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HEALTH IMPLICATIONS OF APARTHEID IN SOUTH AFRICA

by

the Director-General of

the World Health Organization

[Note: This issue of Notes and Documents reproduces a preliminary survey of the health implications of apartheid in South Africa, presented by Dr. Halfdan T. Mahler, Director-General of the World Health Organization, to the fifty-third session of the Executive Board of the WHO in Geneva, in January 1975. The Director-General concludes that "the health situation of the groups discriminated against by the policy of apartheid will not likely improve as long as the policy exists."

The United Nations Special Committee against Apartheid had requested the WHO to prepare a study on the effects of apartheid in the fields of health and medicine, and to call upon members of the medical profession to take action against apartheid.

Following consideration of the preliminary survey, the WHO Executive Board adopted a resolution on 31 January 1975 in which it stated:

> "Fully aware that the policy of apartheid has serious health implications, both physical and mental, for the populations living under that policy,
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> 1. "REQUESTS the Director-General to continue to collaborate with other organizations and institutions of the United Nations system to enhance concerted international action against the policy of apartheid;
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> 2. "FURTHER REQUESTS the Director-General to explore with other organizations of the United Nations system appropriate ways to ensure the success of the United Nations Decade for Action to Combat Racism and Racial Discrimination."]

GENERAL CONSIDERATIONS

Terminology

In South Africa the population is officially classified into four different ethnic groups: (i) whites, comprising all those of exclusively European descent; (ii) coloureds, who are of mixed European and non European descent; (iii) asiatics, a group of diverse ethnic origins, including, for example, both Indians and Chinese; (iv) Bantus, the indigenous inhabitants of the country. Of a total population of over 21 million, group (i) constitutes about 18%, group (ii) 9%, group (iii) 3% and group (iv) 70%.

Groups (ii) (iv) are commonly described collectively in South Africa as "non-whites", but this term occasions resentment. As the South African Institute for Race Relations has reported,

> "When operating in a society which differentiates between people on the grounds of skin colour or racial descent it is essential, however repugnant, when describing legislative measures, party political attitudes, educational and other services, to refer specifically to peoples of various racial groups. For purposes of brevity, a collective term for those who are usually discriminated against is often necessary. But it has for long been recognized that the term 'Non White' gives offence. Being a negative description, it detracts from human dignity."

The Institute decided that when it was essential to use a collective term "black" would be preferable to "non white". 1/

Nevertheless, in the present report the term "non white" has been used, without implying any endorsement of it, solely to avoid possible misunderstanding on the part of those unfamiliar with the situation. The term "non European" would, of course, have been equally negative. The segment of the population described in official South African terminology as "Bantu" is referred to in this report as "African", except in the case of quotations in which the former term is used.

Sources

It must be stated at the outset that WHO does not dispose of firsthand information on the health situation of South Africans, and that morbidity and mortality statistics for the indigenous African population as a whole are lacking or totally inadequate. Nevertheless, relevant information may be derived from a number of sources. Among these are the documents of the Unit on Apartheid of the United Nations, and the annual surveys of the South African Institute for Race Relations. A search of the medical literature of South Africa, aided by access

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1/ Horrell, M., Horner, D., Kane Borman, J. and Margo, R.(1973) A survey of race relations in Africa, Johannesburg, South African Institute of Race Relations, p. 25.

through the WHO MEDLINE terminal to the computerized data base of the National Library of Medicine, Bethesda, Maryland, United States of America, reveals a good deal of material on diseases of poverty and malnutrition, such as kwashiorkor and pellagra, but these are mostly clinical and laboratory studies on small series of cases, and do not provide information on the general prevalence of the diseases.

The WHO library possesses a few annual reports of South African governmental institutions directly or indirectly concerned with health, and of medical officers of health of some major cities. Some of these are 10 or more years old, and no recent reports have been received. Nevertheless, the information that the older reports contain continues to be relevant, as little has been reported in the past two decades to suggest that the general picture of health in South Africa has been transformed. Broadly speaking, this is one of very high standards of living and health care for the whites and varying degrees of poverty, squalor and disease for the remaining majority of the population, especially for those who are the original inhabitants of the country. Such a state of affairs is perpetuated by the policy of apartheid.

HEALTH CONDITIONS

Mental health

It is obvious that mental health and social well being are closely linked to the enjoyment of human rights as defined in the Universal Declaration of Human Rights of the United Nations. Most such rights are legally denied to the non white South African. Wherever discrimination exists it excites resentment, frustration, and may lead to acts of violence. Only in South Africa is racial discrimination made compulsory by the Government as a national way of life. Of the total South African population more than 80% are non whites who are subjected to the most extreme forms of racial discrimination. About half the African population of more than 15 million is in principle resident in the "Bantu homelands" that constitute approximately one seventh of the area of the country, the rest of South Africa being considered as "white". However, more than 40% of the economically active men in these "homelands" find that the only outlet for their labour is in the "white" areas, in which they are not allowed to establish a home and to which they cannot bring their families. These workers are obliged to carry a valid pass at all times, and if found without one are liable to be fined, imprisoned, or banished to the "homelands". Non whites resident in "white" areas are also treated as aliens in that they are obliged to carry passes. The overt resentment created by this system is illustrated by the demonstrations that have taken place at which passes have been burnt in public. In 1968 there were over one million prosecutions for apartheid "offences". 2/ Added to the indignities of the pass system are the lack of any

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2/ Sachs, A. South Africa. The violence of apartheid, London, International.

political or trade union rights, and the economic need for fathers to leave their families to live in faraway hostels in conditions that provide a natural breeding ground for resort to prostitutes, for venereal diseases, alcoholism, and for crimes of violence. For the wives and children who are left behind the absence of the head of the family must clearly be a disturbing element generating feelings of doubt and insecurity. For the whole broken family, inability to lead a normal family life and consciousness of being regarded and treated as inferiors could not be other than harmful to mental health.

An annual report of the South African Commissioner for Mental Health is published by the Government, and this contains detailed statistics of admissions to and discharges from hospitals of patients of the various ethnic groups with specified psychiatric disorders. However, such statistics provide no indication of the overall prevalence of mental illness. As has been stated of Sub Saharan Africa in general,

> "Such figures are almost certainly totally meaningless, and reflect the paucity of psychiatric diagnostic facilities, communications, and basic health services. They fail to take into account the undoubtedly large numbers of mentally disturbed Africans kept at home, in prison or simply lost in the bush." 3/

Moreover, in the rural areas traditional healers doubtless play an important role in the handling of psychiatric disorders, which are not reflected in any statistics. Of those Africans admitted to South African mental hospitals, almost two thirds are schizophrenics, while one-sixth are suffering from toxic and exhaustion psychosis and one twelfth from epileptic psychosis. Conditions seen far less commonly in the hospitals are, in descending order of frequency, senile and arteriosclerotic psychosis, manic depressive psychosis, alcoholic psychosis, cerebral syphilis and psychoneurosis. 4/ Widespread malnutrition, to which reference is made below, is well known to retard not only physical growth in children but also mental development.

Although comprehensive epidemiological data are lacking the general conclusion may be drawn that the framework for social existence imposed by apartheid could hardly fail to be inimical to mental health and social well being.

Physical health

It has been seen that precise information on the prevalence of psychiatric disorders in the non white population of South Africa is not available. The same applies to communicable and deficiency disease in the indigenous African population. There are nevertheless conclusions to be drawn from investigations made and partial statistics published both in respect of urban and rural populations.

3/ German, G. Allen (1972) Brit. J. Psychiat., 121, 461.

4/ Henning, P.H. (1973) In: Campbell, G.D., Seedat, Y.K. and Daynes, G. Clinical medicine in Africans in South Africa, Edinburgh and London, Churchill Livingstone, p. 408.

It is generally accepted that one of the best indicators of levels of health is the rate of infant mortality per thousand live births. There are wide differences in this rate for different ethnic groups. For example, in 1971 the provisional rates for whites, Asians and coloureds were respectively 21.0, 35.6 and 122.2. 5/ No rates are available for Africans, but as they constitute the segment of the population with the lowest standard of living and the least access to medical care it is a reasonable assumption that theirs would be the highest infant mortality. A study of 1115 families in Transkei (a "homeland") in 1968 1969 showed the infant mortality to be 216 per thousand live births. 6/ The mortality from all causes under age 10 was 34.3% and it was estimated that 58% of the deaths could be attributed to malnutrition or gastroenteritis.

In Johannesburg the rates of infant mortality in 1970 were 20.26 per thousand for whites, 29.30 for asiatics, 66,07 for coloureds and 95.48 for Africans. Maternal mortality rates for the same ethnic groups were respectively 0.48, 1.91, 0.63 and 2.53. 7/ According to the South African Minister of Statistics, in 1969 1971 the average expectation of life at birth for different ethnic groups was

Whites		Asiatics		Coloureds	
Men	Women	Men	Women	Men	Women
64.5	72.3	59.3	63.9	48.8	56.1

No figures are given for the African population. 8/

According to the South African Bureau of Census and Statistics, the ratio of deaths under one year to all deaths, in percentages, was

	Whites	Asiatics	Coloureds
1939	13.3	25.1	32.0
1958	8.4	24.6	36.9

Thus, over a 20-year period the figure for whites improved remarkably, that for asiatics remained virtually static, while that for coloureds worsened. No figures are given for Africans. 9/ According to official statistics, the corresponding figures for the year 1970 were 5.6 for whites, 17.5 for asiatics, and 34.2 for coloureds. 10/ It will be noted that the figures for coloureds is worse than it was 31 years ago. Again, no figures are given for Africans.

5/ Demographic yearbook, 1972, New York, United Nations, 1973.
6/ Connor, B.H. (1970) Lancet, 1, 768.
7/ Johannesburg, Health Department, Medical Officer of Health's Report 1969 and 1970. [Johannesburg, no date] Appendix D.
8/ Horrell, M. and Horner, D. (1974) A survey of race relations in South Africa. Johannesburg, South African Institute of Race Relations.
9/ Union of South Africa, Bureau of Census and Statistics, Union statistics for fifty years, 1910 1960, Pretoria, 1960.
10/ South Africa, Department of Statistics, South African statistics 1972.

All available evidence points to a gross discrepancy in the health status of whites and non-whites, the least favoured being the indigenous African population and the two outstanding causes of ill health and premature death being nutritional deficiencies and communicable diseases.

Malnutrition

The prime cause of nutritional deficiencies is poverty, although there are other contributory factors, of which one of the most important is the migrant labour system, which results in the disruption of families.

> "Disrupted home life is a very serious problem of wide scope in South Africa. Because of the patterns of economic development and political policy in South Africa, the home life of millions of Blacks in South Africa is broken or disrupted. This situation contributes to the 'mentality' and 'culture' of poverty described, and promotes mal-adjustment. Malnutrition becomes rife under such conditions." 11/

Moreover, in the "homelands" to which many Africans have been compulsorily transferred, there is only 20% of the total cultivable land in the country, very little irrigation, and much soil erosion. A further contributory factor is that many of the able bodied men in the "homelands" become migrant workers in "white" areas, leaving behind the elderly, the infirm, and the children. It has been estimated that two thirds of Africans living in any industrial complex are living below the "poverty datum line", defined by the Association of Chambers of Commerce as a monthly income of R75. 12/ In the rural areas, natural disasters such as droughts may worsen the nutritional situation. The widespread epizootics of rinderpest in the 1890s resulted in many areas in a too great dependence on maize as the basic foodstuff. As in most cultures, there may be prejudice about certain articles of food, and this may mitigate against full advantage being taken of all available resources.

According to the National Nutrition Research Institute of South Africa pellagra "occurs with considerable frequency among the Bantu" 13/ and "kwashiorkor is a nutritional disease of wide occurrence and great importance among the non European population of South Africa". 14/ During 1960, in an attempt to survey the nutritional situation, the Institute sent a questionnaire to all South African medical practitioners. 15/ Although some 6000 questionnaires were dispatched, only about 400 replies were received. However, the small number of physicians replying reported a total of 4417 cases of kwashiorkor, 3478 of marasmus and 3132 of pellagra. In a report on the survey, the authors state that

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11/ Van der Merewe, H.W. (1974) South African Medical Journal, 48, 1669.
12/ United Nations, Unit on Apartheid (1972) Facts and figures on South Africa, Notes and Documents, No. 16/72, New York
13/ National Nutrition Research Institute (1963) Annual Report 1962-63, Pretoria, Council for Scientific and Industrial Research.
14/ National Nutrition Research Institute (1962) Annual Report 1960-61, Pretoria, Council for Scientific and Industrial Research.
15/ Potgieter, J.F. and Fellingham, S.A., Incidence of nutritional deficiency among the Bantu and Coloured populations in South Africa as reflected by the results of a questionnaire survey, Pretoria, Council for Scientific and Industrial Research, 1962.

> "it is today generally conceded by nutritionists that malnutrition is a major problem in the Republic and assumes serious proportions in the younger non White age groups".

Extrapolating the data obtained, they estimate the average incidence of kwashiorkor for the whole country to be 5% of children under 12. For marasmus the estimated incidence varied from 2% to 9.6% according to area, while for pellagra it was 1.8% for all ages.

According to the South African Department of Health, protein-calorie deficiency and pellagra "are still the two most common deficiency syndrome in the Republic". 16/ Other deficiency diseases such as scurvy, beri beri, nutritional anaemias and rickets are also common, and lesser grades of malnutrition result in retarded growth and iron-deficiency anaemia in children. At an outpatient clinic, 30% of non white children between three and seven years of age showed evidence of rickets. 17/

Communicable diseases

If the nutritional situation of non whites in South Africa is deplorable the situation in relation to communicable diseases is no better. It is widely recognized that malnutrition predisposes to communicable diseases, and the interaction of these two factors results in an alarming incidence of illness and premature deaths. This massive morbidity could be drastically reduced by adequate nutrition, health education, improved sanitation and housing, immunoprophylaxis, and domiciliary chemotherapy, without the need for costly hospitals or refined medical equipment.

According to the South African Department of Health, there were 246 cases of smallpox in the Republic in 1969 and 121 cases in 1970, all of them in Africans. 16/ For the two-year period 1969-1970, there were two cases of louse-borne typhus in whites, none for asiatics, two for coloureds, and 221 for Africans. Notifications for other communicable diseases in 1970 were as under:

	Whites	Asiatics	Coloureds	Africans
Leprosy	2	1	4	742
Puerperal sepsis	3	8	13	128
Tuberculosis (respiratory)	799	902	6 388	54 525
Trachoma	0	0	0	121
Tetanus	1	30	42	231
Typhoid	60	32	231	4 109

16/ South Africa, Department of Health, Report for the period ended 31 December 1969 and 31 December 1970, R.P.61/1972. Pretoria, The Government Printer.

17/ Uys, C.J. (1966) South African Medical Journal., 40, 159.

The Department of Health stated in 1972 that "Tuberculosis is still a major public health problem", but it appears very doubtful whether the coverage of case-finding in the African population is sufficiently thorough to reflect the true prevalence of the disease. For example, in an epidemiological survey made in 1971-1972 in the Transkei "homeland" by a South African Tuberculosis Study Group on a random sample of the population, 15.8% of children in the age-group 0-4 years were "positive to the Mantoux test using 2 units and 10 mm induration as lower". 18/ It was also found that 58% of schoolchildren of 7-14 years that were tested "were positive reactors (Heaf grades III and IV) to human PPD. Therefore, more than 250 000 children qualify for a course of isoniazid prophylaxis".

There can be little doubt that it is equally difficult to assess, except on the basis of sample surveys, the incidence of other communicable diseases in the African population, for whom adequate vital and health statistics do not exist.

The medical officer of health of the municipality of Cape Town reported that in 1972 the ratio of whites to non whites treated for sexually-transmitted diseases in municipal clinics was respectively 1.6 and 22.4 per thousand inhabitants. 19/ Such a disproportion can hardly be dissociated from differences in the socioeconomic and educational status of the respective groups, and also from the rootless situation of the migrant workers living far from their wives and families and from the social solidarity of their traditional environment.

HEALTH CARE

The foregoing section provides indications of a massive incidence of somatic disease among the non white population of South Africa, and especially among the Africans. This high morbidity is not reflected in such information as is available on provisions for the delivery of health care. According to official statistics there were in 1958 21 535 hospital beds for white patients and 49 743 for non whites. 20/ These figures imply that about 43% of the total number of hospital beds were reserved for the white minority representing only approximately 18% of the total population. In other words, the least provision was made for those with the greatest needs. In the same year the number of beds in maternity homes was officially given as 1804 for whites and 856 for non-whites. A later estimate, attributed to the Director of Strategic Planning of the South African Department of Health was that in the "white" areas in 1972 there were 10.00 hospital beds per thousand of population for whites and 5.57 for non-whites. In the "homelands", where health standards are almost certainly lowest, the figure was 3.48. 21/

18/ South African Medical Journal, 1974, 48, 149.
19/ City of Cape Town, Annual Report of the Medical Officer of Health for the year 1972 / Cape Town, no date, p. 63 /.
20/ Union of South Africa, Bureau of Census and Statistics, Union statistics for fifty years, 1910-1960, Pretoria, 1960.
21/ Horrell, M. and Horner, D. (1974) A survey of race relations in South Africa, Johannesburg, South African Institute of Race Relations, p. 352.

In South Africa the delivery of health care is dominated by the principle of racial segregation, different ethnic groups being allotted to different hospitals, or sections of hospitals, clinics, and dispensaries. Ambulances for whites cannot be used to transport non-white patients and vice-versa. "Black doctors are not allowed to treat their own patients in provincial hospitals if this would involve their being placed in a position of authority over white nurses." 22/ This system of delivering health care not according to need or to the availability of the best resources is in flagrant contradiction with the system of ethical values that has prevailed in the medical profession since Hippocratic times. The practical consequences of such a system are illustrated by the experiences of a social scientist who reported of Johannesburg and neighbouring areas in 1972. 23/

> "To get an idea of the extent of inequality of medical care, I visited white, colored, and African pediatric units in the same evening - all funded by the same governmental authority. In the African hospital, the wards were extremely crowded with very limited staffing. In one of the infant units I saw two nurses attempting to feed, change and generally cope with 37 very sick children. I then went to the comparable white hospital where two nurses were caring for five white children who were less ill. The comparable unit for coloreds in the same hospital was somewhere between these two extremes. Generally, the physical facilities and amenities followed the same pattern.
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> "I also visited the major hospital serving the colored community in Johannesburg - Coronation Hospital - and the various areas in which these persons live. Although conditions are not quite as harsh as in the African community, they are generally comparable. Housing is inadequate and frequently unavailable, community conditions are poor, and malnutrition and preventable diseases are common. Medical services cannot cope with the magnitude of disease and pathology created by community conditions. From many of the colored areas, trasnportation is especially difficult to Coronation Hospital, and medical services in the community are rudimentary. As 'separate development' proceeds, persons and communities are evicted from their homes and involuntarily relocated, producing profound social and family problems."

An example of the extent to which racial attitudes influence health care is to be found in a South African regulation of 1962 requiring that human blood collected for transfusion should be labelled in accordance with the ethnic origins of the donors. 24/ Article 40 (4) (g) of the First Schedule of this regulation requires that every container of human blood should, inter alia, be labelled according to

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22/ Horrell, M. and Horner, D. (1974) A survey of race relations in South Africa, Johannesburg, p. 352.
23/ Mechanic, D. (1974) Politics, medicine, and social science, New York, London, Sydney, Toronto, John Wiley and Sons, P. 30.
24/ Republic of South Africa, Government Gazette Extraordinary (Regulation Gazette, No. 146), No. R.1950, Regulations for the control of blood transfusion services, 30 November 1962, p. 28.

"The racial origin of the donation which may be indicated by the following code letters:

W for whites;
K for coloureds;
A for Indians or Asiatics; and
B for Bantus."

Blood donations are "deemed safe for issue as human blood" if the donor has no previous history of malaria or viral hepatitis and if the blood is seronegative for syphilis. No explanation of the purpose to be served by indicating the ethnic origin of donors is to be found in the regulation, which contains no prohibition of inter-racial blood transfusion.

Shortly after the regulation was promulgated, two scientists of the Human Sero-Genetics Unit of the South African Institute for Medical Research, Johannesburg, published a detailed serological study of blood samples of different ethnic origin, from which they concluded: "we have established that there is no serogenetic reason for the labelling of containers of human blood with the race of the donor". 25/

Commenting on this study in the same journal a physician attached to the South African Blood Transfusion Service acknowledged that "the safety of blood for transfusion has nothing whatever to do with the race of either the donor or the recipient". 26/ However, he defends the racial labelling of blood containers on the ground that "it is unfortunately true that in the Republic of South Africa at the present time, all the principal diseases which may be transmitted by transfusion (syphilis, viral hepatitis, and malaria) have higher incidences in non-whites than in whites". He adds that the hazards of these diseases cannot be entirely excluded by laboratory tests, and that white donors are to be preferred because of "their greater freedom as a group from infectious diseases due to their better socioeconomic and living conditions".

No indication is given of the reason for collecting blood alleged to be suspect, nor of the use to which such blood is put. In a subsequent letter the same writer quotes the head of a blood transfusion service as saying that Africans were paid 1 Rand for half a litre of blood and that "African women, in particular were anxious to have the R 1 to buy food". 27/

THE HEALTH PROFESSIONS

One of the consequences of the policy of apartheid is that in South Africa health professionals with the same qualifications and skills receive different rates of pay according to their ethnic origins. In the medical press a correspondent writing from Cape Town pointed out that a recent advertisement in the South African Medical Journal by one of the provincial administrations announced pay scales for coloured and Asian physicians that were only 76% to 81% of those offered to their white colleagues. For African physicians the corresponding figures were 61% and 74%. 28/ Greater discrepancies exist in the salary scales for white, coloured/Asian, and African health personnel, such as nurses, radiographers and physiotherapists.

25/ Nurse, G.T. and Jenkins, T. (1973) South African Medical Journal, 47, 56.
26/ Shapiro, M. (1973) South African Medical Journal, 47, 361.
27/ Shapiro, M. (1973) South African Medical Journal, 47, 1091.
28/ Bernadt, I. (1973) British Medical Journal, 3, 632. (An editorial note in this issue states that the journal "has now stopped accepting advertisements from South Africa unless assured that no discriminatory salary attaches to the post.")

As a measure for levelling the effects of salary differentials for physicians, the Medical Committee of the Transvaal Study Circle decided to organize a Salary Equalization Fund. Referring to this Fund in the medical press, the former secretary of the medical committee pointed out that not only did African physicians suffer from salary differentials, but that they were denied the senior appointments, married quarters, travel allowances, and recreation facilities that were available for white physicians. 29/

"It was in this atmosphere of frustration and fear that we, the more privileged Blacks (Asians and Coloureds) decided to upgrade the salary of our less privileged Black colleagues (Africans) to our level. With the assistance of Black doctors, mainly G.P.s, we started the Salary Equalization Fund."

According to another source, in 1973 the Municipality of Johannesburg "decided that it will no longer continue the differentiation of its large municipal staff and has levelled up salaries with no racial discrimination". 30/

At the twenty seventh World Medical Assembly of the World Medical Association (WMA) in October 1973 the following resolution was passed by 56 votes to nine:

> "BE IT RESOLVED by the 27th World Medical Assembly meeting in Munich that the WMA vehemently condemns religious, racial, colour or political discrimination of any form in the training of medical practitioners, and in the practice of medicine and in the provision of health services for the peoples of the world, and
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> BE IT FURTHER RESOLVED that the Council of the WMA be instructed and empowered by the 27th World Medical Assembly to investigate as carefully and as fully as possible the issue of discrimination in the training of medical practitioners and in the practice of medicine and in the provision of health services." 31/

It is to be noted that the South African member of WMA, the Medical Association of South Africa (MASA), has consistently expressed its opposition to the policy of differential rates of pay for physicians of different ethnic origins. In July 1968 at Pietermaritzburg the Federal Council of the MASA passed the following resolution:

> "That Federal Council considers that salary differentiation among full-time medical personnel should only be on the basis of grading, service and merit. It urges the authorities to give sympathetic consideration to removing the present source of friction regarding the differential salary structure existing between White and non White doctors."

29/ Dinder, F. (1973) British Medical Journal, 4, 783.
30/ Woodman, H. (1973) British Medical Journal, 4, 51.
31/ Wld. Medical Journal (1974), 21, 10.

An editorial in the South African Medical Journal recalling and reaffirming this resolution concludes with the words: "there must come a change, for we can no longer tolerate the situation". 32/ The MASA, while being predominantly white by sheer force of numbers, does not itself practice racial discrimination, and has office holders of other ethnic groups.

The numbers of physicians of different ethnic groups in South Africa are disproportionate to the size of the respective populations. According to a statement of the South African Minister of National Education, the physician-to--population ratios in 1972 were: 33/

White	1:	400
Indian	1:	900
Coloured	1:	6 200
African	1:	44 400

These figures do not directly reflect the availability of health care for the different ethnic groups, as many non whites are treated by white health personnel. They do, however, illustrate the discrepancy in the availability of facilities for medical education.

According to the South African Institute of Race Relations, a total of only 252 African physicians had been trained as at the end of 1971, all of them at the Universities of the Witwatersrand and Natal. Since 1966 Africans are eligible only for training at Natal except by special ministerial dispensation. Before it was prevented by law from admitting African students except by special dispensation, the University of the Witwatersrand had trained 103 African physicians. In 1973 it had only one African medical student. 34/

The disparity between the number of white and non white medical and dental students in relation to the size of the populations of the various groups is striking. According to the Minister of National Education, 34/ the numbers of undergraduate medical and dental students in 1972 and the numbers who qualified in medicine or dentistry at the end of that year or early in 1973 were:

	Students		Qualified at the end of the year	
	Medical	Dental	Medicine	Dentistry
White	3 710	708	440	67
Coloured	142	6	19	-
Asian	445	16	47	1
African	202	7	15	-

32/ Editorial (1971) South African Medical Journal, 45, 541.
33/ Horrell, M., Horner, D., Kane Borman, J. and Margo, R. (1973) A survey of race relations in South Africa, Johannesburg, South African Institute of Race Relations, p. 404.
34/ Horrell, M. and Horner, D. (1974) A survey of race relations in South Africa, Johannesburg, South African Institute of Race Relations, p. 353.

According to the same source, the equivalent figures in 1972 for pharmacy students were:

	Students	Qualified at the end of the year
White	1 660	not stated
Coloured	104	6
Indian 35/	54	16
African	66	2

There were in addition three African postgraduate students in pharmacy.

In the nursing profession, the proportion of non-whites to whites was as at the end of 1972, according to the South African Nursing Council, much higher. 36/

	General nurses	General nurses with additional qualifications	Midwives	Other 37/ nurses
White	9 805	14 013	1 047	1 270
Coloured and Asian	854	2 069	265	73
African	3 421	8 714	1 707	434

It was estimated in 1970 that the ratio of nurses to population for different groups was: 38/

1 white nurse to 256 whites
1 coloured nurse to 1202 coloured people
1 African nurse to 1581 Africans.

According to statistics furnished in 1973 by the Deputy Minister of Bantu Development, the numbers of health personnel in the "homelands", to serve a population of some 7 million people, were: 39/

	White	African
Medical practitioners	45	9
Physiotherapists	18	26
Radiographers	36	40
Dentists	4	-
Pharmacists	26	4
Nurses and midwives	586	10 725
Health inspectors	26	11
Health assistants	-	72

35/ Only second and third year students. A figure for the first year was not given.
36/ Horrell, M. and Horner, D. (1974) A summary of race relations in South Africa, Johannesburg, South African Institute of Race Relations, p. 355.
37/ Psychiatric, paediatric, etc.
38/ Horrell, M. and Horner. D. (1973) A survey of race relations in South Africa, Johannesburg, South African Institute of Race Relations, p. 405.
39/ Horrell, M. and Horner, D. (1974) A survey of race relations in South Africa, Johannesburg, South African Institute of Race Relations, p. 350.

There is some uncertainty about the figure of nine African physicians in the "homelands". This was given in the published report of a parliamentary debate in 1972, but the Ministry of Bantu Administration later informed the South African Institute of Race Relations in a letter of 7 September 1972 that the current figures was 70, and that there were 15 African physicians in the Transkei "homeland". 40/ There is no indication whether or not the figures quoted for the "homelands" as a whole take into account foreign physicians working in mission hospitals.

SUMMARY AND RECOMMENDATIONS

Although comprehensive health statistics are unavailable for South Africa as a whole, and are especially lacking for the Africans who constitute about 70% of the total population, such information as is available both from official South African sources and from the South African medical literature provides sufficient evidence of massive prevalence of preventable disease and premature deaths due mainly to nutritional deficiencies and infections. This burden of disease is most severe in Africans, less in coloureds and Asians, and least of all in Whites. The discriminatory measures to which non whites are subjected cannot be other than harmful to mental health. Apartheid results in the segregation by law of all services for the delivery of health care according to racial group, those whose need is greatest having the least access to preventive and curative facilities. This inequality in health care is reflected in such vital statistics as are available. The unscientific attitude underlying the whole concept of apartheid is illustrated by the legal requirement to label blood for transfusion according to the ethnic group of the donor. It is equally illogical that health personnel with the same qualifications and skills should receive different rates of pay determined by ethnic considerations.

The prevailing situation stemming from the policy of apartheid presents an obstacle to the achievement of the highest level of health for all individuals.

The Director General believes that the health situation of the groups discriminated against by the policy of apartheid will not likely improve as long as that policy exists. Attention is therefore focused on continued cooperation and concerted action with the United Nations and the other members of the United Nations system; greater dissemination of information, relevent to the health concerns of the Organization regarding apartheid as and when it becomes available; more intensive studies by the Director General on the impact of racial discrimination and apartheid on the level of health of individuals and communities and the delivery of health services to the affected populations and groups; and through enlisting the cooperation of organizations, Member States and other concerned entities. The Board may find that other actions to be undertaken, either separately or jointly with other organizations, are called for to eliminate racial discrimination and apartheid within the framework of the United Nations Decade for Action to Combat Racism and Racial Discrimination. 41/

40/ Horrell, M., Horner, D., Kane Berman, J. and Margo, R. (1973) A survey of race relations, Johannesburg, South African Institute of Race Relations, p. 405.
41/ United Nations General Assembly resolution 3057 (XXVIII).