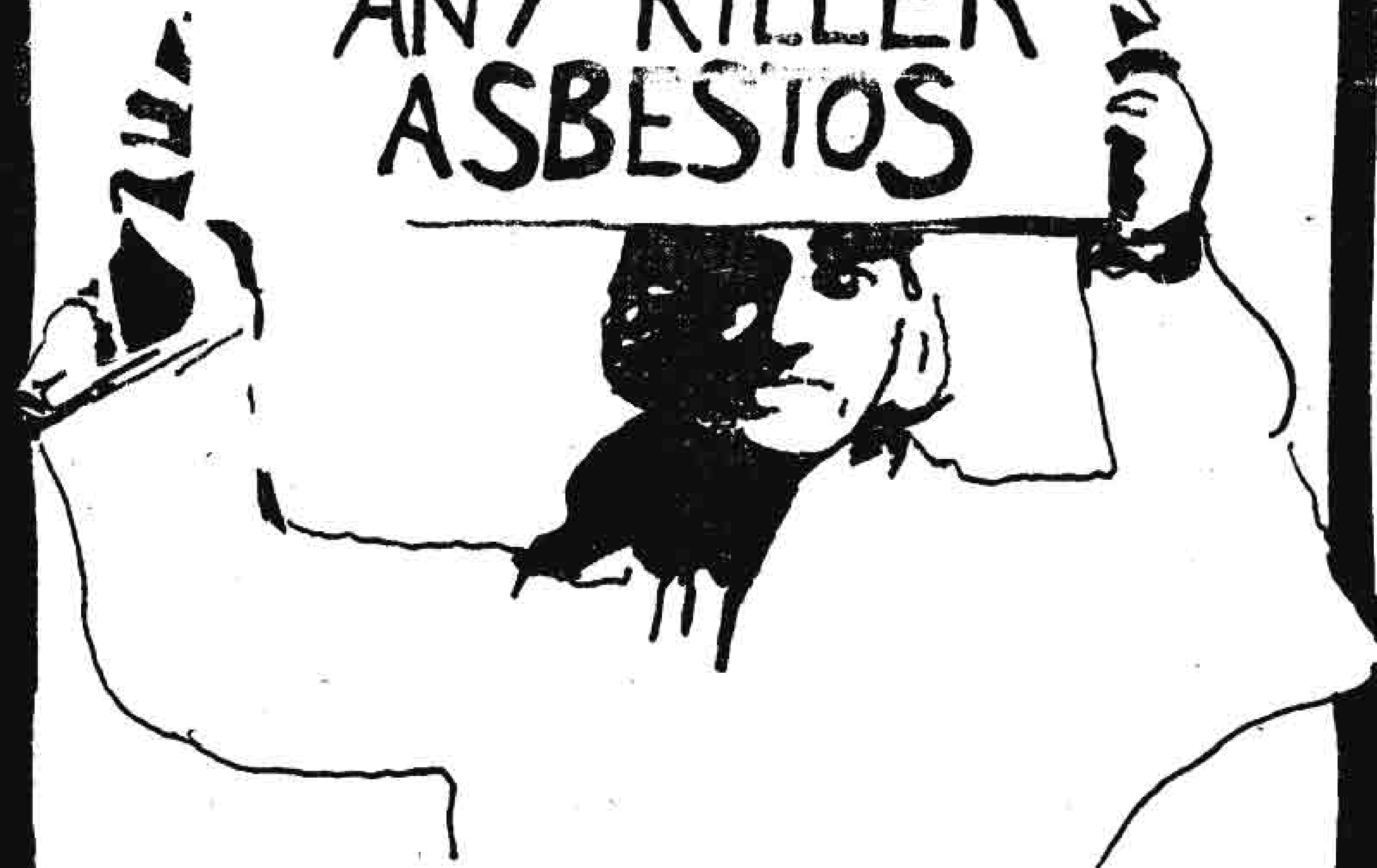
CRITICAL HEALTH

FEBRUARY, 1981 NUMBER 4



CONTENTS

FEBRUARY, 1981. NUMBER 4

EDITORIAL PAGE 2

ASBESTOS IN SOUTH AFRICA PAGE 4

EDITORIAL COMMENT - THE M.A.S.A. AND THE BIKO AFFAIR PAGE 18

RESTRICTED VISION PAGE 24

BREASTFEEDING, THE MULTINATIONALS AND INFANT FORMULA - A SECOND LOOK PAGE 26

AMERICAN MEDICAL ASSOCIATION PAGE 49

EDITORIAL COMMENT - BANNING OF "FRONTLINE ON HEALTH IN AFRICA" PAGE 52

DON'T LET INFORMATION PILE UP —

USE IT!

EDITORIAL.

Our first article in Critical Health No. 4 deals with asbestos, its uses and effects in South Africa. Asbestos is a dangerous substance used fairly extensively throughout the world. While more and more countries are recognising its harmful effects on health, and are attempting to deal with the problem, the South African authorities make little or no effort to rectify the situation.

This article looks in-depth at the subject. It is hoped that this will be the first in a series of articles dealing with industrial health - an important area of investigation if we are to work towards a more just and healthy society.

In the second article, we take another look at the infant formula food industry. The article was written by two readers in response to the article "The Baby Killer" which appeared in Critical Health No. 2. It deals with the historical aspects of the infant formula food industry and the promotional activities of this profitable industry. The article provides great insight into the motives of the industry and complements our previous discussion of the subject. It is important, however, to see this industry as just one example of how multinational companies operate in a way that is detrimental to health.

Also in this article is an editorial comment on the Steve Biko affair and the Medical Association of South Africa and a comment on the banning of a recent publication dealing with health in South Africa. We also have short articles on World Vision's "40 Hour Fast" and on the impending visit to South Africa of a delegation of the American Medical Association.

As always, we wish to encourage our readers to use Critical Health as a forum for the exchange of ideas on health-related issues.

We wish to point out that only three issues of Critical Health were published in 1980. All subscribers, however, will receive the four editions for which they have paid.

EDITORS:

Clifford Goldsmith
Susan Goldstein
Keith Klugman
Anthony Zwi

The articles printed in Critical Health have been collated by the editors and do not necessarily reflect their views.

Critical Health is an independent publication and is not financed nor produced by the University of the Witwatersrand Medical Students' Council.

This issue of Critical Health was printed by the Printing Unit, Wits Medical School, Esselen Street, Hillbrow.

SUBSCRIPTION FORM

Please send me the next four editions of CRITICAL HEALTH.

NAME ....

ADDRESS ....
....
....

Enclosed is the total amount of ....

(30c per copy within Southern Africa ie. RI.20 for four editions. $4 or £I.50 OR the equivalent in local currency for four editions anywhere else in the world.)

Back copies available on request.

Please send your subscription forms to:
CRITICAL HEALTH,
c/o Medical Students' Council,
Medical School, University of the Witwatersrand,
Esselen Street, Hillbrow,
Johannesburg, 200I.

ASBESTOS IN SOUTH AFRICA

ASBESTOS IN SOUTH AFRICA.

Introduction:

Health of workers in South Africa has always been neglected. They are subjected to poor living conditions with little or no sanitation, low wages, overcrowding and are often unable to buy good food. All this contributes to disease among working people in South Africa.

A big factor which undermines the health of workers is poor working conditions. People are exposed to poisons, dangerous dusts, chemicals and unguarded machinery. They have too few breaks at work, and work very long hours. Accidents occur frequently claiming lives and limbs. Disease and disability at work has been neglected for a long time.

Capitalists set up factories with the express purpose of making profit. They need to protect the worker only to the extent that he/she can carry on working. In a situation where there is vast unemployment workers are easily replaced. Safety equipment, machinery guards and safe processes are all expensive to the capitalist and decrease his profit. Thus it can be seen that because profit is the main object and numerous workers are readily available measures to protect the health of workers are neglected.

Asbestos is one type of material which workers are exposed to which causes severe disability and even death. This paper attempts to discuss asbestos in South Africa, how it effects workers and their families and why the situation continues to exist.

What is Asbestos?

Asbestos is a type of non-metallic mineral rock that splits into fine fibres when processed. There are two groups :

Serpentine Group:

Chrysotile falls under this group - also called white asbestos, it is used for textile manufacture, brake linings, clutch facings, boards, insulation products and asbestos cement pro-ducts. In South Africa this is found near Barberton and is mined by Kaapsehoop Asbestos, Stella mine and Beatrice mine and mill.

Amphibole Group:

a. Crocidolite - also called blue asbestos. It is very strong and is acid resistant. The longer fibres are used for heat insulation (lagging), acid resistant packings and battery boxes, gaskets and gasmark fitters. The shorter fibres are used in asbestos cement pipes. South Africa is the main world producer of blue asbestos. The mines are owned mainly by General Mining, Barlow Rand and Everite, and are situated in the northern Cape near Kuruman.

b. Amosite - also called brown asbestos. It is used for insulation in blankets, covers for heavy duty jet engines, and in lightweight board for partitions in ships. It is only found in South Africa, in the northern Transvaal.

In financial terms, for South Africa, asbestos is the second most important non-metallic mineral mined (after coal). 95% of sales were in foreign countries and thus very important in earning foreign exchange for South Africa. Export sales of all asbestos in 1978 were valued at R107,48 million (Financial Mail 3-8-1979).

Manufactured Asbestos Products:

There are more than 3000 products containing asbestos. Some common ones are :-

- Asbestos cement products (about 70% of the world's asbestos is used for asbestos cement). These are building material such as asbestos cement roofing, tiles, boards, gutters, sewerage and other heavy duty pipes.
- Paper, felts, yarn used to insulate roofs and cover pipes.
- Friction materials for brake linings and clutch facings.

The finished products containing asbestos range from heaters to hairdryers.

The companies which produce asbestos cement are also the major raw material producers, i.e. Everite and General Mining.

Because the factories are owned by the same people who mine the raw materials, it means that substitutes for asbestos in these products are likely to be resisted by these factories - they need a place to have their raw materials processed, and their factories assure them a market for the asbestos mined. There are a number of similar materials which could be

substituted, e.g. ceramic foam (1). However these substances although apparently safer than asbestos have not been fully tested yet and one needs to be wary of them.

Diseases related to Asbestos.

1. Asbestosis - in this disease the lungs or the linings of the lungs are scarred,by asbestos fibres inhaled from the air. When the lung is scarred it does not function as well as it should. Depending on the amount of damage the person may have difficulty in breathing especially when exercising.

   The fibres remain in the lung and can continue to cause more and more damage even if the person is no longer exposed to asbestos dust (2).

   This lung damage may eventually result in heart failure if the exposure has been heavy enough.

   If only the linings of the lungs are scarred (pleural asbestosis) the person will not feel breathless. Only special tests like X-Rays will show up the damage.

   It has been found that between 20% and 50% of people with asbestosis die of lung cancer or mesothelisma (6).

2. Lung Cancer - in the 1950's it was shown that a person exposed to asbestos has a 9 times greater chance of getting lung cancer than a similar person who is not exposed.

3. Mesothelioma - this is a type of cancer of the lining of the lung and sometimes the lining of the abdomen. It was found that mesothelioma is much more common in people exposed to asbestos (not only people who work with it but who live near mines and whose families work with it),than in the general population. In fact it is virtually unknown, except associated with asbestos (3).

   The lung cancer and the mesothelioma can take between 15 and 30 years to develop. Both these cancers are fatal within a short time, most people die within five years of diagnosis.

People exposed to Asbestos in South Africa.

The amount of people exposed is very difficult to estimate. One can work out how many people work directly with asbestos: in 31 mines,21 665 workers (4). In 1976 the Erasmus Commission of enquiry into occupational health reported a total of 6000 workers employed at 34 different factories in South Africa

manufacturing and using asbestos as one of the materials.

The number however of those exposed while mixing and using insulation compounds, doing building work, working with asbestos textiles, repairing brakes and clutches is unknown. It is also very difficult to know how much exposure these people get.

There are other ways of being exposed to asbestos too :-

Environmental Exposure: 35% of household members of families of asbestos exposed workers have been found to have x-ray changes of the lung, i.e. asbestosis (there is also an increased incidence of mesotheliomia.)

People who live in the vicinity of asbestos factories and mines have higher rates of mesothelioma than the general population. In a series of 100 cases of mesothelioma in South Africa, almost all were connected with the area of the Western Cape Asbestos fields. In some cases exposure was only for a period of days or weeks (5,6).

Construction, demolition work, wear and tear leading to disintegration of asbestos products in buildings may expose people. Many roofs in South Africa are made from asbestos cement.

Mining for other materials may be in contaminated rock resulting in the exposure of these miners and the general public.

Household goods such as toasters and hairdryers emit small quantities of asbestos fibres - these may be a source of contamination in the home.

The result of asbestos use in South Africa.

In South Africa asbestos is an important earner of foreign exchange. South Africa produces 5 of the world production of asbestos, and is the only country which produces blue and brown asbestos.

SOUTH AFRICA'S ROLE IN WESTERN WORLD MINERAL SUPPLY						
MINERAL COMMODITY	EXPORTS		PRODUCTION		RESERVES	
	RANK	%	RANK	%	RANK	%
Platinum group metals	1	91	1	91	1	89
Vermiculite (crude)	1	80	2	38	2	29
Vanadium (metal)	1	73	1	56	1	90
Gold (metal)	1	67	1	73	1	64
Manganese metal	1	67	1	55	—	—
Ferrochrome	1	58	1	33	—	—
Andalusite/Sillimanite	1	49	1	37	1	45
Diamonds (gem)	1	46	1	46	1	large
Chrome ore	1	40	1	51	1	84
Manganese ore	1	36	1	36	1	93
Ferromanganese	1	22	2	12	—	—
Fluorspar	2	21	1	13	1	46
Uranium (metal)	2	20	3	11	2	18
Zirconium (concentrate)	2	9	3	11	3	12
Titanium (ilmenite, rutile)	3	20	3	18	5	8
Asbestos (fibre)	3	12	3	10	2	8
Coal (bituminous, anthracite)	4	13	4	7	4	10
Antimony (metal)	6	7	2	20	2	18
Iron ore	7	5	7	5	6	6
Nickel (metal)	7	3	5	5	5	8
Copper (metal)	7	3	8	3	13	2
Tin (metal)	9	1	8	2	13	1

The results in South Africa of the use of asbestos can be seen from the mesothelioma register (1979) (7):

Total number of cases of mesothelioma = 712.

	% Total Cases:	% Composition of work-force in asbestos mines:
White	51,8	5%
African	28,0	92%
Coloured	20,0	3%

It can be seen that the above table must have excluded numerous cases of mesothelioma among Africans - 92% of the workforce but only 28% of the cases of mesothelioma. This is because there is no statutory follow up of miners after they have left the mines, poor facilities, and general unawareness in the medical profession of mesothelioma.

We can therefore assume that the total number of cases is more than 712. If one bears in mind that mesothelioma is rapidly fatal, this is an enormous number.

10. In the 1978 report of the Medical Bureau for Occupational Diseases, the following figures were found :-

Total number of asbestosis cases certified in the preceeding year

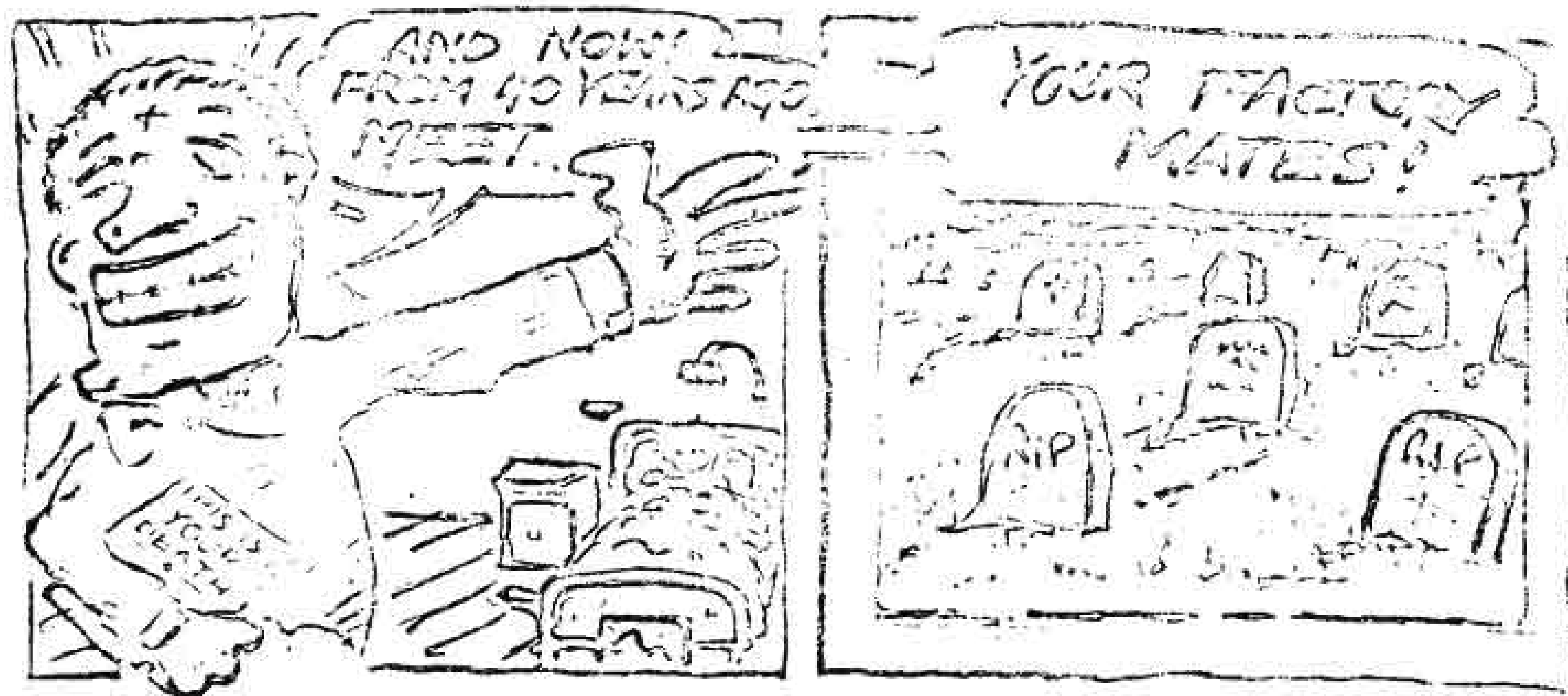
Whites - 241
Blacks - 323

If we consider again the fact that blacks make up 92% of the workforce, we must be forced to admit that the real figure for blacks must be much higher.

It should be noted that there are no unions for African mine workers. The African mine workers union was suppressed after a period of labour unrest in the 1940's. There are a number of white unions, the most important being the White Mine Workers' Union.

This is significant as the position of the asbestos industry and conditions at the workplace can be seen in terms of a conflict between the industry (managers), the workers in an organised form (union) and the state.

The roles played by these 3 parties is discussed below :-



Morgan and Seaton, *Occupational Lung Diseases*, Saunders, 1975

The Role of Management:

The asbestos industry is responsible for putting out a lot of information showing only the benefits of asbestos.

The South African Asbestos Producers Advisory Committee was set up especially for this.

The industry does research into the effects of asbestos on workers, research into the levels of asbestos fibre in the air which are safe. The industry also pays for research to be done by other people - either directly or indirectly - by giving money to research institutions. This "encourages" the researchers to see the asbestos problem from the industry's point of view. And if research does show excessive harm caused by asbestos it is not allowed to be published.

Genmin asbestos profits edge up

By Geoff Shuttleworth

The Genmin asbestos twins have both increased profits slightly for the June 30 ended quarter.

Msauli increased taxed profit to R864 000 from R835 000 while Gefco rose to R1,2m from R934 000. This brings Gefco taxed profits for the year to date to R2,1m compared with R3.0m in the same period while in the case of Msauli it reflects a taxed profit of R1,7m (R1,8m).

The amount of dust in the air is measured as fibers per cubic centimeter of air. This measure is often inaccurate and although there has been a lot of research, the "safe" levels in various countries have not proved to be safe. The "safe" level has changed numerous times over the years.

3. Workers may be compensated for diseases they have acquired while working with asbestos. Although this is necessary it is obviously not the most desirable position - workers should not be exposed to these dangers in the first place. Money cannot compensate for lost life.

The Results of the Conflict in South Africa.

There are no statutory limits to levels of exposure on mines, factories, or in the local environment.

Mines: There has been a reduction in dust levels on the mines, but the levels at the moment are still very high.

Table 2:

Airborne Concentration of Asbestos.

Fibres per cubic centimeter.

Years:	Crocidolite (Cape):		Amostite(Tvl):		Chrysotile:	
	Surface:	Underground:	Surface:	Underground:	Surface	Underground:
1940-45	430	23	234	7	17	1
1970-71	12	4	40	2	7	5
1976-77	6	2	7	3	4	5
1971(England) *	0,2		2,0		2,0	

* Recommended Levels.

This can be seen as a result of a weak and divided labour situation with uneven organisations of mine labour as a whole (even though whites are better organised they are still exposed to dangerous levels).

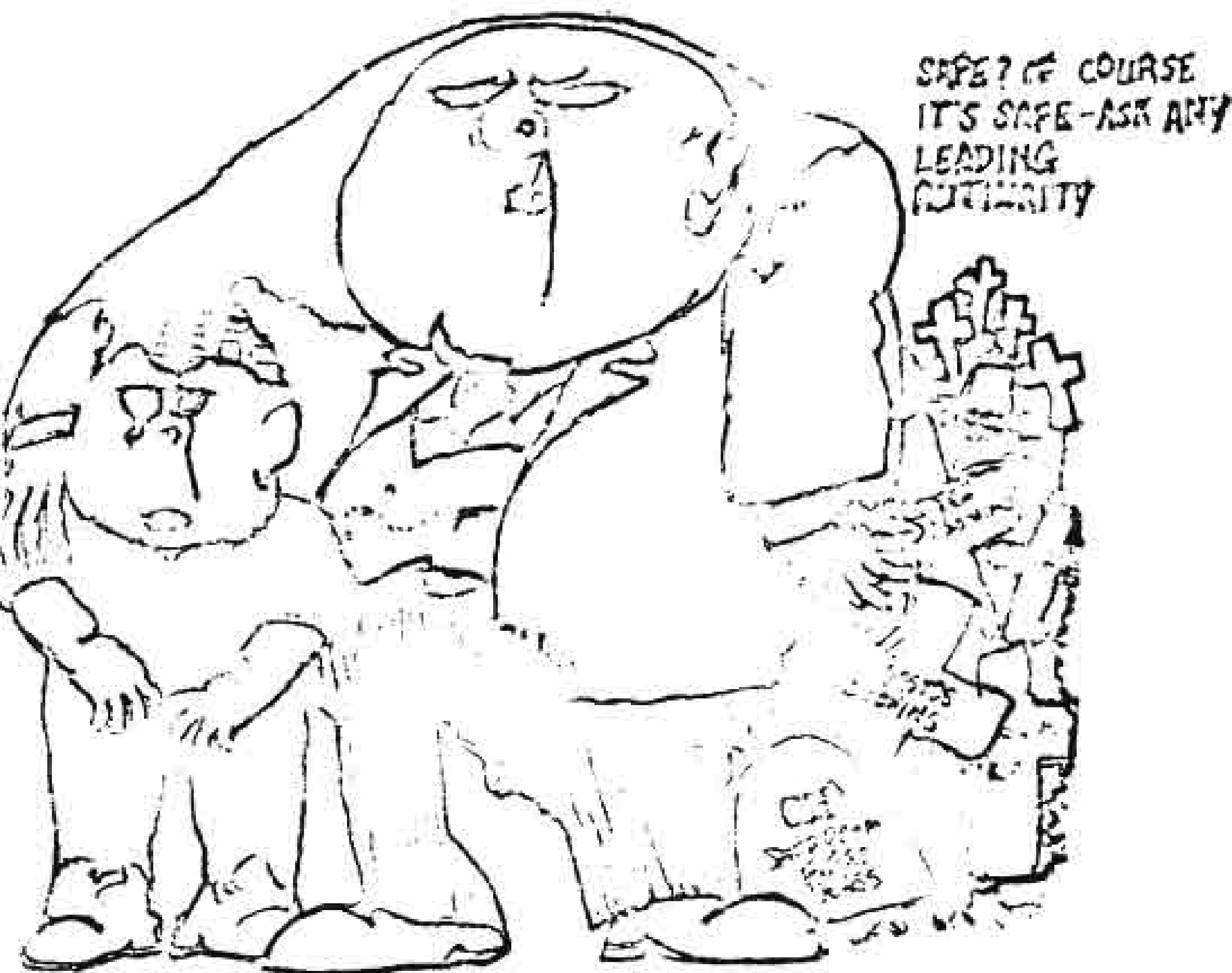
Manufacture:

The asbestos manufacture falls under the Atmospheric Pollution prevention act. An air pollution control officer with the factory owner decide on a level of asbestos fibres in the air.

Management has largely the support of the state as profits are seen to be in the national interest. The industry provides employment for numerous workers also seen to be in the national interest (albeit dangerous employment).

When pressure is put on industry to decrease levels of asbestos in the air or to increase other safety measures - the industry brings out these arguments.

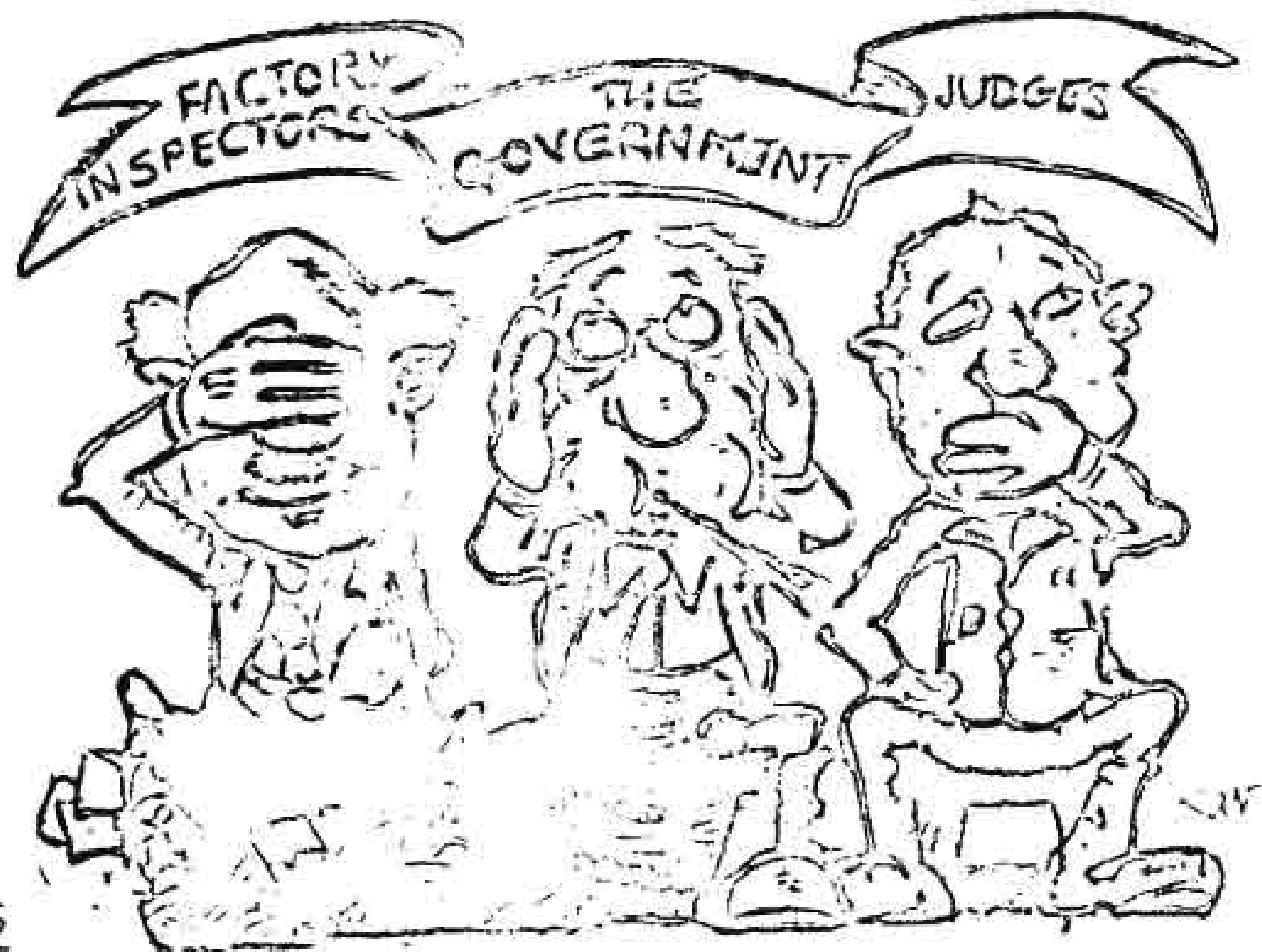
When all arguments and pressures fail management can then transfer production from areas of strict health regulations to areas where they are not strict. This is usually relatively easy as the companies are usually international.



The Role of the State:

Some of the State's functions are to maintain production and national unity. The state having to maintain production will therefore tend to support management. It does this in various ways: management representatives are often included in state research bodies; some countries have legislation which prevents workers finding out the results of an inspection of their factory.

The State also polices the safety regulations by means of factory inspectors. In 1975 in South Africa there were only 29 inspectors for occupational safety covering 30097 factories. The inspectors could not possibly see even a small proportion of these.



The Role of the Unions

The labour movement has rarely the power or the finances to compete with industry and the state. However where there is a strongly organised movement it has been increasingly successful. Pressure from these labour movements has resulted in "safe levels" of asbestos in the air being progressively revised.

It is obvious that where there are no forms of labour organisation the position of the individual exposed is very dangerous and the chances of intervention minimal.

There are 3 possible results of the conflict.

1. The substitution of asbestos by other materials and eventually banning the use of asbestos because of its danger to health.

2. Preventing excessive exposure by keeping down the levels of dust in the air which workers breathe, by using methods such as vacuum extractors.

Taken into account is the cost to industry of reducing fibre levels, thus one can see that the levels are very arbitary, a' the levels are monitored by the factory owner; subjected to inspection. There is however one inspector in the Cape for a area stretching from Okiep to Port Elizabeth. What is strik- ing is that the setting of safe levels is left to the discret' of the inspectors, that there are very few inspectors and thus the monitoring is left to the factory management.

In other countries the work situation is quite different, especially in countries where labour organisation is strong.

United Kingdom:

The safe levels of asbestos are statutory; for chrysotile the safe level is 2f/cc, for crocidolite (blue asbestos) the level is 0,2f/cc which has resulted in an effective ban on its use since 1971. The Trade Union Council in the United King- dom is pushing for a total ban on asbestos.

The Advisory Committee on asbestos set up on 1976 by the U.K. government has recommended that the legal limit be reduced to 1 f/cc for chrysotile, o,5f/cc for amosite and that the use of blue asbestos be formally banned. It also says that there is no safe level for asbestos and that substitutes should be used wherever possible.

Sweden:

Sweden banned blue asbestos in 1976 and instituted a ban on working with asbestos cement products at the same time. In May 1979 a total ban on all asbestos containing products were instituted.

U.S.A.

The U.S.A. has a standard of 2 f/cc for all types of asbestos. The National Cancer Institute and National Institute for Environmental Health Services state in a report that 20-25% of peoplеheavily exposed to asbestos die of lung cancer. 7-10% die of mesotheliama and 8-10% die of cancer of the gastrointestinal tract.

CONCLUSION:

Asbestos is mined and used in manufacturing under conditions which are dangerous to all the workers involved, and which would be totally unacceptable in most other countries.

There is virtually no protective legislation for workers, and although there is workmen's compensation, there has been very

Asbestos ruling by EEC

RDM 19/6/80

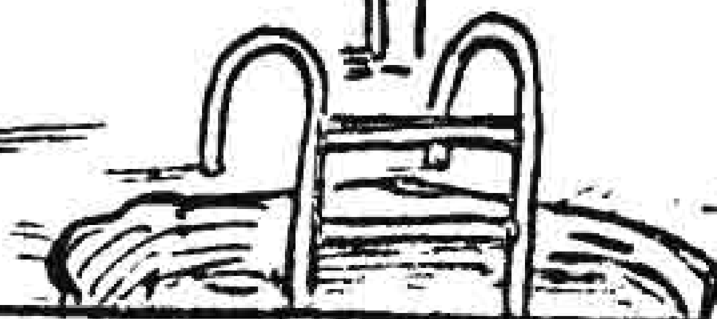
BRUSSELS. — EEC governments have agreed to introduce legislation within four years requiring compulsory health surveillance of workers exposed to asbestos and lead.

At the same time, EEC ministers responsible for employment and social affairs, undertook to introduce regulations within three years which would ensure that workers exposed to five substances are told about their hazards. They are cadmium, mercury, arsenic, asbestos and lead.

The adoption of a draft directive covering health surveillance and warnings means that each member state will undertake to meet the agreed standards through national legislation within the specified period. Originally, the European Commission proposed an 18-month deadline for introducing the monitoring of workers' health after contact with asbestos and lead, but the UK, supported by Ireland, insisted on longer.

Not all states will have to take action on the provision of information on the five dangerous substances because the UK, for example, already requires employers to pass on such information.

Responding to several months of pressure from European unions, the ministers also adopted a long resolution on "guidelines for a Community labour market". In essence this amounts to little more than agreement on what a labour market policy should be in terms of providing training and matching job seekers with available employment. — Financial Times.



— WORKERS STRUGGLING TO SURVIVE OFTEN HAVE NO CHOICE

little attempt to prevent the asbestos related diseases in South Africa.

The asbestos industry, aided by the state, maintain the unhealthy conditions as they are. Change will only occur if workers organise themselves and fight together for their rights.

Workers need to organise themselves into unions which will represent the needs of all the workers. In this way workers can have some say in their work situation, and enter the conflict (management-union-state) from a much stronger position. If a worker or small group of workers enter the conflict alone they will easily be crushed, this is why good organisation among workers is necessary. Once there is good organisation workers (unions) can demand better working conditions, lower asbestos levels, safety equipment, etc.

REFERENCES:

My main source was: Asbestos & Asbestos Related Diseases in South Africa, J. Meyers, SALDRU working paper, No. 28.

1. Asbestos Killer Dust, A worker/community guide: How to fight the hazards of asbestos and its substitutes. BSSRS Publications, August 1979.
2. Department of Mines, Asbestos Symposium. Editor H.W. Glen, 1977, p.116.
3. Diffuse pleural mesothelioma and asbestos exposure in the North West Cape Province. J.C. Wagner, B.J.I.H. 1976, 33, p.147-151.
4. Mining Statistics 1975-1979 (Annual Publications of the Department of Mines).
5. Mesothelioma in household contacts of asbestos workers. H.A. Anderson, Third International.
6. Asbestosis - J. Webster, S.A.M.J. Vol.38, 31-10-64 p.870.
7. Asbestos and Asbestos-Related Disease in South Africa. Jonathan Meyers, Saldru Working Paper No. 28.

BIKO, THE STATE AND THE S.A. MEDICAL AND DENTAL COUNCIL (S.A.M.D.C.) AND, NOW, THE MEDICAL ASSOCIATION OF SOUTH AFRICA (M.A.S.A.).

EDITORIAL COMMENT.

In Critical Health No. 3 we dealt in some depth with the inquest into the death of Steve Biko, the role that the state and the three doctors played in his death and the views of the S.A.M.D.C. on this matter.

It is apparent, from an examination of the evidence led at the inquest and the admissions of the doctors involved, that the inadequate treatment received by the late Steve Biko would have been different had he not been a political prisoner. The doctors did not act with complete clinical independence and this led to the unsatisfactory medical management. (1)

Despite this fact, the S.A.M.D.C. decided that there were no grounds for disciplinary action against the doctors concerned. When we examine the composition of the S.A.M.D.C. and see the close links between it and the Nationalist government, it is not surprising that they reached the decision that they did. (1)

At the time of publishing the last edition of Critical Health, the Medical Association of South Africa, the largest and oldest association which offers membership to doctors, and to which the majority of white South African doctors belong, still had to take a stand on the issue. It was petitioned to hold an inquiry into the conduct of one of the Biko doctors by a number of its members.

The Medical Association of South Africa makes some very admirable statements on ethical principles in its booklet entitled "A Guide to the Maintenance of Ethical Standards".

In this publication they define ethics as "the science which treats the nature and grounds of moral obligation; moral philosophy which teaches men their duty and the reasons for it." (2)

In the introduction to the same booklet the M.A.S.A. say the following "standards have been set for the profession from the early times of Hippocrates, and through the ages

doctors have undertaken to act according to the principles of the Hippocratic Oath. In more recent times there are the World Medical Association which has, in the Declaration of Geneva, given a modern version of age-old rules, the International Code of Medical Ethics and the Declaration of Helsinki, TO ALL OF WHICH THE MEDICAL ASSOCIATION OF SOUTH AFRICA HAS SUBSCRIBED. ((2)Editors' emphasis).

"It is also common knowledge that there are certain customs or forms of etiquette which, although not always in writing, yet constitute conduct which is right and proper for a doctor and a gentleman to observe." (2).

The codes to which the M.A.S.A. subscribes contain the following statements;

> "Into whatever houses I shall enter, I will go for the benefit of the sick, abstaining from all voluntary wrong and corruption ..." (Hippocratic Oath).
>
> "The health of my patient will be my first consideration." (Declaration of Geneva).
>
> "I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient". (Declaration of Geneva).
>
> "I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity." (Declaration of Geneva).
>
> "The following practices are deemed unethical ....
> (b) Taking part in any plan of medical care in which the doctor does not have professional independence." (International Code of Medical Ethics).

Despite all these statements the M.A.S.A. seems to pay little more than lip service to them. At a meeting of the Executive Committee of the Federal Council of M.A.S.A. held on the 22nd August 1980, after referring the matter of the doctors' involvement in Biko's death to the Cape Midlands Branch of M.A.S.A. and the Federal Councils' Ethical Committee for their recommendations, the Executive Committee did no more than sweep the matter aside with a mere noting of

(a) the S.A.M.D.C's decision to take no further action, and

(b) the Cape Midlands Branch of M.A.S.A's decision to take no further action.

At the same time, M.A.S.A. reaffirmed its unquestioning support for the integrity and bona fides of the members of the S.A.M.D.C. (3).

Furthermore, an editorial of the South African Medical Journal (S.A.M.J.) (4) urged doctors to stop criticising the S.A.M.D.C. on their decision in connection with the Biko doctors. The S.A.M.J. is the "official organ" of the M.A.S.A. It backed its plea with the following argument:

> "Perhaps at this point it behoves us to refresh our memories, which tend to be rather short at times. When the S.A.M.D.C. did battle with the Minister of Health with regard to the medical scheme tariff structure, the profession was quick to support the Council and to announce its complete confidence in its integrity and the manner by which it (the S.A.M.D.C.) reached its conclusions on that particular issue.
>
> Must we in truth believe that the professional integrity and common sense of our colleagues on the S.A.M.D.C. has undergone a complete volte-face in such a short time? Has our professional objectivity not become clouded to some extent by subjective or political issues?" (4)

We believe that the executive committee of the Federal Council of M.A.S.A. has, by its resolution and statements, in fact merely endorsed the view that the doctors concerned did not act unethically.

Late in 1980, the Federal Council of M.A.S.A., under considerable public pressure from both inside and outside South Africa, including the threatened resignation of many members, reconsidered its decision to take "no decision". They released the following statement :-

> "The Federal Council "resolves to require the Federal Ethical Committee to give consideration to and to make recommendations regarding the ethical issues raised as a result of the medical care received by the late Mr. S.B. Biko and to give consideration to:
>
> (a) holding its proceedings in public;
>
> (b) appointing counsel to lead the evidence and/or to appoint a retired judge and/or counsel to preside;

(c) inviting Drs. Tucker; Lang and Hersch to take part in the proceedings." (5)

We are immediately struck by the non-committal and toothless nature of this resolution, the fact that it only emerged on second thoughts about the issue and that it was taken under considerable pressure. We cannot help believing that this is merely an attempt to avert any criticism levelled at M.A.S.A. To date, the M.A.S.A. has still not taken a firm stand.

The S.A.M.J. has also refused to publish a number of letters criticising the M.A.S.A., including a letter from the Dean of the Faculty of Medicine, University of the Witwatersrand. (6)

Much can be said about the way the M.A.S.A. has acted on this issue, but perhaps the overriding point that should be made is this :-

The M.A.S.A. has failed to :

(a) take an immediate and unequivocal stand on the unethical conduct of the doctors who treated the late Steve Biko;

(b) make an early and strong stand on the health rights of political prisoners;

(c) voice all possible protests against the way the S.A.M.D.C has acted on the issue or to put any pressure behind the questions they asked of the S.A.M.D.C.;

(d) play a role any different from the cover-up role played by the State and the S.A.M.D.C.

Through their action the M.A.S.A. has shown itself to be an ally of the repressive apparatus of the State.

We should not be too surprised by this statement and the M.A.S.A's decisions, just as we were not surprised by the decision of the S.A.M.D.C. The M.A.S.A. has, despite unsubstantiated statements by Professor de Klerk to the contrary, consistently demonstrated a conservative response in its actions, if not in its words, on the broader issues of health.

One example of these actions is the manner in which it has gone about forging better links with conservative organisations abroad (see the article on the American Medical Association and M.A.S.A., in this edition).

The links between the M.A.S.A., the S.A.M.D.C. and the State are no where better confirmed than by the fact that Professor F. Geldenhuys, President of the S.A.M.D.C., is now also Chairman of the Federal Council of the M.A.S.A.

The M.A.S.A. cannot claim to represent the views of many South African doctors.

The time is right for progressively-minded doctors to resign from the M.A.S.A. and to begin forming new local groupings of health workers through which to express their views. In this way, we can work towards the formation of a national association of health workers, which has a concern for justice, ethics, human rights, and will work towards a just and democratic South Africa - an effective alternative to the M.A.S.A.

REFERENCES:

1. CRITICAL HEALTH, No. 3, 1980.

2. A GUIDE TO THE MAINTENANCE OF ETHICAL STANDARDS, published by the M.A.S.A. 4th Edition (Revised), May 1979.

4. S.A.M.J., Editorial, Vol. 58, No. 7, page 265. 16th August 1980.

3. S.A.M.J., Letter by Professor De Klerk, 13th September 1980.

5. S.A.M.J., Vol. 58, No. 21, pages 829-830. 13th November 1980.

6. S.A.M.J., Letter by B.Bradlow, Vol. 59 No. 2, January IO I980, page 31

DSG/SARS

INFORMATION PUBLICATIONS

The Southern African Research Service (SARS) and the Development Studies Group (DSG) are continuing with their series of INFORMATION PUBLICATIONS.

* POPULATION REMOVALS (already published - R1,00 incl postage)
* DEBATE ON HOUSING (of a more theoretical nature; already published R1,00 incl postage)
* POLITICS IN SPORT (price not available yet)
* POLITICAL TRIALS (price not available yet)

Copies available from DSG/SARS
PO Box 93174
2143 Yeoville, South Africa
Phone: 725-2835 (Jhb code 011-)
(postage rates are those for southern Africa; rates elsewhere available on request)

RESTRICTED VISION = (some comments on the 40 hour famine).

There is a familiar argument against charity and welfare: it is said that they undermine people's self respect, that they create dependence on the giver, and that they ignore the root causes of the problem. In this way, it is argued, charity re-inforces the system that creates the problem, and makes it less likely that the victims will organise towards change.

This argument itself can be criticised. It is a very cynical person indeed who says that starving people must wait until "after the revolution" before they can be properly fed. But it remains true that the effects of any charity programme need to be carefully assessed. For such programmes can be misleading about the root causes of hunger and poverty, and can draw attention away from what needs to be done to change things.

World Vision's "40 hour famine" is a case in point. For the last two years World Vision (an Evangelical Christian body) has organised such "famines". The idea is that people fast and get sponsored for each hour that they don't eat. World Vision uses the money that is raised in this way to sponsor feeding schemes around the country.

According to a publicity pamphlet the fast is "aimed at mobilising public compassion and resources to wipe out malnutrition in Southern Africa." This is where the first question arises. There can be no serious argument about the causes of malnutrition in South Africa. It is unemployment, landlessness, economic exploitation backed by political repression, the bantustan policy and migrant labour that are the major strands in the web of poverty and social disruption that are finally responsible for hunger and starvation. World Vision is doing nothing about these problems, and yet claims, through its 40 hour famine to be trying to wipe out malnutrition. In this way the organisation turns attention away from these problems.

The second flaw in the World Vision campaign is the kind of attitude that it helps to create. Those who have taken part in the fast are offered a sticker to put on their car or school bag. The sticker reads: "I have starved ... so that others won't". There are a number of problems which result from slogans like this.

Firstly, it is particularly self righteous. It says: "I have done my bit for the starving masses. I am a good person". Secondly, the sticker is misleading. Starving oneself deliberately has absolutely no effect on whether other people starve or not. The money could be collected just as well without self inflicted "starving." This starving of oneself is little more than a way of escaping one's guilt at the fact that others are really starving, and feeling good about "doing one's bit". It also enables many people who directly or indirectly uphold the very system that leads to starvation in South Africa to feel complacent about their role.

Indeed, a major criticism of the World Vision campaign, and many similar welfare actions, is that they present the solution to the problem as being non-political acts of individual charity. This ignores two things. Firstly, the wealth of South Africa rightly belongs to all the people of the country anyway. Secondly, a just redistribution of this wealth will only take place when the poor and the starving have sufficient political strength to claim what is rightfully theirs.

Individual acts of charity may be valuable if they help to feed the victims of Apartheid. But to suggest to school children, to churches and to the public that such charity is the solution to the problem is misleading in the extreme because it draws attention away from the political tasks that are necessary to change society.

To achieve these political tasks requires joint and united action. To substitute acts of self-starvation for such united action is to encourage political passivity.

By all means let us try to feed the hungry. But let us also, realistically dedicate most of our energy to understanding and to changing the society that causes hunger in the first place.

BREASTFEEDING, THE MULTINATIONALS AND INFANT FORMULA - A SECOND LOOK

BREASTFEEDING, THE MULTINATIONALS & INFANT FORMULA = A SECOND LOOK.

SHARON FONN & STEVE TOLLMAN.

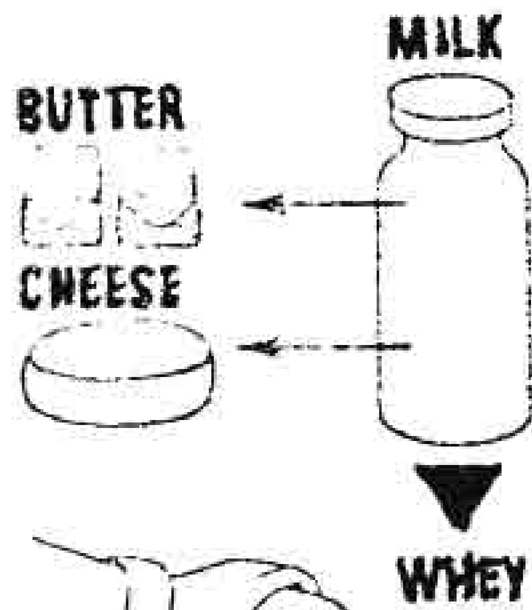
This article was motivated by two considerations: firstly, to give historical perspective to and elaborate on certain of the issues raised in the article "The Promotion of Infant Formula Foods" in Critical Health No. 2, March 1980, and secondly, because we believe the influence of multinationals on the health of communities in developing countries is so extensive as to deserve further discussion. We hope that this article will prompt a third article dealing with strategies for solving the bottle feeding problem and including the progress that has been made by the WHO in trying to control the promotion of infant formula.

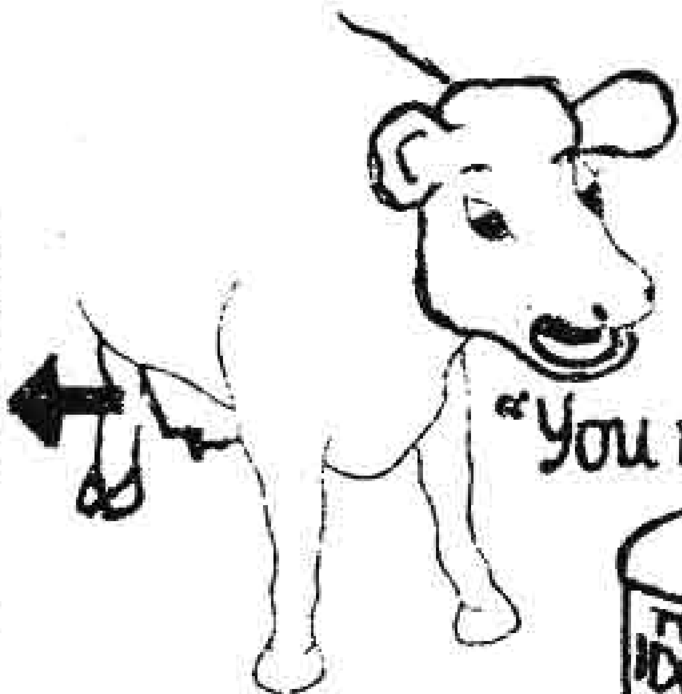
Our article has three sections: the first deals with the development of the Baby Food industry to its multinational status and the effect of the industry on its Third World targets. The second takes a close look at certain of the advertising techniques used by the Baby Food Industry, while the third looks at factors implicated when a mother stops breastfeeding.

The trend away from breastfeeding has its roots in the eighteenth century, when the elite of Britain and Europe found an alternative to the "vulgar" method of breastfeeding in milknurses. These nurses breastfed children as a form of employment. This institution, open as it was to corruption - such as mothers abandoning their own children to earn money feeding others, and the use of alcohol to quiet their charges - fell from favour during the nineteenth century.

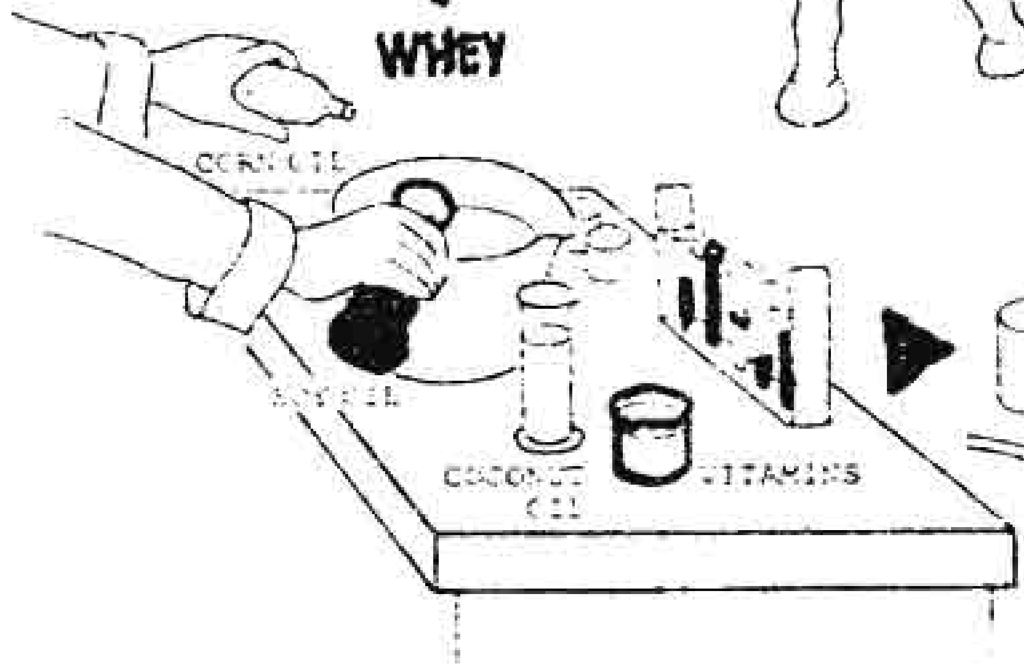
Sterilized cows milk was widely used during the early 1800's and in 1835 condensed milk was patented. In 1866 Nestlé marketed the first condensed milk in tin boxes.

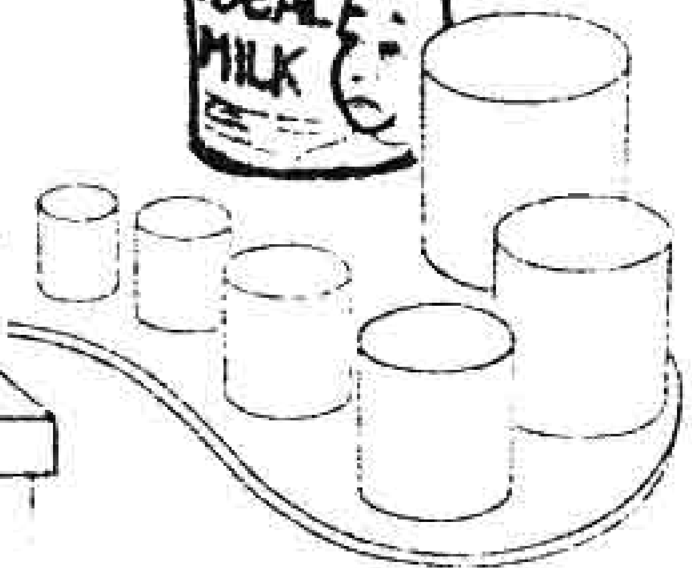
With the separation of milk products into cheese and butter, a use had to be found for the by-products, and in 1892 the first milk laboratory was opened in Boston which resulted in the development of powdered milk. By 1904 powdered milk supplements were widely used in infant feeding.


MILK
BUTTER
CHEESE
WHEY


"You must be joking"

THE IDEAL MILK
THE IDEAL MILK


CORN OIL
COCONUT OIL
VITAMINS



As the baby food industry became more established competition became intense and many manufacturers began a search for export markets. As early as 1928 special export milk was introduced by a British manufacturer as "suitable for use in the tropics". (p.71,(2)). These products were aimed, in the main, at Britons living abroad as officials and civil servants in the colonial governments.

Thus the embryonic links with the Colonies as virgin markets were forged. This was enhanced by the political and moral validation of colonial ideology which propagated the theory that the high technology products and "advanced" western methods could only help the development of the colonies.

War intervened in the 1940's but by the 1950's, after the industrialized world had recovered from its effects, competition became very fierce and western markets were flooded with infant formula. After the initial post war "baby boom" however, the birth rate of the industrialized nations began to decline and expansion of the milk companies was limited in these countries. This pattern was not, however, reflected in the Third World where the birth rate was increasing. Further, third world countries held the added attraction of a totally untapped market vulnerable to the highly sophisticated advertising techniques which had evolved in the West.

The development of third world markets was easily achieved by employing the same channels used by the West during the period of colonial expansion.Thus the emergence of multinational corporations.

We would now like to take a closer look at these third world countries, bearing in mind that they comprise some 2/3 of the world's population.

Using six parameters we can describe the situation that exists in most third world countries:

1. In the average developing country 80% of the population is rural.

2. Of the 20% living in larger towns and cities more than 1/5 live in crowded tenements and shanty towns in the so-called'septic fringe'of these cities.

3. The existing rural health services are stretched to their limit so that less than 20% of the rural population receive any basic health care on a regular basis. Curative services, in the form of hospitals in urban areas, absorb more than 75% of the total health budget. In spite of

the concentration of the health professionals in the cities, the urban population in slums and shanty towns do not enjoy any better health facilities than their rural counterparts.

4. It is estimated that up to 40% of the population of the average developing country exists below the poverty datum line.
5. Only some 25-35% of the population of developing countries is literate.
6. Environmental sanitation is virtually non-existent in these countries. (After Ebrahim (2).)

It is against this backdrop that we should look at the effects of the promotion of infant formula by multinational companies.

The post-war years were accompanied by major nutrition intervention programmes in many developing countries. This took the form of free distribution of powdered skim milk donated by various international agencies. The provision of this milk with its attendant professional and political support attracted mothers to child health clinics and improved their utilization of these services. But it also contributed to the decline in breastfeeding. This was well illustrated in Chile where there has been an almost total abandonment of breastfeeding 20 years after the introduction of the free milk schemes in the 1940's. (11). In Jamaica no such scheme was introduced and yet there is still a trend away from breastfeeding; with 90% of mothers bottle-feeding within 6 months of giving birth (11). Thus, while the distribution of free milk should take some responsibility for the decline in breastfeeding in third world countries, there are other factors which must be considered.

In analysing the reasons behind this trend two factors became apparent, firstly, the aggressive advertising techniques employed by the various milk companies (discussed below), and secondly the phenomenon of "taste-transfer" (9).
This refers to the desire of those in lower socio-economic strata to take on the symbols of modernization and technological advancement they see around them. It is an expression of their desire to aspire to that standard of living which the elite set as a model before them. This factor is well recognised by the multinationals, as Kaplinsky, in his analysis of breakfast foods in Kenya, comments: "the producers of Weetabix in East Africa use the strategy "stick it in at the top of the market and let it sink down " (9).

Emulation of the elite by those of the lower socio-economic strata is well understood by the marketers of infant formula who capitalize on it as is clear in this statement by McIntyre regarding the making of advertisements;

> "... since Europeans have traditionally represented the privileged class to which most people aspire, and have been looked on as consumers of quality products by people in underdeveloped countries, the psychological association between Caucasians and the advertised product can be a positive one" (9).

The association of white-equals-western-equals-quality is a concept which was fathered by the philanthropic activities of the colonial governments before the advent of the multinationals.

Thus the use of "taste-transfer" implies the introduction of imported, high technology, and high cost goods which, in the case of infant formula, gives poor value in relation to the biologically available, non-synthetic, local resource. Added to this, infant formula is unsuited to local conditions.

Who then is most at risk in this market ?

The trend of rural poor to migrate to urban areas is firmly established in developing countries. The table below, displaying the projected population in cities in third world countries in the year 2000, illustrates this point.

	1975	2000
Cairo	6,9	16,9
Bombay	7,1	19,8
Rio de Janerio	8,3	19,3

Projected population in millions in the year 2000 (2).

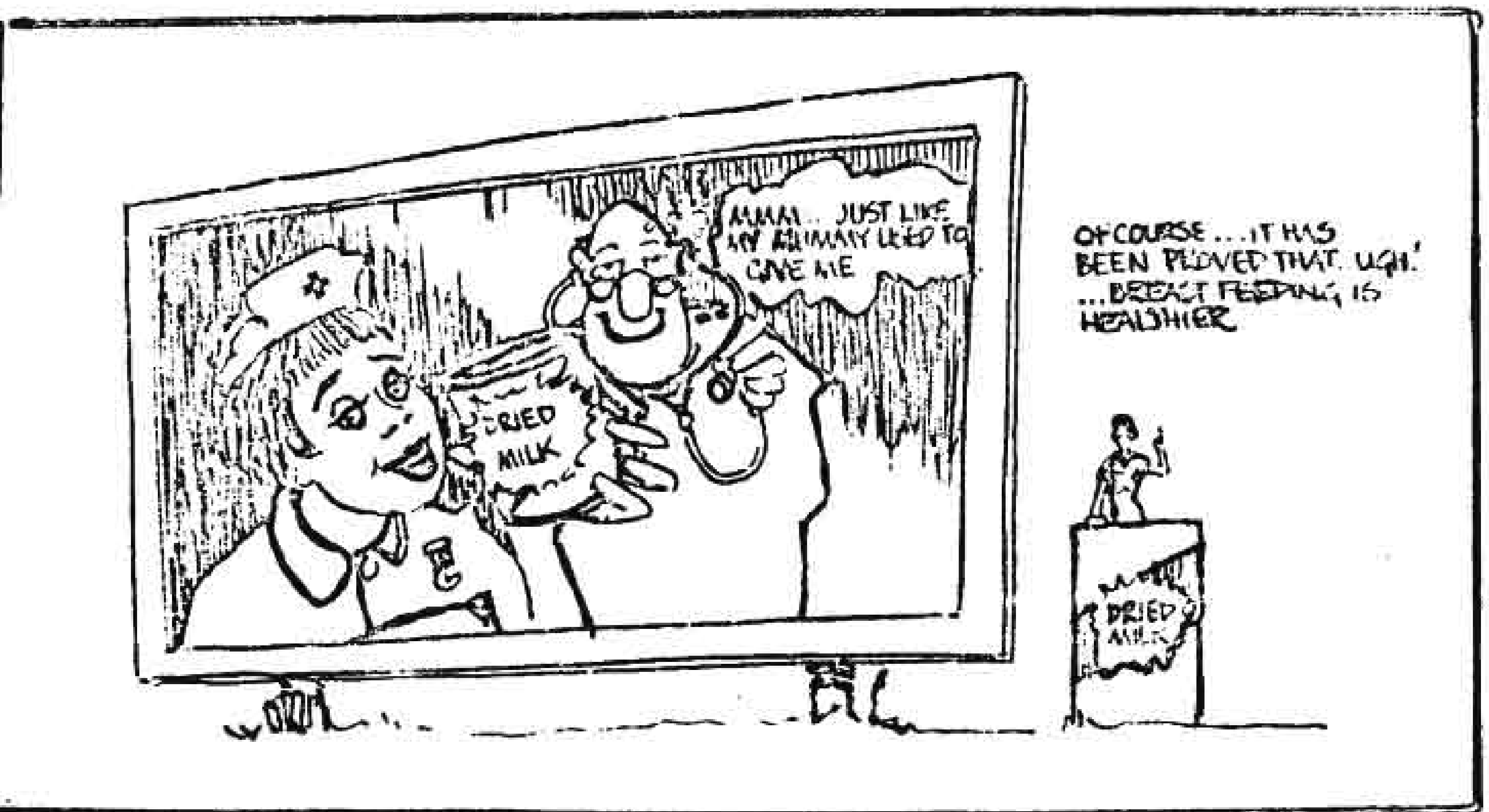
The vast majority of these urban dwellers are the poorest segment of the population, the migrants to the city, who live in shanty towns, forming the city's "septic fringe". They relinquish their social and cultural values and adopt a rootless existence. Thus they are at maximum risk of taking up bottle feeding as a symbol of modernization (2), yet, ironically, they can afford it least.

We would like to focus some attention on the economics of artificial feeding.

The displaced rural family, desperate to find employment but also unskilled, falls into the lowest paid category of workers. In addition, they are not used to operating in a cash economy and will have difficulty budgeting satisfactorily. A close look at the cost of bottle-feeding relative to the minimum wage of a worker in Tanzania, Nigeria, India or Egypt makes the point clear :-

	MIN. WAGE PER WEEK (US$)	COST OF FEEDING A 6 MONTH INFANT PER DAY (US$)	% OF WAGE:
U.K.	39,20	1,3	3,3
Tanzania	7,62	2,44	32,0
India	4,62	1,62	35,1
Nigeria	5,18	2,44	47,1
Egypt	4,09	2,59	63,3

Relationship between minimum wage and % of wage needed to feed a 6 month child. (11).



Reprinted from "Poverty and Power" by Rachel Heatley, RVA.

BREAST IS BEST

Breast-feeding is nutritious, safe, inexpensive, and helps protect infants against disease.

In recent years there has been a tendency towards bottle-feeding babies with powdered milk.

This can cause malnutrition and ill-health because:-

Parents may not be able to read the instructions on the tin.

They may not be able to afford enough of the milk powder and may over-dilute it.

So the baby can become malnourished and vulnerable to disease.

The water which is used to mix the milk powder may not be safe.

Parents often cannot sterilize the feeding bottle and baby may drink in germs.

Economically the migrant family is in no position to use artificial infant feeding products particularly since breast milk is free and avoids many of the health hazards which accompany bottle feeding.

It can be concluded that artificial feeding is economically counter productive on the personal level. This is also true on a national scale.

Breast milk is an important resource for a developing country, e.g. a decline of only 20% in breastfeeding in Tanzania will require importation of powdered milk costing £2 million at 1970 prices. This is equal to 1/3 of Tanzania's health budget for 1975 (2).

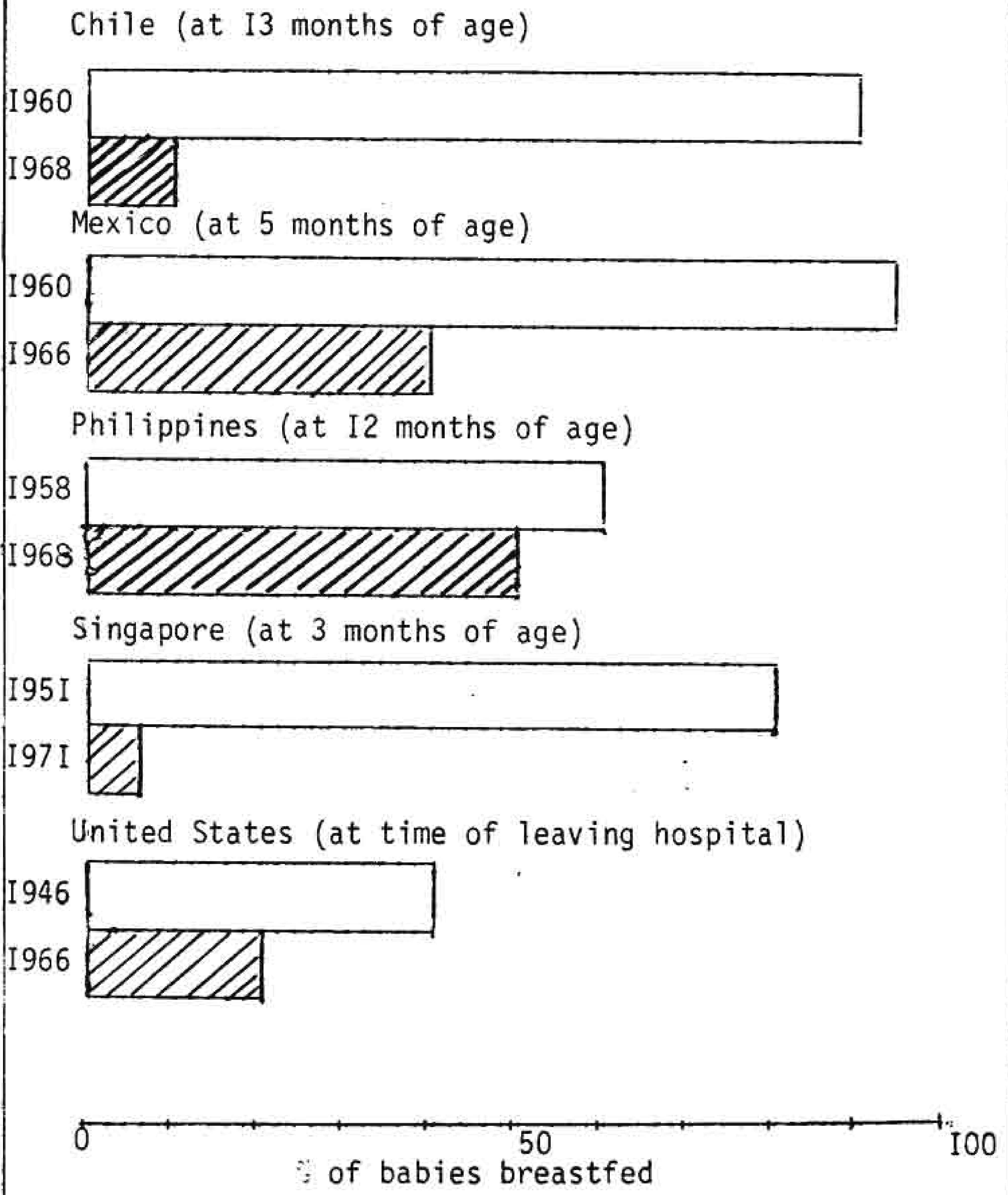
The milk formula industry is not in the hands of the host country but in the hands of the multinationals who "not only introduce and promote the use of high technology goods but also maintain effective control over them. In addition, they

employ a variety of so called "profit management techniques" by which the wealth they help generate is not available at source but is either repatriated or transferred elsewhere". (9).

Thus a developing country can ill afford to allow the swamping of its markets by a product which has such a deleterious effect on the health of its population and its economy.

We have looked at the economic manifestations of the decline in breastfeeding and would like to conclude this section with some further figures which give an idea of the universality of the problem.

In Chile the movement from breast to bottle feeding has been well documented. While more than 90% of infants were breastfed in 1960, fewer than 10% were breastfed in 1968. (3). Further, mortality rates at 3 months of age were 2,5 times higher for children who were both bottle fed and partially breastfed compared with children who were breastfed only. (3). From Mexico it has been reported that while over 95% of infants aged 6 months were breastfed in 1960, the figure for 1966 is about 40%. (3). In Singapore some 80% of 3 month old infants were breastfed in 1951 and approximately 5% in 1971. (3). (See graph below). In Ibadan, Nigeria, a study of infant feeding practices, reported in 1973, indicated that more than 70% of the mothers surveyed began bottle feeding their babies before they were 4 months old. (8).



from Berg (I)

2. ADVERTISING OF INFANT FORMULA.

Most of the promotional techniques used by the Infant Formula manufacturers are well covered in Critical Health No. 2, (12). A more detailed discussion of these techniques can be found in Greiner's monograph, "Regulation and Education: Strategies for Solving the Bottle Feeding Problem" (4).

In this section we plan to look closely at the techniques underlying radio and poster advertising to populations which are, for the most part, preliterate and live in areas where modern facilities such as running water and refrigerators are non-existent.

The marketing of infant formula, is a skilled undertaking. As Crauche (9) has said, "Creating a new market means changing a way of life". Omana, in 1965 (9), discussed the theoretical basis for appealing to the African Consumer. He asks, "Let's see what makes him tick", and replies with the following sketch of "our prime target".

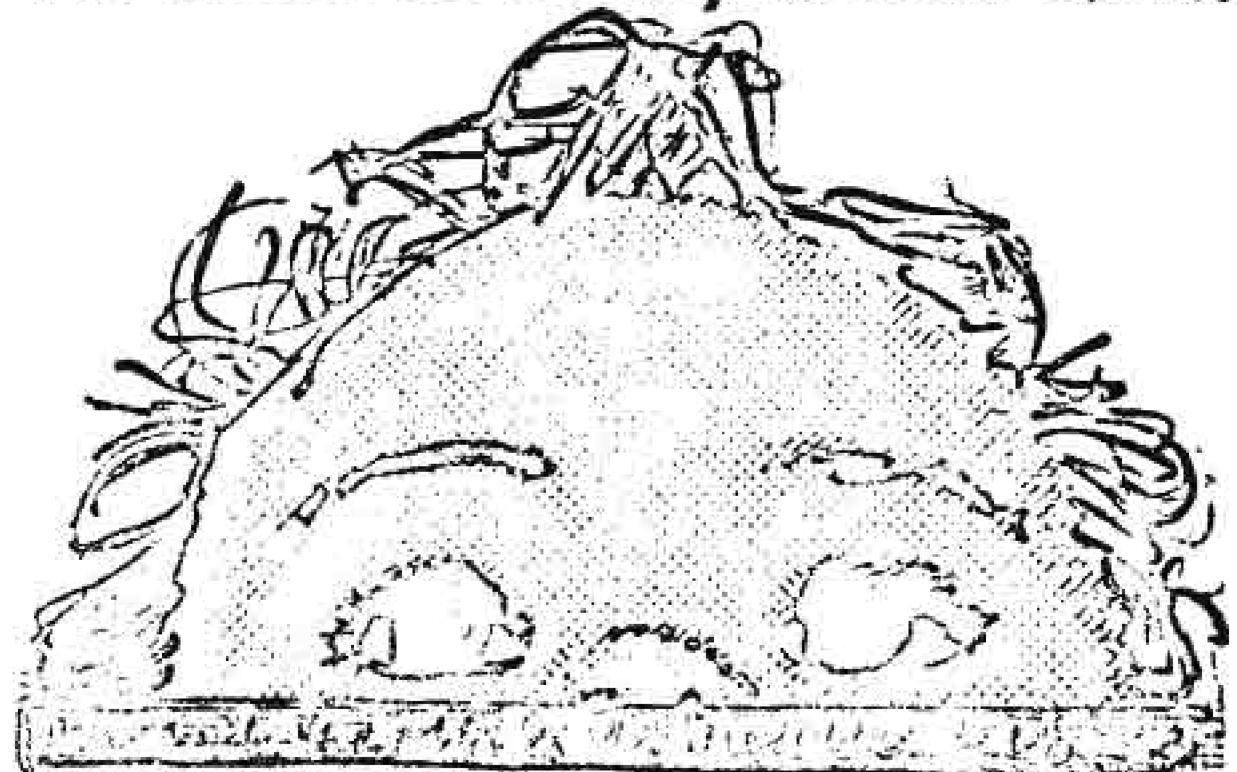
> "I would describe the average African consumer as very unsophisticated and more often than not illiterate. However, he is very quality conscious - to the point of being suspicious! And more important, he is willing and very able to learn. This means he is susceptible in fact, very receptive, to advertising.
>
> In other words, give the African a quality product, priced within his means, advertise in a manner which will reach him, and you will develop a customer with an unprecedented degree of brand loyalty - as Nestlé has been able to do with its condensed milk (9)".

This emphasis on brand loyalty has been used to overwhelming effect in the infant formula industry. Omana continues this offensive account by turning to the question of "formulating the creative strategy":

> "The lion, like the leopard and other similar animals, is a symbol of strength, and therefore you see its frequent use in African advertising. Why?
>
> The African is overly preoccupied with health, strength

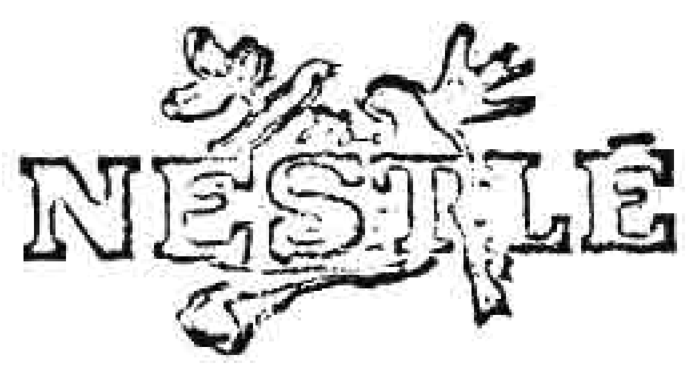
Lactogen Advertisement in a Journal for African Paraprofessionals in the Health Field

No need to worry about me...



I am building up on Lactogen!

Modified and enriched powdered Milk, containing nine added Vitamins and Iron, prepared especially for infant feeding.
...one of the very fine products made by



the company that takes good care of millions of babies on five continents. Founded by Henry Nestle in 1866 at Vevey (Switzerland), Nestle employs today 86,000 people in over 220 factories and 650 administrative centres, sales branches and depots.

NESTLE — symbol of security and service the world over!

This advertisement was taken from the March 1972 issue of AFYA, published in Nairobi, Kenya.

REPRINTED FROM "REGULATION AND EDUCATION: STRATEGIES FOR SOLVING THE BOTTLE FEEDING PROBLEM" BY TED GREINER CORNELL INTERNATIONAL NUTRITION MONOGRAPH SERIES No. 4 (1977)

> and vitality, which is commonly conveyed by the word "power". This emphasis on "power" can be compared to the widespread use of sex in our (U.S.) advertising ." (9).

The strategy described above is referred to in the paper, "Infant Feeding and Child Health in Ibadan (1973)" where the reasons given in advertisements for mixed feeding largely involve the health and strength of the baby; bottle feeding is shown as the means to hasten physical development (1).

Marketing of infant formula, is achieved through several avenues the most important of which, in the Third World, include raio, posters and billboards. A method that has proved particularly effective is the company van equipped with a public address system and facilities for giving away free literature or samples. (4).

The importance of radio is evidenced in the following words from an executive in a Kenyan subsidiary of a multinational infant food company :-

> "We advertise quite a lot, on one kind of medium advertising mainly - that is radio. We don't believe in press advertising since there are not so many reading daily papers. But radio, from what our investigations have shown, is the best and we rely quite heavily on radio advertising (4)".

Langdon, in 1973, monitored Kenyan radio for 3 weeks and found that Nestlés Lactogen, the most heavily advertised infant formula, accounted for over 11% of all Swahili radio advertising time - more than that used by virtually any other brand-name product (4).

The following radio advertisement, accompanied by swinging music and partly sung was broadcast 135 times a month in 1974 in the different languages of Sierra Leone.

> "Bring up your baby with love and Lactogen.
>
> Important news for mothers! Now Lactogen is even better, because it contains more proteins plus vitamins and iron, all essential for making your baby strong and healthy. Lactogen Full Protein now has an even creamier taste and is guaranteed by Nestlé.

HEALTH CARD

Nestlé.

IMMUNIZATION SCHEDULE

AGE	IMMUNIZATION	DATES OF IMMUNIZATION	
Birth or first visit	B C G and polio	B C G	
2 months	Triple antigen and polio	TRIPLE ANTIGEN	ORAL POLIO
4 months	Triple antigen and polio	1	1
6 months	Triple antigen and polio		2
9 months	Measles		3
12 months	Smallpox		
18 months	Triple antigen and polio		
5 years	Double antigen, polio and B C G		

Triple antigen — diphtheria pertussis and teta[nus]

Double antigen — diphth[eria]

NEXT VISIT

This clinic card has been used all over Zimbabwe. It shows the type of advertising used, and also the ties with the Ministry of Health.

Approved by the Ministry of Health

No 04 PRINTED FOR MEDICAL PROFESSION
FOOD SPECIALITIES (PVT.) LTD
P.O. BOX 1668, SALISBURY 1100 C GL

NESTLÉ

CLINIC	No.

ADVICE TO MOTHERS

Breast Milk is the best nutrition available to a young infant, but in circumstances where breast feeding is either insufficient or not adviseable, a reliable supplement or replacement formula is necessary.

CHILD'S NAME

DATE OF BIRTH	M or F	NUMBER OF CHILDREN

MOTHER

[AD]DRESS

[PLAC]E OF BIRTH

IMPORTANT

This is your baby's card. Bring it every time you attend any clinic or hospital.
Keep it clean and safe in the envelope.

Lactogen and Love (4)."

The remainder of this section deals with the various ways illustrations, ranging from billboard posters to labels on cans, can be used to create associations and manipulate situations. Mullers' "The Baby Killer"(11) is the source of much of this information and should be referred to if an in-depth account is desired.

The average poor third world mother has her baby examined at a local clinic. Since clinic funds are always low, the clinic staff will gladly accept educational posters from a milk company representative, in which the only hint of commercialism might be the company logo in a corner of each poster. But the association between the logo and the healthy infant depicted in a number of situations such as having his nappy changed, or being fed his first solids, makes an unmistakeable impression on the mother. This association is endorsed by the posters being displayed in a clinic.

She might have a similar reaction when she sees a picture of a tin of Lactogen on her baby's clinic card. She is unaware that the company gives the cards to the clinic, and she can almost certainly not read the English text inside which says "Breast feed your baby for as long as you can. Breast milk is best for baby and gives him the best start in life ..."

The survey on infant feeding in Ibadan, Nigeria, referred to earlier, has shed some light on the effect of media advertising. Of the 400 mothers questioned,38% recalled at least one advert for baby milk. 12% remembered that Lactogen gives, or restores, babies strength, energy and power; far fewer recalled that "it is good for babies if mother's breast is insufficient", while none had heard that mother's milk was better than Lactogen. The study therefore shows that what appears to be recalled from advertising are positive statements about bottle feeding rather than the important cautionary ones.

Regarding educational literature, it is incredible that Nestlé's "mother book" for East Africa illustrates only bottle feeding. This discrepancy makes it difficult to accept the company's stated intention of contributing to education and

FREE
DUMEX FEEDING BOTTLE

Baby D
2nd President.

Buy two tins of Dumex Baby Food and get a FREE Feeding bottle now!

Dear Dumex Mothers and Babies,

Buy two tins of Dumex Baby Food and send the paper discs from inside the tins to me and I will send you a 250 cc feeding bottle specially made for members of the Dumex Babies Union.

Join the Babies Union now by feeding your baby with Dumex Baby Food so baby will grow fat and strong.

Baby d
2nd President.

Issued by Dumex Limited.
Makers of
DUMEX BABY FOOD.

-cut along dotted line-

DUMEX BABIES UNION.

Please send a FREE Dumex Babies Union Feeding Bottle for my baby. I enclose two paper discs from two Dumex Baby Food tins.
Offer closes 31st December 1972

Name:...
Address:..
....

Send this application to:
The Dumex Babies Union, President,
P. O. Box 2104, Lagos.

F89

REPRINTED FROM "THE BABY KILLER" by MIKE MULLER, PUBLISHED BY WAR ON WANT 1974

co-operation with the medical profession.

The free give-away, depicted in the Dumex advert, can make no pretence at being concerned with giving the mother correct advice on feeding her baby. In South East Asia such a gimmick was getting Dumex a growing share of the infant formula market - so in an effort to maintain their share of the market, Nestlé retaliated with an alternative free-gift offer!

The infant formula manufacturers repeatedly state their concern for the proper use of their products. The following quotation, however, makes it clear that growth and profit are their primary concern :-

> "In Europe progress was slowed down by a certain stagnation in the market due, inter alia, to the continuously declining birthrate. In the developing countries, demographic growth, the rising standard of living and, generally, the endeavours to promote infant nutrition, offer good prospects for our products."
> Nestlé's Annual Report, 1971 (4).

This was followed five years later by the following statements, which confirm Nestlés preoccupation with profit :-

> "Generally sales developed satisfactorily; although the continued decline in birth rate, particularly in countries with a high standard of living, retarded the growth of the market. This resulted in considerably increased competition and a far greater choice of products available to the consumer. In the developing countries our own products continue to sell well thanks to the growth of population and improved living standards."
> Nestlé Annual Report, 1976 (11).

Similar sentiments are voiced by Wyeth who "estimate growth in infant formula products in Mexico of 5% to 10% and anticipate a levelling off in Europe in 1976. In South America, Africa and Asia, Wyeth also foresees growth this year of 5% to 10% provided that economic and political conditions in these areas are relatively stable." (4).

The power of radio in communicating a message to preliterate populations is undisputed. Equally undisputed is the impossibility of communicating a particular message to the same

population in a written form.

The infant formula manufacturers use radio to promote their product - and relegate instruction regarding its use to pamphlets. Their primary concern can only be profit and not people.

To put this into perspective we would like to look at the factors which stop some mothers breastfeeding their children.

3. CESSATION OF BREAST FEEDING - FACTORS IMPLICATED.

Nestlé states that "the preponderance of available evidence points to a mother's need, or desire, to work, as the principal reason for the breast feeding decline."(7)

This view is in conflict with the results reported from a number of studies in various third world countries, as is indicated in the following analysis of studies from 5 countries in Asia, Latin America, Africa and the Caribbean :-

COMMONLY GIVEN REASONS FOR WEANING FROM BREAST:

From Greiner (4)

Place:	Baby old enough or weaned self:	Illness: mother or child:	Insuff. breast milk:	Pregnancy:	Work:	Other:
Phillipines N=245	26%	6%	7%	37%	6%	18%
Colombia N=200	21%	9%	32%	16%	3%	19%
Nigeria N=200	44%	4%	---	2%	0%	50%
St. Vincent N=164	45%	13%	1%	8%	4%	29%
Jamaica N=54	35%	15%	17%	0%	6%	27%

These figures suggest that in many countries no more than 6% of mothers give up breastfeeding as a result of work pressures.

A recent study by Fonn et al, carried out in Diepfkloof, Soweto (3), contains local figures that while at some variance with those expressed above, nevertheless confirm the problems associated with breastfeeding as they are found in developing communities.

It was found that at approximately 3 months post-delivery, 73% of mothers (N=71) were breastfeeding together with some form of supplementation. A minority (17%) were breastfeeding only - a noteworthy deviation from the desired situation. The remaining 10% of mothers were not breastfeeding at all.

Regarding problems with breastfeeding, 24% of mothers experienced these; half of these problems resulted from work pressure, while the remaining half included problems of decreased milk production, maternal sickness and the baby refusing the breast.

Prior to delivery the attitudes of the expectant mothers to breast feeding were assessed. The vast majority of these (there was one exception), expressed the intention to breast-feed. This attitude is consistent with trends in rural areas (8) although it is not characteristic of trasitional and urban societies where traditional know-how and support is often unavailable (5). Significantly, 28% of the women questioned indicated that illness could prevent breastfeeding. This reveals an area of ignorance (referred to below) that may be significantly influencing breastfeeding practice.

In considering the relative advantages of breastfeeding, Morley comments that, "Breastfeeding has some marginal advantages in an affluent and educated home. One is the slightly lower incidence of infective disease (while) a possible more important long-term advantage is the prevention of atherosclerotic disease later in life which may be influenced by the early ingestion of cow's milk protein (p.100; (1))." He states directly, however, that "Breast feeding is essential in the rural homes of developing countries --- in Asia and Africa doctors appreciate that if a child is not breastfed it will die (p.100; (10))."

He writes further, "The medical reasons for discontinuing breastfeeding are few, if any. With modern therapy the traditional reasons for discontinuing breastfeeding, such as leprosy, tuberculosis, or the presence of a breast abscess, are no longer valid. The danger of infection to the baby can be overcome by the use of chemotherapy (10)."

A survey carried out by Morley in a rural Nigeria village supports such a view. Less than 1% of mothers were found to have serious breastfeeding problems, while "between 2% and 3% had temporary trouble due to illness but still breastfed for most of the first 6 months of their babies lives" (11).

These facts are a sharp contrast to the uninformed statement of Ian Barter of Cow and Gate when considering the possibility of removing all infant formula from market outlets (village stores, chemists, milk nurses, etc.) with the single exception of certain designated medical centres :-

> "Well, what would the result be? It would be the death of thousands of children because there are tens of thousands of mothers in these countries who have got to have some substitute for their milk in order to feed their babies (11)."

Despite a scarcity of figures for urban areas in the Third World even Nestlé estimate that perhaps 5% of mothers would experience difficulty in breastfeeding (11).

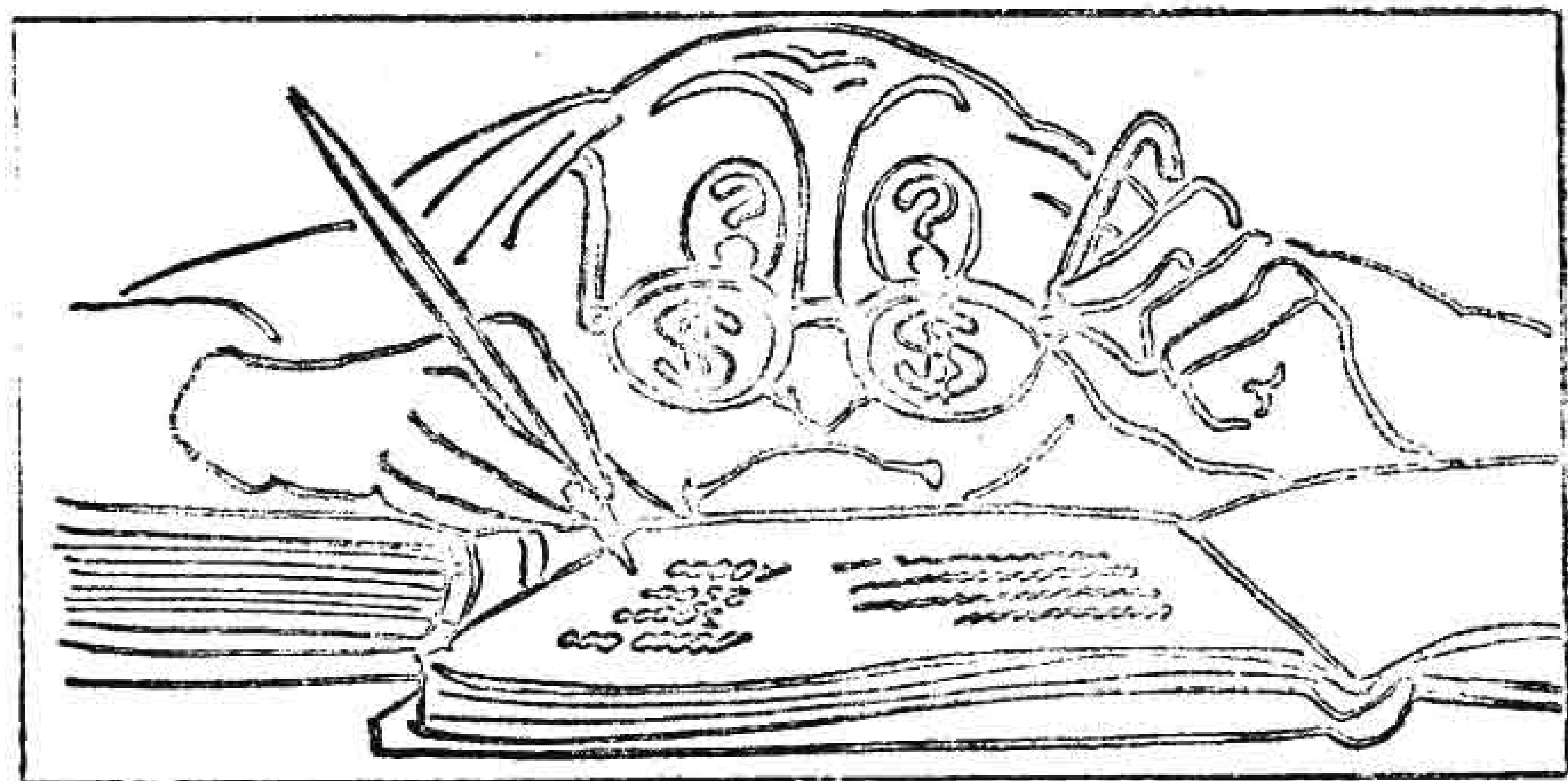
CONCLUSION:

We have tried to analyse some of the advertising techniques used by multinational companies marketing infant formula. In many respects these techniques do not differ from those used in the marketing of any other product and the motivations behind them - to maximise profits - does not differ either. Where it does differ, however, is that here the health of infants is at stake.

Breast milk is an adequate diet for a healthy infant. Infant formula, prepared under suitable conditions, is a reasonable alternative for the 2-5% of mothers unable to breastfeed. But we have seen that the infant formula manufacturers are deliberately aiming at a much larger market - and therefore claims that their product gives the same result as breastmilk.

In fact, quite the opposite results. In developing countries it is widely acknowledged that the use of infant formula is associated with the disproportionately higher infant mortality

Knowing this, can it be ethical for the marketers of infant formula to use their highly aggressive advertising in such a vulnerable market with such devastating effect ?



FROM DEVELOPMENT FORUM JAN '73.

REFERENCES:

1. BERG, A. — The Economics of Breastfeeding in the Nutrition Factor. The Brooking's Institution, 1973.

2. EBRAHIM, G.J. — Breastfeeding - the Biological Option. MacMillan Press Ltd., London, 1978.

3. FONN, S. et al — Breastfeeding - Knowledge and Practice in Diepkloof, Soweto. Research paper submitted to Physiology Department, University of the Witwatersrand, 1979.

4. GREINER, T. — Regulation and Education: Strategies for Solving the Bottle Feeding Problem. Cornell International Nutrition Monograph Series, No. 4. Cornell University, 1977.

5. HELSING, E. — Breastfeeding and the Mother. Giba Foundation 45 New York 1976.

6. JELLIFE, P. & JELLIFE, D. — Breast is Best. New England Jounral of Medicine. October 27, 1977, p.912-915.

7. LATHAM, M.C. — Statement before the Governing Board, National Council of Churches, New York, November 3, 1978.

8. MARGO, G., BORAIN, Y., WELLS, G.et al — South African Medical journal 53(1) 1. 1978.

9. MEDAWAR, C. — Insult or Injury. Social Audit Ltd., London, 1979.

10. MORLEY, D. — Paediatric Priorities in the Developing World. Butterworths & Co. (Publishers) Ltd., London, Boston, 1977.

11. MULLER, M. — The Baby Killer. War on Want, London, 1977.

12. CRITICAL HEALTH. — The Baby Killer. No. 2, 1980.

AMERICAN MEDICAL ASSOCIATION DELEGATION TO VISIT SOUTH AFRICA.

The American Medical Association (A.M.A.) has accepted an invitation from the Medical Association of South Africa (M.A.S.A) to visit this country, in spite of an international academic boycott on links with South Africa. This boycott has been called by various international organisations including the United Nations General Assembly, the Commonwealth Conference, and the Organisation of African Unity, and aims to isolate South Africa economically, militarily, academically, and in the sporting field. It is an attempt to exert peaceful pressure on South Africa to end apartheid.

In spite of this international boycott, the A.M.A. is seeking to strengthen its links with the South African Medical profession. This appears to be a prelude to M.A.S.A's attempt to gain readmission to the World Medical Association, part of South Africa's policy to seek credibility and acceptance in the international community. The visit of the A.M.A. will thus give the impression that South Africa and its health care are "not so bad" and that international contact will help promote change in this country.

The A.M.A. will undoubtedly justify its visit by stating that it will conduct its own in-depth"unprejudiced" examination of health care in South Africa to determine the adequacy of the system. In addition the A.M.A. will justify its visit by claiming that it will exert pressure on the South African Medical profession to make positive changes in the health care system. In this way the A.M.A. aims to give credibility to its visit as well as to the South African Medical profession.

TONUS 5 AUG 1980.

MASA accepted internationally

THE South African Medical Association will be represented at the annual meeting of the American Medical Association later this year.

Speaking in Pretoria, Dr. Marais Viljoen, Secretary General of the Association said, "The friendly invitation of the A.M.A. to attend their meeting in Chicago later this year is an indication of the acceptance of South Africa in international medical circles".

There are also indications that the A.M.A. will be sending a delegation to South Africa in the near future to examine the system of medical services here.

The visit by the A.M.A. will focus on such questions such as "are South African doctors properly trained" and is "hospital and private practice of a sufficiently high standard". It is far less likely to attempt to assess whether "the South African health system is appropriate to the needs of all her people". In addition, the programme for the A.M.A.delegation is likely to be carefully planned by the South African authorities. The A.M.A. will not come into contact with the migrant labour system, forced population relocation, the bantustan policy and the oppression and unemployment that are the background to health problems in South Africa.

There is thus a great likelihood that the report of the A.M.A. will be inaccurate and will gloss over the extent of health problems in South Africa and their causes. There is thus little hope of any meaningful change resulting from their visit, and it should be viewed as a breach of the international academic boycott.

AMERICAN MEDICAL ASSOCIATION DELEGATION TO VISIT SOUTH AFRICA

The American Medical Association (AMA) has accepted an invitation from The Medical Association of South Africa (MASA) to send a delegation to the Republic in February to examine medical practice here. . . .

Discussing his visit Dr. Viljoen reported that 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 to the Biko case. MASA was undoubtedly as heartily welcomed as any of the other overseas associations and it is clear that the South African medical profession is highly regarded by the world medical community.

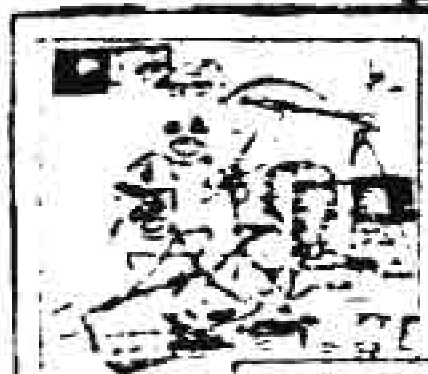
The only false note sounded during the meeting, as far as SA is concerned, took place during a meeting of the American Medical Association's Board of Trustees which had been requested by the Secretary of the Nigerian Medical Association, Dr. Beko Ransome-Kuti, during which he criticised SA for its alleged policies of discrimination against blacks in general and black doctors in particular. The criticism was, however, short-lived when the AMA trustees pointed out to him that many of them had been to SA and that his facts were incorrect. . . .

Dr. Viljoen said that South Africa also received considerable support from Dr. Andre Wynen, Secretary General of the World Medical Association (WMA) who recently visited South Africa. Following recent discussions it seems that the proposed amendment of WMA by-laws to provide for division of the Africa region into three sub-regions, and related amendments, will receive almost unanimous support from the WMA Council at its meeting in October. Should this come about, the MASA will most certainly apply for re-admision to the world body and it would appear that such application will be very favourably received.

Extracts from an article appearing in "Pulse Beat" - September, 1980.

AFRICA

subscribe to ...



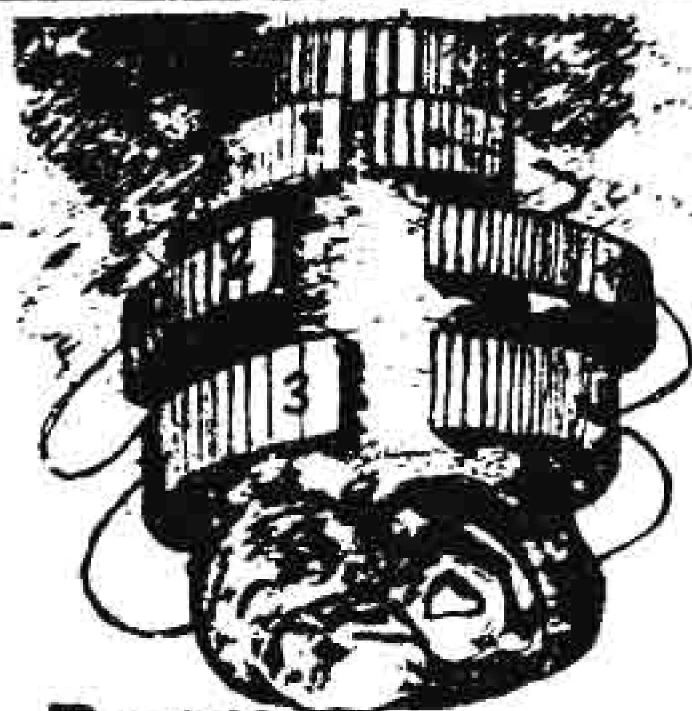
AFRICA PERSPECTIVE

AFRICA PERSPECTIVE, a quarterly journal, started in 1974, attempts to raise the level of discussion on African, particularly Southern African events, through articles that are both theoretical and factual, both historical and current. Some of these have been about resettlement, women, state and labour, underdevelopment, industrial conflict, the role of the reserves in S.A., local political bodies, and the growth of capitalist agriculture.
African countries which have been looked at are Mozambique, Uganda, Tanzania, Angola, Namibia, and Zaire. Issues planned will focus on the social consequences of the use of machinery in S.A. industry, and on the Southern African states.

LOCAL SUBSCRIPTIONS-R3,80 FOR 4 ISSUES. POSTAGE INCL.

PERSPECTIVE

WRITE TO: PO BOX 32267, BRAAMFONTEIN, JOHANNESBURG, 2017.



Work in Progress

is a journal which explores and presents ideas and material about contemporary South African society. WIP appears five times per year.

regular features

include summaries of political trials, and items on resistance by the working class.

some articles

in previous editions have dealt with the Glenmore resettlement issue, Winterveld, the Wiehahn and Riekert Commissions, African women and labour, the Solomon Mahlangu case, the Eveready strike, literature and its relationship to society, bus boycotts and the Pietermaritzburg Treason Trial.

subscriptions

are available to organisations, individuals, and groups who wish to distribute WIP.

<u>Rates in Southern Africa:</u>

Individuals: R5-00 per annum.
Organisations: R10-00 per annum.
Group distribution: 80c per copy. Reduced rates and/or a certain number of complimentary copies can be arranged on request.

<u>Rates elsewhere:</u>

Western Europe and the United Kingdom: Individuals: R12-50 per annum.
Organisations: R16-00 per annum.

North America and Canada: Individuals: R15-00 per annum.
Organisations: R25-00 per annum.

(Rates include second class air mail postage).

For further details and [illegible]:
The Editors,
PO Box [illegible],
[illegible]
[illegible]

EDITORIAL COMMENT ON THE STATE's BANNING OF "FRONTLINE ON HEALTH IN AFRICA".

South Africa has no press freedom!
We are therefore not surprised at the State's banning of newspapers and other publications. We nevertheless wish to express our total disgust at the bannig of "Frontline on Health in Africa", produced in Cape Town. Obviously the State wishes to silence all accurate discriptions of the extent of ill health and its causes in South Africa, as well as all criticism of this situation. Through actions such as this the State seeks to maintain the present unjust and unequal system. They cannot possibly succeed!

****

We would like to thank Cynthia for her help with typing and John for doing the printing.