfusion Centre, Professor Peter Brain, said Durban could become one of the world's largest producers of the newly-developed drug, Interferon, which would eventually be used to fight a variety of viral infections from the common cold to chronic hepatitis.

Professor Brain said it was planned to establish a plant similar to that in Finland which was the world's biggest producer of the drug.

The work was being done in collaboration with the National Institute for Virology in Johannesburg, which would carry out research under Professor Barry Schoub of the University of Witwatersrand.

Professor Brain said Interferon - which was produced in small quantities in the human body - was being tested on cancer sufferers in the United States.

The initial live batches of the drug were produced by Mr S H McMenamin of the National Blood Fractionation Centre at the Paradise Valley Laboratories, near Durban.

Research

Bob Molloy writes that Interferon research is being carried out by a small group at the University of Cape Town.

Professor W du T Naude, head of the department of bacteriology at UCT medical school, said that work on the mechanisms of the production of Interferon in living cells was under study.

It had been found that Interferon could be produced by introducing an "arbo virus" into a culture of chicken cells. The virus, carried by ticks and certain flying insects, caused fever and skin rash in humans.

There were several means of producing Interferon. These included the work on white blood cells carried out at Durban; use of tissue cultures, and the employment of genetic engineering techniques in which the genetic code for Interferon was inserted into a bacterial cell, causing it to become a living "factory" producing the anti-viral drug.
More money for preventive medicine

THE ASSEMBLY. — Government spending on preventive medicine would be stepped up during the next few years, the Minister of Health, Dr Lapa Munnik, said in the Assembly yesterday. He was replying to the debate on the third reading of the Medical, Dental and Supplementary Health Service Professions Amendment Bill, which among other things makes the Minister the final arbiter in determining fees for medical services.

He said that if only 1% more of the Health Budget was spent this year on preventive medicine, it would amount to R15 million. This would have to be achieved by reducing spending on curative medicine.

The Bill was supported by the Official Opposition and opposed by the New Republic Party.

Mr Nigel Wood (NRP Berea) said that if the Minister had the final say in the determination of medical fees and declined to approve an increase, he could alienate a large section of the medical profession. They could in turn take it on less patients and do less work with the result that more people would turn to provincial hospitals for treatment. This could lead to a socialisation of medical services.

Dr Munnik described Mr Wood's argument as "an Alice in Wonderland story with a medical connotation".

He pointed out that he only had the final say as far as the statutory tariff was concerned, and that he had nothing to do with private tariffs.

19, 40, 000 beds for male, female, and married women in hospitals in the town which are hospital, the town.

The恐超fee of Durban, in the area, is about Rama, or 700, 000 beds for people, for the accommodation.

Another measure is that the hospital, the town.

Conclusion: The Minister of Health, Dr Lapa Munnik, said that if only 1% more of the Health Budget was spent this year on preventive medicine, it would amount to R15 million. This would have to be achieved by reducing spending on curative medicine. The Bill was supported by the Official Opposition and opposed by the New Republic Party.

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More money promised for preventive medicine

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Dr Munnik described Mr Wood's argument as "an Alice in Wonderland story with a medical connotation".

He pointed out that he had the final say only as far as the statutory tariff was concerned and that he had nothing to do with private tariffs.

"A doctor's first duty is to his patients and many of them have received no pay at all for services rendered. It is unlikely that they will go on a sort of a go-slow strike.

"I have no intention of socializing medical services in this country.

"If any one does this it will be the medical profession itself, by for instance doing less work and pricing themselves out of the market."

The bill was read a third time and the objection of the NRP was recorded. — Sapa
Maize clue in cancer incidents

Since early 1975, scientists have been intrigued by statistics which showed that in certain areas of Transkei, the incidence of oesophageal cancer was high, while in other areas it was comparatively low.

A team of experts, drawn from many scientific disciplines, began to examine the environment in high and low incidence areas to pinpoint a factor which was present in one area and absent in the other.

The scientists have examined the proportion of trace elements in maize leaves from both high and low incidence areas and have found that levels of manganese absorbed by the plants seems to be a vital factor.

Prof Laker said that while it was too early to draw conclusions from information gleaned from these experiments, it would be "immoral" for scientists to ignore the results and not continue with research.
Police test lethal spray
to destroy dagga

A herbicide described as "highly dangerous" has been used by the South African Police in an experiment to destroy dagga plants in a remote region of the country.

Parquat, the trade name for paraquat dichloride, was used on one occasion in an experiment conducted by the South African Police in conjunction with the Council for Scientific and Industrial Research to test its effectiveness on immature dagga plants.

The same herbicide was used in an American-funded programme to wipe out dagga plantations in Mexico.

But, according to a spokesman for the National Institute on Drug Abuse in Washington, the programme was halted and parquat withdrawn when it was discovered that contaminated dagga could cause severe lung damage.

"Parquat was withdrawn in the summer of 1978. We regard it as a highly dangerous substance," it was stated.

Professor D A H Taylor, of the department of chemistry at the University of Natal, said he had been astounded to learn that parquat had been described as a "harmless" herbicide.

"It is anything but harmless. It is a nasty, vicious substance that can kill in nasty, vicious ways."

According to his files a lethal dose of parquat was about 15 g. In lesser doses there was a "delayed toxicity" that became apparent about two to three weeks after absorption.

"Basically parquat attacks the lungs. It makes them grow. The substance can be absorbed through the skin, inhaled or taken by mouth.

"The only time that parquat is harmless is when it has come into contact with the ground. It is a highly ionised chemical and is deactivated when it comes into contact with the earth."

It was widely used by the agricultural sector because of this property.

Professor Vic Leary, head of the department of pharmacology at the University of Natal medical school, said that if parquat had been an experiment to "within 48 hours the person would experience symptoms of kidney and liver damage."

He cited a case of a 15-year-old boy who accidentally swallowed a mouthful of 20 per cent parquat solution and died.

In lesser doses a person who absorbed parquat could develop lung trouble after a latent period of about two weeks.

"Scared fibrosis may occur and lead to death, while with very heavy doses the brain is affected and convulsions may occur."

Test

According to the statement released by the Police Director of Public Relations 'a herbicide containing 200 g/litre parquat was used on one occasion only in an experiment conducted by the SAP in conjunction with the CSIR to test its effectiveness on immature dagga plants. The herbicide has not as yet been put to use.

"The dosage effectively used in the experiment is 50 ml of the herbicide dissolved in 10 litres water and applied under pressure."

"As all herbicides can be regarded as harmful, in one or another way this experiment was conducted in a remote spot on a small scale with the necessary precautionary measures."

"We are aware of the fact that a herbicide was used in Mexico to destroy dagga plants but we are unaware that it has been recently withdrawn."

"The herbicides used by the police in the experiment is locally obtained in the trade. It is unknown whether it is imported or not."

Spraying dagga plants with parquat in a "remote part of South Africa"
APPOINTMENT OF COMMISSION OF INQUIRY INTO HEALTH SERVICES

It is hereby notified for general information that the State President has been pleased to appoint a Commission of Inquiry as follows:

COMMISSION

by the State President of the Republic of South Africa

To:

Gerald William Gaylard Browne
Hermanus Steyn Breytenbach
William Matthew Charles Davidson
Daniel Johannes de Villiers
Jean Nathaniel du Plessis
Phillippus Johannes Kloppers
Hilda Margaret Lessing
Nicolaas Salomon Louw
Georg Marais
Francois Pieter Retief
Johannes Jacobus Steyn van der Spuy

Greetings!

Whereas I deem it expedient to appoint a commission to inquire into and report on the matters mentioned hereinafter;

Now, therefore, by reason of the great trust I repose in your learning, judgement and ability, I hereby authorise and appoint you, Gerald William Gaylard Browne to be Chairman, and you,

Hermanus Steyn Breytenbach
William Matthew Charles Davidson
Daniel Johannes de Villiers
Jean Nathaniel du Plessis
Phillippus Johannes Kloppers
Hilda Margaret Lessing
Nicolaas Salomon Louw
Georg Marais
Francois Pieter Retief
Johannes Jacobus Steyn van der Spuy

to be members of a commission with the following terms of reference:

With a view to the rationalising of services, the promotion of more effective services and the placing of the costs of the services on a sound and firm basis, to inquire into, to consider and to report and make
No. R. 80, 1980

COMMISSION OF INQUIRY INTO HEALTH SERVICES IN THE REPUBLIC

Under the powers vested in me by section 1 of the Commissions Act, 1947 (Act 8 of 1947), I hereby declare that the provisions, except the provisions of section 4, of that Act shall apply to the Commission of Inquiry into Health Services and I hereby make the regulations contained in the Schedule with reference to the said Commission.

Given under my Hand and the Seal of the Republic of South Africa at Cape Town this Second day of April, One thousand Nine hundred and Eighty.

M. VILJOEN, State President.

By Order of the State President-in-Council:
L. A. P. A. MUNNIK.

SCHEDULE

REGULATIONS

1. In these regulations, unless the context otherwise indicates—

“Chairman” means the Chairman of the Commission;
“Commission” means the Commission of Inquiry into Health Services referred to in this Proclamation;
“document” includes any book, pamphlet, record, list, circular, plan, placard, poster, publication, drawing, photograph or picture;
“Inquiry” means the inquiry conducted by the Commission;
“member” means a member of the Commission;
“officer” means a person who has been appointed or designated to assist the Commission in the performance of its functions;
“premises” includes any land, building or structure or any part of a building or structure, any vehicle, conveyance, vessel or aircraft.

2. A copy of this Proclamation shall be published in the Gazette.
Shock findings at mental home

CAPE TOWN—Shock findings in a University of Cape Town study of a state-run Peninsula home for mentally retarded, show that half the child inmates were abandoned by parents and that 27 who died within a three-year period were given pauper burials because relatives could not be traced.

The home, a former TB hospital at Westlake, known as the Dr A. J. State Care and Rehabilitation Centre, is administered by the Department of Health. It is described in the study as “barrack-like and linked by long colourless passages.” Visitors complained of “absence of colour, pictures and architectural variation.”

The study adds that it is “an apartheid institution catering for persons status designated as Coloured and in need of residential care.” There were 930 adults and children in the care of the centre with another 800 on the waiting list from the Cape Town area alone.

After admission it was found that there appeared to be “a total or near total breakdown in the relationship between parents/guardians and their children” of which the most severe form showed “arising from either falsification of addresses supplied, or charges of address without keeping the institution informed.”

Only about seven percent of the parents or guardians visited their children on a regular basis. A more conservative estimate, about 50 percent of the children at Dr Stats may be regarded as having been largely or totally abandoned by their parents or guardians, the report said.

The findings are reported to have been caused by Mr Joubert, a senior lecturer in the Department of Sociology.

When one child died during the research period, the burial was long delayed in an attempt to trace the parents. Even the police failed to find them. Eventually the child was buried an unclaimed pauper.

“That such burials of mentally retarded children at Dr Stats common was confirmed by figures supplied by the centre. Between March, 1977 and August, 1979, the centre had given 27 deceased children pauper burials either because their parents or guardians could not be traced, or because they refused to claim the body,” Mr Joubert said.

A previous study of severe mental retardation in the Coloured community had found the prevalence to be “slightly less than for the white group.” At present, more than 9,000 Coloureds may be mentally retarded as against a 1967 maximum estimate of 16,000 whites.

The UCT study also found that comparisons between facilities for white, Asian, Coloured and African mentally retarded showed “sharp inequalities.”

In 1978 there was one bed for every 298 blacks, one for every 398 whites, one for every 939 Coloureds, and one for every 488 white mentally retarded persons. In addition, the grants available to parents and guardians who cared for seriously mentally retarded persons at home, provided a clear example of discrimination.

According to figures provided by the Department of Health in its 1978 report, whites were paid R250, Coloureds and Asians R72 and blacks R23.75.

Mr Joubert warned against applying social welfare type solutions, favored in Western countries—such as the move to de-institutionalise care centres and return patients to their families with a State subsidy.

Under-privileged groups in South Africa were “quite different” from those in advanced countries. Up to 70 percent of the children at the home were there because their parents “cannot or do not want them at home even with good prospects of some form of caring or assistance.”

“Since this form of change is slow in emerging, it appears that ‘total’ institutions for the mentally handicapped children of the poor will continue to be needed and must hence be provided,” Mr Joubert said. — DDC.
Puffers won’t be pressured.

Political Staff

THE ASSEMBLY. — The Government disclosed this week that it planned no major propaganda campaign to discourage smoking, and revealed that in 1979 it derived R12 500 000 in customs duty and R289 million in excise duty on tobacco products.

The information was released by the Minister of Finance, Senator Owen Horwood, and the Minister of Health, Dr Lopa Munnik.

Replying to questions tabled by Mr Alf Widman (PPP Hillbrow), Dr Munnik said his Department had no specific counter-propaganda programme to offset the effects of cigarette advertising, although it was pressing on with its health education programme to discourage smoking.

Asked how much was being spent on the project, Dr Munnik said that because it formed part of a general health education drive, it was impossible to determine annual expenditure on this part of the project.
CLIVE ROSENDORFF

On the heart beat

Totally relaxed in a rocking chair, Professor Clive Rosendorff, Wits University Medical School's head of the department of physiology, hardly fits the label of gung ho alarmist.

But this cardiologist, who has just received the rare honour of being elected a fellow of the Royal College of Physicians at the tender age of 42, has some alarming things to say on coronary heart disease in SA, with special reference to executives.

Rosendorff, also director of the university's Circulation Research Unit and a senior physician in the department of medicine, is co-director of the Johannesburg Hospital's hypertension clinic.

The research unit, which claims some pioneering discoveries in the fields of hypertension and coronary heart disease, researches diseases of affluence: cardiovascular diseases like heart attacks and hypertension, as well as diabetes and obesity.

Says a lean and fit looking Rosendorff, somewhat sadly, "The health of white South Africans is poorer than that of comparable groups in England and Wales, particularly in two areas — coronary artery disease and strokes, of which we have the highest incidence in the world. We beat the Brits, the Americans and the British into a cocked hat."

Cigarette smoking is heavily implicated, he says. And the cigarette smoking rate is "extremely high in SA where cigarettes have a higher nicotine tar content than overseas."

Other factors implicated are blood fats or cholesterol in the blood which tends to be high in SA males, and the very high incidence of hypertension.

Rosendorff: "We have an appalling track record of coronary heart disease in the prime productive years. Heart attacks are occurring in men in their thirties, are very common in the forties and extremely common in the fifties."

Unfortunately, hypertension, long implicated in heart disease, gives no warning. "Until all the organs like the kidneys and heart collapse or the person gets a stroke."

Regular check-ups — annual for men in their forties, twice-yearly in the fifties, are essential to determine hypertension. It affects over 30% of adult SA males, black and white. However, drug therapy today is both effective and has few side effects.

Rosendorff graduated as a medic at Wits in 1962, then lectured in the Department of Medicine at St Thomas' hospital in London and "picked up a MRCP" (membership of the Royal College of Physicians — a pretty tough hurdle to cross as any medic knows) while he was there.

At the same time he gained a PhD from the University of London in cardiology, channeling his research into "how hypertension affects the blood flow through the brain and the heart muscle."

White SA males have a major problem with alcohol. "We have four times the cirrhosis rate here compared with the UK. White South Africans are a pretty slothful, glibulous, slothy lot. We don't exercise, we all eat and drink too much."

Business people, especially, tend to poor eating habits. They skip breakfast, have vast business lunches, and often big dinners. Some advice handed out at random: Cut down on super and prime grade meats, dairy products, saturated fats, liver, kidneys, shell fish, imported cheeses and chocolates. Whole grain breads are allowed, so are fruits, vegetables and lean meat and fish.

Rosendorff obviously doesn't over-indulge. He's lean as a pike staff and only pulls cigars — without inhaling.

Right now his research focuses on "spasm in the coronary artery." It can be triggered off by emotional upheaval or severe exercise in somebody who is not fit. It's worsened by high cholesterol levels.

Says Rosendorff: "Most of the really big advances in drug therapy are made by the drug companies with huge financial resources and not by universities."

The word "breakthrough" makes him laugh. "It's the most over-worked word in the media. The time taken to repudiate a 'breakthrough' used to be a month, now it's two days."

In published research, 98% is not original work. "It's embellishment of someone else's work. It's repetition, it's dull. Nine out of every 10 ideas come to nothing."

What is the panacea for today's health problems? His hawkish features break into a sardonic grin before he answers, "It helps to choose your parents..."
Call for funds for medical research

By MARILYN ELLIOTT

MORE State money had to be pumped into medical research if the SA Medical Research Council was to enter new and necessary fields, the MRC president, Professor A.J. Brink, stated in the annual report of the MRC tabled in Parliament yesterday.

Prof. Brink pointed out that manpower was not being utilised and the MRC could not provide sufficient posts for qualified people who wanted to make medical research their career.

"In spite of 10 years of steady development, the MRC's major problem remains the availability of sufficient funds to satisfy the need for urgent research and provide facilities for researchers," Prof. Brink said.

Annual parliamentary grants to the MRC have increased from R200 000 in 1959/60 to R206 000 in 1968/69. This reflects a budget growth of about 3% a year.

At a Press conference in Johannesburg yesterday, a member of the MRC and director of the Witwatersrand Dental Research Unit, Prof. D.S. Cleaton-Jones, said a lack of funds would result in medical research not reaching its full potential in South Africa and a brain-drain of medical researchers.

Studies show that South African spends 0.5% of per capita on medical research, from countries like Canada and Australia.

Despite the crippling shortage of funds, the MRC has made major breakthroughs in many fields. Some of the highlights include:

- The two major causes affecting black males in Southern Africa are cancer of the esophagus and primary liver cancer.
- The MRC's National Research Institute for Nutritional Diseases was able to show a close relation between the level of the intake of a folic acid, aflatoxin, and the appearance of primary liver cancer.
- The aflatoxin fungus grows on peanuts, cassava and maize and communities using these types of food are exposed to high levels of the toxin.

The study has had important implications for industry and led to the introduction of control measures to ensure that processed food is not contaminated with this toxic mould.

The MRC, in collaboration with other research organisations, has found that plant coastal contains certain liver-damaging seeds.

Aflatoxin, which is found in certain liver-damaging seeds.

The National Research Institute for Nutritional Diseases embarked on a pilot study of common risk factors in the Southwestern Cape. The institute examined 750 whites and found that the highest percentage of risk factors was in 35%, high blood pressure in 27%, 22% of the population between the ages of 45 and 65 smoked more than 10 cigarettes a day and 53% were overweight.
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Annual parliamentary grants to the MRC have increased from R2 080 000 in 1970/71 to R5 200 000 in 1979/80. This reflects a budget growth of about 5% a year.

At a Press conference in Johannesburg yesterday, a member of the MRC and director of the Witwatersrand Dental Research Unit, Prof P E Cleaton-Jones, said a lack of funds would result in medical research not reaching its full potential in South Africa and a brain-drain of medical researchers.

Studies show that South Africa spends 33% less per capita on medical research than countries like Canada and Australia.

Despite the crippling shortage of funds, the MRC has made major breakthroughs in many fields. Some of the highlights include:

- The two major cancers affecting black males in Southern Africa are cancer of the oesophagus and primary liver cancer.
- The MRC's National Research Institute for Nutritional Diseases was able to show a close relation between the level of the intake of a toxic mould, aflatoxin, and the appearance of primary liver cancer.

The aflatoxin fungus grows on peanuts, cassava and maize and communities using these types of food are exposed to high levels of the toxin.

The study has had important implications for industry and led to the introduction of control measures to ensure that processed food is not contaminated with this toxic mould.

The MRC, in collaboration with other research organisations, has found that plant deficiencies almost certainly influence the occurrence of oesophageal cancer.

- Using American studies as a guideline, the MRC's transplantation research unit found that a specific type of irradiation on experimental primates has improved tolerance of transplant organs.
- The National Research Institute for Nutritional Diseases embarked on a pilot study of coronary risk factors in the South-western Cape. The institute examined 7 938 whites and found a high prevalence of risk factors. High blood cholesterol was found in 33%, high blood pressure in 27%, 22% of the population between the ages of 16 and 65 smoked more than 10 cigarettes a day and 35% was overweight.
Mother claims she was 'kicked out'

A CAPE TOWN mother has alleged that she was ordered out of an ambulance in which her son lay dying because it was "for whites only" and that it took an hour for the ambulance to deliver the child to hospital where he was certified dead.

The allegations have been strongly denied by the Cape Town ambulance service which claims there was no delay, that there was no race discrimination in transporting patients and that Mrs. Salle of Athlone was not ordered off the vehicle by any of its men.

Mr. H. van Zyl, deputy ambulance chief for Cape Town, said his station's records were open to inspection by the public.

Abdurragaan Salle, a nine-year-old pupil at Sur- rrey Primary School in Athlone, was critically injured by a bus in Heim Road, Athlone on Wednesday evening after he and friends visited a shop.

Mrs. Miriam Salle, the boy's mother, who lives with her seven remaining children in an old bus off Plum Road, Surrey Estate, said she arrived at the accident about half an hour after it happened.

The ambulance was at the scene and Abdurragaan was in the back of the vehicle.

"I got in, the back and my boy was still breathing. However an ambulance man told me he did not think he was still alive," Mrs. Salle said.

"A man — I don't know if he was a policeman or an ambulance man — then shouted, "get that woman out of here, this is a white ambulance," she said.

"I don't know why they didn't take him to hospital. It was nearly an hour after the accident happened and he was still lying there. The ambulance men would not tell her to which hospital they were taking her son. She had to telephone around to find out that Abdurragaan had been taken to the Red Cross Hospital and then the mortuary.

Mr. Basil Warner, chief of the Provincial Administration's Cape Town Ambulance Service, said there were no race barriers when patients were transported to hospital.

His men were aware of this.

"There was an ambulance on the spot when the accident happened. I can assure you that there was no delay and not one of my men told Mrs. Salle to get out because the vehicle was for whites only.

"Another ambulance nearby with two ambulance medical assistants was radioed for help. They took four minutes to get there and saw the boy was dead."

The second ambulance left because they had a woman in convulsions on board and the ambulance with the boy pulled out immediately, he said.

"The boy was taken to the mortuary an hour after the accident happened. In that time the procedure at the hospital where the boy was certified dead was also completed.

26 April:

Student representatives meet throughout the country and resolve to continue their boycott 'until there is tangible evidence that our grievances will be redressed'.
Interns protest at 'agitation' label

Medical Reporter
THE Interns Committee of Groote Schuur Hospital is circulating a petition protesting against a statement made by the Minister of Health, Dr L. A. P. A. Munnik, that certain doctors were involved in agitation about nurses' salaries.

The petition has so far received a good response, not only from interns but from doctors and professors at all levels attached to Groote Schuur Hospital and the University of Cape Town's Medical School.

In Parliament this week Dr Munnik said a few doctors were involved in agitating about nurses' salaries. "But we know who they are and I want to very seriously warn them to leave the nurses alone and practise their own profession," he said.

The Interns Committee told The Argus the petition was aimed at making the point that the position was not as Dr Munnik said.

Doctors supported the nurses' pay demands, and had made no secret of the fact, but they were not acting as agitators.

The committee began circulating the petition yesterday, and when it is complete it will be sent to Dr Munnik.
health pattern similar to the white group.

All this points to the important role to be played by the private sector in assisting employees with housing, transport, day care facilities, and wages that are adequate to allow employees to provide for their own health care.

All developing countries are faced with a thorny problem. Is it better to provide some health care to all or total health care to a few — and nothing to the remainder? “The choice which Ghana faced in 1976 was typical of this dilemma. A 300-bed hospital at Tema cost 22.4m with running costs of 500,000. For the same cost it would be possible to build 240 health centres at West African standards,” according to Dr David Whittacker of the SAIMR.

It seems that the Department of Health is well aware of this. Says Health secretary De Beer: “SA faces a very complex problem. On the one hand we are a developed country and on the other a developing country. And the problems of developing countries in providing health care are different from those of developed countries.

“We are trying to maintain a balance between providing primary health care for all and the need to maintain and extend tertiary health care particularly with regard to research facilities. We are aware of the fact that we can’t do one without the other and there is always the danger of channelling more into tertiary than primary services.”
Health and school linked

THE home environment often made school health education almost useless, a speaker at a health conference in Pretoria said yesterday.

Speaking on the second and last day of the South African National Council for Health Education conference at the CSIR conference centre, Dr F Auerbach said there was "deep scepticism in educational circles about the trend towards asking teachers to take over the parents' role."

Dr Auerbach, organiser at the Teacher Centre of the Transvaal Teachers' Association, said: "Classroom instruction can't remedy deep-seated social ills."

However, he said, it was worthwhile to have health education in schools, because medicine and education had to join forces. "It could even affect the survival of mankind."

Dr Auerbach stressed four priorities in health education: housing, family life, nutrition, and the control of stress.

He said that without adequate housing as the first foundation it was difficult to embark on any successful programme of health education. Bad family life, too, was a disruptive influence on possible improvement in health education.

He appealed for a restarting of the school feeding programme to combat the effects of malnutrition — so badly felt in the black community.

The number of young suicides stemming from poor school results and modern stress was also worrying, said Dr Auerbach.

"We must extend children, but not stretch them on the rack of ambition," he said.

When asked in a panel discussion following his speech, whether he thought teachers were qualified to give health education, Dr Auerbach said: "Let's not fool ourselves, teaching is in a crisis. There are white schools with five teachers short. In some Indian and coloured schools there no pupils, or if there are, they are unwilling to be taught."

He said that unfortunately this type of classroom situation adversely affected health education.

"If only we could properly educate a single generation of adults," he said. — Saps.
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Munnik inquiry meets

Staff Reporter

Mr Gerald William Gaylard Browne, former Secretary of Finance, has been appointed chairman of the Commission of Inquiry into Health Services.

The commission, appointed by the Minister of Health, Dr L A P A Munnik, met for the first time in Cape Town yesterday.

Other members are Professor Hermann S Breytenbach, Mr William M Davidson, Mr Daniel J de Villiers, Dr Joan N du Plessis, Dr Philipus J Kleppers, Mrs Hilda M Lessing, Professor Nicolaas S Leuw, Professor Georg Marais, Mr Francois R Relief and Mr Johannes van der Spuy.

The terms of appointment are to rationalize health services, promote effective services and put costs on a firm basis.

Special attention will be paid to:

- Administrative costs, profits and remunerations.
- The extent to which recommendations of the inquiry into the pharmaceutical industry have been implemented and their effect.
- The extent to which the recommendations of the inquiry into private hospitals and unattached operating theatres have been implemented and their effect.
- Services and facilities supplied by the State.
- Range of cost of services provided by local authorities.
- Costs of conducting a pharmaceutical practice.
- The average taxable income of doctors, dentists and supplementary health staff.
- Patients over-use of services, possibility of disincentives to over-use, extra payments by members of medical aid schemes and contributions by employers.
- Any related matters.
Study Traces History of Disease

The Cape Times, Thursday, August 5, 1930
Bosses are asked: 85 pay $17/80 workers' medicines

A joint committee of the Medical Association of South Africa and the South African Pharmaceutical Society yesterday asked employers to help low-income workers who can't afford vitally-needed medicines when they have been injured.

A statement issued in Pretoria said: "The associations have asked employers to provide company orders to accompany Workmen's Compensation Act prescriptions, accepting responsibility for payment. Accounts for prescriptions would then be sent directly to the employer, who would then claim the amount back from the WCA Accident Fund."

A Massa spokesman said: "Some workmen incur considerable financial hardship after injury. This usually affects those in the lower-income groups."

The main financial problems include not only loss of salary, but also that he must pay for his own medicines before, and even after, the Workmen's Compensation has accepted his claim. Obviously, the workman deprived of his income — and often without savings — is unable to purchase the drugs he needs.

At present, employers sometimes help, and often the doctor supplies drugs from his own stock, but no proper system has been set up to handle the problem.

"In less than 3% of WCA claims is liability by the scheme not accepted, so the MASA believes few employers would be risking loss by underwriting the cost of medicines in these needy cases." — Sapa.
Mr Barnes added: 'It is accepted throughout the world that if disposable medical products are exposed to a certain amount of radiation, they are unequivocally accepted as sterile.

'The goods are placed in containers and the radiation goes right through them, killing any microbes, so they remain sterile until the seal is broken.

'The process is virtually identical to that used in hospitals when cancer cells in a patient are killed by exposure to a controlled amount of electro-magnetic energy from a "cobalt bomb".

'The energy also strengthens the rubber and plastic in disposable equipment. For example, surgeons' gloves are made 10% stronger, and artificial limbs, besides being sterilised, have their abrasion resistance reduced by 30%.

'We will also be able to make cable insulation for the electronics industry stronger and more heat resistant, so the industry will be able to use thinner and lighter cable,' Mr Barnes said.

An Atomic Energy Board spokesman said that though South Africa was a leading country in the development of food radurisation, it was premature to discuss its commercialisation.

Discussing the safety aspect of the plant, Mr Barnes said: 'There are more than 80 plants like this round the world, but to my knowledge there has never been an accidental emission of radiation. We have to provide a detailed evaluation of the project to the AEB, who will only licence us to operate when they are satisfied it is completely safe. We are also in contact with the Department of Health.

'The cobalt is stored in a concrete structure with 2m-thick walls which significantly exceeds the safety margin required.'

Mr Barnes added that there was export potential for gamma-sterilised disposable medical supplies.

AN ATOMIC plant for sterilising South Africa's medical supplies is being built at the Isando Industrial complex near Johannesburg.

The process will also be used to improve the quality of cable insulation used in the electronics industry.

The plant — the first commercial undertaking in South Africa based solely on the use of nuclear technology — will be run by Isoster Ltd, and is owned on a 60-40% basis by Federale Volksbeleggings and the Industrial Development Corporation.

The installation, costing R3.5 million, will be operating by the middle of next year.

Since 1971, a pilot plant at the headquarters of the Atomic Energy Board (AEB) at Pelindaba has been used to sterilise disposable syringes, surgical gloves and instruments, bandages and swabs.

Mr A J van den Berg, chairman of the IDC, said last week: 'The Atomic Energy Board found the pilot plant so successful that they invited the IDC to take it on a commercial scale. There was great interest from overseas concerns, but the IDC decided to form a wholly South African consortium for the project.'

Mr A S Barnes, general manager of Federale Volksbeleggings, said yesterday: 'In the process, pre-packed medical supplies pass through a chamber where they are exposed to the electro-magnetic energy released by Cobalt 60 in the form of gamma rays.

'Unlike atomic materials used in nuclear power reactors, Cobalt 60 does not leave any residue of radioactivity in an object which has been subjected to its rays.

'The saving in manpower through gamma-radiation has led to increased demand for disposable medical products in hospitals throughout the world,' Mr Barnes said.
Doctors reject plan for ‘health profile’

By MARILYN ELLIOTT

A HEALTH programme for executives being planned by the National Development and Management Foundation of South Africa has been severely criticised by the Medical Association of South Africa.

The association believes the NDMF programme has little medical value, no scientific basis, and is not economically justifiable.

A spokesman for the association said in Pretoria yesterday: “We firmly believe in the value of approved preventive and community health services. But the evidence gleaned by the association, including a roundtable discussion with the NDMF at which we put forward our views, suggests that the programme is unsuitable for South African needs.”

The association has made its views known to the registrar of the SA Medical and Dental Council, and the director of the NDMF.

According to the association, the scheme will prove to be extremely expensive, and it argues that studies overseas, including views expressed in “Lancet” (the British medical magazine), suggest that the value of a battery of tests being suggested for executives will prove to be marginal.

Yesterday, the executive director of the NDMF, Mr P W Pienaar, said he was amazed and disappointed by the association’s criticism.

“Although I do not wish to comment at this delicate stage, I feel I must. I think the association has thrown this programme out on spurious grounds. The reasons given for dismissing it are ridiculous, vague, and contradictory. It is not true that this programme will be costly. We have already conducted surveys among executives which show that they want the service and are prepared to pay for it.”

“With the present cumbersome system, an executive may have to go to four different doctors or specialists to find out what his various health problems are. With this programme, he has one stop, finds out exactly what his ‘health profile’ is, and takes it to a doctor for appropriate treatment.”

“The plan to start such a unit has been backed by both the past and present Ministers of Health,” he said.

At a conference four years ago attended by Dr Schalk van der Merwe, then Minister of Health, the NDMF was asked to explore the possibility of a special health service for executives and others in commerce and industry who have to deal with a lot of stress.

Mr Pienaar said that although the programme has not yet been formally submitted to the SA Medical and Dental Council for approval, this will be done in the near future. Nothing about the programme will contravene medical ethics, he says.

“At a discussion with the Medical Association a while ago, it was agreed that we should go ahead with the programme. Now the association has decided against it. I hope that we can discuss this again and come to some suitable arrangement. We would like the association’s co-operation.”

Meanwhile, the association’s spokesman said yesterday: “Time and again, the most effective form of screening and preventative medicine has proved to be a regular check-up by a person’s own family doctor, who has regular contact with the person and family. In this manner the doctor can take a long-term view of any individual’s health. The programme being put forward by the NDMF will not have these advantages.”
THE COST of South Africa's medical services was astronomical and was increasing annually, the Administrator, Mr Gene Louw, said last night.

Speaking at the Carinus Nursing College graduation ceremony in the City Hall, Mr Louw said that the Cape had a proud record in the fields of intensive care, nuclear medicine and organ transplants.

These services, however, cost a great deal. Figures for 1978, the latest available, showed that the Cape Province's hospital services dealt with 531 020 in-patients and 5 776 693 out-patients.

Last night saw the graduation of 312 nurses, 76 having completed a 3½-year course in general nursing and midwifery, 182 having passed a three-year course in general nursing and 60 a two-year course for enrolled nurses. This represented a pass-rate of almost 100 percent — 28 percent with distinctions — with a 40 percent honours pass-rate in social sciences.
Govt attacked over medical services

By ARNOLD GEYER

THE Government has been accused of feeding wrong information overseas about the quality of South Africa’s medical services.

Two physiology professors at the University of the Witwatersrand have strongly criticised Scientific Progress — a journal published on behalf of the Prime Minister’s Scientific Advisory Council — for drawing “unjustified and misleading” conclusions from reports on the ratio of doctors to population.

The Government-sponsored publication claimed satisfactory medical services were available for most South Africans.

But Professor D Mitchell and Professor C.H Wyndham, writing in the latest issue of the South African Journal of Science, said:

- QwaQwa — with a population of 250 000 — had only two doctors;
- If the total estimated population of the country were divided by the estimated number of economically-active doctors, there was an overall doctor/patient ratio of one to 1 900, but for the black homelands there was only one doctor to about 50 000 people;
- Although the average ratio was one to 1,900 in 1975, only 28% of South Africans lived in area where the ratio was one in 2 000 or better; and
The two academics said they based their conclusions on the same survey — by the Human Sciences Research Council in 1975 — as Scientific Progress did.

"Even if one accepts as a crude index of the quality of medical services the ratio of doctors to population, the conclusion drawn by Scientific Progress is unjustified and misleading," they wrote.

The rural areas of South Africa, particularly the homelands, had a ratio of doctors to patients which, even if estimated optimistically, was typical of Zambia, Ghana and other Third World countries.

"And few would consider such a complement satisfactory.

"As Scientific Progress is circulated internationally from the Prime Minister's Scientific Advisory Council, the publication has a special obligation to be both circumspect and credible," they said.

Prof Mitchell and Prof Wynnham also quoted from the most recent report on the distribution of doctors in South Africa, by the University of Cape Town and the University of the Witwatersrand.

Findings of the survey, which are to be printed in the next edition of the South African Medical Journal, include:

- The ratio of doctors to patients in rural areas, including "white" areas and homelands, was one to 18,800.
- More than 90% of the listed graduates from UCT and Wits and more than 80% of those from the Pretoria and Stellenbosch campuses worked in urban areas; and
- Since 1946, there had been a progressive gravitation of doctors towards the urban areas.

"The discrepancy in medical care for blacks and whites also emerged in a recent survey conducted by the Southern African Labour and Development Research Unit of the Universi-
Heart still
No 1 killer,
say insurers

CAPE TOWN. — Cardio-vascular diseases accounted for nearly half the deaths recorded in South Africa last year by the eight largest life insurance companies, says the Life Offices' Association of South Africa.

In its annual review of life insurance, released yesterday, it says coronary disease is the most common of these diseases.

The association adds: "Another cause for public concern is the number of deaths due to road accidents, particularly among younger people."

The association represents 33 insurance companies who transact more than 99% of South African life assurance business.

It lists the main causes of death as:
- Cardio-vascular diseases 48.8%;
- Violent causes — including road accidents — 15.4%;
- Cancer 14.2%;
- Respiratory diseases 6.8%;
- Other causes 14.8%.

The review says these figures can be expected to differ from those for the entire public as they are in respect of insured people only.

Insurance and benefit payments were made last year at the rate of R2 600 000 every working day of the year, the association said.

Total pay-outs for the year were R630-million compared to R551-million in 1978.

Payments — including bonuses — on death and disability (R204-million) and policy maturity (R138-million) increased steadily, as did payments on annuities and other pension benefits (R149-million).

Total income for the companies was R2 496-million — against R1 927-million in 1978 — with premiums making up R1 705-million of this amount.

The offices held assets totalling R9 103-million against their liabilities to pay future claims under policies still in force.

This meant assets were up 24.1% on the previous year.

Total net additional money that became available for investment through life insurance was R1 497-million. — Sapa.
Surgeon backs Nyangas

The Star's Africa
News Service

SALISBURY — One of Zimbabwe's top surgeons, Mr Ian Rosin, has added his full support to the campaign to include nyangas (traditional healers) in the country's National Health Service.

Mr Rosin said that between 40 and 50 percent of the illnesses in the country were psychosomatic, and could be dealt with only by nyangas.

"These illnesses cannot respond to pathologic treatment," he said.

He praised the Minister of Health Dr Herbert Ushewokunze for his stated intention of amending the Medical and Dental Act to allow nyangas to take part officially in the health service.
5. Die Raad kan goedkeuring verleen vir die installering van enige fabrikaat, type, klas of model huis- of buitenshuis gebruiklike toestel, met dien verstande dat die Raad oortuig is dat sodanige toestel voldoen aan die vereistes van klousule 2.


BYLAE

Die gebied begrens deur Queens Park-laan, Victoria-weg, Sourtrivierweg, Voortrekkerweg, Swartrivierpark-weg, Setaarsweg, De Waal-rylaan en Onseltieke Boulevard, tot by 'n punt oorkant Queens Park-laan.

No. R. 1550

25 Julie 1980

WET OP MEDIENSE SKEMAS, 1967

Kragtens artikel 30 (3) van die Wet op Mediense Skemas, 1967 (Wet 72 van 1967), soos gewysig, kongdig ek, Joseph Petrus Hermanus Steyn, Registeraar van Mediense Skemas, hierby die geldetarief in artikel 1 (1) van genoemde Wet sedert en deur die Minister van Gesondheid, Welsyn en Pensioen goedgekeur, soos volg af:

GELDETARIEF TEN OPSIGTE VAN PRIVATE HOSPITALE

1. Die tarief wat in Bylae A hiervan uiteengeps is, geld ten opsigte van private hospitale vir Blankes met hoogstens 70 geregisteerde bedden.

2. Die tarief wat in Bylae B hiervan uiteengeps is, geld ten opsigte van private hospitale vir Blankes met meer as 70 geregisteerde bedden.

3. Die tarief wat in Bylae C hiervan uiteengeps is, geld vir beide sodanige kategorie hospitale.

4. Die tarief sluit algemene verkoopstel in, behalwe op items met betrekking tot medisyne, verdwinningsmiddels en verbandgoed.

5. 'n Komitee van vyf lede, van wie die Verteenwoordigde Vereniging van Mediense Skemas drie benoem en die Verteenwoordigde Vereniging van Private Hospitale twee benoem, word saamgestel om aansoeke van private hospitale met minstens 61 geregisteerde bedden vir Blankes, om die toepassing van die tarief in Bylae B geënt te word hospitale te wees wat meer as 70 sodanige beddens het, te oorweg. Bedoelde komitee bepaal die procedure wat by die aanhoor van sodanige aansoeke gevolg moet word, en die beslissing van bedoelde komitee is afdoende.

6. Hierdie tarief is ter vervanging van die tarief wat by Gowermenskenningsw. 2853 van 28 Desember 1979 gepubliseer is en tree in werking op 1 Augustus 1980.

BYLAE A

Staaldele

Hospitale moet die presiese tyd van toelaat en ontslag op alle rekenings aandui. Staaldele word geef toe die volle daagtjies tarief indien toelaat vir 12000 gesked en toe die helfte van die daaglikse tarief indien toelaat ná 12000 gesked. Staaldele word geef toe die helfte van die daagtjies tarief indien ontslag voor 12000 gesked en toe die volle daagtjies tarief indien ontslag ná 12000 gesked. Met dien verstande dat die minimum bedrag wat geval word, gelijk is aan die tarief vir een volle dag.

<table>
<thead>
<tr>
<th>Algemene saal</th>
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<tbody>
<tr>
<td>57001 Chirurgiese gevalle, per dag</td>
<td>24,00</td>
</tr>
<tr>
<td>57002 Toraks-chirurgiese gevalle, per dag</td>
<td>25,00</td>
</tr>
<tr>
<td>57003 Neurochirurgiese gevalle, per dag</td>
<td>25,00</td>
</tr>
<tr>
<td>57004 Mediense en neurologiese gevalle, per dag</td>
<td>25,00</td>
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</tbody>
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5. The Council may give approval for the installation of any make, type, class or model of household fuel-burning appliance, provided it is satisfied that such appliance is capable of complying with clause 2.

6. This Order shall come into effect on 7 April 1981.

7. This Order shall be called the Eighth Smoke Control Zone Order.

SCHEDULE

The area bounded by Queens Park Avenue, Victoria Road, Salt River Road, Voortrekker Road, Black River Park Way, Setlers Way, De Waal Drive and Eastern Boulevard, to a point opposite Queens Park Avenue.

No. R. 1550

25 July 1980

MEDICAL SCHEMES ACT, 1967

In terms of section 30 (3) of the Medical Schemes Act, 1967 (Act 72 of 1967), as amended, I, Joseph Petrus Hermanus Steyn, Register of Medical Schemes, hereby publish the following tariff of fees, as referred to in section 1 (1) of the said Act and approved by the Minister of Health, Welfare and Pensions:

TARIFF OF FEES IN RESPECT OF PRIVATE HOSPITALS

1. The tariff set out in Annexure A hereto shall apply in respect of private hospitals with no more than 70 registered beds for Whi es.

2. The tariff set out in Annexure B hereto shall apply in respect of private hospitals with more than 70 registered beds for Whites.

3. The tariff set out in Annexure C hereto shall apply in respect of both categories of such hospitals.

4. The tariff shall include general sales tax except on items in relation to medicines, drugs and dressings.

5. A committee of five members shall be established, and shall consist of three members nominated by the Representative Association of Medical Schemes and two members nominated by the Representative Association of Private Hospitals, to consider any applications from private hospitals having no fewer than 61 registered beds for Whites to be regarded for the purposes of the tariff in Annexure B as if they were hospitals with more than 70 such beds. The procedure for hearing such applications shall be laid down by the said committee and the decision of the said committee shall be final.

6. This tariff is substituted for the tariff published in Government Notice R. 2853 of 28 December 1979 and shall come into effect on 1 August 1980.

ANNEXURE A

Ward fees

Hospitals shall indicate the exact times of admission and discharge on all accounts.

Ward fees shall be charged at the full daily rate if admission takes place before 1200 and at half the daily rate if admission takes place after 1200. Ward fees shall be charged at half the daily rate if discharge takes place before 1200 and at the full daily rate if discharge takes place after 1200. Provided that the minimum amount charged shall be equal to the tariff for one full day.

<table>
<thead>
<tr>
<th>General ward</th>
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<tbody>
<tr>
<td>57001 Surgical cases, per day</td>
<td>24,00</td>
</tr>
<tr>
<td>57002 Thoracic cases (surgical), per day</td>
<td>25,00</td>
</tr>
<tr>
<td>57003 Neurosurgical cases, per day</td>
<td>25,00</td>
</tr>
<tr>
<td>57004 Medical and neurological cases, per day</td>
<td>25,00</td>
</tr>
</tbody>
</table>
DDT banned, but Dept of Health goes on using it

By Hannes Ferguson, Farming Correspondent

The State's Department of Health sprays hundreds of tons of DDT in the Transvaal and Natal Lowveld every year although the poison has been banned in South Africa since 1976.

An investigation has revealed that the department uses up to 500 tons a year.

The department is the only body in South Africa legally permitted to use DDT, and the active ingredients of the otherwise banned insecticide are specially imported for the department.

Scientists allege that the continued use of DDT by anti-malaria teams in northern Natal and parts of Kwazulu is contaminating Kosi Bay.

Mr G Beggs, a senior officer of the Oceanographic Research Institute at Durban, said malaria-spraying units were responsible for a build-up of the DDT level in the Kosi Bay estuary. This was a threat to marine life.

This was confirmed by a representative of the Council for Scientific and Industrial Research in Durban, who added that as recently as last year a tanker used for mixing DDT concentrate had been cleaned by using local river water.

The DDT was subsequently washed into the river by rain. This led to DDT being identified in the top layer of the ocean floor near Kosi Bay.

SAMPLES

The CSIR took extensive samples in a country-wide survey of marine pollution.

Dr J W J van Rensburg, regional director of health for Natal, confirmed that DDT was used intensively in the hinterland of Kosi Bay to stem the advance of malaria from Mozambique.
International lab congress in Durban

DURBAN. — The concept of medical technology had changed considerably over the past 30 years and continuing education in this field was an absolute necessity, the Minister of Health Dr. L. A. P. A. Munnik said yesterday.

Dr. Munnik opened the 14th Biennial Congress of the International Association of Medical Laboratory Technologists here yesterday.

This is the second congress of the association to be held outside Europe since the first was held in Switzerland in 1934.

Addressing more than 500 local and overseas delegates, Dr. Munnik said that originally a qualification in clinical pathology, embracing microbiology, chemical pathology, haematology and histology, had been sufficient.

“However, with the advances in medical science during the past two decades, more and more technologists are becoming specialists in one of the disciplines,” Dr. Munnik said.

Today an aspirant technologist could qualify in 16 different categories, and to aid continuing education, an advanced school of medical technology has been established at the South African Institute for Medical Research in Johannesburg.

“The demand for laboratory services all over the world continues to grow and this, coupled with the shortage of technologists in areas away from main centres, places a greater emphasis on the role played by the technologists in the health team, he said.

Several workshops and more than 120 scientific lectures will take place during the congress, which will go on until Friday.

There will also be a trade exhibition, put on by 40 companies.

Dr. Munnik will attend a state banquet tonight, and the mayor of Durban, Mr. Haydn Bradfield, will host a civic reception for the delegates. — Sapa
Close care gap, doctors urged

By MARILYN ELLIOTT

SOUTH African doctors were urged yesterday to insist on quality care for everyone, to remedy the present imbalance of high-quality care in some fields and disturbing neglect in others.

The call came from Professor D J du Plessis, vice-chancellor and principal of the University of the Witwatersrand, in the opening address at an international cardiology congress in Johannesburg.

Prof Du Plessis said although South African doctors were highly skilled in the most modern treatment of coronary artery disease, the country's incidence of rheumatic heart disease equalled that of most undeveloped countries.

"There is, therefore, evidence of great advances — concern for the welfare of some people — and also of distressing neglect and a disturbing lack of interest in a disorder which is producing immense disabilities in another section of the population."

"It seems that individuals under certain circumstances cannot expect the same concern from our medical profession."

"While it is easy to blame the authorities, the profession must accept part of the blame for what has taken place."

Dr Du Plessis said it was time the medical profession in South Africa demonstrated it was aware that it operated in an unique society.

A new era of medical investigation and endeavour was required to fulfil the increasing expectations of many people who did not yet benefit.

In a paper delivered yesterday, Dr M E Edginton, of the Department of Community Medicine at Wits, drew attention to the high incidence of rheumatic heart disease in Soweto.
American delegation of doctors for SA

THE American Medical Association has accepted an invitation from the Medical Association of South Africa to send a delegation to the Republic in February to examine medical practice in South Africa.

It will be the second Ama team to visit South Africa, where US doctors will examine the structure of medical practice.

The invitation was issued to the American Medical Association (Ama) by Dr Marais Viljoen, secretary-general of Masa, during the recent annual meeting of the Ama in Chicago.

The delegation will include senior Ama members, Dr Lowell Steen, chairman of the American Medical Association's board of trustees, and the president of the American Medical Association Dr Robert Hunter.

"Throughout the recent Ama meeting, which was attended by delegates from many other overseas medical associations, Masa received a warm welcome and at no stage was reference made to alleged discriminatory practices in South Africa or the Steve Biko case," the statement said.

"Masa was undoubtedly as heartily welcomed as any of the other overseas associations and it is clear the South African medical profession is still highly regarded by the world medical community.

"The only false note sounded during the meeting, as far as South Africa was concerned, took place during a meeting of the American Medical Association's board of trustees which had been requested by the secretary of the Nigerian Medical Association, Dr Beko Ransome Kuti. During this meeting he criticised South Africa for its alleged policies of discrimination against blacks in general and black doctors in particular.

"The criticism, however, was short-lived when the Ama trustees pointed out to him that many of them had been to South Africa and that his facts were incorrect," the statement added. -- Sapa.
THE COMMISSION will undertake its preliminary investigations through four expert committees which will deal with the following main subjects contained in the terms of reference:

1. Hospital and public health services;
2. pharmaceutical services;
3. medical services; and
4. health services professional matters.

Interested parties who wish to submit evidence to the Commission are invited to submit concise memoranda relating to the aforementioned subjects to the Secretary: Commission of Inquiry into Health Services, Private Bag X63, Pretoria.
Why Natal has to care for KwaZulu sick

Mercury Reporter

IT WAS highly unlikely that KwaZulu could run its hospitals on the R35 million allocated, Mr Frank Martin, MEC for hospitals, said yesterday.

'That budget is probably one of the reasons why Natal is caring for most of KwaZulu's patients — and we don't have enough money either. A big hospital like King Edward VIII takes R27 million to R30 million a year to run.'

Natal has a R96 million budget for hospitals alone while half KwaZulu's R88 million health budget goes on pensions. Natal theoretically serves a population of about 4 200 000, compared with KwaZulu's estimated 3 200 000.

'But we are catering for far more than the number of people registered as Natalians — there are also

KwaZulu Zulus, Transkeians and Basotho,' Mr Martin said.

'Co-ordinating Natal and KwaZulu hospital services would save money of course but we are all trying to find out how far we can go before the Government steps in.'

According to Mr Martin, all aid Natal might give to the homeland is governed by the Financial Relations Act. This lays down what the Province is allowed to spend — and that doesn't include looking after patients from KwaZulu. The Government doesn't provide money for that, said Mr Martin.

'In the interests of South Africa, Pretoria should take heed of the Province and KwaZulu's suggestions,' Mr Martin said.
Health hazard rears before your very eyes

A NEW health hazard is rearing its ugly head in the office.

The ubiquitous video display unit — the keyboard and television screen connected to a computer — is considered by some experts to be potentially damaging.

And if the use of computer terminals grows at the rate which some pundits would have us believe, it is a health hazard to which increasing numbers of the population will be exposed.

In the US more than 1 million video display units (VDUs) were in use last year and the number is expected to increase dramatically in the near future.

Again in the US many top executives run their own personal computers in their offices. VDUs, therefore, represent a health hazard to all ranks of worker.

In the past there have been several scares about possible risks of ionising and non-ionising radiation being emitted from the screen, particularly because operators sit only a few feet away, and for much of the working day. But no proof has been found.

However, a survey conducted in the US has found that VDU operators suffer far more than do other colleagues from a wide range of health problems and stresses.

The study, conducted by the National Institute for Occupational Safety and Health, looked at three major sites where there were a number of operators using VDUs and compared them with other workers on the same sites.

A much greater number of the VDU operators suffered from eye strain, blurred vision, irritated eyes, sore shoulders and wrists and hand cramps than did the other groups with whom they were being compared.

Not only that, in all three sites the VDU operators reported more general health complaints than did the control groups. They also seemed to suffer more noticeably from stress and reported irritability, depression and anxiety.

The National Institute for Occupational Safety and Health study — found that the use of the VDU alone was not the sole cause of higher stress and health complaints from the users. It found that the different working conditions, reflected in the amount of control the operators had over their jobs, was a marked factor.

In other words, those operators who worked to high production demands and tight deadlines, but had a great deal of control over how these demands were met, reported a lower level of complaints about their jobs.

On the other hand, where work was carried out under pressure at a fast pace and it was boring or repetitive, and where the operators had little control over how it was done, more stress was caused.

The study suggests that ergonomic solutions to improve the design of work stations — as academics are given to call the place where a VDU operator works — and which might solve problems like eye strain, pains in the neck and shoulder and sore wrists, are not enough.

It concludes that any ergonomic solution must be supplemented with a proper design of the actual tasks which VDU operators are to carry out if they are not to go on suffering from more illnesses and stresses than workers in conventional jobs.
Looking at future of medicine in SA

MORE than 1,000 doctors, including delegates from Europe and the United States, are expected to attend the biennial congress of the Medical Association of South Africa (Masa) to be held in Pretoria from July 6 to 11 next year.

Speaking at a Press conference in Johannesburg yesterday, the chairman of the organising committee, Professor Frans Geldenhuys said:

"The congress theme will be to look at the future of medicine in South Africa in the next decade -- a period which is expected to see many major developments.

"New and exciting medicines will be coming into use in the next 10 years, medical research and Europe will speak at the conference seeking the causes of diseases such as cancer and the role of the doctor as the leader of a multi-disciplinary health team will be taking on greater emphasis.

Prof Geldenhuys, who is president-elect of Masa, said that medicine also had to face the challenges of a population with an increasing percentage of old people.

The conference, to be held at the University of Pretoria, would act as a forum for the discussion of these challenges as well as bringing together many leading figures from the local medical profession. A number of important international authorities from the US and Europe will speak at the conference.
Medical and dental fee review

The medical tariffs committee of the SA Medical and Dental Council this week reviewed doctors' fees and will make recommendations whether or not increases are justified.

The Medical Association and the Representative Association of Medical Schemes replied to requests to consider medical tariffs and on Tuesday and Wednesday this week the tariffs committee dealt with the written recommendations.

Last week the dental tariffs committee considered recommendations.

Medical aid schemes are opposed to further tariff increases requested by doctors and dentists.

There was a storm of protest last November when doctors were granted a massive 52.45 percent increase.
Chemists issue drug warnings

Staff Reporter

MANY pharmacists throughout South Africa are now handing out instructions on the risks and side effects of drugs when they dispense them to the public.

There is no law stipulating written information, but Mr. Frans Eckard, the president of the South African Retail Chemists and Druggists' Association, said many pharmacists were supplying the instructions because they recognised the need for the public to have the information.

"At the moment, it is entirely up to the individual pharmacist to decide whether he wants to do so. Many pharmacists are providing instructions on a trial basis because they recognise the need. I think we will go ahead with it," Mr. Eckard said.

When drugs are dispensed in small quantities, written information about side-effects are not provided. Pharmacists provide verbal information on drugs, but they recognise that this is not sufficient.

Mr. Rupert Lorimer, the Opposition spokesman on consumer affairs, yesterday congratulated pharmacists.

"I hope this information will be extended throughout the country. It is highly commendable in the light of the misuse of drugs."
Gesondheidsprojek kom vir almal in SA

Deur THINUS PRINSLOO

'N OMVATTENDE nuwe gesondheidsplan vir alle rasse in Suid-Afrika word vandeesweek aangekon-
dig. Dit gaan onder meer om die oprigting van verskeie gemeenskap-ge-
sondheidsentums.

'n Wye reeks dienste — van basiese tandheelkunde tot sekere psykiatriebehan-
delings — gaan verskaf word by die sentums wat in die on-
derskeie gemeenskappe in Suid-Afrika opgerig sal word.

Die nuwe benadering gaan veral om die verstalling van voorkomings-en basiese ges-
ondheidsdienste. Daar gaan nou met Suid-Afrika se buur-
state geskakel word.

Dr. L. A. P. A. Munnik, Minister van Gesondheid, begin die week al om met die leiers van swart nasionale state te beraadslaag om beter koördinering van gesond-
heidsdienste te bewerkstellig.

Die nuwe gesondheidsen-
trums gaan met die eenpa-
rigte goedkeuring van al vier provinies opgerig word. Die Departement van Gesond-
heid sal die bou van die sen-
trums koördineer.

RAPPORT verneem die sentums sal tussen R500 000 en R1 miljoen elk kos. Daar word beoog om die eerste van die sentums binne 'n jaar te open.

Daarna sal hy 'n voorkeurlys aan die Kabinet voor die oprigting van die sentrum.

Die volgende dienste gaan onder meer by die sentums verskaf word: gesinsbeplan-
ning, voor-en na-sorg van kraamgevalle, voedingsadvies, die immunisering wat plaaslike besture op die oom-
blik behartig, spesiale psyki-
atriese dienste soos die verlig-
ting van spanning, en ook tandheelkunde.

By die sentums gaan gro-
ter gebruik gemaak word van
susters wat spesiaal opgelei sal word.
SA's health care system — don't criticise the science that saves

PROFESSOR Savage's comments (Inside Mail Oct 13, 15) on the ill effects of the philosophy of apartheid, the urgent need for improvement of the socio-economic political lot of the black people and the need for improvement in the health services should receive wide support.

But his diagnosis as to how this has come about with the emphasis on medical technology and his prescription for alleviating the evil are clearly open to question and is not helped by the fact of misrepresentation.

Historically the medical system has largely derived from the famous Flexner report on medical education to the Carnegie Foundation in 1912. It was Flexner who introduced the basic sciences into medicine which in the end not only produced the means of preventing the killer diseases of diphtheria, measles and polio- myelitis etc, but also provided the antibiotics to control pneumonia, meningitis etc, as well as the remarkable advances in medicine which have been achieved over the last 40 years.

Now, secure from the ravages of these diseases, Prof Savage calls the discipline of medicine and fails even to mention that it is the very efficiency of medical control of the generally acknowledged to be open to question and not only South Africa but the rest of the world — the population explosion. Nor is recognition given to the pill — also a product of medical technology as a major contribution to the solution of this problem.

Apparently tuberculosis has little to do with the tubercle bacillus. The reason why tuberculosis declined in the 1930-40 era was in part due to better socio-economic conditions but mainly due to the isolation of all "open" and active carriers of tuberculosis in sanatoriums (when the sanatorium was emptied to take war casualties in Britain, tuberculosis increased widely in prevalence).

It was medical 'technology' that produced the anti-tuberculous drugs Streptomycin, INH etc, which for the first time ever controlled "the Captain of the house of death — the consumption" to the enormous relief of mankind and destroyed the tubercle bacillus, so allowing patients an early escape from the often fatal experience of year-long (or more) isolation in a sanatorium.

Nobody would possibly deny that malnutrition in poor, overcrowded surroundings aids the spread of tuberculosis. But that the control of the tubercle "germ" is of no importance is nonsense. The World Health Organisation claims to have eradicated smallpox off the face of the earth by no other means than eradicating the "germ" from human carriers by vaccination. Furthermore, the recognition of the germ cause of disease has had a profound influence on crop protection and, through veterinary science, on animal husbandry, increasing and ensuring food supplies.

It is the very success of the methods it has developed and, coupled with the urgent public demand for control of these diseases, that has delayed medicine in giving due emphasis to the community approach.

Action is being taken to improve the training of students. who, despite their meetings about the state of training in community health, are generally poorly motivated once they have tasted the element of dealing with sick patients.

Curricula have been altered stressing preventative and community health and development in the first two years of training so it can have maximum impact on optimum development. Concern also centres around the methods of selection of students solely on scholastic attainment. Currently selection of some students has not taken into account their personality, motivation, concern and compassion — very difficult to assess and even more difficult to avoid charges of bias in selection, but well deserving of a trial.

Medical people in South Africa have not been unaware of the need to improve community health. Thirty years ago Kark, at Polokwane, developed preventive and community health services, now being hailed as a novel, which were ahead of anything in the rest of this world. Subsequently, he was first Director of the Institute of Community Health in the Faculty of Medicine of the University of Natal.

Disillusioned by the total lack of State support, he eventually moved to Israel where he built up what is probably the top institute in the world in community health founded on his medical experience and the system he developed in Natal.

Subsequently, the Rockefeller Institute, similarly disillusioned by State lack of interest and the shelving of all the recommendations of the Gluckman Commission, withdrew its financial support, so the institute closed.

The Faculty of Medicine of the University of Natal has since then repeatedly requested the executive council to establish a community health centre in Umlazi township specifically to help in training black students, but has been unable to get State permission.

The College of Medicine of South Africa devoted its second symposium to the health services in Southern Africa. It was widely acclaimed by visitors from many parts and by the paramedical disciplines and welfare services which participated. One of its many recommendations was that health services should be linked with education and that in the black areas the health clinics should be built adjacent to the schools — to adults, school children and infants could all be involved in a single concept of health education and prevention.

The centre of gravity of the problem is that health services, the control of tuberculosis and other communicable diseases is the responsibility of the Department of Health which is under the control of the Department of Health. If this is so, it will be the Department of Community Health which will provide the anti-tuberculosis and other communicable diseases is the responsibility of the Department of Health which is laid down in the Act of Union and nothing can or will be done without its concurrence or consent.

Recently State Health, righteously concerned by the state of health of much of the community for which it is responsible, has established Community Preventive and Community Health using the prestige of the Medical Schools to add authority to the Chairs and attract staff.

But what is disturbing is that State Health still continues to operate on the basis of "who cries the loudest". It is short-sited and in the face of opposition to apartheid with a common register, equivalent standards of training and of medical care in the teaching hospitals, but it is prevented from widening its facilities by the lack of State legislation and control of the State Health service. It is no longer able to get State permission.

South African medicine is not "deeply permeated with apartheid". In fact the separation of medical facilities and training is generally deplorable. In many ways it is in the forefront of opposition to apartheid with a common register, equivalent standards of training and of medical care in the teaching hospitals, but it is prevented from widening its facilities by the lack of State legislation and control of the State Health service. It is no longer able to get State permission.

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Recently much concern has been expressed as a result of Mr Justice Didcott's comments on the Trojan horse being used to undermine the Court of Appeal. There is considerable concern in medical circles that the Government intends a wider take-over of faculties of medicine in the universities, divorcing them from their university ties and allegiance and establishing a Medunsa-like system under the control of State Health.

P. SMYTHIE (Emeritus Professor of Paediatrics, University of Natal), Nottingham Road.
This is the way to a healthy nation

AT LAST — a relevant national health plan! Dr LAPA Munnik's announcement of a health service which will put the emphasis on preventive and primary health care, instead of the present curative hospital services, is splendid news. And it is no less welcome for being decades overdue.

It is at last a recognition that this country has an inappropriate bias in its health services — what Professor Michael Savage has termed a white, urban hospital-centred bias rather than a black, rural, preventive bias.

Prof Savage's views, the subject of much argument in this newspaper's letters columns, coincided with the cholera outbreak in the Eastern Transvaal. It is precisely that epidemic, and its frightening spread to reach 239 reported cases in one month, that has underlined the inappropriate bias of our health services, and the importance of the Minister of Health's announcement.

Cholera is, as we pointed out at the onset of the epidemic, a Third World disease out of place in a country which boasts expensive, ultra-modern hospital-based medicine. The reality in South Africa is a situation in which conditions of poverty, ignorance and impure water supplies are conducive to the spread of diseases such as cholera.

As Dr Tim Wilson, a community health expert put it: "If I have typhoid I want a decent doctor, but if I have a clean water supply in the first place, I am unlikely to get typhoid."

The Government has finally grasped this need for a basic level of minimum health covering safe drinking water, sufficient food, housing, sewerage and waste disposal. Dr Munnik's department will coordinate the work of other Government departments in this respect — we hope with the minimum of bureaucratic hold-ups.

Dare we hope this will mean a stop to the indiscriminate dumping of blacks in inhospitable areas for ideological reasons?

And health centres staffed by nurses will take preventive medicine — family planning, TB detection, child feeding, care of the aged — to the adults and children before they become candidates for those "disease palaces" of past hospital planning.

Of course, problems abound. But this is a start.
Matanzima warns against ‘quacks’

By WILMAR UTITING

THE State President of Transkei, Paramount Chief Kaiser Matanzima, this weekend called on the territory’s citizens to seek medical treatment only from properly-trained people — and to shun homeopaths, naturopaths, “quacks” and other “impostors who are doing all in their power to draw your minds into the dark ages”.

Chief Matanzima’s attack on homeopaths, herbalists and naturopaths was the theme of his speech to 2,500 members of the Mampondenisi tribe. The occasion was the official handing over of a R100,000 clinic to Transkei by Johannesburg Consolidated Investments. The company employs more than 12,000 Transkeians at the Rustenburg Platinum Mines.

The chief called on his people to place their trust only in trained medical personnel and to use the clinics to their fullest advantage.

“The Government of South Africa recognises these homeopaths. I disagree with them,” he said. “Medical impostors” felt they could move round willy-nilly in Transkei, trying to take the place of those who had spent many years training and were dedicated to improving the health of the Transkei people, he said.

A Transkei Department of Health spokesman later explained that Chief Matanzima felt strongly about unqualified practitioners. So do members of the department since their operations were seriously jeopardised recently by the arrival in Umtata of two South Africans.

The department, with few clinics and a scant staff, was fighting ill-health on many fronts — a rising TB and infant mortality rate, alcoholism and malnutrition — and ignorance, the spokesman said. Recently another problem was added to the list: care of the mentally ill.

The two South African men had taken rooms in the centre of Umtata, claiming to be “naturopaths” and saying they could cure patients for R10.

They had operated with “financial success,” “treating” 400 to 500 people a day.

The Department of Health said the South Africans had operated fraudulently. Patients were asked by a receptionist what their symptoms were. The descriptions were relayed to the men through a microphone. Then the patients were ushered in for a consultation.

The men, dressed in long white gowns, threw bones and then described the patients’ symptoms. Impressed, they paid R10. But patients with pneumonia were merely given a few vitamin pills or injections. Patients with diseases of the eyes actually lost their sight and then went to the Department of Health in despair.

The men were finally deported.

“We actually don’t object to them if they come with proper qualifications and are kept under control,” the spokesman said.

He said the government’s criticism of untrained people dabbling in medicine did not extend to witchdoctors.

They operated within the tribal structure and were invaluable in that they actually sent people to the clinics when they believed they were ill, he said.

The doctor said that in spite of the growing number of clinics and doctors, TB, the scourge of the homeland, was still rife and “well-nigh uncontrollable”. Official statistics of the prevalence of “open” or infective tuberculosis are 4% of the 3,000,000 population, but practicing doctors believe this figure is an optimistic one. Also optimistic, they say, is the official infant mortality figure of 360 in every 1,000.

“People have babies in the bush. They don’t register them. When they die they are buried with no official certification. Official statistics are just guesswork”, one doctor said.

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Klaas van der Poel, PhD

Curriculum Vitae

Desert of Industrial Systems

He has taught courses in Management Information Systems and Operations Research at the Business School of the Universities of Cape Town and Stellenbosch.

He has been a consultant in manufacturing, control and production systems for several companies. His experience includes the design and development of systems for the world's leading manufacturers.

He has a degree in Operational Research from Tilburg, Holland. He has

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Klaas van der Poel
To amend the Medicines and Related Substances Control Act, 1965, with respect to certain definitions; so as to provide for the amendment of entries in the medicines register; to provide for the transfer of certain certificates of registration; and to alter certain designations; and to provide for incidental matters.

BET IT ENACTED by the State President and the House of Assembly of the Republic of South Africa, as follows:

1. Section 1 of the Medicines and Related Substances Control Act, 1965 (hereinafter referred to as the principal Act), is hereby amended—

(a) by the substitution in subsection (1) for paragraph (a) of the definition of “advertisement” of the following paragraph:

“(a) appearing in any newspaper, magazine, pamphlet or other publication; or”;

(b) by the insertion in that subsection after the definition of “approved name” of the following definition:

“certificate of registration” means a certificate of registration issued under section 15 (4), 15A (4) or 15B (4);”;

(c) by the insertion in that subsection after the definition of “dentist” of the following definition:

“Director-General” means the Director-General:

Health, Welfare and Pensions;”;

(d) by the substitution in that subsection for the definition of “Minister” of the following definition:

“Minister” means the Minister of Health, Welfare and Pensions;”;

(e) by the insertion in that subsection after the definition of “prescribed” of the following definition:

“public” includes a section of the public concerned in manufacturing, dispensing, selling or administering or the issue of prescriptions for, medicines or a Scheduled substance;”;

(f) by the deletion in that subsection of the definition of “Secretary”; and

(g) by the substitution for subsection (2) of the following subsection:

“(2) A medicine shall, notwithstanding the fact that its components are identical to those of any other medicine as to physical characteristics, quantity and quality, for the purpose of this Act not be regarded as
PRESS STATEMENT BY DR. THE HONOURABLE, L.A.P.A. MUNNIK,
MINISTER OF HEALTH, WELFARE AND PENSIONS ON A HEALTH SERVICE
FACILITIES PLAN FOR THE R.S.A.

This plan is one of the most important developments in Health
Services during the past decades. It shall promote the accent
on preventative and basic primary health care instead of the
present curative hospital services.

Embargo: Monday 3 November 1980 at 19h00

Pretoria

3 November 1980
1. One central body will be responsible for the overall planning of health services, the formulation of health policy and determining of strategy.

2. The Department of Health, Welfare and Pensions will serve as co-ordinator in the compilation and revision of the national health plan and will guide all and every health authority responsible for the establishment of health service facilities.

3. The Department of Health, Welfare and Pensions will timely and regularly provide information concerning any matter which may have an influence on service rendering, for example development or resettlement plans, to all service rendering bodies. All the health authorities will, in the same manner, provide the Department with information which may have an influence upon any health matter.

4. The health service plan will be cognisant of the health services in the National states. Liaison with the Regional Health Organisation of Southern Africa (RHOSA), will be maintained and extended.

5. Health service facilities will, as far as possible, be shared by health authorities. Where one body incurred capital expenditure for health services and such services are shared with another body, there will not be a contribution regarding capital expenditure, but expenditure may be recovered by means of recovery of rent or other agreements. With regard to personnel all health authorities will, without recovering of cost, supplement each others' services as far as is practically possible with retention
(b) **Food**

The production of food is primarily the responsibility of the private sector under guidance of the Department of Agriculture and Fisheries. The provision of food to supplement in protein and vitamin deficiencies for indigents is the responsibility of the Department of Health, Welfare and Pensions and local authorities. The role of voluntary organisations is just as important and community involvement and participation must be encouraged.

(c) **Sewage and waste disposal**

The disposal of sewage and waste as well as the establishment of sewerage plants is an essential function of the local authorities and administration councils.

(d) **Housing**

The provision of sub-economic and economic housing to eliminate undesirable housing is necessary to create a minimum level of health.

In conjunction with the authorities concerned, the Department of Health, Welfare and Pensions will act as co-ordinator to introduce guidelines for the establishment of services with minimum standards for these four basic subsistence needs.

Private practitioners who obtain first-hand knowledge of general health problems related to the community, and who can determine the leading causes, will have a very important function in this field by bringing it to the attention of the authorities concerned.
will on purpose enact co-operation with voluntary service organisations for these organisations to play an active supplementary role in the rendering of health services.

The private practitioners as well as other health professions are members of a community, and on account of their training and knowledge, have the expertise to guide and actively participate in such service organisations' activities.

(b) **Community health nursing**

The following higher category service has preventive and curative tendency and will mainly be rendered by nurses in the community to that part of the population depended on this service. Home visits will be done under guidance of fulltime and/or part-time physicians. Existing and available accommodation, improvised for clinic services for example school hall or any other vacant room in a house, business centre, etc., will be used. The financial provision for such a nursing service will be provided by the Department of Health, Welfare and Pensions and/or the provincial administrations and/or local authorities. The service should in general and mainly be rendered by local authorities and provincial administrations with consideration to certain services like psychiatry, family planning, combating of tuberculosis, geriatric care, etc. which are primarily the responsibility of the Department of Health, Welfare and Pensions.

(c) **The community health centre (CHS)**

This is the highest category service on this level and seems to be the largest present need of that part of the population dependent on public health services. Preventive,
(iii) The establishment of a CHC is primarily the responsibility of provincial administrations and/or local authorities.

(iv) For the service to be a success it is important that where a CHC is erected, opportunity will be given for the rendering of services by all the health authorities concerned. In order to encourage the rendering of services by private practitioners, the health authorities will have to consider consulting room facilities for private practice on a selective basis at certain CHC.

(v) The establishment of a CHC will be a joint undertaking by all the health authorities concerned. Provision of funds by the central government will only be made available in terms of the norms already expressed. Where a local authority undertakes the erection of a CHC with government subsidy it will comply with the said norms.

(vi) Family planning facilities at CHC are the greatest priority. For the full development of all the primary health services the support of the community and service of private practitioners will be essential. The private practitioner will provide guidance and support to community nurses and voluntary health organisations, in first-aid and emergency services and with family planning and sterilisations; he will also be able to undertake part-time sessions and give advice on immunisation and a healthy life-style.
In order to obtain an efficient and economical unit, bed provision will consist of 500 beds and in exceptional cases it will be allowed an increase to a maximum of 800 beds.

Provincial administrations themselves will determine which hospitals should be promoted to the status of a regional hospital.

Level VI - The academic hospital
This hospital will provide for the academic health components; that is, training, research and service rendering on a comprehensive and sophisticated basis.

As far as is possible these hospitals will be limited to 800 beds. Only in unusual circumstances and with approval from the highest level may the beds be supplemented in which case it may not exceed 1 200.

Issued by the Department of Foreign Affairs and Information at the request of the Department of Health, Welfare and Pensions.

PRETORIA
3/11/80
Health services to be changed

CAPE TOWN — South Africa can expect a major announcement in the next few weeks on the re-shuffling of the country's health services, the Minister of Health, Dr L. Munnik, said here yesterday.

Dr Munnik was speaking at the official launching luncheon of South Africa's first national heart week.

He said it had become increasingly obvious that health services had to be streamlined to emphasise the role of preventative rather than curative aspects.

Dr Munnik told an audience that the 18-month-old national heart effort had grown into a "magnificent campaign" to try to prevent cardiovascular disease, a condition for which South Africa — with the highest heart attack rate in the world — is notorious.

Citing obesity, smoking, high blood pressure, tension and lack of exercise as the main risk factors associated with heart disease, Dr Munnik said the control of such bad habits was not only the responsibility of the individual but the whole community.

— DDC.
Govt censures for 'neglect' of health services

Mercury Reporter

SOUTH Africa is in the grip of its third crisis in health services this year and the Government deserves 'severe censure' for its neglect of basic services, Mr. Nigel Wood, MP for Berea and NRP health spokesman, said in a statement at the weekend.

'First there was typhoid in Inanda, then rashes in Natal and now the cholera outbreak in the Eastern Transvaal,' he said.

Vacancies

Quoting from the latest annual report of the Department of Health, he said there were 1,149 vacancies for which health personnel alone. Health Inspectors were 22 percent below strength; district surgeons 22 percent and nurses 57 percent.

'Clearly these facts have a significant bearing on the crises we have suffered this year. The Government must take urgent and decisive action to fill the vacancies.'
‘Marxist’ medicine is not healthy for South Africa

As a member of the paramedical profession since 1978 and now as a medical student at Pretoria University, I was disappointed to read Prof Michael Savage’s article “The development and underdevelopment of South African health” and “Diagnosis of failure and a new prescription” (Inside Mail Oct 13 and 15). I found them very negative and stereotyped.

I worked at the World Health Organisation (WHO) in Geneva for two years as a research assistant for a study of the health and psycho-social implications of apartheid. My work entailed the collecting of all available information on South Africa’s health and disease patterns and health services and I researched scores of papers written by all sorts of experts and quasi-experts who attempted to examine these factors.

I found there were basically two broad categories of papers. Firstly, those written by laymen, usually in the media, or by experts on the “evils of the apartheid-capitalist system”. The papers in this category are basically a rehash of each other and barely distinguishable one from another.

The other broad category consists of articles written by professional medical personnel who have worked or are working in South Africa. These articles are reports of results of scientific research which has highlighted certain undeniable differences in health patterns, growth patterns and health services for the various races in South Africa. It should however be born in mind that some disease patterns differences between blacks, Asians, coloureds and whites can be attributed to genetic differences and not only to differences in health services.

Prof Savage’s article falls very clearly into my first category of attacks on South African health services. His criticism of the biological model of medicine can only be described as simplistic, narrow and inaccurate. His arguments are not original, not well-founded and are straight parroting of views of people like Ivan Illich (author of ‘Medical Nemesis’).

All his criticisms of the health care system seem to be based on the belief that the answer to the so-called “crisis” he describes would be the implementation of some sort of socialist health care system in which the State would plan and determine the allocation of health care resources. A basis of absolute equality for all — this would inevitably result in great regressions in areas like research and training of skilled medical personnel.

No knowledgeable health official in South Africa can deny that more emphasis should be placed on preventative health care — and this is being done. In the same way the State together with the South African medical profession is making every effort to improve the health care system through better and more relevant training, development of ancillary health and welfare services, creating awareness of the different health and psycho-social problems facing different race groups, increasing the number of health personnel and the elimination of all discriminations based solely on race.

Even some of the most dogmatic anti-SA researchers at WHO admitted that in comparison with the rest of Africa, the health services for blacks in South Africa could only be criticised by a hypocrite. The contribution by South Africa to fighting disease and to WHO projects in the rest of Africa, for example immunisation, should not be overlooked.

Obviously, economic, social and political factors contribute to mortality and morbidity rates in many societies, however the Marxist-influenced argument that a clinical and biological attack on sources of disease is therefore inadequate is a non sequitor. The Marxist solution would be to implement a centralised system which would dispatch doctors to where the bureaucrats found them to be required, according to a planned system.

They would also reallocate research and hospital construction funds to rural development schemes, based on the belief that the majority of diseases in South Africa would not occur under different political and economic circumstances.

Michael Savage must bear in mind that South Africa is in a unique stage of development hovering between Third and industrial worlds. This places particular demands on the health system and requires a delicate balance of emphasis placed on the varied services provided. We must be able to satisfy the demand for sophisticated technological medicine and we must be able to supply primary health care where needed.

For example, our health care system must be able to cope with malnutrition of the Third World — marasmus and kwashiorkor — and malnutrition of the industrial world — obesity and the accompanying aggravating factors and complications. These are medical problems and can be treated as such. Social, economic and political problems such as poverty, overcrowding, inadequate sanitation, must likewise be treated as social, economic and political problems. Where these overlap with or cause medical problems the solution must be a joint one.

The Marxist viewpoint, that medical problems of a society such as this can only be solved by a total restructuring of the political and economic system along socialist lines is a fallacy. As one who has knowledge of health care systems in various African and socialist states, I am convinced of the inherent superiority of the free enterprise system to provide for its people’s health care needs.

Finally, I must reject Prof Savage’s assertion that “health is far too serious a matter to be left solely in the hands of the health professionals”. There must of course be democratic control of the activities of medical professionals but we must at all costs avoid the health care system becoming a socialist political football.

What is needed in SA’s health care system is more constructive contribution to its improvement and less Marxist influenced negativism. — Mrs I E Williamson, Sunnyside, Pretoria.
Apartheid and health don’t mix

MRS I E WILLIAMSON’S attack (RDM Oct 21) on Professor Savage’s articles on health in South Africa cannot be allowed to go unanswered.

MRS Williamson presents herself as a medical student and a “member of the para-medical profession”. She omits to mention that according to newspaper reports (Beeld Jan 25 and RDM Mar 6) she was a South African spy within the World Health Organisation.

Thus it is not surprising that she indulges in South Africa’s most pervasive traditional sport: that of labelling all unwelcome comment and criticism as Socialist/Marxist.

The absence of fact or rational argument makes her letter difficult to contradict. Nowhere does she tackle the substance of Prof Savage’s arguments. Nonetheless the following points need to be made:

• She argues that some of the differences in disease patterns between different population groups “can be attributable to genetic differences”. The diseases responsible for the majority of deaths amongst African children are: parasitic/infective, respiratory, and nutritional/metabolic. None of these are genetically related. According to Wyndham and Irwig, the mortality rate of children between the age of one year in 125/1,000 amongst Africans, and 22/1,000 amongst whites. Presumably Mrs Williamson does not believe that African children are genetically predisposed to die.

• On the one hand she says that Prof Savage’s arguments are “straight parrotry of views of people like Ivan Illich”. On the other hand she says that Prof Savage wants a centralised, socialist health care system. If she had ever read Illich, she would know that this is the last thing that Illich wants. He regards all health care systems, be they capitalist or socialist, as being evil in themselves.

• Mrs Williamson argues that the “State, together with the medical profession is making every effort to eliminate all discrimination based solely on race. Perhaps an examination of the relative amounts spent on, eg Baragwanath Hospital and the Johannesburg Hospital would disabuse her of this fantasy. The laudable aim of equality can never be achieved within segregated facilities.

• She argues that health services for blacks compare favourably with those of the rest of Africa. Mitchell and Wyndham state that QwaQwa, with a population of 300 000, has only two doctors. This figure should be compared with a figure for urban areas of one doctor per 6575 people, rather than with figures from other countries. These misleading statements aside, Mrs Williamson’s letter consists of little other than unsubstantiated generalisations and personal opinions such as “the inherent superiority of the free enterprise system to provide for its people’s health care” and that socialist health systems “inevitably result in great regressions in areas like research and training of skilled medical personnel”.

Mrs Williamson is, of course, entitled to her own opinion. If she wishes to convince others of her correctness she should rely on reasoned argument rather than smear.

The words “socialist” and “Marxist” appear no less than eight times in her letter, as if mere repetition of these tedious slurs were sufficient to disprove any argument. In fact her letter tackles none of the basic themes of Prof Savage’s articles. These are that apartheid and poverty in South Africa must carry substantial blame for much of the ill-health that exists in South Africa; that the current practice of health care is inadequate to deal with these health problems; that some of the most exciting attempts to provide social justice in health are to be found in countries that white South Africa regards with suspicion because they are black, or socialist, or both.

Mrs Williamson states that “there must, of course, be democratic control of the activities of health professionals”. This laudable aim will surely not be achieved until all the people of South Africa are able to exercise democratic control over all aspects of their lives. — P C DE BEER, Mayfair, Job.
Secret of healthy diet simple, says doctor

The dietary aspect of the risk factors for heart disease was overwhelming. The body could not stand an imbalance in the diet, and eventually was forced to complain—usually by means of a heart attack.

The main risk factors were high cholesterol levels, high blood pressure and smoking.

The study had shown that one in three people had abnormal cholesterol levels.

HIGHEST

South Africa's cholesterol intake was the highest in the world, corresponding to the fact that the country also had the highest number of deaths from heart disease.

South Africans ate too much saturated fat, animal protein and salt (proved to cause high blood pressure).

Saturated fats were necessary, but should be taken in balance with polyunsaturated fats.

The ideal cholesterol intake for each day was a maximum of 300 milligrams. One egg contained this amount.

FORMULA

Dr Labadarios said the formula for a healthy heart was to keep cholesterol low, stop smoking, control blood pressure, take exercise, relax, and have a moderate alcohol intake (half a bottle of wine or the equivalent alcohol value a day).

A small portion of good food was good, but thinking that a little more of the same food would be better was a fallacy.
McCarthyism is also no solution to SA's health problems

BEING located in a university, I am used to critics who attempt to be rational and fair in their arguments. It is an interesting experience therefore to be exposed to a different type of critic, none other than Mrs Craig Williamson whose letter (October 19) attacks my articles on South African health care (Inside Mail, Oct 13, 13).

By means of carefully worded smear and innuendo, Mrs Williamson's letter appears to engage in an attempt to label me a Marxist and thereby to avoid the substance of my argument. This I believe to be a crude McCarthyite technique. But I do not intend to give way to her overt thread of argument.

Mrs Williamson creates two broad categories of papers on health that she sees written by academic Marxist/socialist-influenced so-called social scientists whose works are not only ultra-left politically and aimed largely at the inanities of the "apartheid-capitalist system" and the like. In short, significantly, she puts in quotes in spite of the fact that it is not mine.

The other category she creates is that of papers written on health "by mainstream scientists who have worked or are working in South Africa".

Her simple division of writings on South African health reminds one that there are two categories of readers of writings on South African medicine (those who divide the writings into two types and those who don't) but should learn many people puzzled as to how she would classify papers, published in reputable journals like the SA Medical Journal, on such important topics as malnutrition but written by social scientists.

On the basis of her argument one can only assume that what she really wishes to propose is that all writings on South African health care not written by professional medical personnel are Marxist/socialist influenced.

Her simplistic classification system inevitably leads her specifically to classify as being "Marxist/Socialist-influenced" and she then asserts that the arguments she presents are "inaccurate". In spite of failing to specify even one factual inaccuracy, she charges unknowingly into creating an inaccuracy of her own by accusing me of "straight parroting" of the views of Ivan Illich.

As Mrs Williamson writes (ii), this foolish "researched scores of papers" on South African health, I can only assume that she would have come across a valuable collection of such papers ("The Economies of Health Care in South Africa", edited by Gill Wescott and Frances Wilson) and then in Volume 1 that I devote two pages specifically to rejecting the views of Illich. I suggest that it is Mrs Williamson's claims and standards of accuracy that need to be called into question.

By smear, innuendo, spurious classifications and inaccuracy, she lays down a particular ideological framework of criticism, spawning many red herrings. Her letter then edges toward what she views as the substance of my arguments (not however before demonstrating that peculiar brand of a "Marxist/Socialist influence on an ill-written racial sideline "some disease pattern differences between blacks, Asians, coloured and whites can be attributed to genetic differences").

Specifically she states that I "would seem to argue for a socialist health care system" in which the State would plan and allocate health care resources on the basis of absolute equality for all". The fact that I do not agree to this in my articles is of no bother to her (to save her the work and because I am doubtful of her ability to interpret my writing accurately, I add that nowhere have I argued this). This foolish debating trick leads her into a weak attempt to destroy arguments I never made and I can see no reason to reply to her statements.

Mrs Williamson then develops her style of argument by writing, "it is no criticism of the most dogmatic anti-SA researchers at WHO admitted in passing that a large number of the rest of Africa, the health services for blacks in South Africa could not be criticised by a hypocrite."

Here she sails dangerously close to labelling as hypocrites a range of distinguished South Africans such as those who have served on Government commissions that have been critical in their evaluation of health services for blacks in South Africa.

Finally, it is most interesting to note that Mrs Williamson, according to the Rand Daily Mail (Mar 8), has admitted to being a spy working for the SA Police while employed at the World Health Organization in Geneva.

In that report she was quoted as saying, "My real aim was to get as much information as possible on activities in the medical world while working as a nurse."

One is led to ask what was her real aim in writing such a letter. Her use of the word Marxist (five times), Socialist (four times) and her classification of a "Marxist/Socialist influence on an ill-written racial sideline "some disease pattern differences between blacks, Asians, coloured and whites can be attributed to genetic differences"

suggest that someone is studying those dark days of America's history dominated by Senator Joe McCarthy's witch-hunts and attempting to apply similar techniques in contemporary South Africa. These techniques were decisively rejected by the American people and so too will they be rejected in South Africa.

Crude smear, innuendo and inaccuracy do not form a response to serious issues concerning the current state of health care in South Africa but they are, however, a sad commentary on Mrs Williamson.

MICHAEL SAVAGE, Associate Professor, University of Cape Town.

Argument on health care problems is confused

WHILE Michael Savage's article on the development and underdevelopment of South African health services (Inside Mail Oct 15, 15) attempts to uncover the Fall of the South African system of health care, there are certain confusions in his argument which are not unfamiliar to those of us who have followed his debates over the British National Health Service.

On the one hand there is the view that medical science and the health services can make little contribution to the overall health of the population, and yet so much effort is spent revealing the inequalities of health care in relation to the health needs of the people.

To quote from Prof Savage's article in your pages, "South African medicine is skewed towards providing services for the affluent...it is skewed away from providing adequate health care coverage for the poor and for workers."

Either the health services do not matter, in which case their organisation and distribution is a matter of considerable public concern, or else they are irrelevant to the health of the population and we need only find out how we have an accidental and fortuitous redistribution of health care by the medical profession and the state.

Between conspiracy theories and moral rectitude, it would be more appropriate to consider disease as the current outcome of the historical development of South Africa, and understand the role of the health care services in that light.

UCT study critical of health and nutrition

Science Reporter

HIGHLY CRITICAL studies of the mining industry, occupational health, nutrition, the pharmaceutical industry, medical education and mental health were published this week in a collection of papers from the Southern Africa Labour and Development Research Unit (Sadru) of the University of Cape Town.

The collection, the second of two volumes covering a conference on the economics of health in South Africa, among other things criticizes the Erasmus Commission of Inquiry on Occupational Health for praising the mining industry while failing to pay attention to the high number of victims of dust-induced diseases.

It also points out, at a most embarrassing time of industrial unrest, that the commission "sees a constructive role for white trade unions, but does not see this role extended to all workers".

"On the contrary," says the report, "it ascribes industrial peace to the absence of black trade unions in the Republic and a striking absence of industrial organization in certain factories."

Migrant labour

A backhander for migrant labour appears in a paper on malnutrition which states that "no claim is made that migrant labour, per se, causes malnutrition - rather, that the extensive physical disruption of family life which it causes, fosters extensive desertion by folk of their dependants and an illegitimate explosion whose nobby wants, nor can provide for. When this occurs on a wide scale in a poverty situation, widespread malnutrition occurs."

The treatment of long-term psychiatric patients is covered in a number of papers on mental health, one of which criticizes the Smith Mitchell "empire" of privately-run institutions.

This group, which embraces more than 80 companies and operates 12 mental institutions in addition to five TB, geriatric and surgical medical sanatoria, receives a daily taffiff for pa- tient from the Department of Health. The report says that "despite the fact that Smith Mitchell is a private profit-making enterprise, their links at the Smith Mitchell institutions are accounted from the Department of Health. Although the situation has changed since 1963, the department still employs key staff at these institutions."

Because of the wide-ranging activities of Smith Mitchell "it was not possible to refute the claim (made by a Swedish newspaper) that the company had made a profit of R10,5 m in 1973."

"It is clear that Smith Mitchell do profit; otherwise they would not operate. They have no competition in the field of mental health. The extent of profitability in this area remains a secret," the paper added.

The pharmaceutical industry comes in for its share of criticism in two extensive papers on the manufacturing of ethicals and the economics of prescribing such drugs.

Profits are shown to be higher than average for all manufacturing industries. A breakdown of costs brings out the fact that the drug companies spend almost four times as much on promotion as they do on research, and almost as much on the entire cost of manufacturing, while at the same time maintaining that one of the reasons for high prices is the high cost of research.

'Priorities'

One paper points out that "criticism has often been leveled at the fact that meticulous (medical reports) are not knowl-edgeable enough to give doctors adequate information on new products. Adverts aimed at recruiting medical representa-tives require only a manipulation certificate, but stress that selling experience is essential. This may indicate the priorities of drug firms."

It refers to the controversial use of free gifts, samples and bonuses. "Gifts are given to doctors to encourage them to prescribe a particular brand of drugs. Doctors may also be given a bonus for prescribing drugs, or are often able to get a free sample with every pack- age of drugs ordered. The result is that doctors can gain by prescribing (and selling) the higher-priced items."

The editors of the collection are Dr Francis Wilson of the UCT School of Economics, and director of the SADRU.
The crisis in South Africa's health system

Diagnosis of failure ... and a new prescription

In his final article on South Africa's health system, Michael Savage, Associate Professor of Sociology at the University of Cape Town, suggests a three-point plan for the creation of an effective model to combat disease and illness in the Republic.

To be made to close the gap between its teaching and its delivery, such a gap can only be closed in this area by the medical profession actively involving itself in community development programmes as one segment of a total response to disease.

However, it cannot be exercised in working out how best this can be done. As De Beer has pointed out several community development schemes have helped obscure the roots of disease, either by encouraging survival strategies that ultimately only make the existing social order more palatable, or by engaging in projects, such as India's "Green Revolution" which benefited the richer peasants so much more than the impoverished farmers off the land.

There are three post-1994 steps:

- Analysis and evaluation of the experiences of other countries' health care systems.
- An involvement in community development that can be begun now.
- If South Africa is to become a health-promoting and healthy society, it needs more social structures and new medical structures.

This means that medicine must reject the belief, unfounded in fact, that its technology by itself can improve the health of any large population.

To improve health levels, patterns of income distribution, employment, government policy, agriculture, population density, and the health of any population requires at least two medical systems.

One such system would be directly involved in the promotion of health-promoting social structures.

In South Africa this results in an immediate obligation on the medical profession to undertake all aspects of apartheid that has institutionalised a range of political and social constraints that deny the effect of good health to large sections of the population.

At the same time, there is an opportunity for the profession and of the society should be used to develop a new and innovative model of health care delivery. Neither the current deficiencies facing South Africans are great but none greater than their potentialities.

- In Part One of this series Dr Peter Savage was mistakenly referred to as a member of the University of the Witwatersrand.
SOUTH AFRICAN HEALTH
UNDERDEVELOPMENT OF THE DEVELOPMENT AND

Widespread poverty and malnutrition become intertwined in contributing social policies which are associated with South African medicine. The approach to the provision of health to become effective medicine must approach the health sector's medical, educational and physiological.
HEALTH AND DISEASE —

GENERAL.

10/1/81 — 31/12/81
ALGEMENE KENNISGEWING

DEPARTEMENT VAN GESONDHEID, WELSYN EN PENSIOENE

De volgende konsepwetontwerpe word hierby vir algemene naying en kommentaar gepubliseer.

1. [Konsentraat ten opsigte van Grootte, 1981]
2. [Konsentraat ten opsigte van Voeding, 1981]
3. [Konsentraat ten opsigte van Skauningsmiddels en Onmigdheid, 1981]
4. [Konsentraat ten opsigte van Grootte van Gevangen, 1981]
5. [Konsentraat ten opsigte van Gesondheid, 1981]

GENERAL NOTICE

DEPARTMENT OF HEALTH, WELFARE AND PENSIONS

The following Draft Bills are hereby published for general information and comment.

Any comment and representations thereon should be forwarded to the Director-General: Health, Welfare and Pensions, P.O. Box 3879, Cape Town, 8000 on or before 4 February 1981.

(a) Health Amendment Bill, 1981;
(b) Foodstuffs, Cosmetics and Disinfectants Amendment Bill, 1981;
(c) Hazardous Substances Amendment Bill, 1981;
(d) Mental Health Amendment Bill, 1981.
Poisoned bread in Natal: 2 die, 23 ill

Own Correspondent

DURBAN. — Two people have died and 23 have been admitted to hospital after eating suspectedly poisoned bread sold in the Richards Bay/Empangeni area of Natal.

A dock worker at Richards Bay went into convulsions while working on a ship, fell into the bay and drowned before he could be reached.

A second dock worker had convulsions and died before he could be taken to hospital.

Twenty-three people were admitted to the Ngwelezane hospital near Empangeni suffering from convulsions and doctors treated other people at home.

Panic spread through the Zululand area yesterday when it was discovered that 2,400 loaves of brown bread possibly containing a dangerous poison had been sold on Thursday.

Shops were inundated with telephone calls and residents flocked to stores to return bread.

Tests on the samples of bread, which was sold out at the Zululand outlets, are being carried out by International Consulting Laboratories in Durban. A spokesman for the laboratories said the results might not be known until Monday.

The first indication of the suspected bread poisoning appeared on Thursday morning when a driver working for a Richards Bay bakery complained that he was feeling ill.

At 1 pm on Thursday a worker painting the deck of a ship at Richards Bay suddenly had convulsions and drowned after falling into the sea.

Soon after, another worker in the harbour area showed similar symptoms and died before he could be taken to hospital.

Post-mortems are being held.

said: "We immediately contacted local radio stations to warn Zululand residents once we suspected that the batch of 2,400 loaves might contain poison."

It is suspected that the bread was contaminated by flour transported by train from a company in Durban to Richards Bay.

Railways authorities and the Railways Police are investigating the possibility that the truck used to carry the 270 bags of flour may have previously carried poison and that the flour may have been contaminated in transit.

"Against policy"

A spokesman for the SAR in Richards Bay said it was strictly against their policy to use for the transportation of foodstuffs trucks which had carried any other goods, but the possibility that this had happened was being investigated.

Although all cargo records were computerized, the trucks' contents of the past few weeks would not be known until about Wednesday, he said.
The owner of the transport firm which carried the flour from the railway depot to the bakery said their lorries were used only for the transportation of foodstuffs and clothing. There was no chance that the flour had been contaminated while it was in his company's care.

A spokesman for the group of which the Richards Bay bakery is a member said it was believed that the poisoning was caused by their bread.

"One of our bakers smelled the flour early on Thursday and suggested it might be contaminated. We informed the public," he said.

Staff of the Empangeni War Memorial Hospital are on standby, but by late last night no victims of suspected poisoning had been admitted there.

The medical superintendent of the Ngwelaane hospital, Dr M. Girdwood, said 23 people had been admitted on Thursday night suffering from convulsions, apparently caused by a chemical poison which attacked the central nervous system. However, all had recovered during the night and some were discharged yesterday morning.

Doctors in the Zululand area reported that they had treated a number of people with diarrhoea symptoms, possibly caused by a mild form of poisoning.

The manager of the Richards Bay bakery which baked the suspect bread, Mr Cliff Webb,
Post-mortems are being

The medical superintendent
said 33 people were admitted
and some were discharged.

Doctors in the Zululand area
said that a new disease was
tevents for the past few
weeks. The case was treated
by a local doctor and

A spokesman for the Saldanha Group said he was
not aware of any contamination in their products.

We informed the police and
the Department of Health.

The Rovos Rail announced
that all trains had been
tracked and disinfected.

The train was due to arrive
in Cape Town later today.
Two people have died and 23 been given medical treatment on the scene.

Two poison deaths.

Poisoned loaves.

A chemical prick, no doubt, says the chemist.

DURBAN.

One correspondent.

The chemical reaction was that which happens when sugar is mixed with loaves of bread and a chemical reaction occurs.

The company said:

"We have a number of employees who have been affected."
Cape Provincial Institute of Architects' Prize
For the best student in:-

Sixth Year
P F Dunckley

Helen Gardner Travel Prize
For a student who has satisfactorily completed 1st, 2nd and 3rd major course
P A Rappoport

Molly Gohl Memorial Prize
For the best woman student in third year.
Miss C Tredgold

David Haddon Prize
For the best student of Architecture (or Quantity Surveying) in the subject of Professional Practice.
D H Pryce Lewis

General J B M Hertzog Prize
For the best final year student
S A Read

Osbourn Prize
For the best work in fourth year.
D H Pryce Lewis

John Perry Prize
For the best work in third year.
R A van Rosenveld.

**Hunt to find poison source**

**By RAY JOSEPH**

CHEMISTS in Durban are working round the clock analysing samples of suspected poisonous bread after two people died and another 53 were admitted to hospital in the Richards Bay-Emangeni area.

A spokesman at the laboratory conducting the tests said yesterday that tests were proceeding at the moment, but we do not have a positive result as yet.”

Mr Cliff Welsh, manager of the Richards Bay bakery which made the bread, said yesterday that 2 400 brown loaves had been sold from the suspect batch.

“But today (Saturday) many of our trucks are coming back with full loads. People are not accepting the bread,” he said.

The two dead men were both dock workers at Richards Bay harbour.

One suffered convulsions and fell into the harbour and drowned, while the second went into convulsions and died before he could be taken to hospital.

**Discharged**

Panic spread through Zululand on Friday as people converged on shops to return bread.

Railway police are investigating the possibility that a truck which transported flour to Richards Bay may have earlier carried poison and that the flour was contaminated in transit.

Dr M Girdwood, superintendent of the Ngwetane hospital — where 53 people were treated — said the last admissions were at 10 pm on Friday.

All those treated had eaten bread and came from the area between Richards Bay and Emangeni. Most had now been discharged, and none were serious.

“The symptoms were fairly alarming. They were all suffering from convulsions, which were apparently caused by a chemical substance attacking the nervous system,” he said.

The bakery manager said the affected flour had been isolated and “there is nothing wrong with the flour we are using now.”
Call for stricter firearm laws

Own Correspondent

CAPE TOWN. - The principal surgeon and clinical head of surgery at Johannesburg's J G Strijdom Hospital, Dr G. A. G. Decker, has called for a tightening up of laws regarding possession of firearms.

In the latest South African Medical Journal, he says that during the first 11 months of 1989, 18 whites were admitted to his hospital's general surgical wards for treatment of gunshot wounds.

"In only two cases were the wounds sustained as a result of armed robbery. Seven were shot because of a dispute with a member of the patient's family, or as a result of a brawl in a bar. In eight of the patients the injuries were self-inflicted as a result of attempted suicide or accidental firing of the firearm.

"One of the patients was a 17-year-old girl who happened to be in the line of fire of a drunken 24-year-old man brandishing a pistol while allegedly trying to help a relation who was being assaulted in a bar lounge of a hotel. The girl sustained a penetrating abdominal wound with injury to the right kidney and stomach.

"The man who fired the pistol was found guilty of being in illegal possession of a firearm and ammunition. He was cautioned and discharged."

Dr Decker said it was obvious that too many South Africans owned firearms. Many of these people were emotionally unstable and untrained in their use.

"Is it not time the laws concerning the possession of firearms were changed to ensure that only carefully selected applicants are granted a licence to possess a firearm?" the doctor asks, saying our laws do not offer an adequate deterrent sentence that will prevent the irresponsible use of firearms.

Dr Decker believes the experience of gunshot wounds at the J G Strijdom Hospital is probably not unique and that most urban hospitals could produce similar figures. Unfortunately, he says, many victims now reach hospital, but go directly to the mortuary."
Thousands of loaves dumped in poison fear

Meanwhile, bread sales at Richards Bay Bakery have dropped dramatically, with people either baking their own bread or buying from other outlets.

The area manager for Sasko, Mr. Hob Bradbury, said the bakery had suffered a substantial loss of trade. He said there had been a lot of consumer resistance, and quite big cuts in orders from our retailers. He said: "Our main concern is that if something was wrong with the bread it should be put right. "We will continue to give top service as in the past and we hope our business will come back."

Meanwhile, bread sales at Richards Bay Bakery have dropped dramatically, with people either baking their own bread or buying from other outlets.

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2. Mr. N. B. WOOD asked the Minister of Statistics:

(1) How many (a) Whites, (b) Coloured, (c) Indians and (d) Blacks in the different professions associated with health services emigrated from South Africa during the last 12 months for which figures are available.

(2) What is the number for each race group in each such profession?

The MINISTER OF STATISTICS:

Preliminary figures for 1980 are as follows:

(1) (a) 227.

(b), (c) and (d) 24 (separate figures not available)

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<thead>
<tr>
<th>Profession</th>
<th>(a)</th>
<th>(b)</th>
<th>(c)</th>
<th>(d)</th>
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<tr>
<td>Dentists</td>
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<tr>
<td>Veterinarians</td>
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<td>Pharmacists</td>
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</tr>
<tr>
<td>Dietitians</td>
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<tr>
<td>Professional nurses</td>
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<tr>
<td>Physiotherapists</td>
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<tr>
<td>Radiographers</td>
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<td></td>
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<tr>
<td>Osteopaths</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Total</td>
<td>227</td>
<td>24</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FEBRUARY 1981

The MINISTER OF HEALTH, WELFARE AND PENSIONS:

(1) (a) 111.

(b) 93.

(2) 1 January until 31 December 1979.
(a) to (d)

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<th>Coloured/Indian</th>
<th>Black</th>
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<tr>
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<tr>
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</tr>
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<td>(fixed)</td>
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<tr>
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<td>23 100</td>
<td>23 100</td>
</tr>
<tr>
<td>(fixed)</td>
<td></td>
<td>(fixed)</td>
<td>(fixed)</td>
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<tr>
<td>Senior Specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior Medical Superintendent</td>
<td>22 200</td>
<td>22 200</td>
<td>22 200</td>
</tr>
<tr>
<td>(fixed)</td>
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<td>(fixed)</td>
<td>(fixed)</td>
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<tr>
<td>Principal Medical Officer</td>
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<tr>
<td>Specialist</td>
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<td>(fixed)</td>
<td>(fixed)</td>
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<tr>
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<tr>
<td>Medical Officer</td>
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<tr>
<td>Registrar</td>
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<tr>
<td>(ii) Dentists</td>
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<td></td>
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<tr>
<td>Chief: Dental Services</td>
<td>24 000</td>
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</tr>
<tr>
<td>(fixed)</td>
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<td></td>
</tr>
<tr>
<td>Principal Dentist</td>
<td>22 200</td>
<td>22 200</td>
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</tr>
<tr>
<td>(fixed)</td>
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<td>(fixed)</td>
<td>(fixed)</td>
</tr>
<tr>
<td>Senior Dentist</td>
<td>20 400</td>
<td>20 400</td>
<td>20 400</td>
</tr>
<tr>
<td>(fixed)</td>
<td></td>
<td>(fixed)</td>
<td>(fixed)</td>
</tr>
<tr>
<td>Dentist</td>
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<tr>
<td>(iii) Pharmacists</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Chief: Pharmaceutical Services</td>
<td>22 200</td>
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<tr>
<td>(Provincial Services)</td>
<td>17 520-20 400</td>
<td></td>
<td></td>
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<tr>
<td>Principal Pharmacist</td>
<td>14 220-17 520</td>
<td>13 860-16 860</td>
<td>12 450-15 540</td>
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<tr>
<td>Senior Pharmacist</td>
<td>11 550-14 220</td>
<td>10 650-13 560</td>
<td>9 750-12 450</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>7 740-11 100</td>
<td>7 080-9 300</td>
<td>5 745-8 070</td>
</tr>
</tbody>
</table>
For written reply:

Black states: doctors/dentists/chemists and druggists/veterinarians/nurses.

10. Mr. N. B. WOOD asked the Minister of Co-operation and Development:

(1) How many trained Black (a) doctors, (b) dentists, (c) chemists and druggists, (d) veterinarians and (e) nurses are serving the Black people at present in the Black states whose governments have not taken over health services;

(2) which governments have not taken over health services?

The MINISTER OF CO-OPERATION AND DEVELOPMENT:

(1) (a) Nil.
(b) Nil.
(c) Nil.
(d) Nil.
(e) 700.

(2) kaNgwane and kwaNdebele Government Services.
BRITISH doctors are to be warned against prescribing deberdon, an anti-nausea drug widely used among South African women during pregnancy.

The warning to all GPs will recommend that the use of any drug, including deberdon, be avoided "if at all possible" during pregnancy.

The warning reflects the continuing conflict of scientific opinions over whether the drug increases the possibility of deformity in babies. The warning begins: "There have been a large number of epidemiological studies of deberdon. Although there have been some formations associated with pregnancy, a casual relationship has not been established."

A spokesman for the drug's manufacturers in Britain said in the future the company would not be promoting the drug, but it would be available to any GP who wanted to prescribe it. — Observer News Service.

G L Croom

Chemical

L Menga

Drawing

Best classwork in engineering

Awarded to the student with the

Sammy Scotland Memorial Prize

J Rens

Civil Engineering

Student in land surveying or 

examinations to the best make

Prof. George Moutas Prize

B F McClelland

Fourth Year (Gold Medal)

Miss N. C. Davison

Third Year (Silver Medal)

Miss C. Littlewood

Second Year (Bronze Medal)

For the best student in each course.
### WHITE COLOURED ASIAN BLACK OTHER TOTAL

<table>
<thead>
<tr>
<th>Disease</th>
<th>564</th>
<th>8,365</th>
<th>644</th>
<th>36,164</th>
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<th>45,895</th>
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<tbody>
<tr>
<td>Typhoid</td>
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<td>54</td>
<td>76</td>
<td>3,530</td>
<td>12</td>
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### THURSDAY, 26 FEBRUARY 1981

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<td>66</td>
<td>6</td>
<td>94</td>
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<td>chus</td>
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<tr>
<td>Primary Malignancy of Lung</td>
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<td>9</td>
<td>5</td>
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<td>103</td>
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<td>Malignant Neoplasms of Pleura</td>
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<td>0</td>
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<td>33</td>
<td>1</td>
<td>71</td>
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<td>111</td>
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<td>0</td>
<td>0</td>
<td>4</td>
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</table>
Mr. N. B. WOOD asked the Minister of Mineral and Energy Affairs:

Whether steps have been taken to reduce the lead content in petrol; if so, what steps; if not, why not?

The MINISTER OF MINERAL AND ENERGY AFFAIRS:

No, because the lead content of petrol conforms to the specification of the South African Bureau of Standards.
303. Mr. H. E. J. Van Rensburg asked the Minister of Health, Welfare and Pensions:

How many cases of lead poisoning were reported in 1980?

The MINISTER OF HEALTH, WELFARE AND PENSIONS.

4.
Hierby word bekend gemaak dat die Staatspresident sy goedkeuring gegee het aan die onderstaande Wet wat hierby ter algemene inligting gepubliseer word:

Medical care in SA 'excellent'

The quality of medical care in South Africa was excellent, the executive vice-president of the American Medical Association (AMA), Dr. James Sammons, said yesterday.

Dr. Sammons is a member of an AMA delegation that is taking a "hard look" at the health manpower situation in South Africa in a follow-up to its visit here two years ago.

The delegation has also reaffirmed its support for the SA Medical Association's return to the World Medical Association.

REASSIGNED

South Africa resigned from the world body in 1976 because its finances were in a complete mess and because different principles were applied to different countries.

Dr. Sammons said that South Africa's approach to health manpower solutions was "very good" and equal to any in the world.

He added that the United States and South Africa shared similar problems regarding shortages of doctors and nurses and the high cost of medical care.

The AMA delegation consists of the association's president, Dr. R. B. Hunt, chairman Dr. L. Seen, deputy executive vice-president Dr. J. Miller, and legal adviser Ms. Betty Jane Anderson.

They will leave for Australia tomorrow, where they will continue their investigation into health services.
New black medical trade union to be formed today

BY MARLAIN PADHAYCHEE

THE Medical Association of South Africa (Medas) — criticized for its handling of the Steve Biko Affair — faces opposition from a new black medical trade union to be formed in Durban today.

And the organizers of the new health workers' association which will include doctors, nurses and hospital workers as members, strongly believe that Medas's handling of the inquiry into the death in detention of the Black Consciousness leader is the major catalyst in the launching of the new body.

Two similar associations have already been formed by doctors in Cape Town and Johannesburg and efforts will be made to coordinate the formation of a national body which will eventually supplant Medas.

Leading medical men will gather at the Medical School in Umbilo Road this afternoon at 2pm to officially launch the association which will dedicate its efforts to underprivileged people in rural areas.

Acting president of the Natal Coastal Branch of Medas, Dr John Hamilton said yesterday: "Soba are not desirable. We welcome a special body to provide health care in rural areas which is of great need."
Hierby word bekend gemaak dat die State President sy goedkeuring gegee het aan die volgende wet wat hierby ter algemene kennis gepubliseer word:


It is hereby notified that the State President has assented to the following Act which is hereby published for general information:

Hierby word bekend gemaak dat die Staatspresident sy goedkeuring gegee het aan die onderstaande Wet wat hierby ter algemene inligting gepubliseer word:


It is hereby notified that the State President has assented to the following Act which is hereby published for general information:

Genetics tests for future parents urged

Own Correspondent
Durban

All couples intending to marry may have to be medically examined first to determine whether they are likely to have genetically impaired children.

This recommendation is contained in a 198-page detailed research report commissioned by the Department of Health.

The report also recommends keeping a central register on all children born with genetic diseases. The register would also record the names of the parents.

Dr Giovanni Urbani, of the Human Sciences Research Council, who undertook the investigation, said he knew the recommendations would be controversial but pointed out that there was tremendous hardship for all concerned when a genetically impaired child was born.

In an interview, he pointed out the wisdom of a medical examination for a couple before they married and cited the example of Prince Charles's fiancée, Lady Diana, who had been declared medically unfit by the royal family.

Dr Urbani said that if there was more than a 50 percent chance that a child might be genetically impaired, it was better for the parents to adopt or to resort to artificial insemination.

An additional factor was that often when a genetically impaired child was born, the parents could not cope. This led to divorces and further hardship and expense.

In his report, Dr Urbani said the occurrence of genetic impairments should not be underestimated.

He listed the following impairments: deafness, blindness, defective eyesight, impaired hearing and grave mental retardation, porphyria, haemophilia, muscular dystrophy, marble bone disease, hairlip and cleft palate, spina bifida, cystic fibrosis, Huntington's chorea, Klinefelter's syndrome and Turner's syndrome.

For example, he said, one child in every 50 suffered from hyperlipidaemia, one in 300 from porphyria and one in 2,000 from spina bifida.

Other recommendations in the report include that the existing genetic services section of the Department of Health be expanded, counselling programmes for parents and teachers of handicapped children in respect of care and education should be compiled, research should be undertaken into the education of handicapped children and significant tax concessions should be given for parents of handicapped children.

Section (c) Total payment

The distribution of work is shown in the table. The distribution is calculated by the terms and payment (a)

Gross leave

Total payment

He estimated that for every 1,000 cases of spina bifida, there are 3,000 cases of mental retardation and 2,000 cases of blindness.

It appears then, that either farmers or actual payments, or that many of the factors...

It appears then that either farmers or...
Giving birth in poverty or in wealth

already established in township areas.

Once the clinics proved to the communities they served that they were part of the hospital, those "birth-units" handled all normal deliveries.

This cut down hospital intake by 50%, says the professor.

The midwives staffing these clinics received regular in-service training to upgrade their skills.

A consultant from the hospital visited the clinic every week, helping the staff to screen patients for complex obstetrical problems which needed referring to the hospital. And the consultant provided a regular exchange of information between the clinic and hospital staff.

After a normal birth, mother and baby were kept under observation for six to eight hours before their discharge. Daily post-natal visits by the midwife in the days following birth ensured patients received efficient after-care.

This is the system the professor chose to alleviate overcrowding in the King Edward Hospital in Durban in 1975.

He increased the number of urban black maternity clinics and the upgrading of the midwives' skills is continuously appreciated.

Three consultants oversee the clinics. Every clinic is visited weekly. The midwives receive in-service training at the hospital for two weeks of every year.

Some of the clinics are enormous, says Prof Philpott - some reginor 2 000 births annually.

Should an unexpected complication occur during birth or labour, each clinic is equipped with a two-way radio link to the senior registrar of the obstetrical ward at the hospital.

Since the clinics and birth units were established, perinatal deaths have dropped considerably.

Dr J V Larsen, previously a superintendent of the Charles Johnson Memorial Hospital, a large hospital near Dun-

dee, is one of the consultants.

He has extensive experience of the needs for improved perinatal care in rural areas.

Dr Larsen is in charge of the newly introduced advanced midwifery course - a diploma recognised by the Nursing Council in 1975.

This course, says Professor Philpott, qualifies a midwife to deal with all obstetrical complications, short of abdominal surgery.

Twelve midwives from KwaZulu and Natal are trained every year. As post-graduates they are based at rural hospitals.

Though working under a doctor, they are virtually in charge of the obstetrical department including outlying clinics which might be attached to the hospital. Training involves management skills and relates to all aspects of maternity care, before and after birth.

Some rural areas have no hospital at all, a fact discovered when Professor Philpott's department conducted a survey a few years ago.

If also showed, he says, that many patients at the hospital were coming from areas up to 90km away for a normal delivery.

Regarding clinics, he gave the example of an area with a large population of about 200,000 people, between Scottburgh and Pietermaritzburg, which is only served by two small clinics.

In some areas, because of the lack of either clinic or hospital, many deliveries are delivered - and pregnancies monitored - by "alternative birth attendants".

These are women who, traditionally, are chosen by their communities to serve as midwives. Illiteracy might be a problem but, says the professor, these women possess incredible midwifery and mother-craft acumen.

With increased on-the-spot instruction, Prof Philpott and his associates believe, these women have an important part to play in the care and safety of pregnant mothers in remote rural areas.

They need to learn, for example, how to anticipate or diagnose an obstetrical problem in advance; how to refer patients for specialised care.

But first the training programme - already formulated - must be accepted by the Nursing Council. The professor says negotiations are already underway and the council is sympathetic with their proposals.
STAAATSKOERANT, 10 APRIL 1981
No. R. 774
10 April 1981
CUSTUMS AND EXCISE ACT, 1964
AMENDMENT OF SCHEDULE 1 (No. 1/1/744)
Under section 48 of the Customs and Excise Act, 1964, Part 1 of Schedule 1 to the said Act is hereby amended as set out in the Schedule hereto.
D. W. STEYN, Deputy Minister of Finance.

SCHEDULE

I

II

III

IV

Statutory Tariff Heading

1

Rate of Duty

Statutory

1

General

M.F.N.

no.

25%
or

60c

per

no.

103

5c

Note.—The rate of duty on diodes of a value for duty purposes not exceeding 50c each is increased from 5% to 50c or 60c per 100.

BYLAGE

I

II

III

IV

Statutory

Raisie

Skat van Reg

Statutory

Fondheid

Ameren

M.F.N.

general

75%
or

60c

per

100

5c

Opmerking.—Die skat van reg op diodes met 'n waarde vir belastingdoelkeinde van hoogste 50c elk word van 5% na 25% of 60c per 100 verhoog.

DEPARTMENT OF HEALTH, WELFARE AND PENSIONS
No. R. 777
10 April 1981
MEDICINES AND RELATED SUBSTANCES CONTROL ACT, 1965 (ACT 101 OF 1965)
The Minister of Health, Welfare and Pensions has, in terms of section 35 (1) (xxiv) and (3) (b) of the Medicines and Related Substances Control Act, 1965 (Act 101 of 1965), made the regulations in the Schedule hereto.

SCHEDULE

1. In this Schedule, unless the context otherwise indicates, the expression “the regulations” means the regulations published under Government Notice R. 352 of 21 February 1975.
2. The following regulation is hereby substituted for regulation 32 of the regulations:
32. (1) Any person registered as a midwife, in terms of the Nursing Act, 1978 (Act 50 of 1978), who wishes to purchase, acquire or keep for administration in a midwifery service, the scheduled substances set out in Annexure C shall apply, in writing, to the Regional Director: Health Services, of the area concerned for a permit, giving the following particulars in such application:
(a) The type of midwifery service for which the scheduled substances are required.

DEPARTEMENT VAN GESONDHEID, WELSYN EN PENSIENIE
No. R. 777
10 April 1981
DIE WET OP DIE BEHEER VAN MEDITISNE EN VERWANTE STOWWE, 1965 (WET 101 VAN 1965)
The Minister of Health, Welsyn en Pensienie het in krantens artikel 35 (1) (xxiv) en (3) (b) van die Wet op die Beheer van Medisyne en Verwante Stowwe, 1965 (Wet 101 van 1965), die regulasies in die Bylare hiervan uitgevaardig.

BYLAGE

1. In hierdie Bylare, teny dit uit die samehang anders wys, betref die "die regulasies" die regulasies uitgevaardig deur die Gwaenserskooningswering R. 352 van 21 Februarie 1975.
2. Regulasie 32 van die regulasies word hierby deur die volgende regulasie vervang:
32. (1) Iemand wat inhoue die Wet op Verploegking, 1978 (Wet 50 van 1978), as 'n vroëlvrou geregistreer is en wat geneesbehou swaar uitgees in Aanhangel C vir toediening by 'n verloskundige geval wil koop, verkry of aantrek, moet skriftelik by die Streekdirekteur: Gesondheidsdekte van die betrokke gebied aanbeveel (voor so'n permut of in sodanige aanvaring die volgende besonderhede verstrek:
(a) Die type verloskundige diens waarvoor die gelaste stowwe benodig word.
### Table Fourteen (Table forty-three)

<table>
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<th>Year</th>
<th>% of Costs (Table Twenty Two)</th>
<th>% of Operating Income (Table Twenty One)</th>
<th>% of Income (Table Twenty)</th>
<th>% of Gross (Table Twenty One)</th>
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<tr>
<td>2001</td>
<td>60%</td>
<td>60%</td>
<td>60%</td>
<td>60%</td>
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<td>2002</td>
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<td>2003</td>
<td>60%</td>
<td>60%</td>
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### Table Fifteen (Table thirteen)

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<th>Year</th>
<th>% of House andDonkeys (Table X)(Table X)</th>
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<td>60%</td>
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<tr>
<td>2002</td>
<td>60%</td>
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<tr>
<td>2003</td>
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### Table Sixteen

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<td>2002</td>
<td>60%</td>
</tr>
<tr>
<td>2003</td>
<td>60%</td>
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</table>

### Table Seventeen

- **Pathway:** Medical Centre
- **Purposes:** The Medical Centre will be built as an extension to the hospital's existing facilities.
- **Plan:** Construction of a new medical centre.
- **Scope:** The centre will be the first of its kind in the area.
- **Timeline:** The centre is expected to be operational within two years.
- **Doctors:** A team of experienced doctors will be recruited to staff the centre.
- **Funding:** Funding for the project is expected to come from both the government and private donations.

### Table Eighteen

- **Table:** Table Eighteen
- **Data:** Various data points related to the medical centre's operations and finances.
- **Remarks:** Additional information and notes related to the table data.
The department of health is responsible for the provision of health services to the people of South Africa. This includes the administration of legislative health policies and the provision of health services through public and private sector entities. The National Health Insurance (NHI) is one of the major initiatives aimed at ensuring universal access to quality health care.

Medical Centre Opening

Dr. Mohamed disclosed that the opening of the new medical centre was a significant milestone for the community. The centre, named the People's Health Centre, would provide a range of health services including primary care, maternal and child health, chronic disease management, and mental health services.

The centre was designed to accommodate a population of approximately 10,000 people and would serve as a hub for community-based health care. It would also house a pharmacy, laboratory, and a dental clinic.

The opening ceremony was attended by local leaders, health officials, and representatives from the Department of Health. The centre was expected to significantly improve access to quality health care in the area.

Conclusion

The opening of the People's Health Centre is a testament to the commitment of the Department of Health to improving the health outcomes of the people. It is hoped that the new centre will be a model for future health care delivery in South Africa.
Health
services
‘facing
collapse’

Own Correspondent

Nearly a quarter of the
posts in the Department of
Health are vacant and
some services run the risk
of collapsing.

The department’s 1980
annual report, issued in
Pretoria, reveals that suf-
ficient personnel could not
be trained or retrained to
keep the department’s es-
sential services operating
efficiently.

The general revision of
salaries last year had not
brought any improvement
and the recruitment of
staff in the Witwatersrand
area had virtually ceased.

The report indicated that
the department could not
meet its commitments even on
the basis of minimum effi-
ciency, the report said.

NURSING

The worst affected ser-
vice were the nursing
of state patients,
health inspections,
medico-legal examinations
as evidence in courts and
information services for
pensioners.

The report showed a
shortage of nearly 30 per-
cent of nursing staff in
posts from sister to nurs-
ing assistant, and a similar
lack of medical officers.

A total of 231 people
resigned from the depart-
ment last year and a fur-
ther 176 have retired or left
because their contracts
had ended. In the same pe-
riod 3629 people joined
the staff.

“As a result of the staff
situation, essential serv-
ices for which the depart-
ment is responsible are
being rendered unsatisfac-
torily and certain services
run the risk of collapsing,”
the report said.

“On other levels the
quality and extent of ser-
vice is handicapped by a
shortage of staff.”
Medical indaba

By LEN MASEKO

A THREE-DAY conference titled “South African Health - History of the Main Complaint” which intends looking at the political, social and economic history of this country is to be held at the University of Witwatersrand between tomorrow and Wednesday.

The conference, an annual event organised by the Wits Medical Students’ Council, is also aimed at striving for an effective and equal health system in the country.

Topics which will be discussed at the conference include malnutrition; labour and health; food as a weapon of war; overpopulation; the development of the health care system in this country and the introduction of white man’s diseases in South Africa.

The aims of the conference are

• to give the public and the students a new approach to health and disease and broaden the narrow perception of health held by health workers.
• to show that causes of illness — psychological, sociological and economic cannot be dealt with within the realms of purely scientific medicine.

It will be held at the G R Bozzoli Sports Centre, University of the Witwatersrand in Braamfontein.
Swindle!

Says medicine

Will be banned

Company

Ciskei minister

Doctor

Time report

Sunday Tribune, July 6, 1981
Govt orders tough health care curbs

By ADA STUIJT

THE Government has issued a tough directive to curb spending in major State health services — retroactive to the beginning of the year.

The memorandum sent this week to all regional health directors and medical superintendents outlines steps to cut back services and freeze personnel levels in the TB prevention, mental and family health service programmes.

Dr J de Beer, Director-General of the Department of Health, Welfare and Pensions, says in the memo that inflation problems have prompted the department to take strong action to curtail spending.

He says services are being cut back or ended "only in those departments in which damage would be minimal".

Yesterday Dr Marius Barnard, Progressive Federal Party spokesman on medical affairs, slammed the cuts and said the nation's health services were deteriorating rapidly.

"It is rather foolish to make cuts in preventive care programmes, as these specifically save money for the State in the long run," he said.

The cuts will also have a serious effect on the mental health services, where the Government's measures include cutting off applications for financial aid for mentally-handicapped patients at home.

In the Johannesburg area alone, an average of 200 black homes a month will not receive aid unless they applied for it before last March.

Thousands of these "single-care" applications for mentally-retarded patients have been held back since March because the Department of Health has frozen funds, according to an executive member of the Mental Health Society in Johannesburg.

Single-care funds are R100 a month for white guardians, R20 for blacks, and R50 a month for coloureds and Indians.

In addition, psychiatric out-patient levels are frozen at the 1980 level — meaning no new psychiatric out-patients may be accepted except when previous patients vacate programmes.

In the TB prevention programme the Government has ordered that:

- The "wonder" drug rifampicin may only be dispensed at the same level as last year;
- No mobile X-ray units may be bought except to replace existing units.

Family care programmes will be hampered, because from District Surgeons to out-patient clinics and to individuals will be curtailed.

In the dental care services, information and preventive services will be kept to a minimum.

All present vacancies for health inspectors at local level are frozen and may not be filled without prior Department approval.

The memo asks regional directors to advise local health authorities of the cutsbacks "in the most tactful way possible".
Govt cost cuts seen as hazard to health

By CLIFF FOSTER
ALL regional health directors are being ordered by the Government to enforce spending cuts in major services, and the Eastern Cape, which has escaped the worst of the hospital crisis so far, is going to be affected along with all the rest.

Services to feel the axe are TB prevention, mental care, and family health programmes.

Blacks are likely to suffer most.

The cuts are retroactive to the beginning of the year.

Col W E Hawkins, secretary of the Port Elizabeth branch of Santa, the TB association, said the cuts would prove to be a false economy because reducing preventive care would result in a rise in the number of cases.

"People suffering from TB will be passing it on to others all the time," he said.

The branch's Santa hospital at Bethelsdorp is "bursting at the seams", he said. "We are a 300-bed centre and we are running at an average of 400 patients.

"This is caused to some extent by the country districts sending us patients they can't handle for proper treatment."

The branch, he said, had applied recently for Government funds to expand the hospital but this had since been rejected.

The regional health director for the Eastern Cape told the Weekend Post today he had not yet received a copy of the directive.

When he does he will learn that in the TB-prevention programme, the Government has ordered that:
- The "wonder" drug, rifampicin, may only be dispensed at the same level as last year.
- No mobile X-ray units may be bought except to replace existing ones. (Santa in Port Elizabeth does not have a mobile unit.)
- Family care programmes will be hampered because visits from district surgeons to outpatient clinics and individuals will be curtailed.
- In mental health services, measures include cutting off applications for the rest of the year for financial aid to support mentally-handicapped patients at home. (Single-care funds are R189 a month for white guardians, R69 for blacks and R82 for coloureds and Indians.)
- In addition, psychiatric outpatient services are frozen at the 1984 level of increasing no new psychiatric out-patients may be accepted except when previous patients vacate programmes.

In dental care services, information and preventive services will be kept to a minimum.

All present vacancies for health inspectors at local level are frozen and may not be filled without approval.

The cuts have drawn a sharp reaction from Dr Markus Barnard, PFPA spokesman on medical affairs. He slammed the proposals and said the nation's health services were deteriorating rapidly.

"It is foolish to make cuts in preventive care programmes, as they save money for the State in the long run. For instance, in the TB prevention programme, the cuts will cause more expense, the State in later having to treat more TB patients."

W. POST 18/7/85 85
State's health spending cut

JOHANNESBURG: A memorandum received on Thursday by all regional health directors and medical superintendents in the country advises large financial cuts to be made — retrospective to the beginning of the year — in the nation's TB-prevention and mental and family health service programmes.

Dr J de Beer, Director-General of the Department of Health, Welfare and Pension, warns in his memorandum A3/218/8 dated July 18 that because of the country's inflation problems, the department is taking strong steps to curtail government spending.

"Only in those departments in which damage would be minimal, are services cut back or ended," he said.

Dr Marius Barnard, PFP spokesman for medical affairs, criticized the cuts and said the nation's health services were deteriorating rapidly.

He said, "It is rather foolish to make cuts in preventive-care programmes, as these specifically save money for the State in the long run. For instance, in the TB-prevention programme, the cuts will cause more expense to the State later on, having to treat more TB-patients."

The most serious effect — besides the TB-prevention programme — will be felt in mental health, where the government has, among other measures, stopped financial applications for support of mentally-handicapped patients cared for at home.

In the Johannesburg area, a monthly average of 200 black mentally-handicapped will not be able to receive financial aid for their home care unless they applied for it before March 1981.

Thousands of these 'single-care' applications have been held back since March because the Department of Health has frozen funds, according to an executive member of the Mental Health Society in Johannesburg.

In addition, personnel vacancies have been frozen for the following health services:

- TB prevention.
- In this programme, the drugs must be dispensed under strict controls.
- Family Health Care Clinics.
  - All family-care programmes will be hampered because visits from district surgeons to out-patient clinics and individuals will be curtailed.

Dr J de Beer

Dr Marius Barnard

Dental Care.
- Requests for dentures will be considered only in the most necessary cases.
- Information and preventive services will be kept to a minimum.

Health Inspectors.
- All present vacancies for health inspectors at local level are frozen and none can be filled without prior Health Department approval.
- A final warning, all regional directors and medical superintendents are "seriously requested to personally see to it that these measures are strictly followed."

The memo states that regional directors will have to advise local health authorities of these cutbacks "in the most tactful way possible."

An executive member of the Mental Health Society in Johannesburg said the directive was "ridiculous" because it was issued in the second half of 1981 when most departments had already overspent the budgets for the first half.

"Especially in mental-health care, we work on a preventative basis, because our goal is to prevent mental patients from being hospitalized."

"This cut-down completely negates our service. We deal with at least six certifiable, while mentally-ill patients a week in the Johannesburg area alone who walk into the out-patient clinics for help.

"In black areas, an average of 12 severely mentally-ill patients daily are certified for hospitalization at out-patient clinics in the Johannesburg area."

No reply

"What is even worse is the complete curtailment of the single-care grants. In March, the 219 applications for single-care of black patients were not even replied to, and only in June did we hear that the money supply for these mentally-handicapped patients had dried up."

Dr G Viljoen, secretary-general of the Medical Association of South Africa, said last night that he could not comment on the directive before studying it.

No Department of Health officials could be reached for comment last night.
‘Horror births’ row over drug on sale in SA

BUT DOCTORS SAY ‘DON’T WORRY’ AFTER UK STUDY

A “PRETTY INNOCUOUS” anti-nausea drug, said in Britain to be the cause of horrible deformities in unborn infants, is freely available over the counter from South African chemists.

The medicine is a Schedule Two drug, Debendox, which is used to control morning sickness.

It is featuring in a Thalidomide-type row in Britain in spite of assurances from doctors and the findings of a medical study that it is “not specifically” the cause of malformation in babies.

A petition with 6000 signatures has been sent to Prime Minister Mrs Margaret Thatcher urging that the drug be banned. Many parents in the UK and America have started boycotting the drug, which opponents claim has crippled 2000 babies worldwide.

By CHRISTINA PRETORIUS

However, tests carried out by doctors and reported in the British Medical Journal, found that of 620 pregnant women given the drug only eight – or 1.3% – gave birth to a malformed infant. Of 22,337 women not given the drug, 467 – or 2% – gave birth to malformed babies.

Nevertheless, a Debendox Action Group has been started in England to get the drug banned. It has been reported that about 500 British parents are suing the American manufacturers for R300-million following the births of their malformed infants.

The British Committee of Safety in Medicine feels that prospective mothers “are probably safer not using Debendox”.

“Although there is no proof that the drug is directly responsible for the babies being born deformed some people believe there is a connection,” said a spokesman for the committee.

“Doctors are probably better not prescribing it during pregnancy.”

But the South African manufacturers of the medicine, Meridian National, claim the drug to be 100% reliable.

“There’s absolutely nothing wrong with it,” said managing director, Mr Jack Lipworth.

“All this fuss about babies being born crippled is a load of nonsense.

“We don’t have a high turnover in the drug but neither have we received any complaints about it.”

A spokesman for South Africa’s Pharmaceutical Society felt the drug was “pretty innocuous”.

“When all the fuss broke out over the drug in England and America we went into its merits very carefully and couldn’t find a single reason to ban it in South Africa,” he said.

“It is absolutely reliable and has a proven track record. We simply can’t consider taking it off the market,” he said.

Mrs Valerie Alexander, chairman of the British Debendox Action Group, took the drug and gave birth to a child whose arms ended at the elbows.

Mrs Alexander is responsible for the petition which has been sent to Mrs Thatcher.

“A lot of people have suffered because of the drug and we want to put an end to the horror by having it banned,” she said.

Debendox... could it cause deformities in babies?
Death lurks on the back of those transport trucks

BY SAVVAS GEORGIADES

DANGEROUS chemicals which could wipe out whole cities were being transported on South African roads without any regulations to control their movement. Fifty containers of an extremely deadly insect poison, Demeton, disappeared last week from the back of a truck, near the Ben Schoeman Highway. More than 100 containers are still missing. One spillage of this substance could prove fatal. The poison can be absorbed easily, through the skin, or by inhalation.

Mr J C Hillman, senior research officer of the South Africa Transport and Road Research, said the institute had been asking for years for legislation to control the transportation of hazardous substances. He said there were insufficient controls and legal requirements to restrict such transportation to competent, properly equipped and responsible operators.

Independent ombudsman Mr Eugene Roelofse said the loss of the 100 poison containers highlighted the need for stringent controls. "Tests of poisonous chemicals are transported on South African roads and nothing is done to regulate how they should be transported," he said.

Mr Roelofse said one truck carrying hazardous substances could destroy a city if the truck was involved in an accident. "Poisons in terms of 'The Road Transport of Goods Act' should be transported only in a 'safe' way," he said.

The Minister of Health, or his department, should have the power to draft regulations since 1972. "I think the minister should be allowed to give thought to the huge amount of poison that can be shipped in whatever fashion the minister chooses, without warning being given to the public," he said.

Mr Roelofse said manufacturers should apply voluntary controls.

A spokesman for Sanitation Chemicals said 11 of the 150 containers which fell off the truck were still missing. As far as the company was concerned everything had been done to ensure the safety of the containers. A White supervisor had seen that they were secure - bolted and that a tarpaulin had been properly fastened over the load.

Mr Roy Ross, head of the Automobile Association's road traffic affairs section, said: "We are not very happy about the transportation of chemicals and have been representations about badly stacked goods in the back of the truck." He said a Hazchem code placard displayed on the side of the truck helped minimize the danger as the series of symbols and numbers could be translated by Police, fire or traffic officers enabling them to take the necessary action in the case of accidents.

A spokesman for the Department of Health admitted there were no regulations controlling the transportation of poisons. The department, in conjunction with the transport companies concerned, was however, considering regulations and their enforcement, he said.

In a document published in April this year, Mr Hillman warned: "The increasing use of dangerous chemicals and petroleum products by South African industry makes it necessary for some form of control to be introduced in order to regulate the transport of poisons before a major disaster occurs, such as happened in Europe.

"Many of these substances are hazardous to man or his environment and the quantities currently being transported by road through our cities have exposed our society to the very real risk of a major disaster." The transport of two classes of hazardous substances is controlled by South African law. These are explosive and radioactive materials, which are subject to the Explosive Act No 26 of 1958 and the Atomic Energy Act No 90 of 1957 respectively.

The Acts strictly control manufacture, storage, handling and transportation of these substances and are actively enforced.

Flammable liquids are subject to control by municipal bylaw.

Mr Hillman said the Road Transportation Act of 1977 and the growth in industrial demand for transport services had increased the likelihood of accidents becoming involved in this field of transportation.

"Any member of the public can buy a package and subject it to a restricted hazardous substance, including the carriage of hazardous materials except flammable liquids," he said.
65 down with typhoid at mine

Sixty-five people were taken to hospital after an outbreak of typhoid fever at the Kloof gold mine near Westonaria.

Doctors say the disease was prevented from spreading.

Goldfield's public relations officer, Mr. Joe Moller, told The Star: "The outbreak started at the beginning of this month but has been brought under control and the source of infection has been removed."

Mr. Moller declined to name the source of infection but said 18 of the 65 people had since been discharged from hospital.

Mining sources said the most likely source of typhoid fever would be unpurified water from the Vaal, which is used underground as service water.

While clean drinking water was provided at all levels on gold mines it was not unusual for workmen to drink the service water because it was more easily available, they said.

Although chlorinated the service water was not sterilised and germs could find their way into underground working places.

Doctors at the mine said the disease was prevented from spreading because it was contained within the mining compounds and the hospital.
Health cuts will save only R2m

CUTS in the Government’s health budget will affect more than 900 000 patients, yet the savings will amount to no more than R2 million, say spokesman for the various services affected.

The cut-back directive created a stir at local and Government levels and the Department’s officers are holding an urgent meeting in Pretoria this morning to discuss its implications.

According to a Department of Health memorandum – sent to regional health directors and medical superintendents country-wide – health jobs in TB prevention, mental and dental health services and family service programmes are frozen.

Services have been frozen at 1980 levels despite the effects of inflation.

Dr Marius Barnard, Progressive Federal Party spokesman on medical affairs, called the cuts “rather foolish”.

**Thousands**

“It would be better if the Government concentrated savings attempts on fields where only a few patients were affected. The present cuts will affect many thousands of patients of all races,” he said.

“For instance, they should avoid duplication of services in the same area – such as the additional R1 500 000 heart unit at J G Strijdom, when one is already available at the Johannesburg Hospital.”

In mental health, the total amount spent for single care grants for home care of mentally handicapped patients was R1 620 000 in 1980.

Mental health clinic officials said more than 2 000 black patients in the Soweto area alone were on an application list for these grants – now frozen for all who applied after March this year.

By freezing these grants R1 500 000 was saved.

Last year’s total of 667 922 psychiatric out-patient visits may not be exceeded, although more patients were treated in the first six months of this year than last year.

In the TB programme the drug Rifampicin – used extensively for last year’s 11 999 patients – may not be used in greater quantities than it was in 1980.

**Doctors**

Doctors prefer this drug. Although it costs three times as much as other drug combinations, it sterilises lungs much quicker and therefore saves money in hospitalisation costs.

A TB specialist at the Medical University of Southern Africa, Professor E Glatthaar, said a 3-drug combination must usually be given for not less than four to six months, as patients quickly developed a resistance.

“That’s why Rifampicin is so marvellous. It sterilises the lungs much quicker – within six months or less – as opposed to other drugs taking perhaps six to nine months.

“The cost for rifampicin is R100 per patient care as opposed to the total cost of R100 for the other kinds,” he said.

But these figures do not take into account the longer hospitalisation required.
confidence in the Health-Centre concept.

The location of these Health-Centres was mainly socially or geographically underprivileged communities, in accordance with the recommendations of the Nuffield Provincial Hospitals Trust. They were usually unable to pay for their medical care and had a great lack of basic medical infrastructure.
Die volgende konsensusontwerpe word hierdie week in algemene inheering en kommentaar gepubliseer. 

Komentaar daarop en vertoë deurontwerp moet voor 31 Augustus 1981 aan die Directeur-generaal: Gesondheid, Wesyn en Pensioene, Postbus 579, Kaapstad, 8000, gestuur word.

(a) Wysigingswetontwerp op Gesondheid, 1982;
(b) Wysigingswetontwerp op Vuegselskywing en Sterilisasie, 1982;
(c) Wysigingswetontwerp op Apotheke, 1982.
Minister rejects medical fees hike

Mail Reporter

The Minister of Health, Dr L A P A Munnik, has rejected the South African Medical and Dental Council recommendations for increases of 25% in dental fees and 50% in physiotherapist fees.

The recommendations, made in April, have been referred back to the council for further consideration. The Minister, it is understood, was not satisfied that the motivation for the increases was strong enough.

According to a spokesman for the council, the diet and physiotherapist fee subcommittees were meeting to review the extent of the increases. They would report to a full council meeting in October after which a fresh submission would be made to the Minister.

This means that increases in the tariffs could be delayed until the end of the year, as the Minister is given three months to respond to any application for fee hikes.

Last month Dr Munnik acknowledged increases of 30% in doctors' fees. But here, too, he said the Minister was not satisfied and referred the application back to the council.

Not only did the Minister question the extent of the increases asked for, but after having agreed to them, he delayed their implementation until September 1.

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Professorial Prize

The highest marks in the subject obtained for the Surveyors' Prize Cape Chapter of Quantity Surveyors' Key 2001 was obtained by M T Butler, of the University of the Western Province.

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Surveying Quantity
Let us be honest and state clearly that better health through preventive health education lies in the hands of those members of a health team who have cared for and cured the patient in the past. They are the people that have the credibility and the trust and the confidence of the patient. Consequently increased expenditure in the preventive field should be to those people in the community who practice comprehensive medicine curative and preventive and can apply it. Dr. David Sone's essay on 'Primary Prevention' by Nuffield Provincial Hospitals Trust concludes that isolated schemes are unproven and expensive except immunisation.

THE FUTURE
What of the future?

I would like to see our new and highly enlightened Health Act fully implemented as soon as possible with a unified curative and preventive service run from community health centres.

I would like to see medical administrators who were health and community orientated as well as disease and hospital orientated. I would like to see medical administrators who were trained in this field and not just failed clinicians. I would like to see proper training facilities for those who work in the community. In our free contraceptive services, mankind now, for the first time, has the power to control his destiny. I would like to see communities accountable for their population growth and those that show responsibility receive the benefits due to them.

IN CONCLUSION
The role of modern medicine should be to help us safely into this world and comfortably out of it during life to protect the well and care for the sick and disabled.

It has been said that historians of 20th century medicine might easily be overwhelmed by the spectacular break-throughs and technical wonders wrought by the fruitful marriage of medicine and the scientific method, and overlook some of our human and equally difficult accomplishments in the organisation and delivery of health care. The use of health teams may well come to rival our brightest technological triumphs by the way they have gone about changing attitudes to health, by mobilising communities at the grass roots, activating them in decision making and self care.

Our society now believes, amongst other things, in the probability of death and the personal responsibility for it. Dying is now a social issue and the organisation of the dying is a social responsibility, not a medical one. It has been said that no society can be made healthy until it accepts this responsibility for the sick and the dying. The dying of an old person is not a medical tragedy, it is a life event in the life of a community and the community has a responsibility for it. The organisation of the dying is an important part of the organisation of the sick, both of which are important parts of the organisation of the community.
Political changes ‘key to SA health’

Medical Reporter

The health of people would not improve unless South Africa saw political and economic changes, the organisers of the University of Cape Town’s medical students conference said last night.

“Health in South Africa is not simply a result of infections by bacteria, it is a product of the country’s economic development,” they said in a paper presented by one of the conference organisers, fourth-year student Mr David Goldblatt.

South Africa’s two biggest health problems were tuberculosis and malnutrition, with black people contracting 58 percent of TB cases.

“Black South Africans bear the brunt of all diseases,” said Mr Goldblatt.

DEATH RATE

The probability death rate for black babies was up to six times higher than that of white infants, he said.

Another speaker, Dr Nobby Jinahbhai of the Durban Medical School’s community health department, said local health services were divided artificially and fragmented by complex legislation.

The Health Act of 1977 had aggravated this fragmentation.

Both Dr Jinahbhai and Dr John Frankish, of Heidelberg Hospital, agreed that South Africa’s health services had been affected by a majority of patients not having a say in decision-making processes that affected such services.

MORE STAFF

“I am sure that if local communities were consulted they would want more medical personnel at day hospitals,” said Dr Frankish.

Day hospital doctors each usually saw between 70 and 80 patients daily which meant: on average consultation could last five minutes only.
LIFE ASSURANCE

Hearty gains

The contributions of the life assurance companies to campaigns combating premature death from heart disease could be reaping rewards.

Fewer insured people died of heart diseases in 1980 than in 1979. According to the Life Offices’ Association of South Africa’s annual review of life insurance cover, there were 7,766 claims for death resulting from cardio vascular disease, which is 2.4% fewer than 1979.

A possible reason for this slowdown in heart deaths is the greater public awareness of the contributory factors to coronary disease. The review points out that “considerable financial and other support to the campaigns to fight heart disease has been provided on an individual basis by member companies.”

The main causes of death recorded by the eight largest life offices during 1980 (with 1979 figures in brackets) are as follows:

- Cardio-vascular diseases 46.4% (48.8%);
- Violent deaths 14.9% (15.4%);
- Cancer 13.4% (14.2%);
- Respiratory disease 8.1% (6.8%);
- Other causes 17.2% (14.8%).

As the table shows, the rate of increase in group and pension business dropped back sharply to 16.2% from 44.1% in 1979. The Association says that the 16.2% is closer to real growth in new pension business. In 1979 and to some extent in 1978, numerous private pension funds came into the ambit of the assurance industry thus grossly exaggerating the growth figures. A spokesman from the Association says that in future the review will probably separate the two figures.

The marked increase in individual ordinary premiums of 25.3% (13.4%) is attributed by the Association to the growing popularity of life insurance policies as a means of investment.
The two major Government to control:
1. Export-market dealing, etc.) is tax 75 per cent. The increased by 9 per cent or more than 100 per cent may be at best, therefore tax rate of 40 per cent.

The basis for export sales year worked on the average.

2. Sales tax and export refundable and can be the exporter. This includes in the manufacturing.

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(Excluding the MRC)

Yes.

**EXTRACT FROM LETTER FROM THE INDUSTRIAL DEVELOPMENT CORPORATION TO MR A. MENDELSOHN**

... Should you wish to move your factory to Darling, where the Industrial Development Corporation are planning to erect a set of factory flats, you may qualify for the decentralization concessions of the Board for the Decentralization of Industry, Pretoria.

Whereas Darling is at present not officially classed as a decentralized growth point by the Department of Planning, the Decentralization Board may consider granting you concessions on an ad hoc basis, with your case being considered on its individual merits. You should in the first instance, therefore, apply to the Decentralization Board for decentralization concessions, which to our knowledge of the policy of the Board, are likely to comprise the following:

1. **INCOME TAX CONCESSIONS:**

   Your income tax payable will be reduced by amounts equal to the following percentages:

   (1) 40 per cent of total wages paid to all or additional Blacks employed by you over the first two years after establishment at Darling.
Small families first priority, says Loubser

Provincial Staff

THE quality of life of all people in South Africa will have to be improved on a broad front if the authorities envisage health for everyone, the MEC in charge of hospital services, Mr P J Loubser, said yesterday.

V.C. MAINE

Introduction

These notes are based on a preliminary Mrs Anne (Bailen) Zurne on 15th April (30th April and 20th May 1980) and a s during this period. The tapes have been material deposited with the Department Cape Town. The tapes give insights in Six, its shops, streets and celebration happened to Russian Jewish immigrants

Anne Zurne was born in 1907 - second c and Esther Bailen. What is told here story. Hyman Bailen - born in Omsk in the Tsar's army, who left Russia for the 1890s. Anastasia (known as Esthe country) was also a Bailen, a cousin was born in Tomsk in 1881, became sew in Siberia, and was sent by her parent 1900, when their community was threat

Had the way been paved by other family, for the Bailens were connected to the Pol renown, and others. In time to come, sister followed, but lived in Lourenc husband was established. It is not to District Six, or what employment he look up on his arrival.
MEDICINE IN CRISIS ... AND THE YOUNG ONES CONTINUE TO DIE

Every second African and coloured person who dies in South Africa is a child under five, says one of the country’s top medical men, Professor Solly Benatar. This striking statistic has been revealed by Professor Benatar in his inaugural address as head of the University of Cape Town department of medicine, as part of a devastating analysis of the state of health care in the country.

Groote Schuur Hospital ... serious damage was done by inadequate budget increases

Tribune Reporter

Reflects a trend in developing countries where over-promotion of drugs, many of them with little therapeutic value, attracts expenditure on these by people who often do not have enough money to feed themselves.

"In 1978 only 2.2 percent of the allocated health budget was spent on preventive medicine and this was increased to 2.85 percent last year. This was still highly inadequate, but additional funds alone would not solve the problems," he said.
He is also head of the division of medicine at Groote Schuur Hospital.

He says the high number of "black" and "coloured" children dying is a "sense of great concern", especially as the figures for whites compare favourably with those in America.

Other important points he made include:

- The percentage of the Gross National Product spent on health declined from 4.2 percent in 1950 to 2.4 percent last year and is now only a third of the percentage spent in America, Germany and Sweden.

- Serious damage was done to Groote Schuur Hospital by "clearly inadequate" budget increases in the late 1970s and while the Cape Provincial Administration had realised the serious consequences of the cutback, this would take a long time to repair.

- Morale dropped, and many senior staff left for more satisfying and financially rewarding work in the private sector or overseas, and had had to be replaced by more junior staff, whose further training would take a considerable amount of time.

- While only 7 percent of government expenditure went to health services, 18.5 percent went to defence.

- The cost of one tank could provide a thousand classrooms for 30,000 children and that of a modern jet fighter could be used to finance 40 village pharmacies.

- Professor Benatar said the majority of resources were spent on curative services in the towns, so many people in the lower socio-economic groups, living beyond the confines of major cities, were still dying prematurely of infective and other preventable diseases.

- Less than 2 percent of health expenditure in South Africa was on research and development, compared to 19 percent in America, while a disproportionately large 21 percent was spent on drugs and pharmaceuticals in this country, compared to 8 percent in America.

- This high percentage of the health budget spent on drugs and pharmaceuticals

"Dr Johann de Beer, Director General of the Department of Health, Welfare and Pensions, has recently announced that this percentage will be steadily increased annually over the next 20 years and by the year 2000 will constitute 15 percent of the health budget.

"Within a few days of this announcement a memorandum was received by regional health directors and medical superintendents throughout the country, informing them that large financial cuts would be made in the nation's tuberculosis prevention programme as well as in mental and family health service programmes.

"In view of the very high incidence of tuberculosis in South Africa this is not only totally inappropriate, but also irreconcilable with the apparent increased expenditure being devoted to preventive medicine."

Professor Benatar says that if we continue to spend less and less of our Gross National Product on health and at the same time increase the proportion of the total preventive medicine, we must recognise that our curative health services will inevitably deteriorate.

"New district hospitals will not be built at the rate required to cope with the growth in population and teaching hospitals will have to take on even greater work load, and thus function more and more as service district hospitals.

"Teaching standards will be eroded, the quantity and quality of research work being done in our medical schools will fall, and the quality of general care, which has been notable in our teaching hospitals, will also deteriorate.

"A careful look at the use of our currently available scarce facilities in South Africa will show that these are already being stretched to their limits."

He adds: "There is no doubt that the medical profession, particularly in the modern westernised society, is facing a crisis characterised by rising costs of health care and criticism of doctors lack of compassion and humanity, their arrogance and narrow education."
There IS a crisis, Dr Munnik!

Health services facing collapse, Govt report warns

By HELEN ZILLE

SOME health services are threatened with collapse by serious staff shortages, the Department of Health, Welfare and Pensions warns in its annual report tabled in Parliament yesterday.

The warning comes less than a week after the Minister of Health, Dr L A P A Munnik, denied there was a serious shortage of nurses and described the situation as a "so-called" crisis.

In sharp contrast, the report of his department for the past year warns it will not be able to meet its commitments "even on the basis of minimum efficiency", because of the serious staff shortages.

Shortages of nursing staff and health inspectors have reached serious proportions, it says.

"As a result of the staff situation, essential services for which the department is responsible are being rendered unsatisfactorily, and certain services run the risk of collapsing."

The report says staff shortages reached "dramatic proportions" towards the end of last year, and Dr Munnik, Opposition spokesman on health, said yesterday that according to his information, the situation had deteriorated since then.

Dr Munnik attacked Dr Barnard for "devoting a large portion of his speech in Parliament last week to attempting to show there was no serious nursing shortage."

"Instead, he said the position was due to surplus hospital beds for whites," Dr Barnard said.

"Either the Minister is wrong, or his department and the country's leading doctors are wrong.

Prove it"

...he said it was up to Dr Munnik to prove his competence..."and if he cannot, he should resign or be replaced."

At the Cemara Debate last week during the Cemara Debate, Dr Munnik said he wished to analyse the "so-called crisis."

In the Cape Province, 99% of the existing posts were filled. "Is this a crisis?" Dr Munnik asked the House.
Infant mortality

Dr. M. S. Barnard, Minister of Health, Welfare and Pensions.

What was the infant mortality rate for (a) Blacks, (b) Coloureds, (c) Asians and (d) Whites in the (i) urban and (ii) rural areas of South Africa in 1980?

The Minister of Health, Welfare and Pensions:
Data is not yet available for 1980.

Example 2: Price

This raises the problem of depreciation and depreciable assets. The problem does not arise if the leased asset is a capital asset because the lease is not an agreement to purchase. The payments would be charged against the lease benefit. The payments were front-end loaded, portion of the lease benefit was not recovered in the first year. This is an important point in the determination of the lease benefit that the lease payments be charged against income in such a way as to be consistent with the matching principle.

Reasonable doubt, 16 years.

Exercise of which is assured beyond the term and a reasonable period exists, the lease exists which may be extended from the owner of the asset. The lease is of longer term than the period over which the payments are spread.

(a) Where the initial term of the lease is shorter than the period over which the lease payments are spread.

(b) Where the lessee has to make payments equal to the annual payments into use.

(c) Where the initial term of the lease is longer than the period over the term of the lease.

The following examples -

Fallout to match costs against revenue, and others.

ED22 notes that if lease payments are expressed as a fixed amount plus a percentage of turnover. The expression of such amounts is understandable since they do not represent a firm commitment.
High medical cost a health threat

Science Reporter

THE nation's standard of health is threatened by soaring costs of medical care, the heavy workload on health-care personnel and the lack of facilities in rural areas, according to Professor A J Brink, president of the Medical Research Council, in his annual report.

The report, tabled in Parliament yesterday, said that research in the past had made real contributions to the prevention and treatment of physical illnesses.

This expertise could also be successfully directed to improving the ability of the medical profession to help the patient in need.

The Tuberculosis Research Council was currently testing a number of new drug combinations aimed at the reduction of treatment time. About 1 000 patients had taken part in a trial of the drugs and the majority had been cured within four months. Seen against the annual state budget of R58m, this represented a major saving.

The problem of relapse and readmission to psychiatric hospitals in South Africa was being investigated by the MRC's unit for research into clinical psychiatry based at the University of Cape Town.

This was a national health problem as readmissions to psychiatric hospitals were about 60 percent. Factors such as family pressures, psychological and social problems and failure to take prescribed drugs had already been identified but more information was needed to enable specific action to be taken.

At Garenstraat Hospital an MRC-supported project was investigating a nutrition education programme for mothers of under-nourished pre-school children admitted to hospital. It was hoped that the education programme, tailored to the family's resources, would help to lower the readmission rate.

Other studies which had looked at outpatient waiting times in large hospitals had identified bottlenecks in patient flow.

Links aid research

Science Reporter

INTERNATIONAL co-operative agreements arranged by the Medical Research Council have proved of great benefit to medical research in South Africa.

An agreement with the Israeli National Council for Research and Development is working well - so far three scientific meetings in cardiology, immunology and infectology have been held with prominent scientists from both nations taking part. A further meeting has been arranged for March, 1982 in Cape Town.

The theme of the meeting will be the medical care of children, with emphasis on the newborn - an area of mutual concern in both countries. According to Professor A J Brink, the MRC's president, a joint research programme particularly in coronary heart disease would be of great advantage.

Other agreements with overseas agencies have enabled the MRC to provide sophisticated services for medical research which would not have been possible because of high costs.

A computerized biomedical information service, which at the press of a button gives access to thousands of medical publications throughout the world, is an example.

Centre aiding cancer studies

Science Reporter

CONSTRUCTION of the R16-million Nuclear Accelerator Centre in the Cape has reached an advanced stage and is already an aid in cancer research, Dr P D R van Heerden of the Medical Research Council said yesterday.

According to the MRC report, the Nuclear Accelerator Centre at Faure, on the outskirts of Cape Town, is one of six similarly sized centres in the world but is unique in that it has a triple function - basic research in nuclear physics, manufacture of radio-isotopes for use locally and abroad, and applications in the biomedical sciences. The centre will give new hope to cancer sufferers and a 30-bed hospital is to be built nearby.

Preliminary tests at the centre are expected to begin in 1984, the report said.
Hypertension - a big killer in the townships

Severe malignant hypertension is 'extremely common among urban blacks, etc.,' the Medical Research Council said.

The findings of Dr. B. D. Miller of the University of the Witwatersrand, who documented the prevalence of hypertension in black patients admitted to a Johannesburg hospital.

A quarter of the patients taking part in the test died and 60% needed hospital treatment.
Shift is to preventive medicine, says MP

HOUSE OF ASSEMBLY. — The government intended solving most of the country's health and social welfare problems through good co-ordination, planning and the establishment of community health-care centres, Dr W J Snyman (NP Pietersburg) said yesterday.

He said during the debate on the budget vote of the Minister of Health, Welfare and Pensions, Dr L. A. F. A. Munnik, that the intention was to shift the accent from curative to preventive medicine, and this year's budget showed an increase of R130 000 for the treatment of diseases related to malnutrition.

He said that in an earlier speech in the Assembly, Dr Marius Barnard (FDP Port- town) had stated that 50 000 people were dying every year from diseases related to malnutrition.

"These figures are wrong and are clearly an effort to bring South Africa's medical services into discredit in the eyes of the world."

The official figure for all population groups in the country was 3 185, and Dr Barnard could have obtained these figures had he approached the Department of Health.

Dr Snyman said he favoured the fluoridation of drinking water in South Africa, pointing out that there was proved evidence that it prevented tooth decay.

Arguments that the fluoridation of water resulted in diseases such as cancer, loss of concentration and intelligence and an increase in the incidence of mongols, were unfounded, he said. — Sapa
1. In hierdie Bylae, ten spyte van die samehang anders blyk, beteken "regulasië" die regulasië opgestel deur die Minister van Gesondheid, Welsyn en Pensioene, op aanbeveling van die Suid-Afrikaanse Geneeskundige Raad, in 1974, as veral geneeskundige praktisië, die volgende omskring in te voeg:

"die Wet" die Wet op Geneesheer, Tandarts en Aanvullende Gesondheidsdienskundige Gedrag, 1974 (Wet 56 van 1974).

3. Opmerking (3) van die opmerkings by regulasië 4 (3) word hierby geneesheer deur die woord "drie" in die derde reël te vervang deur die woord "ses".

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**SCHEDULE**

1. In dieselfde Suid-Afrikaanse Geneeskundige en Tandheelkundige Wet, 1974 (Wet 56 van 1974), en het enige uitdrukking waaraan 'n betekenis in die Wet geheg is, d Rudd betekenis en ten spyte van die samehang anders blyk, beteken-

"artikel" in artikel die Wet.

2. Registrasieegel betaalbaar kragtens die bepaling van die Wet is soos volg:

(a) Deur 'n geneesheer of tandarts wat voldoen het aan die bepaling van artikels 24, 25, 26 of 27; R75.

(b) Deur 'n student, student-interim, intern, seldskundige, intern-seldskundige of 'n lid van 'n aanvullende gesondheidsdienskundige Gedrag; R10.

(c) Deur 'n seldskundige of tandarts vir die registrasie van 'n seldskundigheid; R100.

(d) Deur 'n persone wat kragtens artikel 35 'n adisonele kwalifikasie registrē; R10.

(e) Deur 'n geneeskundige tefnoloog, radiografis, psigotegnisk of seldskundige vir die registrasie van 'n adisonele kwalifikasie in die betrokke beroep; R10.

3. Geld betaalbaar kragtens die bepaling van die Wet vir terugplaas van 'n naam op 'n registreer, is soos volg:

(a) Deur 'n geneesheer of tandarts—

(i) naam teruggeplaas kragtens artikel 19 (5): R50;

(ii) naam teruggeplaas kragtens artikel 42 of 51: R75;

(b) Deur 'n seldskundige of lid van 'n aanvullende gesondheidsdienskundige Gedrag—

(i) naam teruggeplaas kragtens artikel 19 (5): R10;

(ii) naam teruggeplaas kragtens artikel 42 of 51: R10.

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**THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL—REGULATIONS RELATING TO THE FEES PAYABLE**

The Minister of Health, Welfare and Pensions has, on the recommendation of the South African Medical and Dental Council, in terms of section 61 (1) (e) of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974), made the regulations set out in the Schedule hereto.
Political Staff

HOUSE OF ASSEMBLY. — Professor A. M. Brink, chairman of the Medical Research Council, has said that the health of all South Africans is being affected by certain problems connected with the provision of health services.

Writing in the council’s annual report tabled yesterday, Professor Brink said there was "an overwhelming need to undertake research on the delivery of health care".

He also said the country had lost "numbers of our best scientists". However, younger scientists were showing considerable promise and encouragement to research concerning specifically the health problems of South Africa.

The soaring costs of medical care, the growing need to provide health facilities in many rural communities, the increasing workload placed on the available healthcare personnel and critical problems affecting the standard of health of all South Africans, Professor Brink said had been overcome by the involvement of the council and researchers who would help to ensure that the health needs of South Africans could be met.

On an interview, Professor Brink said it was worrying that South Africa was losing so many of its best scientific researchers, because of limited professional structures and research fields.

It was hence necessary, he said, to travel overseas and encourage as many men of research who had left South Africa. Most of them had left for professional and not political reasons.

It was a great blow to South Africa, he felt, that brain power and at the same time it was costing the country a lot of money.
Munnik talks of 'total health' idea

HOUSE OF ASSEMBLY. — The Budget vote on Health. Welfare and Pensions was passed yesterday after heated debate over the government's pension policy.

The minister, Mr L A P A Munnik, said during the debate that in future his department would try to bring home a total health concept to the population.

He announced that his department would be distributing a booklet to the aged in October dealing with healthy diets and the promotion of health in general.

"The question of how we eat is important and we must tell the people that they can eat well and healthily at a reasonable price."

"We must base our dietary needs on the requirements laid down by the World Health Organization."

"If we eat better there will be less chance of coronary and other diseases." The minister said that the booklet, which would be distributed to the aged, would be followed up by regular pamphlets on health.

Dr L A P A Munnik said that many of the problems of health, welfare and pensions were at present being investigated by a commission.

The report of this commission, expected by the middle of next year, would probably be the most important in the medical history of the country.

He had asked the commission to bring out its report in sections and had already received the first. Details would be released as soon as he had studied them.

The government was concerned about the plight of pensioners who had been caring for themselves for years, but due to inflation were finding it increasingly difficult to make ends meet.

"A country which does not care for its aged has no future," the minister said.

The vote was approved.

SAPA

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Crackdown by health authorities

East Rand Bureau

A canteen at a Wadeville glass factory, four butchers, a cafe, a fish and chip shop, a bakery and a land development company have been fined for contravening Germiston's public health laws.

Consul Glass, Rossouw Road, was fined a total of R155 for:

Not keeping the premises and cooking utensils in a sanitary condition, failing to stock goods to allow adequate access for cleaning, failing to provide fillers in the canopy above the cookers, failing to provide approved towelling at the wash basin and failing giving a statutory notice.

Four Germiston butchers were fined a total of R330 for contravening the Food, Cosmetics and Disinfectants Act.

They are Olympia Butchery, Haley Street, Parkhill Gardens (R200); Parhan Butchery, Germiston South (R40); Checkers Meat Market, Klippoortjie (R40) and Central Butchery, Oosthuizen Street (R40).

Harris Fish and Chips Railway Street was fined R200 for failing to keep its premises in a clean condition and for disregarding a statutory notice.

Musical Cafe, Goldeneslys Road, Malvern East, was fined R70 for storing goods so as to preclude effective cleaning, employees failing to wear protective clothing and failing to keep protective clothing in lockers.

Alloro Bakery, Railway Street, Johannesburg, was fined R40 for not protecting food from contamination.

Tuckers Land and Development Corporation was fined R50 for disregarding a statutory notice.

All paid admission of guilt fines.

[End of document]
A burnt out case?

Government health services in SA are in a sick and sorry state. In the Transvaal alone, 20% of the 10,263 available white hospital beds are empty because of acute staff shortages, whilst all but the seriously ill are being turned away. Health services throughout the country are in a state of similar crisis.

Despite Health Minister Lapa Munnik's protestations to the contrary, the annual report of his own Department of Health, Welfare and Pensions warns that staff shortages have reached such serious proportions that "essential services run the risk of collapsing."

Yet private hospitals, where there are no staff shortages, are by no means full although their bed occupancy rates have increased sharply over recent years. In the Seventies, there was a boom in the building of private hospitals but probably not a profitable one. Nearly all pgy clinics built claim they lost money as bed occupancy rates were not as high as they had expected. For example, the original owners of the Park Lane in Johannesburg, built at a cost of about R5m, were forced to lease it to another group.

At present, 80 private surgical and medical hospitals offer 24-hour service nationally — supplying between 6,000 and 7,000 beds — but exact occupancy rates are unobtainable. Neither Munnik Finger, chairman of listed Amalgamated Medical (AMMED), owners of five clinics, nor Buxy Bloch of Clinic Holdings, owners of 13 clinics, is willing to disclose them.

However, according to John Randall, chairman of the Representative Association of Private Hospitals (RAPH), "private hospital bed occupancy rates now average 70% in direct contrast to 55-60% occupancy rates of the past few years."

This indicates that private hospitals are increasingly becoming alternatives to State institutions. Some believe that they offer a better service than the State, others are compelled to use them simply to obtain treatment. According to Dr Neville Howes, chief superintendent of the Johannesburg Hospital "only the most serious patients are being admitted. Others are being referred to private nursing homes and hospitals."

There is also a cost dimension to the issue. According to one clinic owner: "The average stay in a private nursing home is now four days, whereas in a State hospital it is 9.2 days. Private hospitals are definitely more cost-efficient than State hospitals."

But a shorter stay cannot simply be attributable to the high costs of private hospitalisation forcing a need for greater efficiency. The rapidly growing membership of medical aid (MA) schemes means that increasing numbers of people can in fact afford private hospitalisation. Presently, approximately 80% of white, 20% of coloured people and an increasing number of blacks are members of such schemes.

The demand for private medical facilities can be expected to increase due to rising incomes. A growing number of firms expanding fringe benefit programmes to include black members and a drop in the standards of State-supplied medical services.

Middle-income black patients or MA members will no longer pay up with the 200-300% overcrowding at Soweto's Baragwanath hospital with its consequent delays in care and attention. After a directive earlier this year by the Minister permitting private hospitals to admit black patients, they have been swift to respond.

Says Joseph Steyn, Registrar of MA schemes: "There are 251 registered MA schemes in SA, with 1,291,986 white members and 297,962 dependents. There are 418,191 black, coloured and Asian members with 243,143 dependents — 909,354 people."

A study undertaken by the PE Consulting Group SA — a private sector management consultancy — reveals sufficient demand from private paying black patients in Soweto to fill at least 100 beds and maintain a minimum of three operating theatres.

The survey estimates that at least 8% of all black patients treated can afford private hospitalisation. This suggests that if Soweto has a population of 1m, 100,000 can afford private treatment. So a 100-bed private facility there could in fact be underestimating demand.

The relative cost of private medicine has long been the focus of heated public debate. Yet Munnik has approved an increase of 9.9% in doctors' fees and a 5.5% increase in the costs of private hospitalisation from September 1. In addition, it is likely that contributions to medical aid funds will increase between 12% and 13% before the end of the year to keep pace.

The fact of the matter is that the cost of private hospitalisation is approaching market clearing levels. Therefore costs appear high mainly in relation to heavily subsidised State facilities which in turn bear little relationship to true cost. Fees at provincial hospitals are calculated according to a sliding scale determined by income. The average fee paid by a hospital patient is R2 per day, the top rate being R25 all-inclusive. Some patients without MA membership pay as little as R2 a day. However, a recent survey revealed that the actual cost of hospitalisation on a daily basis was R122.29 (a figure calculated over the period April 1980 to end-February 1981).

In private hospitals, where the cost of treatment has increased 26% since last year and is due to increase a further 10% from September 1, the daily bed rate alone is R135.50, excluding medication.

The cost of a bed is just the beginning. According to Medschemes' Keith Hollis: "At present, a three to four week stay at a private hospital for treatment of a coronary thrombosis costs between R1,000 and R1,500. This would include a possible one to five days in intensive care costing R80 a day. If the patient has had no surgery and is placed in a general ward, this would cost R25 a day for two to three weeks. Drugs are the major additional cost and could amount to R600 for a person hospitalised for one month."

These tariffs compare well with the cost of hospitalisation in other countries. For example, hospitalisation in Canada costs R291 a day. Netherlands R144. US R144 and Britain R144.

Last week Munnik announced that an investigation into the possibility of a differentiated salary scale for nurses was underway and that nurses might be given a special salary treatment similar to that recently given to teachers.

That may help. But at present white provincial hospitals continue to cut ser-
Covered Up

THE BIG

Patients struggle to get compensation
Medical malpractice in South Africa:

By Motien

The 1000

By Motien
Curbs set on local health services

PORT ELIZABETH — A drastic curtailment of the expansion of health services run by local authorities has been recommended by the Department of Health.

All vacant health posts with local authorities and subsidised by the department have been frozen and no additional staff may be taken on to run new clinics completed during the 1981/82 financial year.

Last night the Director-General of Health, Dr J. de Beer, said the money allocated to health this year was sufficient to maintain health services but not to expand them.

The purchase of medicines is to be strictly controlled and expenditure on high protein diets for tuberculosis patients is to be cut.

These are among the money-saving measures to be adopted in the Eastern Cape according to a circular distributed to local authorities by the regional director of health in Port Elizabeth, Dr J. D. Krynauw.

The cutback on funds for the Department of Health is in terms of the government's broad policy to curtail state spending as an anti-inflationary measure.

The measures to be adopted in the Eastern Cape, and which will vary only slightly nationally according to regional needs, came under sharp attack from the Progressive Federal Party's health spokesman, Dr Marius Barnard, who said the decision was a cause for great concern.

He warned that by freezing all vacant posts the already serious nursing staff shortage would be aggravated.

The circular says no vacant subsidised posts may be filled without the prior approval of the department. If this occurs subsidies will be forfeited.

The posts to be frozen include those of nurses and health inspectors.

Dr De Beer said last night that existing health services would not suffer.

The freezing of posts would affect "a few hundred jobs" nationally.

Referring to diets for tuberculosis patients, he said that while a diet needed to maintain the general health of patients would be administered, high protein diets could to some extent be eliminated because of the advent of the new and highly effective TB drugs.

Dr Barnard questioned a health policy which cut back on expenditure affecting largely low-income groups, terming them "preferential cuts".

State Health has provided funds for a subsidised feeding scheme as a stop-gap measure until tuberculotics receive disability grants, which can sometimes take several months to come through.

Because of employer prejudice tuberculotics invariably lose their jobs and have no other source of income. Concerned people have therefore condemned the cutbacks as self-defeating.

Doctors, nursing sisters and Santa officials were adamant that correct feeding was vital in TB treatment. One said: "There is little benefit from pumping drugs into a malnourished body."

— DDC.
It's the kids who die — professor

By Pamela Klein

Half of all deaths of South African coloured people and blacks occurred below the age of five, Professor Eric Wagstaff, head of Community Paediatrics at the University of the Witwatersrand, said this week.

Delivering her inaugural lecture at Wits, she said only seven percent of all white deaths happened at this early age.

Professor Wagstaff suggested that medical graduates, who choose to have exclusively white practices, should not be permitted because more than half all white deaths occurred after 65.

She said doctors needed to become experts in health education because destructive life styles were the root of half white deaths.

In her lecture — entitled “Child Health — Who Cares?” — Professor Wagstaff said infection and nutritional deficiencies were the major health hazards for the last minority of children in South Africa.

Although admissions to Baragwanath Hospital of children with malnutrition had fallen by more than a third in the past 10 years, there was cause for concern about child health in rural areas.

But there was a wide spectrum of malnutrition in southern Africa, ranging from overindulgence among the affluent to deficiency states in the disadvantaged.

She said while nutrition education was important it could achieve little without the availability of adequate food.
Fines for breaking health laws

East Rand Bureau

Two restaurants and a bakery have been fined for contravening Germiston's public health laws.

Vienna Forest Restaurant, Cross Street, was fined R50 for contravening the Food, Cosmetics and Disinfectants Act.

Hobani Restaurant, Dekema Road, Wadeville, was fined R20 for littering a vacant stand.

Olympic Bakery, McAlpine Road, Malvern East, was fined R50 for failing to protect food from contamination.

Other Germiston companies which have paid admission of guilt fines for contravening local public health laws are:

- Germiston Transport
- Brug Street, Elsburg (R30);
- Caledon Iron and Brass Foundry, Van and Brass Foundry (R100);
- Lingen Street, (R100);
- Turnsteel Precision Engineering (Pty) Limited (R100);
- Scrapping Iron and Metal Scrap Limited (R10).

Group, Stanley Road
Town's health threat confirmed

Argus Correspondent

HERMANUS.—Senior officials of the State Health Department have confirmed that conditions in the Zwelihle township here are appalling.

The conditions were described as a health hazard for the whole of Hermanus by the senior inspector of health in his report last month.

In a letter tabled at the town council's monthly meeting, the Health Department states that officials visited Zwelihle on September 2 and found that conditions were as described. They have assured the Hermanus Municipality of their support and they have also taken up the matter with the Western Cape Administration Board.

The minutes of a meeting held between senior officials of the board, the Hermanus Municipality and councillors early this month were also tabled. According to the minutes, the senior health inspector, Mr H. Reesw, said the township had received considerable attention since his report and was 'looking better.'

The council's medical officer, Dr J. Tate, said there was still a danger of an epidemic if present conditions continued.

It was agreed that the only way to solve the health problems in the township was to provide water-borne sewerage, which, according to the regional director of the administration board, Mr. B. Breunissen, would cost about R200,000—an amount which would be impossible to recover from the residents. The State would therefore be requested to finance this scheme.

The chief director of the Western Cape Administration Board, Mr. A.A. Louw, said if there was a health hazard in Zwelihle, it was no worse than in 1973 when the board took over from the municipality.

He said the board could not agree that 'little or no attention'—as reported by the senior health inspector—was paid to repairing facilities. The word 'inadequate' would be more appropriate.

The bucket sewerage system had always been inadequate. Informal quotations for additional toilets were asked for and, if approved, provision for one toilet for every six people would be made, he said.

Mr. Louw admitted that the condition of the toilets was poor but new doors and frames were being provided. The board also admitted that the toilets did not 'look good but, according to Mr. Breunissen, they were cleaned every 14 days.'
Premature deaths deplete work force

By Pamela Kleintal.

Premature deaths of black and coloured people from preventable diseases are a serious loss to South Africa’s workforce, says Professor C H Windham of the South African Medical Research Council.

Writing in the SA Medical Journal, Professor Windham said the proportion of man-years lost due to death in 1970 and 1976 was twice as high for coloureds and blacks as it was for whites.

Causes of death contributing to the difference in rates included tuberculosis, respiratory disease, intestinal diseases and malaria. More of these are associated with under-developed communities where undernutrition, lack of proper sanitation and overcrowded housing is found.

Professor Windham pointed out that, according to mortality rates, South African whites were less healthy than the population of England and Wales.

More than half of all deaths in the economically active age group among whites and Indians resulted from preventable diseases, involving diarrhoea, eye, skin and chest ailments, and the social diseases of modern living.

Professor Windham said entirely different health strategies were needed for white and Indian communities on the one hand, and coloured and black groups on the other.

Among whites one-third of man-years lost in 1970 was due to cirrhosis of the liver, stroke and accidents. 20 percent was due to accidents, 20 percent due to smoking, violence and accidents.

The situation was different for coloureds and blacks, the third of man-years lost was due to accidents. Among blacks 15 percent was due to homicides. Infection and parasitic diseases accounted for 11 percent — with 8 to 9 percent due to tuberculosis — and coronary artery diseases accounted for 11 percent.
MoH hits at low wages, poor housing

By NEVILLE FRANSMAN
Municipal Reporter

FARMERS in the Greater Cape Town area have been criticized by the Cape Divisional Council Medical Officer of Health, Dr L R Tibbet, who says in his annual report that poor living conditions and low wages continue to contribute to serious health problems among farm labourers.

He also warned that “we appear to be losing ground in the battle against tuberculosis in the coloured population groups”.

In his 1980 report on the Combined Health Control Scheme — which covers a vast area stretching from Cape Point in the south to Mamre in the north (excluding the Cape Town municipality) — he said the farming population of the Phillipi area was one of the most depressed, with no community resources whatsoever because of the scattered nature of the relatively small population.

Alcoholism and poverty were rampant, with poor nutrition and a very low quality of life.

Dr Tibbet added: “An attempt to motivate the employers (in Phillipi) has not been successful and required the right person.”

Referring to Constantia, he said: “Poor housing and low wages of much of the farm labour continues to contribute towards the problems of alcoholism, tuberculosis, child abuse and neglect and malnutrition, all problems in one of the country’s ‘wealthiest areas.”

‘Alarming’ VD

In the Durbanville area nearly 5,000 visits to clinics were made during the year because of venereal disease. A VD survey there had indicated “a most alarming incidence of 15.7 percent in the farming population of this area”. All steps had been taken to institute appropriate treatment and preventative measures.

Earlier in his report, Dr Tibbet said the unward incidence of syphilis in Durbanville was not surprising when taken in conjunction with the housing report on the farming areas.

Overcrowding was apparent in 46 out of 70 dwellings and with poor hygiene and sanitation, the ideal conditions for endemic syphilis and other diseases arise. Infestation of flies can only complicate matters.

“It appears that much more thought, work and finance must be put into housing and socio-economic conditions of farm labourers, not only in the Durbanville area,” he said.

Referring to the southern areas such as Noordhoek, Stellenbosch and Kommetjie, he stated: “The poultry farms, with much poverty and malnutrition, have fortunately been closed down.”

Kisselvlei was a particularly “socially-depressed area with many problems, including a high incidence of TB”.

Ravensmead was one of the most depressed areas and this was reflected in the high incidence of TB, meningitis and measles. A clinic venue in the Stoney Hill area was an urgent priority and there was a “crying need” for creches and pre-school centres.

Elsie’s River was “beginning to take shape” and “the fruit of long years of planning and industry is at last being borne”. Community activity is coming more and more to the fore.”
Whether any provision is made for financial assistance to be provided to passers-by who are injured as a result of political acts of terrorism; if not, why not; if so, what form of assistance is rendered in these circumstances?

The MINISTER OF HEALTH, WELFARE AND PENSIONS:

No, the matter falls outside the scope of functions of the Department.

Mr. G. B. D. McIntosh: Mr. Speaker, arising out of the hon. member's reply, is he not aware that there is at least one known case where as a result of a bomb exploding in Durban a family has been seriously distressed financially, and would he not consider working out something to assist innocent people who are injured as a result of such explosions?

The MINISTER: Mr. Speaker, as the hon. member knows, the necessary machinery exists in my Department. If somebody becomes unfit for work for some reason or other—e.g., if he is run over by a car or injured by a bomb explosion or whatever—he can apply for a disability pension in the usual way. I think that is what the hon. member has in mind, but I do not intend to make special arrangements to protect people who happen to be in the vicinity when a bomb explodes.
New health scheme for all SA

A SIX-TIER health facilities plan has been instituted to provide a comprehensive health service to all South Africans, the Minister of Health, Dr L A P A Munnik, said yesterday.

He was speaking at the opening of the Second Technocratic Exhibition at Groote Schuur Hospital, Cape Town. The exhibition was organised by the South African Association of Hospital Engineering Technicians.

The Minister said the health facilities plan comprised services such as the provision of basic needs - clean water, adequate food, clothing and housing — as well as health guidance and primary health care.

Other levels of service were provided by community, regional and academic hospitals. In the immediate future, more attention would have to be given to community-oriented health services, Dr Munnik said.

He called on the private sector to help provide health facilities to the country’s people.

"The role of the private sector in providing facilities is of cardinal importance in our comprehensive health planning. The finance and manpower needs of our services in relation to our resources precludes a State-controlled service," he said.

Dr Munnik said the cost structure of the private sector should be such that an increasing proportion of the population could make use of their facilities while the State (and consequently the taxpayer) would have a decreasing financial burden.

Discussion

The cost and cost effectiveness of medical and technological progress was the subject of discussion throughout the world and steps had to be taken to curtail cost escalation, Sapa quotes the Minister as having said.

"In South Africa we are committed to a system of norms including need and cost norms. These norms also aim at matching the needs of the community with the facilities to be provided.

"The role of the private sector in providing facilities is of cardinal importance in our comprehensive health planning," he added.

"However, in South Africa we are in a unique position. Our needs range from the very basic to the most sophisticated and our services have to be spread proportionately in order to cover the entire field.

"The private sector has an important responsibility to bring into being services affordable to the population," said Dr Munnik.

"In considering the various aspects of the health facilities plan, I know of no more significant development than the involvement of the private sector in our planning," the Minister said.

Delicate

"The delicate inter-relationships between the responsibilities of the private sector and the State and the consequences of policy changes could be far reaching.

"It is my considered opinion that the cost structure of the private sector should be such that an increasing proportion of the total population could make use of their services while the State, and consequently the taxpayer, would have a decreasing financial burden.

"In such a system, the need for mature financial discipline is essential," Dr Munnik said.
THE parliamentary session ending in Cape Town today has again underlined the parlous state of occupational health for the country's 5.5-million industrial workers.

That much has emerged in replies by the Minister of Health, Dr L A P A Munnik, to a series of probing questions in the House by the Opposition spokesman on health matters, Dr Marius Barnard, on the outcome of the Erasmus Commission of Inquiry into occupational health.

Nearly six years ago, the commission, which was chaired by the same judge who head the inquiry into the former department of information, Mr Justice Rudolf Erasmus found that there was an alarmingly high rate of occupational disease in industry and on the mines.

Although some of its comments were platitudinous on management, the Erasmus commission report revealed extremely dangerous working conditions and an increasing rate of occupational disease.

Comprehensive

It found that 5.78-million (71.9%) of the eight million economically active people in South Africa were not covered by legislation relating to occupational disease. It also found that management was not industrial health-oriented.

The commission pointed out that South Africa was one of the few industrially developed countries without a comprehensive health system for the protection of all industrial workers and th
MEDICAL SERVICES

Appropriate treatment

There is consensus that SA's medical services are in need of radical restructuring. The FM recently recorded the extent to which public facilities are under strain. But that is only part of the problem.

The Federated Chamber of Industries (FCI) recently set up a study to consider the increasing demand for health services that is being placed on the manufacturing sector. It was particularly concerned at trends towards the centralisation, and socialisation, of medicine. It now argues that free enterprise principles should be applied to the system in the search for solutions.

The basis of the argument is that health, like low-cost housing, education, and social pensions, would benefit from this process.

In all sectors of social welfare, the FCI says, the fundamental problem is similar. The State has accepted for itself a primary (and often exclusive) responsibility for the provision of basic services funded from tax revenues. These services are often of a high standard (and) the fact that these services are free or heavily subsidised stimulates demand. The demand for medical services is massively augmented by the rapidly growing black populations in both urban and rural areas.

So: "Increasingly the basic health services face the burden of providing relief from the effects of poverty, malnutrition, overcrowding and ignorance. Differentiation in the provision of health services also threatens to become a political issue."

The policy of cheap, freely available state services depresses the overall supply of such services, not only in the state but also in private institutions. There is a shortage of doctors and nurses in state hospitals, affecting even essential facilities. Worsening the situation is the fact that pay differentials between SA and overseas have led to a brain drain. But there is an ever-rising demand that a high level of services be extended to the public on a non-compensatory basis.

Between 1973-1979, the amount spent on health in SA and the homelands rose more or less in line with inflation from R508m to R1 112m — though this amount, as a percentage of GDP, actually declined from 2.7% to 2.4%, especially after 1976. In the homelands the figure was 0.5% of GDP up to 1976, but fell to 0.2% in 1980 with an absolute decline in the amount spent on health services in that year.

Government health services are either free, or the scale of fees is scheduled according to the patient's means — excepting communicable diseases like tuberculosis, leprosy, typhoid, malaria and VD. No patient is barred from treatment because of inability to pay; a tradition which makes sound long-term social and economic sense, considering the potential for a build-up of resentments over inadequate services for blacks, and the actual loss of man-days once disease takes hold beyond the preventable stage.

This access to medical facilities should not be interfered with, though restructuring would mean a greater allocation of funds at the lower end of the spectrum.

There is evidence of a considerable imbalance between the amounts spent on whites, coloureds, Indians and blacks. And a further imbalance exists between services available in rural as against urban areas. The doctor/patient ratio for urban whites is less than 1:1 000; in some black rural areas it is 1:2 000.

In addition, there is a complicated institutional framework for the services, with the Department of Health controlling six decentralised services; the involvement of the Department of Education and Training, while the provinces and homelands, both independent and non-independent, have their own health functions.

The major structural division, of course, is between the public and private sectors. Co-ordination tends to be on an ad hoc basis, and the state health services carry a heavy burden of care for those who present themselves for treatment whether or not they are in a position to pay the market rate for these services. To this extent, SA's medical services are socialised, and private health services operate largely on a parallel basis.

A certain amount of what can be called cross-subsidisation occurs. This applies not only to richer patients being treated in subsidised state institutions. In some cases public health services are directly subsidised by the private sector, as in the supply of pharmaceuticals. About 60% of medical drugs are supplied through the state health services under a tender and code list system. Direct state intervention in the production of pharmaceutical products and medical equipment is widespread — and threatens the long-term supply.

The system therefore faces certain critical choices. There can be:
- Increased centralised control over medical services, including the supply of drugs;
- The re-establishment of market disciplines so that prices can play a primary role in regulation.

The second option diminishes, but does not eliminate, the role of the State. The maintenance of essential standards in training and practice, the control of harmful drugs, and surveillance of malpractices and the abuse of market power would remain in the public domain.

But, in arguing that free market principles should be given greater sway, the FCI points to the debilitating effects of centralisation — the placing of industrial health facilities under the DOH, with factory inspectors reporting to the department, is one example. The process contributes to a gross loss of efficiency in public health services.

To achieve an acceptable level of health services the following reforms are suggested:
- The first line of defence should be effective suppression of major communicable diseases;
- There should be an adequate geographical spread of primary health care services;
- The balance between preventive and curative elements of health care should take into account the cost of delays — the burden on the taxpayer of therapy for those who have to be hospitalised because of failures of early diagnosis or preventive treatment;
- Co-ordination between the private and public services, and involvement of the private sector in industrial health;
- Control of standards and institutional care which permits access by the needy to adequate health care facilities;
- Adequate training facilities for doctors, dentists, nurses, paramedics and health care workers as well as pharmacists; and
- The construction of acceptable community clinics.

These can all be secured within a less centralised system.

The existing structure of state hospitals and clinics is fundamental to the system, and a central authority is needed for the effective operation of health care services at all levels. But the management of this structure should be more sophisticated and subject to disciplines normally thought of as the preserve of the private sector.

The structure must become more responsive to the needs of users. This would mean matching various levels of health care requirement to the appropriate institutional.
levels — for example, greater use of home nursing, community and industrial health clinics, education for prevention, and responsible self-medication.

A fundamental reform would be to adopt a market-related pricing structure which takes income differentials into account. Those who can pay the market rate for services should not be subsidised. To secure this, facilities, services, and medicines should not be specified above the optimum level dictated by medical needs.

The objective must be to work towards integration of the services. But if state institutions have to function more as private institutions they must be given greater autonomy to specialise, set scales of tariffs and remuneration levels for different staff skills, and actually compete with other state-owned and private institutions.

The basic problem remains that of the poor — how to subsidise those who cannot afford market-related tariffs. There are three possible approaches: subsidising the individual; subsidising an institution; and a medical insurance/medical aid solution.

All three must be used, the FCI argues, though there should be no automatic subsidy for institutions. Subsidisation here should be contingent upon proof that a particular patient can pay only a specified amount.

As state subsidisation is diminished, resources would be diverted to primary remedial and educative medical systems aimed at malnutrition, the diseases of poverty, and ignorance of basic health care.

Here, too, the private sector has a role. It should be encouraged to establish its own primary health care centres — in particular, industrial health facilities. These should be eligible for government subsidies on the same basis as state institutions.

There should be no health levy on employers, and “to avoid double taxation the subsidisation of welfare services must be channelled through the State Revenue Fund as the taxation system is the only equitable base for subsidisation.”

Such greater co-ordination between the services, and the setting up of market mechanisms, would represent “a complete break with the present system of differentiated, subsidised and over-utilised medical services concentrating on curative rather than preventative medicine.”

This would indeed be a radical restructuring of the present system. A large number of representative bodies would have to be consulted. But it would certainly assist in arresting the deterioration of services.
Government must act to prevent diseases

By ADA STUIJT

A SENIOR paediatrician in Natal says the Government should be spending more money on primary health care rather than on sophisticated health care in towns.

And Dr Walter Koening, senior paediatrician at Natal's King Edward VIII Hospital who has completed a survey on primary health care facilities in four Natal communities, revealed that the Government does not have reliable statistics on black infant mortality, one of the criteria on which a country's quality of primary health care is judged.

Primary health care directs attention to the root causes of diseases, such as unsafe drinking water, lack of sanitation and poverty.

"Most of the public money is spent on sophisticated health care in towns to care for patients, with the result that many people still die prematurely from infectious and other preventable diseases," he said.

Four deaths

Only a month ago, a major cholera outbreak in Bophuthatswana, 40km north of Pretoria, was traced to the heavily-polluted Apies River, used as the only water source for the hundreds of thousands of people living along its banks. Four deaths resulted and hundreds of victims were treated on an emergency basis.

Five ways of evaluating the quality of a country's primary health care are the availability of enough clean, treated water and safe sanitation, the infant mortality rate, prevalence of preventable diseases, nutrition of children in particular and the community at large, and how important the Government rates primary health care facilities in its budget.

But the major problem -- and primary health care's first concern -- is the availability of clean water. Among the communities on which he based his study, Dr Koening noted that two of them relied almost completely on a stream for their water source and the earth's surface for their sanitation.

In only one community -- KwaMashu -- there were outside taps and toilets available. Hiabisa, Inanda-Nkutwane and Masele have pit and surface sanitation exclusively.

"It is thus not surprising that water-borne diseases (typhoid, cholera, malaria) continue to be a major problem."

Dr Koening attacked the Government for not providing reliable statistics on black infant mortality, quoting from the Department of Health's latest publication which said that "data on blacks for the outlying rural areas were not available because of the customs, mores and level of education of those communities concerned."

"It is interesting to note how the blame has been placed on the shoulders of the community and no mention is made of the task of health care facilities," Dr Koening said.
A primary problem

Large numbers of people living in rural KwaZulu are still succumbing to diseases which could quite easily be prevented, according to Dr Walter Loening, senior paediatrician at the King Edward VIII hospital in Durban.

According to Dr Loening, the hospital took in 2,000 tuberculosis patients last year. Of the children admitted, 74% had a respiratory infection or gastro-enteritis while 45% were malnourished. Studies carried out on infant mortality rates show that in the Inanda/Ndwele area as many as 134.1 deaths/thousand are recorded. In other areas like Mawela, the figure is around 111.4. This compares with the national rate of 122/1,000 for coloureds, 38 for Indians and 29 for whites.

Loening says there is a direct correlation between high infant mortality rates and poor primary health care. For example, in the Inanda Ndwele district and Mawela, almost 100% of the inhabitants draw their drinking water from streams. At the same time, there are no proper facilities for the disposal of excreta. Consequently, debilitating water-borne diseases are a danger.

Loening criticises government for spending money on sophisticated institutions like Tygerberg, Johannesburg General, and Groote Schuur hospitals, without treating the root cause of the problem. He points out that Groote Schuur has just been allocated R140m for expansion, yet the KwaZulu government cannot obtain 1% of that figure for the provision of primary health care. He argues that this hardly makes sense as it is obvious that a small sum of money spent on primary care could obviate the need for vast hospitals for tertiary care.
A stinking health hazard

THE refuse dump on the western side of Atteridgeville/Saulsville township is a smelly health hazard and an eye-sore say angry residents living nearby.

The dumps are situated near the Bathokwa Lower Primary School and Flavius Mareka Secondary School and the people staying around Lephora, Lekekeke, Lemong and Lefesdi streets have to put up with the offensive smells which have "been haunting us for almost eight years," a resident said.

The SOWETAN visited the area and found the stench unbearable in the nearby houses despite all the windows and doors being closed in an effort to prevent the large swarm of flies from the dumping ground.

Mrs M Mabaso, who suffers from high blood pressure and lives right opposite the dump was found with a piece of paper hitting at the numberless flies. "I'm tired of this set-up, these deadly things even drop into our pots on the hot stove. Now that I have a week-old baby, I cannot use an insecticide and the doors and windows are always closed. I suffer from high blood pressure and I sweat like hell," she said.

Mr B Mkhonza, an inventory control manager of Checkers in Johannes- burg, condemned the authorities for turning a blind eye to their complaints about the "terrible smell and the flies breeding in the rubbish."

He added: "We have tried to use various insecticides in an effort to clear our homes of flies, but to no avail. I have a metre-long fly catcher in every room, but these are smeared with flies after only two days. There are millions of flies breeding in that dirt."

His wife, Miriam, said she cooked their lunch and supper at about 5am to avoid "the rush. These flies are a real menace, they even fall into our food."

 Asked how she coped with washing outside, Mrs Mkhonza said, "Man, they crawl all over my body. It's terrible!"

Mr J Piattjie said he was particularly scared about the potential health hazard, "especially for the children."

"The authorities should do something to prevent this terrible stench. There are also some whites who came and dumped rotten meat which creates an awful smell," he said.

Mr A F Aap, director of technical services for the administration board of central Transvaal, said he had not yet received complaints about the refuse. "I can assure you that the matter will be attended to from today," he said.

UNBEARABLE: That's what we found about the stink coming from this dump.
Training
The cost of training a new worker must be considered.

Overtime
Overtime may have to be worked in order to meet production deadlines.

First aid
Instead of members of the first aid staff attending to accidents, they could check on health problems.

Investigation
There are costs involved in the investigation of accidents and completing the necessary reports. Bureaucracy can delay the efficient resolution of an accident.

Required clerical control
The claims on the Accident Fund require clerical skills and this naturally costs time and money.

Equipment repairs
The cost of repairing or replacing damaged equipment is incurred during the clean-up and the re-setting of machinery.

Like all icebergs, the mass below the surface is the most dangerous, especially when we consider what these hidden costs could add up to. Some writers maintain that the ratio of insured costs to hidden costs should be 1:4. Others maintain that no definite ratio can be arrived at. It is suggested that each firm does its own exercise and calculates the total costs of its accidents, not necessarily on a sampling basis. This was done recently at a certain firm and it was found that the medical and other insured costs came to about R600.00. The hidden costs in loss of production and contract penalties amounted to more than R6 000.00 - a 1:10 ratio.

It may be said that because of an accident, no actual difference in production is noticed. It may be true that the output from the plant is the same whether accidents take place or not but what must be very obvious is that if the output is to remain the same it must be produced at a higher cost. NOSA is extremely anxious for more firms to introduce systems whereby the total cost of an accident can be determined in their works. A draft accident report form can be supplied by NOSA together with suggested methods for collecting data.

SECOND ICEBERG EFFECT
If one iceberg were not enough to emphasise the terrific amount of avoidable waste which is taking place in South Africa, there is a further iceberg which relates the frequency of injuries to the number of accidents which take place.

It should be made quite clear what an accident is. It is an unplanned, uncontrolled event that interrupts or interferes with the orderly process of the production activity or process.

accident may cause damage, to production delay without necessary injury may or may not result from the smooth flow of production.

which cause accidents, these being the physical conditions. Either of them may cause the accident.

by F.E. Bird and G.L. Germain, it is 000 accident cases were made relationship between an accident that on an average there were 16 damage to property and 1000 nature for every disabling injury, purures, which we have no reason of facts, we come to the shockingly 224 000 multiplied by 600 our statistics in total and which attention of management. The accidents may vary from very minor to machinery and only minor mention.

accidents we have only tackled 16% of the problem.

OUR PROBLEM
According to the Workmen’s Compensation Commissioner’s figures we experience over 333 675 injury-causing industrial accidents a year. This excludes those injuries requiring first aid treatment only. These accidents, which exclude home and road accidents involving private vehicles, result in some 31 000 people being permanently maimed each year. The estimated potential and actual loss of man-power is 29 000 000 man-days.

This latter figure is equivalent to about 100 000 workers lying idle every working day and this far exceeds our present effective immigration growth.

The Workmen’s Compensation Commissioner and the accident funds approved by him pay out approximately R26 200 000 a year by way of compensation, rehabilitation and medical expenses because of injuries.

CHALLENGE
This surely must be one of the greatest challenges for South African management to plan their efforts of accident prevention on scientific lines dovetailing into their day-to-day managerial activities.

There is no doubt that with NOSA’s guidance and expertise the injury and accident rate can be greatly reduced.

Industrial accidents are costing South Africa about R1100 million a year, through loss of productive time. In addition, more than 2 000 people are killed and 30 000 are permanently disabled. In the above graphs, the real costs before and after an accident are measured in terms of a fall in production and the overtime expenses required to maintain production levels. The effect on profits is dramatic, with a drop from R300.00 to R75.00 as a result of inadequate safety precautions.