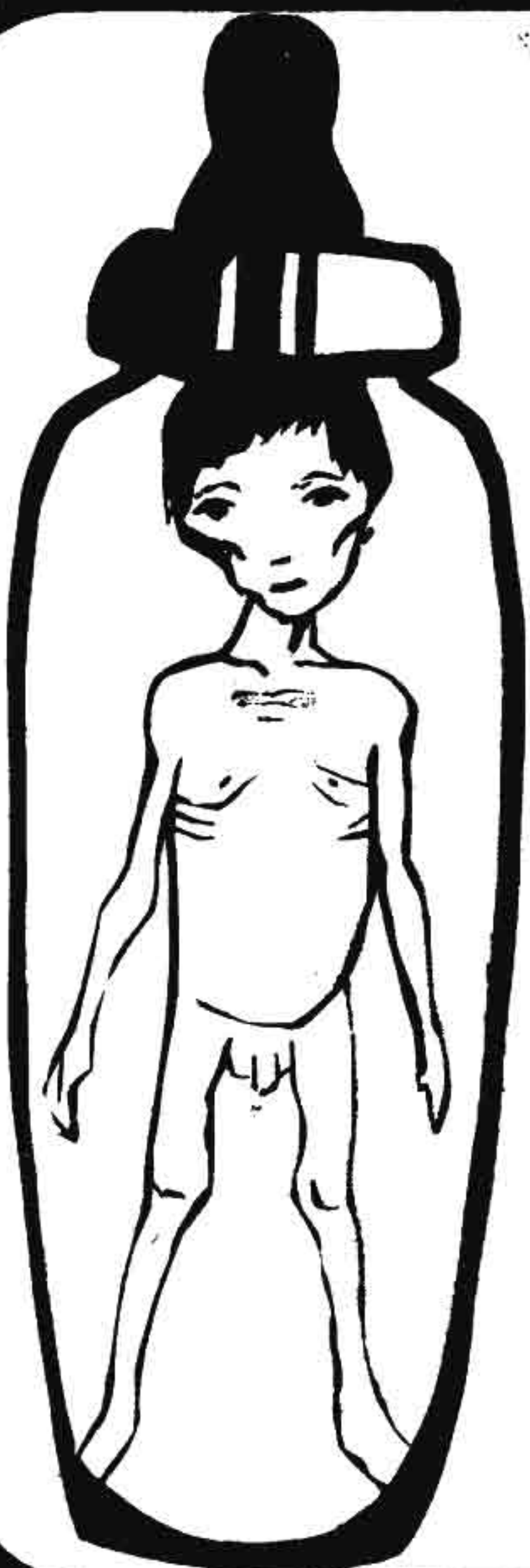
CRITICAL HEALTH

No. 2 30¢



THE BABY KILLER

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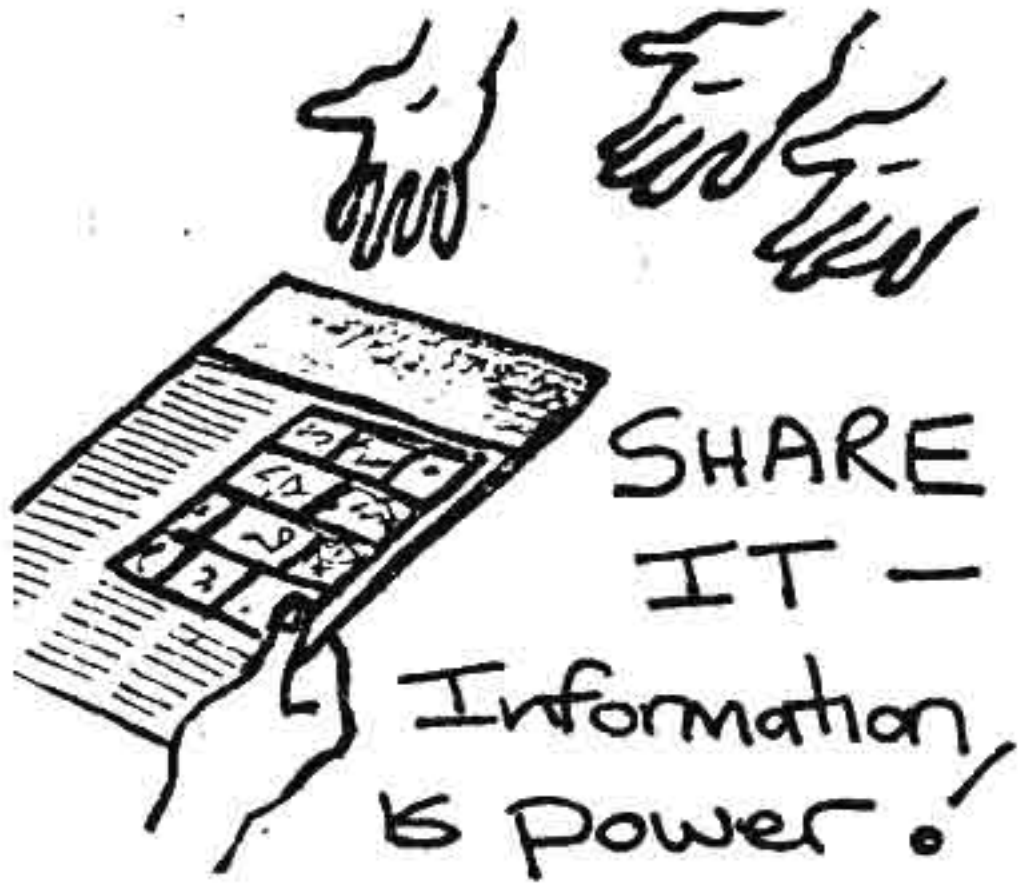

EDITORIAL.

So far CRITICAL HEALTH appears to have had a favourable reception, with approval being expressed in a number of letters to the Editors. But if CRITICAL HEALTH is going to be a success, it is vital that we receive contributions from different centres around the country,including your thoughts on any issue, letters of criticism, or even straight facts. Don't wait to be asked, send your contributions now.

The leading article of CRITICAL HEALTH No.2 is on breast-feeding, or rather how the battle against the breast continues to be waged by the milk companies. This is an important issue, considering the unacceptably high levels of malnutrition in this country. The principle "profit above all else", is clearly detrimental to the interests of the majority of the people.

An article written by Marit Kromberg who has worked in Botswana for many years and who has an in-depth knowledge of the problems confronting health schemes in rural areas appears in this issue. The concept of Primary Health Care is explored and the possible dangers of co-option of health projects by an undemocratic State are explored.

Two articles have been included as part of our series concerned with "Understanding Community Health". The first of these deals with Development and Underdevelopment in South Africa. It is essential for all health workers to understand the origins of the unequal distribution of wealth, and the inadequate distribution of social services in this country. Only then can we begin to confront the rea issues and appreciate the role we may play in bringing about a more just society for all South Africans.

The second article deals with the uses of epidemiology, and aims to give health workers an understanding of the fundamental importance of this tool in the solving of community health problems. Epidemiology could be described

as the key basic science subject of community health, in much the same way as physiology relates to clinical medicine. The dangers of epidemiology; the abuse of this tool, are not often considered. In this article the author presents this aspect of the problem in a most enlightening manner.

Unfortunately we have been forced to raise the price of CRITICAL HEALTH- due to our underestimation of the costs of distribution. From now on a yearly subscription will cost R1.20, and each copy will cost 30 cents.

"New"Johannesburg Hospital?

1979 saw the completion of the R156 million new Johannesbur Hospital project. Early in 1980 it's opening was met by a large outcry in the news media from hospital staff and public alike. The main criticisms revolved around mal-administration, inefficiency, and inaccessibility.
Unfortunately, we believe these critiques have not gone to the roots of the problem or asked the question "What are the real causes of the problems we now see?"
An oversized disease metropolis has been builtin the Northern Suburbs of Johannesburg, perhaps the wealthiest ar most priveleged sector of the South African Society. The majority of these people can easily afford the already overgrown private medical services, while this new hospita is inaccessibke to those people "south of the railway line' who require a State-financed medical service.
Moreover, this enormous sum of money has been buried in secondary medication, while the real need is for comprehen-sive health care. What is required is an extensive network State-funded local clinics in both urban and rural areas, easily accessible to the people and able to provide them with primary,secondary and tertiary care.
The days of giant hospitals are over as we should have learnt from countries like Tanzania and Mozambique, still South Africa's plans forge ahead for further disease palaces in many other white centres; Pietetmaritzburg, Cape Town, Pretoria etc.
Is the ultimate objective better and better health care for fewer and fewer priveleged people?

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The articles printed in CRITICAL HEALTH have been collated by the editors and does not necessarily reflect their views.

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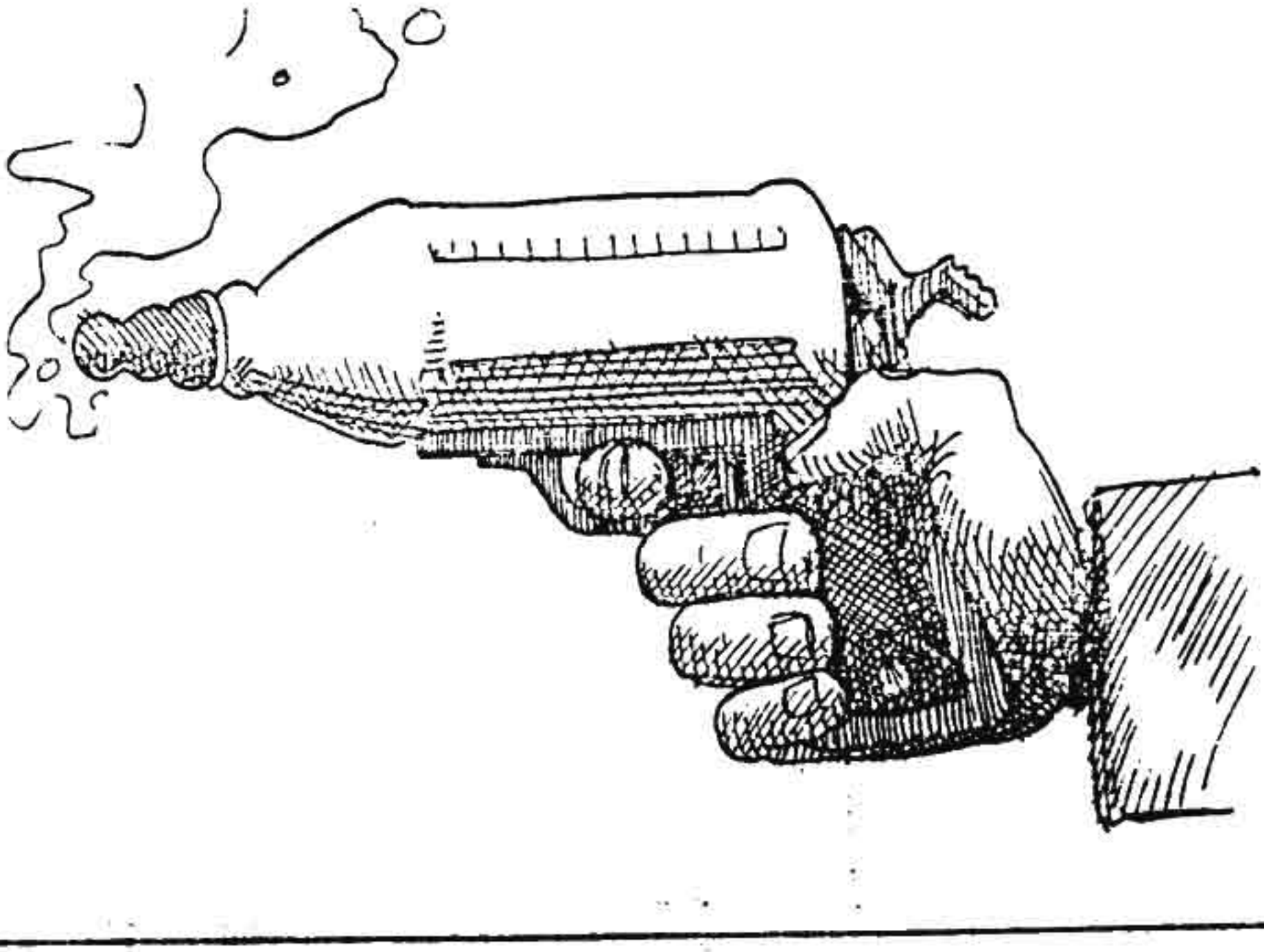
MULTI-NATIONALS AND HEALTH, PART 1:

THE PROMOTION OF INFANT FORMULA FOODS.



MULTI-NATIONALS AND HEALTH, PART I:

THE PROMOTION OF INFANT FORMULA FOODS.

During the 1960's, doctors and health workers around the world began to express concern about the rate at which mothers in the underdeveloped regions were taking up bottlefeeding their children as a substitute for breastfeeding them. They said that intensive advertising by the manufacturers was playing a significant role.

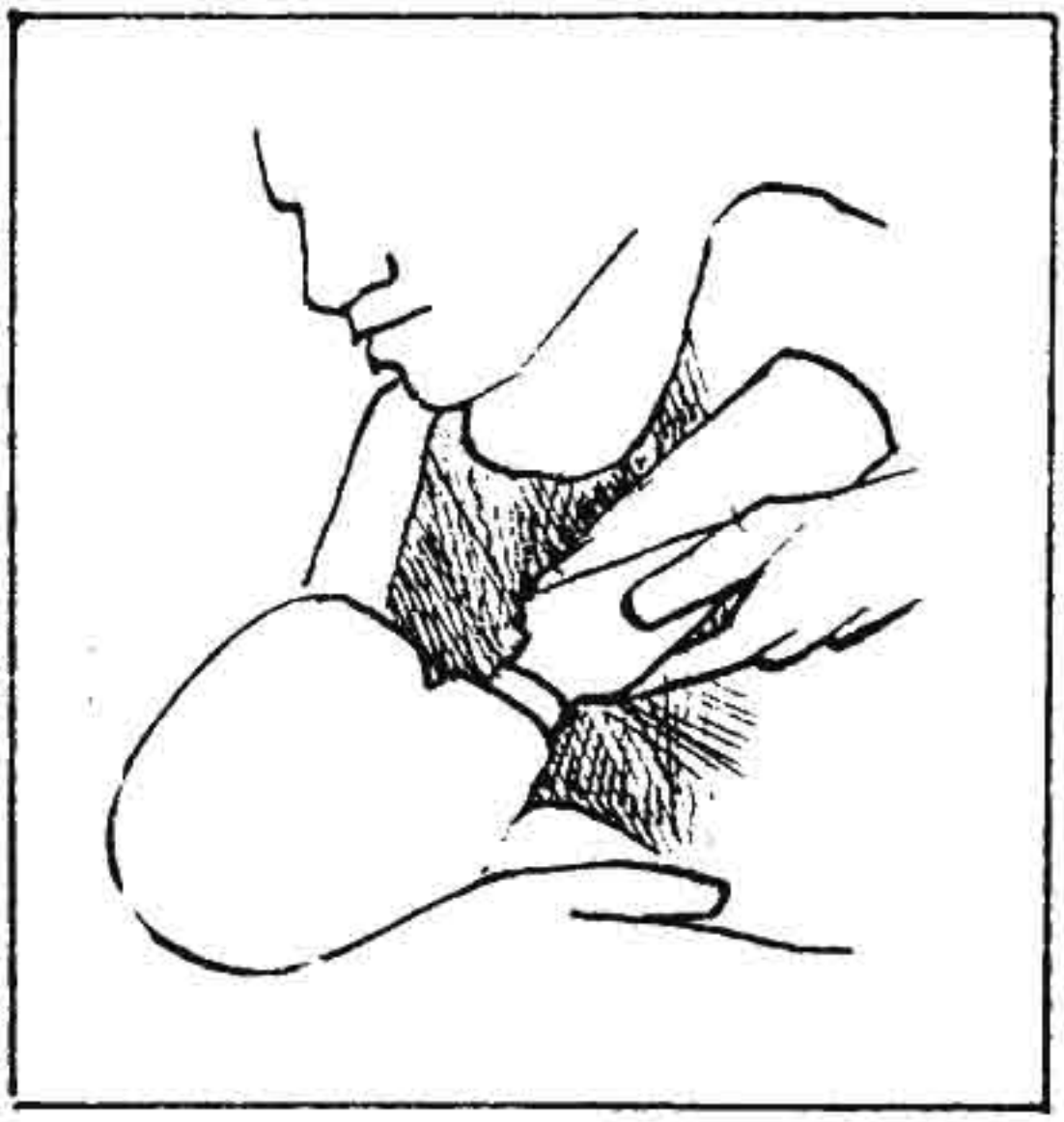
In 1974 a pamphlet entitled "The Baby Killer" was published in the United Kingdom by an organisation called "War on Want". Research into the marketing practices used in Africa by the manufacturers of infant formulas had been undertaken, and this pamphlet was the result. Severe criticism was levelled particularly against Nestlé and one other company.

In 1975 a group in Switzerland published a German translation entitled "Nestlé Kills Babies". The company was understandably upset (slogans like that are not good for business if they catch on) and sued for defamation. Nestlé won their case on a technicality, but the company nonetheless came in for some severe criticism from the judge.

The publicity from the case sparked off a growing international campaign which has had the companies feeling increasing pressure in the form of adverse publicity, court cases and boycott campaigns. In October 1979 a World Health Organisation Conference was held in Geneva to discuss the whole issue.

What is all the fuss about? First let us look at some of the difficulties and dangers that are involved in bottlefeeding.

1. The milk companies admit that breastmilk is ideal. Their research efforts are directed at ever closer imitations of breastmilk. Millions of Rands are spent researching, developing and marketing a commodity which is available much more cheaply and in a purer form as breastmilk.
2. The cost of adequately feeding a child with formula milk for a period of six months is at least R120-00c. Add



to this the cost of bottles, fuel for sterilisation purposes and so on, and this amounts to very nearly the total cash income of many families, particularly in rural areas. Yet the cost of feeding the mother a little more, so that she can breastfeed adequately, is comparatively negligible.

3. Any switch to formula foods becomes irreversible after several days of not breastfeeding, for the mother will probably be unable to resume adequate breastfeeding. This is because breastmilk needs a frequent sucking stimulus to be produced; if this does not occur, the milk dries up. Anything which casts doubt on a mother's ability to breastfeed will lead to reduced confidence, and hence reduced ability.

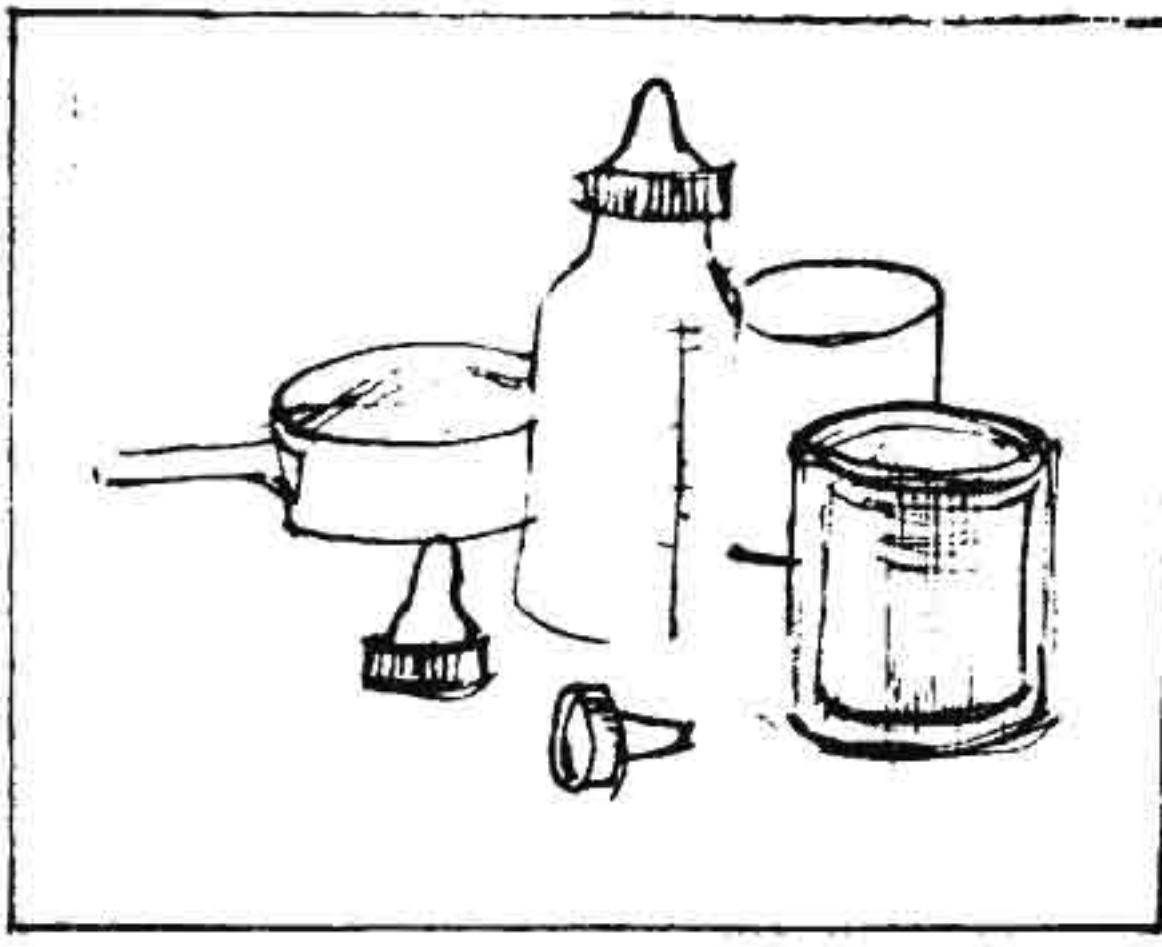
4. Once a child has sucked a bottle, (s)he becomes unwilling to revert to suckling at the breast, because it is more work.

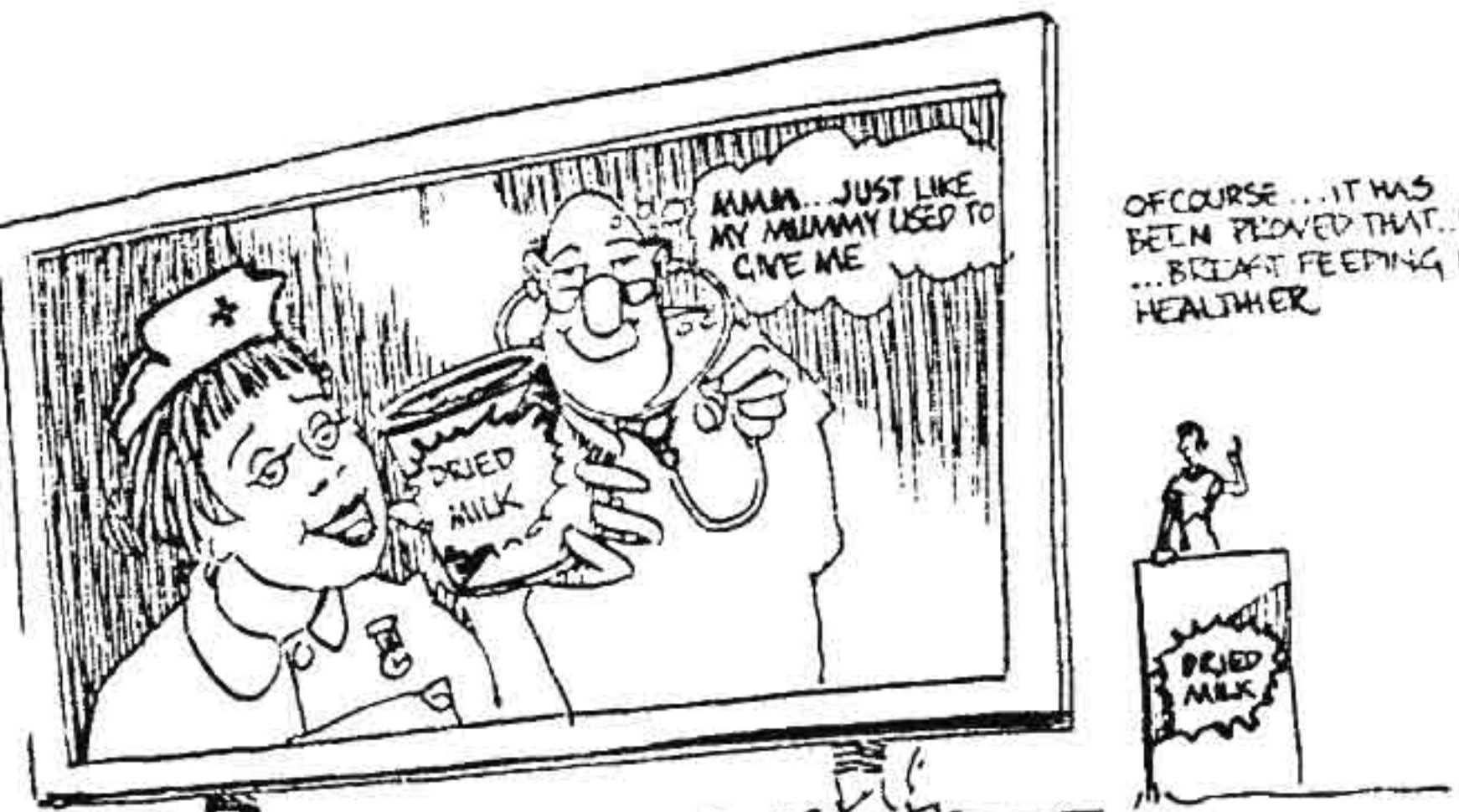
5. Because of the expense involved in formula feeding, mothers will often over-dilute the powder in order to make it last longer. This leads, of course, to severe nutritional problems. This problem is compounded by widespread illiteracy and a lack of adequate explanation on the use of the formula.

6. It is found that in order to be able to afford even an inadequte supply of formula milk, some mothers will economise on food for the rest of the family, thus having a bad effect on the nutrition of all the other family members.

7. Formula milk almost always comes in powdered form, and so needs to be mixed with water. This is a problem in a world where the majority of the population does not have access to uncontaminated water. The children are thus subjected to very high dangers of infection. Boiling the water and the bottle is extremely difficult in areas where fuel is in constant short supply. And it is almost impossible to keep either the milk or the bottles clean if there is no refrigeration.

8. Breastmilk has certain properties that protect the child against infection during the early stages of its life. This protection is particularly important for the children of the poor, as they are more susceptible to disease and infection. No formula milk is able to provide similar protection.




AHHH... JUST LIKE MY MUMMY USED TO GIVE ME
DRIED MILK
OF COURSE... IT HAS BEEN PROVED THAT.. UGH! ...BREAST FEEDING IS HEALTHIER
DRIED MILK

In summary, there is no doubt that bottlefeeding under the social economic and environmental conditions experienced by a very large proportion of the population, is a dangerous activity. It contributes to a vicious cycle of infectious disease and malnutrition, which causes dehydration, and often death. There is no doubt that bottlefeeding kills babies. More accurately, there is no doubt that many bottle fed babies die in ways that they would not have if they had been breastfed.

Yet breastfeeding is on the decline around the world, and it is declining at an alarming rate. Apart from anything, this huge drop in breastfeeding means that a great deal of money is being spent on buying a commodity which is a poor imitation of something that is available at a fraction of the cost. And this is money spent by people who can ill afford it, and who could use the money for much more socially productive purposes.

What has caused this literally suicidal swing to bottlefeeding? It must be recognised that the causes are many and complex. They surely include the following:- bottlefeeding is very convenient for the wealthy (for them it is safe enough, and it is something that can be left to a nurse/maid/babysitter); for working mothers there must be some difficulties involved in breastfeeding their children; bottlefeeding has become something of a status symbol in the eyes of many; and there is a great deal of ignorance about the advantages and disadvantages of bottle and breastfeeding - up till quite recently, this ignorance was not uncommon even within the medical profession.

So there are real material conditions which have made the swing to bottlefeeding possible, and even likely. But it is necessary to examine more closely what it is that has actually made it happen. In this regard, the rest of this article is going to look at the aggressive advertising and promotional campaign that the manufacturers have undertaken around the world, despite clear evidence that breastfeeding is, at the moment, the only sensible option to the majority of mothers around the world.

What techniques have been used to promote the use of infant formulas?

1. Firstly there is the normal range of advertising techniques: billboards, advertisements and product displays are to be found all over. Their prime intention appears to be to

convince the consumer that the product being advertised will ensure smiling good health for all babies. Aside from these "normal" advertising techniques there are a number of unconventional methods which the companies have used to promote their products.

2. The employment of health professionals.

Nestlé have employed nurses as "milk nurses", "mothercraft nurses", "health educators" or whatever. They theoretically help at hospitals, clinics and through home-visits, with health care, health education and nutrition promotion. In fact they act as promotors for the products of the companies that employ them - handing out free samples to mothers, doctors and nursing staff. They have often been found to operate within the malnutrition wards of hospitals. The obvious intention (or at least the obvious consequence) is to create the impression among the mothers of sick infants that there is a link between the company and the health service. In other words, the impression is that Nestlé, hospitals and clinics are all important parts of bringing up healthy well-fed babies.

There are other forms of promotion which appear to be aimed at reinforcing this impression.

3. In gynaecologists' waiting rooms, in maternity wards, in clinics and pharmacies around the world, there has been left an endless supply of leaflets, booklets and posters, offering information, advice and free samples. This material is left by the milk companies, and appears to be free and friendly help about child rearing and feeding. The material seems to show a real care and concern about the new born baby.

But closer inspection reveals a distinct bias. In these publications much more space is devoted to bottlefeeding, and what to use than is given to breastfeeding. The simple fact is that this material is distributed free by companies whose major interest is the promotion of bottlefeeding, and the overall effect of this material is to create the impression that bottlefeeding is the natural, normal thing to do. The fact that much of this material is available from places associated with health care and medicines must affect the way that the products being advertised are perceived by the average consumer.

Nestlé has taken this approach one step further by producing

and sponsoring a large number of "health education" posters. In many hospitals and clinics around the country you will find, pasted up on the walls, posters with a happy smiling baby and a caption reading "breastfeeding is best" or something similar. This seems good and well. But it reinforces the impression that the company is concerned to promote health care rather than its products. In addition, many of the people who go to rural clinics are illiterate, and what they see is in fact a picture of a healthy similing baby and a Nestlé sign in the bottom right hand corner of the poster. What logical conclusion can they draw other than that the hospital agrees that Nestlé and healthy children go together?

4. The promotion of bottlefeeding as the "natural" "normal" way to feed a baby has some dangerous side-effects. The logical conclusion to draw is that breastfeeding is difficult. This stimulates a fear of inadequacy in mothers which in turn makes it less likely that they will be able to breastfeed adequately. There is a very delicate relationship between a mother's confidence in her ability to breastfeed and the actual production of adequate milk. In addition, the first time something goes a little wrong, the mother is more likely to blame it on there being something wrong with her milk, and so she may start to supplement with a substitute. This is also likely to reduce her ability to produce breastmilk.

   This tendency to reduce a mother's ability to produce milk is part of at least one specific promotional technique.

5. Free Samples. These are widely distributed, often by company "health educators" (or whatever the currently fashionable name is), but sometimes also by the clinics or at shops, pharmacies and so on. It would be a most unusual mother, especially a poor mother, who did not gratefully receive a free sample of food for her baby. But the consequences of accepting the sample can be most unfortunate. The free sample may last a week, or longer if the mother over-dilutes it. In the end of the week the mother's milk supply will have been drastically reduced, or completely dried up. So the baby in effect, has become "hooked" on formula milk, which is not as good for him/her as mothers' milk, which she may not be able to afford and the use of which may, under certain circumstances, be lethal.

6. Baby shows are one particularly bizarre opportunity for handing out free samples. Throughout the world, and in

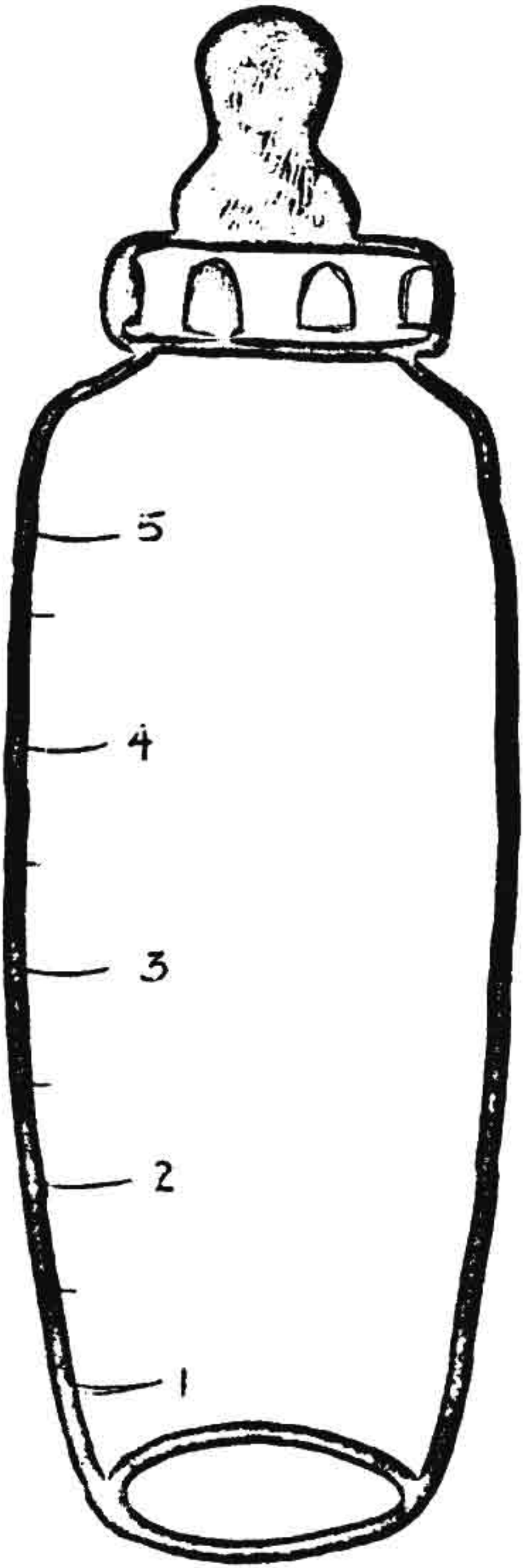
parts of South Africa, Nestlé has organised, inspired, or offered prizes at baby shows held to find the "best" baby in the district. It is claimed that these shows are a form of "health education". In fact, apart from the presentation of "free prizes" these shows are another way for the companies to appear to be identified with the health service, as the shows often take place at hospitals and clinics.

7. One might well ask where the medical profession is in all of this, and how they have allowed such a situation to develop without loud and powerful intervention; particularly, one might ask how the profession has allowed the hospitals and clinics to be used as a base for the promotional activities described above.

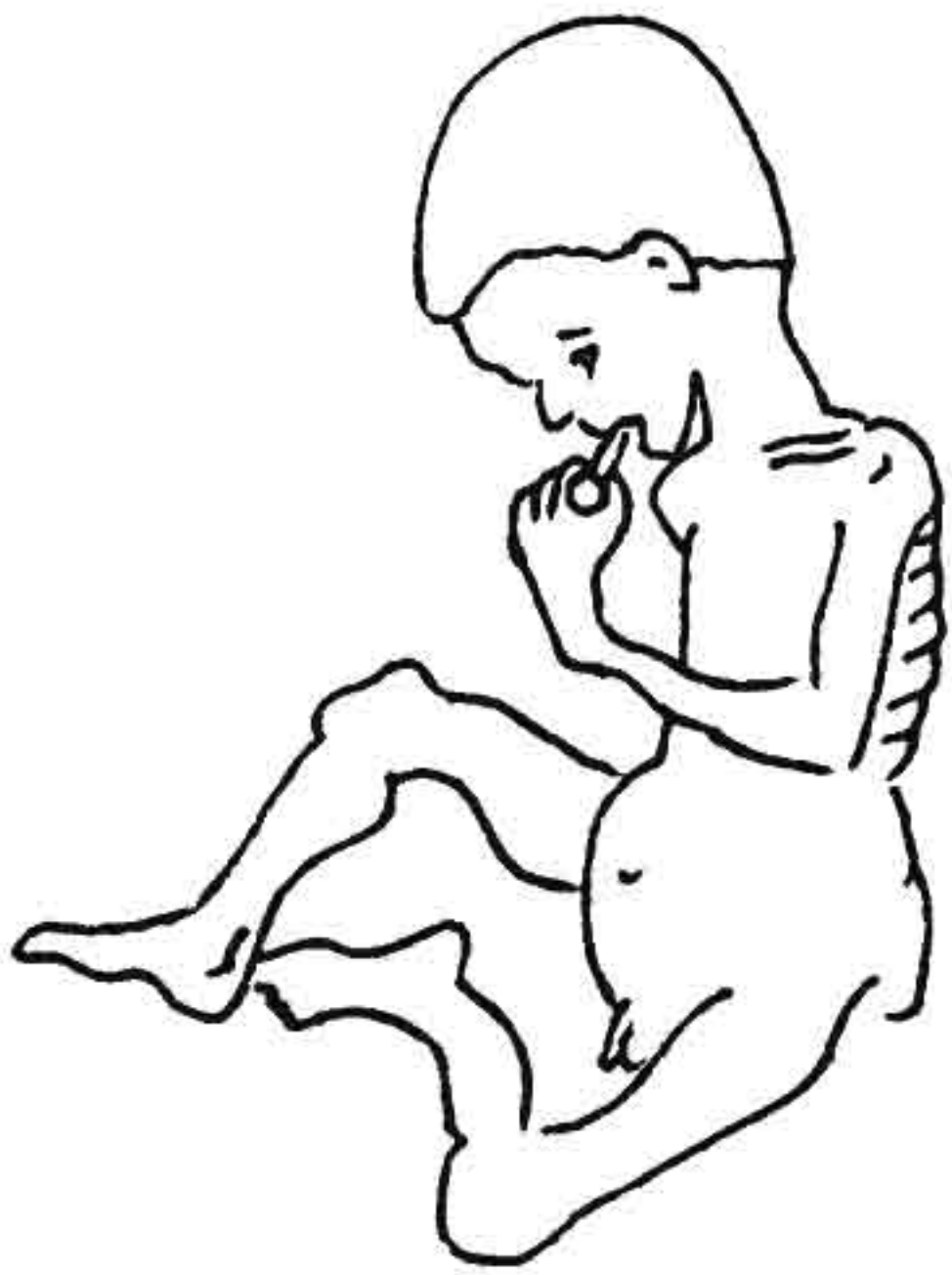
The first answer is that the profession as a whole seems to be peculiarly ignorant on the subject. There is virtually no teaching about breastfeeding at Wits Medical School. There is also no attempt made to pinpoint the dangers for children inherent in bottlefeeding as opposed to breastfeeding. Much of the advice that doctors give is, as a result, inadequate. For example, mothers are usually told to feed their children in four hour cycles to begin with. But this is in fact a cycle for formula fed children, and children being fed at the breast may in fact demand to be fed much more often. This again tends to promote a feeling of inadequacy and anxiety in the mother, so threatening an adequate milk supply. (This misinformation about feeding cycles is a frightening example of how formula feeds have established themselves as the norm).

There may however be a slightly more sinister reason for the silence of the medical profession: the sustained campaign which has been directed at the profession by the milk companies Formula advertisements in medical journals are a model of scientific statement and moderation - full of facts and figures This, of course, is in stark contrast to the emotive and sentimental advertisements to be found elsewhere.

Further Nestlé is very "generous", to use a polite word, towards the medical profession. Many conferences are supported by the company, which also gives a large cash prize to the best final year paediatrics student at Wits University. Much health educational material and various aspects of some community health programmes are sponsored by the company. This may appear to be very laudable, but it does also have the



THE BABY KILLER



effect of making the profession as a whole, and even those who are concerned with community health, reluctant to oppose the promotion of formula foods.

Over the years, there has been increasing attention focused on the promotional activities of the baby food companies, and the effects that the use of their products has on the infants and babies of the poor. This has led to a series of protests, th establishment of numerous action committees and, most recently to a World Health Organisation meeting in Geneva in October 1979, at which a series of agreements were reached with the companies. There have been codes in the past, and much of th activities of the action committees has revolved around highlighting discrepancies between what the companies say they are doing, and what they are actually doing.

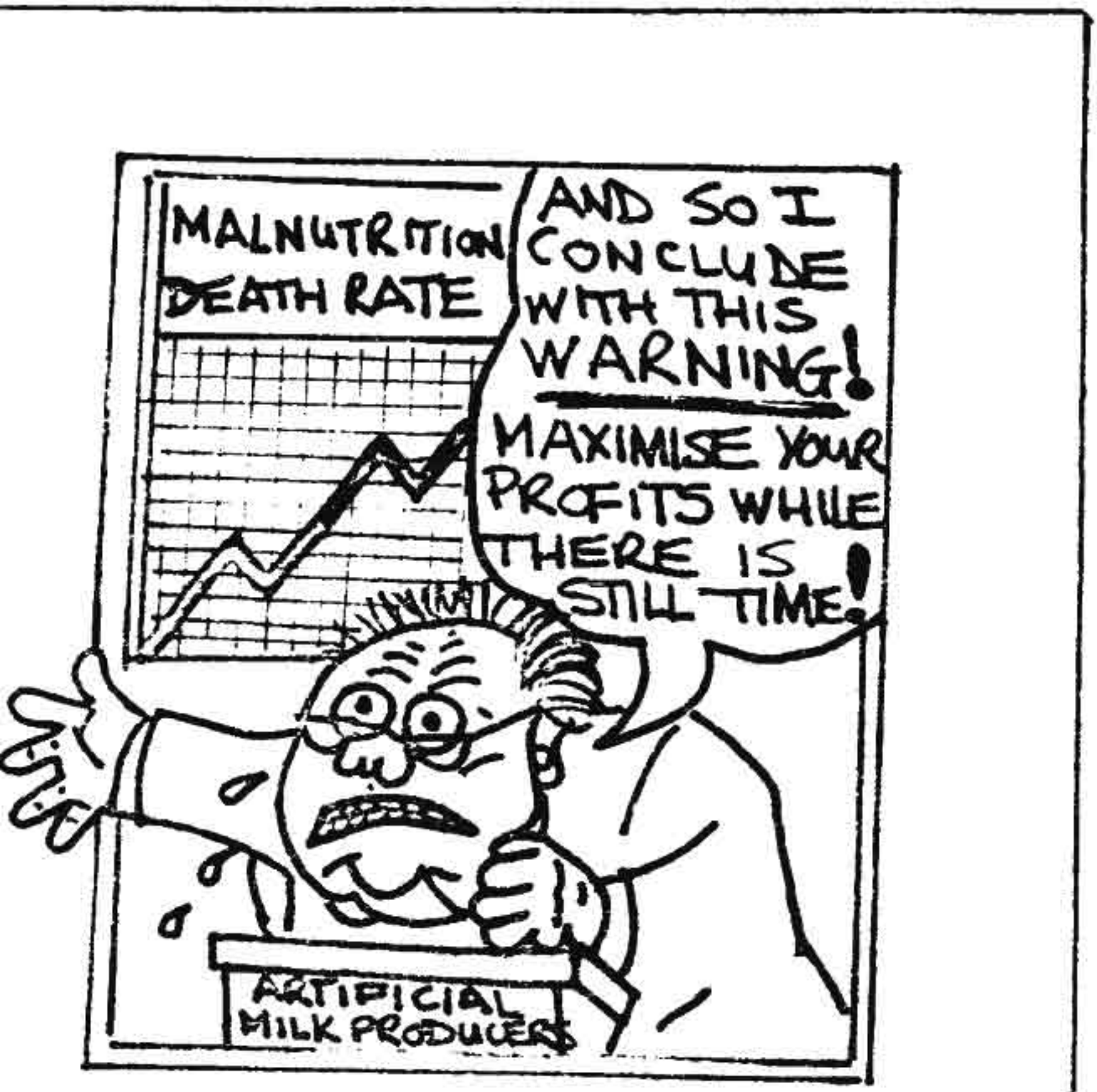
CONCLUSION.

It has become almost a cliche to say that health cannot be divorced from questions of politics and economics. Much has been said and written about the development of South Africa's political and economic structures and the consequent underdevelopment of the health of much of the African population, particularly in rural areas.

So, too, it has become widely accepted that turning health care into a commodity to be bought and sold creates a total imbalance in the whole delivery system. Health care becomes something which can be bought by those who need it least - the rich white urban population. The most helpless victims of the course of capitalist development in South Africa, the rural poor, are those who can least afford to pay for health care. They are also those with the very least political power. It follows that they have the least access to it.

The story of infant formula promotion highlights another aspect of the way the development of capitalism has impinged upon the health of the masses: where the creation of profit is the highest good, people become mere tools and objects in the achievement of wealth; they have no value of their own.

It matters not that the usage of what you are producing and selling is demonstrably harmful or even lethal(at least where there is widespread illiteracy and inadequate access to clean water, fuel and hygienic living conditions). It


MALNUTRITION DEATH RATE
AND SO I CONCLUDE WITH THIS WARNING!
MAXIMISE YOUR PROFITS WHILE THERE IS STILL TIME!
ARTIFICIAL MILK PRODUCERS

matters not that you are producing a substance that is a poor substitute for the natural product (breastmilk) that is available at a fraction of the price. It matters not that the product has been developed for use in the homes of the rich, and that the conditions in the third world differ markedly. All that matters is that in a free market society one should be free to trick, cajole, convince and otherwise persuade as many people as possible that they need what you are trying to sell them. What matters is that you have produced something, and the economic laws are such that you are under an almost moral duty to sell it, without regard to the consequences for the health of the victims.

The cigarette industry is the clearest proof that companies are allowed to manufacture death, and then use almost any means to try to persuade you to buy their product.

The infant formula industry however is a special case. The ultimate consumers, babies, have no choice in whether they should use the commodity or not. In addition the industry has taken the promotion of its products to unusual heights of sophistication. (The cigarette industry does not use the health service as a base for the promotion of its products).

There is no doubt that attempts should be made to monitor and control the promotional and advertising activities of the infant formula industry. But it should be recognised that the industry is not an aberration. It is rather a good example of a system that allows, in fact encourages the production and distribution of ill health; which ranks people's importance according to their place in the market, rather than their humanity; which regards corporate profit as more important than social good.

DEATH

DIARRHOEA

INFECTION

POOR HYGIENE

LOW RESISTANCE

POOR NUTRITION

LACK OF EDUCATION

LOW INCOME

MIGRANT LABOUR

UNFAIR DISTRIBUTION OF LAND AND WEALTH

INFANT AND YOUNG CHILD FEEDING.

A WHO/UNICEF Meeting on Infant and Young Child Feeding was held in Geneva, Switzerland, October 9-12, 1979, attended by governmental, non-governmental, and infant food industry representatives. Five working groups outlined a series of recommendations which were incorporated into a final statement. The parts of the statement and the recommendations that relate to nutrition and food are abstracted below.

Breastfeeding is an integral part of the reproductive process, the natural and ideal way of feeding the infant, and a unique biological and emotional basis for child development. This, together with its other important effects on prevention of infections, health and well-being of the mother, child spacing, family health, family and national economics, and food production, makes it a key aspect of self-reliance, primary health care, and current development approaches. It is therefore the responsibility of society to promote breastfeeding and to protect pregnant and lactating mothers from any influences that could disrupt it.

In order to accomplish this task, health services should ensure that :-

-- Obstetrical procedures and practices promote and support breastfeeding.

-- Breastfeeding be initiated as soon as possible after delivery (normally within the first half hour).

-- Mothers be encouraged and permitted to keep their babies with them post-partum to facilitate on-demand feeding.

-- Supplementary bottlefeeding of water or formula be discouraged for optimal breastfeeding.

-- **No complementary feeding be started before 4-6 months if the mother is healthy, well-nourished, and fully breastfeeding her infant.**

-- **Preference be given to contraceptives which do not interfere with lactation.**

-- Facilities be made available to mothers of hospitalized infants so that they can continue to breastfeed.

-- All health workers who provide information to mothers on breastfeeding be committed to the promotion of breastfeeding.

Education programs should :-

-- Provide mothers with enhanced understanding and acceptance of breastfeeding.

-- Include other family members (fathers, grandmothers, etc.) who can encourage breastfeeding.

-- Teach mothers about suitable weaning foods which can be made in the home from locally available foods.

The work place should :-

-- Provide facilities so that working women may breastfeed.

-- Ensure job security for pregnant and lactating workers.

Participants in the sessions concerned with infant formula marketing practices decided that there should be an international code regulating the marketing of infant formula and other products used as breastmilk substitutes. The code should be supported by both exporting and importing countries and observed by all manufacturers. WHO/UNICEF has been asked to organize the process to prepare such a code, being sure to involve all concerned parties. Included in this code would be such statements as :-

-- There should be no sales promotion (including promotional advertising) of products to be used as breastmilk substitutes or bottlefed supplements and feeding bottles to the public.

-- Promotion of such products to health personnel should be restricted to factual and ethical information.

-- Facilities of the health care system should never be used for the promotion of artificial feeding.

-- Advertising or promotional distribution of samples of breastmilk substitutes through health service channels should not be allowed.

-- Artificial feeding should not be openly demonstrated in health facilities.

-- In order to avoid the risk of conflict of interest, no personnel paid by companies producing or selling breast-milk substitutes should be allowed to work in the health care system, even if they are assigned more general responsibilities that do not directly include the promotion of formula.

-- Foods produced and distributed for infants and young children should be labeled to indicate proper and safe home preparation.

-- Governments should adopt the recommended international standards covering foods for infants and young children that have been developed by the Codex Alimentarius Committee on Foods for Special Dietary Uses.

-- Products that are not suitable alone as weaning foods should be required by proper regulations not to be packed, labeled, advertised, or otherwise promoted in ways that suggest that they be used as a complement or substitute for breastmilk.

The entire group strongly expressed the opinion that these recommendations, in particular those on marketing, if accompanied by strong local government commitment and enforcement, should correct some of the poor feeding practices reported through the world.

(Copies of the complete "Statement on Infant and Young Child Feeding" FHE/ICF/REF/6/Rev.2 may be obtained by writing to: WHO: Geneva, Switzerland).

NEW BUDGET:

Bread to go up

POST 27/3/80

Let them eat cake!

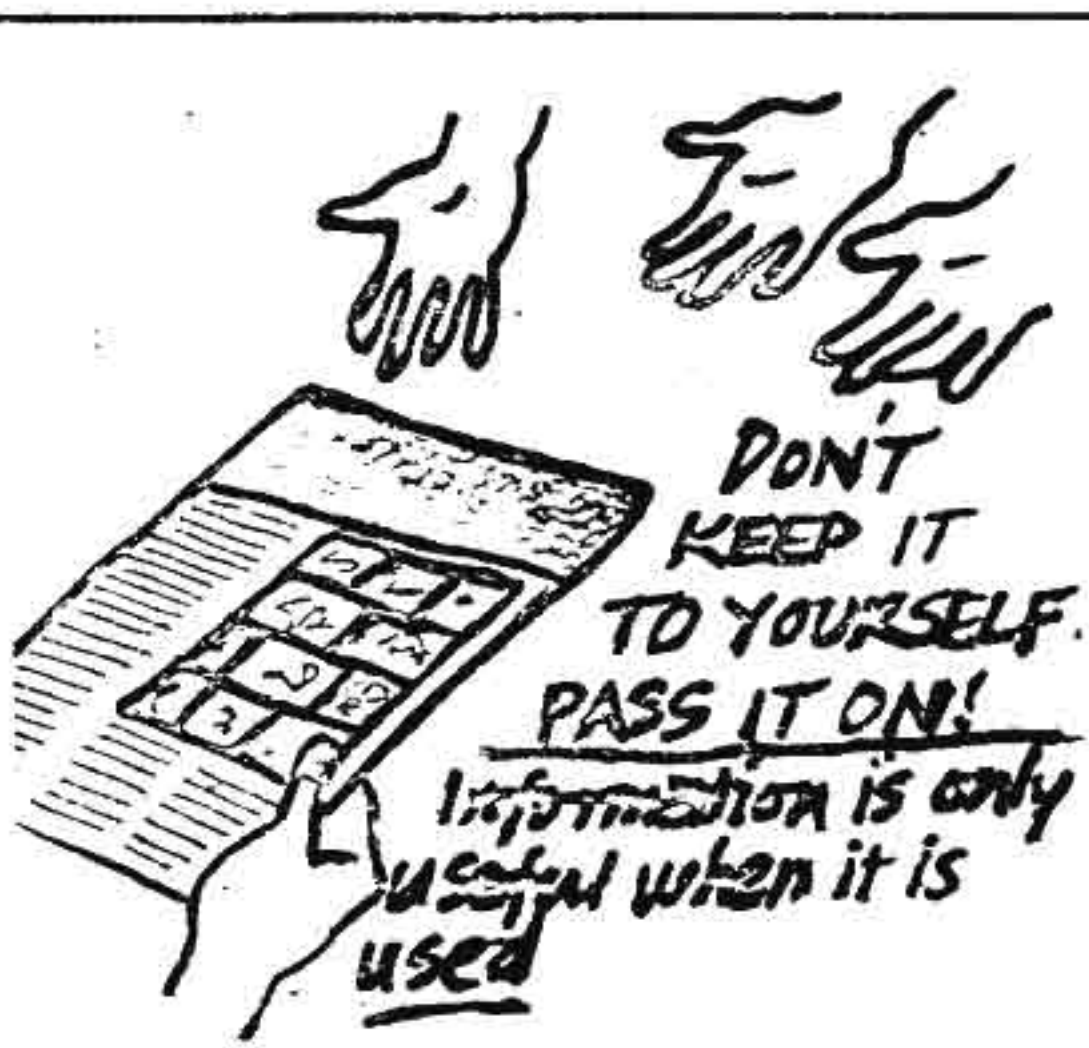
UNDERSTANDING COMMUNITY HEALTH:-

An ongoing feature of "Critical Health" aiming to develop an awareness of the basic concepts and principles essential to the field of community health.

This edition - two articles;

1. DEVELOPMENT AND UNDERDEVELOPMENT IN S.A.

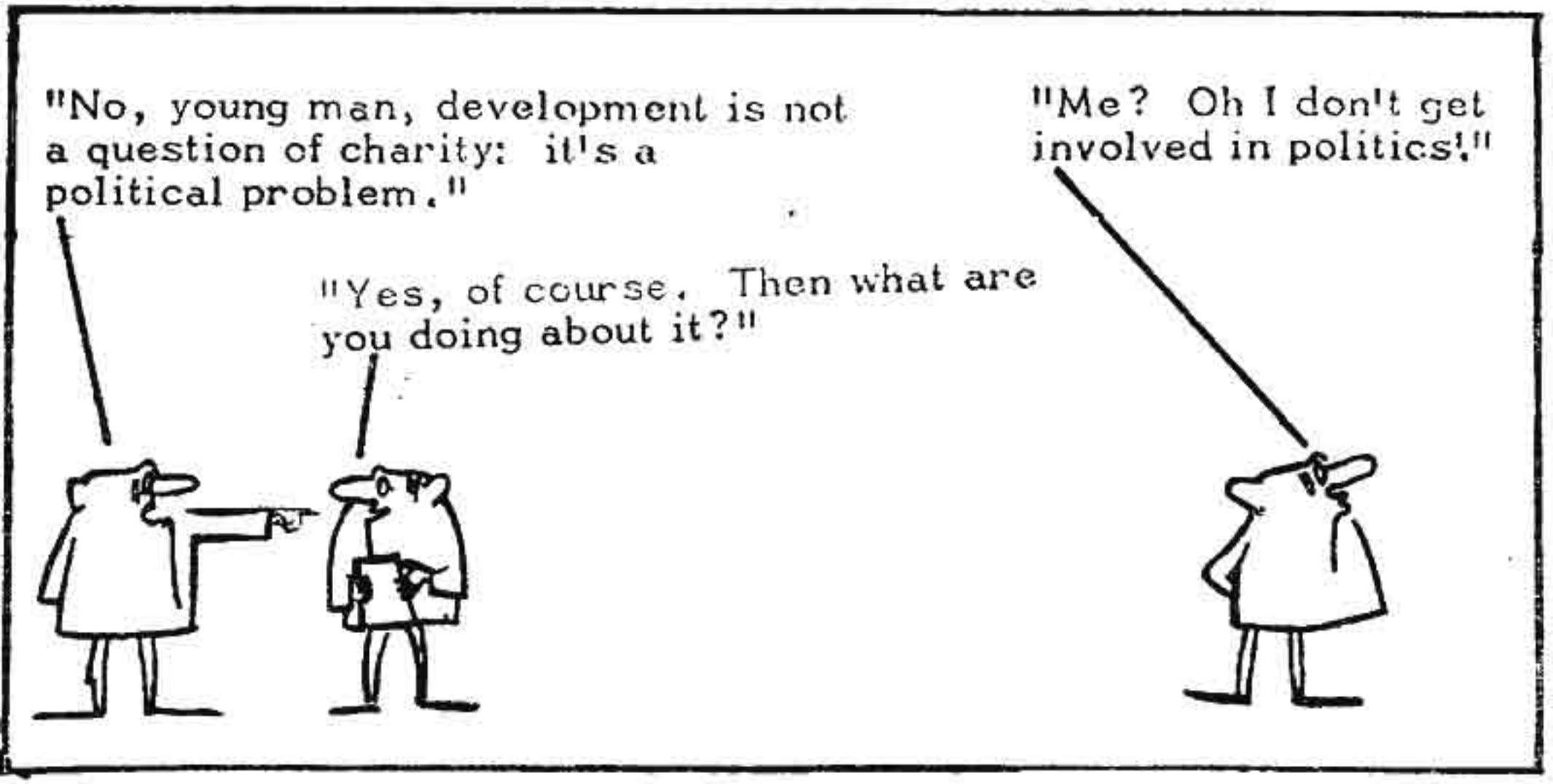
2. THE USE OF EPIDEMIOLOGY IN SOUTH AFRICA.



DEVELOPMENT

&

UNDERDEVELOPMENT



DEVELOPMENT and UNDERDEVELOPMENT.

The conventional explanation of underdevelopment in the West is that it represents the persistence of traditional subsistence oriented economies. Applied to South Africa this gives rise to the dual economy thesis. This idea posits the existence of developed and underdeveloped areas in the same country. The developed areas are said to be the result of the initiative, enterprise and skills of white settlers. These settlers came to Africa from literate societies with market economies characterised by private ownership of the means of production and wage labour. They encountered societies which were non-literate, subsistence oriented and pre-capitalist without private property in land or wage labour. The white settlers set about revolutionising the slow pace of life. Their skills and drive initiated the creation of a far more wealthy society. But the indigenous population proved slow to see the benefits of the new way of life. For the most part they clung to their outmoded ideas and customs. The underdeveloped areas in South Africa today represent the remnants of the traditional societies which have failed to adapt their production and institutions to the modern world. Such views give rise to statements such as the following which was made in Parliament in 1978. "Are living standards not linked with the ability to live creatively, to be enterprising? Is it not the problem of Africa that so few people have the ability to be enterprising and to contribute to capital formation?"

The relationship between the developed and underdeveloped sectors is seen as being primarily of benefit to the underdeveloped. Sadie states that "as the population of the Reserves increased and their primitive agriculture could no longer feed them all, some of them could migrate to the neighbouring white parts of the country where ample opportunities for earning a livelihood already existed. The necessity for creating new sources of income on their own initiative did not arise." The points stressed are the voluntary nature of migratory labour and the lack of initiative on the part of African people and the corresponding life-boat function of the developed areas.

Opposed to this view is that which stresses that underdevelopment is not an original condition which has persisted into

modern times. Its roots do not lie in the traditional economy and in traditional values and institutions even if there is some superficial resemblance to traditional society in the underdeveloped regions. In fact the developed/underdeveloped dichotomy is the result of intense interaction between indigenous and settler peoples. An interaction which has produced a new society different both from pre-colonial Africa and from the imperial countries. The essential cause of underdevelopment is seen as rising from this interaction and not as lying in the nature of pre-colonial societies.

At this point let us turn to look at the history of white settlement in South Africa.

First a brief look at the pre-colonial societies. Before the arrival of whites there were three distinct groups of people in Southern Africa. There were nomadic San hunter gatherers who were dispersed in small groups over much of Southern Africa with the main population concentrations in the western Cape and the mountain ranges. The nomadic Khoikhoi grazed large herds of cattle and sheep in the northern and Western Cape. Both the nomadic groups had a fairly restricted material culture because they had to be able to carry whatever they owned with them. The Khoikhoi lived in larger groups than the San because their herds and flocks gave them a more secure material base. The third group was the African people. Their economy was based on agriculture and pastoralism. They had a settled way of life, and a secure material base. This allowed the development of a variety of crafts and in particular the mining and working of various metals, most importantly iron. There were relatively large settlements reaching up to 20,000 people in the Western Transvaal. There was considerable trade within and between these groups in things such as tobacco, skins, cattle and iron.

Competition over the control of this trade had been one of the factors in the growth of several fairly large kingdoms in the Western and Eastern Transvaal. A similar increase in the size of political units had taken place in the Nguni area (Natal). At the beginning of the 19th century population pressure on land further heightened tensions and the result was the emergence of the Zulu kingdom under Shaka. The wars surrounding the formation of this kingdom affected large areas of Southern Africa. People fleeing from Shaka's attacks in their turn attacked others on the Highveld and in the

HOW OUR GREAT DEMOCRATIC CULTURE CIVILIZED THE AFRICAN NATIVE...

1 SLAVERY, PART of our noble Heritage, constituted the first great step...

2. MISSIONARIES spread the word of God

3 THE WEST, to ensure a high standard of living for the African, introduced capitalism

4 & 5 OUR, a 'moral and legal obligation' would incorporate the African into our economic system

6. COLONIZATION meant responsible, orderly government - by whites, of course!

6. JUSTICE. The key to Western Imperialism, then prevailed.....

Orange Free State in order to secure the land and stock on which their survival depended. The result was that large areas were depopulated. This depopulation coincided with the arrival of small groups of whites from the South. The whites were able to occupy the depopulated areas without meeting much resistance. This lead to the well maintained myth that there was no one living in the interior before the whites arrived.

At this point let us return in time to trace the history of the white settlers. After their arrival in 1652, the whites had rapidly dispossessed the nomadic Khoikhoi herdsmen in the Western Cape of their herds and grazing lands. This was achieved through a combination of factors. The whites possessed firearms which gave them an advantage when it came to violent confrontation - a fairly frequent occurrence. They persuaded the Khoikhoi to part with herds and land they did not take by force, in exchange for liquor and beads. Missionaries launched an attack on the idealogical foundations of Khoikhoi society. Whites introduced a series of diseases which proved fatal to large numbers of the Khoikhoi. Most notable of these was smallpox, followed by various venereal diseases. Finally whites were able to take advantage of the divisions between Khoikhoi groups. On several occassions one group of Khoikhoi allied with the whites to attack a third group.

In this way the whites secured the lands and stock which were the basis of the early settler colony. Some of the Khoikhoi became labourers on white owned farms and vineyards, others became bandits on the periphery of the colony or migrated to more marginal lands in the Northern Cape and Namibia. The San hunter gatherers were largely exterminated by the settlers in protracted series of ruthless campaigns.

As the white settlers continued to expand in search of grazing for their new-found herds they came into contact with the African people in the Eastern Cape. They were not able to dispossess them of their land and cattle with the same ease,

but they did eat away at the borders. The whites also put an end to the gradual drift southward of the African people which had been going on ever since they first crossed the Limpopo river, sometime before 500 AD.

By occupying the areas between the various groups of African people and over the years conquering more of their territory the whites laid the basis of the racial division of land. In the 20th century this was to have serious consequences as the Black population expanded within a restricted area. In the early colonial period the effects were not so serious because of the patterns of land-holding which developed. The whites established title to large areas of land in terms of their own legal conventions. They only used a small portion of this land. When Africans returned to this land they became squatters in terms of white law. They were forced to render some type of tribute to the white owners. This might take the form of sharecropping, of paying rent, or of giving the white owners a certain amount of labour. Generally the first was the most common in the early period. Africans occupied and worked most of the land. Much of the surplus which was generated by these activities now went to the white legal owners of the land. Before the arrival of the Whites any surplus over subsistence requirements had remained in African hands and went to generate local industries such as iron and leatherwork, or it was simply accumulated in the form of cattle, where it served as an insurance against hard times or was used as a source of political patronage.

So, much the same thing happened here as had happened at the Cape. The whites secured the resources they needed to establish an economy by taking them from the black people. The other important fact to bear in mind is that many African people were now dependent on whites for their access to land.

Surplus accumulation took place in white hands, while its extraction from blacks contributed to their underdevelopment. On land not privately owned by whites the different settler governments tried to secure any surplus by taxing Africans. The early settler economy was characterised by a series of mechanisms for extracting surplus from the indigenous population.

Most of the Whites themselves were subsistence farmers with lifestyles very similar to those of the Khoikhoi and African peoples.

The small capitalist agricultural sectors were confined to the ports in the Cape and Natal - the only places where a market economy of any extent operated. These capitalist sectors experienced great difficulty in securing labour, essential to capitalist production. As long as direct access to land was available to Africans they preferred to avoid wage labour, even if access to land was conditional on supplying tribute or labour to a white landowner. Because of this slaves had to be imported to meet the need for labour at the Cape and later indentured labourers were imported to Natal.

The settlers' hold on some of the more isolated areas was tenuous. They had to abandon some of the settlements in the Northern and Eastern Transvaal as a result of attacks by the African peoples in these areas.

The discovery of minerals in the interior changed the fortunes of the settlers quite dramatically. Imperial troops were sent in to conquer or subdue the independent African states. Settlers and capital came to Southern Africa from Europe in hitherto unheard of quantities.

To develop the mining industry and to create the infrastructure in the way of railroads etc, large supplies of labour were needed. This labour was drawn largely from the newly conquered black states. War had disrupted the economies of these countries forcing many men out to seek employment. The new colonial regimes did their bit to ensure that this supply of labour would not dry up by imposing taxes. The taxes were intended not only to ensure a labour supply but also to ensure that any surplus within the black society was transfered to white hands.

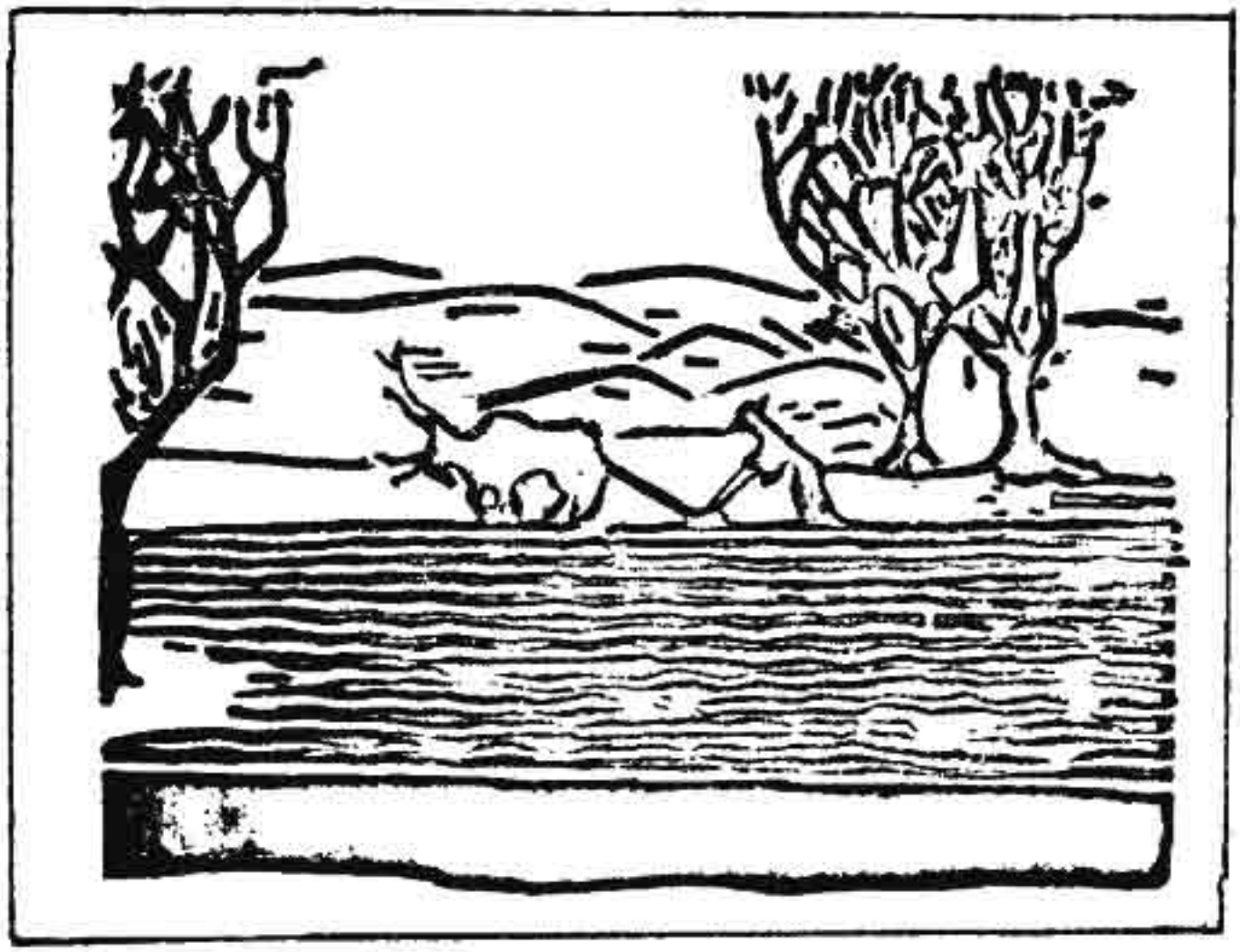
For mine-owners and other employers, African labour had an unexpected bonus. Because men came to the cities and industrial centres without their families, employers found that they did not have to pay the costs of supporting their families, or those of providing things such as housing. This naturally meant that the employers could make much greater profits. These high profits became a feature of the South African economy attracting much foreign investment.

This was the basis on which the South African economy developed; ie migrant labour and the retention of access to the means of subsistence by workers and their families, relieving the capitalists of the costs of paying for the reproduction

of the labour force. In this situation what was needed was a balance that would ensure that the black labourer was sufficiently dependent on wage labour to make it essential for him to offer his services to the capitalist, while at the same time ensuring that his family could meet sufficient of their subsistence requirements so that reproduction of the labour force would continue. In the early years the problem of securing sufficient labour tended to be the main one. Attempts to force black people onto the labour market included taxation by the settler and later Union Governments rents extracted by landlords, and the use of traders as labour touts. They advanced goods or money to Africans against their contracting themselves to work for a certain period of time on the mines.

At first a considerable number of blacks were able to avoid wage labour by exploiting new opportunities for making a cash income. Many went into transport riding, carrying goods from the ports to the minefields. Others expanded their production of food as the opening of new inland markets boosted the possibilities in this field. Although these activities showed that black people did not lack the enterpreneural spirit they were for the most part, to be short-lived initiatives. Railways put an end to transport riding and opened the interior to cheap imports of grain. White farmers, also aware of the possibilities,brought their political power into play to eliminate competition from black farmers. From early on white farmers improved their competitive position vis a vis blacks through gaining preferential access to credit facilities and agricultural support services.

In addition to this there has been a continued programme of price supports to agricultural products and a tariff structure on the railways that favours agricultural produce. With new markets opening up white landowners began to look to production rather than rents as a course of income. Tenants were evicted, and there was an attempt to convert those who remained into labour tenants rather than rent-paying tenants. After Union these attempts culminated in the 1913 Land Act. By restricting black land purchases to about 13% of the land it ensured that white farmers would not have to compete with blacks in land purchase. The latter were consigned to land which was for the most part isolated from markets by a lack of access to railways and with very few roads. Most of the land in black areas was under tribal tenure which facilitated subdivision amongst members of a growing population which increased problems of overcrowding. By converting all



tenancies into labour tenancies the Land Act ensured a supply of farm labour. Over a period of years it resulted in a large number of evictions from farms. The Reserve areas increasingly became congested with the influx of these people and as early as the 1920's there is evidence of pressure on land in some areas. Grazing lands were being encroached on for residential and agricultural use. In the 20's the Native Economic Commission warned of the danger of the Reserves becoming deserts. The ensuing underdevelopment of these areas and their declining productivity had been ensured and landlessness amongst black people assumed growing proportions. Evidence before the Natal Local Lands Committee in 1916 attested to the existence of people with no arable or grazing lands in the Reserves. These people were now faced with the prospect of depending entirely on migrant labour for their earnings, and their complete proleterianisation and urbanisation appeared imminent. Urbanisation amongst blacks had already occurred to a limited extent, but if it was to become the general pattern, the justification for cheap labour would disappear while a large black urban proleteriat would threaten political stability and demand housing and other expensive services. So in 1923 the Urban Areas Act was passed, the first in a long series of measures to attempt to control the influx of black people to the towns.

The high rates of capital accumulation in mining secured by the exploitation of black labour were used to subsidise the development of white capitalist agriculture. That is the secret of its growth and not the dynamic qualities of the white farmer. in the period 1910 to 1936 the State spent over £113m on agriculture. This can be compared with a total agricultural production in the period of about £910m. Thus about one eighth of the agricultural sectors' contribution to GNP was represented by State expenditure drawn mainly from taxes on gold mining.

After the coming to power of the Pact Government representing a coalition of national bourgeois interests with white working class support in 1924, State capital was used to promote secondary industrialisation. The aim was to decrease South Africa's dependence on the developed Western countries and create work for the flood of poor whites who had also been pushed off the land by the development of capitalist agriculture, as well as providing an economic base for the national bourgeosie. Following the 1922 strike the privileged position of white workers was entrenched by the Pact Governement in a number of legislative measures. The wage disparities between black and

white workers were given legislative protection and the latter enjoyed preferential placement in the expanding State sector of the economy. In this way the national bourgeosie secured the support of the white working class in maintaining their political dominance. State support for secondary industry has been mainly in the form of protection for infant industries through setting up tariff barriers and the promotion of a State capitalist sector in the area of heavy industry providing capital goods. This policy was made possible by the high profits derived from gold mining, which of course depended on the high rate of exploitation of black labour. After a rather shaky start in the 30's, manufacturing expanded rapidly during the Second World War when imports were difficult to obtain. In 1948 the contribution of secondary industry to GNP exceeded that of mining for the first time. This had remained the situation up to the present.

As time went on, the effect on the reserves was disastrous. The wage structure meant that there could be very little private accumulation by black people. Migrant labour absorbed the energies of the most productive members of the black population. There had been no significant attempts by Government to improve production in the black areas through education, extension services, the development of infrastructure or by making capital available. The Reserves had suffered from almos total neglect while population pressure increased rapidly. In addition these areas were expected to act as a convenient hold-all to which the unemployed, the aged, and the problems of social dislocation engendered by migrant labour could be consigned, further increasing pressure on their limited resources. Responsibility for these problems was given to the extended family, while what remained of the traditional hierarchy was propped up by the State and used to combat the growth of political movements which threatened the established system. The result was a rapid deterioration of subsistence production and its ability to supplement black wages. A substantial portion of the Reserve population no longer possessed any agricultural land. This was as high as 30% of the population in some areas by the 1940's.

On the basis of this evidence it is clear that underdevelopment in South Africa has its roots in the extraction of surplus from indigenous societies and in the exploitation of their labour. In the urban areas there had been a steady increase in the size of the black population and in the proportion of the total black population who were permanently urbanised, from

2,6% in 1911 to 24,3% in 1970 (a total of 4,989,000). These people came both from the reserves and the white farms. For black farm-workers conditions had steadily declined, reflecting attempts by white farmers to deprive them of grazing and arable land in order to put this land to use for their own production. The expansion of secondary industry during and after the war offered these people opportunities of finding work. The labour force in this sector of the economy grew from 207,797 in 1945 to 864,300 in 1970.

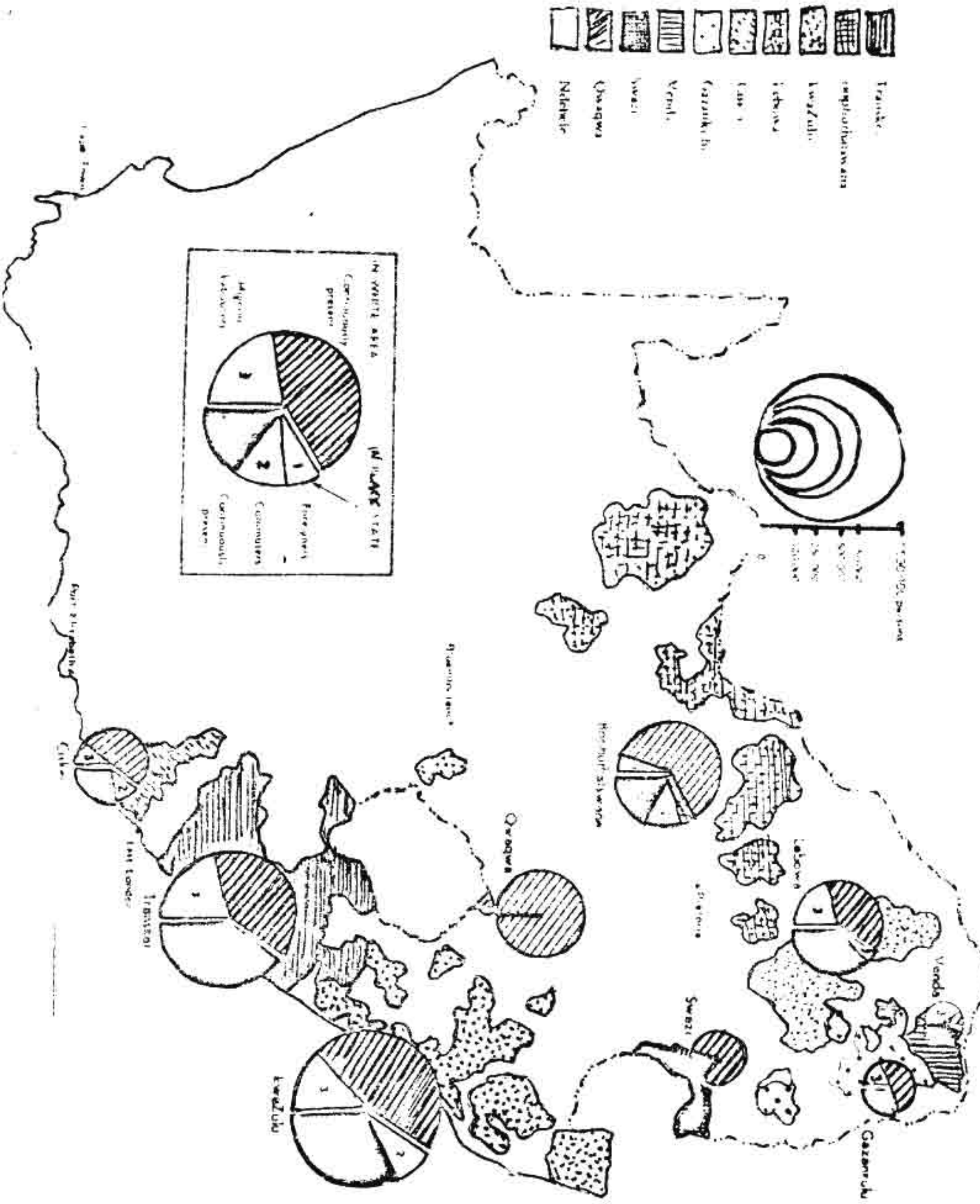
Urbanisation and industrialisation led to an increase in political conflict and industrial action in the 1940's as the black proleteriat and petit bourgeosie increasingly demanded the satisfaction of their needs and aspirations in the urban areas. The response of the ruling United Party was to propose a relaxation of restrictions. They took the view that the growth of secondary industry required a permanent black labour force who would satisfy the demand for semi-skilled workers. The Smit Committee of 1942 recommended a gradual phasing out of migrant labour and the abolition of the pass laws. Social welfare legislation would be extended to black urban workers and there was talk of recognising black trade unions. The complete disappearance of migrant labour was not contemplated. The mines, for instance, would continue to use migrant labour. The Government proved reluctant to tamper with existing institutions and little came of these liberalising tendencies. Nevertheless the discussion of such possibilities was a threat to the position of white workers whose living standards depended on restricted access to skilled work and the protection of those skills from erosion through job reclassification and fragmentation. For nascent Afrikaner capital and petit bourgeois groups it meant the threat that high levels of capital accumulation would be denied by increases in labour costs. The new National Party Government after 1948 acted to secure their interests.

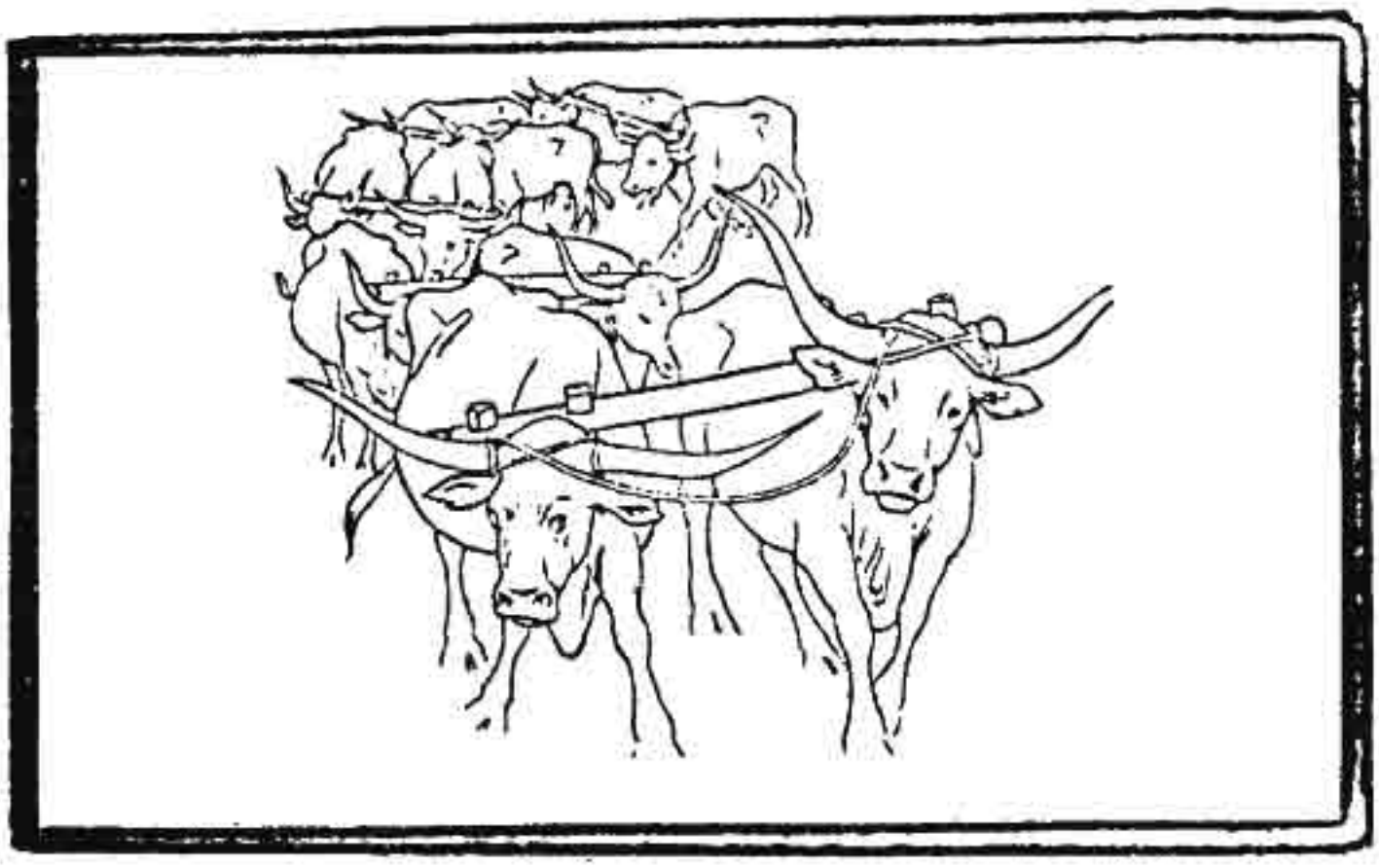
Apartheid,based on the assumption that economic integration would lead to political integration,aimed at the exclusion of all blacks from the white area, except those blacks on whose labour the economy was dependent. Even these people were to be denied any permanence there. Instead they were to be encouraged to develop their own areas. As time went on separate political institutions came to be seen as the guarantee of Afrikaner self determination.

In this situation the Apartheid regime had acted to maintain

BLACK LABOUR FORCE

INSIDE AND OUTSIDE THE BLACK STATES, 1970





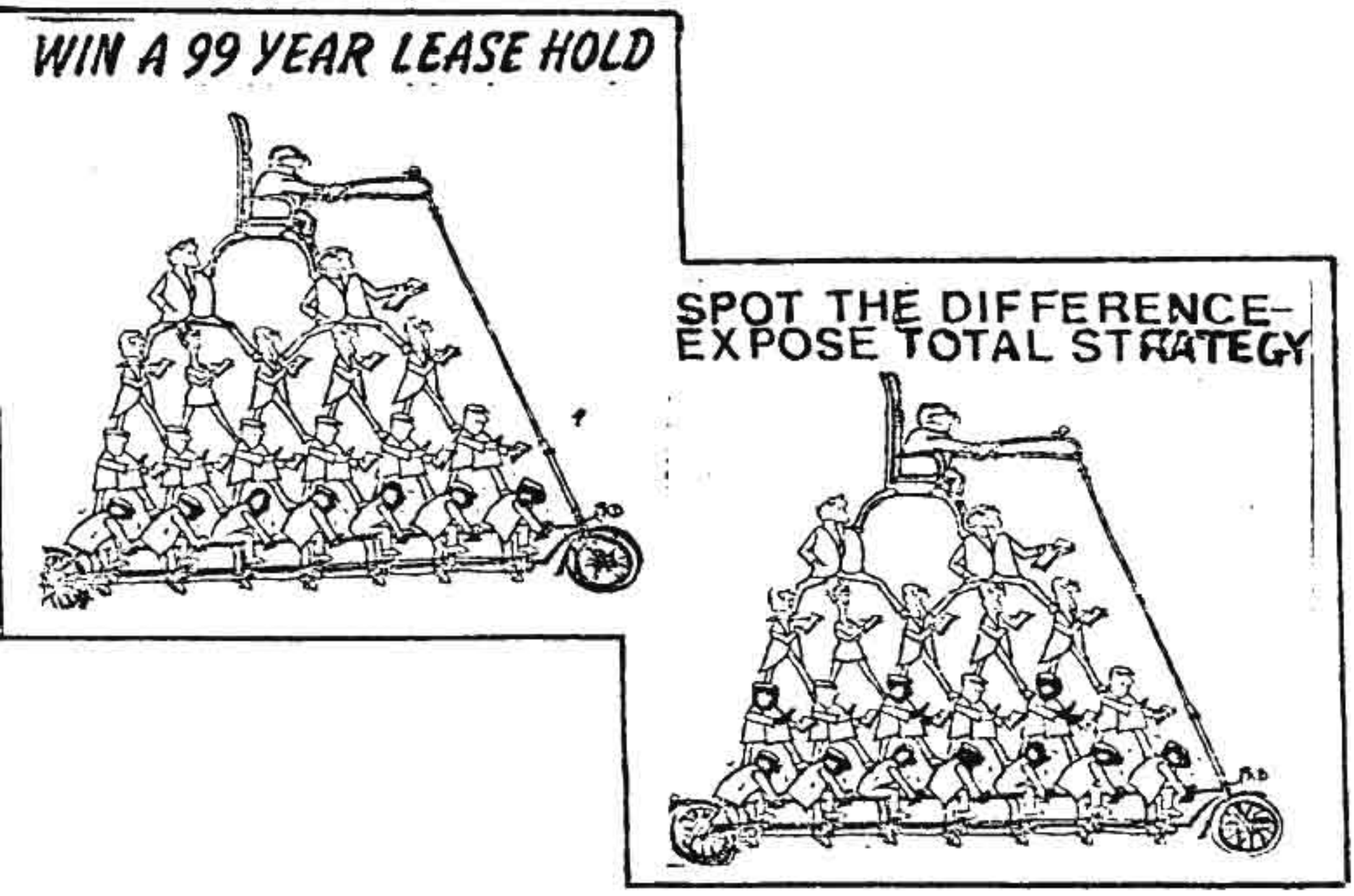
Cheap labour power and the high rate of capital accumulation as the labour force becomes increasingly proleterianised, dependant solely on wages as a source of support. To enable capital accumulation to continue at a high level it is essential that the subsistence requirements of the black labour force be kept as low as possible. At the same time there is an interest in promoting the growth of a more well to do black middle class.

The maintenance of low subsistence levels amongst black workers requires the use of institutional arrangements backed by coercive measures to eliminate attempts to secure an improvement in the black workers' economic condition. In the white areas this has meant a tightening of influx control measures and of their enforcement in the hope of removing all those blacks not essential to the economy from the white areas. Along with this has gone new machinery to direct the flow of labour and to ensure an adequate supply of farm labour. Industrial decentralisation aims to create conditions in which capital can continue to expand and accumulate while at the same time avoiding the problems of further concentrations of black workers in the established industrical centres. To promote decentralisation various tax breaks are offered to capitalists who move enterprises out to the border industrial areas. In addition it is pointed out that in these areas;

> "The great advantage for the entrepreneur is the availability of Bantu labour and the absence of restrictions in making use of that labour ... use can be made of large numbers of Bantu women to meet the shortage of unskilled labour ... (and entrepreneurs can) pay skilled and semi-skilled Bantu lower wages than they would be compelled to pay them at the moment ... and a classification of a large number of posts as semi-skilled might likewise lead to lower wages."

In fact wages in these areas range between 45% to 60% of those for equivalent work in the established industrial areas. The existence of large numbers of unemployed helps to keep wages down and to keep workers docile.

By creating independent Homelands separate from the white areas, low levels of subsistence can be justified by comparisons with other underdeveloped nations. Publications sympathetic to Government policy stress this comparison at the expense of comparisons with the high living standards of white South Africans. Capital as a whole benefits from these attempts

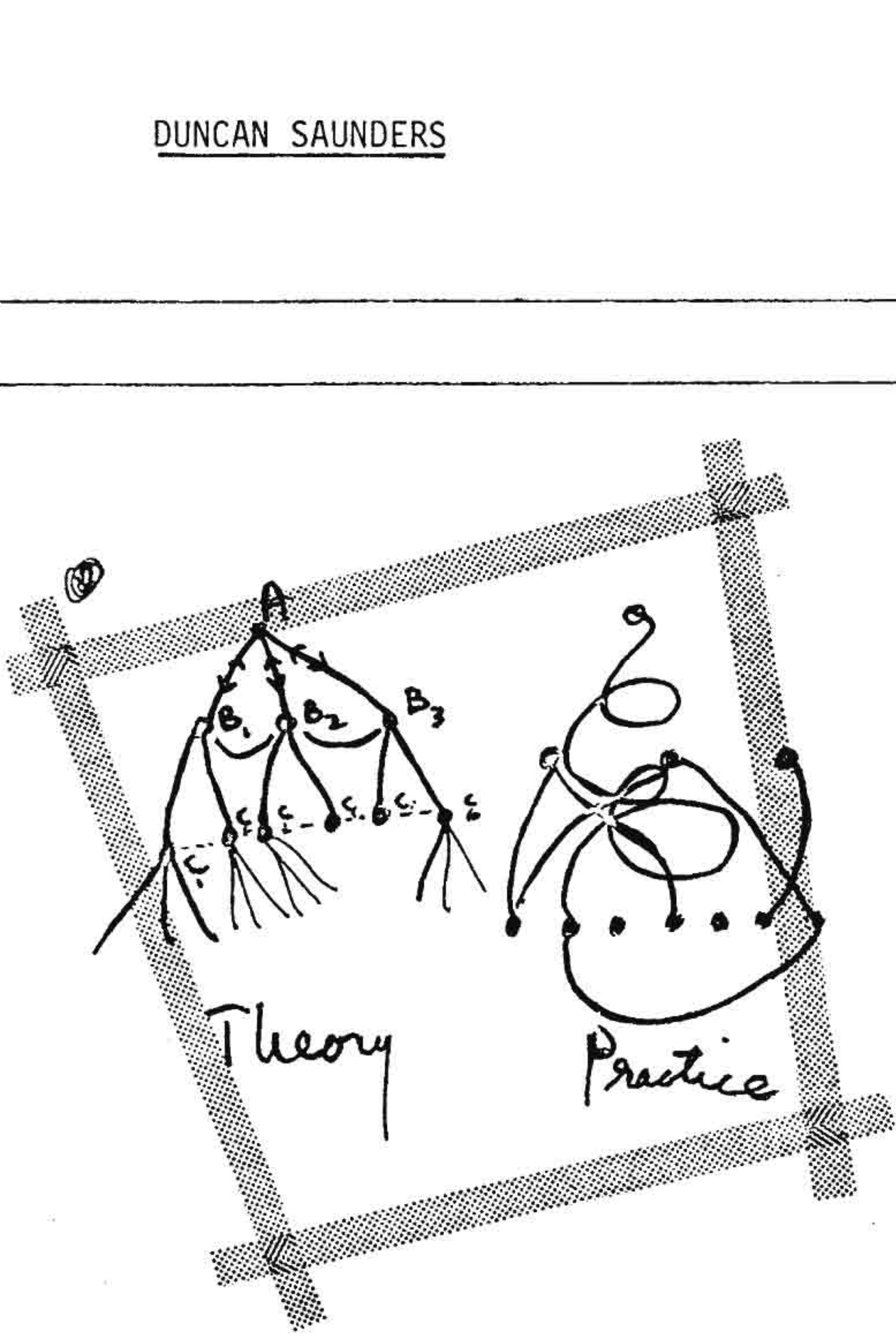


to keep black wants tothe lowest possible level. Calculations such as the poverty datum line and the minimum effective level, (whatever the stated intentions behind them), play an important part in justifying and maintaining the wage differential between black and white.

At the same time there has been an attempt to displace Black political aspirations to the Homelands. Development policy in these areas has been aimed at the creation of a black bourgeoisie who could be relied on to promote the "free enterprise system" and support the Homeland political elites. Their dependence on cheap labour would ensure their sympathy to the interests of capital in Southern Africa as a whole. Chronic shortages of capital and disposable income have severely limited the effectiveness of this policy. Black businessmen have resisted attempts to consign them to the underdeveloped areas and persistently demanded the right to share in the exploitation of the wealtheir markets in the established urban areas. In this endeavour they have been supported by elements of white capital concerned to defuse unrest in these areas by the creation of a stable black middle class. By promoting interests such as home improvement they hope that these individuals will be persuaded not to consider too deeply the lot of black workers and the unemployed in the Homelands. That this strategy bears some hope of success is shown by a statement in the "Rand Daily Mail" of April 4, 1978. Bob Hitchcock, Race Relations Correspondent of the newspaper talks to a group of Soweto's elite. One of them characterised as a tough talking insurance consultant has this to say on influx control. "It's a matter of numbers. I don't want Soweto flooded out any more than it is with jobless blacks from hell-and-gone". Well that is the opinion of one man, and one cannot say how pervasive an attitude it represents. It is therefore clear that development work in the Homelands or in the urban areas faces the constant possibility of strengthening the classes who profit from the exploitation of cheap labour in Southern Africa. Development of this nature can only extend the present inequalities, and by strengthening class alliances across racial barriers give them a greater validity.

USES OF EPIDEMIOLOGY IN SOUTH AFRICA

DUNCAN SAUNDERS



USES OF EPIDEMIOLOGY IN SOUTH AFRICA.

The aims of this article are :-

1. To introduce some perspective on the use of epidemiology.

2. To encourage greater use of epidemiology by those interested in the health of the people of South Africa.

WHAT IS EPIDEMIOLOGY ?

The epidemiological study of disease has a long history - one as old as medicine itself. However, it is only comparatively recently that epidemiology has become a recognised discipline.

Modern epidemiology began in the nineteenth century with the study of infectious disease epidemics. An example is John Snow's investigation of an outbreak of cholera in London in 1854. He demonstrated by careful investigation that the epidemic was associated with contaminated water supplied by one of the water companies which served the city. His achievement was all the more remarkable if it is borne in mind that it occurred ten years before Pasteur discovered bacteria. Today, a pub stands at the site of the pump, the handle of which Snow is said to have removed, thereby stopping the epidemic.

Since then the scope of epidemiology has broadened considerably to include the following aspects of population health problems :-

(i) The size of the health problem (how much of a health problem is there ?).

(ii) The determinants of a health problem (what factors are associated with the health problems ?).

(iii) The evaluation of measures taken to improve health (Whether an action or treatment works or not ?).

By a population is meant any group of people with something in common, e.g. living in the same geographical area (e.g. population of Cape Town) or people suffering from a certain disease (e.g. Epileptics).

When the term epidemiology is used in this article we mean the method of looking at population health problems rather than the body of knowledge about population health problems resulting from the application of the epidemiological method. Therefore epidemiology is a way of obtaining or assessing evidence about population health problems.

Over the years various principles have been developed which form the basis of the design of epidemiological studies. Study designs appropriate to answering each of the questions listed above have been developed based on these principles. Epidemiologists are in general agreement about the validity of these study designs. The studies can be characterised as fitting into one of the following broad categories :-

(i) A descriptive study is concerned with ascertaining the size of a health problem.

(ii) An analytic study is done to find out the factors associated with a health problem.

(iii) An intervention study is done to find out whether an action or treatment has the desired effect.

ISSUES RELATING TO EPIDEMIOLOGICAL STUDIES.

Before mentioning examples of epidemiological studies it is worth considering some issues relating not to the design of studies but to the decision whether or not to undertake a particular study. These issues are often socio-political.

1. What harm can the study itself do ?

There is increasing awareness of the harm that medicine can do (1) (iatrogenesis). This is not confined to side-effects from treatment (e.g. deafness as a result of streptomycin treatment) but can also be in the form of less obvious effects such as overdependence and anxiety. An example of this is the morbidity caused among children with innocent heart murmurs who falsely perceive themselves to have heart disease (2). Also

if one "labels" a person as having a disease without there being provision made for treating it, the person may well be worse off than before. In this respect the adage - no survey without service - is worth remembering!

2. Will the study obscure real causes of health problems ?

The root causes of major causes of ill-health are socio-political. Epidemiological surveys may tend to blur the issues and create the impression that something is being done while the root causes remain unchanged. A lot of the research into protein energy malnutrition falls into this categary.

3. Is a study necessary to help one decide on a cause of action ?

Does one need to show that poor housing conditions are associated with a greater prevalence of certain diseases (e.g. Tuberculosis) before housing is improved? Is adequate housing not a right needing no justification on grounds of measurable morbidity ?

4. Are there more pressing questions that need to be answered?

In health care we are concerned with allocation of scarce resources. Epidemiological studies can help us make these decisions. At the same time we need to consider which areas need investigation most urgently. A National Heart Effort has been initiated by the South African Medical Research Council to combat the epidemic of ischaemic heart disease in South Africans. The initial research effort will cost more than 1 million rands. This will be raised by public subscription. While ischaemic heart disease is obviously an important health problem, is it not as important to evaluate interventions aimed at reducing the high mortality rates of Black infants in this country?

At present in South Africa these decisions are made by health professionals and politicians non-representative of the majority of the people. Therefore it is not surprising that the questions being studied are not those relevant to the problems of the majority of the people.

5. Are the results of academic use only or are practical steps going to be taken to use them to make policy decisions ?

A study of Soweto children in 1972 (3) showed one of the highest prevalence rates of rheumatic heart disease in comparable studies anywhere. However, up to now,no co-ordinated steps have been taken to deal with this problem. Meanwhile in nearby Johannesburg an enormously expensive hospital has been erected.

These considerations may appear to be negativistic and may act as a disincentive for one to undertake any studies. However, useful studies, many not costly in terms of time and money, can be done. The next section describes some of the ways in which epidemiology can and has been used.

USES OF EPIDEMIOLOGY.

It is useful to distinguish between studies where a community is the population being studied and those where patients of the health service are being studied. In the former one hopes to collect information which can be used to improve the health of the community. In the latter one hopes to benefit the recipients of the service by using the information to reorganize the provision of the services.

(i) Health Service Based Studies.

A practice profile study e.g. the Cape morbidity survey (4) describes the pattern of illness seen by the service. The collection of these data can be incorporated into the running of the service. Knowing the relative frequency of the conditions one may be able to make more rational decisions about the allocation of staff and resources. The above study described the pattern of diagnoses of 15 general practitioners over a period of 12 months. Its findings were to be used for training medical students in primary care.

By evaluating differences in radiological assessment (5), prescribing habits (6) and the use of special investigations (7) by different staff members, one can provide information that may be useful for promoting discussion on the optimal use of drugs, x-rays and special investigations.

For conditions requiring long term treatment (e.g. hypertension or tuberculosis) it is important to know whether patients take their treatment regularly. A study done in Johannesburg (8) showed that less

TABLE 1:

AGE SPECIFIC MORTALITY RATES OF DIFFERENT POPULATION GROUPS IN THE R.S.A. (1970) - (DEATHS PER 1000 POPULATION).

	AGE (YEARS):								
	INFANT	-1	1-4	5-14	15-24	25-34	35-44	45-54	55-64
WHITES	21,6	22,7	1,1	0,5	1,5	1,7	3,8	9,0	20,1
ASIANS	36,4	41,4	3,6	0,8	1,4	2,3	5,6	14,5	33,9
COLOUREDS	132,6	139,4	14,7	1,2	2,7	5,1	8,8	17,0	31,2
BLACKS	123,9?	135,8	15,6	1,4	3,0	4,9	8,3	15,3	27,7

than a third of diagnosed hypertensives were still returning for treatment at the end of one year. The above study also looks at the problem of lack of standardization of management of patients.

Apart from evaluating how we are providing health care, we can also evaluate whether health care does any good. This requires more complex methods, ideally randomized controlled trials. Probably in South Africa this kind of study should be mainly concerned with evaluating ways of improving the effectiveness of already tested drugs and techniques e.g. testing new strategies for improving compliance of anti-hypertensive drugs (9).

Many health service based studies can be done from routine patient records if these are accurately kept.

Population Based Studies.

In order to estimate the extent of health problems in a community one may use statistics already routinely collected. Wyndham and Irwig (10) have analysed the mortality rates and causes of death by age, sex and ethnic group in South Africa from official death and census statistics.

The age specific mortality rates are shown in Table 1.

About half the deaths in the Black and Coloured populations occurred in the children aged 0-4 years. In addition gastro-enteritis and pneumonia were shown to be the cause of death in 60% of Black and Coloured infants and children. The implications for health planning are obvious. Kustner (11) showed the trends in typhoid fever, tuberculosis, poliomyelitis and malaria from official notifications.

However, one may need more accurate data than can be collected from routinely collected statistics and then one needs to do special surveys.

Examples of studies of this kind are :-

(a) A study to determine the prevalence rate of rheumatic heart disease in Sowetan Creche and primary school children (3) showed an extremely high overall privalence rate of 6,9 per 1000.

(b) A study to determine the extent of malnutrition of young children (12).

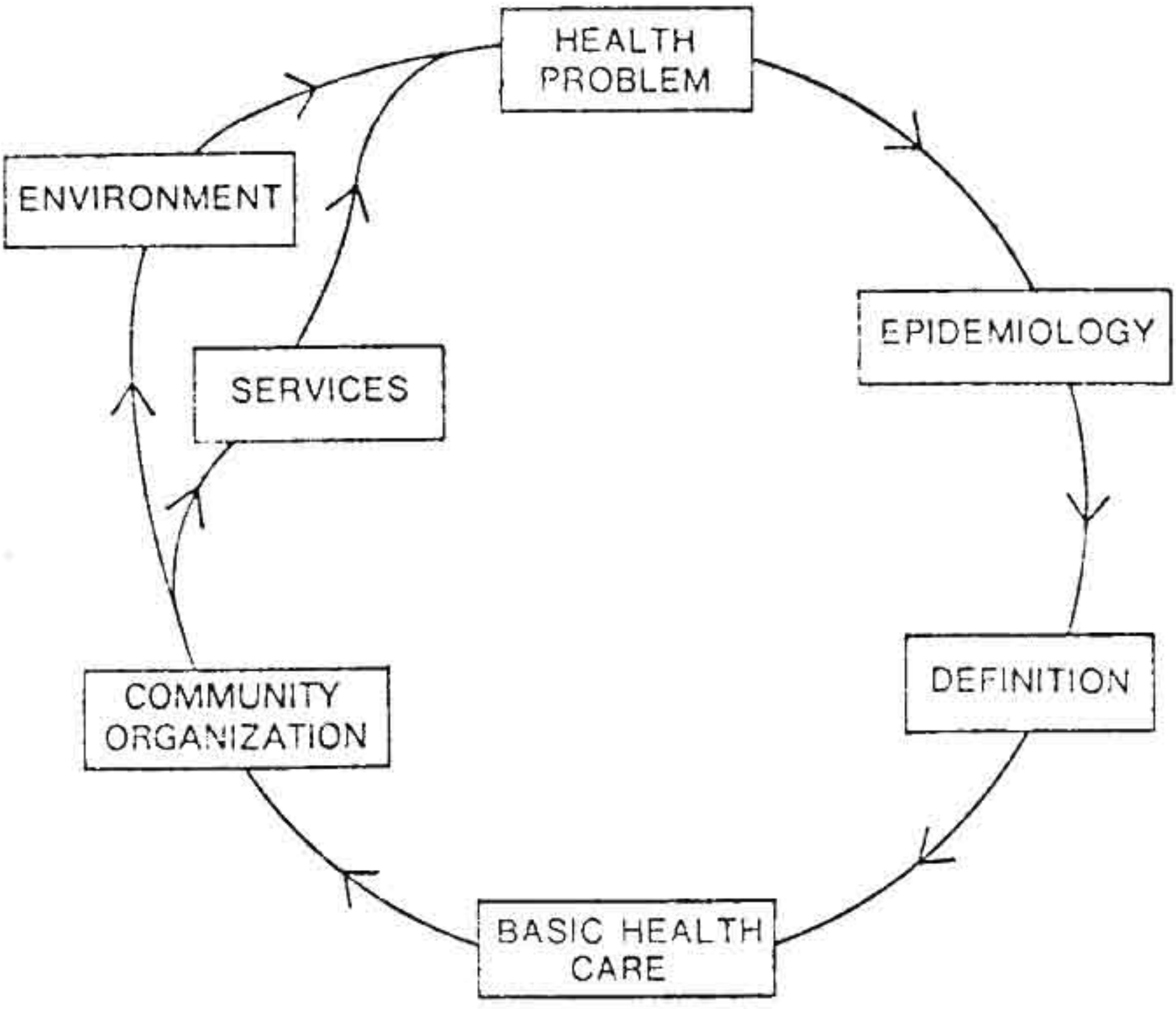


Fig. 1.1. Flow diagram illustrating the relationship between epidemiology, community organization, and basic health care.

Taken from: Basic Health Care in Developing Countries
An epidemiolocical perspective
Edited by Basil S.Hetzel

In addition one can do surveys to evaluate the impact of health interventions.

Sutter and Ballard (13) reported that voluntary health workers were effective in the control of trachoma. Kark and Cassel (14) reported health improvements which could be attributed to a health programme.

Epidemiological studies may be difficult and costly. However, many can be done without great expertise and at little cost. For instance, from routine clinic records it is easy to see whether hypertensive patients are coming back for treatment regularly and whether their blood pressures are controlled.

In the next issue of Critical Health, the design of a Descriptive Study will be discussed. References mentioned in this article appear below. A short bibliography also appears at the end of this article for those who want to read more about epidemiology. If people are planning studies and feel they would like to discuss it with a person with some epidemiological experience, a resource person can be contacted through the editors of Critical Health.

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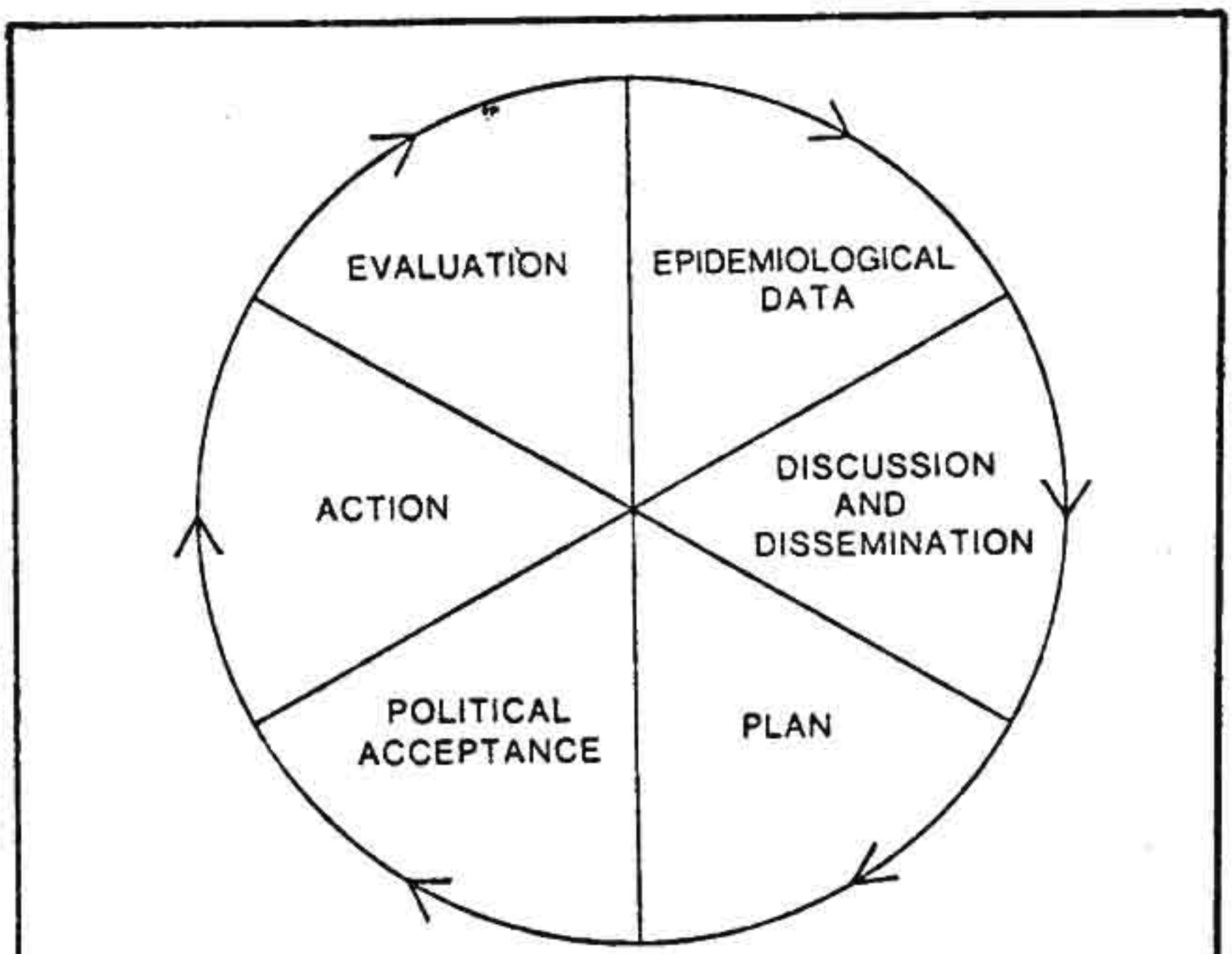

Fig. 1.2. Model of the social process linking epidemiology to basic health care.

Taken from: Basic Health Care in developing Countries
An epidemiological perspective
Edited by Basil S. Hetzel

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OR

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OR

BUILD MORE THAN SIX BASIC HEALTH CLINICS

OR

YOU CAN SPEND IT CELEBRATING THE END OF HEALTH YEAR !

A banquet extravaganza

By TONY STIRLING
Chief Reporter

RDM NOV. 24 '79

THE DEPARTMENT of Health's banquet at a Johannesburg hotel this week to mark the end of Health Year staggered many guests — they estimated it cost about R30 000 of the Health Year budget.

One guest said "I was disturbed. I thought the money left in the Health Year budget should have been spent on a worthwhile public health project instead of being lavished on a function like that".

The food and drinks bill was estimated at about R10 000, but one source estimated the "trimmings" added on another R20 000.

● About 420 people attended the function in the Carlton Hotel on Tuesday night;

● Each male guest received a pair of 9ct gold plated cufflinks carrying a Health Year motif. The women received silver pendants. The gifts were wrapped in special wrapping paper;

● The menus for the function were three pages long and printed in gold lettering. Each menu contained a leather book marker, engraved with gold lettering;

● The dinner itself was described by the Carlton as a "R15,45 a head menu".

It consisted of Avocado Ritz, soup, a health salad, lamb, desert, biscuits and cheese and coffee. South African wines, liqueurs and sherry were also served.

● A number of works of art, commissioned by the department from various artists, were unveiled.

● Gifts were made to the Minister of Health, Dr L A P A Munnik, and his predecessor, Dr Schalk van der Merwe, of prints of the art works commissioned by the department.

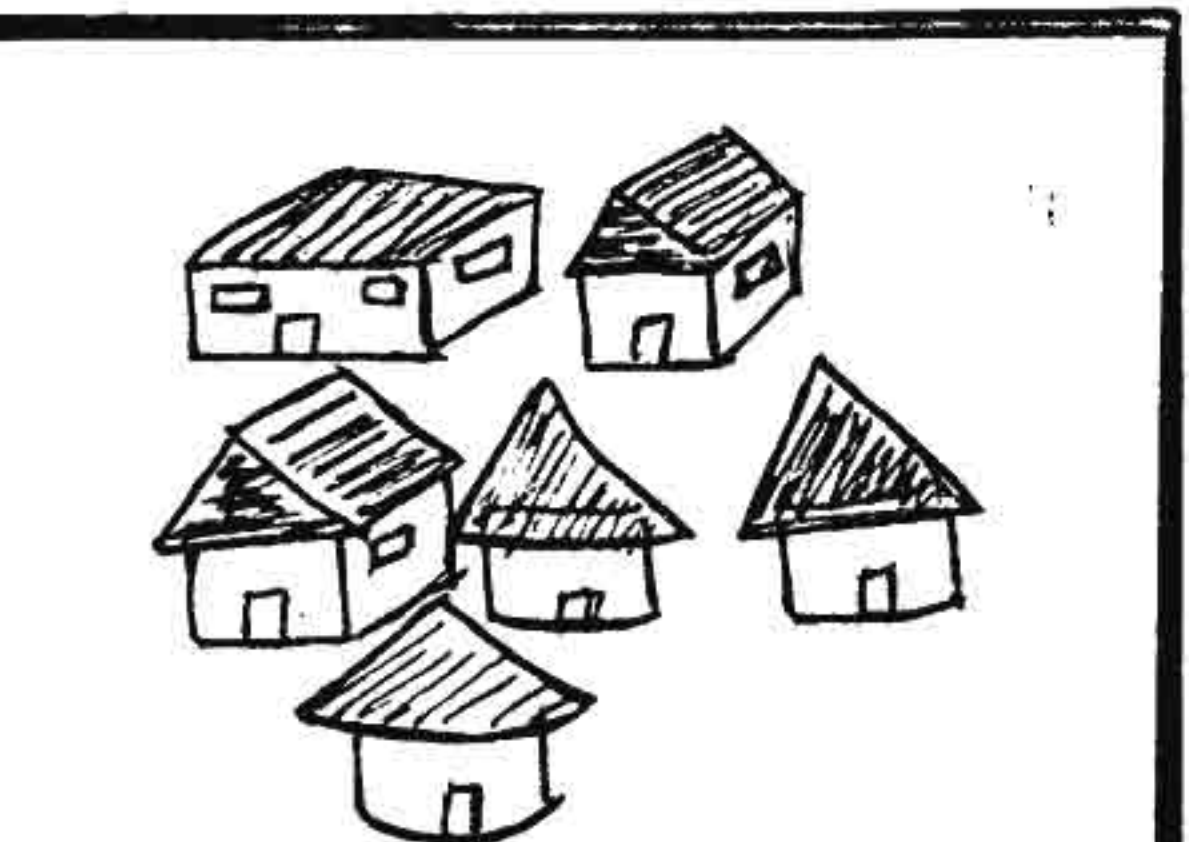
While many critics of the banquet praised what had been achieved by the department in its Health Year programme, the "extravagance of the occasion caused raised eyebrows".

Dr J de Beer, the Secretary for Health, said last night he did not know the cost of the function but confirmed it was paid for by the Department of Health.

He viewed the banquet as a small gesture of appreciation for the voluntary workers who had put in many hours of work to make Health Year a success. The department had received many messages of appreciation for the function.

It was 'a small gesture'

From Page



EPIDEMIOLOGY SOUTH AFRICAN STYLE.

Dr. Grove the director of Hospital Services in the Transvaal was recently questioned about the shortage of hospital facilities for blacks in Soweto :-

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The Star Tuesday January 8 1980 13

Q: What is the acceptable ratio of doctors to patients (not beds) in white hospitals in the Transvaal? What is the ratio in black hospitals?

Dr Grove: "There is no ratio of doctors to number of beds or number of patients. The total time spent by doctors in all their activities is taken as the criterion for the number of posts of medical doctors to be created. There is no difference between standards applied to different races of patients."

Q: What is the acceptable ratio of nurses to patients in white/black hospitals in the Transvaal?

Dr Grove. Staff allocation is not done according to a fixed ratio. In both white and black hospitals, the nursing staff for each ward is determined according to the discipline and activity in the ward based on a set of norms applicable to all hospitals.

Q: How many general practitioners are there in private practice in white areas in the Transvaal? In black areas of the Transvaal? In Soweto?

Dr Gove: No replies to these questions can be furnished.

Q: What are the major illnesses in the white population of the Transvaal?

Dr Grove: We don't keep statistics on this.

Q: What are the major illnesses in the black population of the Transvaal? In the black population of Soweto?

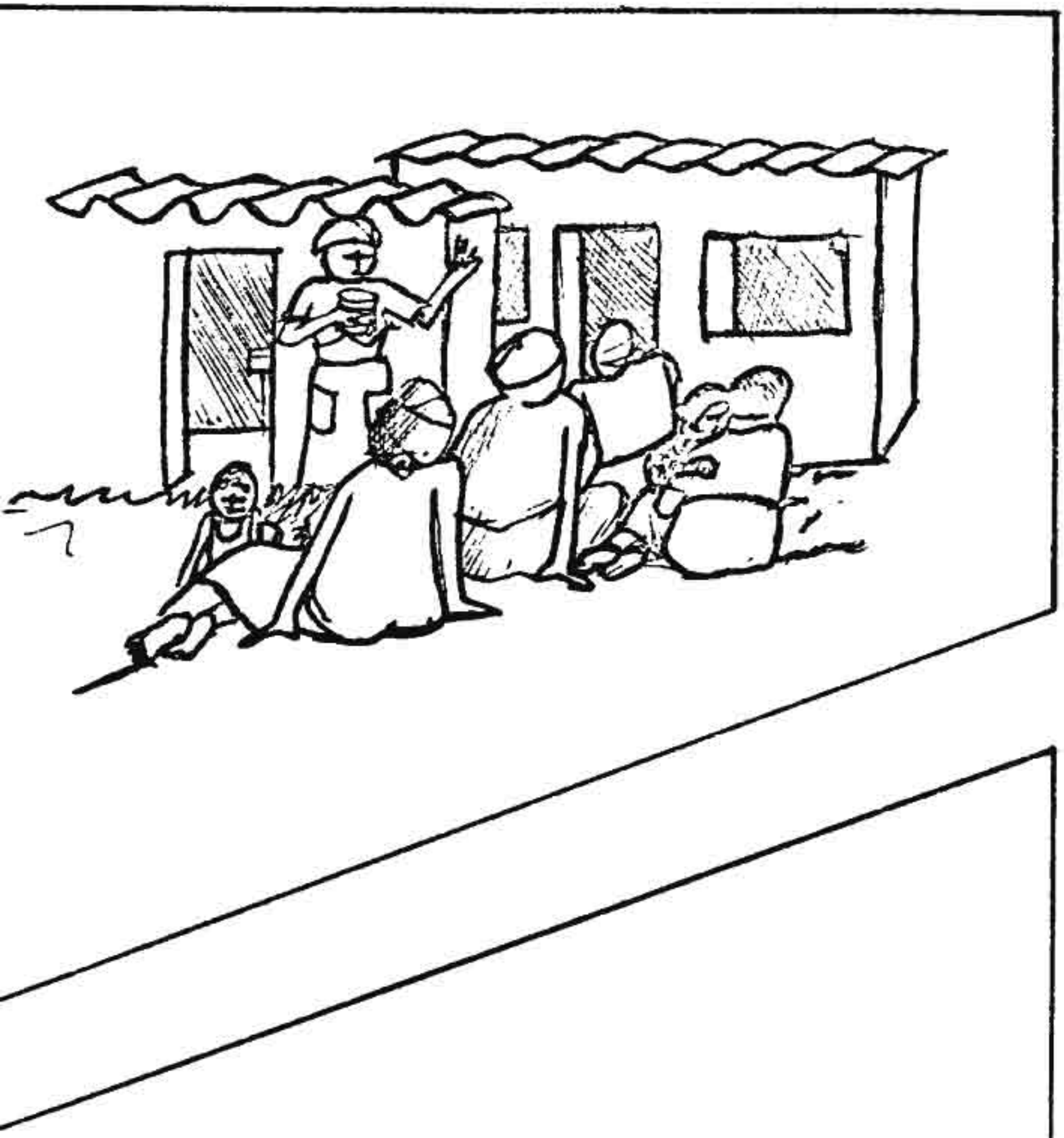
Dr Grove: We don't keep statistics on this either.

Q: Do these illnesses necessitate different forward planning for the different groups? If so, can you please expand?

Dr Grove: Falls away

Q: How much has the Government spent on white hospitals in the Transvaal in the past ten years? How much has the Government spent on black hospitals in the Transvaal in the past ten years?

Dr Grove: This department cannot comment on the spending by the Central Government on non-provincial hospitals. The Provincial Administration is responsible for expenditure on provincial hospitals. Most of the provincial hospitals in the Transvaal are multi-racial and expenditures by these hohpitals in respect of the white and non-white sections are not kept separately. Expenditure by these hospitals on medicines provisions, electricity and water supply is not allocated to the white and non-white section separately.



PRIMARY HEALTH CARE
NEW MUSIC - OLD HARMONY

BY MARIT KROMBERG

PRIMARY HEALTH CARE

NEW MUSIC - OLD HARMONY

COMMUNITY PARTICIPATION IN DECIDING ON AND SUPPORTING PREVENTATIVE HEALTH PLANS

The concept of primary health care now espoused by the World Health Organization (WHO) and the UN Children's Fund (UNICEF) has resulted from the conflict between the need to reach all the people with health care and the scarcity of resources available for health in most developing countries. Identified as a root cause of the inadequate care in less developed countries is the fact "that their patterns of medical care and education of health personnel are copied closely from the Western countries" (Health and the Developing World, J. Bryant).

With the entry of WHO into the arena, primary health care has received a new boost. A vast army of researches, health and development planners, with WHO, UNICEF and the World Bank in the vanguard, are seeking new formulae, new policies and approaches and new projects through which all people may achieve better health. The seven principles formulated and revised by WHO in 1975 have been accepted by most agencies and institutions as guidelines:

* Primary health care should be shaped around the life patterns of the population it should serve and should meet the needs of the community.
* Primary health care should be an integral part of the national health system, and other echelons of services should be designed in support of the needs of the peripheral level for technical supply, supervisory and referral support.

* Primary health care activities should be fully integrated with agriculture, education, public works, housing and communications.
* The local population should be actively involved in health care activities to match health care with local needs and priorities. Community needs require a continuing dialogue between the people and the services.
* Health care should rely on available or untapped community resources.
* Primary health care should use an integrated approach of preventive, promotive, curative and rehabilitative services for the individual, family and community. The balance between these services should vary according to community needs and may well change over time.
* The majority of health interventions should be undertaken at the most peripheral practicable level of the health services by suitably trained workers.

The overall goal is better health. Old patterns focusing on hospitals and advanced technology are largely irrelevant for developing countries and, in fact, often not very suitable for the countries where they originated. In its search for an appropriate health technology the WHO has made another discovery: Health is political! As Halfdan Mahler, WHO Director-General, declared in 1976 to the World Health Assembly: "For all the speed with which disease technology has been flourishing in recent years, it has been failing in its purpose because the social, economic and political contexts in which it is being applied have changed. The extension and refinement of this technology on the one hand and its increasing complexity and cost on the other, have led to a contradiction between the technical potential and the socio-economic ability to apply it to all who need it."

This, however, is not the only contradiction, and I would like here to examine a number of assumptions underlying present attempts at improving the

health of the underprivileged masses of our world.

The first assumption is that health care produces health. To contradict this there is evidence put forward by such sober organizations as the World Bank, that socio-economic conditions have a much more profound influence on the health of a population than the health service. In preparation for a WHO Conference on Recent Trends in Maternal and Child Health in Europe (Moscow 1974), a survey was conducted where European national programmes were given a score for quality of care, on the basis that the more varied the items which a service offered and the larger the number of people who use it, the higher the score. The scores were plotted against maternal and perinatal mortality statistics for the same European nations, but high scores on quality of service did not automatically correspond with low mortality, except in countries with a high standard of living.

Although most speeches, papers and projects now emphasize the importance of socio-economic conditions and stress the need for intersectoral integration, the political implications of this are seldom pursued. If unfavourable socio-economic conditions are seen as the fate of the losers in a competition for resources and power at the various levels (international, national and local); it may not be an easy task to persuade the winners to give up their privileges. Instead we find health planners taking upon themselves the task of developing health care which will compensate for the unfavourable political environment without creating any disturbance. We find institutes of development studies attempting to develop a set of indicators with which to assess the "quality" of health care, basing the evaluation on cost-benefit analyses of the relationship between services provided and measurable health changes resulting from them! It is a relief, then, to come across admissions such as the following from an address by Cvjetanovic to the Ciba Symposium Human Rights in Health, 1973: "I shall ignore the unquantifiable aspects of different socio-economic systems

and their respective merits and disadvantages for health. These are indeed of great importance, but at present we lack a methodological framework to do them justice."

I would like to argue that the methodological framework is lacking because we are afraid to face up to the challenge of the "unquantifiable". The result is that most health planners draw attention to the social, economic and political factors, and then go on to ignore them.

HEALTH CARE DOES NOT PRODUCE GOOD HEALTH.

Health care does not produce good health. The most we can expect from an effective health service is good care, while the need for care is determined by other factors, most important of which may be the extent of poverty and the ideology of the prevailing economic policy. But even effectiveness of care is a questionable concept where there is poverty. There is an unresolved conflict of interest between those who have power, money and knowledge and those who have none. In communities where disease is related to poverty and injustice, it is a mistake to believe that an "effective" health service can be neutral. If we hesitate to take sides, if we refuse to identify with any interest group within the community, we shall inevitably be co-opted by the strong necessity to serve their interests. The second assumption, that health care can be politically neutral, is not valid.

The reality of the conflict between the haves and the have-nots also contradicts another assumption, that a poor, rural village is a homogeneous, harmonious community. Unless profound political changes have been introduced on a national scale in order to counteract oppression of the weak by the strong, rural villages consist of several communities, divided by age, sex, status, religion, caste and class interests. The health sector has failed to transcend these divisions in the past, and every new project or policy which refuses to

accept the existence of such a conflict runs the risk of repeated failure. Again and again it has been found that communication across class divisions is not possible. The idea that the local population should be actively involved in the formulation as well as the implementation of health care activities through a continuing dialogue between the people and the services is unrealistic in a class-structured society.

Some 10 years ago, the response to projects which promised to lift the poor out of their poverty might have been enthusiastic co-operation, even competition among the poor, until it became clear who were the real proprietors, who were in fact benefiting. In all cases where the poor did not benefit, non-co-operation and apathy replaced the original enthusiasm. Repeatedly bitten, now shy, the spirit of self-help is hard to find.

DANGERS OF CO-OPTION.

A WHO/UNICEF study found that several successful health care programmes had developed a new type of health auxiliary, now known as village health workers or "barefoot" doctors (embodied in WHO principle No. 7). (See Development Forum, May 1978). Apart from the fact that they are cheap and easily trained in adequate numbers, this type of health worker has been seen as a tool to help overcome traditional barriers of communication. Some succeed and some fail. Evaluators assess basic qualifications, selection criteria, effectiveness of training and supervision, but the following example illustrates another aspect.

Since 1970 a type of village health worker, the Family Welfare Educator (FWE) has been trained in Botswana. For several years I was very closely associated with the programme in which I had considerable faith. We rejected the idea of recruiting volunteers, since we wanted workers to come from the poorest families, who would by definition need to be compensated for the loss of the economic activity of this member.

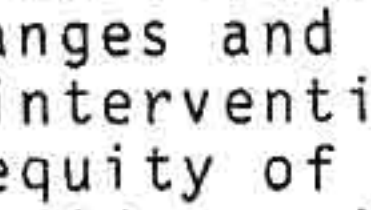
The problem then was how to pay them. As daily paid casual labourers they would have no guarantee of permanent employment, no rights to holidays or sick leave, they would receive no increments for experience, and at the end of their working life they would "retire" without any pension. In all these respects they would be no different from the majority of the rural population, but we felt that it would be unrealistic to expect FWEs to accept such conditions after training when no one else had to. The pre-service training lasted only 11 weeks, but experience and supervision over several years would mean indefinite on-the-job training.

On the other hand, the leap from payment as casual labourer to the lowest rung on the ladder in local government service involved multiplication of the monthly salary by a factor of three, as well as the introduction of a number of other privileges. Over the years the differentiation in rural incomes has increased, and FWEs are extremely well paid today. This means that FWEs identify with the bureaucratic class now, and no longer with the rural poor. There is also considerable competition to be selected for training as FWEs, which the better-educated daughters and nieces of the richer families often win. FWEs are now saying that the poor are extremely "difficult to understand", as well as unco-operative.

Lifted out of the context of poverty and co-opted into the bureaucratic structure, FWEs have lost their identification with the people they are serving, and therefore their effectiveness as a vehicle for change. The effect of the status promotion of the FWEs has been to depoliticize health once more, and render rural health care innocuous in political terms, but perhaps at the cost of decreasing effectiveness.

The invention of the village health workers is thus no guarantee that a project will have any relevance to the hitherto underprivileged. The language, socio-economic background, education and training of the village health workers are not decisive for their effectiveness in communica-

ting with the poor. The basic question is whether they are identified with the deepest aspirations of the underprivileged, and whether the political system in which they work will permit such identification.



co-operatives and workplaces

HEALTH IS POLITICAL.

My argument with the new policies for a more equitable distribution of health resources is that although the vocabulary and the technology have changed, it is not intended that anything else shall. Health is political. It has to do with the fair distribution of the basic requirements which make health possible, and it is unrealistic to expect that effective measures for change should be adopted by a class or a government which profits from the present bias in distribution. Or in the words of C. Elliott in his book "Patterns of Poverty": "Ruling groups have little incentive to undertake the structural changes and the budgetary cost of the kind of direct intervention that is usually required to secure equity of access for the excluded, as long as confidence in the (existing structure) is maintained. When it breaks down - there is an incentive to set in train no more than sufficient change to restore confidence in the system."

The world-wide concern about the inadequacy of the old system of health care is an indication of a certain amount of lack of condifence on the part of the consumers. The present level of ill health in the world is a threat to the groups in power whose prestige is being undermined, and whose own lives are at risk from potential epidemics.

The old kind of health service, which was almost exclusively curative, served to disguise the true nature of ill health. The new emphasis on preventive health care has revolutionary potential. Health education is eminently suitable for conscientization programmes to enable people to realise that they and their children are prey to preventable disease because they are poorly fed, lack good housing and adequate clothing, because

they are unskilled and unemployed.

EDUCATION FOR PARTICIPATION IN COMMUNITY AND POLITICAL LIFE

REAL HEALTH CARE.

Health education has revolutionary potential, if it leads to awareness, organization and action. But if people are to participate in a real and relevant way in their own health care, it means they also have to participate in the control and exercise of power.

At the moment most health workers, including the planners, are keeping themselves busy counting the casualties of the continuing conflict, developing appropriate technology and working hard to reduce the damage to a minimum. Naturally our duty is to relieve suffering, but our duty goes beyond curative and palliative care. If we are serious about preventive care we have to look at the evidence we are collecting to see what it means, and to use the information politically. A severe problem in this context is the larger percentage of expatriates in the health services of almost all countries. Expatriates are in a particularly weak position when it comes to political involvement. However, unless we find a way to work politically we shall be making ourselves accomplices in a confidence trick.

ADEQUATE WATER SUPPLY

METHODS OF INCREASING LAND PRODUCTIVITY

SKILLS RELATED TO EMPLOYMENT AND INCOME OPPORTUNITIES

LITERACY

IMMUNISATION AGAINST MAJOR DISEASES

CHILD–CARE AND HOME RUNNING

SAFE SANITATION

NUTRITION, HEALTH, HYGIENE TRAINING

If There Are No Side Effects,

DRUG	UNITED STATES	MEXICO
Tetracycline [ANTIBIOTIC USED AGAINST VARIOUS INFECTIONS; LEDERLE LABORATORIES.]	***Caution against use:*** By infants, children; during pregnancy; with liver or kidney impairment (latter can be fatal) or if overly sensitive to light. ***Adverse reactions publicized:*** Vomiting, diarrhea, nausea, upset stomach, rashes, kidney poisoning. Can poison fetus.	***Caution against use:*** By infants, children; during pregnancy or if overly sensitive to light. ***Adverse reactions publicized:*** Vomiting, diarrhea, nausea, upset stomach.
Ovulen [BIRTH CONTROL PILLS; G. D. SEARLE CO.] IN U.S., USED FOR CONTRACEPTION ONLY. IN SOME LATIN AMERICAN COUNTRIES, SEARLE RECOMMENDS IT ALSO FOR REGULATING MENSTRUAL CYCLES, PREMENSTRUAL TENSION, AND MENOPAUSAL PROBLEMS.	***Caution against use:*** If patient has tendency to blood clot, liver dysfunction, abnormal vaginal bleeding, epilepsy, migraine, asthma, heart trouble. ***Adverse reactions publicized:*** Nausea, loss of hair, nervousness, jaundice, high blood pressure, weight change, headaches.	***Caution against use:*** If patient has tendency to blood clot, liver dysfunction. ***Adverse reactions publicized:*** Nausea, weight change.
Imipramine [ANTI-DEPRESSANT; CIBA-GEIGY.] IN U.S., USED FOR DEPRESSION ONLY. IN SOME LATIN AMERICAN COUNTRIES, CIBA-GEIGY RECOMMENDS IT ALSO FOR SENILITY, CHRONIC PAIN AND ALCOHOLISM.	***Caution against use:*** If patient has heart disease, history of urinary retention, history of seizures, manic disorder or is on typhoid medication. Not recommended for children or during pregnancy. ***Adverse reactions publicized:*** Hypertension, stroke, stumbling, delusions, insomnia, numbness, dry mouth, blurred vision, constipation, itching, nausea, vomiting, loss of appetite, diarrhea, sweating.	***Caution against use:*** During first trimester of pregnancy. ***Adverse reactions publicized:*** Dry mouth, constipation, itching, sweating.

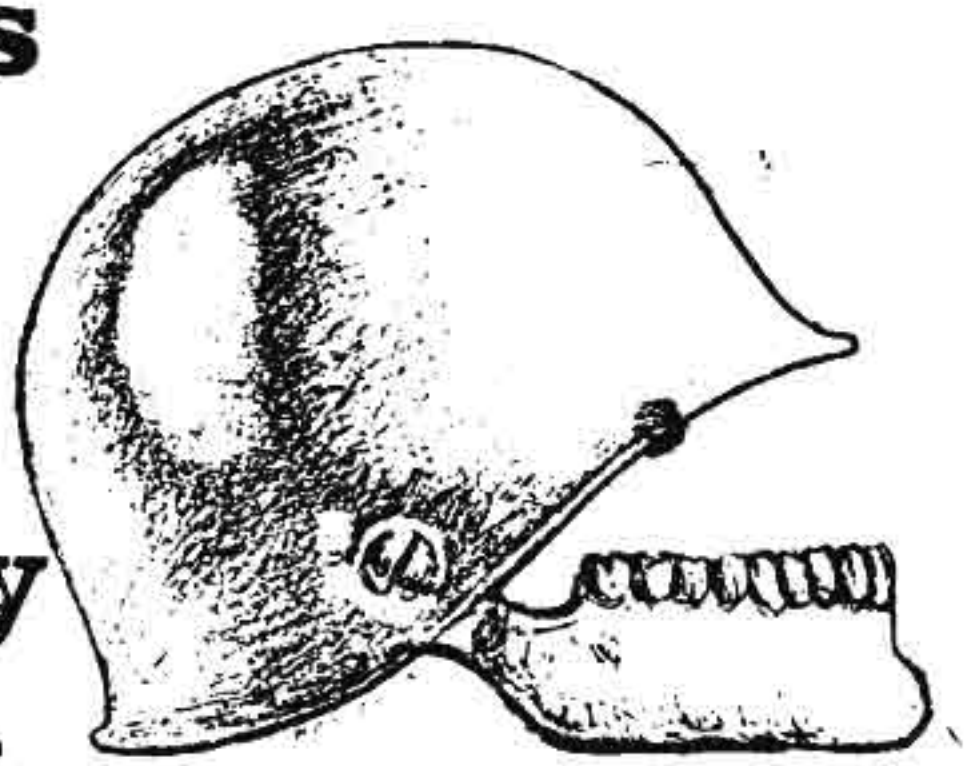
This Must Be Honduras

CENTRAL AMERICA	BRAZIL	ARGENTINA
Caution against use: None ***Adverse reactions publicized:*** None	***Caution against use:*** By infants, children; during pregnancy. ***Adverse reactions publicized:*** Vomiting, nausea, upset stomach, rashes.	***Caution against use:*** None ***Adverse reactions publicized:*** None
Caution against use: If patient has tendency to blood clot liver dysfunction ***Adverse reactions publicized:*** Nausea, weight change	***Caution against use:*** If patient has tendency to blood clot. ***Adverse reactions publicized:*** None	***Caution against use:*** If patient has tendency to blood clot ***Adverse reactions publicized:*** None
Caution against use: If patient has heart disease. ***Adverse reactions publicized:*** None	***Caution against use:*** If patient has heart disease. Not recommended for children or during pregnancy. ***Adverse reactions publicized:*** None	***Caution against use:*** May exaggerate response to alcohol. ***Adverse reactions publicized:*** None

Source: *Culled from* The Physician's Desk Reference—*the standard handbook for U.S. doctors, containing information drug companies supply about their products—and comparable foreign guidebooks.*

The money required to provide adequate food, water, education, health and housing for everyone in the world has been estimated at $17 billion a year. It is a huge sum of money

...about as much as the world spends on arms every two weeks.



The New Internationalist

BOOK REVIEW.

Economics of Health in South Africa, Volume I.
Perspectives on the Health System.
Edited by Gill Westcott and Francis Wilson.
Ravan Press, Johannesburg 1979.

This publication marks an important stage in the discussion of health-related problems in South Africa. It is a selection of papers presented at the Economics of Health Care Conference held at the University of Cape Town in 1978. It was organised by the South African Labour and Development Research Unit (SALDRU) and the South African Medical Scholarship Trust (SAMST), and was an important contribution to the critical debate of health in South Africa. Not everybody who would have liked to attend that conference or who would have benefited from the massive amount of research that was discussed there was able to be at the conference, and therefore this publication is particularly welcome.

This 430 page book is the first of two volumes which together will provide a comprehensive picture of the main thrusts of the conference. Volume I contains a summary of all the papers delivered at the conference (a total of 75), together with statistical material and a number of papers on questions of finance, political economy, and planning as well as dealing with specific case studies in situations both urban and rural. The volume concludes with some reflections on the issues raised by the conference as a whole.

The summary of papers presented at the conference is 56 pages long and groups papers under the main areas covered by the conference. Sections covered are Health Statistics, Planning the Health System, Health Structures in Southern Africa, Health Personnel, Occupational Health, Nutritional Status and Policy, Tuberculosis, Indigenous Healing in South Africa, Mental Health Services, and the Cost-Effectiveness of Medical Care and the Price of Drugs. This entire section of the book is excellent in that it isolates the important questions facing people involved in health care in Southern Africa today, and provides a wealth of information.

The range of facts covered is immense and includes information like the following :-

In South Africa, no regular data are available on the amount of disease and illness present in the community, whether at a national, provincial or local level. The only exception to this are the 28 infectious diseases which must be statutorily notified.

The distribution of doctors in South Africa varied (in 1969) from 1 doctor per 969 population in the 13 largest urban centres to 1 doctor per 23,000 population in rural areas.

Seventy-three percent (73%) of Whites in South Africa are covered by medical aid schemes while very few blacks are.

Only 5½% of South Africa's doctors practice in rural areas and villages where over 50% of the population in South Africa live.

Nurses trained in primary health care can deal with over 80% of the cases presenting at a clinic. Only 15-20% need be seen by a doctor, and only 5% need to be referred to a hospital.

Industrial accidents in South Africa cause annually the loss of more than 2000 lives, the permanent maiming of 36,000 men and women, and severe injury to 110,000 hands, 50,000 feet, and 40,000 eyes.

These are just some of the numerous facts and figures contained in the summary - probably the most important part of the publication.

The rest of "Perspectives on the Health System" contains some 16 original papers on health-related topics in South Africa, critiques of various aspects of health care in this country, and case-studies from both urban and rural projects.

The final chapter in the book is by Francis Wilson and is titled "Reflections on the Economics of Health in South Africa" in which he reviews the conference on the Economics of Health Care, and provides a brief overview of the interrelationship between "Health" and "Economics". He

comments that the course of the conference swung away from the economics of health care to a concern with the priorities for better health in Southern Africa, and this is certainly what makes the conference and this publication of value to all people concerned with health.

The final section of the publication is a comprehensive bibliography containing a wealth of references grouped under headings such as Health Policy: General, Health and Society, Comparative Health Care systems, and the Pharmaceutical Industry. The bibiliography could be more complete, for example the excellent journal "Social Science and Medicine" is not listed separately. However there is certainly a considerable amount of material listed and conveniently arranged into general topics of interest.

The entire publication is not without its flaws. For example, the editors state that they have "excluded all papers whose primary focus was on countries other than South Africa (including Transkei, Bophuthatswana, and Venda)." Surely the health problems in these so called "independent" areas are our concern, and we can learn much from them and contribute much to them? Another flaw is the poor use of tables in the publication. The article on the Care Groups at Elim, for example, contains a number of tables which are not numbered, and are not adequately described in the text.

In conclusion, "Perspectives on the Health System" is an important contribution to the analysis and debate of health-related issues in Southern Africa. I strongly recommend Volume I and eagerly await the appearance of Volume II. The information contained in these volumes reveal a seriously unhealthy situation in this country. The editors themselves note that they "know that healing can be a painful process, but the urgency cannot be exaggerated. To find chronic and widespread malnutrition in a country which exports food surely indicates that something is wrong."

ANTHONY ZWI.

The publication is available directly from Ravan Press, 409-416 Dunwell, 35, Jorisson Street, Braamfontein, 2001, at a cost of R4-15c. or via the post from Ravan Press, P.O. Box 31134, Braamfontein, 2017, at a cost of R4-31c.

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Sue for artwork
Africa Perspective, UNICEF and "Mother Jones" for material.

BEMUSED MAGAIZA LIT THE LAMP
TO LOOK FOR LOST ILLUSIONS
HIS YOUTH, HIS HEALTH, WHICH STAYED BEHIND
DEEP IN THE MINES OF JOHANNESBURG.

-- NAEMIA DE SOUSA.