CRITICAL HEALTH

MAY,1983. NO. 9

women and health

60c

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WE APOLOGISE FOR THE INCREASE IN PRICE TO 60c STARTING WITH THIS ISSUE. WE HAVE NOT RAISED THE PRICE OF CRITICAL HEALTH FOR TWO YEARS, BUT OWING TO INCREASING COSTS CANNOT POSSIBLY KEEP THE PRICE AT 40c FOR THIS ISSUE. WE REMAIN COMMITTED TO KEEP THE PRICE AT A LEVEL THAT WORKING PEOPLE AND STUDENTS CAN AFFORD, AND THERE WILL BE NO FURTHER PRICE INCREASE UNTIL AT LEAST THE BEGINNING OF 1984.

ACKNOWLEDGEMENTS

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EDITORIAL

Doctors and the whole health system are a very important part of defining what it means to be a woman in our society. For the apartheid capitalist system to work, women must "know their place". Their labour in the factories and the unpaid service role they play in looking after the present and future workers is needed to keep South African society going. And modern medicine plays its part in the exploitation and oppression of women in our country - whether they are the patients who receive health-care, or the nurses and workers who are responsible for the everyday running of the health services, women seem to bear the brunt of the health system in South Africa.

This issue of Critical Health examines the position of women in the health services, both as receivers of health-care and as providers of health-care, and its relationship to the position of women in wider society. Articles take up in different ways important considerations of "women and health", but all relate to women's lives and their health.

A few brief comments on women in South Africa will help to understand our concerns:

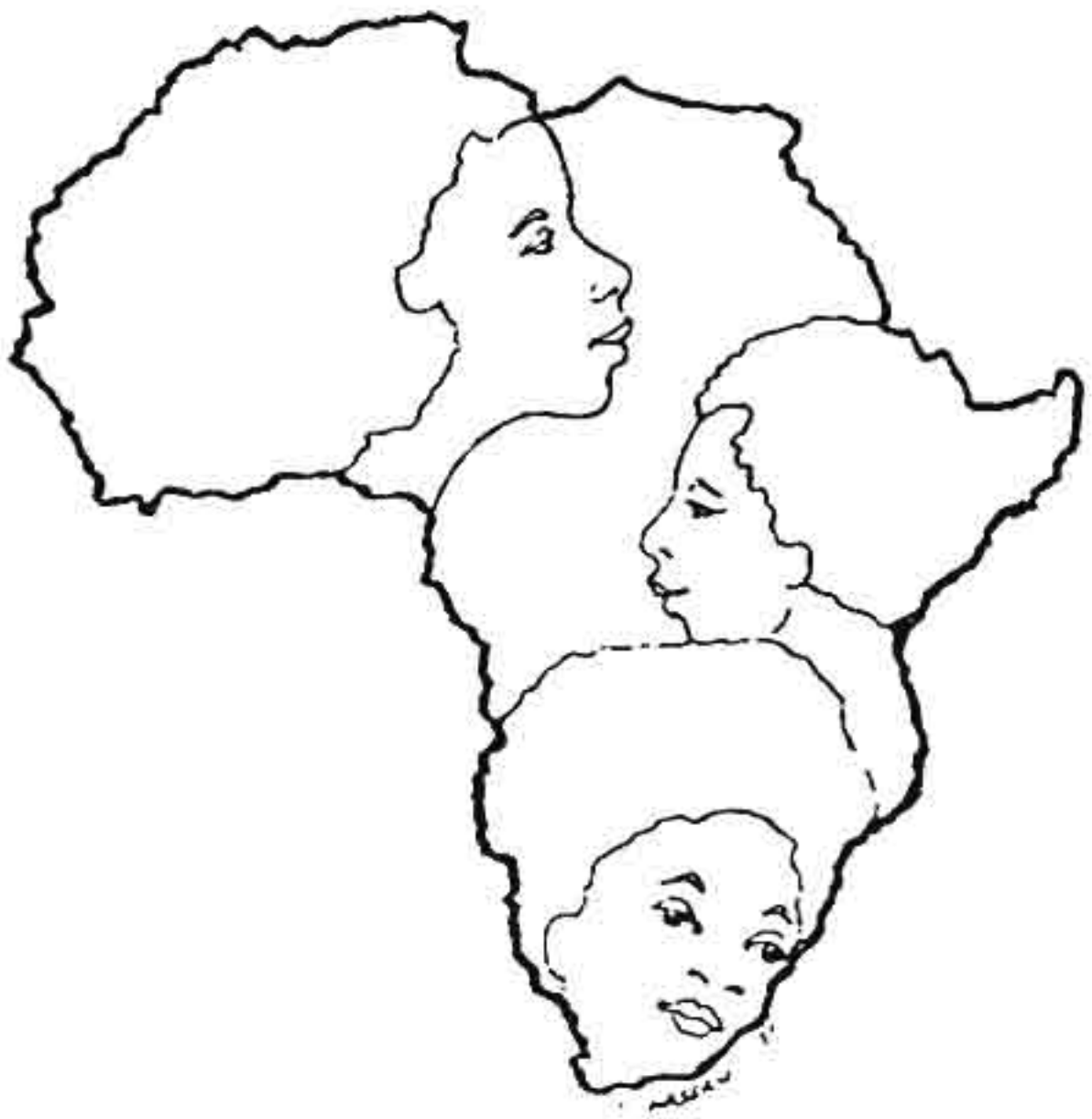
WOMEN IN SOCIETY

A feature of the 20th century has been the increasing number of women working in wage labour. As a result, women workers form an important part of an exploited working-class which suffers low wages, poor working conditions, inadequate social services and the like. At the same time, they experience this exploitation in a way specific to them as women. They form the lowest-paid, least skilled and most insecure section of the workforce.

Urban working-class women are divided between domestic work and factory work (mostly in textile, clothing and service industries), and the majority

are domestic workers. A large number of rural women find employment on farms. The point is that in both domestic and farm labour working conditions are the worst in South Africa. Wages are not regulated by the Industrial Conciliation Act, and there is no unemployment insurance or worker's compensation in the event of injury. Influx control perhaps hits women hardest - since jobs for women are decreasing rather than increasing, their option is a life of subsistence (or rather, non-subsistence!) in the reserves.

In the urban areas, permanent domestic work is on the decrease. Approximately 75% of black African women are not engaged in formal full-time employment and



tend to become fragmented and isolated. They are often forced into activities like hawking, running shebeens and prostitution.

In general then, the majority of women in South Africa experience oppression as members of a working-class.

At the same time, however, working women have continued to be responsible for another kind of "domestic labour" - the housework in their own homes! This amounts to working a double shift, where women are expected to care for children, cook and maintain an efficient household in addition to working for a wage.

Although more and more women have become workers, there has been no real change in the ideology of male supremacy. Rather, women come to be seen as less effective mothers because their work interferes with their mothering, and less effective workers because their responsibilities as mothers interfere with their work. Women can be seen as both workers and mothers in this changing ideology, but still in a way that they are seen as inferior and therefore oppressed in relation to men.

For black women in South Africa, the "double shift" is compounded by racial oppression. The Group Areas Act restricts blacks to residence in particular areas, resulting in inadequate housing, overcrowding, slum conditions and a serious housing shortage. Influx control dictates whether women (and men) can remain in urban areas or not. In addition, black women also suffer racial insults, for example being called "girls" when they are mature women.

So we can see that black women in South Africa suffer what has been called a "triple oppression" - as women, as a racially oppressed group and as a working-class.

WOMEN AND HEALTH

This edition of Critical Health deals with ways in which the social position of women in South African society influences their health and the way that they participate in the provision of health. An important article deals with the position of women health workers and the kind of exploitation they experience, and another piece deals with the history of the struggles of these women in South Africa.

Other articles deal with the suffering and oppression of women factory workers and women in the bantustans, and the consequences this has for their health. Particular attention is directed at the mental health problems of the women in bantustans. Finally, crucial health issues facing all women, such as rape and cervical cancer, are dealt with.

ABORTION

Owing to production difficulties, a planned article on abortion has not gone into this edition. However, abortion remains a crucial political and health-related issue for all women and men. We would welcome contributions on this for future editions.

NEXT ISSUE- HEALTH SERVICES

The next issue of Critical Health will deal with health services in South Africa.The issue will aim to deal with the following topics:

1)The inadequacies of the present health services
2)The state's response to the crisis in the health services.
3)The response of communities and democratic organ organisations to poor health services.
4)Alternative health services.

Critical Health would welcome any suggestions,comments,criticisms,articles or graphics on the above theme.Please send these to :

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WOMEN HEALTH WORKERS

This article was written after a series of interviews with a number of different women health workers, ranging from sisters to domestics, at Baragwanath and Hillbrow hospitals. In doing so an attempt has been made to demonstrate the position that black women health workers occupy within the South African health care system and the particular working conditions to which they are subjected.

The health care system supports the status quo in that it reflects and reinforces many aspects of oppression and exploitation. This is clearly demonstrated by the heirarchical structures within the health care system. The nature of these structures is such that control is located in the hands of a minority of people, generally highly skilled white male professionals, who are placed in a position where they make all the decisions concerning health policy.

The majority of health workers are women who almost always occupy positions subordinate to those of men. This sexual division of work is further compounded by racial and class divisions. Black women health workers are even more exploited than their white collegues.

Age also constitutes a form of discrimination. Older women tend to be employed in the lowest status job categories, such as manual work, with the lowest pay.

The question of skill is central to any understanding of the heirarchical health structures. The definition of 'skilled work' is manipulated to conform with society's idea of women's work which is generally to carry out orders given by the male superiors. Thus women health workers have very little control over the work they do. By and large they carry out the orders and routine work tasks determined by their superiors. The people who carry out these tasks tend to be classed as 'unskilled' or 'semi-skilled', whereas the people who give the instructions are generally regarded as skilled.

As a result of this definition of 'skill', women health workers are allowed very little responsibility in the decision making process despite the extent of their experience and their training. Highly qualified sisters who have worked in hospitals for along time cannot, even in emergency cases, decide what treatment to give a patient without first consulting with a doctor. During the nineteenth century Florence Nightinggale outlined what she thought the role of the nurse should be, she said:

> *"We nurses are and never will be anything but the servants of doctors, and good and faithful servants we should be, happy in our dependence which helps to accomplish good deeds".*

It is obvious that this ethic still holds, although contradictions can sometimes be seen. For example, during night shift, nurses take on more responsibility because of the lack of doctors.

Furthermore the role that women hospital workers play is much the same as the women's role in the home. One feminist writer argues that the relationship between the doctor, the nurse and the patient is analogous to the family relationship. She says that:

> *"Nursing is distincly women's work ... women are particularly filled to the onerous task of patiently and skillfully caring for the patient in faithful obedience to the physicain's orders. Ability to care for the helpless is women's distinguishing mark. Nursing is nothing".*

Let us now consider some of the specific working conditions at Baragwanath and Hillbrow hospitals.

Many women health workers are married with families to look after. Like all black working mothers they wake up earlier than the other members of the family (sometimes as early as 4 am.) to do their household chores. Only when everyone is washed, cleaned and fed can the women health worker rush off to work.

The work that women health workers do is both emotionally and physically strenuous. Student nurses complain that their free time is mostly taken up by washing their uniforms, and sleeping because they are so tired. On top of this nurses have to work three months nightshift a year, a situation which is particularly stressful.

The health authorities further entrench divisions among health workers by ensuring that there is little social contact during working hours. White doctors often eat in a separate room from black doctors, and qualified nurses are barred from eating with student nurses. Cleaners, porters and other workers also have their own eating rooms.

The meals that the hospital provides are also different for different job categories. While doctors are served substantial and relatively good meals, most black health workers

complain about the food. One cleaner at Baragwanath referred to her meals as 'dog food'. She said:

> *"Last week they served us dog food, it was all pink. You could see it was Epol. But I have to eat it because at home there is sometimes not even bread to eat".*

Further discrimination against women health workers concerns their maternity leave. Women are sometimes forced to stop working when they are six months pregnant. Although many of

them feel capable of working much longer. Most of them actually need to work longer because they need the money. Unemployment insurance is usually only granted for three months (see article on Maternity Benefits). Child care facilities are not available at the hopitals. Children have to be entrusted to the care of other people which is often an added expense.

Transport is a further expense. Although the hospital administration provides transport facilities or transport allowances up to R120.00 per month for doctors travelling to and from Baragwanath, it does not give the equivalent to those cleaners travelling from Soweto to Hillbrow. Some of these workers get only R12.00 per month as a transport allowance, regardless of how far they have to travel or what shift they work.

Many women health workers are the sole breadwinners in the family but their wages do not nearly cover their basic needs. One cleaner at Baragwanath receives R120.00 per month. She has three children (two of whom are at school and require books and uniforms), a mother, a father and four other brothers and sisters to support. She has no other source of income, not even from the father of her children. Cleaners at Hillbrow hospital start off at R75.00 per month and gradually, over a period of two years this is raised to R120.00 per month. If they do piece work they can get up to R135.00 per month. Overtime is not remunerated.

A study by Van Rensburg revealed that in 1975 black student nurses received 50% of the wages of white student nurses. Black nurses are sceptical of the recent wage increase proposals. It is clear that the proposals are primarily an attempt to persuade white nurses to remain in the profession. The higher one is in the nursing hierarchy the greater will be the increase. The wage increases will therefore primarily benefit senior white nurses. It is important to note that pay increases for other health workers have not been suggested.

The hospital authorities appear to be prepared to use any means at their disposal to prevent any form of health worker organisation, without which changes within the health

services may never happen. Strategies to confront the administration with specific demands have to be developed. Black women health workers are, however, generally reluctant to strike. One sister argued that:

> *"The patients in the hospital are our mothers, our fathers, brothers and sisters. If we do not look after them no one else will".*

Another health worker agrees, but she adds:

> *"No we cannot strike. It is our moral obligation to our people, but we know that the hospital management continues to use this reasoning as an excuse to oppress and exploit us. We must develop other strategies to voice our demands".*

CONCLUSION

In this article, it has been argued that exploitation of women health workers is compounded by the well developed hierarchy within the health sector. In this hierarchy, class, race sex, age and staff differences are maintained and reinforced. These divisions result in specific oppressive working conditions, a number of which have been examined.

The demand for improved working conditions is tempered by the moral responsibility society places upon those who provide essential services. This applies more to the health services then any other sector of society. Furthermore, women health workers are forced into a role as the "carers" of society. This situation acts as a deterent to confrontation between the health service authorities and the exploited workers.

A CHRONOLOGY OF WOMEN'S STRUGGLES IN HEALTH

1913 - Formation of the South African Trained Nurses Association (SATNA). The original aims were to promote the professional interests of nurses and to suppress the practice of nursing by unqualified persons.

1927 - White nurses at Mafeking Hospital object to Dr. Molema, a black doctor, seeing white patients at the hospital. The nurses went on strike demanding that Dr. Molema be prevented from seeing private and fee-paying patients at the Hospital. Dr. Molema sued the nurses and won his case. A fund was established by the white population of Mafeking to help the nurses pay the costs of the case and the settlement.

1942 - A meeting was held in Johannesburg to discuss organising nurses into a trade union. The meeting was addressed by Union workers who proposed a constitution at the meeting. The South African Trained Nurses Association (SATNA) opposed unionisation. Amongst their objections were comments that "a political aura clung to such organisations", nurses would have to join an organisation that was "not professional", and that the "social stigma" of being union members was undesirable. They also complained that a trade unionist had said "give us the nurses of the country and we shall have any government where we want them".

1944 - The Nursing Act, No. 45 of 1944, was passed. This made the unionisation of nurses, illegal, and called for the establishment of the S A Nursing Council and S A Nursing Association. The Act also enforced

compulsory membership of SANA, denying nurses the freedom of association.

1949 - Student nurses at Victoria Hospital in Lovedale strike in support of a colleague who was unfairly suspended. The student nurses suspected that Nurse Dladla was victimised because of her part in a petition complaining about aspects of the hospital. The student nurses refused to work, slept outside, and refused to eat at the hospital. The parents formed a Committee and made certain request to the Hospital Board to ensure nobody would be victimised for their part in the strike. The nurses subsequently went back to work. Later the same year another crisis occurred at the hospital when nurses refused to attend certain religious meetings. Eventually the Superintendent had the hospital closed as a training hospital for nurses.

1958 - The government stated that all nurses would require pass-book numbers in order to register for nursing or to undertake further courses in their training. This was part of an attempt by the State to get black women to accept pass-books. The Federation of South African Women and the ANC Womens' League opposed this and organised a public campaign against it. Over 500 women attended a meeting inside Baragwanath Hospital even though the police put up a massive display of security in order to intimidate the women.

1959 - The South African Congress of Trade Unions (SACTU) started a Hospital Workers Union and began organising in Durban and Cape Town.

1960 - Health workers at Karl Brenner Hospital in Stellenbosch strike in demand for better wages and working conditions. White nurses supported the black unskilled hospital workers who were striking. Shouting "we are with you". The Hospital Workers Union was demanding "a pound a day".

1961 - Twelve nurses were caned by a matron at King George TB Hospital in Durban. A strike was organised by

the Hospital Workers' Union and skilled and unskilled workers supported the demands that the matron be fired. Other demands of the workers included demands for equal eating facilities, proper food, the establishment of an employment insurance fund, and the end to racial discrimination in the hospital service. Over 300 hospital workers participated in the two week strike. The hospital was cordoned off by police. Community members donated food in support of strikers. International support for the strike was offered by unions in Canada, England, Latin America, USA and Europe. Some of the demands of the workers were met but others were ignored. Twenty-one workers were dismissed.

1961 - Hospital Superintendent fired after releasing details of the number of deaths and casualties in the Sharpeville massacre. Community Health Workers in the area supported the Superintendent.

1972 - Black doctors in Durban go-slow in protest against unequal salaries for doctors.

1973 - Student midwives at Zulu McCord's Hospital protest at their low salaries. They were earning less than forty rands per month when they decided to strike in favour of higher wages.

1980 - Health worker organisations were established in Natal, the Transvaal, and the Cape. These organisations aim to break down traditional barriers between health workers by bringing them together in one organisation. These organisations accept all hospital workers as members, regardless of their skills or level of training.

1980 - Hospital workers in Cape Town ask the General Workers Union to assist them in organising themselves so that they can raise problems and grievances with the hospital authorities. The Union soon achieved majority membership in many hospitals and representative workers' committees were established in these hospitals.

1981 - Crisis at Baragwanath Hospital. Radiographers who have received only one year's training get much lower wages than fully qualified radiographers. Those who trained at Baragwanath had no choice but to do the one year course. Although many of these supplementary radiographers had served at Bara for many years, their conditions of work are poor and salaries are very low. Thirty seven radiographers leave Baragwanath Hospital in protest. Community members and Trade Unions pledge support.

1982 - Nurses oppose forced segregation into separate homeland nursing associations. Nurses oppose re-organisation of S.A. Nursing Association which still ensures that white nurses dominate the organisation.

1982 - Alternative Medical Association proposed by doctors dissatisfied with the Medical Association of South Africa (MASA). The organisation aims to work for a healthy society in which the health of all people is promoted in a just and democratic society.

1982 - The National Medical and Dental Association (NMDA) is formed. Dr Delisa Mji, general secretary of NMDA said:

> *"We are a nonracial body of progressive doctors and dentists and we recognise the link between health and socio-economic issues. We also recognise that the attainment of optimum health is only possible in a free and democratic society".*

The organisation intends to seek international recognition, and has begun recruiting members.

The Association stated that MASA (the Medical Association of S.A.) has failed to articulate the health needs of the majority of South Africans and identifies closely with the State and its policies.

1982 - 400 workers at Hillbrow Hospital strike in demand for more pay and better working conditions. The workers included cooks, domestics, cleaners, clerks, and typists. An elected committee met with hospital

authorities and presented the demands of the workers to the superintendant. Some of teh strikers carried placards saying "We are working for peanuts" and "50 per cent increase". The workers have not won their demands but are deciding on how to organise themselves to articulate their demands.

The chronology presented above is incomplete. CRITICAL HEALTH is interested to obtain more information about the above events, and occurances not documented. We would appreciate any letters, press cuttings, documents, etc. dealing with the organisation of health workers.

WRITE TO :

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NAMDA

NATIONAL MEDICAL AND DENTAL ASSOCIATION

This new association was formed in Natal in September last year.

NAMDA has not been formed in opposition to MASA (Medical Association of South Africa), nor is there any intention to repeat the functions of MASA.

The intention of NAMDA is to explore the interaction between health and economics, health and politics and health and social organisation.

NAMDA has committed itself to creating the conditions for optimum health which can only exist in a free and democratic society. Its aims and objectives include :

+ to attain the highest possible level of health for all the people of South Africa;

+ to emphasise both preventive and curative health services;

+ to actively develop community and worker participation in all matters of health.

The immediate priority of the association is to increase membership and establish effective inter-provincial channels of communication.

NAMDA recognises that it is a fledgling body and that it has people of different persuasions in its ranks. It has committed itself to accomodate as many interests as possible without jeopardising its fundamental goals.

The general programmes of NAMDA will cover as wide

a field as possible so as to cause least disagreement and provide firm continuity to the association.

The strategic programmes are seen to require specialised subgroups that could explore the questions of primary health care, medical evaluation and education, poverty and health, bantustans and health, etc.

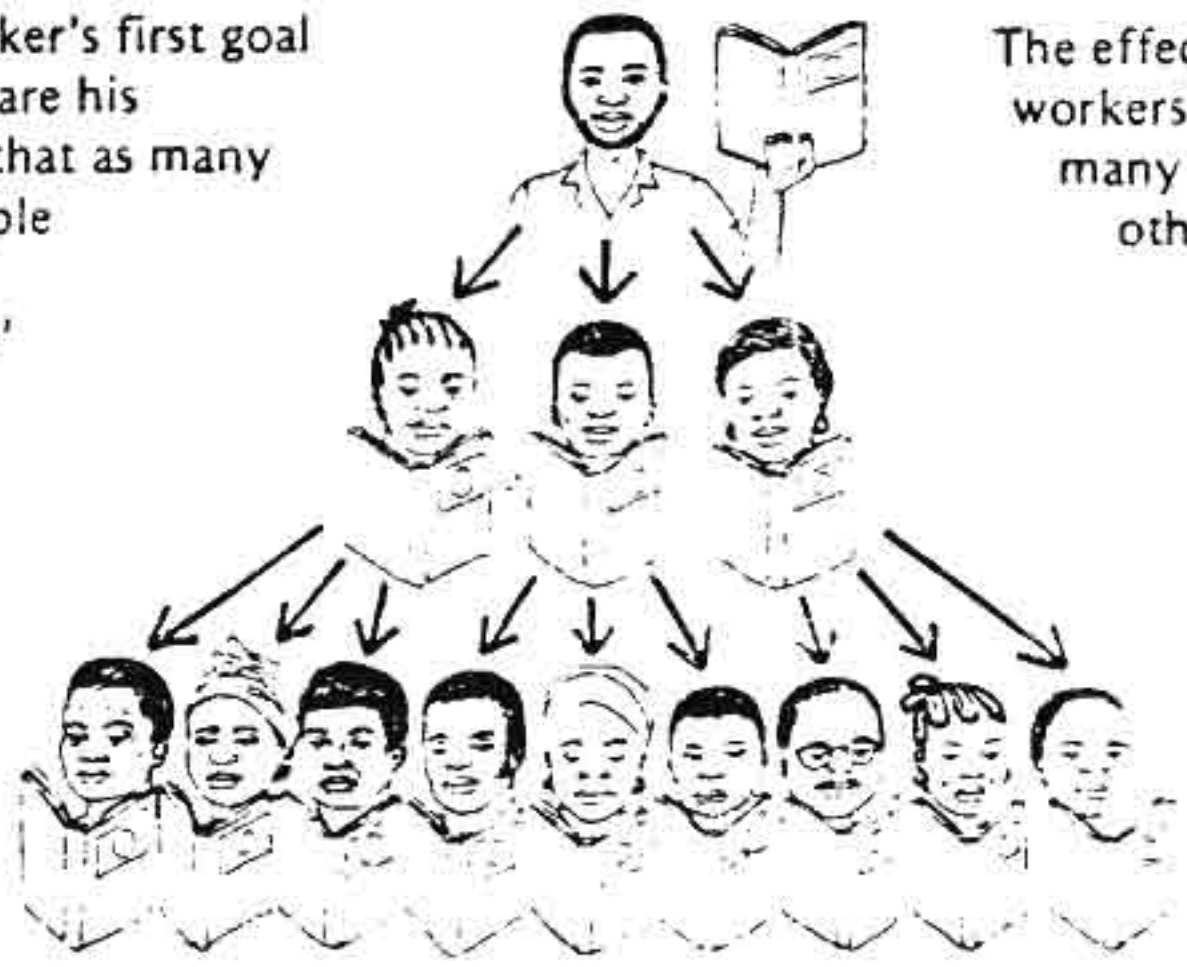
NAMDA also recognises the need to monitor abuses to health in South Africa, e.g. the Biko affair.

Ordinary membership is open to all registered medical practitioners and dentists in South Africa. Associate membership is open to medical and dental students and to medical practitioners in other countries.

For application forms and further information about NAMDA, please write to:

P O Box 17160
Congella
4013

The health worker's first goal should be to share his knowledge, so that as many people as possible also become 'health workers' among family and friends.



The effectiveness of health workers can be multiplied many times if they help others in neighboring communities to obtain and use appropriate 'self-help' books.

WOMEN, WORK & HEALTH

The daily lives of most working people involve some kind of danger to their health. Dangers include carrying heavy loads, unsafe machinery, exposure to poisonous substances, long working hours and stressful jobs. Over the years, workers have fought for health and safety guarantees, and in some countries these have become a normal and expected part of union negotiation. In these places, health and safety have been recognised as the right of workers.

In South Africa the picture is not as bright. Legislation covers some issues (through the Factory Act and Shops and Offices Act), but is limited and its implementation is not guaranteed. In most cases health and safety issues have been left for individual councils and unions to take up.

One of the areas least considered by such organisations has been the health of women workers. There is a tendency for trade unions and community organisations not to make demands which relate specifically to the form of oppression which women suffer. This is because, although women face specific forms of oppression, they are a relatively unorganised group. In addition men are traditionally seen as "workers" and women as "childbearers" even though women form a substantial part of the workforce. The fact that they remain primarily responsible for housework and childcare has allowed the reality of their place in wage employment to be ignored. This means that women are the least researched members of the workforce. Most studies of occupational health hazards use young men (and in the USA they are usually super-fit military men) as the sample, and therefore draw conclusions that do not accurately reflect on the average working population and especially not on women.

The question as to the occupational health hazards for women covers a number of areas:

- workplace procedures and substances that endanger pregnant women, their future children or their subsequent fertility,
- stress caused by the demands of housework in addition to a full day's wage-employment,
- hazards in those jobs traditionally undertaken by women e.g. health workers, textile workers, laundry workers.

DANGERS AT WORK WHICH MAY AFFECT THE ABILITY OF WOMEN AND MEN TO HAVE HEALTHY CHILDREN

There are many different sorts of work that may be dangerous to one's ability to have children. Many substances may lead to sterility, miscarriage stillbirths or birth defects.

A child is harmed at a number of different stages during his or her development. Damage can occur to the eggs of the mother, the sperm of the father, to the child while it is still in the womb, or to the child when it is growing up.

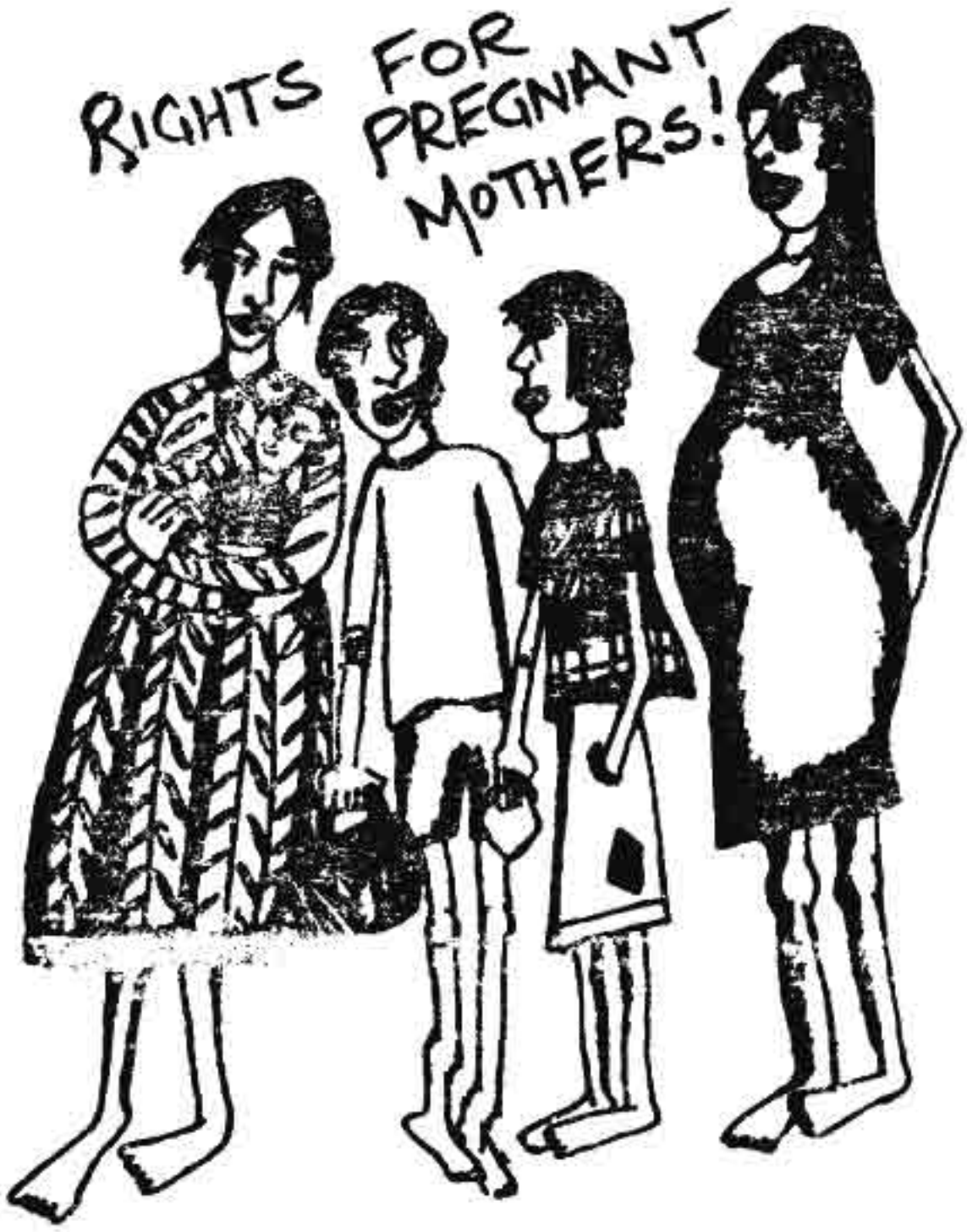
1. Harm to sperm and ovary

Certain chemicals may change the genetic makeup of cells. This is called mutation. Mutations in the man's sperm cell or the woman's egg cell can lead to birth defects or spontaneous abortions. Mutations are caused by many things including X-rays, lead, some pesticides and chemicals such as vinyl chloride which is used in making plastics. Studies have shown that communities near vinyl chloride plants have more children with birth defects. Anaesthetic gases used in operating rooms also cause mutations. (see section on health workers.)

Hospital workers, people who work in plastics manufacturing, drycleaning and perfume manufacturing, textile spot cleaners and electronic equipment cleaners may all suffer from mutations. Even long after the worker has left that job, her damaged eggs, or his damaged sperm can cause a miscarriage, still birth, or make the child defective.

2. Harm to the foetus

A teratogen is a substance which passes from the women's blood through the placenta to the unborn child, and harms the child. This can cause spontaneous abortion, still births or birth defects. Well known examples are lead, mercury, benzine, organic dyes and radiation. In fact these also endanger the health of the worker whether male or female. Viruses can also damage the foetus. The best known example is German measles. This affects health workers, primary school teachers, social workers, animal handlers, meat inspectors and others.



3. Harm to the child

Children are exposed to work hazards in two ways: through the mother's breast milk, and through substances brought home by the worker on his or her hair, clothes, or shoes. Things like pesticides, food additives, drycleaning solvent (see laundry workers) which have entered the mother's milk can poison the child. An example of substances brought home by the worker is asbestos. The families of asbestos workers experience a high rate of mesothelioma, an unusual form of cancer caused by asbestos. The asbestos fibres are brought home on work clothes and spread to the rest of the family. Children of motor mechanics, painters and other workers exposed to lead run a greater risk of getting cancer than non-exposed children.

Clearly both men and women can be harmed by substances in the workplace which they in turn can transmit to their children. This fact is

frequently ignored by those employers who do recognise the potential dangers to women's health. This leads to the ironic situation in which women are kept out of dangerous industries to "protect" them and thier future children, and men remain in those industries unprotected. They may then suffer sterility or some other hazards that may be passed on to their children.

So although it is crucial that health hazards to women are better researched, and consistently taken up by workers and unions, the ultimate intention must not be to remove women from dangerous situations, but to remove the dangers themselves to make workplaces safe for all workers.

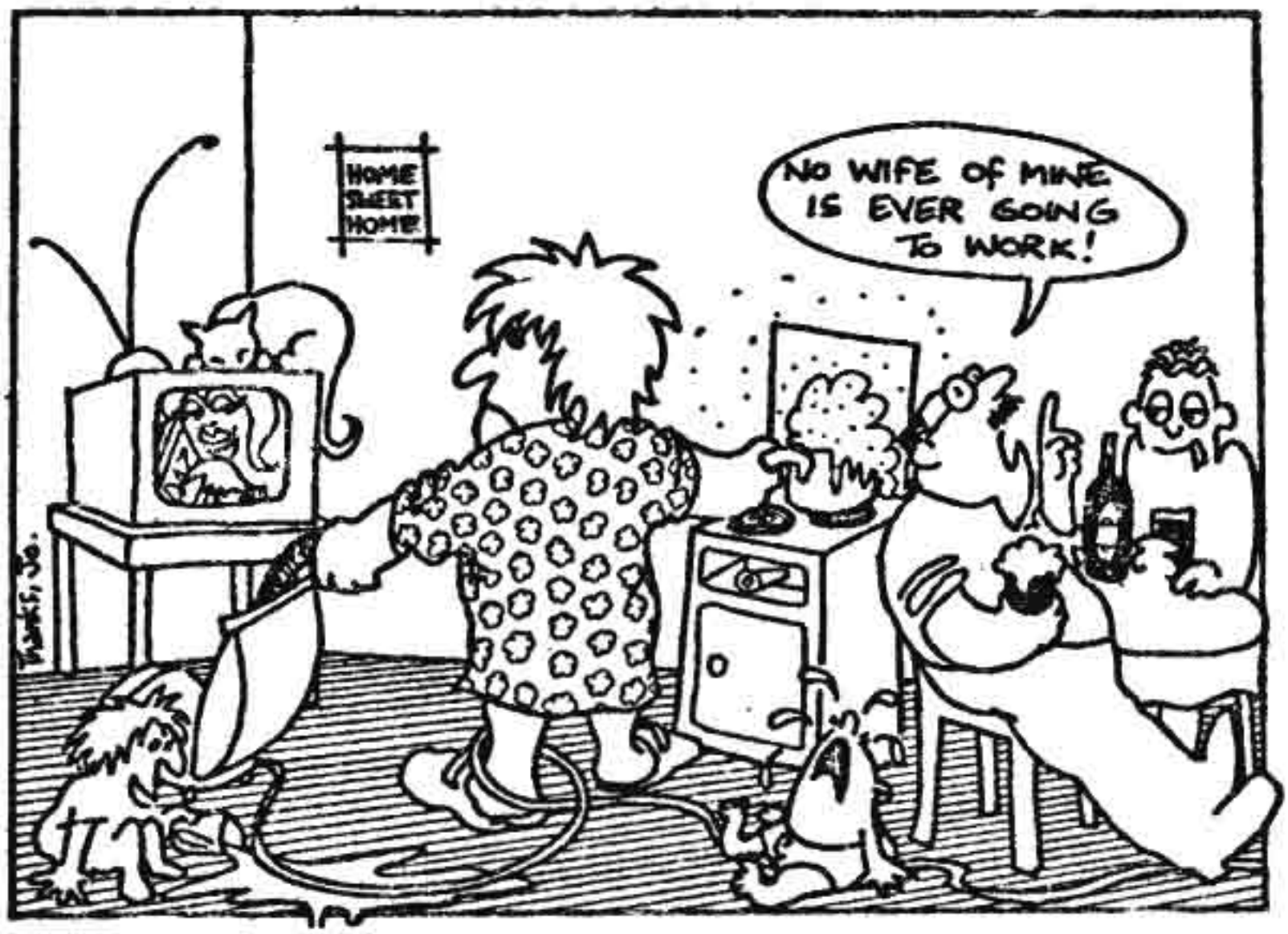
If workplaces were bound by adequate health and safety regulations, they would be safe for all workers and women would no longer be discriminated against when looking for work.

Only by demanding one health standard for all workers, which recognises these dangers, will their health and that of their children be safeguarded.

STRESS CAUSED BY UNPAID DAILY HOUSEWORK PLUS DAILY WAGE EMPLOYMENT

Women often work a full day in a factory and then go home to housework. This is one aspect of health that applies specifically to women.

Very often women have to do very heavy work in their homes - scrubbing, washing clothes, etc. This is very tiring when they have already been



working for a whole day. It is a great burden for women to carry alone, and it affects their health in many ways. Although there is little research, it seems that one of the main health risks of this double job for working class women is the stress caused by having so little time and so much work.

Stress can cause physical and psychological changes. Tension and depression are common. So are other disorders related to stress such as hypertension (high blood pressure).

An extreme example of the problems described occurs with shiftworkers. Women who work at night arrive home just in time to make breakfast for their husbands and children. After cleaning the house and shopping, there are only a few hours left to sleep in the afternoon before their children come home and they must cook an evening meal.

Shiftworkers suffer from nervous disorders much more than day workers. The symptoms are general weakness, an inability to sleep, depression and aggression. As they get older they suffer more.

In one study, 70% of shiftworkers over the age of 40 suffered from sleep disorders. Some countries like Belgium, Norway and Sweden have banned night work in all industries except those which cannot stop production.

In South Africa the Factories Act has prohibited women from doing night-shift work, with a few exceptions, unless the employer gets an exemption through an industrial council. This involves the worker "agreeing" to do shift work, and the employer applying for each worker. But under the present move towards non-discrimination between the sexes, women may be forced to do shift work in the way men are. Alternatively shift work could be stopped for all workers, but this is most unlikely. This is a good example of the way in which so-called non-discrimination can lower the health and safety standard for women instead of raisingit for all people.

– now for the other 40 hours!

Another major effect of the long hours taken up in work, is that women seldom have the time to do anything else. There is seldom even time to visit friends, or even for church - the one escape to which many women are attracted. This may be very demoralising and a further cause of stress.

In addition it means that very few women have time to involve themselves in union activities since union meetings are usually after hours. This creates further problems because if women are not actively involved there is nobody to express thier needs and to ensure that they are taken up by the unions. The health rights of women are therefore further diminished by their lack of access to unions.

HAZARDS IN WOMEN'S JOBS

This section looks at two of the types of work which employ mostly women, and the known dangers of these jobs. The two jobs selected and describrd below are health workers and laundry workers.

A: HEALTH WORKERS

Ironically hospital workers face a high level of risks to their own health. Some hospital hazards endanger all health workers and some affect only workers in particular jobs.

All healthworkers are exposed to infection and other hazards.
Health workers run the risk of picking up patient's infections such as hepatitis, TB, skin infections and other contagious illnesses. This happens through direct contact with patients. Other infections can be transmitted through waste materials. Used hypodermic needles may poke through plastic rubbish bags and prick maintenance workers. This can cause severe illness such as hepatitis.

X-rays can also damage people's health. Portable x-ray units are often used in places where people work without protection against exposure to x-rays. People who are exposed to too much irradiation may suffer from genetic damage, sterilisation, or even cancer at a later time in life.

Microwaves and ultraviolet light are also used in hospitals and may eventually irritate the skin or cause cataracts in the eyes if people do not have adequate protection.

Most injuries to hospital workers result from strain and falls. Workers may hurt their backs while lifting patients and moving heavy equipment. Many suffer from other problemsbecause they rarely get a chance to sit down and rest. The main

reason for many of these injuries is a shortage of staff and equipment.

Operating theatre staff

Female operating theatre staff may have a higher rate of miscarriages than other hospital staff. This is because of exposure to anaesthetic gases, which very often leak into the air from unsafe anaesthetic equipment. The gas can cause genetic damage, liver damage, miscarriages and possibly cancer. Theatre staff must demand that anaesthetic equipment is fitted with devices which can collect leaking gas.

Laboratory workers

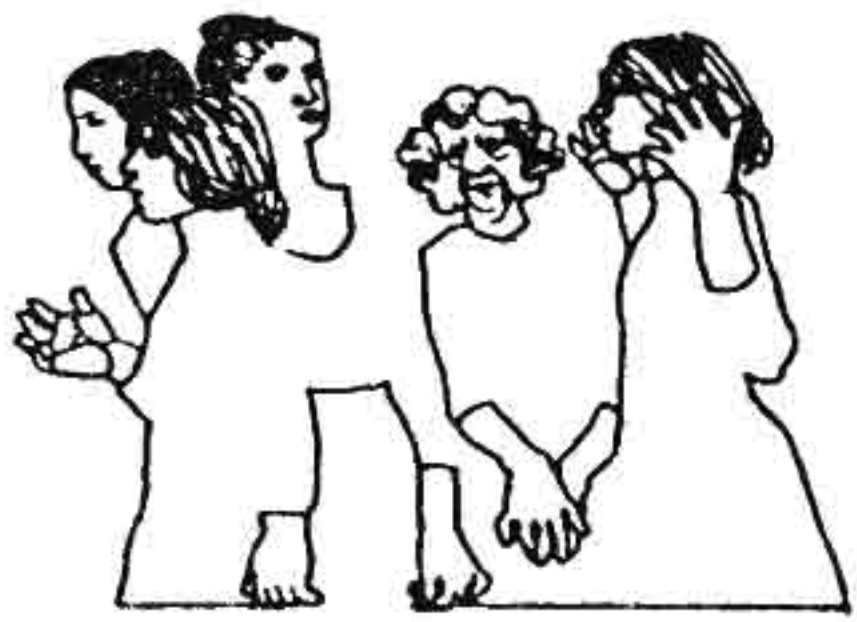
Laboratory workers are exposed to infectious specimens (and cultures). People who work with blood or equipment with blood on it are especially in danger. Some steps to avoid this danger are to provide protective clothing, to label infectious samples clearly and to use adequate handling techniques.

B: LAUNDRY WORKERS

Laundry and dry cleaning workers face a number of serious hazards. Laundry workers are exposed to a range of chemicals including formic acid which irritates the skin and mucous membranes, oxalic acid which irritates the skin and may cause kidney damage, hydrogen fluoride which will eventually cause lung damage (the symptoms are coughing, breathlessness and general irritability), and carbon tetrachloride and bleaches which are serious skin, eye and upper respiratory tract irritants. Laundry workers can also develop diseases from exposure to clothes contaminated with such dangerous substances as asbestos and lead.

Dry cleaning workers are exposed to perchlorethylene or trichloroethylene, the solvents used

to "dryclean". These are potentially addictive drugs. Too much exposure causes giddiness,nausea, co-ordination loss, and eye and throat irritation. Because they are addictive, people can begin to tolerate high levels of exposure without obvious ill-effects. But they are capable of causing liver damage in the long-term. Some solvents are suspected carcinogens and suspected of harming the foetus.



Although the factories act provides regulations for adequate ventilation these are often not adhered to.

Other hazards result from heavy work. Laundry workers often suffer back problems from heavy lifting, varicose veins from over-exertion and long periods of standing, and burns from clothes presses. Abortion may result from over exertion and heavy work. A Johannesburg employer remarked that a US expert referred to his manual pressing machines as "Abortion machines", because pregnant women who operated these machines daily might miscarry as a result. Some women workers in the laundry made the following comments about their jobs:

"Healthy? No you can't be healthy in this job"

"Sometimes I feel sickly at work, maybe I'm going to get the TB;that ammonia is too strong, I feel dizzy, it can make a person drunk you know, and they don't give us anything for it. I am coughing a lot."

"I am not healthy. My body is always sore, it's tiredness."

FORTHCOMING FROM SARS

SOUTH AFRICAN REVIEW 1

In early February 1983 over 40 social analysts met in Johannesburg. Out of their weekend meeting, convened by SARS, a new book emerged - the South African Review.

Written around the theme of crisis and restructuring, the first edition of the Review covers six areas in which the restructuring of South African society is evident:

THE ECONOMY
POLITICS
WOMEN
LABOUR
REPRODUCTION (health, education, housing)
SOUTH AFRICA'S RELATIONSHIP TO SOUTHERN AFRICA

Concentrating on the state's response to a generalised crisis in society, each section contains a number of articles analytically reviewing trends of 1982.

The SOUTH AFRICAN REVIEW is published jointly by SARS and Ravan Press.

Expected publication date is July 1983.

Enquire at your local bookshops, or contact SARS directly.

WOMEN WORKERS, MATERNITY BENEFITS & TRADE UNIONS

The industrial hazards to women's fertility have already been covered. There are documented cases in which women have chosen to be sterilised rather than lose their jobs. To choose between job security and your baby's health is a very dismal choice indeed. It is perhaps the most extreme example of the way in which women child-bearers, can be prevented from taking up employment.

In South Africa there is an additional aspect to the question of women's control over their own fertility: their right to bear children. Women are often questioned about whether they want to have children before they are employed, and the government increasingly offers contraceptive services to factories. The advertisement (page 30) amply describes their attitude to women and how their concern is for a stable, productive workforce. Workers are instruments in that production, not people.

Once women are employed they must deny their right to bear children, if they want to retain their jobs. This enforced seperation of the roles of child-bearer and worker is most visible in the position of pregnant workers. An organiser for the Commercial Catering and Allied Workers Union of South Africa (Ccawusa) said that his union tries to get agreements with employers that pregnant women will not have to work in unhealthy conditions. If their job involves hard labour, they should be transferred for the durati on of their pregnancy. But he says that women often hide the fact that they are pregnant for the realistic fear of losing their jobs. On the whole in South Africa, it is NOT accepted that

pregnant women have as much right to work and to return to their jobs, as other workers.

Extract from Family Planning Association brochure aimed at employers...

THE MOST IMPORTANT REASONS FOR SUCH AN EXTENSIVE PROGRAMME MAY BE SUMMARISED AS FOLLOWS:

- The establishment of a stable and productive work force to increase overall profitability;
- The stabilising effect it has on the economy of the country resulting in bigger investment possibilities for overseas investors;
- Without planning, the service period of women is often interrupted due to unplanned pregnancy;
- Workers from overcrowded, unhappy homes are less productive and often suffer from poor health;
- Male workers must be motivated to support their wives in the use of modern family planning methods;
- The smaller family norm leads to a higher standard of living;
- Many male workers are laid up because of venereal disease;
- The costs relating to the recruitment and re-training of workers can be drastically decreased.

YOU, AS EMPLOYER, GAIN-

- a more <u>productive</u> worker with fewer family problems on his mind;
- a more <u>motivated</u> worker with a planned family life;
- a <u>healthier</u> worker who can provide better in the daily needs of his smaller family.

Both the Factories Act and the Shops and Offices Act provide that pregnant women can claim Unemployment money for the last month of their pregnancy and the first two months after they have given birth. (For detailed regulations see box on UIF).

But there is no definitive guarantee that women must be allowed to return to the job that they left. It is therefore important that such agreements must be made by unions and industrial councils.

In a random survey of industrial councils and unions in Johannesburg, the following answers were given to the question "HAVE YOU NEGOTIATED ANY RIGHTS FOR PREGNANT WOMEN IN RELATION TO MATERNITY LEAVE?"

African Food and Canning Workers Union
No formal agreement. Some committees have negotiated with management for a woman to return to her job, but only if a job was going, so whe would not necessarily get back her old job.

Building Society Officials (Industrial Council)
Each society has their own policy. It is usually left to the discretion of the manager, who takes into account the particular worker, how long she's been there and job efficiency. "Have there been any changes to remove sex descrimination?" "We have no sex discrimination".

CCAWUSA
"Some companies have specific policies on maternity leave. You must sign a resignation form before you leave and 'you may come and try' when you want to return to work".

Chemical Workers Industrial Union
There is no right to maternity leave, but women expect to have maternity leave, so it often comes up in factories. Committees have taken it up in some factories but usually women only get back their jobs if there's one going at theetime of their return.

Clothing Industry Industrial Council
Maternity leave is granted one month before

delivery and up to two months after the birth. The job has to be kept open for the woman. If she does not go bakc two months after the baby is born, then the employer can give the job to somebody else.

CUSA

The union has negotiated some recognition agreements which increase the time a woman can take off before birth of her child, from a month to 6 weeks, and the time after birth from two to three months, with the woman retaining her job. Sometimes employers argue that a job cannot be kept vacant, but that isn't true for routine jobs. The union president said that at their last seminar people had pressed for greater financial benefits, although men sometimes think the issue is over-rated. The union has also negotiated paternity leave for fathers for two or three days after the birth of their child. Some companies have agreed to this, others have not.

South African Hairdressers and Cosmetologists Association

Women have no guarantee of returning to their

jobs, if they fall pregnant and leave and don't make arrangements with their employer. It is up to the employer.

Transvaal Knitters' Association

There is an industrial council agreement, clause 9: "No employer shall terminate the services of any employee by reason of such employee a) approaching confinement provided the employee returns not later than two months after the date of confinement " But the council spokesperson said that more often than not the returning worker lost her job, and it was difficult to prove that the reason was the pregnancy because employers have to give the workers only 5 days notice anyway. The council can only take up workers claims if they were not given paid notice.

South Africa's stand on maternity leave is a far cry from many other countries. One must always bear in mind that the law does not necessarily reflect practise. Nevertheless it is an indicator of the degree to which women's rights as mothers and workers are recognised. The following chart summarises the legislation on maternity rights in Southern African countries, as they affect women in the retail shops trade. The writer presumes that these apply across the board, but would welcome any further information.

Laws regarding maternity protection in Southern African Countries

BOTSWANA: Six weeks leave before and six weeks after confinement on at least quarter pay. Guaranteed job back after maternity leave. Mothers are allowed half an hour twice a day during working hours for nursing their infants.

LESOTHO: Six weeks leave without pay before confinement and six weeks after, on

production of a medical certificate. Half an hour off twice a day is permitted during working hours. An employee cannot be given notice of dismissal while on maternity leave.

SOUTH AFRICA: No provision is made for maternity leave with the right to reemployment. But a pregnant woman must not work in a factory for 4 weeks before and 8 weeks after confinement, and she can get unemployment insurance (see box).

SWAZILAND: Six weeks leave before and six weeks after confinement without pay. On resuming employment wshe is entitled to continue with her previous job or an equivalent one without loss of seniority.

HOW TO CLAIM MATERNITY BENEFITS:

REMEMBER:

The law says that a pregnant woman must not work in a factory :

-- for 4 weeks before her baby is born, and
-- for 8 weeks after her baby is born.

YOU CAN GET UIF MATERNITY PAY:

-- if you have lost your job because you are pregnant OR
- if you are getting less than one-third of your wages because you are pregnant

HOW TO CLAIM:

-- to qualify for maternity benefits you must have been employed for at least 18 weeks during the year before the expected date of birth of your child.

-- you are then entitled to benefits for 18 weeks before the expected date of birth and 8 weeks after the birth. For each 6 weeks you've worked you get one week's benefits. So, to claim the full 26 weeks, you need to have worked for 3 years.

-- in order to claim maternity benefits you must go to the unemployment insurance offices, at the labour department, where you will be given a form which must be completed by your doctor. You must take your contributors record card with you. Your employer must give you this card when you stop work.

-- it is important to claim as soon as possible after you stop work as you will only be paid benefits from the day your form is completed.

-- you will be paid 45% of your monthly salary. Payments of maternity benefits are made by cheque at two monthly intervals through the post and declaration forms for futher benefits are posted with cheques to you. The forms must not be posted back before the date shown on the top of the form.

PASS IT ON —INFORMATION

IS POWER

"HOMELAND" WOMEN

This article aims to explore conditions which lead to health problems for women in the bantustans. It will examine the conditions of rural women's daily lives, as well as the social, economic, and political context that shapes their lives. For health problems of rural women arise directly from the conditions of their lives.

In the bantustans the majority of the adult population is female. This is no accident. The entire system of influx control and the pass laws are geared to keep women in the rural areas so that the migrant labour system remains intact. As government commissions have pointed out time and again - if the women come to town there will be an increasing necessity for the provision of family housing, schools and hospitals to provide for the needs of an urban working class. The maintenance of families in bantustans has also been a convenient rationalisation for low wages paid to migrant workers.

Despite this women have not stayed trapped in the bantustans. They have come to towns to look for work and to live with their families. But as the pass laws have become more strict and unemployment has become worse and worse - it is harder for women to leave and they are forced to survive as best they can.

The bantustans are overcrowded; their agricultural capacity is pretty well exhausted. There are enormous problems of landlessness; there is virtually no work for people. And this situation stands only to become worse. The apartheid dream of stemming the rate of urbanisation may have well become true. The latest population census shows that more and more africans are in bantustan areas.

So from the start, women in the rural areas have to grapple with an environment that is hostile to them. Poverty, unemployment and landlessness define their lives. And the illnesses and diseases that they suffer are a direct reflection of this.

Let us look at this more closely:
Women in rural areas have very heavy, and often very lonely responsibilities. They are the adults who have to bring up families and care for the aged. They have to feed and clothe them, have to look after their health. But as most women know, to obtain food, or the cash to buy it is in itself a major battle. In conditions of extreme poverty, it is often the adult women who go without and starve themselves rather than their families.

Apart from diseases directly related to malnourishment and stress, this situation is one of extreme stress. Tension-related illnesses and mental breakdowns are the outcome. The daily lives of rural women are also physically very hard. By far the majority of rural villages do not have piped water, or adequate roads. Many women spend large parts of their day trudging up and down stony hills to fetch water, find wood, go to the trading store, or get to the main road to catch a bus. And these are tasks that are often carried out by very young, or very old women.

Agricultural work too is very heavy. Apart from cultivating their own land - if they are lucky enough to have any - the agricultural labour force is increasingly female. Work for white farmers is not pleasant. The pay is low - sometimes not even a rand a day for 12 hours work. There is no security for the farmers prefer to pay their labour on a daily basis; there is no midday meal provided; there is no protective

clothing; and there is no legal protection at all for farm-workers. Worst of all, the way the recruiting operates sometimes forces women to turn their families into child labour. A woman with a child is far more likely to get a day's work than a woman alone.

As far as medical services are concerned, the situation can at best be described as bleak. Medical facilities are not free. And in situations of desperate poverty, the ± R3 needed for hospital attention, the ± R1 for the clinics may mean that people put off attending to their sicknesses for as long as possible. The hospitals and clinics that do exist are overcrowded and understaffed. The long distances that have to be travelled to get to them also mean that people do not seek medical attention lighty. Most serious for women is that this general situation applies to maternity care. Delivery and ante-natal care are costly and beyond the reach of many.

Apart from, the attitude of health workers towards women, is

in itself problematic. Endless lectures about balanced diets regular examinations and sanitation are a joke in conditions of extreme poverty. Rural women, like their urban sisters, often end up feeling that it si they who are totally responsible for both their own illnesses and those of their family.

Lastly the rural power structure militates very heavily against women being able to control any aspect of their healt needs and care. Tribal authorities are male only. They are an elite grouping who often act in their own interests rather than those of the majority. Issues such as the siting of clinics and dams are ones crutial to the health of rural people. Women have no say in these decisions - particularly the poorest who need them most.

The depressing nature of the situation is in many ways overwhelming. But the health of rural women and indeed all rural people, is something that has to be fought for - not through charitable stop-gap solutions - or through 'gifts' from the authorities, but through grassroots organisation and educatior that can mobilise people to develop their own alternatives, and challenge the bases of the system that perpetuates their exploitation, oppression and ill-health.

DON'T KEEP IT TO YOURSELF —

PASS IT ON !

INFORMATION IS POWER

PRIMARY HEALTH CARE IN SOUTH AFRICA

Most health services provide curative or preventive services. Primary health care aims to provide promotive preventive, curative and rehabilitative services in one.

WHAT IS PRIMARY HEALTH CARE?

Primary Health Care (PHC) is a World Health Organisation concept, and is defined as essential health care made universally accessible to the whole population with full community participation. PHC deals with the main health problems, provides promotion of proper nutrition, safe water and sanitation services, maternal and child care, family planning, immunisation, control of prevalent disease, health education, and treatment for common conditions. PHC should be an integral part of the country's health system, and should be part of an overall economic and social development, without which it is bound to fail.

PRIMARY HEALTH CARE IN SOUTH AFRICA

In 1980, the National Health Policy Board made Primary Health Care the basis of the National Health Facility Plan for South Africa, including the homelands. PHC is viewed by the National Health Policy Board and by many health workers as an apolitical "cure-all" - a method of improving the health status of the whole population without requiring any overall change in the social and political system.

This paper shows how rural health services under the banner of Primary Health Care, help to support the existing political system.

PHC SHOULD BE UNIVERSALLY ACCESSIBLE:

Health services are not free. They are also geographically badlysituated and transport is expensive. These problems make it difficult for people to get comprehensive health care.

Underprovision of health services available to the urban and rural poor leads to overloading of the services and long delays.

Queues last the whole day...

PHC SHOULD OFFER ESSENTIAL HEALTH SERVICES:

Primary health care should be part of a policy to provide basic social and environmental services such as water, sanitation, education, employment, transport, and housing services.

The priorities of the state should be to combat the diseases of the majority of the people such as infective diseases and the diseases of poverty. However, the present provision of social and environmental services favours the white urban dwellers. The health priorities of the state are largely those associated with diseases related to the western lifestyle, (diseases of that minority of the population) such as heart attacks requiring an emphasis on expensive and sophisticated treatment.

PHC SHOULD BE BASED ON FULL COMMUNITY PARTICIPATION

This means that the community should control their health services and should decide on issues like what services are provided, where they should be sited, and at what fee.

In South Africa, community participation is usually limited to powerless, unrepresentative advisory committees.

WHY IS THE PHC PROVIDED BY WOMEN?

The vast majority of health care providers in rural (and urban) areas are women. What are the reasons for this?

Most rural men work as migrant labourers, and so the majority of those able to work in rural areas are women. Few men work in primary health care because the opportunities for well paid employment are few, and men are expected to earn sufficient money to support the family. Furthermore, health work and nursing are usually seen as "women's work", because of its similarity to "mothering".

PHC is directed mainly at women and children because they make up the majority of the population in rural areas. The emphasis is on promotive and preventive health work. This involves an emphasis on changing the behaviour of the patient. Persuasion is thus a large part of the work of PHC workers, and women are thought to be best able to influence other women.

HOW IS PHC ORGANISED IN RURAL AREAS?

Health services in rural areas usually consist of hospitals, clinics, and community-based services. The provision of PHC takes place mainly in the clinics and the community-based services.

The clinics are usually staffed by one or two state-registered nurses, who frequently have very little training to provide PHC services. The clinics provide all aspects of health care, curative, promotive and preventive service. Simple health problems are usually dealt with by the nurse, who has a limited range of medicines and facilities at her disposal. Antenatal care and uncomplicated deliveries take place at these clinics. Health education, "well children's clinics" and immunisation are provided and the nurse may do some home visiting. More serious health problems are referred to a hospital.

The clinic services however, have large gaps in the provision of comprehensive health care and the community-based services are meant to fill these.

The community based services are often staffed by two types of personnel. These are community health workers who are usually state-employees and trained for six months, and voluntary health workers who receive limited training.

These personnel are supposed to promote improved personal habits and they encourage vegetable gardening, attendance at immunisation clinics, purification of water, and sanitation. Their curative skills are limited to a few simply treated illnesses such as infantile gastroenteritis (diarrhoea and vomiting), which responds well to oral fluid replacement.

Both categories of personnel usually wear distinctive uniforms resembling those worn by nurses, while the lay workers wear distinctive head-scarves, dresses, matching skirts and berets. This serves to distinguish them from the other members of the community.

The community health workers are often selected by the local chief and are frequently related to the chief or local businessmen and traders. They are paid approximately R100 per month and are supervised by hospital-based personnel.

The lay workers are usually volunteers, and their knowledge comes from lectures and demonstrations by the community health workers and other health service personnel.

HOW DO THESE PHC WORKERS REINFORCE THE EXISTING INJUSTICES?

Primary health workers have many beneficial "medical" effects. However, they also have some detrimental social effects.

1) PHC as practised in South Africa tends to shift people's attention away from the social and political causes of ill health.

2) PHC provides the appearance of a comprehensive rural health service, while in fact services remain totally inadequate.

3) PHC services tend to co-opt a number of articulate members of the community who might otherwise be active in demanding improved services.

4) PHC works against democracy and real community control of health services by placing some community members in positions of status above others without making them responsible to the community.

SHIFTING ATTENTION AWAY FROM SOCIAL ISSUES

Community and lay health workers often inspect people's homes and advise them on how to promote improvements in the health of their families. Often, however, these workers blame those that suffer from disease. Poor hygiene, for example, is blamed on laziness and not on poor water supply. Malnutrition is blamed on ignorance and not on poverty.

In this way the PHC blames the victims of ill-health for their problems. The health services often view community members as "ignorant, lazy, and stubborn" and the community-based workers absorb some this attitude. PHC workers thus often shift attention away from the real causes, and this confuses the community and reduces the pressure for the overall social and political change.

PHC IN SOUTH AFRICA PROVIDES THE APPEARANCE, BUT NOT THE REALITY OF A COMPREHENSIVE HEALTH SERVICE

To the unaware person, a health service consists only of uni-

formed people, treating and preventing disease from hospitals and clinics. In rural South Africa, PHC provides this appearance. The hospitals and clinics exist, albeit of often relatively poor quality. The community workers, who are usually uniformed, look like fully-trained nurses. The whole service, especially the community-based services help to persuade outsiders and the community that the state cares for the poor.

The state pays the salaries, buys medicines and vehicles, and provides hospitals and clinics. All of this gives the appearance that the state is concerned.

At the same time the health service demands that the community also must help to pay - by giving money towards the building of clinics, by chlorinating their own water, by building their own sanitation facilities, and by paying a fee at the clinic.

If disease and illness is still rife, then it is often blamed on the people themselves, because it is said that the state has already made its contribution to health. In this way, a substantial portion of the costs of providing rural health care, such as purifying water, providing clinics, housing and the costs of medical care itself, are passed onto the rural communities.

PRIMARY HEALTH CARE SERVICES CO-OPT MANY POTENTIAL CRITICS

The health services act as major employers of trained and semi-trained people, such as nurses and clerks, in rural areas. This helps pacify a potentially powerful and articulate group by "buying" them with jobs and bringing them under state discipline.

PHC IN SOUTH AFRICA WORKS AGAINST DEMOCRACY

The community health workers and lay health workers are not democratically appointed. They are usually chosen by local authorities, and are responsible to them and the health services only, and not to the community.

The position-holders in these groups of community health workers are frequently teachers or the wives and daughters of

chiefs and businessmen. These health workers often hold similar views to the officials and businessmen, and may blame the community members by saying that they are "lazy" and "dirty". These health workers often behave in an authoritarian way. For example, they sometimes demand fines from people if their yards are dirty.

The lay health workers are usually passive, but they too may become affected by the authoritarianism and arrogance of the elites, and may take similar attitudes. Thus, the community based health personnel may reinforce the powerlessness of the community in the name of promoting their health, by dividing the village into "clean" and "dirty", "educated" and "ignorant or "officials" and "villagers".

The services draw their authority from the existing power-structure and not from the will of the people. The health workers therefore often tend to side with the officials, against the common people, on many issues. The combined effect is to reinforce the undemocratic power structure and perpetuate the disunity in the villages.

This prevents united action to achieve community demands. The fustration of community members is often directed at the individual low level officials, instead of at the system itself.

CONCLUSION

In South Africa, the health services reflect and promote the present inequalities in our society. Primary health care in rural areas helps to define conflict in those areas by:

* providing a highly visible "gift to the people" which costs the state very little

* causing conflict within communities and perpetuating disunity and undemocratic structures

* "buying off" with jobs or status, people in rural areas who might otherwise have been critical of the homeland system

* turning the blame for health problems away from the social system and instead onto the victims of the system.

These effects occur because of the undemocratric structure of the society and its health services. Even when progressive health workers have been involved in primary health care projects in South Africa, they have failed to overcome many of these problems.

ORGANISING FOR MENTAL HEALTH

Thousands of women in the rural reserves of South Africa are being given long term drug therapy as psychiatric out patients. We spoke to ten women, half of whom have been hospitalised as psychiatric patients, and who are receiving drug treatment. They have recently formed a women's club with motivation from a local social worker who sees their mental health problems as stemming almost exclusively from the stressful socio-economic conditions these women have to endure. Similarly, she sees the solution coming from a relief of these stresses and thinks that group work and community organisation are part of this solution. She rejects drug therapy, accompanied in dire cases by food rations in the form of 'poor relief' as anything but stop gap, crisis control measures with no long term benefits for either the mentally ill woman or the community to which she belongs.

Here is part of the discussion we had with this group, translated from Sotho.

Q . : How did your group start?

Mrs P : One of our members went with the social worker to another village where the women have had a club for a long time. She was very impressed with the food in the gardens of those women, so she came home and told us we should also start a club and grow food for our children.

Q : Mrs M, why did you go to the social worker?

Mrs M : It was that time when I came from Groothoek hospital. I slept for 2 months at Groothoek, then when I came home I found my children were living with no food at home, just asking some food from my neighbours, so I went to the social worker to ask help with buying food.

Mrs K : (social worker) When Mrs M. was admitted to Groothoek, she could take only this small baby with her - the one you see here which is now about 5 months old. The other children were left at home to look after themselves. There was no assistance from the government or anywhere for them. That's why these other women had to look after them. They gave them food, money for school, everything. You know, Mrs M. did not know what was happening to her children while she was in hospital. She just had to stay there for two months worrying whether her children were managing at home. Then when she came, she found that her neighbours had been helping the children.

Then she came to see me because she was desperate - there was no food from the fields, there was no money because she is the breadwinner in the family. She told me that usually she goes to work on Schoeman's farm (former Minister of Agriculture) but now since she has been sick, she had been staying at home. I wondered what I should do to help this woman. Usually I don't like poor relief ' it keeps you alive for today but tomorrow you can starve - so I didn't see that as a solution. I suggested to Mrs M. that she talk to her neighbours, several of them are struggling with similar problems, and see if we could not form a womens group which could do things such as buy vegetable seeds together in bulk, then work as a group on each others gardens. I saw that as a possible long term solution to some of the difficulties these women were having - if they could co-operate and have a joint interest, it would help them to overcome the frustrations and despair which made them be admitted to Groothoed and treated at depressive psychotics. They just give them injections, pills and what not, then when they are a bit calm, they discharge them, send them back to the very home conditions which drove them into this condition in the first place. They know, they say people are mad, but it's mostly that they are suffering terrible burdens from living in these barren, dry places with no employment possiblities, no income, children and so on, that they just can't stand it. As a social worker in the rural

areas, almost each and every day you find one or two of these cases at your office. What can you do?

Mrs R : It's good that we have made a club, because we know that if one of us goes to hospital, others will be looking after her children.

Q : How many of you have been to hospital?

Mrs R : You mean to Groothoek?

Q : Yes

Mrs S : We are five. Others also go, but from the members of our club, we are five.

Q : Do you also get treatment at the local hopital?

Mrs M : Yes, some others go every month for injections, others get only tablets. They say we must take those tablets every day otherwise we'll do funny things.

Q : What do you do together in your club?

Mrs P : We are growing vegetables and making fences for the gardens from aloe branches because we haven't got money for wire. We will work together more when our work in the fields is finished. We are still working hard in the fields.

Q : What do you grow in the fields, and how much land have you got?

Mrs M : I've got only this field we are sitting in. It is 7 acres but because of lack of money, another rich man ploughs for me, then I give him half of what I grow. He ploughs then I've got to look for my own seed - I just ask seed from anybody who can spare some.

Q : Don't you keep seeds from the last harvest?

Mrs M : I did keep seed from last year, but they became clouded with ants, so they were useless. Then I just

asked some mabele (sorghum) seed from anybody and some mealie seed, and planted them.

Q : What do you do with the grain you harvest?

Mrs M : I grind it with a stone, then make porridge for my children. Sometimes, I also get merogo (wild spinach) from the field. But since we came to this place, we do not get good harvests. We used to live on the other side, but they said we must move and come to live here. Then, after we moved, my husband died, so I've got nobody who can help me. My children are still at school.

Q : How many children have you got?

Mrs M : They are five; the first-born is a boy doing Form 2, next is a girl - she is 15 years, born 1967. She is staying with a school teacher in Johannesburg as a baby sitter. She is not attending school, she just looks after the children of the school mistress. That mistress from this place, then she saw that I was struggling with my children, so she said I must give my daughter to her to go to Johannesburg. She said she was going to send her to school. Now when my daughter came home at Christmas, she gave her R20, but my daughter said she was not attending school. She is looking after the small children of that mistress every day without wages. But what can I do because I've got no money?

Then, the third-born is a boy of 12 years, doing Std.1. The other two are here with me in the fields - this one is a boy of 4 years and this one is a girl - she's 5½ months. After my husband died, another man told me he wanted to marry me, but when I got this baby he ran away.

Q : How do you think that working together in the club can help you all to solve some of the problems you have?

Mrs M : When we work together we can talk and then the work goes quicker and it is less tiring. Also when, you've

got problems, maybe the others can help you. The trouble is we are all new to this place. We come from different places. My home is far away, then I came here with my parents five years ago. They said we must move from our home because they say they are going to make some big farms there. I think that's why I became sick because it's not good to go to a new place.

WOMEN AND MENTAL HEALTH: A COMMENT

In the last issue of Critical Health we argued that so-called "mental illness" comes about as a consequence of the social conditions under which we are forced to live. We saw that working-class people experience poor working conditions and inadequate living standards as a result of low wages; and that this causes a great deal of mental suffering and breakdown.

The discussion with Lebowa women above shows that mental health is also a social and political issue in the poverty stricken and underdeveloped areas of South Africa. The hardship which these people suffer is on two levels: as women, and as the "forgotten people" of South Africa's bantustans.

All women experience the kind of pressures which make them prone to mental breakdowns. We must realise that this is not the result of female hormones, but is directly related to the social role and position of women in society. Women are oppressed in the home and at work. Society expects women to be passive, to repress their anger and frustration, and to bear the burden of having

and raising children in isolation. Is it any wonder that women become depressed, feel persecuted and experience mental health problems?

Of course, for women in the rural areas the position is much much worse. Life for them is a constant battle to survive, to feed themselves and their children, to scratch together some money to buy essentials. Very often they are forgotten by their men, who go to the towns, and because of their own hardships, do not send money back to help feed children. As Mrs K. points out, these conditions lead to huge frustrations and despair which are treated as "depressive psychosis" at Groothoek and other hospitals.

Why are these women given drug therapy - pills or injections - when they go for help to Groothoek after a mental breakdown? As Mrs K. says, it does not help the women to be given drugs, and then "when they are a bit calm", to be discharged. The point is that the hospital authorities (state health) do not want to recognise that social problems and poverty lead to mental suffering.

By giving women drugs to "cure" their frustrations and despair, they pretend that the problem lies inside the women themselves (for example, in "chemical imbalances" in their brains which they are supposed to have been born with). This allows the system to deny that mental ill-health is a consequence of the oppression and poverty brought about by apartheid, that the problem lies outside the women in the sick society in which they live.

There is also an element of political control in the drug therapy. If women are given injections or tablets ever-time they experience anger or despair about their lives, then they will become "calm". This will mean that they will be less likely to want to change the social conditions which cause their suffering: they will be less angry about apartheid, and about the bantustans.

Fortunately, the women at Groothoek are not letting this happen. By working together, and organising themselves into support groups, they will be able to cope better with their frustrations. The important point is that they will support one another, and there will be long-term benefits for the women. As a group, they will better be able to begin to change the inadequate social conditioins which oppress them.

And they will be showing the way to mental health workers! Only collective community and trade union action can change the mental suffering that poverty, poor working conditions, political harrassment and the oppression of women bring about.

A VILLAGE PLAY

During a recent meeting of women's organisations in the Northern Transvaal, one group of village women were asked to give a presentation on the theme of group organisation.

They chose to do a play about the importance of group organisation in relation to health in their village. This is a synopsis of their play, which was presented in Pedi.

SCENE 1

An old woman starts suffering form pellagra dementia(1). People in the village send a telegram to her daughter who works in town. She has done well for herself and 'arrives' wearing high heels and pretending to be driving a car.

She tries to explain to her mother that she needs to go to hospital, but the old woman refuses, saying she will die if she goes there.

1) pellagra dementia - mental disorder due to vitamin deficiency

SCENE 2

Her daughter eventually persuades the old woman to go to see the doctor and they get into their imaginary car, the old woman shakily leaning on a tree branch and talking nonsense.

SCENE 3

On arrival at the hospital they are met by the 'doctor' dressed in a white sheet and carrying a chrome-plated coat hook for a stethoscope. The doctor is played by a woman who used to work in an urban hopital as a nurse-aide; she brings to the role years of experience of the treatment the old woman is likely to get.

She examines her, starting with the inevitable and derogatory "What's the matter, gogo (2)?" Speaking the only few sentences of english in the play, she announces at the end of her brief examination, shouting into the old woman's face, "You are too bloody weak!" This obviously sounded familiar to the largely Pedi-speaking audience, who responded with laughter and applause.

The 'doctor' tells the daughter that her mother must eat fish, meat, eggs, fresh vegetables, milk etc.

They leave the doctor and head back for the drought striken homestead where the old woman lives.

SCENE 4

Meanwhile, the village women have been discussing the old woman's illness, and the plight of many people, both old and young, in their community who suffer from malnutrition-related sicknesses.

They have heard of women in neighbouring villages forming groups to work collectively on projects involving vegetable growing, chicken keeping, fruit tree planting etc. They hire a truck from the local shopkeeper to take them into the

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2) gogo - grandmother

local centre, where there is a social worker who is helping such groups to organise themselves.

The women tell the social worker of the old woman with pellagra, and of their ideas to work together to tackle the problem of malnutrition. She agrees to help them.

SCENE 5

The women go home and go from house to house telling people in the village of their plan to work together. They form a women's organisation and start projects to provide food and build health.

RAPE

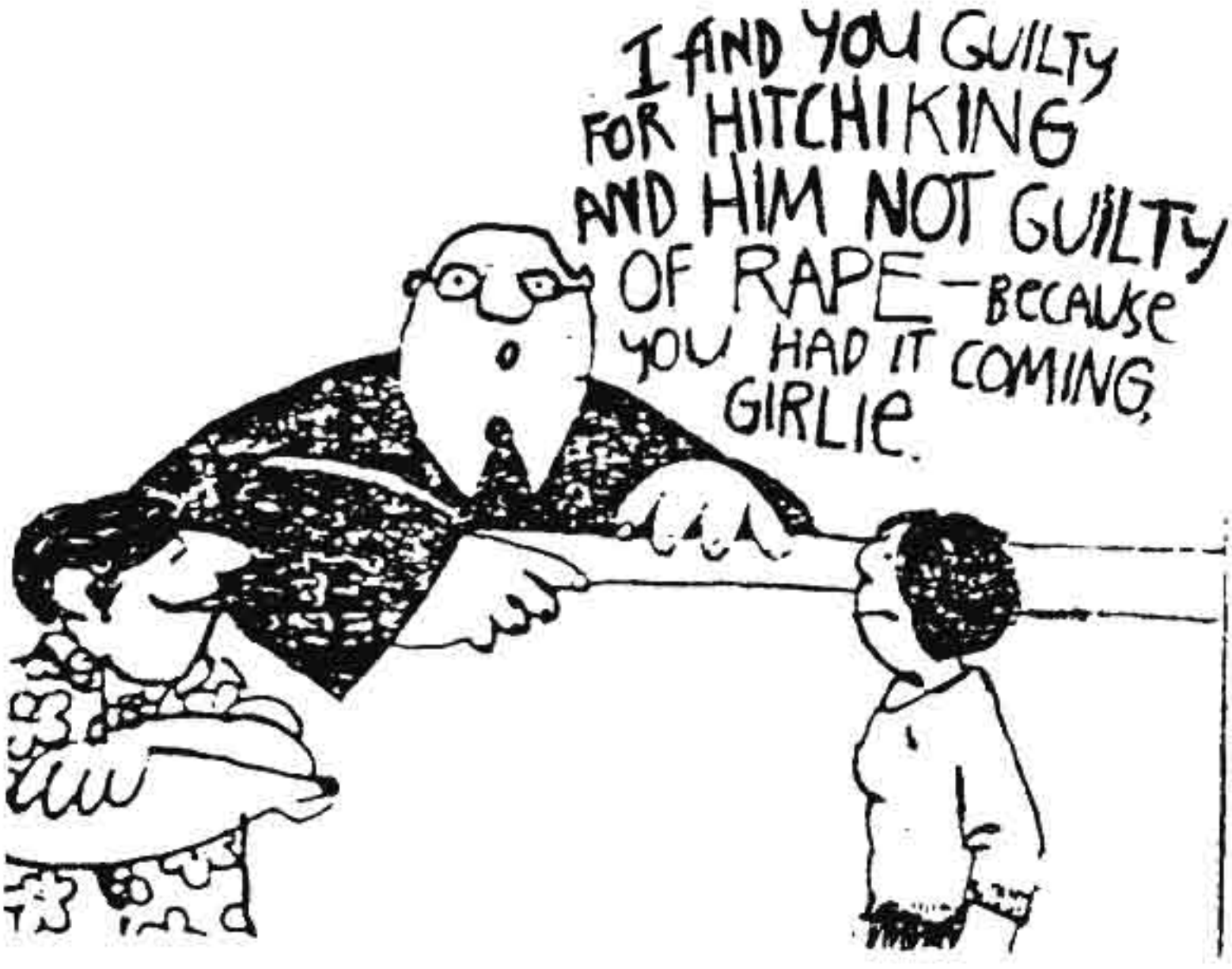
In South Africa there were 14 000 reported rapes from July 1980 to June 1981. According to statistics compiled both here and overseas, only one in twenty rapes is reported to the police. This means that we can estimate that 280 000 women were raped in that one year.

Rape is committed by men from all social-economic classes. Rape victims range in age from small babies to old women, they can be rich or poor; the women's appearance is not a factor in determining whether or not she is raped. Women are often raped by men they know, the rapist can be an uncle, or friend or boss or someone who lives down the road. Very often women in factories are harassed by the boss or foreman.

People often believe that rape is the woman's fault. They believe that she asked for it because whe was alone, or she looked sexy or she hitched a lift or she talked to a man. Even friends or the police will try to blame the woman and excuse the man. But rape is not a woman's fault. Rape is a crime of violence (like an assault) where sex is the weapon that is used to hurt and to degrade women. Men do not rape because they get turned on - in fact most rapes, especially gang rapes, are planned in advance. Rapists are not sex-starved, most have a wife or girlfriend and have a regular sex life.

So why do men rape?

Society teaches men and women how to behave and how to be the ideal person. Men are told by their parents, friends, advertisements and movies how to be the perfect man. A man is supposed to be big, strong and protective. He should be sexy, reliable and rich. Men are supposed to be able to fight and have a good job. But, it is not possible to be the "ideal man". Society puts a lot of barriers that prevent men from being rich or sexy or attractive. On the one hand men get the message "you must be successful" and on the other hand society keeps men powerless by controlling most aspects of their lives. Men are taught by society to see women as inferiors and therefore feel they have the right to possess women. Men rape because they want to feel powerful - in the



same way as a bully beats up a smaller person to feel powerful.

When a woman is raped she often feels a sense of shock and of shame. She is often badly hurt, both physically and emotionally. She often is blamed for the rape and so she may feel guilty (blaming herself). She will try to think of a reason why she was raped. Perhaps she will think it was the clothes she was wearing or the place she had visited. Because of these guilt feelings she may be too scared to tell anyone that she was raped and will have to live with the experience alone.

Rape is often a life threatening assault and women who are raped say that fear of death is the most traumatic aspect of the rape. Often a rape victim will have problems sleeping, she may have nightmares, she may have eating problems and feel nauseous. She may burst into tears for "no reason" or be afraid to leave the house at all. If women are to survive rape they need to be helped to overcome feelings of fear, guilt and shame. Rape victims need to be given practical advice about the treatment they may need, and they need to be listened to to enable them to work through the rape experience.

What can be done?

If a woman has been raped and is badly hurt she must go to the hospital immediately. Sometimes doctors at the hospital do not want to treat rape victims because they are afraid they will have to be a witness at the court case. This is not true. The doctor must treat the rape victim and if she wants to report the rape she can go to the police after being treated. She can report at any police station, not necessarily where the rape occured. At the police station she will have to answer many questions about the rape and sign a statement. The police will give her a form to fill in and may take her to the district surgeon who will examine her. The district surgeon has to write all the injuries that he has seen. Some

problems which have arisen are that the women must go to the district surgeon alone and she may have to wait hours for the district surgeon to arrive. The district surgeon is only available at specific times and the woman is seldom aware or made aware of this.

If the rapist is caught, a court case will be held. The woman will be called as a state witness. Any woman who does not want to continue with the case or will not testify can speak to the prosecutor so as to cancel the case, but he is allowed to subpoena her and she will then have to give evidence.

There are two medical problems which a rape victim must be aware of :-
Veneral disease and pregnancy.
A woman who has been raped must go to the hospital for tests to see if she has caught V.D. from the rapist. V.D. is easy to treat if it is treated early. If a woman is not using

contraceptives when she is raped she could become pregnant as a result of the rape. If she reports the rape to the police, she is allowed to have a legal abortion if she wants one. A district surgeon and two other doctors have to agree that the pregnancy was as a result of the rape, before she can get a legal abortion. If she does not report the rape she will not be able to get an abortion.

Any woman raped can get medical and legal advice and councelling from a Rape Crises Centre:

Johannesburg	: *783-5027*	
Durban	: *33-3333*	*code from JHB (031)*
Cape Town	: *21-5420*	*code from JHB (021)*
Pietermaritzburg	: *56279*	*code from JHB (0331)*
Randburg	: *726-6602*	

People Opposing Woman Abuse - Johannesburg.

CONTRACEPTION

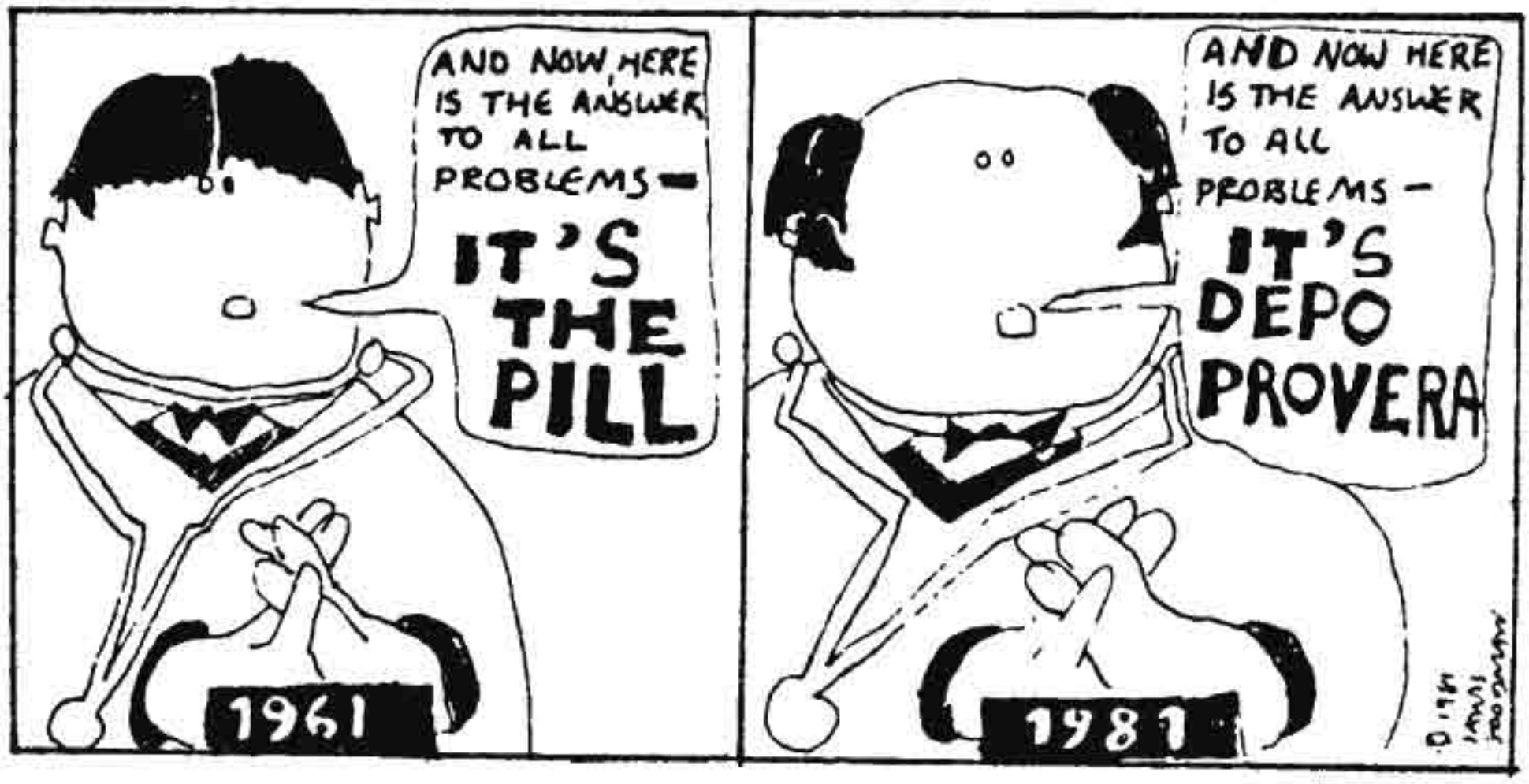
In the last 18 months contraception has become an issue for discussion amongst progressive health personnel and communities. It is an issue which appears to be very simple - All women have the right to contraception, to deciding if, when and how many children to have. Thus the government should provide contraception facilities for women, which they do. The complexities of the issue arise when one notes that behind this apparently helpful service to women, are a string of contradictions and health abuses.

Contraceptive services (so called Family Planning services) are provided separately from other health services. One frightening result of this is that women who do come into contact with health personnel through 'family planning' clinics are not examined properly or checked for other illnesses like cancer of the cervix or hypertension (common illnesses amongst South African women). This indicates a lack of concern for women's health, especially as this information is needed to help select the correct contracetive for any particular woman. Also the 'family planning' clinic is often the only clinic visited by a woman, particularly in the rural areas.

The range of contraceptives provided are largely the more dangerous varieties like the injection and the pill. Intrauterine devices (loop) are also used and the diaphragm which is least harmful to women's health is hardly used at all. Women are seldom given adequate information on the pro's and cons of each type of contraceptive, allowing them to make their own choice. For example, in a Department of Health book called 'Self Help in Health', the entire section on the contraceptive injection reads:

> *"This injection works in the same way as the pill but is given every three months only. This is a useful method of family planning for the woman who is inclined to forget to take the pill".*

There is not a single reference to any of the side effects, known dangers and potential dangers of the injection. In the section on the loop there is no mention of increased cramps, heavy blood flow during menstruation or the increased possibility of pelvic infection which can lead to infertility. Nor is there any mention of the fact that it is possible to fall pregnant while using the loop.



Critical Health met with a group of Soweto women to discuss their feelings about contraception. Parts of the discussions have been transcribed because they reflect the complexity of the contraception issue, and begin to ask what type of service would be adequate.

PARTS OF A DISCUSSION ABOUT "FAMILY PLANNING" BY SOWETO WOMEN

1) Family Planning

-Who ever thought of this family planning I think was very broad minded ... in many ways. Firstly I think family planning has minimised the number of abortions that used to occur before; so that you don't find babies lying around in dustbins, some just left on doorsteps as was the case before. I mean, the young girls are concerned, they

use these contraceptives. The family planning with the married couples is also very good, because you're able to plan with your husband; to say I want so many children and in that way they are able to live within their means.

-I think the original reason for family planning as I understood it and as it was advertised was that it enabled the woman to space the pregnancies. You can decide if you want the babies after two years or after three years. But lately even the adverts are not saying that anymore, they are saying 'plan a smaller family for a bigger future' - which I think is not quite right. And like all the people I feel I must have only one child and that's it. I think if people want six children they must be encouraged to have six children as long as they can afford it.

-Some people believe that family planning is the answer ... because the adverts don't show the bad about family planning. At baby clinics there's always a lecture about how to look after you children and feed them. At the family planning clinics they don't give a lecture. The government is afraid that if they give a lecture, the people will run away from the family planning clinics and they'd lose their prey.

-All along I've been thinking maybe they're avoiding (the effects of) overpopulation, like building houses and paying us.

-The government wants to decrease the number of the population. The black nation is the majority, they're trying to lower us.

2) Men and Family Planning

-Some men are willing to co-operate, but then with the young ones, some don't co-operate at all. So that if the young women want to use these contraceptions they do it without the husband knowing it. I know of many cases.

-You see some of our men think that family planning, contraceptives, as far as they know, are encouraging women to

go on the loose because she could do exactly whatever she likes with whoever she likes.

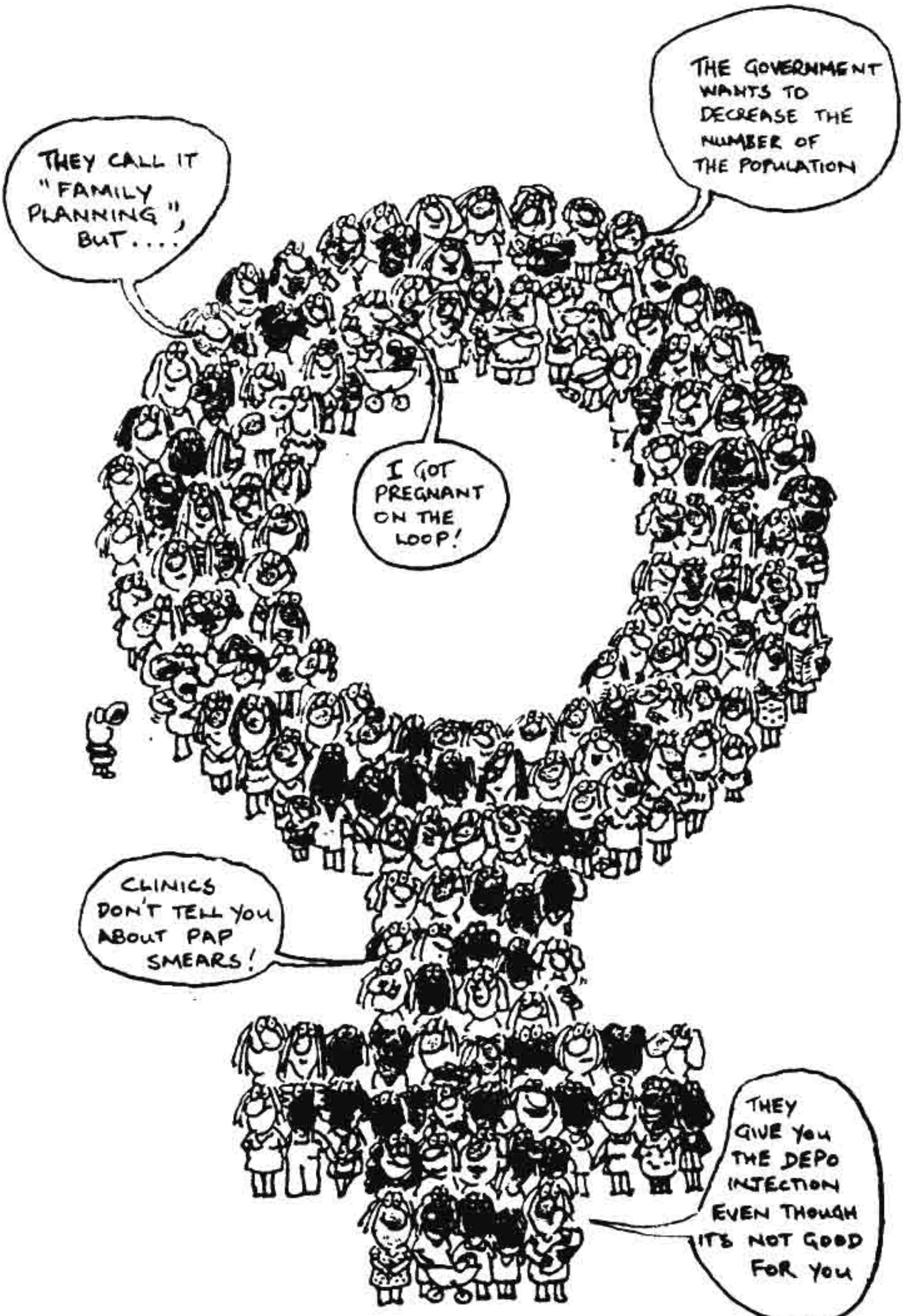
-At school those boys which are a bit grown up do think about it, but the young ones, 17 or 18, they just take it as a joke. But the grown up boys they do think about it and sometimes they do advise their girlfriends - they usually ask them if they are taking them.

-Well I have boys and I must honestly confess I've never talked about it, except that at one time one of my little boys came with a girlfriend. When they went out, typical of black woman, instead of me talking to my son, I spoke to the girl because I think its easier for a woman to speak to another woman. But it was in my son's presence. I said, " ... what I want to tell you here and now is that he is a boy and you are a girl and in our situation girls look after themselves. Don't make him a husband, because if you make him a husband, he's not going to marry you". I was schooled by my mother if you don't look after yourself, nobody will.

3) Side Effects of Family Planning

-Okay let me tell about me. I've got a four year old baby, a kid. The time he was two years I was using a pill. From there I forgot a pill one day, then I became pregnant. Then I commit an abortion. From there I use an injection. That injection condemned me until now. Since last November (1981) I've never seen a period until now. Then last month I was in a check-up. He's instructed me that I will stay another year not having a period. It's just a hell of a problem for me. The others are menstruating - just not me.

-But usually in a clinic they do explain that about an injection. They tell you it might stop your period. So we are not the same. I use it for the past five years. I never had any menstruation and I never had any headache or those veins or whatever the case may be. I was just right.


THEY CALL IT "FAMILY PLANNING", BUT....
THE GOVERNMENT WANTS TO DECREASE THE NUMBER OF THE POPULATION
I GOT PREGNANT ON THE LOOP!
CLINICS DON'T TELL YOU ABOUT PAP SMEARS!
THEY GIVE YOU THE DEPO INJECTION EVEN THOUGH IT'S NOT GOOD FOR YOU

-I usually have the giddiness almost every day from the pill. I got giddy and felt like vomiting. So I stopped that, then I took the loop. But the pill - I can't loose my weight now. I'm staying fat.

-I got pregnant on the loop.

-They should explain the side effects. They just want to limit the black people.

-Not all of us have gone to school. Had we gone to school we would ask the nurses about these things (pap smears, side effects) and the government would know that people in the townships are asking about these things.

4) Abortion

-And in my experience if you are pregnant and you have a loop introduced, it makes you have an abortion.

-If you want an abortion you ask your bosom friend confidentially to take you to somebody she knows.

-Depending on the months. If it's one month it's R10, two months R20, three months R30, etc.

-Some go to Bara hospital with sterility of some sort. But there are some of these backyard abortionists. I know of one woman who is just nobody but she specialises in that. She's very clever that girl. She starts it and then she says "When you see the signs, run to the hospital". I think that helps a lot of people because when it starts happening they are there - doctors never say its criminal if you come and you need help they help you.

5) Single Women with Children

-If you had a child when not married in the old days it was a disgrace. People would tell their daughter, "don't go near that one".

-Now today it's a common thing. No sun falls down, no heads grow horns!

6) School and Family Planning

We have nurses from the family planning go to school. They educate you how to go about it,the family planning, without your man knowing anything about or your sisters, you know its your secret. It's a blessing, you can finish off your school.

7) The Family Planning Clinic

-They are going to give you the DP(Depo provera injection) even though it's not good for you. They wont give you the contraceptive that you want.

-In the clinic, they are not concerned about your health. The only thing they are concerned about is that you don't get more kids. For example, many don't know about pap smears. I didn't till I went to a gynaecologist. If they cared they'd explain.

-I think it's important that people, if they go there (clinics), they go there knowing.

CANCER OF THE CERVIX

Cervical cancer is an abnormal growth occuring in the opening of the womb. If detected in its early stages, the disease can be totally cured; if unattended, it is fatal. The incidence of cervical cancer in black South African women is amongst the highest in the world. In spite of the success of treatment most of these women still die from the disease.

DETECTION OF CERVICAL CANCER;

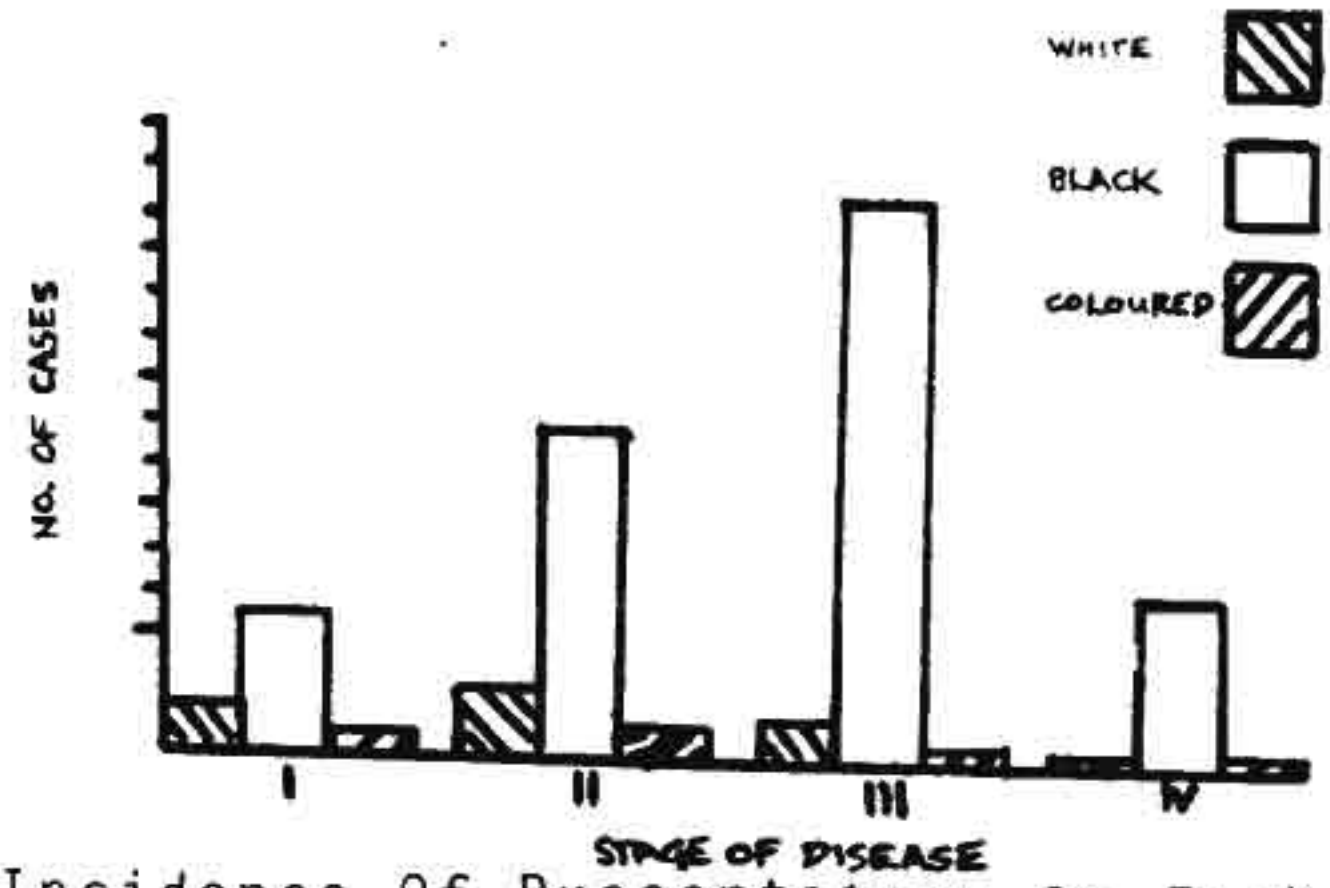
The most reliable means of detection is the Papanicolou((pap) smear. This can detect the disease even in its earliest stage during which there are no feelings of illness. This test should be painless.

THE NEED FOR EDUCATION.

Because the early stages of the disease are symptomless, the disease will progress unnoticed (unless regular pap smears are done) and will only be detected upon appearance of symptoms late in the disease process. Therefore awareness of the need for regular pap smears must be created. Unless this active education is carried out, women will still only come to hospital with the onset of pain, discomfort or bleeding at which stage the disease has progressed too far for curative treatment.

WHY IS THE INCIDENCE OF CERVICAL CANCER HIGHER IN BLACKS.

As can be seen from the graph (p.71), more black women get the disease than whites do; most of them presenting in the later stages of the disease while most whites present in the earlier stages. The causes of the disease are uncertain but a number of factors have been implicated.A relatoinship with a frequent change of sexual partners and be-



Racial Incidence Of Presentation In Each Stage Of Ca Cervix, Witwatersrand

gining sexual intercourse at an early age has been documented. Migrant labour and Influx Control have often been responsible for these lifestyles be cause they disintergrate the family and often prevent people from establishing long-term sexual relationships. An association between the disease and poor living conditions has also been suggested These factors help to explain the alarming difference in the incidence of the disease between black and white South African women as seen below.

THE INCIDENCE OF CERVICAL CANCER IN BLACK AND WHITE SOUTH AFRICAN WOMEN

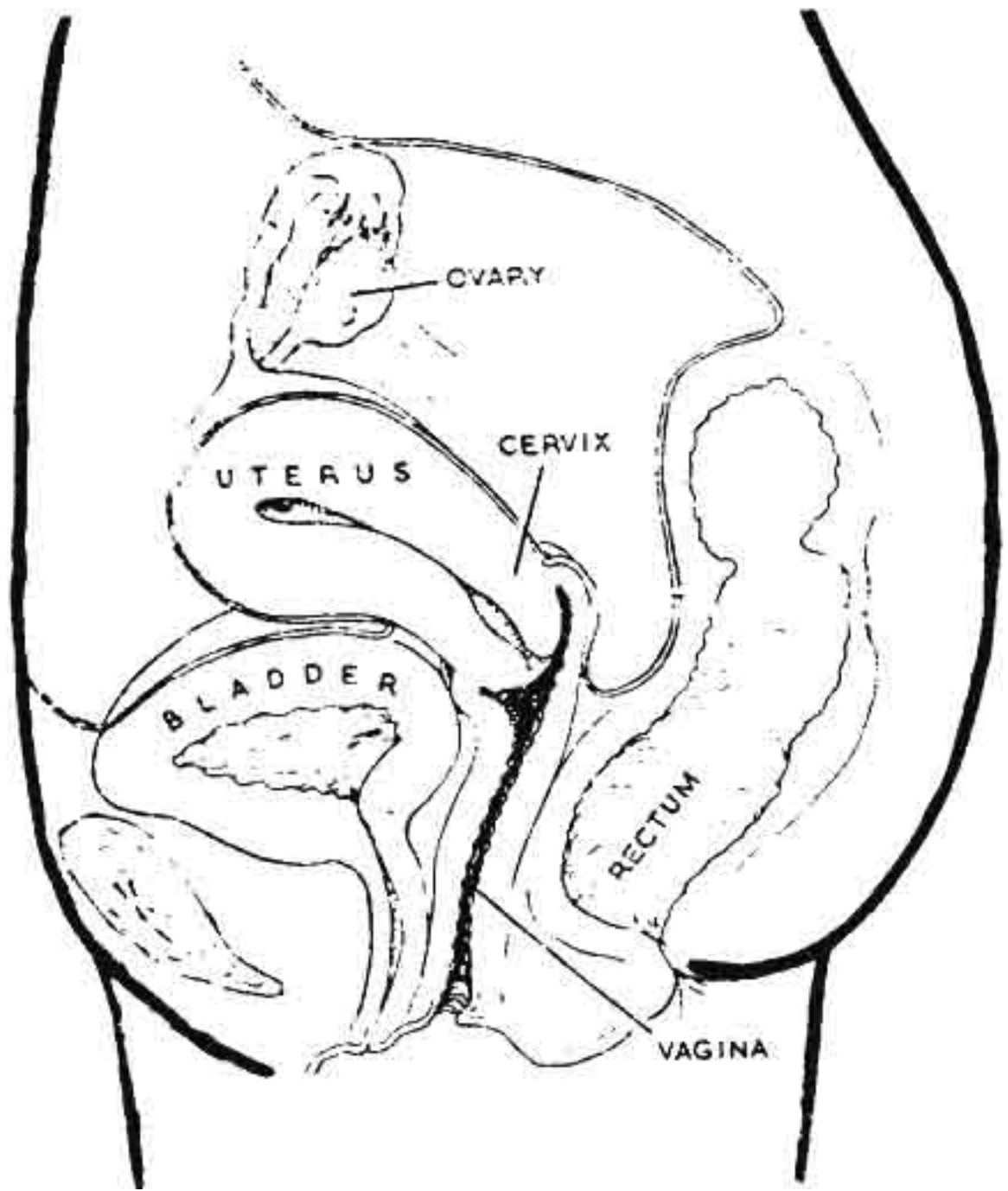
35,6 per 100000 black women

8,08 per 100000 white women

The National Cancer Association of South Africa (NCASA) reports that four out of five women who come for treatment can no longer be cured. This is because they come to hospital in the later stages of the disease.

WHY DO WOMEN COME TO HOSPITAL IN THE LATER STAGES OF THE DISEASE?

At present, there is no major active campaign to inform women about the disease, how to detect it and how it can be cured. Most women therefore do not know about pap smears, or of their importance. Pap smears are not routinely done at family planning clinics - the one place to which even rural women have access. Even if women ask for a pap smear to be done, the clinics may not have the necessary facilities or follow-up services to contact the women who are found to have cancer of the cervix. Many clinics also charge a fee for a pap smear to be performed and this is often beyond the means of most black women. Although the situation varies from doctor to doctor, a large proportion of women who have private gynaecologists will be more likely to have a pap smear . The majority of black South Africa women do not have access to a private doctor.



NCASA AND THE FAMILY PLANNING ASSOCIATION

At present only two organisations are actively involved in education about and screening for cervical cervical cancer. They are the NCASA and the Family Planning Association of South Africa. Neither of t these are state run and neither receive a substantial subsidy from the government. In addition, cervical cancer forms a very small part of their activities. The NCASA focuses primarily on lung and breast cancer (the latter especially being found predominantly in white South Africans). Information on pap smears may be given to women who go to family planning clinics and certain hospitals, but this is very random and depends once again on the discretion of the individual health worker present. The need for awareness of the severity of the disease and the high cure rate on early detection extends to the health workers as well.

ATTEMPTED SCREENING PROGRAMMES

Some attempts at screening have been made. The South African Institute of Medical Research set up a programme in Soweto in which they trained large numbers of workers to analyse pap smears (cytologists) Doctors and other health workers (not appreciating the need for pap smears) did not take advantage of this facility so the project was underutilized. The project did not however include an education programme for health workers or for the communities involved and therefore was unsuccessful.

Projects in Natal sent mobile clinics into the townships and rural areas to screen women by doing pap smears. Because these projects did not arise out of discussions with the communities the objectives of the project was unclear and the women met it with some mistrust. To many the pap smear was seen as a method of indiscriminate sterilization and so regarded the project as yet another way for the state to exert control over women.

WHY IS CERVICAL CANCER NEGLECTED?

In spite of the availabilty of a relatively simple screening test and the documentation of an almost 100% cure rate if detected in its early stages, the state puts very little money into educating and sc screening of cervical cancer. In fact many clinics have been requested to reduce the number of pap sm smears taken. The reason given id the cost of performing these tests. The state is unwilling to spend money to provide facilities for pap smears, to train and employ cytologists who analyse the pap smear in order to detect cancer and to stage the disease. The state is unwilling to spend money to creat the awa awareness of the disease, its early simple painless detection , its treatment and high cure rate. All this is far cheaper than treating an advanced case of cervical cancer which usually requires lengthly hospitalisation.

This reflects a broader pattern of health care distribution in South Africa.. Health services are la largely orientated towards meeting the needs of the minority of the population. The health needs of the Blacks are of little concern to the state even in the case of an easily curable, but lethal disease like cancer of the cervix.

In addition, because the disease has been associated with women who have many sexual partners, this has resulted in women being blamed for contracting the disease. Thus shifting the responsibility for preventing the disease away from the state and places it on the individual.

Education around cervical cancer is crucial because it is only once women have access to information c concerning the disease, that they can begin to make demands to combat it.

HUNGER

"This deteriorating situation poses a dilemma for the wealthy, food-surfeited citizen of the developed world. He must decide whether he has a moral obligation to feed those who are starving even if the food shortage in the poorest countries could have been prevented by population control."
11 November 1974, Life Magazine, USA

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"Western economists like to quote outside factors – such as nature, climate, population growth – as being responsible for the food deficiency from which so many former colonies suffer. But the real causes responsible for the hunger of some 400 million people are . . . colonialism and imperialism, neocolonialism, and international monopolies."
2 November 1974, Neues Deutschland, German Democratic Republic

"Efforts to banish hunger throughout the world at the unique conference in Rome are being sabotaged by a depressingly large number of the 130 countries present, who seem more interested in turning it into an old-style 'anti-colonialist' revivalist meeting. Their argument is the familiar, all-purpose one that anything that goes wrong in a developing country, after however many decades of independence and however many billions of dollars of aid, is due to 'colonialist exploitation' in the past...(But)... It is embarrassingly clear that some of those that are now hungry would not be so under the old, efficient and incorrupt colonial administration."
11 November 1974, The Daily Telegraph, UK.

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"The developing countries are fully capable of solving the food problem, provided they win complete political and economic independence, rely chiefly on the strength and wisdom of their own people and, making full use of their resources, strive to increase farm production and develop their national economies step by step in a planned way."
7 November 1974, Hsinhua News Agency, People's Republic of China

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1. I find Critical Health useful ---------- Yes/No

   because _____

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3. I dislike Critical Health because _____

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5. I usually pass my copy of Critical Health to other people to read Yes/No

6. Other comments/suggestions _____

   _____

   _____

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Name: _____ Address: _____

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People interested in being placed on a mailing list to be informed of any theses or occasional papers dealing with the politics of health in South Africa should send their name and address to CRITICAL HEALTH, P O Box 16246, Doornfontein, 2028.

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CRITICAL HEALTH is a publication dealing with health and politics in South Africa.

CRITICAL HEALTH aims to:
*present a critique of "health" in South Africa;
*provide ideas for the role health workers can play in providing a healthy society;
*show that health is a basic right;
*provide a forum for the critical debate of health-related issues;
*give insight into the political nature of health.