CRITICAL HEALTH

NOVEMBER, 1981 40c No.6

FOOD —

FOR PEOPLE
NOT FOR PROFIT !

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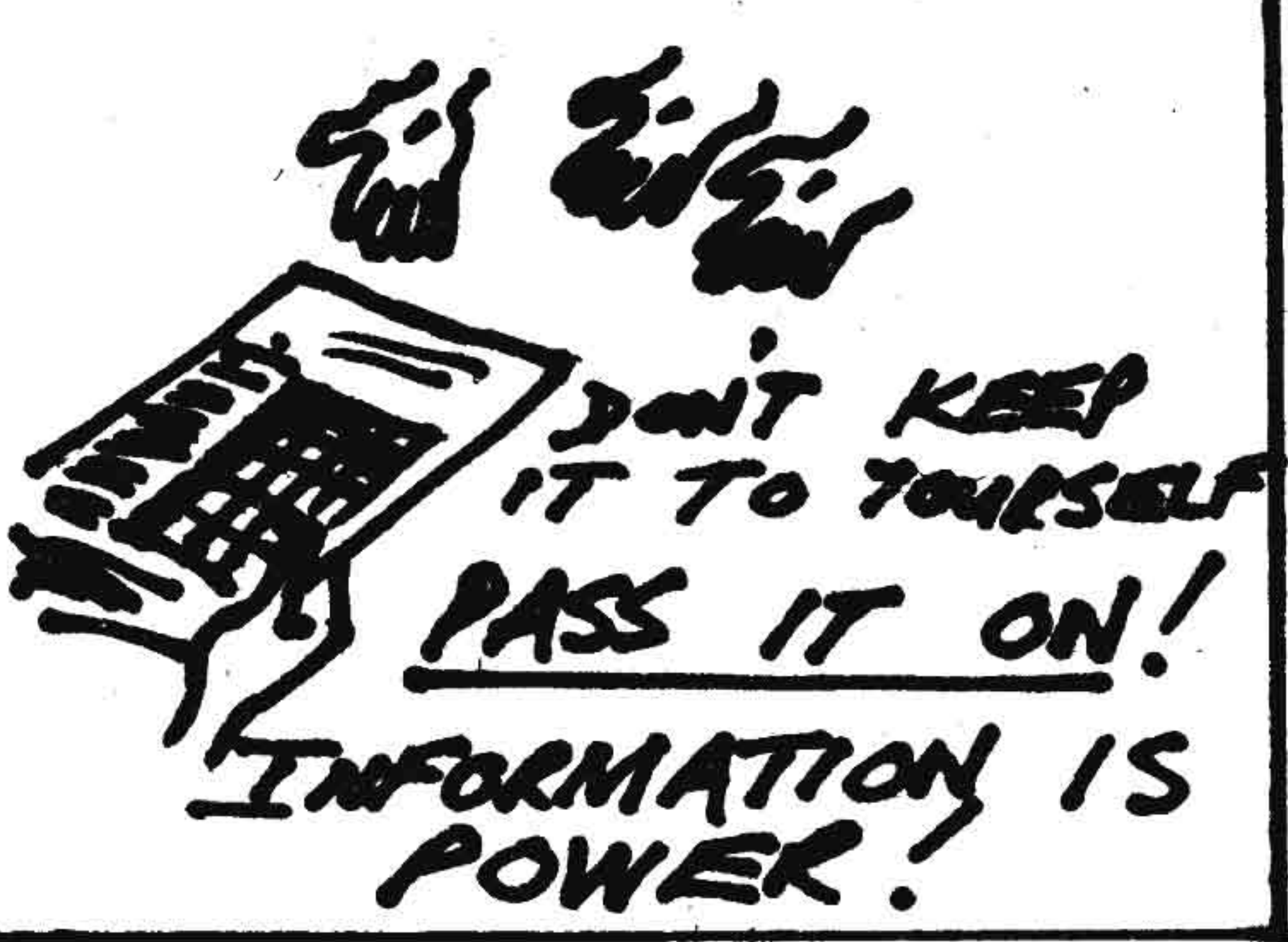
Nov., 1981



EDITORIAL

After a long period of re-evaluation Critical Health goes to print again. You will see that we have re-orientated the publication on the basis of criticism received from readers. We hope not only to serve an information role, but also to play an active part in supporting and furthering progressive community health struggles. We would like Critical Health to be one of the resources that democratic people use in laying a solid theoretical foundation for future action.

This issue focuses on FOOD, an essential, life-sustaining substance, the availability and distribution of which highlights the unequal access to resources in our capitalist society. Moreover, this maldistribution is strategically manipulated and controlled by the ruling powers in the interest of the ruling powers.

One aspect of a just and democratic society is that all will have access to the quality and quantity of food necessary to enjoy life to its fullest potential. It is this we must strive for and to this end we must understand the nature of food today and yesterday.

Also in this edition we begin an ongoing education series presented in cartoon form. We hope that this will provide further insight into basic political concepts as they relate to health.

We not only welcome, but depend upon critical feedback for this publication to be useful. Please do send us criticism and suggestions.

Readers and organisations should feel free to use any material we produce. In fact, we encourage that it be reproduced and disseminated.

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SURVIVAL IN A CISKEIAN RESETTLEMENT CAMP.

By: Jacklyn Cock.

In the last issue of Critical Health, Mare poses the question, "How do people survive in areas of relocation?". The following account of nutrition patterns at Kammaskraal illustrates the extremely low levels at which people do so.

Kammaskraal is a resettlement camp in a remote area of the Ciskei, with a population of almost 1,000. The present inhabitants were moved there in May and June 1980, and given tents and rations for three days. There is no employment in the area so the majority are dependent on migrant remittances and state pensions.

Kammaskraal is a place of hunger and despair. All around there are people sitting alone or in small groups, listless and apathetic. Researchers were frequently told, "We are starving here". From questionnaires administered to a random sample of 83 households it is clear that the majority subsist on an extremely poor diet of maize, bread, tea and sugar. Almost half (42,7%) of the households interviewed said they eat meat less than once a month. Almost half (41,5%) eat eggs less than once a month, and the majority eat fish (70,7%) and cheese (70%) less than once monthly. Two journalists who visited the community in October 1980 reported that they "found adults who had not eaten for three or four days". (Eastern Province Herald, 7-10-1980). "We live on samp because mealie meal is too expensive and we save that for the children. When the food runs out we try to borrow from neighbours".

Clearly such low levels of nutrition generates other problems. For instance, malnutrition is a major obstacle to learning. The headmaster of the community's primary school commented that the children "try to work, but because they are undernourished, they soon lose interest, due to hunger". (Evening Post, 27-09-1980). Malnutrition may also be an obstacle to finding employment. In 1980 the mines were employing 2,000 people from the Peddie District but in November of that year seventeen people were turned down by the

mine recruiting agency because they were "underweight". Several informants reported that there was a great deal of illness in the community and related this to "cold and hunger" "People are dying like flies", one informant said. Another commented, "no money, no food, no blankets. The people they live in a tent - it's wet, damp and cold. They are dying here".

FOOD EATEN IN KAMMASKRAAL HOUSEHOLDS *

Eat meat less than once a month	42,7%.
Eat eggs less than once a month	41,5%.
Eat fish less than once a month	70,7%.
Eat cheese less than once a month	70,0%.
Eat only once a day	6,2%.
Eat two meals daily	48,8%.
Eat three meals daily	45,0%.
Eat maize (mealie meal and samp) every day	90,1%.
Eat green vegetables daily	8,5%.
Eat rice or potatoes daily	2,5%.
Drink milk every day	14,8%.
Drink tea or coffee daily	91,4%.
Drink tea or coffee less than once a week	2,5%.
Eat jam less than once a month	73,8%.
Eat sugar every day	91,5%.
Eat sugar less than once a week	2,4%.
Eat bread every day	79,3%.
Eat bread less than once a week	2,4%.

* Information was obtained from questionnaires administered to a random sample of 83 households.

Informants related the health problems of the community to lack of proper sanitation and a polluted water supply. Sanitation consists of holes in the ground under a zinc shelter. One person reported, "There are problems with disposal because most people do not dig another hole when the first hole is full. When it rains, germs from the

toilets wash down to the dam. That is why the water is so unhealthy". The dam is also used by stock. A mobile clinic visits Kammaskraal once a week and charges 50c per treatment. According to one observer the most common "treatment" dispensed is packets of skimmed milk powder. Two community nurses are employed on the site to teach health education. The nearest hospital is in Peddie (40 km away) and Numpumelelo (50 km away).

TK

Kammaskraal is an isolated example of a very widespread process. Resettlement has already occurred on a large scale in the Ciskei - 100,000 people since 1970. (Nash and Charton, 1980; 22). According to the Quail Report over 400,000 "Ciskeians"are liable to be resettled including 68,500 "illegal" urban dwellers, 265,000 from villages and "black spots" and 99,250 of those resident on "white" farms. This estimate is based on the natural increase in population and the decreasing demand for labour due to farm

consolidation and mechanisation (Quail Report, 1980: 15,29, 128-131). The last figure illustrates clearly how resettlement is related to economic processes - in particular, the process of agricultural consolidation amd mechanisation which makes increasing numbers of workers redundant and superfluous to economic requirements. Many of the inhabitants of Kammaskraal are such "surplus people". Relocating them in remote, inaccessible resettlement camps is an extremely efficient method of control. Ultimately, resettlement is about the political, economic and idealogical control of the black working class. Conditions at Kammaskraal illustrate the human cost involved.

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THE POLITICAL ECONOMY OF NUTRITION

THE POLITICAL ECONOMY OF FOOD PRODUCTION AND NUTRITION IN SOUTHERN AFRICA IN HISTORICAL PERSPECTIVE.

By David Webster.

"The abundant health enjoyed by these people (the Xhosa) must undoubtedly be principally ascribed to the simple food on which they live: milk, the principal dish, which is supplied in abundance by numerous herds of cows; meat, mostly roasted; corn, millet and watermelons, prepared in different ways, appease hunger ..."

Ludwig Alberti, 1807(1).

"The tuberculosis scourge is undoubtedly on the upgrade in the Native Territories and especially in this district with its high rainfall and congested population. Unsatisfactory conditions of living and nutrition are amongst the chief factors in spreading the disease. The chief maladies have been those of malnutrition ... the former accounted, I'm afraid, for a considerable infant mortality and pellagra-like conditions among the adults."

Engcobo District Surgeon, 1937 (2).

The two contrasting quotations cited above cast into stark relief the changes that have overtaken the Transkei (and the rest of Southern Africa) from the pre-colonial period to the present. In this paper, I shall attempt an historical overview of the process of underdevelopment which has reduced the indigenous population of Southern Africa from a position of adequate subsistence cultivation and pastoralism to a state of chronic poverty, hunger and malnutrition. I choose to close the chronology in the 1930's, but the structures and processes remain and continue into the present; probably conditions are even worse today.

I realise that there is considerable controversy over the concept of malnutrition; that there are those who view it as related to protein deficiency, others who link it to inadequate supplies of calories, and yet others who blame vitamin deficiencies. I do not intend to enter this

debate, for the analysis I provide is pitched at a more fundamental level, one that logically precedes the particularities of protein and calorie: I shall be looking at food production itself, and will trace the decline in both the quality and quantity of food production and consumption. I am in agreement with Fox and Black, in their exhaustive report, when they claim, "... as well as being a problem of physiology, nutrition is also an economic, agricultural, industrial and commercial problem ..." (3). (One should add, political and social problem as well). I also intend to follow their use of the terms "nutrition" and "malnutrition" in "their restricted sense, i.e., as conditions brought about by an adequate or inadequate supply of suitable food ..." (4) I shall use the term "undernutrition".

The Health, Diet and Society of Pre-Colonial Southern African Peoples.

Evidence on the state of health of pre-colonial peoples is rather scanty, but in South Africa we have been fortunate that a number of travellers, missionaries and, from earlier times, victims of shipwrecks, have recorded, sometimes in detail, the dietary habits of the peoples through whose land they travelled. Some of the earliest accounts are by the survivors of shipwrecks, such as that of the Santo Alberto in 1593, which went aground near what is now Port Alfred. They reported :-

> "These (Xhosa) and all other Kaffirs are cultivators of the ground, by which means they subsist. They cultivate millet, which is white and the size of a peppercorn ... Of this millet they make flour, and of this they make cakes, which they cook amongst the embers. Of the same grain they make wine, mixing it with a quantity of water which, when it has fermented in pots of clay and has cooled and turned sour, they drink with great enjoyment.
>
> Their cattle are very fat, tender, well-flavoured, and large, the pastures being rich ... they use milk and the butter they take from it." (5).

This description of early Xhosa diet is not much different from that which is preferred today; the main difference is in the health of the cattle and the richness of the pasturage. Forty years later, another Portuguese trading ship, the Nossa Senhora de Belem, went aground on the Transkei coast. A survivor recorded :-

"The women do all the work, planting and tilling the earth with sticks to prepare it for their grain, which is millet as large or larger than linseed. They have maize also, and plant large melons which are very good, and beans and gourds of many kinds, also sugar canes ... Cows are what they chiefly value: these are very fine ... In the milk season they live chiefly on it, making curds and turning it sour..." (6)

This description of the variety of food cultivated is echoed by later accounts by travellers such as Ludwig Alberti, whose comments are recorded at the beginning of this paper. Alberti also recounted how the Xhosa in 1807 practised hunting:

"... hunting also affords him the opportunity to satisfy his inclination for a meat course. The meat is boiled or roasted..." (7) He adds, "Honey, and a number of wild onions, roots and berries serve as nourishment, though they are usually only regarded as adjuncts and do not constitute their principal sustenance ... generally milk always remains the principal nourishment, and after that, meat." (8).

A consistent picture emerges from these early accounts of the East coast Nguni peoples: that the societies were well fed and healthy, practising cattle rearing as the main economic activity of men, supplemented by the agricultural pursuits of women. Milk, either fresh or sour formed the staple food, with varieties of grain and many other vegetables providing bulk and nourishment. Meat, mostly garnered from hunting (cattle were too highly valued to be slaughtered for their meat) was also quite commonly eaten. Fynn, a trader and confidant of Shaka, recorded events in Zululand between the

years 1824-1836. He recorded the following crops as being grown by the Zulu: four types of millet (of which guinea corn was the principal crop); beans of two kinds; two types of potatoes; four kinds of sugar cane; pumpkins, melons, and gourds. (9) Hunting brought in meat, and wild fruits and vegetables were gathered - berries, imifino (wild spinach), mushrooms, etc. Overall, the diet displayed a variety of protein, calorific content and vitamins.

The coastal zone of South Africa, with its high rainfall and relatively rich soils, is, of course, better endowed than the interior, which was the habitat of the Sotho-speaking peoples. But even here, in the less-favoured central areas, early reports show a varied and well-balanced economy and diet. Among Sotho peoples, less emphasis is placed on cattle, with a consequent consumption of less milk, and more emphasis is laid upon agricultural production. (10)

Quin, a large-scale employer of Black labour, investigated the dietary habits of his workforce, and found malnutrition to be rife. He set about discovering the varieties of the early "traditional" foodstuffs consumed by Pedi, and arrived at the following findings: (11)

Cereal meal porridges (magobe)	48 varieties
Whole grain stews (lewa, dikgobe, masothlo)	13 varieties
Relishes (disebo)	
Pot herbs (morogo)	30 varieties
Seeds (dithose)	4 varieties
Bean gravies (setopja)	3 varieties
Bean stews (lewa)	3 varieties
Meats (dinama)	extensive
Insects (manyeunyeu)	13 varieties
Fruit (Mabilo)	2 varieties
Milk (maswi)	
Salt (letswai)	
Fruits and vegetables (lehlabula)	20 varieties
Beverages (dins)	12 varieties

Quin also calculated the daily calorific intake under normal "traditional" conditions for male Pedi-(the calorific intake

for women and children, he reports, is much less, and in busy times, a man will consume about half the calories calculated below: (12)

Malted beer and fermented gruel (bjalwa or metogo)	4 pints.	-	1500 calories.
Noon meal			
Porridge (bogobe)	35 oz.	-	1000 calories.
Pot-herb (morogo)	6 oz.	-	25 calories.
Evening Meal			
Porridge (bogobe)	35 oz.	-	1000 calories.
Roasted seeds (dithotse)	2 oz.	-	200 calories.
	Total	-	3725 calories.

This ample calorific intake was calculated on an average daily diet, and excludes many of the supplementary foods which would also normally be consumed, either during the meals, or in the course of the day - the fruits, insects and berries picked and eaten while working, or the milk drunk and meat eaten when they were available.

It is dangerous to generalise about early Southern African societies from the scanty evidence available, but there appears to be consensus on certain key issues. Most important is the general acceptance by observers that the indigenous population was adequately fed and were of outstanding physique. Shortages and hunger only occurred in times of ecological disaster - a prolonged drought, livestock epidemic, etc. The societies seem to have been structured along the lines of what Sahlins has referred to as a "domestic mode of production". (13) This is characterised by a simple division of labour along the lines of age and sex (men doing short, intensive and heavy bursts of labour, like tree felling and field clearing, also cattle herding, while women do the more tedious,long-term tasks of planting,weeding, threshing and cooking). The societies were also technologically simple - digging sticks, hoes, and rudimentary ploughs were used. The implements were essentially extensions of the human body, needing human power to guide them.

Perhaps the most notable feature of the early societies was that they were geared to subsistence, and not surplus production.

Production was conducted by domestic units - a man, his wife or wives, and their children, and the unit of consumption was the same group. The goal of production was "livelihood not profits", (14) which meant that a family would attempt to grow enough to last a full year; with a small surplus which would be used for sacrifice to ancestors, or to exchange or reciprocate with neighbours or kinsmen, or to pay as tribute to a headman or chief. Rights and obligations in society were couched in the idiom of kinship, as were property relationships. "Ownership" took the form of obtaining rights of access and use over land for one's lifetime and that of one's descendants. The chief or authority figure normally "owned" the land, but every autonomous adult male (usually a married man) has the right to land, over which he had usufruct - the use-right. The kinship, and in some cases, the political, systems were

Ideas and Action (FAO)

fundamental in kindling together the otherwise potentially atomistic tendencies of this form of household production. Through kinship and neighbourhood a system of communal work parties and a redistributive network was maintained.

It would be wrong, however, to give the impression that pre-colonial Southern Africa was a uniformly egalitarian Garden of Eden. Production for subsistence rather than surplus is prone to failure whenever there is ecological pressure, such as drought or pestilence. Also, many pre-colonial societies were not strictly egalitarian, most notably when the Zulu state began to emerge, followed by the Swazi, Pedi, Sotho and Ndebele. These states were built upon the centralization of power, in the form of regiments, which broke the autonomy of domestic units and their production. The regiments gave surplus labour to their kings in their fields, plundered neighbouring societies for the fruits of their hard labour, or used the threat of violence to extract tribute from subjugated groups. Most societies were able to adapt to these changes. The advent of colonialism, however, was to set in train a much more serious series of changes, from which the indigenous societies would never recover.

The Great Transition: from subsistence cultivator, to peasant, to proletarian.

The transition of the independent black population of Southern Africa from a condition, if not of plenty, then at least self-sufficiency, to one of underdevelopment, poverty, overcrowded reserves and townships is a long and painful one, brought about by a multitude of interlocking causes. Initially, the most important was that of colonialism, which is historically linked to underdevelopment. As Brett argues,

> "Colonialism is a system of rule which assumes the right of one people to impose their will upon another. This must inevitably lead to a situation of dominance and dependency which will systematically subordinate those governed by it to the imported culture social, economic and political life." (15)

I would go further than Brett: colonialism is usually a blatantly coercive system, which uses all the means as its disposal - violence, the economic, political and ideological to dominate, control and exploit its colonized population.

There are many different theories and understandings of the process of underdevelopment, and perhaps we should briefly examine a couple here. The conventional wisdom in South Africa is that the indigenous societies were in an original state of underdevelopment and when advanced technology and expertise were brought by settlers, they were unable to adapt and have remained in a state of backwardness, due to ignorance, conservatism and lack of education. This view postulates a kind of "dual economy", one advanced and capitalist, the other retarded and traditional, existing side by side. Owing to the manifest advantages of the former, it is argued, many individuals from the latter sector got out permanently, or become migrant labourers, to take advantage of wages and consumer goods offered by the former. A good example of this approach is provided by the liberal economist Barber, writing about conditions in early Rhodesia. Originally, he says, African society was characterised by a self-sufficient, subsistence economy. Because of the "narrow horizons" of the traditional societies, they were slow to respond to the introduction of the money economy, and

> "... their opportunities for increasing their real incomes may be delayed. Historically, a prodding from the tax-collector has been required. But, after a period of adjustment, they have attempted to acquire cash either through the sale of agricultural surpluses or through the sale of their labour." (16)

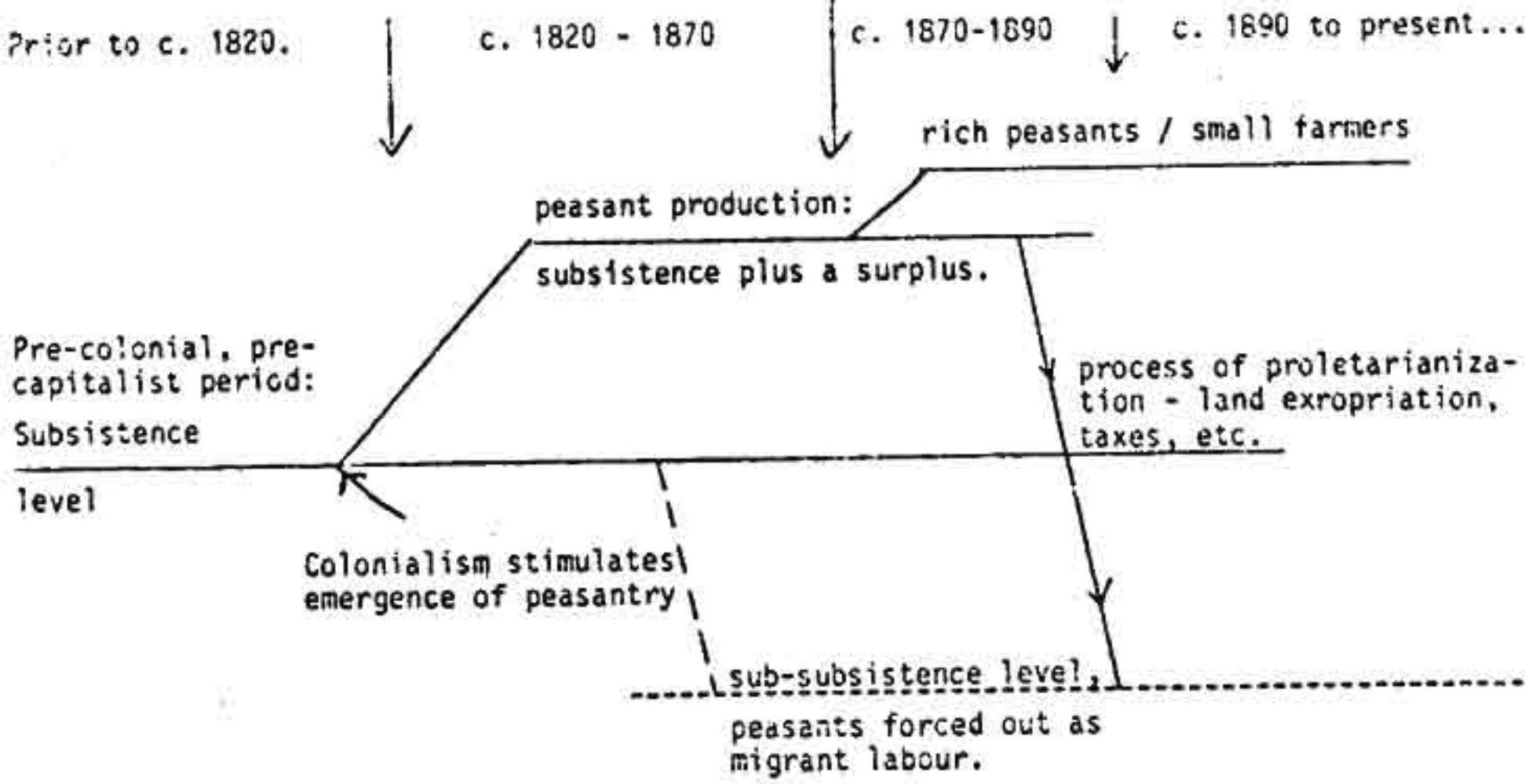
Barber argues that 50 per cent. of the men are in any case superfluous to the "traditional" economy, so that they can be drawn into wage labour, and can be lured by very low wages. This voluntaristic approach, by imputing freedom of choice to the actors, ignores history, or the lessons of history, for there is ample evidence that migrant labour in Rhodesia and South Africa was precipitated by coercive methods, such as land expropriation and the imposition of taxation. Further, the belief that African men were "unemployed" is also misguided. True, in "traditional" society, women work much harder than men, but in terms of their own societal needs, African men perform many socially necessary tasks, including: cattle care, field clearance, hut building, harvesting, hunting, not to mention the vitally important political, legal and religious duties. The absence of men as migrants therefore has many deleterious effects on the reproduction of social relationships,

apart from the obvious economic and familial disadvantages.

I do not wish to engage the full debate about the nature of underdevelopment, but it is important to show the bankruptcy of the "dual economy" view. It has been incisively criticised by "dependency theory" writers such as Amin and Frank. (17) It is argued that the so-called "backward" areas are a direct result of the process of development - they are incorporated into the capitalist system of production, and kept in a state of stagnation. They then perform a useful function by housing and feeding, returning migrants and the unemployed; in other words, the reproduction of labour power is carried out in these reserve areas, at little or no cost to capital and the state. But the very "backwardness" of these areas cannot support the migrant for any length of time, this precipitating him or her back to the work centres.

According to Frank, the relation of the developed and underdeveloped areas is a holistic one, where the development of the area is at the direct expense of the other. He phrases it in terms of centres of growth and peripheries of underdevelopment; that the former depends on the labour of the latter, without which its growth would be impossible. By so doing, however, it removes young, able-bodied people from the place they are most needed, thus exacerbating the processes of underdevelopment already set in motion. Frank makes an important contribution when he points out that indigenous societies were in an original state of un-development or non-development, and it is only later, when subjected to pressures from colonialism and capitalist development, that they became progressively under-developed. Certainly, the history of Southern Africa is testimony to this hypothesis.

Frank and Amin have been subjected to criticism for some of their analysis, but none of the critics deny the power of their attack on "dualist" theories of development and under-development. More radical scholars have tightened up the analysis by looking at specific relationships between modes of production and the minute workings of systems of exploitation. I intend to briefly examine some of these, notably by Colin Bundy and Colin Murray. (18) Figure 1 below schematically traces the trajectory of underdevelopment in Southern Africa.



A pattern emerges across South Africa which shows that, far from being locked into a backward economy with limited horizons, unable to adapt to changed circumstances, the indigenous population responded with alacrity and vigour to the new opportunities which emerged with colonialism. Not surprisingly, the Transkei and Ciskei were the first to respond: they were in intimate contact with the White settlers, and responded positively to market opportunities, so that, between 1830 and 1870 a thriving peasantry had emerged in the region, not only meeting subsistence requirements, but producing a healthy surplus for the market. Bundy notes,

> "Throughout the Ciskei, North-Eastern Cape and Western Transkei, peasants gained a foothold as land-holders and cultivators, selling grains, forage, stock, and animal products. They won prizes at agricultural shows in competition with White farmers, and a statistician noted in 1870 that, "taking everything into consideration, the native district of Peddie surpasses the European district of Albany in its productive powers". (19)

The 1870's saw an explosion of peasant activity. Bundy records that,

> "Five hundred wagons of corn were sold by Fingoland's peasants in 1873, as well as a wool crop worth £60,000; and in 1875 the trade of Fingoland "at lowest computation" was ajudged to be worth £150,000. African produce in 1875 was estimated to be worth £750,000... New methods and resources rippled from tribe to tribe, and even amongst the most "backward" tribes crop diversification and wider cultivation were common in the 1880's." (20)

In Glen Gray (now one of the most impoverished areas of the Eastern Cape), a traveller remarked,

> "man for man the Kaffirs of these parts are better farmers than the Europeans, more careful of their stock, cultivating a larger area of land, and working themselves more assiduously." (21)

Similar events were taking place in Lesotho, Natal, O.F.S. and Transvaal. (22) But there were two important trends emerging simultaneously. First, the flourishing peasantry was becoming stratified, so that a class of small farmers was emerging alongside peasants and a poorer group of unsuccessful peasants were being forced back into subsistence cultivation, or worse, to sell their labour to other peasants or to White employers. Second, as the peasantry reached its zenith in the 1870's, so too were the seeds of its destruction being sown, for the discovery of minerals, first diamonds and later gold provided wider markets for agricultural produce, but the mine owners wanted something else more - their labour.

The drive for labour came not only from the mining magnates, but also White farmers; both found that it was impossible to dislodge labour from the midst of a successful peasantry - coercion was required. The peasantry was attacked in the most vulnerable area for an agriculturalist - the land. Successive land appropriations took place, with the Black population being forced onto smaller and smaller pieces of land. In the Ciskei a kind of enclosure system was adopted, where Blacks suddenly found themselves as tenants on White farms. Later, legislation was employed to dispossess Blacks, culminating in the 1913 Land Act, which officially allocated only 13% of South Africa's land to Blacks. Taxation was another means of pressuring the peasantry, as Rhodes so

clearly saw: "We want to get hold of these young men and make them go out to work, and the only way to do this is to compel them to pay a certain labour tax." (23) Taxation was progressively increased, and furthermore, White farmers formed themselves into co-operatives to market their goods, excluding Black participation, and cutting African competition. Infrastructure, such as railways and roads, were provided to White farming areas, not Black. Small wonder that by the 1890's the Transkeian peasants were in crisis, and almost destroyed by 1920.

A similar pattern emerges from the rest of Southern Africa, and Lesotho is perhaps as graphic an illustration as any. In his Ph.D. thesis Colin Murray charts the progress of the region from being a granary to a labour reserve. Compare the following description of Lesotho in the 1880's with the barren country it is now:

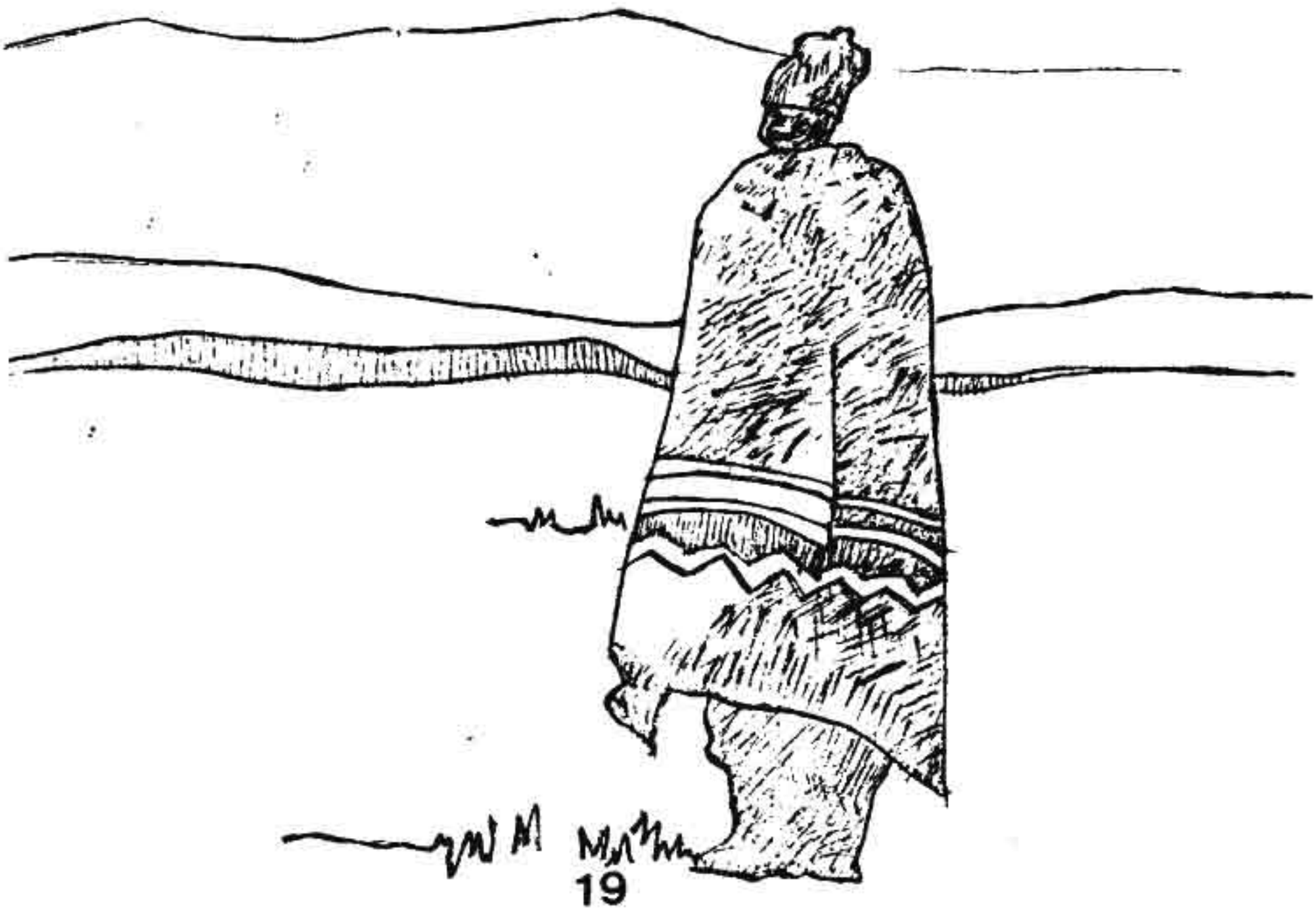
> "Hitherto our Basotho have all remained quietly at home, and the movement which is taking place beyond their frontiers has produced no other effect than to increase the export of wheat and other cereals to a most remarkable degree. While the district in which the diamonds are found (i.e. Kimberley) is of desperate aridity, the valleys of Basutoland, composed as they are of a deep layer of vegetable mould, watered by numerous streams and favoured with regular rains in the good season, require little more than a modicum of work to cover themselves with the richest crops." (24)

The early Sotho areas were much larger than the present boundaries, which were set by the Treaty of Aliwal North in 1869, in which the Basotho were forced to cede much of the land they previously occupied and worked; this expropriation of land insured the long-term demise of the Sotho peasantry. The following year Moshoeshoe died, and by then Sotho independence had ended. But there had been processes set in motion long before this, which were beginning to reach fruition at this time. For some time, Sotho subsistence cultivators had seen the opportunities of the market that was brought by Boer and Briton to the interior, and many had increased their production, selling their surplus, which they then used to buy consumer goods brought by traders. In short, a peasantry had begun to emerge.

Impetus was added to the process of peasantization by the discovery of diamonds in Kimberley. Suddenly an urban area

mushroomed in the arid Karoo, and it needed food and manpower. Sotho peasants responded to the former but not the latter; they increased production, but shunned work in the diggings. In 1873 they exported 100,000 bags of grain and 2,000 bags of wool (Murray 1976: 15), but this was the zenith of their success, for the pressures on the diminished portion of land began to take their toll, and a series of economic recessions, coupled with ecological crises, led to peasants moving into the inhospitable mountains, and many began to turn to migrancy. Rinderpest decimated herds, so much so, that bridewealth was calculated as future surety for cattle (ibid: 16).

The Basotho peasantry made attempts at recovery, the most successful being in the first World War, and wheat exports reached a peak of 256,000 bags in 1919, but stratification and division between rich and poor was growing, and in the early 30's a combination of the world recession and a crippling drought which destroyed crops and killed half the cattle, finally broke the back of the self-sufficient peasantry. In 1933, more than 230,000 bags of maize had to be imported, while as recently as 1929, Lesotho had exported 100,000 bags. (ibid: 17/18). The decline continued, and at the time of Murray's study, villages were producing much less than half their subsistance requirements themselves. (ibid: 21).



The consequences of underdevelopment for health, food production and nutrition.

Successive South African governments were faced with a dilemma: whether to support and encourage the self-sufficient peasantry which emerged in the nineteenth century, or whether to respond to the White (capitalist) farming community and more importantly the mining industry and their demands for large supplies of cheap (Black) labour, which would undermine the peasantry. We know that the latter demands were acceded to, and the processes of proletarianization set in motion (appropriation of land, taxation, the penetration of consumer goods, such as blankets, lamps, etc., which soon became necessities of life for the indigenous population, and aided fortuitously by ecological problems such as droughts and the 1896 rinderpest epidemic) ensured the creation of that supply of labour. It also created a large industrial reserve army, surplus to the immediate needs of employers, but which has historically worked to suppress worker militancy and living standards.

There are, however, costs to the employer and the state in pursuing this strategy: once the destruction of a pre-colonial economy has begun, it is almost certainly irreversible. The underdevelopment of the rural reserve areas proceeds apace, quickly becoming unable to support even a fraction of the population inhabiting it. A settled Black farming strategy, to accommodate some of the surplus population was advocated by the Tomlinson Commission, but rejected. The alternative is a rapid industrial expansion to soak up the extra labour, but South Africa is a peripheral capitalist country, and lacks the level of accumulation necessary. The result is enormous dislocation and extreme unemployment, with all the implications for nutritional levels and morbidity that accompany this.

Migrancy, and its cause, underdevelopment, are locked in a vicious spiral. There are social problems - children without one or both parents for long periods, illegitimacy, prostitution, and the social pathological problems of delinquency, drunkenness and, in single-sex hostels, homosexuality is understandably widely practised. But the economic and nutritional problems are perhaps worse. One of the most serious consequences of labour migration is that the one group of people who are likely to be progressive and innovative, and therefore indispensable to progressive health and

agricultural programmes, i.e. the young men and women, are absent from the place they are most needed. To quote Amin on this point :-

> "The consequence of migration for the regions which supply large labour forces to others is dramatic. First and above all: it excludes all alternatives to increasingly unequal development." (25)

Apart from the absence of those young, able and willing enough to introduce agricultural, nutritional and health innovations, migrancy exacerbates existing problems. Already too large a population of both humans and animals have been forced into inadequate land areas, forcing them to overwork the soil and overgraze pasturage; now, women, who are often unable to clear new fields, continue to work over-used ones in the already impoverished soil.

The rural population is therefore caught in a downward spiral of intensified underdevelopment; the absence of the potentially progressive young and the accompanying decline in agricultural productivity means that economic self-sufficiency slips even further away. The balance swings decisively away from home-production to reliance on cash remittances from migrants and food bought in the trading store. The influence on health is massive. As Quin's research showed, traditional eating habits include a wide and varied vegetable diet to supplement the staples. The staple foods are usually consumed in a whole-grain form, as opposed to the over-refined maize meal sold in trading stores. The decline in cattle stocks mean that essential items of diet, such as milk and meat, are less frequently consumed.

Evidence for this changing pattern of nutrition is vividly portrayed by two reports: that of Fox and Black in the 1930's and of Quin in the 1950's. Let us briefly examine their findings: the former report was commissioned by the Chamber of Mines, who were concerned about the decreasing health and physique of the labourers from the Transkei and Ciskei as reflected in the rejection rate on grounds of health of volunteers who presented themselves at recruiting offices. Fox and Black took as one of their terms of reference that,

> "the nutritional background (of the labour force) is of fundamental importance ... In its turn, as it is now being widely recognised in other parts of the world, the nutritional background depends upon the agricultural situation ..." (26)

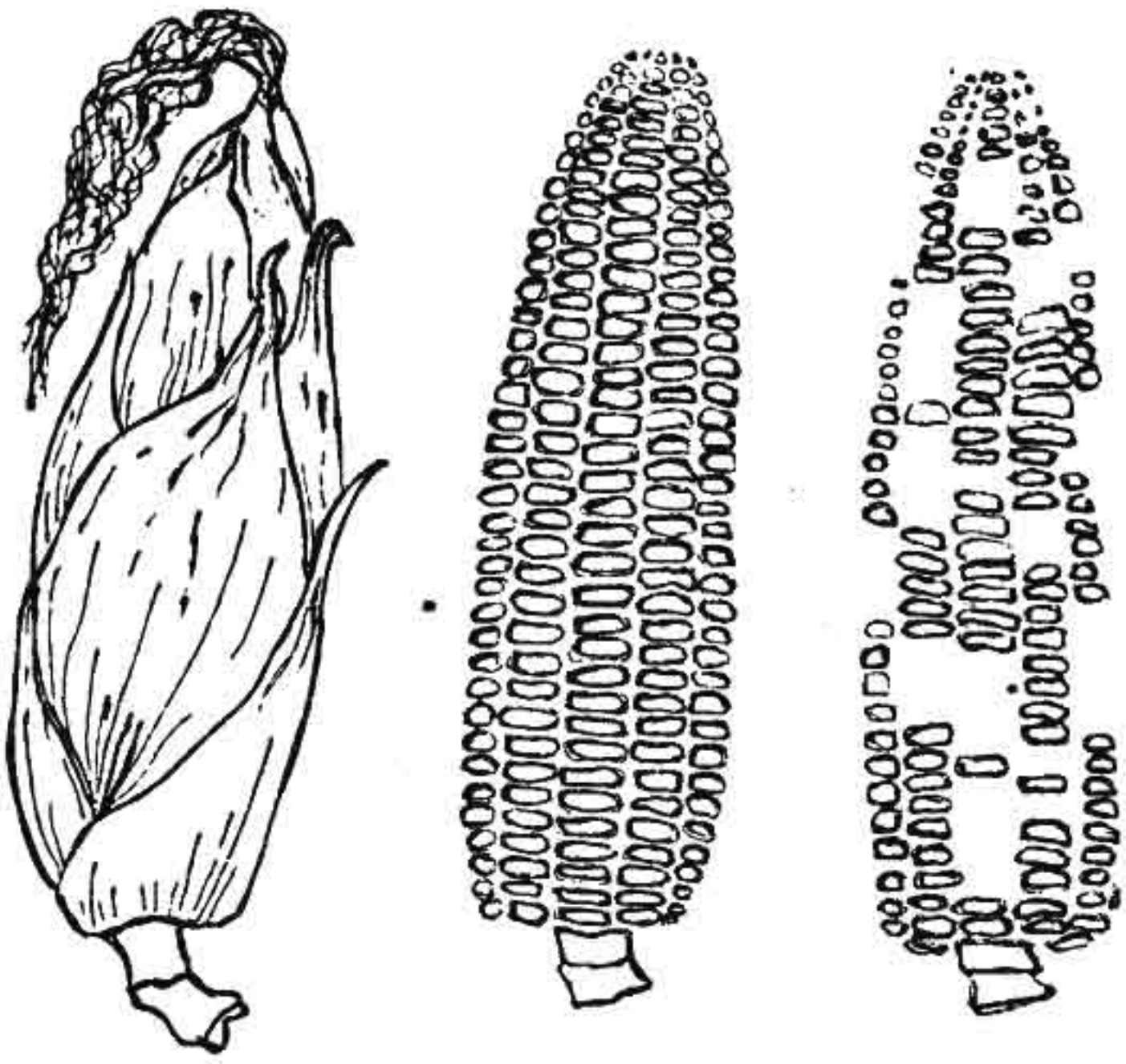
Among the factors affecting the Transkei were an increase of population of 22% in just 15 years while, of course, the land available remained static. In 1936 the population density was 91 per square mile (27), (in most pastoralist societies, a population density of 2-5 per square mile is common, and considered optimal). They went on to report that by the 1930's only one crop was grown in substantial quantities, and there was therefore no crop rotation and, with no land available, shifting cultivation was also a closed option. (28). The relentless decline of the carrying capacity of the land and its ability to support its population at a reasonable level of health was noted:

> "Less than 30 years ago the grass in Pondoland grew so high that it overtopped the head of a tall man. Today such grass is never seen on the commonage of the Transkei, and most of the more palatable grasses have been eaten out and replaced by coarser kinds ... The ploughing of hillsides, due to overcrowding, is common in the coastal districts, and there is every indication that large areas of cultivated land have already become useless." (29)

The inability to produce enough agriculturally to enable the maintenance of health standards and to ensure the reproduction of the labour force was not only due to the chronic land shortage and migrant labour. Another important contributing factor was one that Bundy had noted was emerging almost a century earlier: that of rural stratification. Its physical manifestation was in the form of sheep rearing and wool production. Fox and Black found that the main cause of overstocking was due to the introduction of sheep, and from 1912 to 1936 the sheep population rose from a few thousand to outnumber cattle by 3:1 (i.e. over 3,000,000).

> "From the point of view of food supplies, the introduction and encouragement of wool production is nothing short of suicidal when we consider the density of population and consequent shortage of fresh milk; and oxen for drought purposes. It is the sheep which are driving the cattle off the land, and the average native household is not benefiting ... On the contrary, one should also like to point out that there is such unequal distribution of small stock that it is true to say that a small minority, consisting of Bunga Councillors, headmen and chiefs are gaining a small income from wool at the expense of the food supplies of the many." (30)

They used one location they judged to be typical, and reported that the maldistribution was such that three out of 1000 stock owners owned 70% of the sheep and 50% of the cattle. (31) Thus, in South Africa's rural areas, there was a change from self-sufficiency in local foods to the commercialization of production (notably wool) to the direct detriment of the mass of the population. Fox and Black recorded the changes in diet which led to widespread malnutrition in the Transkeian territories. The early pre-colonial diet of maize, milk, meat, mfino (or wild spinach), and home-made beer was, they judged, both nutritious and satisfying. However, by the 1930's meat and milk supplies were sporadic, and maize had emerged as the main item of diet. The spinach, which is rich in mineral salts (calcium and iron as well as vitamins A and C), pumpkin (with its vitamin A and small amounts of C), monkey nuts (with their high food value), and such items as beans and mushrooms were being eaten in smaller quantities. (32)



The list of symptoms of diminished health and nutrition is endless. Local missionaries, such as Rev. B.J. Ross report that young men's physiques are adversely affected by inadequate diet. (33) Mortality rates for grown children and adults in the 1930's was 60-70 per 1000, while infant

mortality was at a startling 60%, with enteritis being the main cause of death. (34) The Chief Native Commissioner for the Transkeian territories was moved to remark in his 1935-6 report that he was grateful that there had been no outbreaks of epidemic disease because the population was weakened by privation.

> "The menace of (tuberculosis) looms very large and the general physique of the native is steadily deteriorating. The reduction in the milk supply and the lack of hygiene and nutritious food is predisposing the children to this and other diseases due to malnutrition. Urgent and widespread action is called for to safeguard our most valuable asset." (35)

The cumulative evidence built up by Fox and Black is impressive: they are certain that the "physique" of the population has deteriorated, within living memory. (36) They calculate for the whole of the territories a lower infant mortality rate than Ross' local area provided, arriving at 25% (while the figure for Whites in the 1930's was 62 per 1000). They conclude:

> "In addition to the crude shortage of calories which arises when the food supplies are inadequate in quantity are the diseases brought about by qualitative defects in the diet.
>
> Thus a lack of good quality protein leads to the appearance of nutritional oedema, which is not uncommon among the small children; a shortage of fat appears very common, almost usual, while the supplies of calcium and iron leave much to be desired ..." (37)

This pattern of increasing erosion of the nutritional status of South Africa's rural Black population, so vividly portrayed in the 1930's, continues into the present, but I wish to end by looking at the corroborative evidence from Quin's thesis on the Pedi in the 1950's. He also bemoans the loss of traditional food supplies and its effect on nutrition:

> "Whereas nature balanced the food supply of the Pedi, 'civilization' has created a condition that hovers between mere existence and starvation and which has manifested itself in a problem of gross malnutrition." (38).

He attributes this decline to the restriction of land, the change in food habits that was influenced by the arrival of the money economy, and he places much blame at the door of the trader. He argues that the trader soaked up any surplus crops that would otherwise have been hoarded against times of shortage. The Pedi apparently sold the bulk of their crop to meet cash requirements (tax, clothing, lamps, etc.), only to be forced to buy it back, at increased prices, later in the hungry season. The trader's demand for some of the most nutritionally valuable crops, such as beans, was such that almost the entire crop was sold, and not locally consumed. (39)

Fox and Black, and to a lesser degree, Quin, all paint the same bleak picture of a South Africa in crisis around the period of the Second World War. The rural Black population had by then reached a point where it was manifestly failing to reproduce itself; the remainder of the pre-colonial, pre-capitalist economy had long since been shattered, and was now in its death-throes. The evidence for this is not only the mortality and morbidity rates remarked upon in this paper, but also the sudden flood, in the 1930's and 40's, of rural Black people to the cities. Previously, migration took the form of men going out to earn wages; during this period, however, both men and women were leaving rural areas, many of them permanently. Thus emerged the urban consequence of the destruction of pre-colonial economy in the homelands: a massive housing shortage in the cities, in part overcome by the emergence of large and well organized squatter camps to house the surplus population, (40) who felt they had a better chance of survival in the city than in the homelands.

It is in this context that the response of capital and the state must be placed. Capital, perhaps the more sensitive to shifts among the working class, began to realise that adequate supplies of able-bodied workers was endangered, and mining capital, through the Chamber of Mines, commissioned Fox and Black to conduct their study. Quin, somewhat later was also concerned about the health and reproduction of his own workers on the Zebedeila Estates, and the state set up the Gluckman Commission. This latter Commission set about its task of investigating the health conditions of South Africans, and arrived at a set of far-reaching and radical recommendations, including the setting up of a social welfare system of which Britain would have been proud. It is a matter of

history that a change of government shortly followed, and the recommendations were never implemented. Nevertheless, these Commissions indicate an awareness within capital and the state, of the critical and bleak future facing the Black working class.

The picture I have painted of the changing historial patterns of food production, diet and nutrition in South Africa is indeed gloomy, and for many Black people, trapped by legislation and enforcement in our homelands today, the position is probably worse. The person who is committed to the social, economic and health development needs of the majority of South Africans is therefore confronted with almost insurmountable odds. The causes of the problem are deep lying and structural. Perhaps a starting point in the struggle to change them, however, is to analyse those structural conditions, to determine which is cause and which is effect and, in laying bare the means of oppression and exploitation to which the people are subject, make a small start on the long struggle to overcome them.

FOOTNOTES:

1. W. Fehr (translator) Ludwig Alberti's account of Tribal Life and Customs of the Xhosa in 1807, Balkema, Cape Town, 1967:22.

2. F.W. Fox and D. Black, A Preliminary Survey of the Agricultural and Nutritional Problems of the Ciskei and Transkeian Territories with special reference to their Bearing on the Recruiting of Labourers for the Mining Industry. Circa 1938:176 (henceforth referred to as the Fox and Black Report).

3. Fox and Black Report: 100.

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5. M. Wilson and R. Thompson (eds.) The Oxford History of South Africa OUP 1969:80.

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7. Ludwig Alberti's account of Tribal LIfe and Customs of the Xhosa in 1897, Balkema, Cape Town, 1968:23.

8. ibid: 24.

9. The Diary of Henry Francis Fynn Shuter and Shooter, Pub. 1950: 303-6.

10. vide B. Sanson "Tranditional Economic Systems" in W.D. Hammond-Tooke, Bantu Speaking Peopls of South Africa 1974:153.

11. P.J. Quin Foods and Feeding Habits of the Pedi, Wits University Press, University of the Witwatersrand, Johannesburg, 1959:26.

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13. M. Sahlins Stone Age Economics, Tavistock, London, 1972 chs. 2 & 3.

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15. E.A. Brett Colonialism and Underdevelopment in East Africa, London, Heinemann, 1973: vii.

16. W. Barber The Economy of British Central Africa, Manchester, University Press, 1961:93.

17. vide, e.g. S. Amin, Modern Migrations in Western Africa, OUP 1974, and A.G. Frank, The Sociology of Development and the Underdevelopment of Sociology, Pluto Press, 1971.

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19. C. Bundy "The emergence and decline of a South African peasantry" African Affairs 1972:374.

20. ibid: 376-377.

21. ibid: 377.

22. vide, C. Murray Keeping House in Lesotho, 1976, Bundy The Rise and Fall of the South African Peasantry, P. Delius "Migrant labour and the Pedi before 1869" in I.C.S. Collected Seminar Papers, 21, 1977.

22. A. Claasens "The Nature of Early Black/White contact in South Africa" (mimeo) 1977.

24. Murray 1976:15 he is reporting the records of missionaries in R. Germand Chronicles of Basotholand: 319.

25. S. Amin op. cit. : 103.

26. Fox and Black op. cit. : 1.

27. ibid: 35.

28. ibid: 36.

29. ibid: 43.

30. ibid: 44-45.

31. ibid: 45.

32. ibid: 108-120.

33. ibid: 171.

34. ibid: 172.

35. ibid: 175.

36. ibid: 183.

37. ibid: 313.

38. Quin, op. cit. : 274.

39. ibid: 274-275.

40. A. Stadler, "Birds in the Cornfields": Squatter movements in Johannesburg, 1944-1947" in B. Bozzoli (ed) Labour, Townships and Protest, Ravan Press, Johannesburg, 1979 : 19-48.

TRIBALISM AGAINST HEALTH = A REPORT.

Shiluvane Hospital, previously known as the Douglas Smit Hospital, is situated near Tzaneen, in the Eastern Transvaal area. This area is disputed by both Gazankulu and Lebowa. In July this year, the hospital was the centre of considerable tensions between the authorities of the two "homelands".

The events described below illustrate the way in which the apartheid policy has attempted to fragment communities along tribal and ethnic lines. This creates tensions and dissatisfaction that are not in the interests of the communities concerned.

The history of the conflict is detailed below.

In 1976, the State decided to take over all mission hospitals in "homeland" areas. This was done in an attempt to "rationalise" health services, to place hospitals under "homeland" government control, and to remove the hospitals from the liberalising ideologies of foreign mission doctors. Some hospitals, such as Douglas Smit , were located in an area between two "homelands", and the State was undecided as to whom the hospital should be awarded.

Lebowa and Gazankulu both claimed the Douglas Smit Hospital as theirs. The indecision of the Department of Health on the issue led to a statement that Lebowa should administer the hospital until such time as the Department of Health made a final decision on the issue.

It was subsequently decided that because Tsongas, the major ethnic group in Gazankulu had participated actively in the Swiss Mission at Shiluvane and that they had contributed towards the establishment of the hospital, it was resolved to award it to Gazankulu. This was duly gazetted.

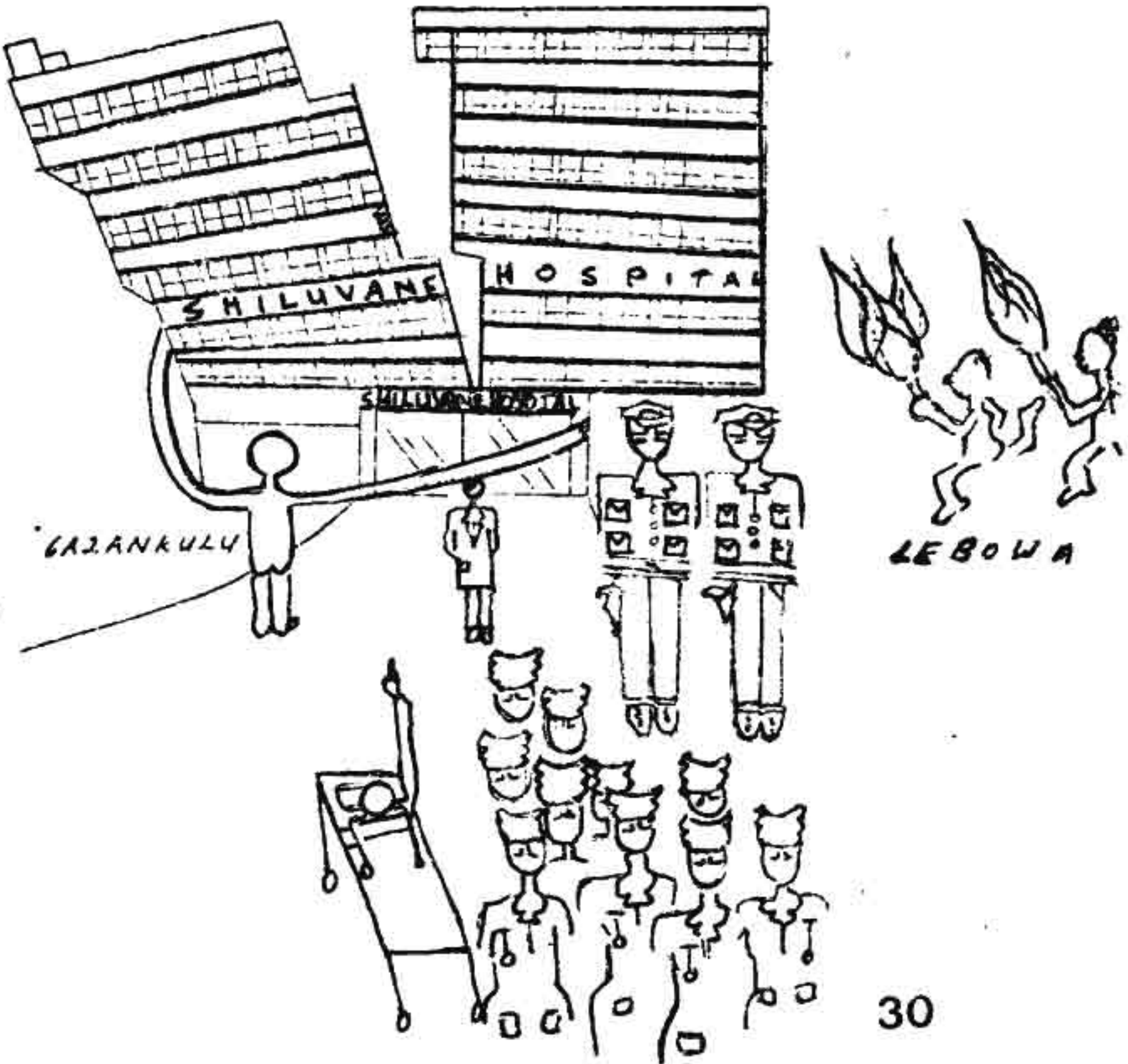
Up to that time the Douglas Smit Hospital had been used by the many Tsongas, Sothos, and Northern Pedis in the area. There was no ill-feeling between the two main ethnic groups in the area before the decision to hand the hospital to Gazankulu, said Pastor Sihlangu who works in the area. He said that more recently some people living in a nearby

settlement without a clinic had been turned away from the hospital because they were Pedis and could not be treated in a Gazankulu Hospital (Sunday Express, 20th September 1981).

It was thus declared that the hospital would be ceded to Gazankulu. A day before the hospital was taken over, it was announced that this was to take place.

The following day, Friday, July 3rd, 1981, Gazankulu officials arrived at the hospital saying they had been instructed to take it over. The administrative staff, seconded by Lebowa, had not been informed of the "take-over" at such short notice.

Over the weekend, the Lebowa Department of Health and their staff at the hospital planned their response. One day the following week, no Sotho-speaking hospital staff arrived on duty. At mid-morning, a stream of Lebowa Government vehicles arrived at the hospital and Sotho-speaking nurses and domestic staff packed their belongings into the vehicles. Patients with Sotho names were put into ambulances, with their files and drips, destined for



other Lebowa hospitals. Of 38 staff, only 14 were left. The matron left. Over 30 patients were removed. Hospital records were taken. Sotho-speaking sisters at peripheral clinices left their posts. The doctor, a Tsonga, remained.

There had also been threats from Sothos that the hospital would be burnt down. The police were called in to protect it.

Gazankulu Health Department responded by recruiting staff quickly from other Gazankulu hospitals. Later, a few Sotho domestic and grounds hospital workers apparently had second thoughts about giving up their jobs as they had been instructed to, and they approached the new administrators of the hospital for their old jobs. They were told that Tsongas had already been appointed to most of them, but that a few Sothos, however, could be taken on again. These workers were later forced, by threats of death from some members of the local Sotho community, to leave their jobs.

This event has not been widely reported. Any additional information about the events that took place at Shiluvane Hospital around July 3rd 1981, would be appreciated by the Editors.

DON'T HOLD ON TO INFORMATION = PUBLISH IT !

The increase in food costs affects particularly the poor. Mr. Cilliers director of the South African Agricultural Union said that the "so-called poor population" was much much"richer" than elsewhere in the world and that the poor paid more everywhere else for food- "so I don't feel sorry for our poor people. There is no need at all to reduce prices for the poor- and no room for subsidies or reductions in G.S.T."(RDM 7-2-81)

From NUSAS Health Fact Sheet

REFINEMENT OF MAIZE.

The late 1960's, 1970's and now the 1980's, have seen an ever increasing emphasis on the sale of more refined grades of mealie meal for human consumption. This refinement has meant that maize - the staple food of most South Africans - has markedly deteriorated in its nutritional value. At the same time, the quality of animal food has improved. The goodness removed from the refined maize, for the people, is fed to domestic animals.

REFINEMENT.

The process of refining maize involves the removal of varying amounts of bran (fibre) and the germ (protein) from the whole mealie grain before milling and sifting. This process means that nutritiously essential fibre, protein and vitamins are removed from the foodstuff. The different grades of mealie meal depend on the extent of refinement. Table 1 lists the five different grades of mealie meal which can be manufactured.

The marked decline in nutritional value with increasing refinement can be seen in pie diagram form in figures 1 and 2.

Thus, the least refined, yellow, unsifted meal has the greatest value nutritionally while the highly refined super mealie meal has the lowest nutritional value.

PRODUCTION AND MARKETING.

Yellow, unsifted meal is only marketed on a large scale for chicken feed and white,unsifted meal is the closest meal to whole meal that is marketed for human consumption. However, by far the greatest emphasis of production and marketing is on the most highly refined grades.

Creative and enticing methods are used to promote super and special mealie meal. Examples, include :

*** Prize-winning competitions for promoting "Induna" - a special sifted meal by Delmas.

*** "Iwisa" - a super mealie meal produced by Premier is promoted through Kaizer Chiefs, a popular black soccer team. The official magazine of Premier Milling says: "In the furthest corners and the remotest fields around our country, the name Chiefs raises an image of soccer, and it is with this tremendous success that Premier Milling has achieved, in a few short months, what many

sponsors have endeavoured to achieve in many years of sponsoring sports ... immediate recognition of the name "Iwisa", which is the group's leading brand of super mealie meal."

*** Attractive billboard advertising, which plays on consumer aspirations (see example).

Advertising of the least refined grades is almost non-existent.

THE HEALTH IMPLICATIONS OF REFINEMENT.

The effects of refinement on health can be looked at in two categories: the lack of protein and the lack of fibre :-

(a) Professor Harry Seftel, Department of African Diseases, at the University of the Witwatersrand, has said that the marketing of increasingly refined mealie meal "can only aggravate the malnutrition problem among black children because their protein and vitamin needs are greater than that of adults."

The decrease in protein is an especially serious problem in lower class families where maize is the main, and often only food consumed and where malnutrition is already very prevalent.

(b) Fibre Deficiency.

Fibre is essential for normal bowel functioning; without it people suffer from constipation. Professor Seftel says "Constipation is now widespread among the urban black population. It has become very serious." Furthermore, low fibre diet has been implicated as a possible cause of disease e.g. bowel, cancer, varicose veins, diabetes and obesity.

It seems that South Africans are paying with their health for eating refined mealie meal.

WHY REFINEMENT ?

Refinement has been practised for 50 years or more, but never on such a wide scale as in the past six years.

The producers would claim that the reason they encourage refinement is that the product lasts longer than coarse mealie meal,that consumers prefer the taste,whiteness and fine texture, and that it cooks far quicker. On the surface, these reasons sound justifiable, but one has to look beyond

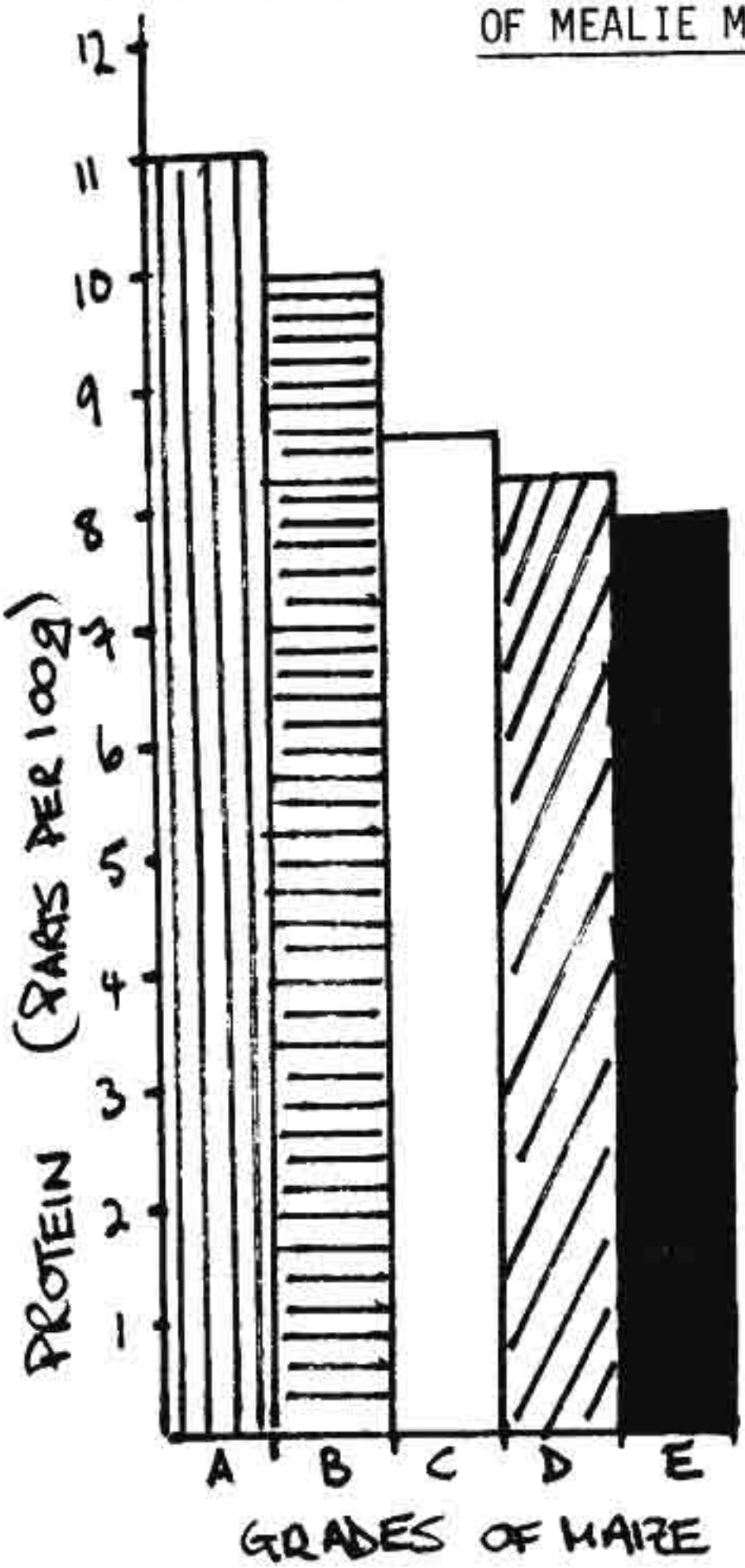
TABLE 1 (2)

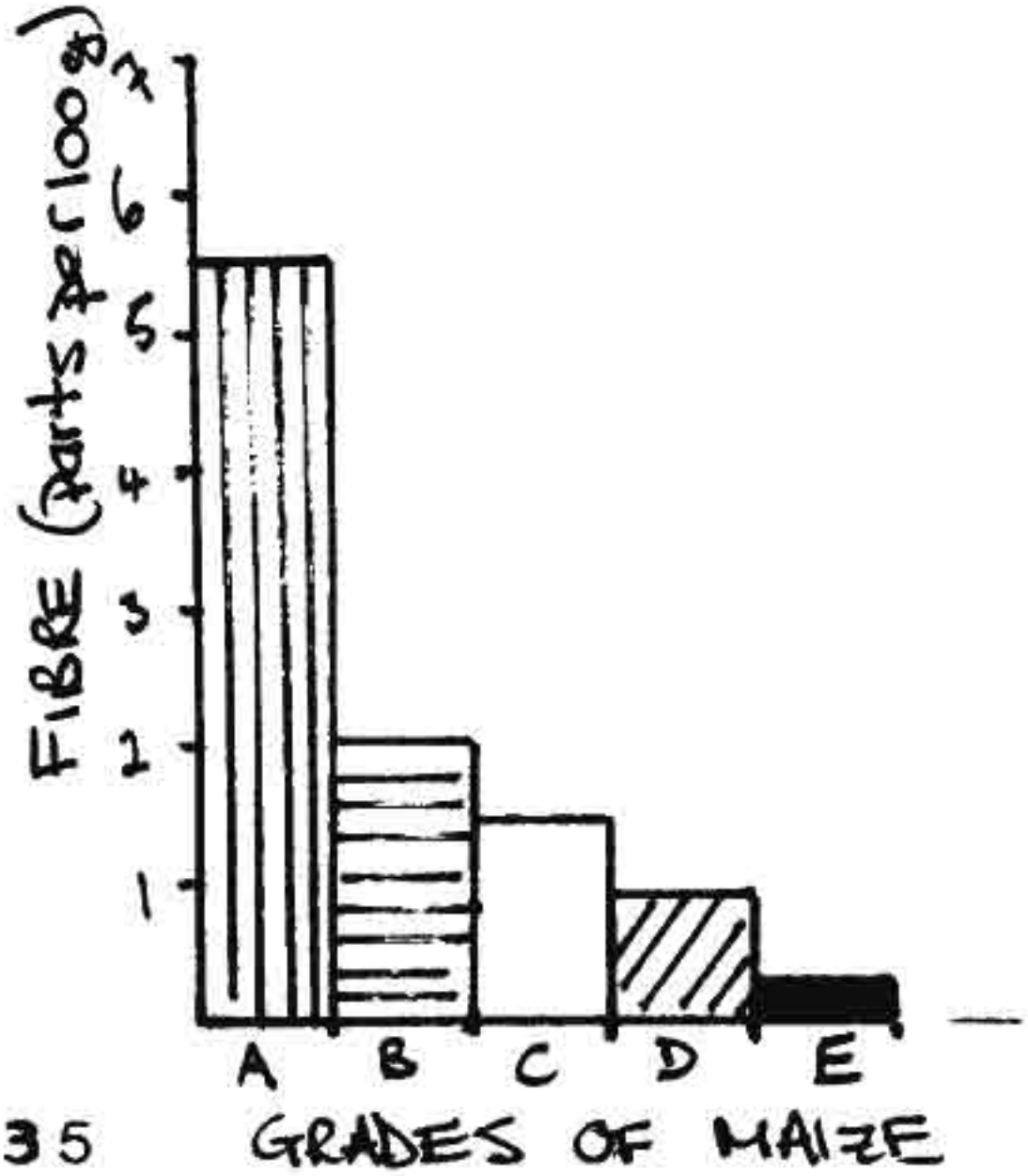
Five grades of mealie meal

Key

A	Yellow, unsifted meal - unrefined
B	White, unsifted meal - 10 to 20% whole grain less
C	Sifted, granulated mealie meal - 30% refined
D	Special, sifted mealie meal
E	Super mealie meal - highly refined

FIGURES 1 & 2 PROTEIN AND FIBRE CONTENT OF THE FIVE GRADES OF MEALIE MEAL (2)





this superficial explanation, to discover the real reasons.

Examine the methods used by the producers to promote and expand the market of super refined mealie meal. These tend to make you question whether the promotion of refined meal is to make life easier and better for the millions who eat more of it than anything else. Some points become obvious:

(a) Coercive and enticing methods of promotion are used, playing on the consumer's weaknesses and aspirations.

(b) Attractive and mystifying names are used for the more refined mealie meal, e.g. "White Diamond"; "Ace"; "Induna". Even the Maize boards' terms "special" and "super" for the more refined meal implies that they are better (super for what? - not health).

(c) The scores of different names for similar products leads to confusion rather than informed buying. The consumer is likely to give up and buy the best advertised product.

(d) No mention is made of the protein, fibre or vitamin content on the packages of most of the refined meals, although it is on those of chicken fodder. No mention is made of the implications of the product for the consumer's health nor the fact that it is promoted over unrefined maize because it cooks quicker and lasts longer, despite the decline in nutritional value.

If refinement was truly in the interest of the people, it would hardly need this kind of promotion. It is little wonder that the milling companies can say 9 out of 10 urban consumers prefer super mealie meal and then proceed to justify its marketing. They say consumers get what they ask for - and must bear the consequences! It would be more correct to say that consumers get what they are told to ask for - and bear the consequences !

TRULY THEN, WHY REFINEMENT ?

The answer to this question is PROFIT.

At the simplest level refined mealie meal (super) costs about 20 cents more per 2,5 kg bag than unsifted mealie meal.

But if we dig a little deeper, we see that profit is negligible compared to the enormous profits reaped from the protein, fibre and vitamins which are extracted by refinement. The germ and fibre are used in the production of animal feed and other products. Thus, by refining mealie meal, they

can effectively use the same raw material two or three times over and the more they refine, the more animal feed they can produce.

Profits are further increased by the milling companies not just selling the extracted products, but by processing them themselves. This is known as vertical integratian or diversification.

The Premier Group owns one half of the dry animal food market (chunks and meal) through the R43-million Epol business.

They own Sunnyside Chickens,who gobble up milling by-products "and lay eggs at a rate proportional to their profitability".

The Premier Group also owns five oil and fat companies, including Epic oils, - where the oil from the maize germ is used. In addition, they have direct or indirect interests in bakeries (46), biscuits (2 plants), preservatives, pharmaceuticals, liquar, general trading and others.

Tiger Oats' activities are similar. Through Delmas, they have nearly 40% of the animal food market. They are also involved in bakeries and confectionary (49), vegetable expressors and refiners, manufacture of fats and peanut butter, manufacture of margarine, egg hatching, producing and processing pet food,manufacture and pharmaceuticals.

This phenomenon of generating profit from the nutrients extracted from our food is not an accident. It is a deliberate policy on the part of the giant milling monopolies.

The proof of this thesis is in the profit figures and statements of the producers.

In a Financial Mail report, Premier's Managing Director, Mr. Tony Bloom, describes how his company recovered from a loss of profit in 1977/78.

"Vertical integration has helped Premier tackle its margins. This inte gration has been a very deliberate policy and gives us more control over costs. Many of the by-products of one division are used in another".

Table 2 shows the profits and turnover of Premier for the last 10 years. The increase in profits with diversification is obvious.

Similarly, Tiger Oats has grown to an annual turnover of R1175 million in 1981.

TABLE 2: REVIEW OF PREMIER'S TURNOVER AND PROFITS - 1971-1981. (1)

	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
Turnover in millions	224.6	257.5	316.7	389.8	464.5	556.0	682.0	763.0	947.0	I 205.0
After tax profit in millions	6.9	8.4	12.0	15.2	19.1	22.0	22.4	24.0	29.0	46.1

CONCLUSION:

The situation with regard to refining of mealie meal should now be a little more comprehendable. It is only one example of many in our capitalist society, where profits for a few come before the health of the majority and in fact at the expense of their health.

Premier claim to have a social conscience by implementing a "social responsibility" policy. This means supporting a long list of black charities. In 1980, they donated R500 000 to the Urban Foundation and 228 soup kitchens in Soweto.

It is our belief that this is not a "social responsibility" but part of their one and only responsibility to greater and greater profits.

Not Premier Milling, nor any other milling company, is interested in our health.

The responsibility for our health is in our own hands - we must grasp that responsibility and fight for our right to health.

And that certainly means fighting the maize milling companies in the process.

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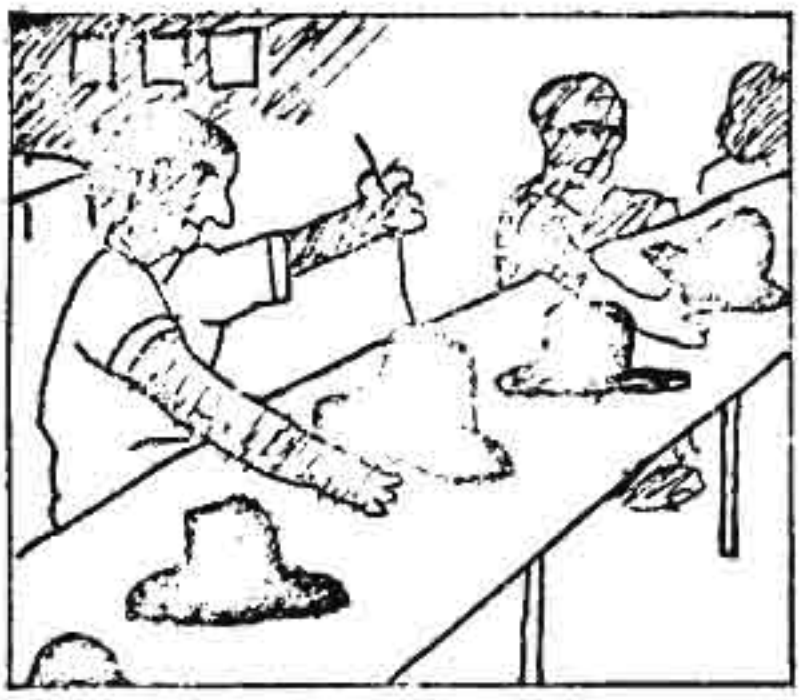
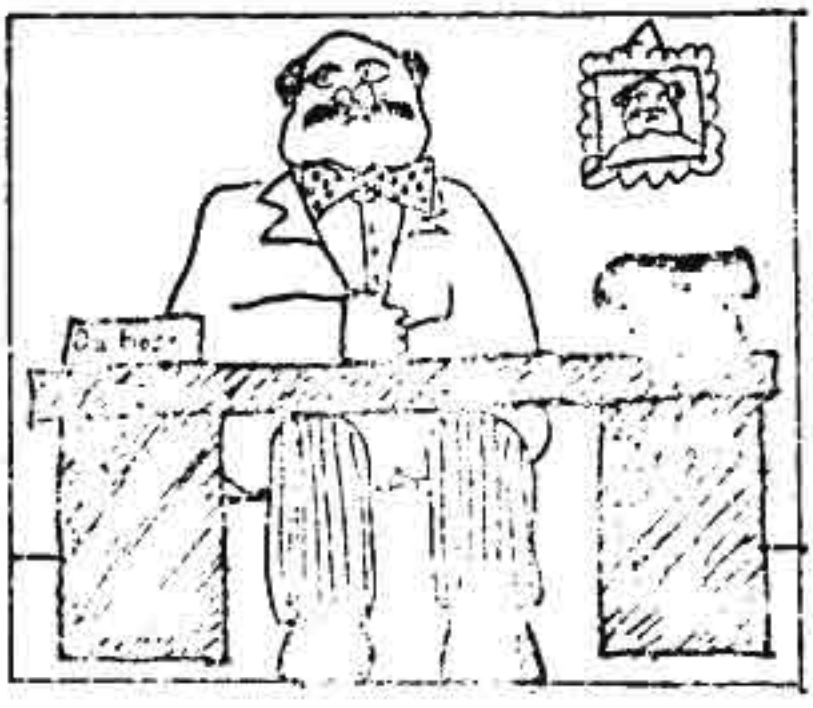
ESIBUEDUELE

What does 'NOMVULA' mean?

"EXPLOITATION" means that one person lives off work done by other people ...



Take Joe, who works in a factory as an example:
Joe makes 6 hats in a working day... 🧢🧢🧢🧢🧢🧢
BUT... his wage is only the same amount of money as 2 hats cost! 🧢🧢
Where is the value of the other 4 hats going?



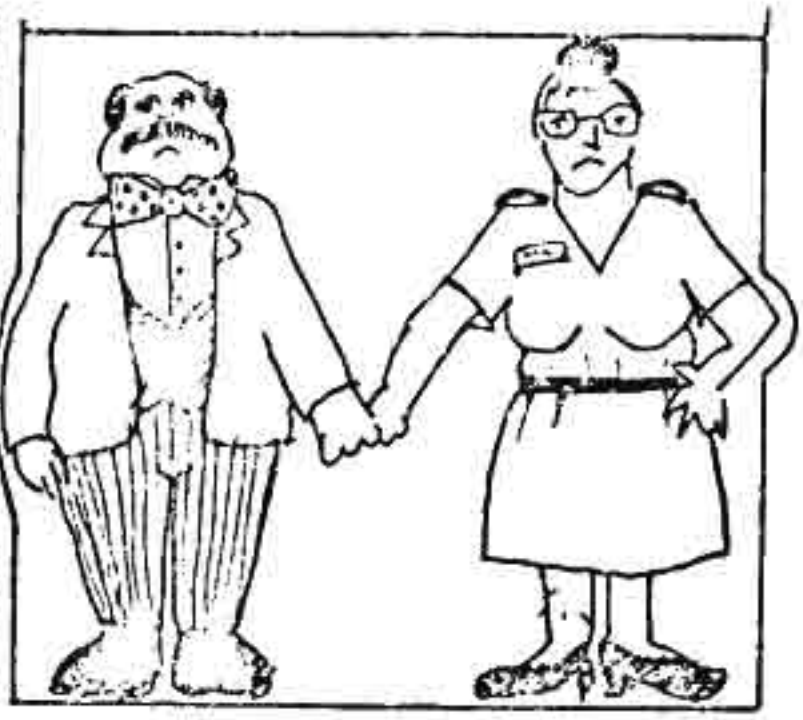
His boss is taking 4 hats worth away... he calls it his "PROFIT" 🧢🧢🧢🧢

He can do this because he owns the factory, and Joe must work for him.

🧢🧢 🧢🧢🧢🧢

AND the "SYSTEM" we live in allows bosses to own factories and exploit workers like Joe.

HOW... then can NomVula be exploited if she is a nurse ?



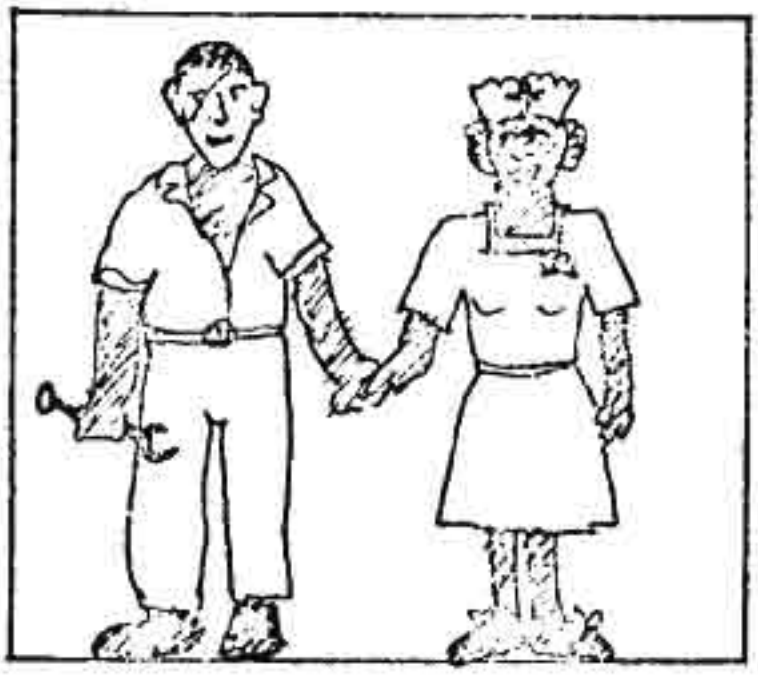
The **SYSTEM** in hospitals is exactly the same **SYSTEM** which is found in factories.

THEREFORE...

Is Matron Minnie in the same position as the factory boss ?

AND

Is Nurse NomVula the same as Joe, the factory worker ?



HOLD IT!

What about doctors like M. Lurgu ?

OR

Hospital Workers like Sebenza ?

IN OTHER WORDS...

How do all these people fit into the system?

THINK ABOUT IT!

See you next issue.

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ACKNOWLEDGEMENTS

Many thanks for this issue to:

Tami
Thea
Cynthia
Kevin
Debby
David

Les
Les
Gerry
Caroline
Paul

Sue
Ian
George
Monty
Peter

THE RADIOGRAPHERS' STRUGGLE.

Thirty-seven "supplementary" radiographers at the big and busy Baragwanath Hospital resigned on 30th June 1981. The factors leading to their resignation is a long story which started well before the current issue of examinations. The struggle by the radiographers for proper working conditions, better salaries, and the provision of satisfactory X-Ray Services at Baragwanath Hospital has become an important community issue.

In brief, Baragwanath Hospital (Bara) decided in 1959 to resolve their radiographer shortage by training black people with standard eight certificates for a one-year period. This was the only training offered. The three-year diploma course was not offered to the trainees at that stage.

These "supplementary" radiographers have trained and worked at Bara since 1959. They have always done the same work as the fully qualified radiographers with diplomas, including routine and sophisticated procedures, worked overtime (unlike the white diplomaed radiographers at the hospital), taken responsibility for training students, and even paid the same annual registration fee to the South African Medical and Dental Council.

In 1979 a three-year diploma course was introduced. "Supplementaries" with more than five years experience and service were allowed to write modified practically-orientated examinations which would enable them to register as fully qualified radiographers, equivalent to those with diplomas. Those with less than five years experience and service were told that they would be allowed to do written practical examinations once they had served for five years.

The good faith of the authorities was shattered earlier this year when they withdrew the right of the remaining "supplementaries" to do this examination without any warning or explanation. Their decision has thus far been final. One of the consequences of this arbitrary, manipulative and discriminatory decision became evident in April this year when the

new pay scales were announced. Those who are "fully qualified" received a 45 per cent increase, while the "supplementaries" received only 12 per cent increases. The authorities thus benefit by having two grades of radiographers as this serves to divide the cohesion of the radiographers as a group, as their conditions of work differ, and it also enables the hospital to make use of cheaper but skilled labour.

The vast difference in salary increases proved to be the final straw in the radiographers' battle for fair conditions - which stretched back many years. Last minute efforts to negotiate a solution were made, but the authorities were disinterested and unbending.

In desperation they resigned at the end of June. The same workload fell onto the remaining 33 per cent of the radiographers. They were so overworked that they too threatened to resign. Two months after the "supplementaries" had resigned, the hospital suddenly stopped all, including emergency, X-ray services between 11 p.m. and 8 a.m. on weekdays. They also cut back on other normal services such as routine X-rays during the day and certain specialised X-rays such as those necessary for the investigation of infertility in women

The T.M.S. takes up the Struggle:

The Transvaal Medical Society (T.M.S.) started to mobilise popular support at the hospital for the "supplementaries" when they first resigned. The campaign, however, really got off the ground when the hospital summarily discontinued the services.

Open meetings were held at Baragwanath Hospital, at which concern and fear for patients was expressed by many who attended. A number of courses of action were launched, including a vigorous press campaign, a widely circulated petition, and collection of information about suffering caused by the closures, for possible legal action later.

It was also widely felt that since the community of Soweto was affected, both community and labour organisations should be drawn into the campaign. A public meeting was held to which over 30 organisations were invited. An action committee was established to mobilise the community's support for the demands of the "supplementaries" and, the T.M.S., and the community at large.

The Authorities - Not Fit to Rule:

From the outset the authorities behaved with alarming callousness and irresponsibility. This attitude fairly characterises their attitudes from the very start of the crisis, e.g. when they summarily withdrew the examination under suspicious circumstances, and further over the years they made no meaningful efforts to attend to the radiographers' difficulties. Furthermore, they made no effort to prevent the resignations.

Initially they refused to be drawn into either private negotiations with the T.M.S. or into any public statements. When they finally did speak to the press, they attacked and slandered the T.M.S., and ignored the issue of the X-ray crisis. When they eventually commented on the crisis, they misled the public by saying that the "supplementaries" had resigned because they had been attracted by the higher salaries in private practice. They knew full well why they had resigned, and knew also that the radiographers couldn't work in private hospitals as their training was not recognised. They also led the public to believe that emergency services did exist when they quite clearly did not.

Finally, on the eve of the public meeting with community and labour organisations, the authorities announced with banner headlines in the press that they were to recommence a 24-hour seven day per week service from that very evening. This plan to reopen the service did not include re-employing the "supplementaries", and it was subsequently learned that the resumption of services was only scheduled to come on full-steam in December.

Although some people saw this move as a T.M.S. victory, the T.M.S. saw it as a cynical move to abort the growing alliance between the T.M.S. and the community by confusing the people. It was interpreted as an insincere effort to resolve the crisis. The T.M.S. recognised that there could be no solution that was not based on the re-employment of the "supplementaries". The hospital had previously tried to run a 24-hour daily service without them and had failed. This "new deal" was based on a formula that had failed only six weeks before. In addition, December - January - a notoriously busy period for the X-Ray department, was looming and if this patch-up solution collapses it will cause extreme hardship for many patients and a serious deterioration in the standard of care offered at the hospital.

This is why all the organisations involved in this crisis reject the current situation, and continue to press for the unconditional re-employment of all "supplementaries" without delay on terms acceptable to them. Then, and only then, will a decent service be acceptable to the people who are served by Bara.

In 1961 a Hospital Workers' Union in Durban was formed by SACTU (South African Congress of Trade Unions) was able to win substantial improvements for African nurses at King George Tuberculosus Hospital in Durban. This followed an incident where twelve nurses were severely caned by the Matron of the Nurses' Home at the Hospital. A major achievement of this struggle was the display of unity amongst workers and the assistance received from workers in many parts of the world.

THE WILSON ROWNTREE BOYCOTT - How it affects us!

Once again the struggles between workers and their bosses has resulted in unfair dismissals, strikes and the refusal to negotiate with a democratic trade union that represents the grievances of the workers.

The dispute at Wilson Rowntree in East London in February this year, resulted in five hundred workers being fired. These workers had gone on strike following the unfair dismissal of three of their fellow workers. These three workers had asked for written permission to fix a machine that they had got into trouble for fixing the year before. The foreman had refused and had fired them.

All these workers belong to the South African Allied Workers Union (SAAWU). The Wilson Rowntree bosses have refused to negotiate with SAAWU or with the democratically elected workers' committee at the East London factory. Instead, they have employed other workers from the many unemployed people in East London to replace those on strike (i.e. scab labour).

The Wilson Rowntree workers are still fighting their bosses over this dispute. They have called on all South Africans sympathetic to democratic ideals, to support them in their struggle by boycotting Wilson Rowntree Sweets and Chocolates, and providing any possible assistance to the striking workers and their families.

SAAWU is an unregistered union, which belives in mass participatary democracy, where all workers have a say in the policy and actions of their union. It is for these reasons that SAAWU is possibly the fastest growing union movement in the country.

The State has responded by launching an all-out attack to crush SAAWU. The South African and Ciskein Police have detained the SAAWU Leaders on a number of occasions. Twenty-four Wilson Rowntree workers who were detained by the Ciskein police went on a hunger strike and many eventually ended up in hospital. Furthermore, a document, alleged to have come from government sources, has put forward a strategy to crush SAAWU. The document was circulated to employers in the East London area.

Why have the Wilson Rowntree workers called for a boycott? The reason is that a consumer boycott plays a number of

roles in helping the struggle against exploitation of workers.

Firstly, it is an economic weapon acting simply to decrease profits. This can be especially damaging to smaller companies. It also creates bad publicity which helps to spread the boycott. Furthermore, it makes a product vulnerable to competition from other companies producing similar products.

Secondly, it helps to unite the community and the workers, by allowing the community to express solidarity for the struggles of the workers.

Thirdly, it unites all those who believe in democracy and justice.

Why then should we, as people in the health sector, support this consumer boycott?

Health is ultimately not determined by doctors and hospitals but by working conditions, wages, housing and living conditions Where demands for changes in these sectors are articulated by democratically elected worker bodies, and community organisations, it is important to support them. Ultimately it is their struggle that is our struggle - the struggle which when won will lead to a truly healthy society.

Furthermore, it is apparent that there are many similarities in the grievances suffered by the East London workers and those of the many exploited workers in the health sector; long working hours, low wages, poor working conditions, unfair dismissals and discrimination on the basis of race and sex.

We are witnessing the State's response to the action of democratic bodies that fairly represent the grievances of the workers. These democratic organisations have continued to develop despite harsh state action. If we as health workers truly believe in democracy, then we cannot allow these organisations to be destroyed.

By participating in the struggles of the workers in South Africa, we will help develop our awareness of both our own situation and that of the majority of the workers of South Africa.

Let us support this boycott and express our belief for democracy and justice.

FOOD FOR THOUGHT = RESOURCES AVAILABLE.

Food is a vital requirement for life. The availability of food, its cost, production, and distribution all indicate certain characteristics of our society. The issues relating to food can therefore be particularly useful for discussion by community organisations, unions, and student groups.

In addition to having ideas for discussion, it is often particularly useful to have available various forms of media to make the activities more meaningful to the participants. Films, books, and slide shows may help raise awareness and generate interest in particular topics.

We present below the outline of a simulation game that can be played in order to raise the awareness of the participants of many cru-ial issues related to food. The game should be adapted to more accurately reflect the problems experienced by those participating.

HUNGER IN OUR LAND = A SIMULATION GAME.

Broadly speaking, this game provides an experimental framework for understanding the present socio-economic and political situation, within a local or a global context.

As stated, the game revolves around "food" issues and should ideally be played over a lunch time meeting. Food is used to demonstrate unequal distribution of resources between rich and poor people. This "rich/poor"theme can be modified however, and the groups participating may be first, second and third worlds, or alternatively, working, middle and capitalist classes. Thus the game is adaptable and should be modified appropriately ("rich" and "poor" divisions will be used in this discussion, but are interchangeable with the above suggestions).

The game is best played with about 30 people in order to create a more visible proportion of rich and poor. Players are separated into the divisions suggested above. Each

person is given a number of tickets, allocated according to which group they fall into, with which they can "buy" thir lunch. In addition, each player is provided with a role-identity instruction sheet explaining into which category he/she falls and the implications of this. (For example: Being a member of the poorer class, you are at a disadvantage - you cannot enjoy eating most of the lunch provided as you do not have the resources , i.e. tickets).

The following proportions of group members may be a useful guide to game organisors:-

	Population:	Players:	Resources:	Tickets:
1st world/capitalist class.	6%.	2.	40%.	76.
2nd world/middle class.	33%.	9.	40%.	17.
3rd world/lower class.	61%.	19.	20%.	4.

"Rich" players are to eat their lunch in comfortable, spacious surroundings, e.g. set tables. "Poor" people are confined to a small space with no tables or chairs. Players in between (e.g. middle class, second world) are provided with modest tables and chairs. All these settings must be organised beforehand, and must be in close enough proximity with one another for players to interact.

A menu stating how many tickets are to be provided by each player in return for an item of food must be displayed. Thus "poor" people may find that they simply do not have the required number of tickets to purchase foods such as meat, but may be able to buy two slices of bread.

The outcome of the game, is ultimately the point of the game. The dilemma of how the players deal with the imbalance in food resources may take various forms. For example, the groups may adopt a more democratic attitude and work towards providing every player with an equal and adequate share of food. On the other hand (the more usual outcome), the game may result in revolution or confrontation where the "poorer" people revolt in order to take over a greater share of resources (food).

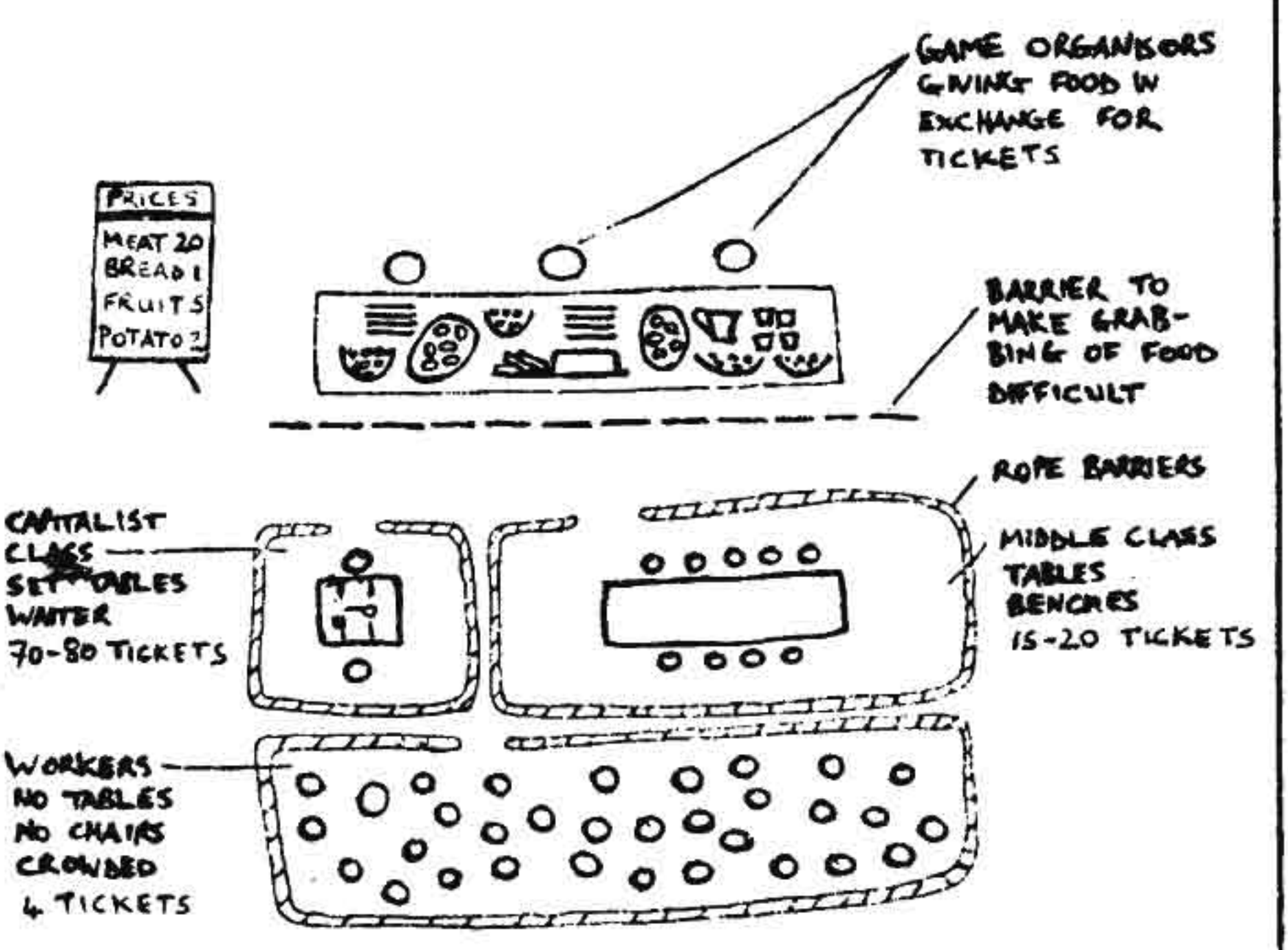
A facilitator is necessary to judge when the game has been played out. An interesting addition to the game, would be to state that the price of certain foods had risen. Reactions to this may be varied, and interesting to observe.

"Debriefing" or discussion sessions should follow the game.

This is a very important aspect and should aim to look at different people's reactions, emotions, and the strategies adopted by members of the different groups. Ideally this should provide valuable motivation for in-depth analysis of the complexities of relationships between rich and poor.

The game is usually extremely successful, in whichever form it is resolved.

SETTING FOR SIMULATION GAME



For more information about the game, contact the Editors.

Adapted from the American Friends Service Committee Publication.

NUSAS NATIONAL DIRECTIVE FOR HEALTH

The second Nusas Health Fact Sheet is now available. The Fact Sheet deals with facts concerning disease and death in the South African population. Excerpts from the Fact Sheet appear below.

**50% of all deaths in the coloured and african population are in children below the age of 5 years. Only 7% of deaths in the white population occur in the same age group.

**Trachoma is an eye disease related to poor water supply, overcrowding, and poor hygiene. It occurs predominantly in the african population group who form 99,7% of all reported cases.

**Life expectancy for males in 1976 was 65years for whites, 60years for asians, 52years for africans, and 51years for coloureds.

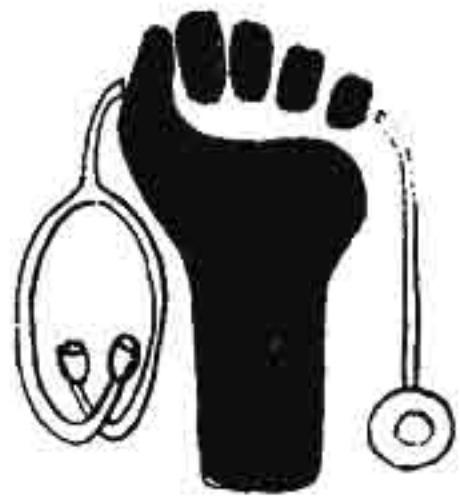
**South African statistics for tuberculosis show that our rates of the disease are amongst the ten worst in the world.

**The Minister of Health was forced to cancel a visit to the Johns Hopkins School of Public Health because of opposition to his visit by staff and students at the institution.

The Fact Sheets are an ongoing series dealing with different aspects of health in South Africa. Subscription to the series is obtainable by sending R2-00c to the Nusas National Directive for Health, c/o Room 109, Wits Medical School, Esselen street, Hillbrow, 2001.

SOUTH AFRICAN HEALTH GROUPS = IN OR OUT?

Two South African health organisations have recently received attention because of their attempts to retain membership of international organisations or to regain membership.



S.A.M.S.A.

The South African Medical Students' Association (S.A.M.S.A.) has been a member of the International Federation of Medical Student Associations (I.F.M.S.A.) for some time. The I.F.S.M.A. was to discuss S.A.M.S.A's continued membership at the meeting of the Association in Australia in August. A number of student groups including the Wits Medical Students Council, the Natal Medical Students Representative Council, the NUSAS National Directive for Health, AZASO, NUSAS, and the Black Students Society (Wits) opposed S.A.M.S.A's membership of the I.F.M.S.A. A memorandum was sent to the I.F.M.S.A. calling on the member associations to exclude S.A.M.S.A. from the international body. At the meeting of the I.F.M.S.A., the president of SAMSA resigned, on behalf of S.A.M.S.A., from the international association. It was apparently clear that had the membership of S.A.M.S.A. been put to the vote, the South African organisation would clearly have been excluded.

M.A.S.A.

In September this year, the Medical Association of South Africa (MASA) was readmitted to the World Medical Association (WMA) at their meeting in Lisbon.

The South African association withdrew from the WMA in 1976 after South African delegates were refused visas to attend a meeting of the organisation held in Japan. India also refused visas to the South Africans the following year. The South Africans also believed the organisation was becoming "too political" (Citizen, 29-9-1981).

This year, the South Africans reapplied for admission to the WMA, after the American Medical Association and the Secretary-General of WMA strongly encouraged South Africa to do so. MASA insisted on changes to the WMA constitution that would prevent any further politicisation of the activities of the WMA. This was accepted by WMA officials (Citizen, 29-9-81).

The move to readmit MASA to the international body was strongly opposed by a large number of black and white health workers and community organisations in South Africa. A lengthy memorandum was submitted to the WMA by groups representative of a large number of black health workers, including the Transvaal Medical Society, the Natal Health Workers' Association, Cape Health Workers' Society and twelve other health worker groups.

At a meeting held in Johannesburg, a large number of other organisations including COSAS, the Nusas National Directive for Health, the Anti-SAIC Committee and others supported this stand. Anti-Apartheid groups in Britain also gave support to the memorandum. In South Africa, MASA arrogantly questioned the credibility of the health-related groups opposing MASA's readmission.

At the meeting of the WMA, it was decided by a narrow majority that MASA should be readmitted. Those countries voting in favour of the move included the United States, Australia and Belgium, while those opposed to it included Britain and Nigeria.

It was stated on the SABC that Cuba too supported the move. It was subsequently learned that the Cubans supporting the move were a group of exiled Cuban doctors and certainly not representative of the Cuban medical profession. The SABC failed to mention that.

Also of interest is the fact that although groups like the Australian Medical Association supported the move to readmit South Africa, this was strongly opposed by groups of doctors, health personnel, church groups, and anti-apartheid groups in that country. (The Age, 19-8-81).

The voting procedure adopted by the WMA received criticism from the UN Special Committee on Apartheid. The voting strength of delegates to the WMA is determined by how many doctors they represent, and how big a financial contribution

they make to the organisation. The delegation from the United States, representing over 200 000 doctors thus has virtual control over the organisation.

The conference was attended by 400 delegates from twenty-four of the forty-five member countries. In the vote on the readmission of MASA to the WMA ten countries supported the move, nine opposed it, and a number abstained. The actual vote, however, was seventy seven for readmission, ten against and eight abstentions (Star, 29-9-81), reflecting the massive voting power of the U.S.A. delegation which had declared its intention to "serve as advocates for MASA" (Star, 28-9-81).

A number of countries attending the meeting, including Nigeria, Ghana, and Liberia threatened to leave the organisation and form a new body if South Africa was reaccepted. A compromise motion proposed by Great Britain suggested the establishment of a fact-finding mission to investigate allegations of unethical conduct by South African doctors. The motion was defeated by a vote of sixty nine to twenty six. Clearly a struggle for democracy within the organisation itself has still to be waged.

WHY EXCLUDE SOUTH AFRICAN ORGANISATIONS ?

Numerous reasons have been put forward for advocating the exclusion of official South African organisations from international groups. Most of the organisations concerned are undemocratic, unrepresentative and supportive of the present lack of democracy in South Africa.

SAMSA, for example, represents students from only three of the seven medical schools in the country. The medical students of Wits and Cape Town recently withdrew from SAMSA leaving only Pretoria, Stellenbosch and Bloemfontein. The Wits Medical Students' Council had objected to the failure of SAMSA to recognise the real health problems of South Africa, to oppose racism in the medical schools and educational

institutions generally and to take up issues such as the threatened closure to Africans of Natal Medical School.

MASA, with 9 740 members does represent the majority of the 14 000 medical practitioners in South Africa, particularly those in private practice. The membership of MASA, however, is drawn from a privileged elite in the South African society, and thus reflects the needs of that elite and not those of the overwhelming majority of South Africans.

South Africa is an undermocratic society with the vast majority of people having no access to real political power. The majority that controls this country uses its power to appropriate the major share of the resources of the country. The political, economic and social injustices are protected and preserved by those that benefit from the system. No organisation rooted in such a select and privileged minority can possibly articulate the needs and demands of the majority of the people. MASA is certainly in a position to reflect the needs of many of the doctors in this country, such as advocating increased fees, but these are not supported by the majority of the population. The majority of South Africans might demand a free and accessible health service for all- but the organisations like MASA would oppose that because it is not in the interests of the private doctors.

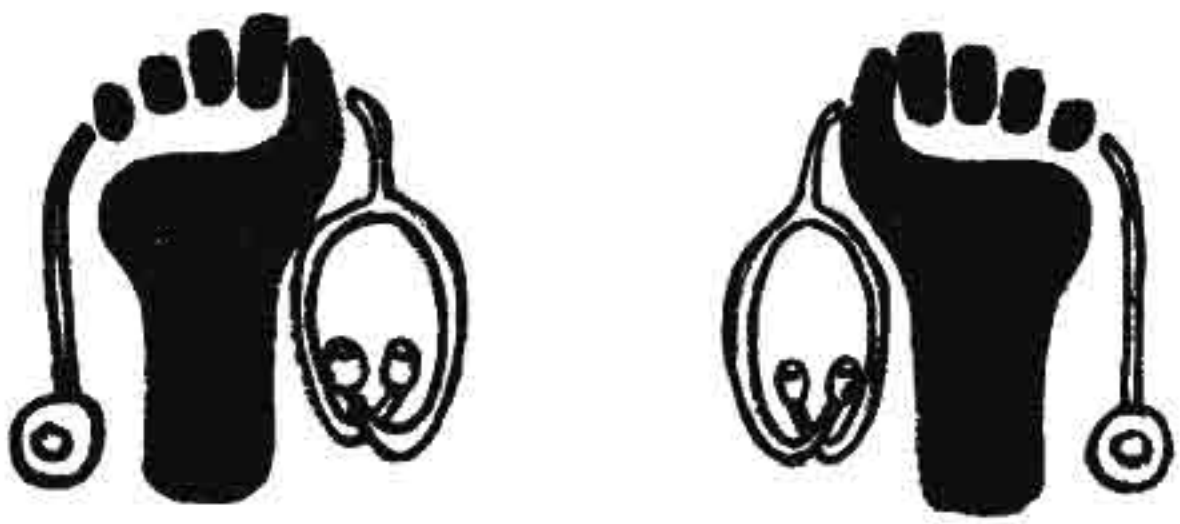
MASA also maintains close links with statutory bodies such as the Medical and Dental Council (SAMDC), which reflects the views of the state on health issues, (see Critical Health, Number 3) and contains an inbuilt majority of government-nominated members. The president of the SAMDC is also currently the president of MASA.

MASA has a bleak record of opposing those aspects of our society which destroy health. Health services are most accessible to those that have political power and those that can afford to pay for them.

Health services are segregated according to racial group and class position. The best health services are reserved for the capitalist class and the skilled workers - unskilled workers are easily replaced when sick and are not in a position to demand adequate services. Poor health results from poverty, poor wages, inadequate housing, improper sanitation and a lack of power and so it is the workers and their families that suffer most.

MASA certainly does not promote the establishment of a democratic society in which health will be a basic right of all who live in the society, and in which the workers will participate in all decisions affecting their lives including the availability and cost of health services. Some people would argue that these issues are not really the concern of MASA, however, it is surely the responsibility of a group like MASA to oppose all those aspects of our society that are detrimental to health and to promote all activities that in the long term, will be of benefit to the health of the majority of South Africans.

Accepting an organisation like MASA to be a member of an international body, gives support to its activities and presently undemocratic role in South Africa.



WHEN SHOULD SOUTH AFRICAN ORGANISATIONS BE RECOGNISED? SHOULD SOUTH AFRICA BE EXCLUDED FROM ALL CONTACT ?

There are growing moves to isolate South Africa from all forms of international sporting, academic, military and economic contact. These measures are aimed at exerting pressure on South Africa to change its undemocratic nature, and to lend support to progressive groups struggling within South Africa.

Those progressive groups within the country, however, would benefit from contact with democratically minded people outside of the country. If there is a move to isolate South Africa from international contact, but at the same time it is recognised that some forms of outside contact are valuable to those groups striving for a democratic South Africa, then how is that exchange of ideas to take place ?

Any overseas visitor lends some credibility to the present South African state. This, however, can be minimised or negated by a careful consideration of the activities of progressives coming to the country.

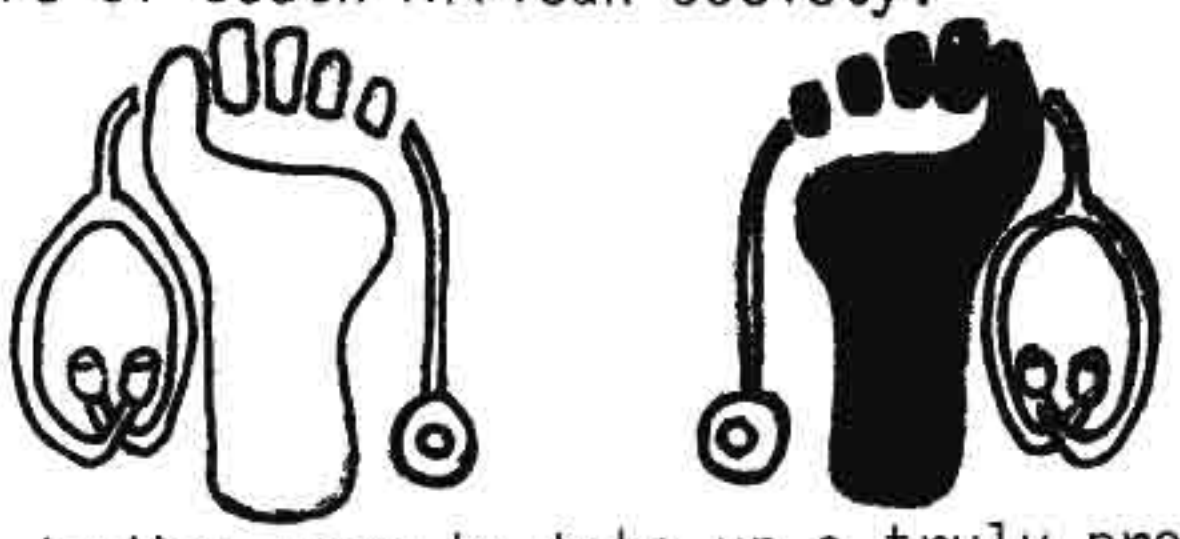
First of all, they should come to South Africa under the auspices of some progressive grouping within the country for example the Natal Indian Congress or NUSAS. Secondly, they should allow the hosting organisation to arrange an itinerary that puts the visiting progressive into contact with those groups that could benefit most from the skills and information available from the visitor. Thirdly, contact should not normally be made with official bodies such as the Medical Association of South Africa, or the state-controlled broadcasting corporation (SABC). The whole visit should be treated as a low-profile affair, rather than arranging the vast news splashes we see when, for example, a delegation arrives from the American Medical Association. Fourthly, the visiting democrat should actively participate in activities organised by progressive local groups and not merely come out under their auspices.

Finally, it becomes the responsibility of the visitor to go back to his country of origin and further the understanding and awareness of South Africa and the activities of progressive groups aiming to build a truly just and democratic society.

In this way, assistance can be given to those struggling for a truly just and free South Africa.

WHEN SHOULD SOUTH AFRICAN ORGANISATIONS BE RECOGNISED?

Recognition should be reserved for those non-racial organisations that are striving for a truly democratic South Africa. This aim must be demonstrated by both their stated objectives, and their activities and actions. Recognition for progressive organisations rather than for the official South African bodies gives support to those struggling for fundamental changes in the structure of South African society.



If official bodies were to take up a truly progressive approach to solving the health problems of South Africa and working for a truly healthy society,then they too should be recognised. It is clear, however, that official South African bodies will never hold such views in the present South African state.

MALNUTRITION = WHY IS IT NO LONGER NOTIFIABLE ?

A notifiable disease is one which, if defected must be reported to the Department of Health. Notification of disease was first introduced in 1919 after the Great 'Flu Epidemic. The Public Health Act of 1919 contained the first list of notifiable diseases. Since then, the list has seen various additions and deletions. The reasons for these changes are often unclear. In this article, we examine some aspects of kwashiorkor, a type of malnutrition, and its removal from the official statistics in 1968.

In 1967 (the last year for which official figures were collected) the following cases of kwashiorkor were notified (1):

Whites	-	7.
Coloureds	-	1 046.
Asians	-	12.
Africans	-	9 765.

In 1968, a spokesman for the Department of Health, rationalised the removal of kwashiorkor from the list of notifiable diseases by saying that "notification was far too time-consuming", "figures too inaccurate" and that a "general idea" of the prevalence of kwashiorkor had been gained by that stage.

It is necessary to look more carefully at this response by the state to a problem of such magnitude, It is important to recognise that kwashiorkor represents a situation of extreme malnutrition which manifests in a specific way. The vast majority of undernourished children will not suffer from kwashiorkor itself, but will neverthless be underweight for their age. Kwashiorkor itself thus represents the tip of the iceberg of undernutrition.

The results of a number of studies of the prevalence of malnutrition among black children in South Africa (2) is of interest.

Group:	Year:	Age(yrs)	Weight 3%*. (%)	Height 3%*. (%)
Transvaal:	1973			
Rural		0-7.	47,3.	
Urban		0-7.	40,3.	
Muldersdrift.	1976.	1-6.	27,6.	22,8.
Soweto.	1977.	2.	18,9.	63,5.
		2-5.	29,1.	66,4.
Umlazi.	1978.	0-1.	6-12.	1-10.
		1-6.	10-30.	35-63.

* This column represents the percentage of children below the third percentile on standard growth charts. In a normal population, 3% of the children of a given age fall below this weight and height. We see here, however, that a substantial percentage of children fall below this line.

Children's growth characteristics are generally evaluated in terms of the National Centre for Health Statistics (NCHS) criteria. While these were originally derived from a population of middle-class American children, it has been proven (3) that under adequate nutritional conditions, african children have the potential to show the same growth patterns (9). These NCHS criteria are in addition accepted by the World Health Organisation and quoted in standard paediatric textbooks.

Referring to the fact that judging by NCHS criteria, one half to two thirds of children in developing countries are malnourished (5), some authors including Richardson have advocated a change in criteria for defining undernutrition They suggest that because so many children are underweight according to the standardised charts, the standardised figures must be incorrect. Their solution is to try and construct local standard figures - where only the most seriously undernourished children will be classified as underweight-for-age.

It is widely accepted that "weight-for-age" and more especiall "height-for-age" data give an accurate assessment of a child's nutritional status (7). A further suggestion made

by researchers like Richardson is that weight should not be compared with age, as is usually done, but with height. An undernourished child may be both shorter and underweight for his age, but because his body proportions are normal his weight-for-height will be normal. Richardson thus makes the statement that only 0,9% of black children (aged 1-6 years) are acutely malnourished, compared with 0,4% of white children (6). A brief survey of any rural paediatric ward refutes this assertion, which has also been questioned by respectable child health workers (2). The effect of manipulating the statistics in this way would be to grossly underestimate the extent of undernutrition in South Africa by hiding the realities that would be revealed by using the generally accepted measures.

in social class V in the UK for 1970 - 1972 — 31 per 1 000 live births.[5] This pertained despite decades of National Health and social services. Other improvements in the public health of the very young in the less privileged populations have been noted.[6,8]

To speak of the problem discerned as 'the tip of the iceberg' without being able to supply valid evidence is entirely misleading. As the Minister of Health noted, it contributes to placing us 'in a very bad light in the eyes of the rest of the country and of the world' (*The Star*, 30 May 1980).

B. D. Richardson

National Research Institute for Nutritional Diseases
South African Medical Research Council
Johannesburg

1. Adam[illegible] Geefhuysen, J. and Hansen, J. [illegible] (1978): S. Afr. med. J., **53**, 703.
2. Richardson, B. D. (1979): *Ibid.*, **47**, 688.

S.A.M.J.(2.8.80)

It is apparent that the state as well as certain researchers use statistics, or abuse them, according to their particular interests. While this is not unique to South Africa it should be well understood. A critique on health statistics in the United Kingdom stated:

> "When we examine these (health) statistics, we are not seeing an objective representation of the physical and psychological well-being of the population - or even of their pattern of health care. What we see is a set of data ... which reflects the particular concerns of the state as the major provider of health care." (8)

The Department of Health and various researchers have thus committed themselves to dealing with the problem by saying that there is no problem. No accurate statistics are kept of the degree of undernutrition in the children of South Africa. Furthermore, attempts are being made to change the standardised weights and heights so that our undernourished child population appears healthy.

Malnutrition is not the result of the ignorance of those who suffer from it. It is a disease that results from the fundamental structure of our society. It is a disease related to the exploitation of workers, the migrant labour system, the high prices of basic foods, the lack of access to land - factors at the very root of the structure of our society.

Should we Notify ?

When one understands its causes, the question arises whether in fact malnutrition should be notified. Some argue that notification will always underestimate, and thereby detract from, a problem of this magnitude. It will also place it within a "medical" framework where it does not belong. However, it can be said that accurate notification, coupled with random monitoring surveys (by democratic organisations and community groups) could attract greater attention to the problem of malnutrition and especially to its causes.

More accurate notification could be achieved by taking into account death from undernutrition, ill-health due to illness to which undernutrition predisposes, and anthropometric data i.e. weight-for-age statistics derived from random measurement surveys.

Undernutrition will not go away by saying it does not exist. It will go away only when the social and economic conditions that predispose to undernutrition are replaced by conditions in a more democratic society. Until that time it is important to know how many people are suffering from this condition which is an indictment of our present society. This information can help generate the awareness necessary to promote a truly democratic society.

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A CONDEMNATION OF REPRESSIVE STATE ACTION

The last few months has seen another spate of political detentions, bannings and other forms of repression.

Critical Health sees this as part of the State's ongoing attack against the democratic and progressive forces. These repressive acts reflect the refusal of the State to recognise the ever increasing demand of the people for a free and just South Africa.

We condemn these acts of the State and reaffirm our commitment to working with others for meaningful change.

"CRITICAL HEALTH" is edited collectively (see page 1), published by the Students' Representative Council for NUSAS National Directive for Health, each of 1 Jan Smuts Avenue, Johannesburg. Printed by the Central Printing Unit of the Witwatersrand, Johannesburg.

A RESEARCH FORUM

At a meeting of people involved in health - related research in the Johannesburg region, it was decided to request Critical Health to play a role as a forum for discussion of health research and thereby bring people in touch with others doing work which they are interested in.

Critical Health will in future attempt to do this. We hope to give a brief but clear sketch of the research being undertaken, together with names and ways of contacting the researchers for those interested in the project.

Communication of research projects is essential and unfortunately lacking at present. We therefore urge you to send the details of any research you may be doing, together with an idea of the scope for others to become involved. We would also like to hear from you if you have something you would like to do, but cannot find an outlet.