CRITICAL HEALTH

JULY, 1980. NUMBER 3

INSIDE: THE STATE, THE S.A.M.D.C. & THE BIKO DRS.

CONTENTS

EDITORIAL.

This is the third issue of CRITICAL HEALTH. We present three major articles dealing with Health in Mozambique, the Biko Saga and the South African Medical and Dental Council, and an article on How to do a Study. In addition we have printed a number of shorter articles.

We have also printed two letters and hope that this will be the beginning of a far more active exchange of ideas through the pages of Critical Health. We believe that the issues raised in this publication need to be discussed critically and we therefore welcome feedback and other contributions.

HEALTH IN MOZAMBIQUE

It is extremely unfortunate that, due to the nature of the present South African State, very little is known about health care in the independent, socialist African States. We have printed an article on "Health in Mozambique" because we believe that progressive thinking South Africans can benefit greatly from a thorough understanding of the changes that have taken place in our fellow African countries and the problems that they have faced and still face today. Their experiences are important lessons for us in South Africa, as we work towards justice and equality for all. This article, which is just an overview of the situation in Mozambique, can only serve to stimulate you to read and explore further. We do hope to look at health care in relation to the political economy of many other African countries in future editions.

THE STATE AND DOCTORS.

In this issue we deal in some depth with the death of Steve Biko in detention and the action of the South African Medical and Dental Council (S.A.M.D.C.)in stifling further enquiry of the role played by the doctors who "looked after" him during his last days.

While the involvement of the doctors and the S.A.M.D.C. should be made more clear by the articles we present, a number of other related issues should be raised.

The first is the role of the S.A.M.D.C. and whose interests that body represents. It has become all too apparent that the interests of the public are not their prime concern.

Secondly, what is the role of district surgeons in upholding the repressive laws of South Africa? We believe they too are a further arm of the machinery used by the State to further the aims of the government.

Thirdly, the role of the State in suppressing the voice of protest amongst our doctors must be considered. Dr. Yusuf Veriawa has been detained for over 8 weeks now and is being held in preventive detention. His "crime" has been to involve himself in community activities and to work for equal education facilities in this country. Dr. Mamphela Ramphela too has been subjected to the repressive laws of the State. Banned some time ago and now working near Tzaneen, she sought permission to attend a course in Tropical Health and Hygiene at Wits Medical School. Needless to say she was flatly refused - a disservice to herself as well as the many patients she sees in the area of her work.

Clearly the State has shown its priorities: Silence all that is opposed to the present structure of our society. That means doing nothing about the Biko doctors, and doing everything possible to prevent others like Dr. Veriawa and Dr. Ramphela from doing anything that may assist the communities in which they are working.

EPIDEMIOLOGY IS THE STUDY OF THE DISTRIBUTION AND CAUSES OF DISEASE.

In this issue we have an article which describes how to do an epidemiological study. Before doing any study one should think of a few things related to epidemiology.

Epidemiology can be used in different ways. For example, the type of thing studied determines the value of the study and the usefulness in practical terms. In South Africa doctors tend to study different variations of malnutrition, whilst the most important study may be to relate malnutrition to migrant labour.

Another aspect is the way in which things are studied - in traditional epidemiology different factors tend to be isolated and causes of diseases tend to be individualised - for example, high blood pressure is always related to some aspect of the individual's life,.and never to work or social class-related stress! The inter-relationship of factors is often ignored.

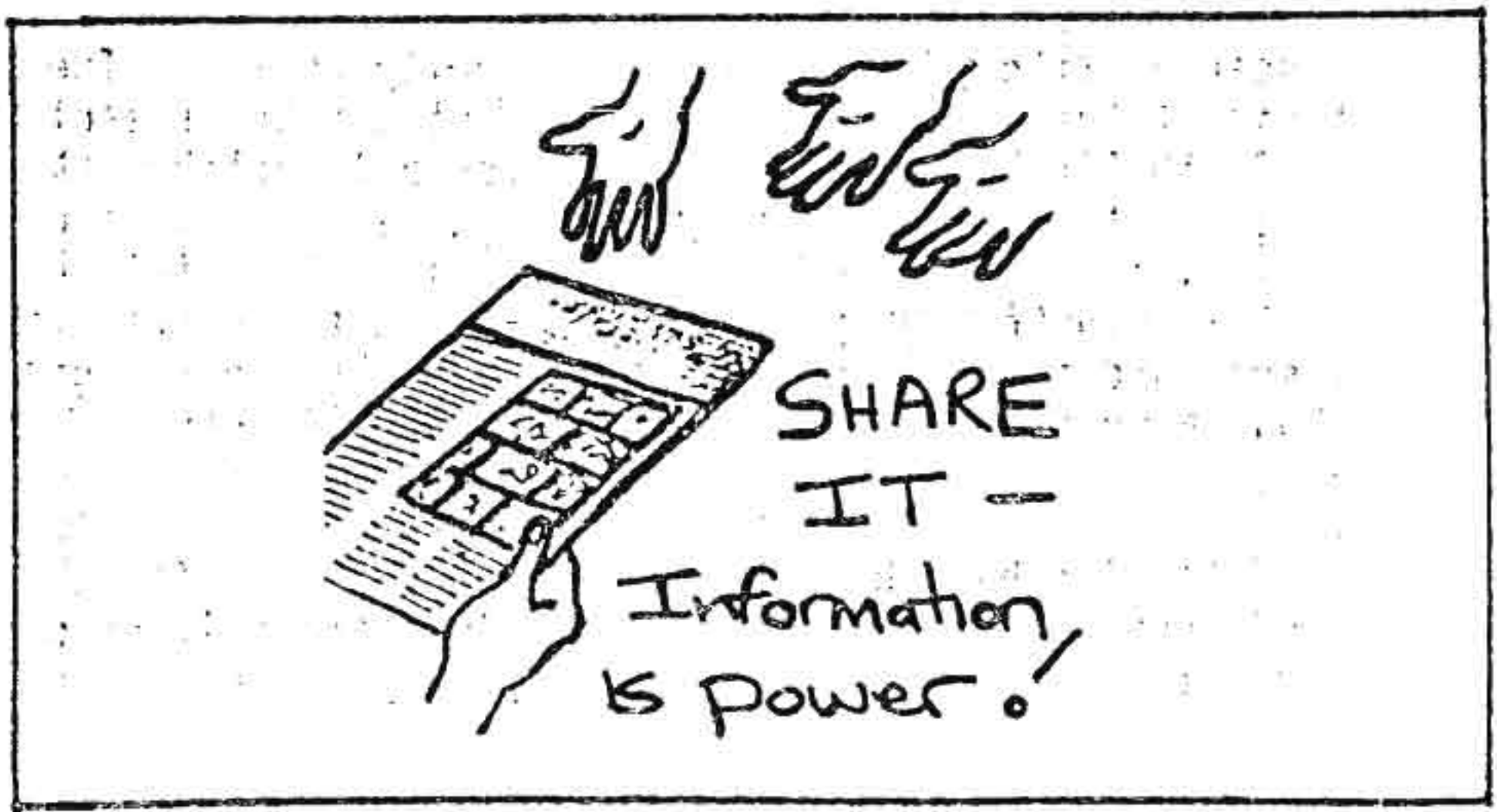
When reading a study one should also be aware of who did the study and why. For example, the management of a factory using asbestos would have different interests to those of the workers who have to handle the asbestos: the managers would be interested in profit and the workers in their health, so studies done by management would be very different to one done by a worker organisation.

Data can also be interpreted in different ways and by leaving out certain things or slightly altering the slant one can make it have a very different meaning

- one shouldn't always believe statistics !

Finally never forget that illness is a historical process, it develops over time, and is related to political, economic and social events of that time

- these should never be forgotten when studying disease.



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HEALTH

IN

MOZAMBIQUE:

FROM EXPLOITATION

TO REVOLUTION

TO LIBERATION

*****

INTRODUCTION.

The views expressed below are not often presented in South Africa. Much has been written and published in South Africa which seeks to denigrate Mozambique. This article, while not denying the problems Mozambique faces today, attempts to trace the historical and political roots of health and health care in that country.

A fair proportion of the article is therefore devoted to the political and historial circumstances at various junctures.

The reader is asked to bear with this for the importance of this perspective will become clear as you progress through the article.

This paper is a review of the literature available, and it must be viewed in this light by the reader.

HEALTH IN MOZAMBIQUE : FROM EXPLOITATION TO LIBERATION

PART 1.

HEALTH UNDER COLONIAL RULE : AN EXPLOITATIVE TOOL.

Mozambique was dealt out to Portugal in the scramble for Africa, late in the 19th Century. It is at this time that this European, colonial power began to wield any real control over the territory, for up until then it had confined its influence to a thin coastal strip from Sofala to Cabo Delgado sufficient for their economic interests in gold and ivory trading as well as the key position it held in the trading sea-route to the far East. From the time of gaining the "right of occupation" until about 1910 - 1920, the Portuguese slowly conquered the interior, and the main features of Portuguese colonialism were firmly established.

During this period, while a considerable measure of decentralization was accepted by a weak government in Lisbon, the very rigid economic ties between Portugal and her African colonies were formed; economic ties which ensured complete commercial monopoly by the colonial power.

The decentralization of the colonies was soon stopped and in fact reversed when a more authoritarian government under Dr. Salazar took power in Lisbon in the late 1920's. The interests of the colonies were made more directly subordinate to Portugal's interests and any liberalizing or alternate policies were avoided.

Despite independence occuring elsewhere in Africa, with the realization by British and French governments that economic domination and exploitation could be maintained under an acceptable but independent ruling class (the so called "flag independence" or neo-colonialism) the imperial doctrine of Portuguese-African "unity" remained largely unchanged until 1974. This was because of Portugal's weaker financial and industrial position in relation to other colonial powers and the fear of economic replacement if they were to withdraw politically.

In response to the swelling tide for self-government of African colonies, and in the hope of admission to the U.N. Assembly, the Portuguese dictatorship executed a "face-lift" on its constitutional policy by changing the term "colony" for "overseas province" and the creation of a mythical concept of a Lusitanian Confederation of people. In all these "provinces" they claimed that all could become citizens of Portugal, all races were considered equal before the law and all could participate in parliament. The truth was very different.

While it was true that some could achieve the status of "assimilated" native and Portuguese citizens, less than 0,75% of Mozambicans ever did. The rest were defined as indigenas (natives).

"Assimilated" natives were required to speak fluent Portuguese and adapt the "habits and customs presupposed for the application of Portuguese common law". This status entitled you to the full Portuguese settlers' education system and freed you from the system of labour and other controls.

"AND WHAT DID THEY TEACH YOU TODAY SON?"
"AMO, AMAS, AMAT"
"... EDUCATION'S A WONDERFUL THING"

On the other hand "indigenas", more than 99% of the population, were provided with only a "rudimentary" education which did not even equip them with literacy.

"Native" labour was strictly controlled in order to extract the maximum from this highly profitable resource. The government and local administers structured a labour system in which less then 5% of the mature, able-bodied males in Southern Mozambique were legally entitled to remain within the confines of their homestead (1950 census). Of the remaining 95%, some worked in urban centres, others as farm labourers for European farmers (+ 16%) and still others as mine workers or foreign recruits in South Africa and Rhodesia. To be "idle" made a person subject to 6 months' forced labour for the government (Shibalo system). Thus the system of labour control ensured that the overwhelming majority of Mozambique males participated in the European economy which was highly detrimental to African peoples' development, but very lucrative for the Europeans.

Her Majecty's Consul General in Lourenco Marques, said in 1951:

> "The uncivilized population comprises over 5½ million natives. It is on their productive capacity that the economy of Mozambique must be based and in consequence, the Portuguese try to inculcate in them, in the mass, the habit of regular hard work and a growing appreciation of the possibility of obtaining a fuller life by being industrious. It is not the Portuguese policy to create a native "intelligensia" - such natives as receive higher education are expected to pass into the class of the "assimilated" natives and to identify themselves with the Portuguese - but it is their policy, slowly and steadily, and as far as their limited financial resources permit, to raise the mental and physical standards of the natives as a whole, in order to render them some receptive to technical and other instruction and to civilized ways."

Harsh measures were used by the colonial rulers to deal with "undesirables" and to suppress nationalist opposition.

It can thus be seen that Portuguese claims of "justice" for all was nothing more than a policy of plunder and exploitation of the great mass of Mozambican workers and peasants, in the interests of the European, colonial power's economy. This policy produced large scale underdevelopment of the masses and forced people off their land. Traditional systems of communal land ownership were broken down, the local social structures of the Mozambican people shattered and the caring social and cultural fabric of communities destroyed. All these can be recognized as the conditions that breed ill-health.

The Colonial Crisis

'The traditional subsistence economies of Africa had provided on the whole a sufficient diet for their populations, as may be seen from the historical fact that no major part of Africa ever appears to have suffered chronic famine in the past. By 1945, however, they were far gone in ruin. Devaluation of the rural economy, coupled with the migrant labour system, and the enclosure of land by Europeans, had reached a point of continental crisis from which no colonial policy-maker could see a clear escape. Official records of the last colonial years are loud with lamentations of despair.'

(Basil Davidson, *Which Way Africa?*, Penguin.)

Health and health care under Portuguese rule reflected the geographical, racial and economic discrimination. The health of white settlers in developed urban areas was built upon the ill-health of the black Africans in the underdeveloped rural areas.

Let us examine the distribution of health care under Portuguese Colonial rule a little more closely.

All modern hospital facilities and doctors were concentrated in the big cities: Beira, Lourenco Marques and Nampula. The settler community in the towns received privileged and segregated health care.

Health care delivery in the developed, urban sector was based around large hospital services and private practice. The emphasis of the service was curative, but some preventive care e.g. vaccination, sanitation, etc. was practiced.

Little interest or effort was shown in providing health care for the rural population, and what there was was usually run by voluntary societies e.g. mission societies, whose ideology usually coincided with the colonial administration. This was particularly true of the Catholic missionary workers and close links with much mutual co-operation, developed between the Catholic Mission and Colonial rulets. Missionaries could at best provide curative medicine, and some midwifery, for a tiny minority of the people. Malcolm Segall estimates that 70% of people lived beyond the reach of any health care.

Two-thirds of the country's 550 doctors were to be found in the capital city (then Lourenco Marques), most of whom were in private practice, which was extremely lucrative. Health to them was a commodity for buying and selling.

One-third of the health budget was spent on the main hospital in Lourenco Marques which was accessible to only 8% of the population- 50% of this budget was spent on a wide range (± 13,000 different types) of drugs.

Segregation in hospital facilities also showed the division in society e.g. the Miguel Bombarda hospital (Lourenco Marques) for urben "indigenas" being bare, overcrowded, and inadequate, while the University hospital (on the same site) was adequately equipped for a modern hospital and served mainly the white elite. Care was graded according to social and racial categories.

Most important of all was the attitude of health workers under colonial rule. Medicine was seen as a professional and technical matter completely divorced from politics. Initiative was inhibited and corruption encouraged. Doctors and nurses did not serve the people, but themselves and their

status. Machel described the hospitals as "rigid" and individualistic and medicine monopolistic.

In rural areas virtually nothing existed in the way of preventive health schemes, health education programmes, mother and child health and vaccination schemes (the army carried out an inadequate vaccination program, without records) despite the fact that a cursory glance at health problems found in the major underdeveloped areas showed that they could only really respond on any general level to this type of care. The curriculum of the medical school also reflected this western, curative bias.

Health mirrored the social and economic situation in the country. Despite the fact that there was no interest by the Portuguese to collect statistics on the poor health in rural areas, some rough estimates are available.

About 90% of the people (11½ million in total) live in rural areas with a population density of 12/sq.km. 20% of population is under 5 and approximately 45% less than 15 years. These figures are comparable with an underdeveloped country and double those of developed countries.

At independence about 30% - 50% of the children suffered from malnutrition. Epidemics of measles, whooping cough, intestinal parasites, e.g. bilharzia and other communicable and infectious diseases are rife. T.B. is estimated at 250/100 000, while the comparable figure for Europe is 24/100 000. Malaria is widespread. Neonatal tetanus occurred frequently since the umbilical cord was often sealed with earth and no vaccinations were given. Occasionally cholera and typhoid outbreaks occurred.

Many similar problems existed in urban slums.

On the other hand, it would be an understatement to say that the white elite enjoyed good health in relation to the Mozambican people.

PART 2.

HEALTH DURING THE WAR AGAINST COLONIALISM : A REVOLUTIONARY WEAPON.

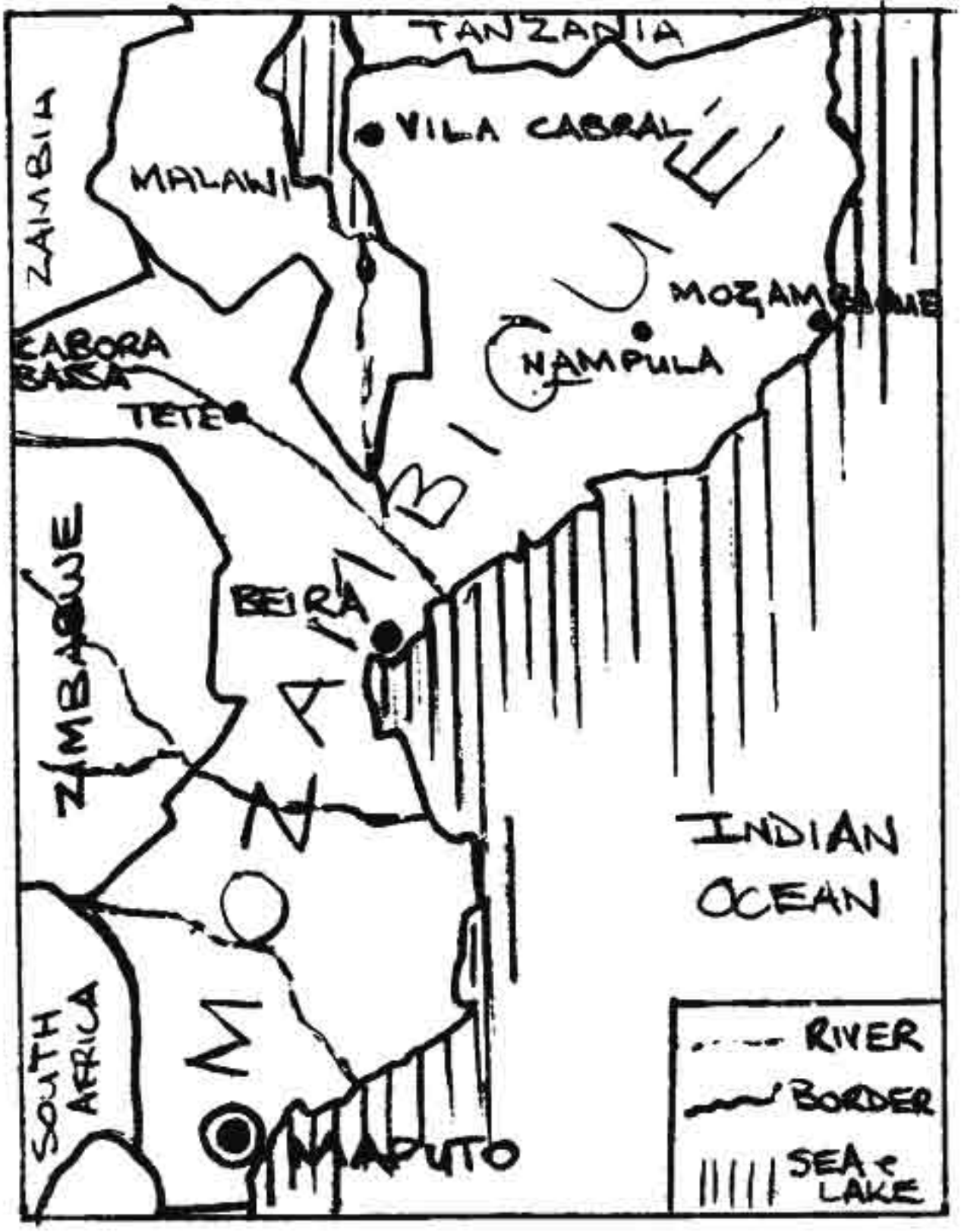
Under this colonial system of repression it was natural that anti-colonial sentiment should swell, that some educated Mozambiquans should develop a political conciousness of their condition in relation to others, and should ultimately organise themselves into Nationalist movements in order to spread this conciousness.

This occurred to a large extent by the early 1950's, when a number of smaller groups existed, but it was not until 25th June 1962 that a single national liberation front under the name of FRELIMO was constituted and the first Congress held in Dar es Salam.

It was only in 1964, after careful consideration of the situation, that armed struggle was adopted to free the people of Mozambique from Portugal's fascist colonialism.

The main area of action after 1964 lay in the two northern provinces of Cabo Delgado and Niassi, where guerilla forces were so successful that by 1968 they controlled the territory.

At this stage they were able to re-open the attack on the Tete front. By July 1968, the second Congress was held inside Mozambique.



The first president of FRELIMO was Eduardo Mandlane, a man of significant leadership, organizational and intellectual ability. His political thought was channelled in four directions:

a.) Formation of a national movement capable of military conflict.

b.) Independence from Portugal.

c.) Fostering of a national consciousness among Mozambicans.

d.) Restructuring of society to ensure true equality with an end to exploitation.

In terms of the fourth goal, Mondlane said: Thus far independence constitutes only one phase of our revolution. Liberation consists of more than merely driving out the Portuguese authority. True liberation requires the constructing of a new society".

He envisaged a society

> "directed towards economic progress .... where the power will belong to the people".

Frelimo had to act as "a guide to the people to end the exploitation of man by man".

Within the liberation zones which FRELIMO controlled, FRELIMO began to implement its plans by providing for the inhabitants in line with its overall political analysis; diversification of agriculture, co-operative and communal village structures and modes of production, cottage industries, education, social and cultural changes, etc.

There was a counter-revolutionary, political and ideological backlash which emerged at the second congress which retarded progress of the movement, including its efforts in health. In 1969 Eduardo Mondlane was assassinated, which was a further setback, but with the eventual appointment of Mondlane's successor, Samora Machel, the rough period was weathered and the party attempted, successfully, to recover lost ground.

From the second congress a clear definition of people's power emerged.

> "In order to consolidate and extend the liberated regions, to promote the social and economic progress of the masses and transform the social basis of society, to create favourable conditions for the victorious development of the revolutionary struggle for liberation, a new type of power was needed. A power that, through its method, nature and aims, would respond to the deep longing for change, and would be a justification for sacrifices taken. A power that would enable the people to live their conquests in their daily lives."

In May, 1970, the Portuguese launched a major offensive in an attempt to regain liberated areas, but they were soundly defeated. The reason for FRELIMO's ever-advancing military successes can be found in the communal action and support to resist the colonialist onslaught; an attitude engendered by FRELIMO's policies and practices and spread through the raising of a new social and political order.

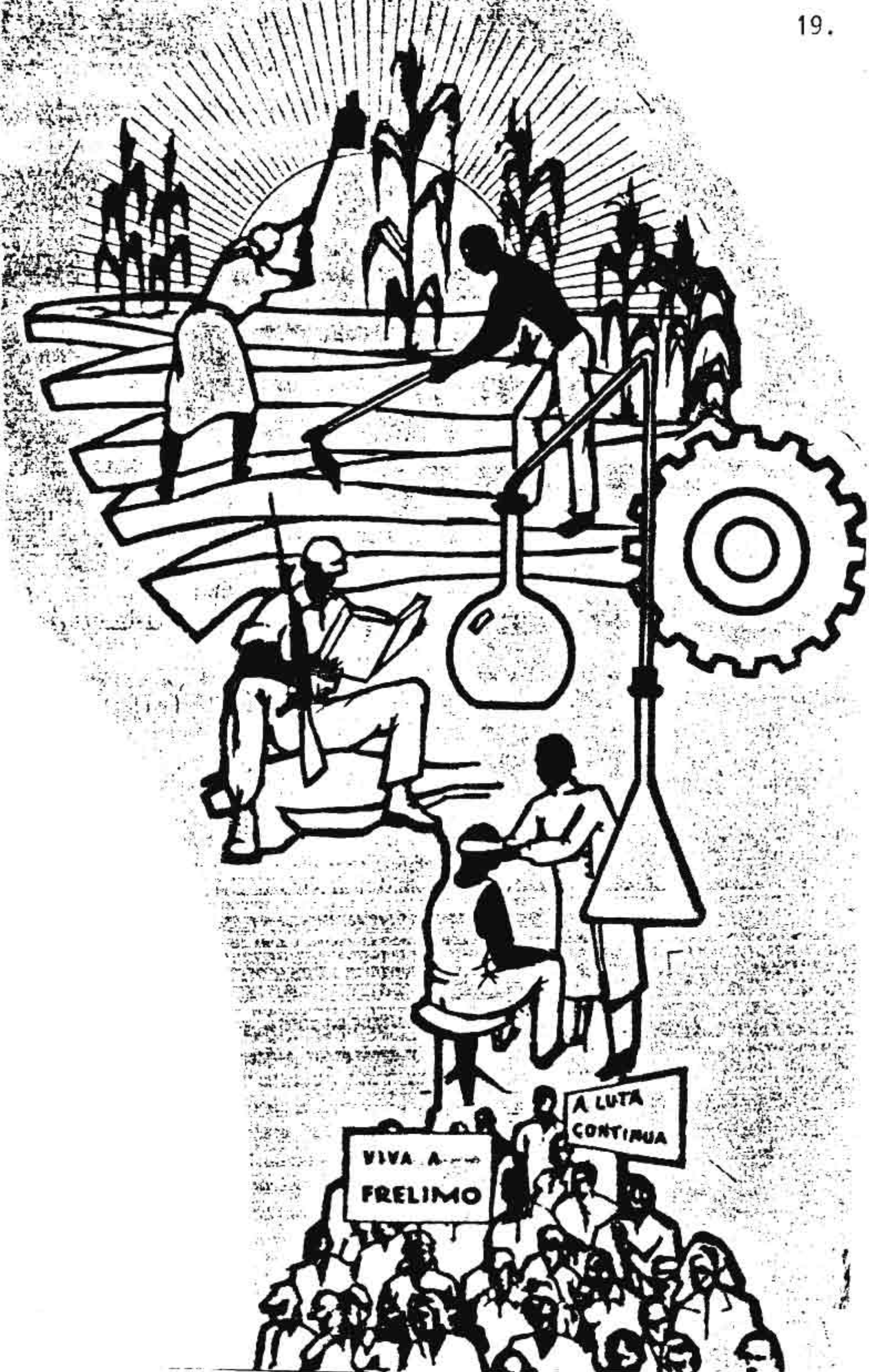
What is that new order in health? The content of the health system is determined by the kind of political power that exists in the society.

In the liberated zones, because the power is in the hands of the masses, the hospitals and health care in that society must necessarily also serve the interests of the people. The hospitals were not only for curing the body, but also for "freeing and forming the mind". Since the health care was inextricably linked with the people, hospitals were viewed as a front line in the creation of national unity and the fight against colonialism. Thus the health care is made up not so much by the medical and technical resources, but by the attitudes of those serving and served in the system. FRELIMO believed that doctors, nurses and health personnel must have a heightened political and class awareness, must have the moral armament of unity and must spread a new mentality to the people they treat.

The health care system should help to dispell tribalism, help to eradicate belief in the supernatural by promoting scientific methods, and replace individualism with team-work.

Thus there was a conscious political decision to emphasize primary or preventive health care. Health was to be seen as a combined effort on the part of the community. The principle task in health is to provide the masses with the indispensible scientific knowledge so that they can understand and fight against the causes of illness. It was necessary to win the enthusiasm and active support of the people for the better health of their own community.

In order to achieve these objectives in health, a hospital school in Southern Tanzania trained health cadres .These cadres were both politically and medically trained and this training emphasized community health but gave some skills in


A LUTA CONTINUA
VIVA A FRELIMO

in curative medicine e.g. treatment of war-injuries.

In a speech at the start of a cadre course in 1971, Samora Machel pointed out that the struggle is one. Even in the field of health two battle lines are drawn up. The "two lines in the field of health" are quite clear when one looks at the two radically opposing health systems that exist in Mozambique at this time - on the one side, the colonalist side, a health care system which promotes the well-being of the elite at the expense of the health of the underdeveloped, peasant sector; where health ensures the domination and exploitation of the masses in the interest of capitalist's higher profits. On the other, FRELIMO's side, a socially and community based health, in the hands of the masses, where preventive rather than curative medicine is emphasized.

Machel believed that by 1971 after only 7 years, Frelimo had done more to improve the health of the Mozambican people than the colonialist power had done in all its occupation. By 1970, 100 000 people had been vaccinated. Many doctors and nurses had been trained and an extensive health education campaign was well underway.

The expansion of health care in liberated areas continued until the fall of the Portuguese dictatorship in April 1974. This event heralded a mass exodus of doctors and other health workers which made the task even more demanding for the new government. Only 85 of the 550 doctors remained at independence in 1975.

PART 3.

HEALTH IN INDEPENDENT MOZAMBIQUE : A LIBERATING FORCE.

Between September 1974 and June 1975 the transition Government administrators consisted of FRELIMO cadres together with Portuguese bureaucrats. Many of the latter were covertly, if not overtly, hostile towards Frelimo and to changes envisaged in the health care system.

The immediate priority was to maintain existing services in the cities and to extend them to urban workers and unemployed. This was no easy task considering the mass exodus of health workers and the poor morale and commitment of those who remained, having led privileged lives unexposed to the political

and military struggle. Old patterns of behaviour continued - arrogance, racism, ill-treatment, authoritarianism - ills which permeated the hospitals under colonial rule. There was serious deficiencies in the medical standards, partly due to lack of staff, but also due to inflexibility of thought, and even a desire to sabotage FRELIMO's efforts. Corruption was rampant.

Independence day came in mid-1975. While the struggle for physical political power was over, the struggle against the colonial inheritance of undemocratic structures, human and economic under development and colonialist mentality had only just begun.

In establishing FRELIMO's development strategy, they attached special value to their chief strength, the mobilization and organisation of the people. There they drew heavily on their experience in the liberated areas.

In July 1975, all health institutions were nationalized and private practice banned,"an essential first step in making the country's health resources available to all the people."

The principle behind the Party's health activities was to make each and every citizen a health agent. Thus there was a fundamental commitment to preventive medicine and to the participation of all in health care, wherein lies the basis of the revolutionary practice of health in Mozambique. In October 1975, a National Environmental health campaign with the slogan "Promotion of Community Health by the Community itself" was launched, in which the rural population were mobilized to dig latrines. Sanitation, one of the corner-stones of prevention of disease, was being spread.

The following year a highly successful second mass campaign was launched - this time to immunize the entire population. The population was so well mobilized that 2½ years later 90% of the 11 million people were immunized.

Legislation was introduced in relation to health care. The law on Socialization of Medicine (Nov. 1977) provided for free emergency and preventive care and the right to free in-patient treatment. Fixed rates were set for non-emergency

TABLE 1.

Extract from a diagram of the new career structure in Mozambique.

Level:	Educational requirements:	Nursing:	Medicine:	Preventive Medicine and Community Health:	Obstetrics:	Child Care and Education
1.	Nine years basic schooling and 2 years university foundation course.	--	Doctor	Senior technician or health officer	Obstetrician	--
2.	9 years basic schooling.	Specialist nurse (eg teaching)	Medical Assistant.	Technician or health officer.	Specialist midwife.	Technician.
3.	6 years basic schooling.	Group A nurse.	Medical agent.	Auxiliary health officer.	Group A midwife.	Agent.
4.	4 years basic schooling.	Group B nurse.	--	Assistant health officer.	Group B midwife.	Auxiliary.

Note: Translation of the terminology has been slightly modified.

out-patient care, the charge for which covered treatment.

The law also dealt with the level at which a patient should seek health care, stating that except in an emergency the person must first go to their local health post and thence can be referred within the health system (see below).

In line with a policy of "good therapeutics at the lowest cost" the Ministry of Health severely limited drug imports and published an annual National Formulary. The 1977 edition had limited drugs from 13 000 to 640 products which could only be prescribed by their generic (chemical) names. This has made a beginning to curbing the intensely profit-orientated and monopolistic Western drug industry.

To examine the present health care system being introduced by the independent Mozambique government, we should look briefly at two areas: the structure of the system and the personnel working in it.

The system combines preventive and curative services based in the village, workplace or residential areas. It is a system of health with the people.

(a) Personnel.

Table 1 outlines the large number of categories of health personnel which have been defined. Their roles become more clear when one sees which level of the health care structure they slot into. (discussed below)

Table 2, below, gives some examples of the length of training of different health cadres.

Perhaps one criticism of the categories is that many are remnants of the old colonial system and while the training of these health workers through the Institute of Health Science and the University has radically changed there is some division of curative and preventive personnel. A more multipurpose health worker may be more appropriate to Mozambique's needs.

There is still a great lack of staff, but already by September/October 1979, 1 200 primary health care workers had been trained and 450 doctors were working in Mozambique (80% foreign "co-operantes" on 2 year contracts)

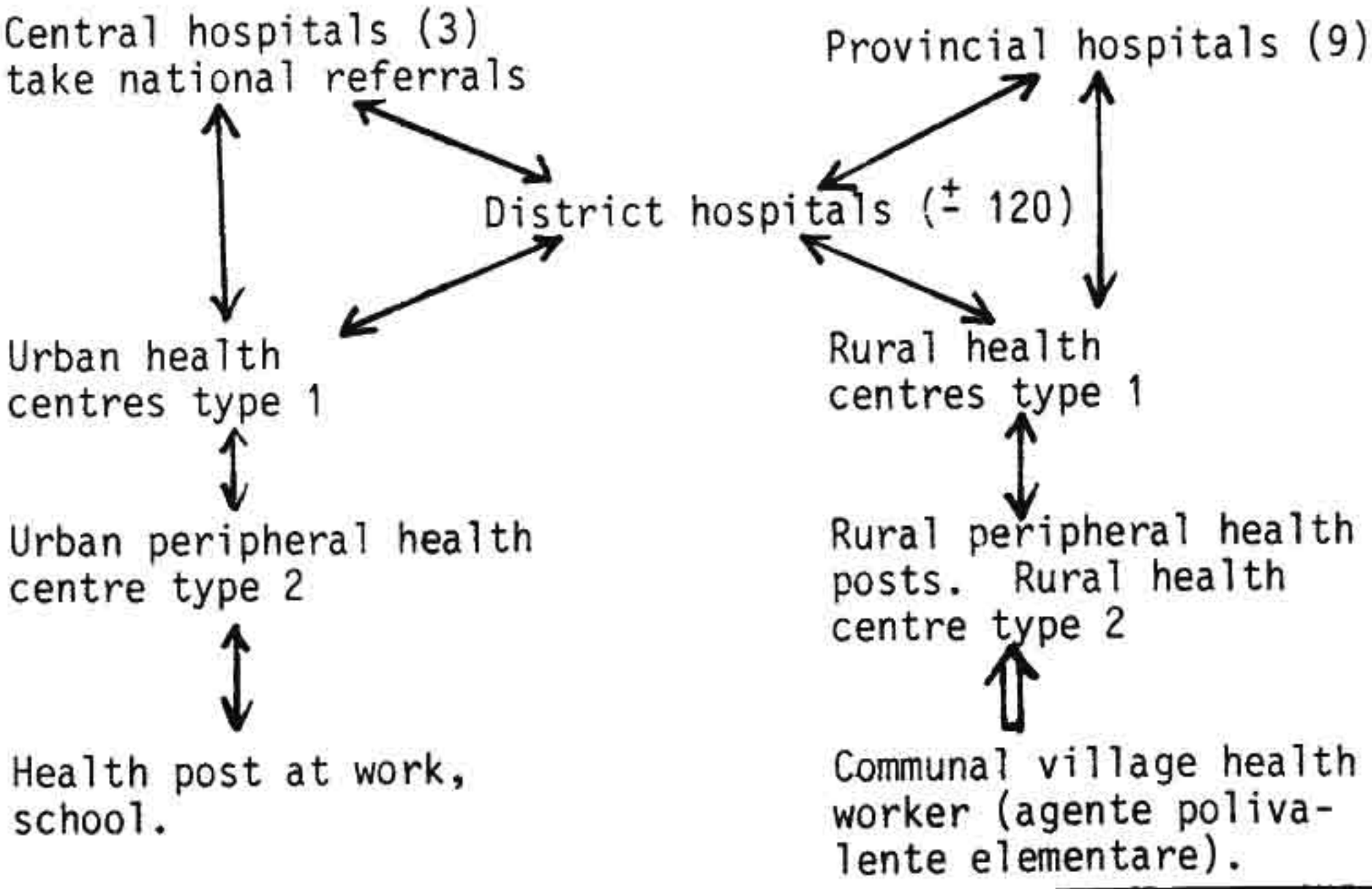
Table 2 Length of training of some Mozambican Health Cadres

Cadre	Years of training
Community health promoter	Few months
Medical agent Public health agent Auxiliary nurse	2
Medical technician Public health technician Nurse	3
Doctor	6(+1 internship)

(b) Structure of the Health System.

Diagram 1 shows the two-way referral for urban and rural areas

DIAGRAM 1



Note:

This is a two-way referral system. Personnel will also travel out from the health centres, when possible, to the peripheral health posts for purposes of supervision and support of junior health workers and to see referrals. Not all districts and provinces yet possess all these intermediate health units.

In the rural area the chief difference between the rural health centre type 2 and type 1 is that the former has no living-in facilities and is staffed by a nursing auxillary or a medical aide and they deal with minor illness or accidents, while the latter have beds (+ 40) and carry out maternity care and simple surgery. They are staffed by medical technicians and/or a nurse (Group A) and preferably a midwife. They are also visited by the doctor from the nearest district hospital.

Urban centres are similarly staffed but have no beds and deal mainly with preventive health care.

Communal village health worker:

It was recognized very early in medical and paramedical training courses that these existing personnel were not enough to extend the health network to the rural areas, necessary to eliminate the profound imbalance between urban and rural care.
In order to harness the power of the people's collective endeavours and to provide social services, FRELIMO, even during the war, emphasized "Communal villages" as the basic structure for the rural people's economic, social and political development. The communal village Health Workers (or Agentes Polivalentes Elementares) were created as a vital link between the health centre workers and the organised community - their main role being to involve the people in promoting their own health and providing a simple curative service. They are chosen by the village, sent for 6 months training and then supported by their community. About 450 have so far graduated, but there are many problems with their functioning.

Central Hospital - Maputo : A case study.

A brief look at the developments at the country's main hospi-

PEOPLE'S HEALTHCARE
ANTI-COLONIAL REVOLUTION
MEDICINE FOR PROFIT
SK

tal provides a very interesting case study of the struggle for change and the methods used to overcome the problems. The structures set up at this hospital are now being used as a model for other hospitals.

The Central Hospital was formed in 1974 by fusing the Miguel Bombarda Hospital and the university hospital (previously catering for black and white respectively).

However, for all the government's early efforts, they were unable to rid the hospital staff of their predominantly colonial mentality. It seemed that this hospital that had formerly used 1/3 of the country's health budget and had held a privileged position in the society, was particularly resistant to change. Complaints ranged from arrogance and apa on the part of hospital staff to poor food, unhygienic conditions and disorganisation. Bureaucracy was extreme.

In a hard-hitting speech by Samora Machel, on the state of the hospital, he described hospitals as "far more than centres for dispensing medicines and cures. A patient's stay in hospital should serve to heighten awareness of nationa unity".

The party appointed a "commission of restructuring" and democratically elected "conselhos" (committees) in each ward or service, thus creating a popular democracy. They also introduced peer evaluation, a code of discipline and developec direct and active links with the community (e.g. clean-the-hospital day).

By involving all the workers, the patients, their families and the city's population in the hospital's problems, very tangible improvements in hygiene and treatment took place within a year. For example, the death rate in paediatrics dropped from 21% (May, 1977) to 14% (May, 1978).

Dr. Fernando Vaz, leader of the "Commission of Restructuring" speaking in May, 1978, said "It is important that our hospitals have medications and surgical equipment, but the decisive factor is the health worker, whose consciousness and attitudes can make the hospital a centre in which we can concretize our political line to 'serve the masses' and

Few newly independent nations have faced as many far-reaching problems as Mozambique. Although 400 years of Portuguese rule ended on June 25, 1975, the legacy of colonialism remained. The Mozambican Liberation Movement (FRELIMO) inherited a country whose population suffered from the brutal afflictions of underdevelopment.

Despite these setbacks the new government, guided by practices developed during 10 years of armed struggle, embarked upon a carefully designed program to unify the country, improve the quality of life for all its citizens, and reorganize the paralyzed economy.

An even more impressive transformation has taken place in the delivery of health care. When the government nationalized the medical profession, it declared that proper health care would be a right rather than a privilege of wealth or race. Today, virtually all medical treatment is free, and the number of people treated in hospitals has dramatically increased despite the departure of most Portuguese doctors. Simultaneously, Mozambican health officials initiated a preventative medicine campaign, involving health brigades who have travelled the countryside where 90 percent of the Mozambican population resides. These mobile units emphasized the need for proper nutrition and sanitation and inoculated the rural population. To date, almost four million Mozambicans have received smallpox vaccinations, and by 1979 it is estimated that 90-95 percent of the population will have been immunized against basic infectious diseases — a figure which will place Mozambique far ahead of most of Africa

Africa Report

July - August, 1978

"Mozambique after Independence"

achieve our political principle that "the revolution liberates the people".

There are many other aspects to the health care system such as preventive dental care, orphanages, creches, the role of the Women's Movement (OMM) in health, occupational health, school health programmes etc. which are unfortunately beyond the scope of this paper.

Conclusion.

While the new Mozambique government has elaborated and planned a health care system and while there have been many successes to date, we must not believe that it is without problems.

It is beset with very serious problems, some of which will take years, or generations, to overcome.

Mozambique is not a rich country; to the underdevelopment inherited in centuries of colonial misrule was added the effects of a war against Portuguese colonization and more recently attacks from the troops fighting for the pre-independence, racist Rhodesian regime. Mozambique's fragile economy was severely weakened and is still recovering from these onslaughts.

Thus history manifests today in the ongoing struggle that must be waged against the colonial mentality, which often has a retrogressive influence, as well as shortages of personnel and supplies, a cumbersome, inherited bureaucracy and an illiterate population.

But there is little doubt that through its emphasis on health education, decentralization of health services, democratization of health care decisions and delivery and the emphasis on primary health care, Mozambique's health system is on the correct road to social justice.

Hence the now often repeated phrase: A LUTA CONTINUA - The struggle continues !

SOME USEFUL READINGS:

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Vol. 1, No. 1, pg 12. October '974.

2. Segal, M.
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New Internationalist.
No. 43, pg. 16, September 19[illegible].

3. Mozambique : Health by the People.
Unicef News Feature Publication.

4. Segal, M.
Democratizing Health.
Development Forum.
Vol. VII, No. 8. Nov/Dec 197[illegible].

5. Paul, J.
Mozambique: Memoirs of a Revolution.
London, 1975.

SKIN-LIGHTENING CREAMS POISON THE SKIN.

A recent article (1) appeared in the South African Medical Journal which drew attention to the fact that many skin-lightening creams are very harmful to the skin.

They contain a substance known as hydroquinone which may have serious effects and leads to the disfigurement of the face. The skin in sun-exposed areas such as the face may become darker with black blotches, leading to the frantic application of more of the skin-lightening cream, which in turn aggravates the darkening of the skin.

The skin lightening creams have limited use in the treatment of white people with skin blemishes. The authors stress that the treatment should be carefully controlled and supervised and should not extend for more than a few months.

The manufacturers of "skin care" products for Black South Africans have an annual turnover of approximately 25 million rands (2). An article in the Sunday Times (Business Times) described the market for "general purpose" items and "skin lighteners" as "phenomenal", "ripe for the picking" and a "roaring trade". The authors of the article in the South African Medical Journal remark that the amount of products sold must indeed be extremely large to produce the vast numbers of people now suffering from skin problems as a result of using these creams.

In South Africa the gap between blacks and whites is wide - the whites, the upper and middle classes, are depicted as healthy, wealthy and happy; the blacks are working class, and seen as poor and unhappy. This is exploited by advertisers to suggest that black people with whiter skins will be happier, healthier and wealthier than their dark-skinned brothers and sisters. In fact the opposite is true - they will be unhappy and unhealthy because of the skin damage resulting from using these creams, also they will be a bit poorer - from buying a totally unnecessary commodity.

Shrewd advertising techniques are employed to convince Blacks that using these "skin lighteners" will lead to various forms of success in economic and social terms. There is, however, no control over the advertising of such creams, and magazines aimed at Black women readers carry numerous advertisements

PACE June 1980

promoting the sale of these harmful products. The magazines feel a need to boost circulation figures, keep down the price, and attract advertising to subsidize the magazine and so editors are generally not willing to leave out advertisements of these products or even to publish articles which might make their readers aware of the dangers of skin-lightening creams.

Clearly, action should be taken to inform Blacks of the dangers of these creams. Chronic long-term use of these skin lighteners is clearly harmful and should be avoided. Action should also be taken to prevent the sale and advertising of these harmful products. Up to now, no sufferers of the effect of these creams have sought compensation through legal channels for the disfigurement they have suffered and this is perhaps a line of action that should be explored.

1. Findlay, G.H. and De Beer, H.A. (1980).
"Chronic Hydroquinone Poisoning of the Skin from Skin-Lightening Cosmetics", South African Medical Journal, 9 February 1980, p.187-190.

2. Creamer, M. (1978).
Sunday Times (Business Times), 22nd October 1978, p.4.

4.

Computerised scanner

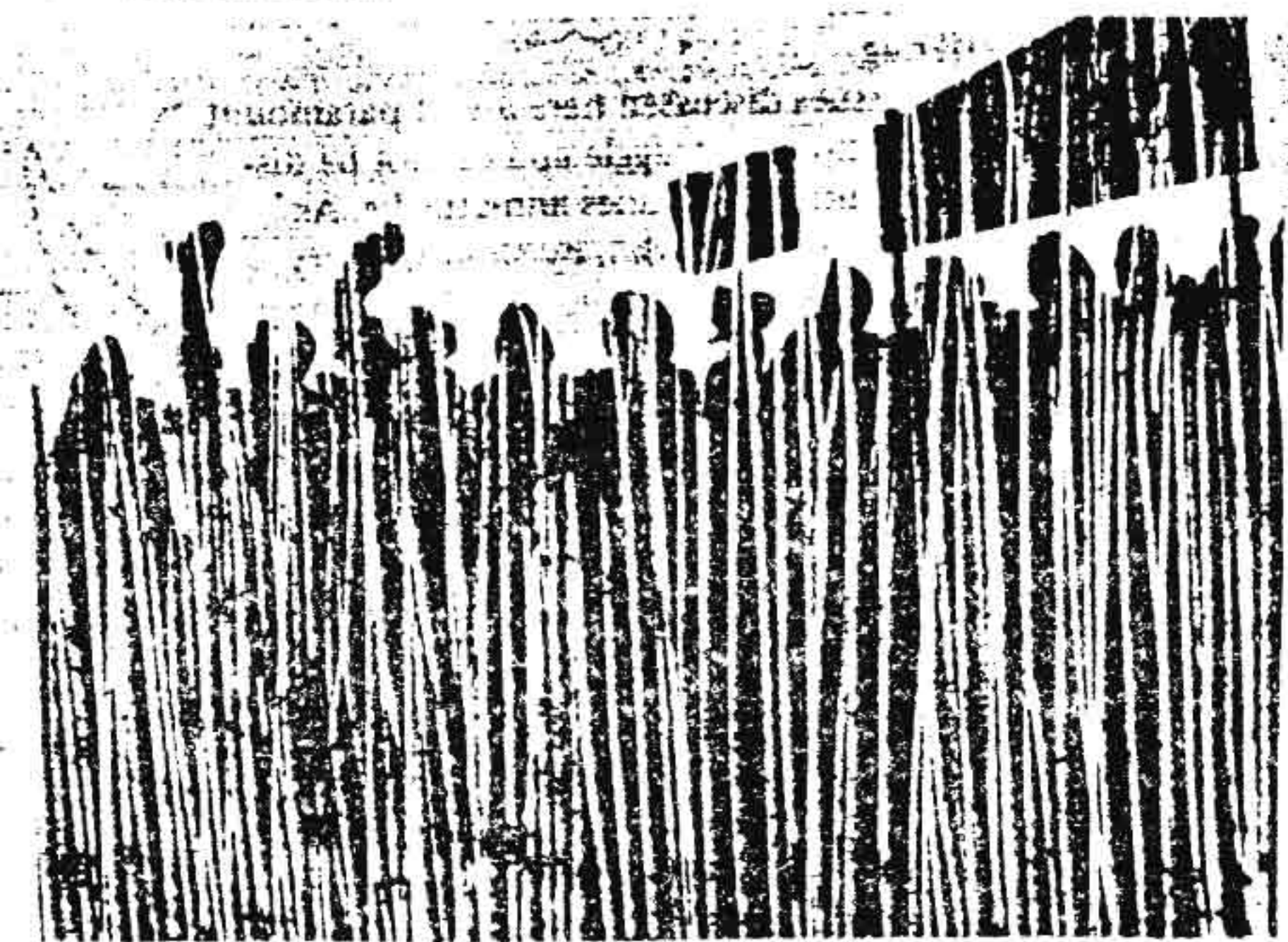
Baragwanath Hospital recently acquired a very sophisticated X-ray apparatus at a cost of R800 000, an event of which Dr. H. Grove, Director of Hospital Services in the Transvaal, is very proud:

"There is reason to celebrate today", said Dr. Grové. "This is, in fact, the first whole body scanner to be purchased in our Province. It is working perfectly. It is working hard and it happens to be the most sophisticated apparatus of its kind in the whole of Africa. Furthermore, it has been installed in a Black hospital."

Does that mean my children won't die of malnutrition any more?

BIKO SAGA

THE ETHICS OF SUPPRESSION



B I K O S A G A:

THE ETHICS OF SUPPRESSION

The death of Steve Biko in detention nearly three years ago, sparked off a major controversy which has still to be resolved That it can never be entirely resolved is obvious; those who were instrumental in causing his death were freed from blame. What can and should be settled is the role that the medical practitioners who attended to Steve Biko played: whether their action or lack of it contributed to his death and whether their actions were in all respects, ethical and devoid of negligence.

Steve Biko, a black consciousness leader, who was banned and restricted to King William's Town in 1973, was arrested and detained on 18th August 1977, under Section 6 of the Terrorism Act. This allowed for his indefinite detention for questioning. He was first seen by a doctor, Dr. Lang, a district surgeon, on the morning of 7th September. The other two medical practitioners, who were also responsible for him were Dr. Tucker, chief district surgeon of Port Elizabeth and Dr. Hersch, a specialist physician.

This article will first look at the sequence of events which ended in the death of Biko, stressing the roles played by the doctors. I will then analyse the actions of the South African Medical and Dental Council (S.A.M.D.C.) in dealing with the complaint lodged against the doctors, following the inquest into Biko's death that culminated in the preliminary Committee of Inquiry of the S.A.M.D.C. deciding not to pursue the matter. ...ently the whole S.A.M.D.C.

On Wednesday morning, 7th Sep... Colonel Goosen of the Security Police (S.P.) reques... ...to examine Biko, stating that he suspected a stroke. ...fter thoroughly examining Biko, issued a short certifi... ...tating

> "I have found no evidence of any abnormality or pathology on the detainee." (1) In a clinical report, dated October 13th, he says he found, in his first examination of Biko, "cut lip, a bruise on the sternum, an inability to move the limbs, swollen hands and feet and slurred speech."

Dr. Lang, when questioned during the inquest, admitted that his certificate was inaccurate.* Dr. Lang did not ask Biko how he received his injuries, although he felt the lip injury could have indicated a head injury. He assumed that this injury occured when Biko had to be restrained. Dr. Lang admitted during the inquest that he believed Biko was shamming (faking illness), accepting that Colonel Goosen's remarks strengthened this belief. He acknowledged that his report was misleading, giving the reason for the unco-ordinated walk of Biko as lack of co-operation when in evidence during the inquest he said it was due to swollen feet. Having left the police station, he gave no instructions for the care of Biko; under questioning from the counsel for the police during the inquest, he said he felt Biko was shamming and he would have had no complaint if Colonel Goosen had wanted to proceed with the interrogation. Dr. Lang said he had treated the patient with the same care as he would any other patient.

The following day Colonel Goosen again expressed concern to Dr. Lang over Biko's condition stating he had not urinated in the previous 24 hours and had refused to eat. Dr. Tucker accompanied Dr. Lang and they examined Biko, finding his blankets wet. Biko complained of vague pain in his head and back and Dr. Tucker found a possible extensor plantar reflex, which is indicative of brain damage. Dr. Tucker did not ask Biko how he received his cut lip, neither did he, in his repor mention how Biko had received the abrasions on his ankles and wrists - these were in fact due to the handcuffs. Dr. Tucker asked Biko if he had any complaints and admitted during the inquest that although he thought Biko could have suffered a head injury he did not question Biko or Colonel Goosen about this.

* This was despite the fact that in 1968 in a document referring to "Untrue or Misleading Certificates and other Professional Documents" the General Medical Council had the following to say :-

> "Any doctor who gives, in his professional capacity, any certificate or kindred document containing statements which he knows, or ought to know, to be untrue, misleading, or otherwise improper, brings himself within the scope of the Council's Disciplinary Committee." (4)

> "If I am called to see a patient and he has a cut on his head then I am interested in treating him and not how he got his cut." (1)

Dr. Lang felt that there was no significant change in Biko and was unsure about the plantar reflex. Yet he did not discuss the possibility of brain damage with Colonel Goosen nor did he suggest that the patient required treatment. Both doctors decided Biko should be transferred to Sydenham Prison Hospital where Dr. Hersch, a physician, could examine him. That evening Dr. Hersch examined him at the hospital and it was decided that a lumbar puncture be performed. During the examination, Biko's movements were strange, he found it difficult to turn over in bed, and he walked with a left-sided

Did Biko matter less?

RDM 19/6/80

SO A CLOSED meeting of the South African Medical and Dental Council has finally decided there will be no disciplinary action taken against the three doctors who attended Steve Biko before he died in Security Police custody in September 1977.

Where does this sorry tale of a two-year delay, unusual secrecy and refusal to act against the doctors even on what is a matter of inquest court record, leave the lay public?

It leaves them with the inescapable conclusion that because Mr Biko was black, a political activist and a Security Police detainee, his life as a medical patient somehow mattered less.

It makes mumbo-jumbo of fine phrases of the Hippocratic Oath, phrases which apparently do not preclude doctors in such cases from filling in false medical certificates or ignoring serious signs or from leaving a patient naked, urine-soaked, manacled to a radiator grille, or from being driven 1 100km through the night in the back of a Land-Rover.

If all that was not wrong, then it must be acceptable medical practice. And a profession, justifiably proud of its world-class medical achievements, is now stuck with defending and upholding such medical practice before the whole world.

limp. At midday it seemed that Biko could not walk. (1)

Dr. Lang admitted it produced a strange picture and he felt Biko had been shamming; during the inquest, he acknowledged that this possibility had been talked about between police and doctors.

On Friday 9th a lumbar puncture was performed by Dr. Hersch; the results showing that there was blood in the cerebro-spinal fluid. This indicated he had either pierced a blood vessel during the procedure or that there was a brain injury. Although he suspected damage to the brain, he did not specifically state it in his report. The previous evening Dr.Hersch had found the patient suffering from echolalia (a speech defect), left-sided weakness and an extensor plantar reflex. Dr. Hersch did not notice a scab over Biko's left eye, yet in retrospect at the inquest he remembered a whitish area over Biko's left eye which he thought was dried saliva . Dr. Hersch said that judging by the rest of the examination, it could almost have been expected that there be a brain lesion there. Dr. Hersch made it clear to Colonel Goosen that there were positive signs of nervous system damage.

On being asked by the counsel for the Biko family, why Biko was not taken to a proper hospital, Dr. Hersch replied :-

"Unfortunately this was not in our hands". (1)

There was no doubt, according to Dr. Hersch that had Biko been a private patient, he would have been admitted to hospital. Dr. Hersch said that Dr. Lang had told him he could not be placed in hospital.

Dr. Hersch recommended that the patient be examined by a neurosurgeon; basing this on the results of the examination done the previous night and the blood in the cerebro-spinal fluid obtained from the lumbar puncture. Dr. Hersch admits he was convinced there was brain damage, although he left it out of his report, regarding it as self-explanatory. He also failed to mention any treatment.

Dr. Lang visited Biko shortly after the lumbar puncture was performed, finding him comfortable and in possession of all his senses. A warder reported to him that Biko had eaten; having earlier been found in a bath with all his clothes on, soaking wet. Dr. Lang did not perform an extensor test as "he did not want to disturb the patient" (1), feeling that the patient's condition was improving. Dr. Lang suggested Biko should be sent to Livingstone Hospital but Colonel Goosen refused, ruling out a private hospital as well. Dr. Tucker

was informed by Dr. Lang that the patient had been examined by Dr. Hersch and an abnormal plantar reflex had been found. Dr. Tucker felt it was a very serious sign of brain damage. However, he did not act because he felt Biko was Dr. Lang's patient.

On Saturday 10th, Dr. Keely, a neurosurgeon, was consulted and after a discussion on the telephone he agreed that there was brain damage. It appears that Dr. Hersch was not perturbed, feeling there was no immediate urgency. Dr. Keely had said that Biko should be kept under observation. Dr. Hersch agreed during the inquest that Dr. Keely meant the sort of observation one would have received in hospital i.e. checks every hour.

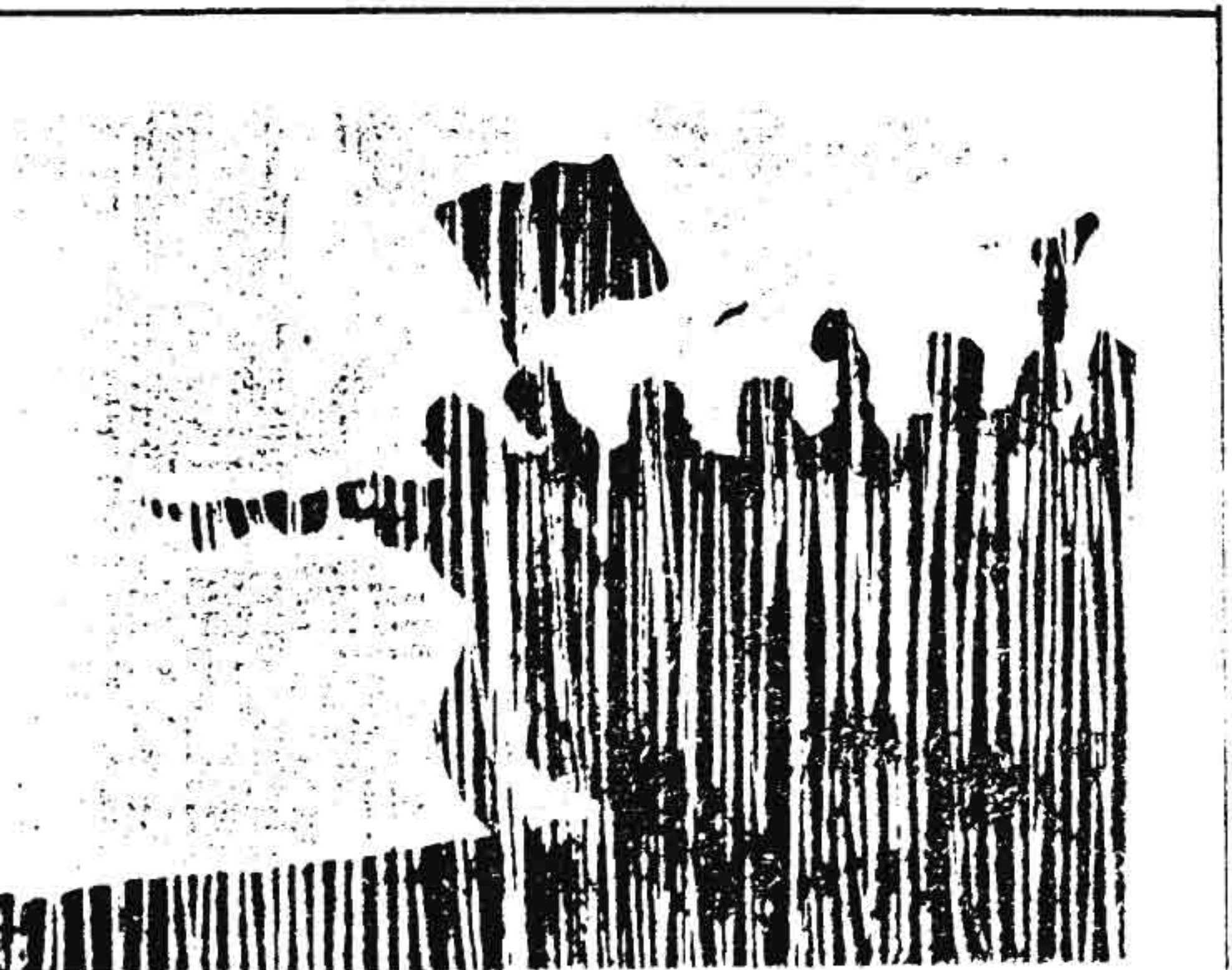
Later on Saturday, Dr. Lang again visited the patient, finding him with no complaints and no change in his physical condition. Dr. Lang wrote out a bed letter stating that he and Dr. Hersch could find no pathology and that the lumbar puncture was normal: coupled with this was the fact that Lang had stated that the plantar test was done on the right instead of the left side.

Dr. Lang said he believed Biko had been improving, basing his evidence on what he heard from the warders. He acknowledged that had he had a free choice, Biko would have been in hospital. Then Dr. Keely told Dr. Lang that observation was necessary, meaning that Biko should go to hospital. Dr. Lang told him that this was not possible as the Security Police wished to keep Biko in a prison cell, and that the doctors would have to do their best under the circumstances.

Dr. Lang, having decided that Biko's condition was improving, gave permission for his transfer back to the Walmer Police Station so that he would be able to observe him more closely. He stated that because the police station was closer to his home, he was able to carry out his observations more easily.

Dr. Lang told Biko that there was nothing much that he and Dr. Hersch could find wrong with him. After the examination, Dr. Lang did not see Biko again, the time being 3.30 p.m. on Saturday.

On Sunday 11th, Colonel Goosel contacted Dr. Tucker to say that Biko had collapsed. When Dr. Tucker arrived to see Biko he found him in a dazed condition with froth at his mouth and breathing rapidly. He examined him in five minutes, testing Biko's legs for spasticity (stiffness) but he did not test the plantar reflex, concluding that there was no change. Asked why he conducted such a brief examination, Dr. Tucker maintained that with the tests he had performed, he could rule out serious



brain disease. Dr. Tucker concluded in his statement that there was no sign to indicate organic disease, although under questioning he admitted this had been incorrect.

Dr. Tucker recommended that Biko be admitted to a hospital and Colonel Goosen said it should be a prison hospital. Dr. Tucker felt Biko was fit enough to travel to Pretoria by road, even though he still did not know the specific results of the lumbar puncture. Dr. Tucker did not insist that he go to a civil hospital because he said he didn't think he could override the decision made by a responsible police officer. Dr. Tucker felt that Biko was possibly still shamming at that stage.

> Mr. Kentridge asked "In terms of the Hippocratic Oath are not the interests of your patient paramount?"
>
> "Yes".
>
> "But in this instance they were subordinated to the interests of the Security Police".
>
> "Yes". (1)

Although Dr. Tucker was told of the specific results of the lumbar puncture before Biko left for Pretoria, he made no effort to intervene. Neither did he nor Dr. Lang, whom he spoke to, send any information to Pretoria so that the medical personnel there could have an outline of the background of the case.

Although the journey to Pretoria started late on Sunday afternoon, Biko had been deprived of observation all day even though Dr. Lang had undertaken to keep him under observation. When Biko arrived in Pretoria, he had to be carried into the hospital on a mat. With no history of the case, the young doctor in attendance, having been informed that Biko had been on a hunger strike, gave him a vitamin injection.

Six hours after arrival, Steve Biko died. Kentridge, counsel for the Biko family described his death as "a miserable and lonely death on a mat on a stone floor".

In my discussion of the sequence of events, I have been forced to omit a large body of evidence, some of which may contribute further to my argument.

SOME QUESTIONS TO BE ASKED:

A number of questions arise from the course of events described above.

* Was Dr. Lang's report, written on September 7th, due to carelessness, or was it intended to be misleading?
* Why did no doctor question Biko as to the origin of his injuries: were they entitled to make the assumptions they did, based on Colonel Goosen's remarks?
* Why, when all the doctors at some stage felt Biko might have suffered brain damage, did none of them question either Biko or Goosen?
* Why did Dr. Lang not keep Biko under regular observation?
* Why did Dr. Lang fill in the bed-letter incorrectly?
* Why did Dr. Tucker allow Biko to be taken to Pretoria?
* Why was no action taken when an abnormal plantar reflex was found, indicating the presence of brain damage?
* If the doctors were not able to persuade the Security Police that Biko needed to be hospitalised, why did the doctors not refuse to treat him as a form of protest against not having total control over the treatment of their patient?

And finally, an important question relating to detention in general. What if Biko had not died and in court he had accused the Security Police of assult. The reports of the doctors would have indicated no injury. Biko would have been branded a liar.

A basic question which needs to be asked concerns the relationship of the doctors with the Security Police. Extracts from the Council's submission on behalf of the Biko family, sum it up.

> "The doctors, for whatever precise reason - felt themselves beholden to the Security Police. They did not query the origin of Biko's injuries and symptoms, either from Biko or the Security Police.
>
> This studied lack of curiosity can only be explained either by their active collaboration with the police or a deliberate election not to embarass the police, nor indeed themselves, by asking questions, to which the answers were obvious."

Why, even if they did not demand that Biko be admitted to hospital, did they not at least demand that the conditions under which Biko suffered be improved. The doctors remained silent. Why?

It is instructive to look at "The Geneva Convention Code of Medical Ethics", which was based on the original Hippocratic Oath.

This states, inter alia, that

- "I will practice my profession with confidence and dignity.
- The health of my patient will be my first concern.
- I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and the patient.
- 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."

The Code was clearly not adhered to by the docotors "caring for" Steve Biko.

SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL.

What is the background to the decision of the South African Medical and Dental Council (S.A.M.D.C.) not to continue the investigation into the doctors conduct?

On 20th December 1977, the Ombudsman of the South African Council of Churches (S.A.C.C.) wrote a letter to the Registrar of the S.A.M.D.C. notifying him of his intention to submit a complaint against the three doctors involved in the treatment of Biko. On 16th January 1978, he submitted a full length complaint, with evidence from the inquest based on reports from the Rand Daily Mail, a list of the sequence of events and questions relating to the conduct of the doctors concerned. (In a covering letter, Mr. Roelofse said "In order to prevent any injustice to any of the doctors, it speaks for itself that the court records and not press reports be used as a basis for your investigations.") He also drew attention to the fact that after the inquest, the presiding magistrate had referred the medical evidence to the S.A.M.D.C. for possible action against the doctors.

Petition on Biko doctors

RDM info

The Biko ghost walks again

Challenging new questions on Biko

Final say on Biko doctors

Daily RAND Mail

THURSDAY, May 15, 1980

The Biko doctors: action needed

RDM 17/6/80

Biko ruling for Supreme Court

In March 1978 letters were sent to the doctors by the S.A.M.D.C., asking for explanations relating to the complaints. The doctors objected to these complaints on the basis of legal technicalities.

Since then, two factors apparently delayed S.A.M.D.C. action on the matters.

Firstly, the civil action brought by the Biko Family against the State, and secondly, the appeal of the doctors against having to give any explanation of their actions to the S.A.M.D.C. The former resulted in a settlement with the sum of R65,000. being paid by the State to the Biko Family and the latter application was rejected by the Supreme Court Judge. The doctors still chose not to furnish any explanations to the S.A.M.D.C.

The delay by the S.A.M.D.C. in acting on the matter was clearly longer than it needed to be, and in so doing, the S.A.M.D.C. to some extent defused the united front of opposition against the whole Biko affair.

The Preliminary Committee of the S.A.M.D.C. sat in April, and reached the conclusion that the conduct of the doctors did not warrant investigation. The statement released by the S.A.M.D.C. dealing with the decision concludes :-

> "the committee concluded there was no prima facie evidence of improper or disgraceful conduct on the part of the practitioners. The committee resolved that no further action should be taken on the matter."

Why did the S.A.M.D.C. go to the lengths it did to get the doctors to furnish explanations (which they never submitted) and then the Preliminary Committee decided that the whole matter need not be pursued? Not only this, but the committee:

- did not release the evidence upon which it based its decision
- refused to name the "experts" upon whom it called for advice
- went through many volumes of inquest evidence in the course of one day

- released its decision before it was ratified by the S.A.M.D.C., a unique and strange precedent.
- four out of the five members were Government appointed. The President of the S.A.M.D.C. chaired the Committee.

Considerable publicity was given to this decision of the Preliminary Committee and calls were made for an urgent meeting of the S.A.M.D.C. to review the conclusion of the Committee of Preliminary Inquiry.

Eventually this meeting was held, behind closed doors, and when the meeting ended the S.A.M.D.C. had decided by 18 votes to 9, to ratify the conclusions of the Committee of Preliminary Inquiry.

The S.A.M.D.C. decision was surprising because many people expected the preliminary decision to be over-ruled, especially in view of the amount of adverse publicity which the original decision had prompted.

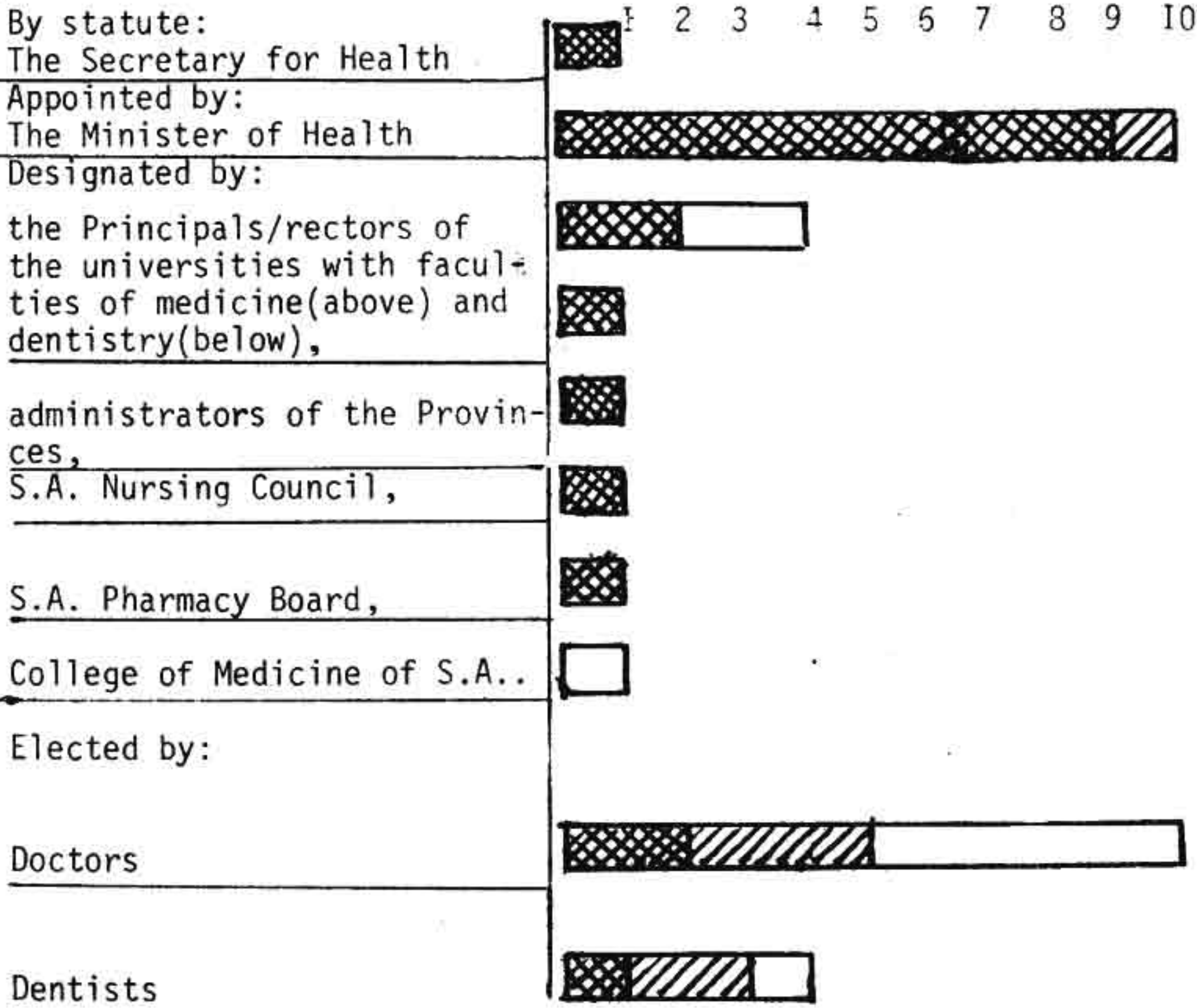
But is the decision of the S.A.M.D.C. really that surprising?

The Council was established on 22 May 1928 under Act 13 of 1928 to exercise the functions of the former provincial medical councils

The Act was amended in 1971 to provide for the establishment of professional boards for professions registered with the Council. Professional Boards have been established in respect of the following: Physiotherapy, Optometry, Medical Technology, Chiropody, Health Inspectors, Occupational Therapy, Psychology, Radiography, Medical Orthotists and Prosthetists, Speech Therapy and Audiology.

In 1974 Act 56 of 1974 replaced the 1928 Act, but stipulated that the Council continue to exist as a corporate body.

48. Derivation of membership



The above diagram illustrates the manner in which members of the S.A.M.D.C. are elected or appointed and their voting on the issue of a further inquiry into the conduct of the doctors who attended to Biko.

The S.A.M.D.C. is composed of 34 members. If one looks at the diagram one can see that only 14 of the members are democratically elected by Medical and Dental practitioners Of the remaining 20 designated members the overwelming majority are directly or indirectly linked with the ruling party in South Africa. Those directly linked are the Secretary for Health and the ten appointments of the Minister of Health, and those indirectly linked are the designee of the Administrators of the Provinces, the five designees of the rectors or principals of Universities with medical or dental faculties (the rectors themselves being approved by the government), the designees of the South African Nursing Council and the South African Pharmacy Board.

It is therefore evident that on any particular decision that the Council faces, there will be a clear majority of members expressing and supporting views which reflect those of the State. Once again if one looks at the diagram the case of the Biko doctors decision can be seen to support this fact.

The case stated above is true even before one begins to look at the views of the elected members. In a society where the training of doctors and dentists is strongly biased to favour the elite, who have a vested interest in maintaining the status quo, it is obvious that an election of members by this group will necessarily represent a majority of conservative views. This shifts the opinion of the body even further towards those of the State. The body is far from representative of the majority of South Africans. Under these circumstances, it is surprising that any member of the body supported a further inquiry into the conduct of the Biko doctors and the fact that 9 members did only serves to show how obvious the need was for a further inquiry.

The bias inherent in the Council, as with so many other institutions in this country, is not accidental. It is structured such that it gives a vague semblance of democracy but this guise merely obscures its true nature. The Council is in fact structured such that it necessarily reflects the views of the State.

The purpose of this is both to ensure that powerful sectors of the population such as the Medical Profession can never organise against the status quo, and furthermore so that the State can exert direct control over these sectors. . This is borne out by the following statement which appears in "A Guide to the Health Act No. 63 of 1977" produced by the Department of Health :-

> "This Council (the S.A.M.D.C.) was established (by the government) to Control the training, practice and standards of conduct of medical practitioners, dentists, and practitioners in supplementary health service professions ...."
>
> "Control over the supplementary health service professions is being introduced gradually. Eventually all such professions will be controlled in the same way as medical, dental and psychology professions." (2)

Despite all that has been shown above, the Council still claims that its first responsibility is to serve as an instrument to protect the interests of the public and that it "should remain the body imbued with the spirit of responsibility in its service to the public". The Council also claims that it is "probably the most senior of statutary bodies and is respected for its impartiality." (3)

How can it claim to serve the people before the medical and dental profession or the government when its structure, constitution, composition and actions do not bear out this statement.

Similarly, other statutary bodies such as the South African Nursing Council and the Medical Research Council are even more heavily weighted to ensure support for the status quo. South African Nursing Council was established "primarily to control the nursing profession in the Republic" (2) and consists of 29 members of which only 10 are elected by nurses, the rest being appointed; 10 by the Minister of Health, 4 representing the Provincial Administration; 1 representing universities with departments of Nursing; 1 representing the Department of National Education, and one each representing the South African Pharmacy Board, the S.A.M.D.C. and the South African Defence Force.

The Medical Research Council (M.R.C.) consists of 14 members all appointed by the State President. The M.R.C. claims to give "priority to those aspects which are most relevant to the needs of the people of South Africa" (2) How can only government appointees feel responsibility to anything other than the government as the needs of South Africa as perceived by the government.

It can be seen from the above discussion that the S.A.M.D.C., South African Nursing Council, the Medical Research Council, and many other statutary bodies control the distribution of health and health services in South Africa in the interests of the ruling class. It is clear that the Medical and Paramedical Profession is not immune from the control exerted by the State over all other areas.

The action of S.A.M.D.C. ~~and in fact, the entire~~ Biko affair should not be seen in isolation. Indeed, those who demand that justice be done in this particular case, should consider the others who die in detention, those thousands who are resettled at the whim of a bureaucrat, those tens of thousands who are arrested for pass offences, those hundreds of thousands of children who succumb to malnutrition and the large variety of control and coercion that this government exerts; because it is all these injustices which are tied up in the web of oppression which pervades this country. Those events are just part of the system which seeks to keep a privileged few in power, allocating resources to a tiny minority (yes, indeed, even medical resources) and ensuring the exploitation of the masses by the elite.

Any demands we might make of the S.A.M.D.C. must be qualified by demanding and working for a society where not only political but also economic oppression becomes an enigma. Only when that society is achieved, will the necessity to detain people be limited to real criminals and the atrocities, like that of the death of Steve Biko, a thing of the past.

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1. Geregtelike nadoodse ondersoek na die dood van Steven Bantu Biko GO 573/77.
2. A Guide to the Health Act No. 63 of 1977, Published by the Department of Health, July 1978.
3. President's Address (S.A.M.D.C.), appeared in South African Medical Journal, 27 March 1965, p.259-261.
4. Oosthuizen S.F., Opening address by the president of the South African Medical and Dental Council. S.A.M.J. 23 Nov. 1968, pp 1245 - 1246.

52. ALSO USED WERE:

* The complaint submitted to the South African Medical and Dental Council by Mr. E. Roelofse, regarding the Diagnosis and Treatment of patient Steve Biko by Drs. Lang, Tucker, and Hersch, during the period September 7th to September 11th, 1977.

* The Medical Evidence recorded at the Inquest into the death of Steve Biko.

* The Judgement in the action brought by Drs. Lang and Tucker against the South African Medical and Dental Council.

DECLARATION OF TOKYO

Guidelines for medical doctors

Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment

Statement approved by the Council of the World Medical Association, March 1975, and adopted as amended by the Twenty-ninth World Medical Assembly, Tokyo, October 1975.

Preamble

It is the privilege of the medical doctor to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

Declaration

1. The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.

DECLARATION CONTINUED

2. For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

3. The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

4. The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment are used or threatened.

5. A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible.

6. Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner.

7. The World Medical Association will support, and should encourage the international community, the national medical associations and fellow doctors to support the doctor and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

8. The doctor shall in all circumstances be bound to alleviate the distress of his fellow men, and no motive -- whether personal, collective or political -- shall prevail against this higher purpose.

POST-SCRIPT : DISTRICT SURGEONS.

District Surgeons are employees of the State. It is therefore not surprising that their activities have been to promote the interests of the State. In the Biko case they clearly admitted surrendering the control of the treatment of their patient to the Security Police. How could this be allowed to happen if the doctors themselves did not support this situation? What safeguards do the public, and in particular, prisoners, have against the power that is exerted by district surgeons? When prisoners are treated by district surgeons it is clear that the doctors are more concerned about security and other matters than about the care of the individual patient.

Health care of prisoners and in particular political prisoners is notoriously inadequate. Prisoners have no access to a doctor, unless the police feel that the prisoner needs medical care, even then the doctor called is a district surgeon and not a doctor chosen by the prisoner or his family. The role of the district surgeon in these cases is well described below.

> "..... the services which district surgeons render to prisoners and persons detained by the South African Police also fall within the definition of personal health services. These services however can have far-reaching legal implications and for this reason they can also be classified as medico-legal services. In view of this and for security reasons it would be advisable that specially selected medical practitioners be allocated by the Department to undertake these services." *

* A Guide to the Health Act No. 63 of 1977.
Published by Department of Health, Pretoria.
July 1978.

Doctor blames 'negligent' blacks for hospital crisis

STAR 8/7/80.

By Willie Nkosi and Mike Overmeyer

Black patients are sleeping on ward floors at the Boksburg-Benoni Hospital — but that is because of "their own negligence."

Dr G C Gravett, the medical superintendent, said building more hospitals to provide for blacks would not solve the problem of overcrowding.

"If blacks were not so negligent then we would not have problems of hospital space," he said.

During winter months, problems of overcrowding were more acute because of lung diseases and weekend violence, said Dr Gravett. In the male surgical ward yesterday, 62 patients had been admitted to fill 39 beds.

"It was our highest intake," said a spoikesman. Normally, with so many patients being admitted, the doctors attend to those who can be treated immediately and discharged.

"For the more serious we prepare felt mats and blankets as beds on the floor at night," the spokesman said.

Dr Gravett felt that in the black community breadwinners preferred buying cigarettes and liquor to feeding their families properly.

"If my children should suffer disease because of the lack of food I would stop smoking now," he said.

He warned that people approaching the Press to expose hospital overcrowding should be prepared to dig into their pockets and pay more tax if they wanted more hospital space and medical schools.

"These are the people who are not prepared to send their children into nursing careers," Dr Gravett said.

He also blamed low nursing wages and long hours for the hospital crisis.

"Women bank clerks work office hours and are not on duty on Sundays and at night. But our hospital staff has to serve the public 24 hours a day," he said.

Because of the staff problems, the idea of more hospitals were not realistic, said Dr Gravett.

The above excert from a newspaper article is extremely interesting. Dr. Gravett, the Superintendent at Boksburg-Benoni Hospital has shown how little understanding he has of health problems in South Africa. He blames "negligent Blacks" for the hospital crisis.

He, however, neglects to say how much money is spent on the provision of Black hospitals or their running costs compared with white hospitals.

In 1978, Johannesburg General Hospital (prior to the building of the Johannesburg Academic Hospital) had 371 000 patient-days and cost the province over R30 million rands to maintain. Baragwanath Hospital had nearly 840 000 patient-days and yet maintenance costs were only R26 million rands (1). If one looked at the urban-rural differences the inequality of access to proper hospital care would be shown to be even worse.

Furthermore, whites have access to other resources besides the Provincial Hospitals. The amount of private nursing homes, general practitioners and specialists catering for the white population further aggravates the inequalities.

South African health services are structured such that proper medical care has to be bought, and is therefore available to those with money. Plans for a private nursing home in Soweto should be seen inthis light - not relieving the hospital crisis at all but enabling those middle-class blacks with money, who least need the services, access to even better health care.

Dr. Gravett is correct in saying that building more hospitals would not solve the problem of overcrowding. Overcrowding in Black hospitals is only partly due to inadequate provision of services. Many of the diseases resulting in the hospitalisation of Blacks are diseases of poverty and underdevelopment. They are the result of such things as inadequate housing, poor sanitation, no access to clean water supplies, migrant labour, etc. The amount of disease of this nature will only be reduced if the structure of society is such that it promotes the health of all - which is not the case in South Africa at present.

Furthermore, Dr. Gravett continues by blaming the buying of cigarettes and liquor for health problems. But he neglects to show that the State has taken virtually no action to reduce the sale of these items - in fact the State actively promotes the selling of liquor in Black townships and compounds by the erection of beer halls. Concerning cigarettes, the Minister of Health, Dr. Lapa Munnik has spoken out against the "Hysterical campaign" against smoking and has stated "I am very satisfied with the tobacco industry and the road we have walked together the past few years" he said (2). Even now the plans to label all cigarette packs with the tar and nicotine content of the cigarettes is not aimed at reducing the amount of smoking, but only at legitamising the tobacco industry and its relationship with the Department of Health. (The tobacco industry will be discussed in a future issue of CRITICAL HEALTH.)

Dr. Gravett went on to blame staffing shortages, long working hours, and poor salaries for making the hospital crisis even worse.

This shows that the problem of inadequate hospital services is due to a society which promotes disease by its very structure which gives access to proper medical care only to those who have money, which promotes the sale of products which are harmful (such as liquor and tobacco), and which does not tackle any of the real causes of ill-health in South Africa.

These are the problems caused by "negligent Blacks" !!!

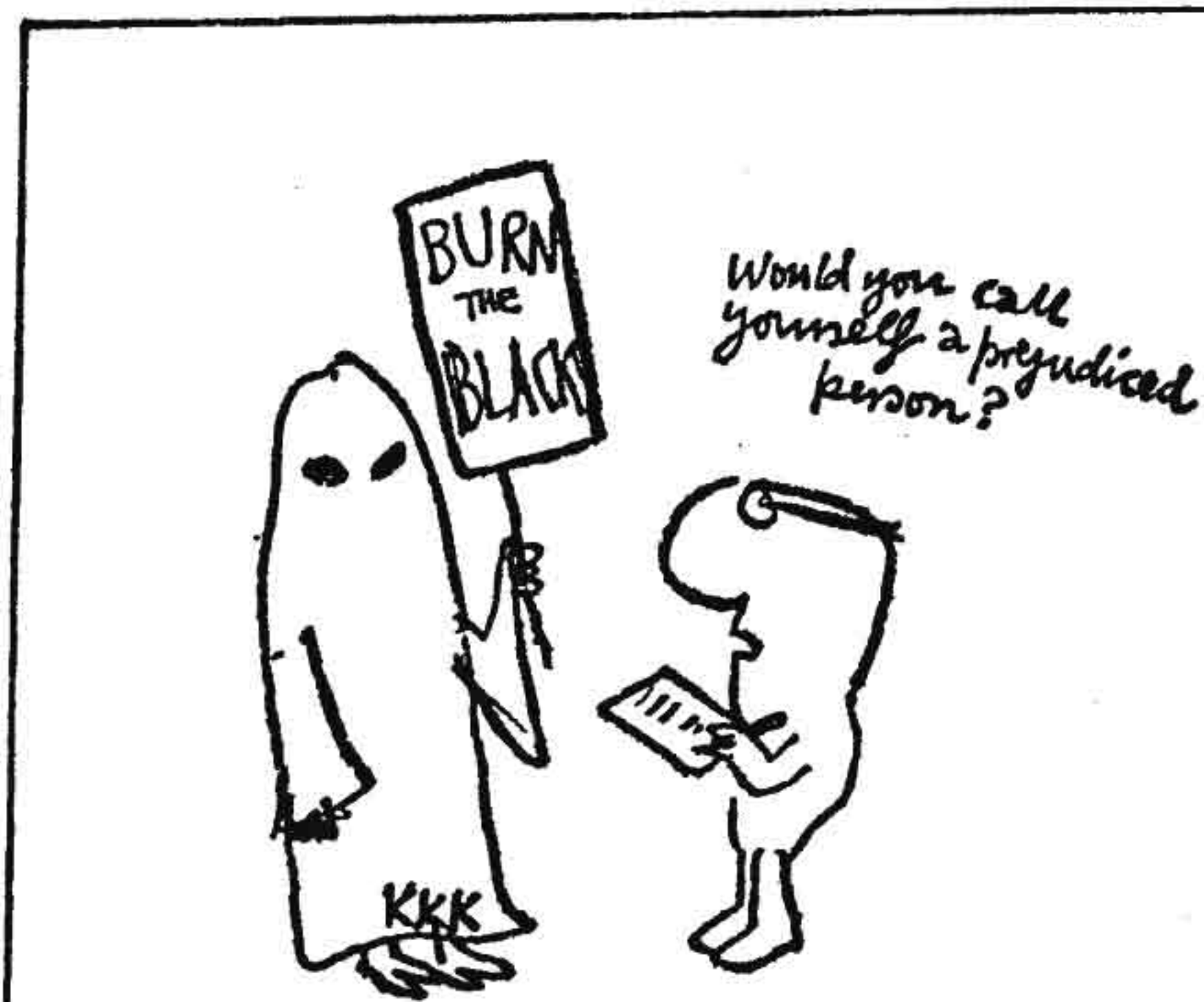
References:

1. Hospital and Nursing Yearbook of Southern Africa, 1979.
2. Rand Daily Mail, May 27th 1980.

EPIDEMIOLOGY:

HOW TO DO A STUDY

BY DUNCAN SAUNDERS



INTRODUCTION.

In the first article in CRITICAL HEALTH, Number 2, on the use of epidemiology in South Africa, which appeared the following was discussed :-

(i) The scope of epidemiology;
(ii) Some issues relating to the decision to do a particular study;
(iii) Examples of ways in which epidemiology can be used (using mainly South African studies).

This article is intended as an introduction for people who may want to do a study but feel uncertain of how to go about doing it. The techniques described may be used for studies of many things that are not necessarily medical but may be health-related. Examples are studies of housing conditions or of level of literacy in a community.

The first section outlines the stages common to all types of studies. The second section deals with some of the methodological issues to be considered when doing a descriptive study.

Stages of a Study:

Table 1 shows the stages of a study as listed by Abramson. Each stage is dependant on the preceding one.

1. Preliminary Steps:

The first steps in converting an interest in doing a study into a concrete proposal are taken by answering the following questions ?

(i) What is the purpose of the study ?
(ii) What aspect of a health problem am I going to investigate ?

Hypertension (high blood pressure) may be a common problem in the area in which one is working.

A number of different kinds of study may usefully be done e.g.

(i) Studies of the prevalence of hypertension in the area.
(ii) Studies looking at factors associated with hypertension.
(iii) Studies looking at interventions aimed at reducing

TABLE 1:

STAGES OF A STUDY.

1. Preliminary Steps.

2. Planning.

3. Preparing for data collection.

4. Collecting the data.

5. Processing and analysing the data.

6. Writing a Report.

hypertension. This type of study may also be useful to decide on what sorts of health care services are needed to deal with the problem.

In addition one may have different reasons for doing any particular kind of study. A prevalence study may be done to help estimate the size of the problem so that appropriate interventions may be planned. Alternatively, the purpose may be to monitor the effect of rapid urbanization on blood pressure. The purpose of the study has implications for the planning of the study such as the choice of population to be studied and the sample size required. Having decided what one is going to investigate, and why, planning of the study can begin.

2. Planning the Study:

The value of a study depends on careful planning. This stage may take longer than any of the other stages or all the other stages combined. Some of the issues to be considered in planning a descriptive study will be discussed in the second part of this article. By the end of this stage one should have a written protocol (outline) which describes what information is needed and how it is to be collected and analysed.

3. Preparing for data collection:

Having finalised a plan for a study one needs to test the methods used and to make various practical arrangements.

Pretesting of methods is always necessary. Sometimes all that is required is to look at a few clinic cards to see whether certain information is routinely collected. At other times a pilot study or "dress rehearsal" needs to be done. The pilot study should be done in exactly the same way as you are planning to do the main study. In this way you can pick up problems with your study (e.g. questions that are not phrased clearly) before you actually start the study itself. At times one is testing to see whether any unforeseen difficulties crop up. Time after time major flaws are detected in apparently well constructed questionnaires. At other times one is looking for particular information. Many studies are inconclusive because sample are too small. A pilot study can help onedecide on the size of the sample needed to answer the question one is asking.

Practical arrangements for the main study may need to be made at this stage, including :-

(i) Finding and training fieldworkers.

(ii) Arranging venues.

(iii) Obtaining equipment and printing questionnaires.

(iv) Obtaining informed consent and co-operation from participants.

4. Collecting the Data:

After the stimulation of planning the study comes the often rather dull period of collecting the data in a systematic manner. At this stage one needs to monitor two aspects of the study.

(i) A record should be kept of participants and non-participants (i.e. those who do not answer the questionnaire). For example people who do not participate (reply) in a questionnaire on level of literacy may in fact be illiterate. In this way one can act either to obtain improved participation in the study or one can collect information to enable one to assess the sample bias caused by the non-participation.

(ii) The quality of the data being collected should be checked.

5. Processing and Interpreting the Data:

Processing the data involves firstly, looking at the data for possible errors of recording and indexing. Following this the data are arranged in the format one needs to interpret it. During the planning stage it is useful to construct dummy tables of the data to be collected. At analysis stage one then fills in the data obtained from the survey in these tables. Interpreting the data involves making sense of them and deciding what the practical implications are.

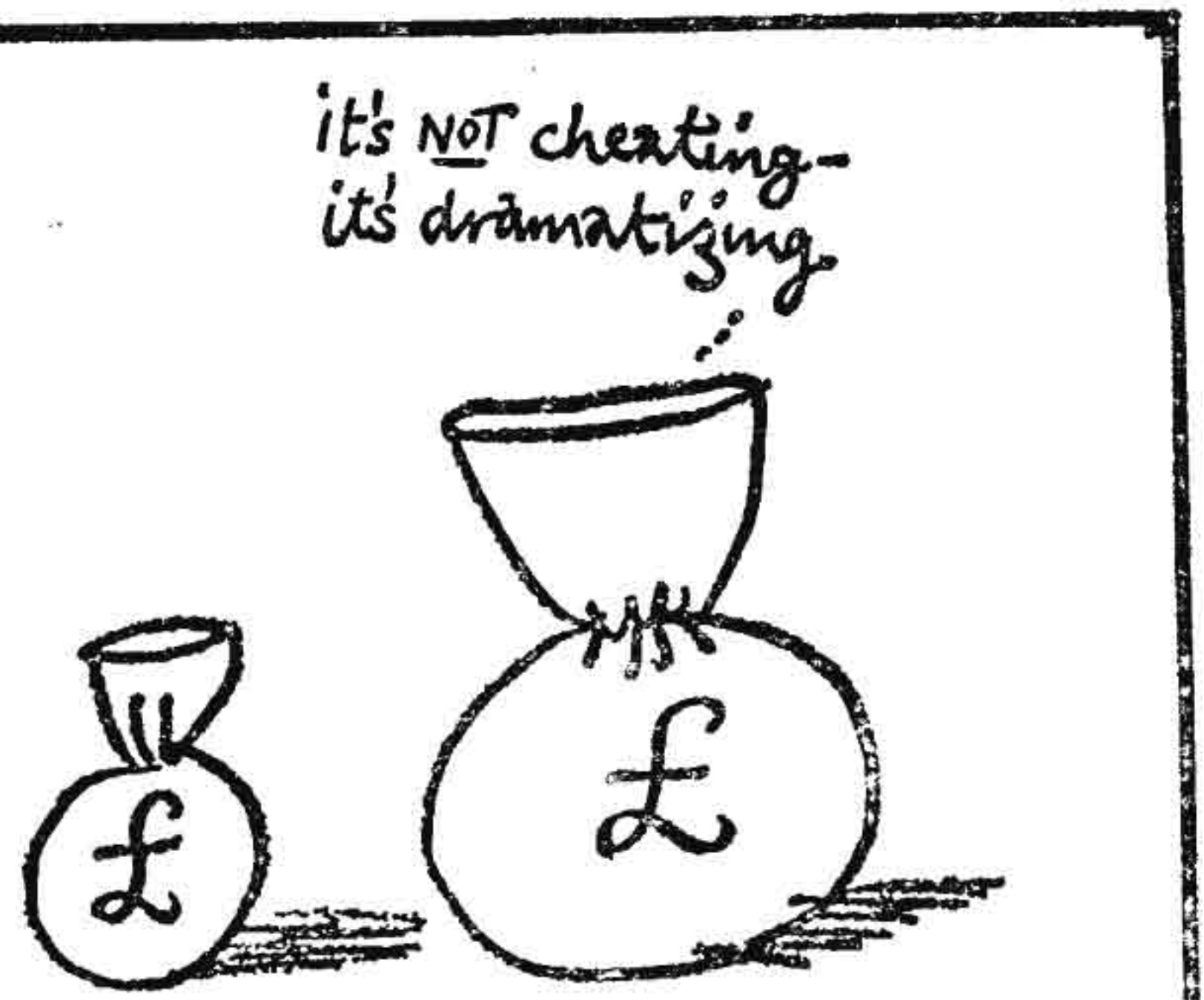
6. Writing a Report:

Even if the results are only of interest to the investigator, no study is complete until a report has been written.

PART TWO.

Planning a Descriptive Study:

A descriptive study is designed to find out the size of a health problem. The design of descriptive studies is rela-


it's NOT cheating -
it's dramatizing...
£
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tively simple. Nevertheless, studies reported in the medical literature are often seriously flawed.

The first step is to define exactly what one wants the study to yield, i.e. the objective of the study. This can usefully be set out in the form of a question with the following characteristics.

1. It can be answered by a number.

2. Each term in the question is clearly defined.

e.g. What is the prevalence of hypertension in population Y at time X ?

The main issues involved in the design of a study to answer such a question are shown in figure 1.

1. <u>The Study Population</u>:

   The choice of study population is often implicit in the purpose of the study. How generalizable one wants the study to be is important in defining a study population. It is inappropriate to use clinic attenders to measure the prevalence of hypertension in the surrounding area. However, this population would be appropriate if one was interested in the hypertension prevalence of clinic attenders. If one wanted to measure the prevalence of hypertension in a particular community, one would have to randomly study members of the community and not only those attending the clinic.

2. <u>Sample Selection</u>:

   To measure the blood pressure of every person in a large city is a difficult task. The effort and expense involved in measuring the prevalence of hypertension can be reduced by sampling. However, the disadvantage of sampling is that one can only <u>estimate</u> the size of the health problem. By using <u>certain</u> sampling methods one can make a statement about the prevalence of hypertension in the whole population with measurable confidence and precision. If one measured the blood pressures on the whole population one could say that the prevalence of hypertension in the population was e.g. 20%. However, if a random sample of people from this population had blood pressures taken one would only be able to say e.g. that one is 95% confident that the prevalence of hypertension is between 17% and 23%.

   It is important to seek statistical advice about the sample size required for a particular study. At this stage one

FIGURE 1.

DESCRIPTIVE STUDY DESIGN.

DESIGN:	ISSUES:
Study Population	Defined ? Generalizable Size
Sample	Random ? Size ?
Measurements	Valid ? Repeatable ? Response Rate ?

may decide to abandon the study because of the large sample needed to obtain an estimate of the required precision. To estimate the prevalence of tuberculosis in a part of Soweto, a study involving 2500 persons was planned. The purpose of this study was to estimate the number of tuberculosis sufferers in the community not known to the T.B. service. However, if positive sputum tests were found at a rate of 7/1000 in the sample one could be 95% confident that the population prevalence rate was between 4/1000 and 11/1000. This estimate was too imprecise to be of help and therefore other methods were developed to find out how adequately the T.B. service was finding tuberculosis sufferers.

3. Measurements:

To be useful, measurements should be valid and repeatable. Validity is the extent to which the measurements reflect what one is trying to measure. With regard to blood pressure the question is :- does an indirect blood pressure reading (sphygnomanometer reading) reflect the intra-arterial pressure ?

Realiability is the extent to which similar information is obtained by repeated measurements. Blood pressure readings on one person may vary either because of variations in the blood pressure, the instrument or the observers. Realiability can be enhanced in this instance by adapting a standard procedure for taking the blood pressure, regular checking of the sphygnomanometers (blood pressure meters) used and training the observers respectively.

4. Response Rate:

As non respondents are often different from respondents it is important that a high response rate is obtained. As a rule a 80% response rate is acceptable. If the response rate is lower than this one should investigate whether the non-respondents are likely to be different to the respondents for the variable being studied.

CONCLUSION:

The intention of this article was to serve as an introduction for people who were uncertain how to go about doing a study. The books by Abramson and Barker are highly recommended for those who would like to learn more about this.

In particular Abramson deals thoroughly with all aspects of study design and illustrates points made with numerous examples and references.

R E F E R E N C E S:

1. Abramson, G.H. (1979)
Survey Methods in Community Medicine.
An introduction to Epidemiological and Evaluative Studies.
Churchill Livingstone, Edinburgh, 2nd Ed.

2. Barker, P.G.P. (1976).
Practical Epidemiology.
Churchill Livingstone, Edinburgh, 2nd Ed.

NOTE:

People interested in doing a study on issues of concern to communities and who require further advice on how to do it are welcome to send their queries to Critical Health and the editors will put them into contact with resource people that will be able to assist them.

TRANSVAAL MEDICAL SOCIETY

NOT FOR GAIN

Dr. Y. Veriava. [illegible] 28266,

Dr. D. Mzamane. Booysens.

Dr. R. Bismilla. 2016,

Dr. R. Gopal. Johannesburg.

Dr. Z. Mayet. 8/7/1980.

THE EDITOR,
Critical Health,
Wits Medical School.

Dear Sir,

Recently a senior physician at one of the provincial hospitals (Transvaal) was detained and is still under detention without being brought to trial. His involvement in the selection of medical students at the University of Witwatersrand, being the chairman of the Medical Staff Association of the hospital at which he works, and his concern for the social standing of all individuals, all indicate that he is a valuable member of the medical profession and indeed of the whole society.

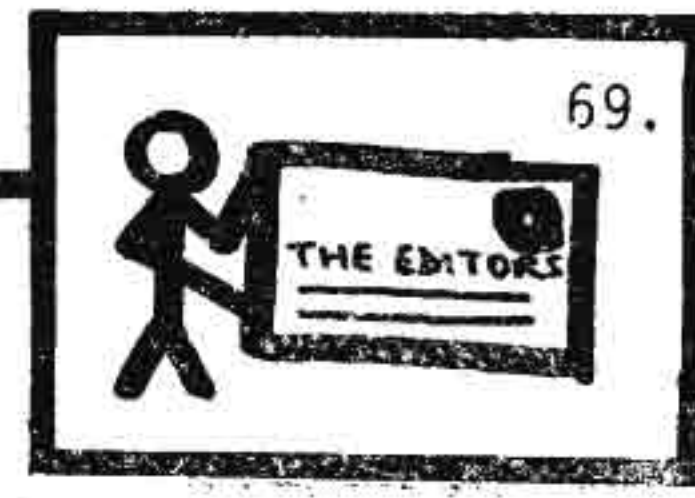
The present trend of medicine internationally places great emphasis on the social aspects of medical care. We are not only concerned about diagnostic and therapeutic consideration, but also about the education of the individual, and the education of society - we cannot hope to achieve a satisfactory standard of medical care without these considerations. The great involvement in primary health care, and the evolving criteria at most universities to select those students who will turn out to be doctors with a greater social awareness, bear testimony to the state of the art of medicine.

Are we, who uphold these principles, who foster these attitudes, and who have a more direct role in determining the course of medicine, not directly responsible for producing doctors of the above calibre? For how long are we going to deny our duty to point out the causes for the greatest part of suffering and discomfort in our society, to actively direct society towards the relief of these ills, and to educate society about the mechanisms of these ills? Or are we going to submerge our heads into the sand and pretend that these duties are beyond the realm of medicine? What will be said of the doctors of 1980?

When a doctor is detained because he is concerned for the fate of our society, which should be the concern of all with a sense of responsibility, then surely it is incumbent on every individual, on every institution and on every governing body to call for his/her release.

We hope that through your magazine you continually (as you have) encourage the social awareness and responsibility of doctors.

Chairman.



THE DILEMMA OF INFANT FEEDING

Are we justified in continuing here unabated the attack directed predominantly at Nestlés in relation to infant feeding, or is there an alternate reasonable and rational approach, to what obviously constitutes a problem of great importance?

All would surely agree on the many established and obvious advantages of breast feeding, and the importance of encouraging and facilitating this in all ways possible. If this message is failing to reach Wits medical students', they must be singularly unaware of or unresponsive to the practices and attitudes and teaching of the Paediatric Department.

In South Africa, we already have an established code of ethics controlling the advertising of commercial infant foods. This precludes advertising such products directly to individuals other than health care professionals. Nestlés have agreed to adhere to this, and it is important that the code is <u>enforced</u> and <u>monitored</u> for all commercial baby food manufacturers.

In a recent case, a trade advertisement was considered unacceptable and as soon as this was pointed out it was withdrawn.

Members of the health professions obviously need to know details of the composition of products available on the market. If we or any of the group act irresponsibly or prove susceptible to bribery, surely we should <u>put our own house in order</u> rather than put all the blame on commercial companies. Ideally formula feeds in the first six months of life should be considered in the same light as insulin for diabetics. Practically this is simply not feasible.

There are a more than negligible number of mothers who in fact cannot or will not breast feed their babies. Are we to slaughter these infants as soon as their plight is recognised or simply condemn them to other non milk alternatives and the probable consequences of slower extermination? Could we perhaps re-introduce wet nurses? Would they be available or acceptable in present day modern or traditional society? These alternatives exist if milk powders are not relatively easily available.

In the light of existing knowledge and facilities can we practice selective breeding by reducing survivors of "poor lactating" stock?!

In fact, the major problem lies in the weaning period six months to 2 years where the dependable availability of an additional source of protein may be life saving. If milk powder is to be used, the importance of reconstituting it correctly and practicing the essential hygeine are paramount. This is where the company demonstrator may be considered justified. However she should <u>only</u> talk to those for whom artificial feeding is an unavoidable fact, or powdered milk is to form a necessary supplement to the weaning diet. Neither rural or urban blacks in our existing situation are as a whole able to produce their own food directly.

Ensuring adequate nutrition is an essential part of infant health care so in the circumstances it is understandable why demonstrations - without advertising specific products should take place at baby clinics. This is difficult to control, but contrasts with the position of smoking and advertising.

One is aware of the great apparent wealth of the commercial milk companies who do however have other interests and products. Steps to ensure that profits from milk powders be controlled and adequate only might reduce over enthusiastic competition in the market. This may well demand our energetic and concerted action.

Health professionals should ensure that they do work with such companies to achieve the desired end of improved infant health. Specific forceful measures should be taken when indicated, and practical positive guidelines offered rather than a general perpetuating condemnation. The extreme alternative of totally eliminating commercial baby foods from the market will create undoubted problems in our present day society - both affluent and "developing."

There is indeed a dilemma, and we all have responsibility in this area.

Lucy Waggstaff

EDITORS' REPLY.

We thank Professor Wagstaff for her comments. A number of issues arise from the letter.

First of all, we do not believe that Nestlé is the only producer of infant formula products that is at fault. A number of other companies have also used unethical advertising and promoting techniques. The Wyeth advertisement printed overleaf is a clear illustration of the type of advertising used to promote the sale of infant formula products.

We acknowledge that a small number of mothers may be unable to breast-feed and we acknowledge that infant formula feeds may be useful in such cases. However, we object strongly to the forms of advertising pressure that have been exerted on healthy lactating mothers to abandon breastfeeding and use artificial feeds. Under such circumstances the use of these unnecessary products may be extremely harmful - with overdilution of the feeds to make them last longer or inability to sterilise bottles properly because of lack of fuel for heating or no access to clean water. Improper use of the feeds may lead to malnutrition and gastroenteritis which leads to the death of many infants.

The collaboration of the infant formula companies with the medical profession continues. An example is a publication of the Medical Association of South Africa which is titled (in Zulu) "You and Your Baby" which is distributed freely. The publication, printed in 1979 contains an advertisement for infant formula products manufactured by Wyeth. A reply-card is inserted whereby the reader may receive free samples of these products directly from the Medical Association Obviously many unaware mothers will think that if doctors are giving these samples out for free then the product must be good for their babies.

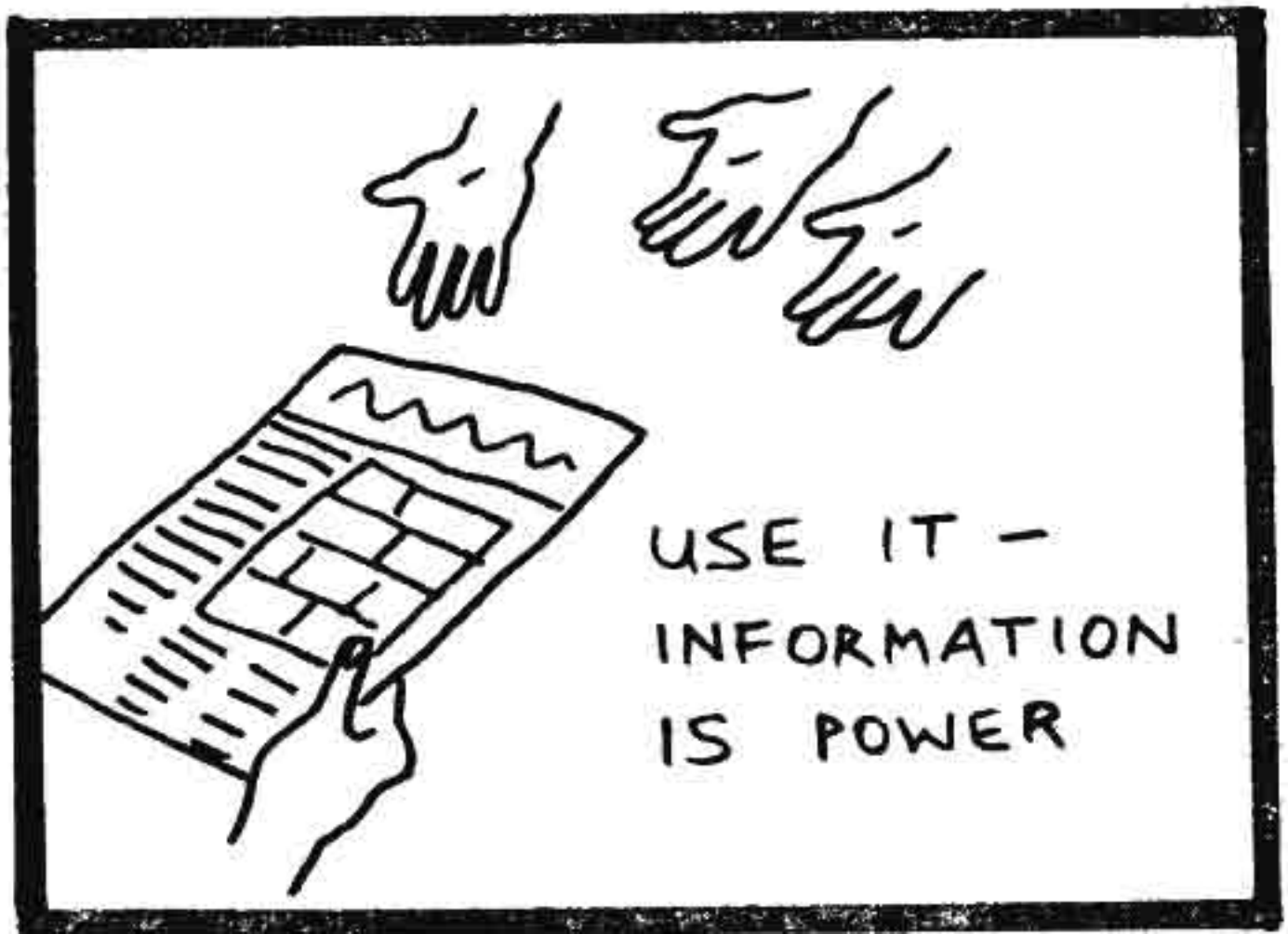
A more recent example of involvement of the infant formula industry was the prominent display of Nestlé posters and products at the South African Nutrition Society Congress held in Johannesburg this month.

The involvement of the health professions directly with the infant formula companies as in these cases is a clear indication of the collusion between the two groups - a situation

which cannot possibly promote an objective awareness of the profit-motive of these companies.

We agree with Professor Wagstaff that steps must be taken to monitor the advertising and promotion of these artificial products. Further, it is important to ensure that the supplying of infant formula feeds is not motivated by profit, but by the need to assist those few mothers who really need an alternative to breastfeeding. Packaging of these products should be standardised to reduce costs and promotion outlawed to prevent manipulation of unwary mothers. The possibility of supplying these feeds by prescription only is also worthy of consideration, although this puts doctors in the position of being even more susceptible to the promotional activities of the baby food industry.

There is no simple answer to this problem. We must, however, acknowledge that there is a problem, that the problem has arisen as a result of the profit-motive of the industry, and that one of the few ways of exerting pressure on this industry is to draw the attention of the public to these anti-social activities.



Good for Babies
Good for Profits
So its Good for YOU

Babies thrive on SMA and S-26 baby-milks
Mothers are constantly demanding these products. That is why you have a higher turnover – which means more profit!

SMA and S-26 – GOOD FOR BABIES
– GOOD FOR PROFITS
– GOOD FOR YOU

STOCK UP NOW – THEY ARE GOOD FOR YOUR BUSINESS

This ad was taken from *African Business and Chamber of Commerce Review*, Mar 1978, a South African publication catering to black businessmen and traders.

WESTERN PROVINCE GENERAL WORKERS' UNION (Formerly
Western Province Workers' Advice Bureau)

1st Floor, Benbow Building, Beverley Street, ATHLONE.
Telephone: 670870

Dear Friend,

You will no doubt have read of the dispute in the Cape Town meat industry, a dispute involving 800 meat workers from 17 different meat firms and their managements.

The dispute started at Table Bay Cold Storage, a firm employing approximately 100 workers, when they demanded that management recognise a democratically elected committee representing the workers at the firm. The recognition of such a committee would then form the basis for future negotiations with management about working conditions in the firm. The Table Bay management stubbornly refused to agree to the workers' demand despite repeated attempts at negotiation by the workers. A similar pattern was followed at National Meat Suppliers, a firm employing about 250 workers.

When the Table Bay workers finally stopped work in support of their demand, their management said that they had dismissed themselves and refused to discuss the matter further. The issue was then taken up by worker representatives of committees in 15 other meat firms, with no success. Finally the workers in these other firms also stopped work in a 1 day protest and solidarity demonstration. When they returned to work the next day, riot police turned them away from the factories. The workers resolved not to return to work unless all the workers were reinstated and the original demands for recognition of workers' committees at Table Bay and National Meat Suppliers had been met. They called on the community for support in 3 areas: 1) a boycott of red meat and red meat products, 2) financial support to enable them to stay out until their demands had been met. 3) community support to dissuade scab labour from taking

jobs in the meat industry.

The struggle of the workers for democratic rights in the factories struck a responsive chord throughout the black community, and their support has been spontaneous and extensive. There is now an almost total boycott of red meat and red meat products thoughout the black community of Cape Town. Meeting after meeting around the Cape Flats have unanimously endorsed the workers' cause.

The dispute has now been continu ing for 7 weeks. The community support is increasing all the time. The workers have remained absolutely united in the pursuance of their demands. The reasonable demands have never altered since the beginning of the dispute.

The workers are being paid R15 a week by the Union to support themselves and their families during the dispute - at a cost so far to the Union of R84 000 (as the dispute enters its seventh week).

The workers are making tremendous sacrifices in the pursuit of their democratic demands, demands which are being echoed all over the country in all sections of the black community. Their Union has committed itself fully to support the meat workers until their demands are won, whatever the cost.

Our struggle is to build up democratic worker organisations to take forward the just demands of the workers. The meat workers' dispute is an importart part of this struggle.

We call on you for your support.

Published by Meat Strike committee
Printed by SRC press.

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Issue No. 2

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