Health Policy Advisory Center

Since its inception in 1968, the Health Policy Advisory Center—known as Health/PAC—has served as a unique progressive voice for changing consciousness on domestic and international health priorities. Through the Health/PAC Bulletin and its books, Prognosis Negative and The American Health Empire, and in its outreach to a national network of grassroots activist groups, Health/PAC continues to challenge a "medical-industrial complex" which has yet to provide decent, affordable care.

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Health Policy Advisory Center
17 Murray Street New York, New York 10007 212/267-8890

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Executive Editor Joe Gordon
Staff David Steinhardt
Volunteers Julie Friesner, Loretta Wavra

Associates Carl Blumenthal, Pam Brier, Des Callan, Michael E. Clark, Mardge Cohen, Debra De Palma, Barry Ensinger, Peg Gallagher, Kathleen Gavlin, Dana Hughes, Marsha Hurst, Mark Kleiman, Sylvia Law, Alan Levine, Judy Lipshutz, Joanne Lukomnik, Kate Pfordresher, Susan Reverby, Leonard Rodberg, Alex Rosen, Dave Rosner, Diane St. Clair, Gel Stevenson, Rick Zall.


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South Africa: The State of Ill-Health

The heightened state of violence in South Africa has created a towering health emergency: Children are languishing in jails, young men are being shot down in black townships, and workers' rallies are being brutally crushed.

All of this is unfolding against a background of massive ill-health produced by apartheid's cruel living and working conditions. As the Pretoria regime grows even more entrenched and isolated, governments in London and Washington continue to play along in a selfish, antiquated game that reaps dollars, pounds and rands, while it wastes women, children and men.

Increased repression is severely straining the nation's chronically deprived black health services, a highly fragmented, ill-equipped, sparse network of overcrowded hospitals and clinics.

As with all South African services, the majority of the people are squeezed onto the bottom rung. The disparities in the separate and unequal health services of the four main "population groups" are extreme: state of the art medicine for whites, while in the black hospitals it's often "one patient under the bed, two in the bed and two on the floor."

Behind the thickening curtain of press censorship, the death toll is climbing. Torture has become routine. In the hospitals, invading security police hunt their own gunshot victims, hauling them off for interrogation, imprisonment, or worse. Clinics are searched and medical records seized. Defiant healers are dismissed or martyred, while acquiescent physicians are pressed to abandon their medical scruples and become accomplices of the state.

Slowly, word of these abuses is reaching our ears, but too many defiant South African voices remain muffled by cement walls. South African health leaders—some of whom speak in these pages—have called on us to help expose these conditions, and we have drawn upon all of our resources in an effort to do so. The result is this special issue of the Health/PAC Bulletin which is dedicated to the many brave people fighting for health and social justice in South Africa. We support your courageous work, and clasp your hands as friends.

As the poison of apartheid continues to flow, we offer our readers and concerned people everywhere this sampling of some of the key issues and concerns surrounding the fight for health there. Our hope is that together we can help speed the hour when apartheid's crushing weight on more than 25 million South Africans will be forever lifted. —The Editors
HEALTH/PAC

"APARTHEID WILL GO"

An Interview with Dr. Diliza Mji

Diliza Mji is the president of South Africa's National Medical and Dental Association (NAMDA), which represents approximately five percent, or 1,000, of the nation's doctors. A thin, energetic man who carries running shoes and English cigarettes with him in his travels, Mji, at 34, is one of the most experienced health care leaders of the anti-apartheid movement.

Sketching the staggering inequities in health services and training under apartheid, Dr. Mji is sober, intense and persuasive, but his good humor is always with him. His attache case is crammed with reports, charts, slides and notes which he often draws upon to sharpen his points.

Dr. Mji toured the U.S. and Canada in May and early June, after receiving Health/PAC's 1987 Samuel Rubin Health and Social Justice Award. He crisscrossed the continent, presenting the two faces of South African health care to medical students, health workers, academics, journalists and ranking political and organizational leaders. While he was in New York, I met with Dr. Mji to find out more about him and his organization's work.

In the mid-1970s, Diliza Mji served as the vice-president and later the president of the South African Students Organization (SASO), which was founded by Steve Biko. SASO's far-flung activities helped forge the first nationwide youth resistance to the Pretoria regime. During the 1976 Soweto uprising, Mji was imprisoned and kept in solitary confinement for six months without charge. He was released in Feb. 1977. Later that year, he was detained again, along with 90 other political activists, this time for 14 months. Upon his release from prison in Nov. 1978, he was immediately served with a restrictive five-year banning order, confining him to one district and preventing him from completing his medical degree.

Mji, the son of physician parents, both with long histories of political activism, was undeterred by government harassment; he secured a court order that allowed him to attend classes and complete medical school in 1979. Today he works as a surgeon at King Edward VIII Hospital in the east coast city of Durban, where he lives with his wife, a teacher, and their two children.

Q: Can you tell us about NAMDA's efforts to aid victims of police violence under the state of emergency?

MJI: The state of emergency was declared with the sole intention of disrupting and disorganizing the political structures of the people. This takes many forms, including direct repression: shooting people when they hold meetings, moving into townships and cordoning them off so nobody can go in or go out. Even if people find their way to hospitals, they are not safe, because if they are hurt and found to be victims of birdshot and bullet injuries, that makes them culpable. They are automatically arrested. You know, it's like a sentence to be shot by the police, ironically. So we found that people were staying away from hospitals with nasty injuries and presenting later with resulting high morbidity and mortality.

Our response was to make contact with the community organizations and provide training sessions in emergency first aid so that at least people in the townships could themselves triage the injured into those who require emergency treatment now, those who can wait, and those who can be handled in that township. We did this because it didn't help if we were simply in contact. If the townships were cordoned off, nobody could go in, right? The people had to be able to look after the injuries themselves. And even if we were in...
The National Medical and Dental Association (NAMDA) was founded in 1982 by practitioners who, as healers and citizens, actively oppose apartheid. NAMDA has emerged as the moral alternative for doctors whose consciences prevent them from participating in the Medical Association of South Africa (MASA), which remains aligned with the Pretoria regime.

The need for a progressive and principled organization intensified following MASA's shameful role in the 1977 police cover-up of the murder in detention of Steve Biko, the leader of the Black Consciousness movement. MASA's complicity with the authorities prompted the members of a smaller group, calling itself the Alternative Medical Association, to create NAMDA as a national body determined to eradicate apartheid and create a democratic health system within a nonracial South Africa.

In five years, NAMDA has attracted nearly 1,000 members, 65 percent of whom are black. Its guiding assumption is that the ill-health of South Africa's majority is inextricably linked to the economic, political and social structure of apartheid. For NAMDA's members, ending apartheid is both the precondition of health and the prerequisite of an effective health care system.

In the face of growing repression, NAMDA members, often at great personal risk, have spoken out against detention and documented the injurious conditions under which detainees are held (see reports in this issue). Beneath its banner "Health Care For All," the organization undertakes a range of practical projects aimed at improving care under prevailing conditions as well as developing comprehensive plans for a post-apartheid health system.

There are two North American solidarity groups with direct links to NAMDA. In the U.S., lines of communication are maintained through the Committee for Health in Southern Africa (CHISA)—see Media Scan—and Health Watch South Africa in Toronto. NAMDA welcomes associate members outside South Africa. For information, write: NAMDA, Box 17160, Congella 4031, South Africa. □

Trade unionist injured by police birdshot is attended by physician, following recent annual general meeting of Metal and Allied Workers Union in Durban.
hospital and they came to us, they would be arrested. Out of these conditions came the program to train first-aid workers. We’ve trained 1,000 people so far.

The importance of this project to us is two-fold. First, it fits in directly with one of our broader aims which is to demystify health. As people gain control over their lives, they also gain control over their health. Second, it fits in so well with the whole new political initiative of people’s power. This power is formed in terms of education and people’s health. These trainees might be the future nuclei of the health committees [in the post-apartheid society].

Q: Can you elaborate your position on detention?

MJI: It was important for us to come out strongly in condemnation of the system of detentions as against MASA’s refusal to condemn it. MASA maintains that the solution to the problem lies in allowing detainees access to certain panels of doctors. We oppose this because it does not make it possible for people to see doctors of their own choosing. But more importantly, we are adamant that the system of detention itself cannot be reformed, because people are dying and will continue to die, despite recommendations made over many months calling for panels of doctors, inspectors of detainees and so on. . . . We’ve concluded that detentions are bad and that the system of detention itself has to be abolished.

Q: What can people in the international community do to help you?

MJI: First, people can become associate members of NAMDA. Second, support our programs: publicize widely whatever information we give you; make it known, because torture and things like that thrive on secrecy, and when the secrecy veil is lifted, it can be stopped. And then there is the inequality of our system: We are now poised at a time in our history when we are preparing for a post-apartheid system. Experiences in other regions have taught us that you need hard skills when the chips are down; some of the ideologically antagonistic professionals will leave, and if they can’t leave, they will stay, but with a view of actually destabilizing the situation. So part of our plan in NAMDA is to develop those hard skills now, to send some of our own people to get training in the disciplines that matter. I’m talking here of epidemiology, nutrition, and so on, which are so important to a country that’s as ravaged by infection and malnutrition as South Africa is.

Of course, there are other areas which are of equal importance, such as engineering: we would like to train as many South African engineers as possible. As far as white and Indian doctors are concerned, I think we’ve got enough. The question is distribution now. We’ve got to start training African doctors, dentists, pharmacists, because all these people cannot be guaranteed to be there Day One post-liberation.

Q: Beyond supporting NAMDA’s work, are there other things that we might do that would be useful, such as speak-

MJI: I’m so glad you brought this up. MASA is presently engaged in a debate about how to handle us. There was a time when they thought we were just radicals making noise, that after a time our energies would dissipate and that we’d just vanish. In fact, we’ve not only survived, but we’re consolidating. Now I think their strategy is to attack us.

Our approach to MASA has been that as long as they don’t attack us, we won’t attack them. And at the present time, frankly, we’re probably not strong enough even to begin to retaliate, because the sort of resources they command are far beyond what we could muster. But that’s just where people in the international community come in, because MASA has close links with the American Medical Association.

The AMA was crucial in bringing MASA back to the World Medical Association . . . . The people in the AMA must be asked whether they know what they’re supporting. They must ask themselves: if they were physicians in South Africa what would their attitude be towards detention? They must be asked to reconcile their answer with the position of MASA on detentions. They must be asked: if they were in South Africa, what would they say about the Group Areas Act, about influx control, about removals? Three million or more people have been resettled in South Africa, with dire consequences on health. They must be asked these questions. And the answers they give should determine their attitude towards the Medical Association of South Africa, which has been silent on all these questions. In fact, they have tacitly supported the government.

Q: We read NAMDA’s offices were raided. Is the government actively working to undermine you?

MJI: Our offices were raided about nine months ago. What the police said when they came was that they were concerned about our discussing the academic boycott at our penultimate congress. We were the first organization to openly debate the question of an academic boycott. We saw the need for this because in medicine, more than in any other field, there’s a lot of traffic from overseas people. Physicians come ostensibly to improve the health situation in the country. Our viewpoint has always been that they come to do more harm than good.

In South Africa, there can never be any external solutions. South Africa’s health status is a result of the apartheid system itself. We’ve never been persuaded that these so-called experts would bring any solutions. They never mingled with any people from the progressive movement. After being in some of the big showcase hospitals, they would go back to where they came from and say what a beautiful system of health care South Africa had! They would never go to the homelands, where the majority of the people live and where they suffer.

So it was against this background that we had debated the question of an academic boycott. Unfor-
fortunately, that debate could not be carried to the conclusion because of the raid and the fact that the state of emergency specifically made it illegal even to talk about that. So, legally speaking, we had to stop the debate, and that was the ostensible reason why we were raided immediately after our 1985 conference.

Q: How do you prepare to meet the possibility of future harassment or repressive police actions?

MJI: I think that one prepares for that eventuality by accepting that it may happen and getting involved despite the consequences, but that’s just a personal view. I think the ability to withstand repression is directly related to commitment, and commitment itself arises out of a clear understanding and appreciation of the workings of the system and of what one is striving for. For NAMDA members that’s a democratic health system—something that people can stand up for.

But this is a very interesting topic you bring up because a lot of people have been asking why we haven’t attracted much more police attention. Personally, I think there’s a lot more happening on the first level of organizations, that is in the political struggle, the trade unions, and student organizations. The police know that we are a service organization. If there were no detainees, they probably think we’d close shop.

The other crucial difference between student organizations and an organization of physicians and dentists is that we represent members of a powerful class. If they interfered with doctors, they probably would have to face a lot of criticism not only from doctors in the country, but internationally. We’ve built a strong international network of friends. Nothing stops the South African government, but it’s something they would have to consider.

Q: Let’s say the government was willing to risk this and moved to crush the organization. How would the leadership and members continue NAMDA’s vital work?

MJI: The straight answer to that is that people would be resourceful enough to get around that problem. The support for this comes from a number of experiences that we’ve had in the history of South African politics. There have been numerous waves of repression that have come and gone, and in the wake of these repressive measures, forms of organization have arisen which have actually been higher than the pre-existing forms.

The examples can be found in the political struggle. At the present time, the NAMDA struggle is just a supportive effort within health, to look after, say, victims of apartheid, violence in the communities, the state of emergency, and when workers’ rallies are crushed.

I am quite certain that there will be opportunities to continue to meet these needs, because they are real needs. As I’ve said, we’ve already produced a base of about 1,000 people trained in first-aid skills. We have not yet evaluated how far these people can go if left to themselves. But what this means is that there is something to start from. . . . The other important factor is the people’s structures which have emerged under conditions of repression: the street committees and the like. These are organs of political power that function at the most direct level. They exist despite the emergency situation. So one thinks that on balance some of our work would carry on. I’m not saying things would continue as if nothing happened. Sure, there would be some amount of disorganization, but it would not be permanent.

Q: You’ve mentioned that your organization is working towards a democratic health system. Is your goal to create a national health service?

MJI: Yes. When we started off, we knew what was wrong with health in South Africa, and we were protesting apartheid as being directly inimical to the health needs of the people. But at that stage—about four, five years ago—we really did not have a vision of what would take the place of apartheid medicine. We had an extensive critique: we could tell you that every minute there is a worker who dies in the mines or what the level of malnutrition is in the homelands. But recently, the political struggle has matured to such a level that it is not oversimplifying to begin to think about a post-apartheid set-up. We are now being faced with the question of what is going to arise out of the ashes of apartheid health. It is a question that is beginning to preoccupy us more and more. The certainty of apartheid going is there. I mean it is going to go. People constantly ask, “What type of health system are you going to put forward in your country?” And we have dodged that question for a long time. There were a number of reasons we couldn’t answer it. We were uncertain about the type of membership we had. NAMDA has a private and a public sector. We were forced at the beginning to tread softly, not to tread on
people's corners. Over the years we've had the opportunity to work through these questions.

So now, we really want to say that NAMDA will put forward as a minimum, as a minimum, a national health service. Because our experiences of places like the U.K. have taught us that it is not enough just to have a national health service. It would seem that there needs to be more; a national health service just looks at the question of health delivery, but there are other aspects to health besides consumption. There are the questions of the production of health: who produces the drugs? where do they come from? and what of national needs and planning? This we believe is a bigger aspect, a smaller part of which is a national health service—but we think this is a good place to begin.

Q: Are you doing anything to help organize nurses?
MJI: There are about 135,000 nurses in South Africa, most of whom are black and female—and that in itself tells you that you are looking at the gender question, right?—and black oppressed people. So the urgency of organizing nurses cannot be overemphasized, because in doing so those aspects of our struggle will be addressed . . . Would nurses (best) belong in a professional organization or in a sort of union organization? Most of us feel that the conditions under which nurses work in South Africa are so bad, I mean the meager salaries, the long working hours and the heavy regimentation at work, and not being allowed to join any organization except SANA [South African Nurses Association] . . . that they may best belong in trade union organizations. This is because the bread and butter issues that confront them are related to their wages and working hours . . .

NAMDA decided in our last congress to put off membership of other categories of health workers for the rest of the year. We're going to examine very carefully the implications that opening up membership might include. But clearly in South Africa today, it would seem that by their sheer numbers nurses cannot be absorbed into a body of doctors that is numerically smaller. As for SANA, it is an absolutely oppressive organization. It can't serve any progressive function. We can't reform it. It is the organization that is actually carrying on the oppressor's work. We might like to break its back.

Q: You were banned, imprisoned and kept in solitary confinement for six months? How does one keep oneself going in the face of such threats?
MJI: These are the realities of the South African struggle. We know we live in an oppressive society. Speculation about what will or will not happen to us is futile. We must act.

Q: How do you respond to those who say it is not a doctor's job to take up political issues?
MJI: There is nothing that anyone can do to bring about conditions of health under apartheid. We are working to democratize society. We don't see a separation between the health struggle and the political struggle. The struggle for health is the struggle for democracy. □

HWA
An Organization for All Health Workers

Among the important organizations in the struggle for a democratic health system in South Africa is the 600-member Health Workers Association (HWA), founded in 1979.

"HWA seeks to represent all health workers and their interests, regardless of their job classification," its general secretary, Dr. Prakash Valabh, recently told the Bulletin in New York. "Only by mobilizing the entire health sector can we bring about change," added the physician from Soweto's Baragwanath Hospital.

In addition to managing several community health projects and providing emergency health training and services, HWA is working with other health organizations to organize a national Health Charter Campaign aimed at involving the South African people in the struggle for basic health rights. Like the historic South African Freedom Charter on which it is based, it expresses the majority's aspirations for fundamental conditions of health and health care. "We see the campaign as a way of putting health concerns into the hands and minds of people in the community," explained Mardulate Tshabalala, an RN who serves as the Association's assistant secretary. "It is absolutely vital to take health concerns beyond the academic and university levels and into the lives of all our people. We also believe that the Health Charter can link health workers with the community so that they can work side by side to bring change."

One of the Association's primary goals is organizing all "non-classified workers" into a newly formed National Health Workers Union, under the banner of the Congress of South African Trade Unions (COSATU).

"Our struggle is in its infancy, and the obstacles are very great," says Tshabalala, "but we are determined to organize all the workers, the porters, the cleaners and the drivers, so that we can all work together to struggle for better health and for the liberation of our people." HWA's address is: P.O. Box 38266, Booyens, 2014, Johannesburg, South Africa.
In response to the abusive political detention of thousands in South Africa, the National Medical and Dental Association (NAMDA) organized a special service in 1985 to help provide care for released detainees. The horrendous conditions—under which blacks are shot at random and an estimated 30,000 people have been held without trial since June 12, 1986—are made clear in two NAMDA reports, "The Treatment of Detainees," (see box) and the following Health/PAC abridgement of its "Report on Detention of Children and Adolescents."

In the past two years NAMDA doctors have seen, examined and counselled over 600 patients who have either been detained or assaulted by law enforcement officers. A significant percentage of these were children and teenagers under 18 years of age. Slowly, we have begun to understand the far-reaching effects that detention, torture and intimidation have on young people. Through selected case histories, we hope to show the responses of youngsters to their maltreatment and to draw some conclusions in terms of our approach to management and rehabilitation. A much fuller and more detailed presentation along these lines is intended at a later date.

In explanation of the brevity of the selection of cases reported here, it should be mentioned that a small group of doctors, all working full-time and giving their services to the treatment of detainees entirely on a volunteer basis, have very little time in the current circumstances in South Africa for the meticulous and painstaking research that is required for a more fully documented publication of this nature.

A 14-year-old, Godfrey, from Daveyton, told us that he was detained by the S.A. Defence Force. Wires were wound around his fingers and attached to a car battery, and he was shocked repeatedly. In the surgery [doctor's office], he sat with his head bent, avoiding eye contact, and saying very little. He had extensive burns to the right hand and thumb, and the nail and the end of the thumb were severely burned. Several of Godfrey's other nails were burned, with adjacent scarring. It was some weeks before the use of his hand returned.

A group of teenagers, about 16 years old, three girls and a boy, had all been detained. They had been given electric shocks and kept in communal cells. Three of the girls who had been in one cell together expressed the same symptoms, and this appeared to be a reflection of their strong identification and support of one another. They complained of pain and weakness in their hands (the site of the shocks) and general body pains. The fourth, a boy, was physically well. The four of them were interviewed together in a group and whilst none of them complained of psychological problems, it appeared evident when they were more closely questioned that they were all suffering from post-traumatic stress disorder.

The severity of this disorder was, however, not as great as might have been expected, and this was also in keeping with the trends that have been observed. These are as follows: (a) that post-traumatic stress disorder is to be expected after torture; and (b) that younger people display less severe symptoms than older people. Related observations are that: (a) being in communal cells with others who are known and trusted can be an important source of support, and may lessen the degree of psychological trauma; and (b) if major symptoms are not reflected, is it not possible that the experience is in fact having deeper and more long-lasting effects on these children?

This group of teenagers clearly indicated that the torture was the most terrifying and serious experience of their detention. They were very much afraid of re-detention and a repetition of this experience. One of this group was a 17-year-old mentally retarded boy who was unable to read or write. Initially he could give no account of what happened to him in detention. He would only say “yes” or “no,” never giving free answers. He sat with his head down, appearing to be very anxious. His verbal response was very limited.

Follow-up is a problem with detainees, but this young man returned on three occasions, on the last of which he was much improved. He no longer appeared to be depressed, and for the first time he was able to tell us what had happened in detention: he had been interrogated and tortured with electric shocks. A relevant
comment: every person seen, regardless of their mental status, should be approached as someone who has been through a very bad experience and is reacting appropriately.

3 At least two 16-year-olds have been seen by the author after periods of detention on the East Rand. Neither had been tortured or kept in solitary confinement. Whilst detention in a communal cell is a highly stressful experience, detainees are nevertheless more able to extract some meaning from it. These teenagers were detained in the first State of Emergency. Each was held in a cell with political comrades from local organisations who were known to them. The environment was a supportive one with some protectiveness from older detainees, and the day was filled with activities and discussions. One of these youngsters was injured in a baton charge at Modderbee, and he complained that the doctor had not attended to his injuries adequately. These were not severe at the time when he was examined, however. He had also participated in a hunger strike.

4 Many students come out of detention with post-traumatic stress disorder. One of the cardinal features of this syndrome is poor ability to read, resulting from poor concentration. These students complain of trying to prepare for exams after missing weeks or months of school and having to contend with a reading disability as well.

5 A 17-year-old youth from Soweto was detained, tortured with electric shocks and kept in solitary confinement, partly at Protea and partly in Krugersdorp. Whilst in detention, and after being tortured, he decided to go on a hunger strike in solitary to protest the quality of the food. He fainted on day three, day four and day five. Thereafter, he was transferred to Krugersdorp and was still kept in solitary, but the food improved.

6 A 16-year-old youth was detained for 10 weeks at the Hillbrow Police Station. He said that he was made to take a shower so that electrodes could be applied to his wet skin. He was then subjected to electric shocks. He complained of anxiety and sleep disorders. He was also depressed and felt that he could not go back to school.

7 Injuries: (a) A 15-year-old youth was shot in the head with a rubber bullet at close range. The shooting was witnessed by clinic staff at Diepkloof Clinic. He regained consciousness after a short time but has no use of his right arm and walks with a very stiff and disabled right leg. Police at the site of the injury claimed that he ran into a gate. Virtually no appropriate rehabilitation services are available in the community in which he lives. His schooling continues to be disrupted.

A woman, one child in her arms, another in police hands, at a tea party for detainees' relatives, organized by the Detainees Parents Support Committee.
(b) A 16-year-old youth was shot on 12 June, 1986—the first day of the second State of Emergency—in Alexandra Township. He was shot whilst walking in the street outside his home at about 7:30 in the evening. There were three similar shootings within the next two hours alone. He was shot in the neck and became quadriplegic. He subsequently had several operations, but his condition deteriorated, and he died three months later.

(c) A five-year-old boy was playing in the yard of his home in Alexandra Township on 12 June, 1986. Police chasing a car used birdshot in a neighbouring street. The birdshot hit five municipal street cleaners (female) and one piece lodged in the cheek of the small boy. It was an uncomplicated injury which healed well, but his mother worried about leaving him and his younger brother at home while she went out to work.

There are many, many more of these cases.

Some general conclusions on the effects of detention on children: The traumatic impact of detention on children can be psychologically devastating. Children are subject to physical violence and abuse; they are separated from their families, friends and intimates; they are cut off from sources of support and help and have to face the rigors of brutal imprisonment alone. Their world is disrupted and no longer predictable. They can no longer play, exercise or interact socially in normal and healthy ways. Especially devastating is that they are hurled into an adults’ world that is violent, abusive and destructive and in which they are at the receiving end, in a helpless and powerless state. . . . They may develop smouldering bitterness and resentment and a thirst for revenge which overwhelms them and propels them along pathways of future violence and abuse. . . . It is undisputed that children are particularly vulnerable to the harmful effects of violence and abuse. They are likely to be damaged or have their personalities deformed. Only harm can follow for a society that brutalises its children—children who may bear the scars of their suffering forever.


The Mistreatment of Detainees

Last April, at the National Medical and Dental Association's national conference in Cape Town, NAMDA physicians presented the findings of their study on the state's mental and physical abuse of civilians in detention. The report was based on detailed interviews and medical examinations of 131 released detainees. A brief summary follows:

The 131 persons in the sample group were released between December 1, 1985, and June 11, 1986, after being held from one to 490 days. The detainees ranged in age from 10 to 60 years of age. Forty percent were 18 or younger. Twenty (15.3 percent) were women. Out of the entire group, 45 reported having been kept in solitary confinement, with 12 saying they had been held in solitary between 120 and 279 days.

Physical assaults were reported by 92 detainees. Assaults with fists, hands, sjamboks (steel-tipped whips) and batons were reported by 89.1 percent of the group. Among these detainees, one quarter alleged that they had been subjected to suffocation techniques, 14.1 percent reported being electrically shocked, and 21.7 percent reported having lost consciousness.

Mental abuse was reported by 103 people. More than half told the physicians that they had been physically deprived by having been denied “basic needs such as water, satisfactory food, exercise, clothing, washing facilities, sleep.” More than one quarter (26.2 percent) reported having been humiliated by being forced to strip naked or denied the use of toilets. Over a third of the detainees reported having been threatened.

Of the 92 detainees who said they had been physically assaulted, the examining doctors found that 46 percent had bruises on their bodies, 45 percent had lacerations and nearly half (46 percent) had more than five wounds.

Among 83 detainees assessed as suffering psychological effects, one third were diagnosed as having post-traumatic stress disorder, 19.1 percent were diagnosed with depression and 10.7 percent with anxiety. More than half experienced sleep disturbances and difficulties with concentration.

The study concludes, “Our code of ethics . . . gives us a clear direction on how the medical profession should respond to evidence of physical and mental abuse. . . . To denounce and expose torture in all its forms. Silence is collusion.”
Nosipho's Gift
A South African Nurse's Story

by Tammy Pittman

For Nosipho, a nurse in a black township near Johannesburg, the struggle against apartheid has entered her life slowly, like ink through a blotter. When asked how she came to be an activist, she gently rejects the word, saying, "Activist is a dangerous term."

Nosipho lives in fear of the police. She does not wish to be seen as a revolutionary. She speaks instead of her growing awareness that the illness and suffering of her patients are caused by the conditions in which they live, conditions rooted in apartheid. "I did not learn that when I received my nursing training in the government centers."

Nosipho, who is black, recently toured the United States with a physician who works with her in the health care clinic of the impoverished township of Alexandra. They came to tell Americans about the contradictions and obstacles they face trying to provide health care in a black city that is at war with apartheid. It was Nosipho's first trip outside South Africa, and she was worried about the risk she was taking.

I met her in June in the home of a South African exile who organizes support for medical dissenters in South Africa. A tall, slender woman, she spoke in a quiet voice, choosing her words carefully, with frequent pauses. She wore a slight, shy smile, but her eyes, very clear and large, were grave. Nosipho is a pseudonym which she chose for this article, explaining that in Xhosa it means "gift."

Nosipho is one of very few nurses in South Africa willing to question apartheid openly. The profession is dominated by whites in its councils and governing bodies, even though the majority of nurses are black. Of nearly 60,000 registered nurses, over half are African, Indian and "Coloured." If enrolled nurses (the equivalents of licensed practical nurses) and nurses' aides are counted, the nursing work force numbers 135,000, only 20 percent of whom are white.

Organizational differences mimic the structures of apartheid. The executive bodies and decision-making committees of the South African Nurses Association (SANA) exclude all but a few well-socialized blacks. Black and white students are trained in different hospitals and, until recently (when the ranks of white nurses began to shrink), blacks were prevented from working in white hospitals.

White nurses earn double the salary of black nurses, despite identical educational and professional standards. Current policy allows blacks in white hospitals, provided no white nurse is available. SANA, which mandates dues-paying membership by all RNs regardless of race, maintains a strictly "neutral" political position and demands a similar closed-mouth attitude from its membership. Dissent from working nurses or students is met with quick dismissal and blackballing within the profession.

"Activist is a dangerous term."

Nosipho points out that most nurses are afraid to challenge these gross inequities. Professional opportunities for the majority of black women in South Africa are limited to teaching and nursing. Women who achieve these careers earn respect, status and a living wage. To risk their jobs by challenging the status quo means a return to menial, low-paying jobs. Not surprisingly, the black nursing work force remains relatively quiet. Sporadic strikes and attempts to organize have been brutally repressed.

For Nosipho, nursing was the only available alternative to life as a domestic. She was born in Alexandra to...
Mourner in Langa Township being carried to safety following police attack.

poor, uneducated parents. Poverty forced her to leave school early to work as a servant in a white Johannesburg suburb. For three years she earned nine dollars a month cooking and cleaning for whites. "I had to start thinking whether this was a way of life," she recalls. "I concluded that it was not my way of life." She enrolled in nursing school in a provincial, blacks-only hospital, selling tea leaves and peanuts on weekends to get by.

For years, Nosipho worked as a hospital nurse, secure in her job and her improved status in Alexandra. As she always had, she saw the suffering and poverty of her patients, but she did not think it was possible to change things. Worse, she says, she had learned in nursing school to blame people for their problems. "I would blame the mother if a child had scabies or was malnourished," she says. Her training encouraged an attitude of contempt toward the patients. "I was taught to believe, 'I'm a professional, I am slightly better.'"

After a time, she enrolled in a primary health care course at the Alexandra Health Center taught by politically aware physicians from the National Medical and Dental Association (NAMDA). "As a primary health care nurse," she recounts, "I was taught that I am not to blame the victim, but I am to look for reasons why the patient is malnourished, why the child has scabies and, together with the mother or the patient, find solutions and see what can be worked out to make life easier all around."

To Nosipho these ideas were revolutionary. "The training in the government centers taught about confidentiality and privacy. But it was my training in primary health care that taught me the patient is intelligent and capable of loving like any other human being. That's where the whole revolution starts—with dignity."

Newspaper For Sheets

Nosipho still works at the Alexandra Health Center, a clinic which has recently revived a tradition of social medicine that directly links individual health to community conditions, which in turn are linked to political realities. The Center sees 600 patients a day from a population of 100,000. It is the only health facility in the township.

Founded in 1926 by an American nurse, Ruth Cowles, the clinic has always operated on a shoestring. Nosipho points out: "Ruth Cowles did not have sheets on which to deliver the babies who were born. So she used newspaper for sheets. In 1951, I was born, and I
was delivered on newspaper for sheets. And now, she says smiling, "in 1987, as a nurse, I deliver babies on newspaper for sheets."

Alexandra Township is known as "the dark city" because it lacks electricity and street lights. "We live in slum yards with 20 families in each yard," Nosipho explains. Each yard is approximately the size of a single family lot in an American suburb; here, single room shelters house each of the 20 families, regardless of their size. The sanitation system consists of two or three buckets per yard, with about 20 people sharing each bucket. The buckets are emptied twice a week. Often they overflow before they are emptied, spilling their contents into the yards and the streets.

"Fortunately," she adds, "we have running water—one tap per yard—which may account for why we don't have cholera in our clinic." On the inside, Nosipho says, most of the single room homes are immaculately clean. "I just want to make you aware that we the people of Alexandra Township do not choose to live in these conditions but are forced to," Nosipho says in her quiet voice.

Alexandra Township has a history of community pride and resistance to apartheid. The city has reacted to the mounting political repression and police violence under the state of emergency with militant street demonstrations. In February 1986, hundreds of youths were injured or killed by the police in five days of street warfare. The bloody confrontation forced a political standoff between the Alexandra Health Center and the police, strengthening the bonds between the clinic and the community.

On the first day of the violence Nosipho learned that angry rumors against the Center were circulating through the community. In the aftermath of street fighting in South African townships, the police frequently descend on local clinics and hospitals to arrest patients with gunshot wounds or injuries, freely assuming that they are guilty of anti-state violence. Nosipho was told by her neighbors that Alexandra residents were accusing the clinic of turning over medical records to the police. She feared an attack against the Center was brewing.

In fact, the community's suspicions were unfounded. In a confrontation with the security police on the second day of violence, the clinic refused to open its records and filed a complaint against the police for intruding on patient confidentiality. The police reappeared several days later with a search warrant and seized over 300 medical records, a blatantly illegal act which received widespread attention in the South African and foreign press.

"Help Save the Kids Who are Dying."

Those five days of fighting take on a special poignancy when seen through Nosipho's eyes. As a nurse, mother and member of the community, she was in the extremely difficult position of trying to help victims of violence who, even though they were her friends and neighbors, distrusted her and her co-workers.

Her 15-year-old son, like most of his classmates, was in the streets during those days. "On the first day of the five-day war," she recalls, "there was a lot of shooting going around and, that night, my son didn't come home." Nosipho says she paced all night between the front and back doors, looking both wide open in case her son should need quick entry to escape the police. "And whilst I was confused and mixed up, he walked in, and he was whole. But he said to me, 'Mom, could you please rush up to the clinic. You must help save the kids who are dying; there are so many of them bleeding away. They are going to need your help there.'"

She arrived at the clinic to find armored police vehicles at both entrances. The police were stopping people as they entered and transporting gunshot victims to a "first-aid" facility on the edge of the township. The numbers of patients coming into the clinics were dwindling. "We knew there were more kids who had been shot who were not getting to the clinic. So we had to go out to the township and look for them."

Nosipho and other health workers spread out into the community in Red Cross ambulances. "But the people were still suspicious. They didn't want to tell us where people were hiding, bleeding away. So I first had to say, 'I am Nana's mother. Nana goes to this school; I wouldn't turn you over to the police. I am here for your welfare.' And after finding out who I was and making sure that I really was who I said I was, then they would say, 'OK, go to this place and you will find so-and-so there.' And that's how we got to help some of the victims. Slowly, toward the end of the week, people started coming up to the clinic."

"I have no idea what will happen to me."

Slowly, Alexandra residents understood that the health center had made a choice and stood by it: to serve the people, not the state. Growing numbers of health care workers are finding that political neutrality under apartheid is impossible. As concerned health professionals have so forcefully demonstrated, apartheid is poison to the people’s health, and health workers like Nosipho increasingly feel an obligation to say so.

Nosipho says she came to tell Americans about conditions in her country, about the war that she and her children and her children's friends are fighting every day. Her decision to leave her home and country to speak about the effects of apartheid on the health of her people has projected her life out into the thin air of personal, visible dissent. She says frankly, 'I have no idea what will happen to me when I return to South Africa.'"
A hail of bullets felled Florence and Dr. Fabian Ribeiro outside their home in the black township of Mamelodi, near Pretoria, December 1, 1986. He died instantly, shot in the chest. She died shortly after in the hospital. Despite state denials, many believe that the shooting of this vocal, politically prominent couple was the work of the security police, acting alone or through paid assassins.

Dr. Ribeiro had emerged as one of the bravest voices in the small but growing chorus of medical dissent in South Africa. He spoke out against the mistreatment of political detainees and rampant police violence. His concern was well known throughout South Africa, where he was one of the original members of the alternative, nonracial medical and dental association, NAMDA.

The state's machinery of abuses were familiar to him both as a clinician and victim. Detention, imprisonment, torture and repeated fire-bombings of their home preceded the regime's final step to silence the Ribeiros. In 1979, following his efforts to help people targeted by the security police escape the country, he was severely tortured. He had also served a prison term in one of the regime's most fearsome places, Robben Island. "There were early indications that somebody was out not just to scare them, but to kill them. They knew they were marked people," Dini Sobukwe, Florence Ribeiro's nephew, recently told me.

Fabian Ribeiro was a physician, one of the few blacks trained in medicine in South Africa. His small office was a refuge where residents wounded by police bullets and sjamboks (steel-tipped whips) found a skilled healer who could be trusted not to betray them.

As one of his former patients, Chaminka Mnombatha, recently put it, "He was known as 'the people's doctor.' But he was more than a medical doctor, he was somebody there for counseling, for encouragement."

He paused and quietly added, "The loss of him in the community is immense."

The death of Fabian Ribeiro is the security state's carefully considered answer to healers, black or white, who use their hands and voices to expose and alleviate the anguish of those caught in its barbed wire net.

Since the latest national state of emergency was declared in June 1986, birdshot, buckshot, rubber and steel-cased bullets have been fired with lethal intent on the streets of townships like Mamelodi. In the documentary film Witness to Apartheid (see review in this issue) viewers meet Dr. Ribeiro, a quiet, reserved man who is seen holding in his open palm the spent bullets drawn from his patients' bodies. In a sober, clinical voice, he calmly reviews the severity of their wounds, providing incontestable evidence that death and torture are routine among the army and police. Ribeiro's brief appearance on film is a stinging rebuke to government claims that its security actions are aimed at calming disturbances. "From the evidence I've got," he tells his interviewer, "I'd say they shoot to kill."

By killing the middle-aged Roman Catholic couple, the regime did more than eradicate a medical opponent of apartheid and its police excesses. "Together and by themselves, they were very forceful opponents of the system," Sobukwe said.

Florence Ribeiro was the sister of the late Pan-Africanist leader Robert Sobukwe, and an active community leader who owned and managed a shop in the township. "She was a completely independent woman..."
and quite fearless,” recalled Chaminka Mnombatha, the former Mamelodi resident who had been treated by Dr. Ribeiro.

Health/PAC tried to reach family members in South Africa about the couple’s work, but the Ribeiros’ four grown children, as well as Florence Ribeiro’s mother, felt that telephone interviews were inadvisable under current conditions there.

Dr. Ribeiro, who was born in Mozambique and trained in medicine in South Africa, saw his patients wherever and whenever they called on him, Mnombatha said. “If he saw less than 50 people a day he didn’t have a busy day at all,” he added. “Often people came who didn’t have a single penny, and he treated them free of charge.”

As a younger man, Dr. Ribeiro had worked as a “head-boy,” or cattle hand. In his practice, he was deeply concerned about the health problems of the laboring men of the township’s crowded hostels, which house the low-paid workforce of Mamelodi’s factories and construction companies. “He was their doctor, he was completely committed to the health of his community,” Mnombatha said.

One cannot overstate the loss of a physician like Dr. Ribeiro in a country where there is one medical doctor for every 90,000 blacks. Since the state of emergency, however, brave doctors willing to risk treating the victims of police violence have become a critical health resource in this nation where the authorities view bullet wounds as evidence of political opposition.

Hospitals are often carefully policed. As Dini Sobukwe recently explained from his U.S. home, “Many of the people who get injured in these so-called ‘riots’ tend to stay away from hospitals and doctors for fear that the police will round them up.” For these people “rounding up” can mean being carted away for interrogation, torture, and even death. As a result, Sobukwe continued, “They tend not to go to doctors and often die of their wounds. Ribeiro not only treated them in absolute confidence, but he was working to tell us what was happening to these people, people being tortured in detention, people being shot. He was very, very brave and willing to risk everything to continue his work.”

By the time of their deaths, the Ribeiros had already moved from their family home to safer quarters. Despite repeated fire-bombings, it was still usable and they continued to visit. On the first of December, two masked men drove up to the home while the Ribeiros were visiting with their children and grandchildren. The killers fired seven bullets and sped off. One of the Ribeiro’s sons gave chase but was repelled by gunfire. The license plates of their cars have been linked to the security police, who deny any knowledge of the killings.

To quote Fabian Ribeiro, “They shoot to kill.”

Hundreds were turned away from the couple’s funeral as the security police cordoned off the roads leading to the township. In other townships beyond Mamelodi, the burials of people like the Ribeiros continue to be banned. Whistling rounds of birdshot, buckshot, rubber and steel-cased bullets continue to maim and kill. Like so many other brave South Africans, Fabian and Florence Ribeiro refused to bow down—even before bullets.
Unhealthy Business

U.S. Health Corporations in South Africa

by Julie Friesner

Since the Bulletin published its 1985 list of U.S. health-related corporations owning subsidiaries in South Africa (Vol. 16, No. 2), at least seven companies have sold their South African operations or are now on their way out. Over one-fifth of the 33 companies on our updated list should no longer have subsidiaries there by year’s end, including major pharmaceutical companies such as A.H. Robbins; Baxter Travenol, which also owns American Hospital Supply Co.; and Dow Chemical, which was South Africa’s largest supplier of pharmaceuticals.

The remaining companies, nearly all of them in the Fortune 500, still represent a fairly sizeable chunk of American investment in South Africa, generating at least $400 million in sales and having at least $160 million in assets. (These are rough estimates and may actually be higher, since many of the companies offer incomplete information.) Total U.S. investment in South Africa in all businesses has been estimated at about $2.3 billion.

Humanitarian Disclaimers

Companies producing health products are quick to claim exemption from the disinvestment campaign on the basis of the “humanitarian” nature of their products. Even Denmark, they argue, which has stringent disinvestment laws, allows its drug companies to operate in South Africa. The Board of Directors of Sterling Drug, Inc., responding to a stockholder proposal on disinvestment (since defeated), noted, “As a health care company, Sterling feels it has a special responsibility to make its products available to the public.” Unfortunately, apartheid ensures that the majority of the South African public has little access to the health care products of companies like Sterling. Moreover, these products are skewed towards the needs of whites, in both the public and private sectors.

Under South Africa’s prevailing economic, health and social priorities, whites are the major purchasers and beneficiaries of health care. Short of providing needed medicine and health supplies at a loss, or promoting radical social and economic change, there is little that American companies can do (or have done) to reverse this basic inequality.

Upjohn profits handsomely from the government’s desire to control the black population.

In the one area where the government does provide free health services for blacks, family planning, a U.S. company, Upjohn, has been quick to take advantage of government-sponsored opportunities to market its controversial birth control drug, Depo-Provera. Prominent South African doctors, such as Dr. Ntatho Motlana, and health groups, including the London-based International Contraceptive Abortion and Sterilization Campaign, have found numerous abuses in the government-approved methods of using the drug among black women. They charge that many women are encouraged and even coerced into getting injections. Often, employers require that black women seeking jobs present their family planning cards as a precondition of employment. While the debate over Depo-Provera rages in the U.S. and abroad, Upjohn continues to profit handsomely from the government’s desire to control the black population at any cost.

U.S. health-related companies try to bolster their image as forces for progress in South Africa in a variety of ways. Some boast of efforts to assist medical clinics in black areas as well as to train and provide health education to township residents. While such programs may benefit the few blacks able to participate in them, none have any impact on the grievously inadequate

Julie Friesner is a public policy consultant and a researcher for the Health/PAC Bulletin.
Everybody trusts the strength of LENNON DUTCH MEDICINES

health system, which thoroughly fails to meet the needs of the majority. Often, in fact, such programs simply benefit the companies by helping them recruit local workers. When American Cyanamid experienced a shortage of white skilled and semi-skilled workers in its Lederle plant in Isando, for example, it initiated vocational programs in black high schools, but only after determining that blacks did indeed have the “potential to learn.”

Change vs. Public Relations

While companies may make a public showing of deploring apartheid by becoming signatories of the Sullivan principles, writing letters of protest to the government, or taking out critical newspaper ads, their obvious concern is to protect their investments. This passage from a 1983 Dow public relations handout tells legions about the reluctance of corporations to put principles before profits: “Change will come to South Africa—either in an orderly, measured way, as is now the case—or in the form of apocalyptic violence. Dow is working toward the former.” (emphasis added)

The public has grown increasingly impatient with such pronouncements. In June, the Rev. Leon Sullivan called for the dissolution of his voluntary code of corporate conduct, because, he says, this approach has failed to weaken apartheid’s grip. Of the 200 U.S. companies remaining in South Africa, 127 subscribe to the Sullivan principles, which were formulated in 1977. Sullivan has called on these enterprises to withdraw and sever their commercial ties by March, 1988.

Clearly public pressure can have an impact. Even Dow, the proponent of “orderly, measured change” began withdrawing its pharmaceutical interests last February, despite turning a profit in the previous quarter. But far from being ended, multi-national investment in South Africa is continuing at all levels of the economy. In the health sector, Proctor and Gamble, which sold its South African-based Richardson-Vicks subsidiary, continues to have lucrative commercial ties with other pharmaceutical businesses in South Africa. There are a multitude of other examples such as this. To get the companies out both on the surface of the economy and beneath it, increased public pressure and real sanctions will be needed.

For more information about what you can do to support disinvestment, contact: American Committee on Africa, 198 Broadway, N.Y., N.Y. 10002.

Multi-national investment is continuing at all levels of the economy.
### U.S.-Based Corporations With Health-Related Subsidiaries in South Africa

#### Companies Still Operating Subsidiaries (as of April 1987)

- Johnson & Johnson
- American Cyanamid
- Colgate-Palmolive
- Bristol-Myers
- Sterling Drug
- Merck & Co.
- Air Products and Chemicals (hospital gas)
- Schering-Plough
- SmithKline, Beckman Corp.
- Eli Lilly & Co.
- Upjohn & Co.
- Premark International (owns Rexall, formerly a part of Dart & Kraft)
- Squibb
- Abbott Labs
- Monsanto (owns Searle Labs)
- Bausch & Lomb
- Carter-Wallace
- Cooper Labs
- Coulter Electronics (medical equipment)
- Dolcin Corp. (pharmaceuticals)
- DuPont
- Vickers Air Shields (medical equipment)
- Marmon Group (pharmaceuticals)
- Medtronic (pacemakers)
- 3-M (owns Riker Labs, S.A.)
- Warner-Lambert

#### Companies Which Have Withdrawn Their Subsidiaries

- McAndrews-Forbes Holdings (owns Revlon, which will sell its S.A. holdings, including Berk Pharmaceuticals, by 12/87)
- Baxter Travenol (owns American Hospital Supply Co.)
- *Proctor & Gamble (owns Richardson-Vicks)
- Dow Chemical
- A.H. Robbins
- Flow General, Inc. (research and biological materials)
- American Home Products, Alcon Labs, Ayerst Labs (all owned by the Swiss-based multinational Nestle, which may still own non-U.S. companies with South African subsidiaries.)

*has no ownership in South Africa but continues to do business through licensing, technical transfer, franchise and/or sales arrangements.

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The Kark Movement
South Africa's Healthy Export

By Mervyn Susser

It's paradoxical that one of the major foundations of the progressive health movement in the world today—and specifically in the U.S.—came from, of all places, the Republic of South Africa, in the work of Sidney and Emily Kark and their colleagues and students. It is also little known. Yet the model for our community health centers, the idea of multi-disciplinary primary health care teams, the fusion of curative and preventive services, health education and community organization, and, above all, the incorporation into primary care of community-based social epidemiology, were all developed in South Africa in the 1940s and '50s. And all were subsequently diffused to the U.S. through Kark's publications, his colleagues who came here to teach and work, and Americans who studied and worked with the Karks and adapted their ideas to the U.S. scene. What began as an attempt to act on the vision of health in a social context has become what we now call "community-oriented primary care," and, in a few instances, a conscious attempt to use health services as an instrument of social and political change. Here, in the first of two articles on the impact of the Kark movement, Dr. Mervyn Susser recalls his South African experiences with the Karks and the origins of the movement. In the next issue, Dr. H. Jack Geiger will pick up the story of its impact in the U.S. between 1957 and 1987.

P

olitical tensions were mounting in South Africa, and the plight of the urban black population was desperate in the postwar years when my wife Zena Stein and I were being trained as doctors. We felt that the situation demanded of us some critical choices about medicine, politics and social action. We were impelled to political and social action, over and above the medical action that was expected of us. This was not the only course open to us. There were at least three available models of activism for health professionals.

In one model, health and politics were segregated activities. Some of the best-known Black political leaders of the time were also doctors, for example, A.B. Xuma (for some years president of the African National Congress); among women, many of the leaders or wives of leaders were nurses. These leaders were a social and political elite. For them, health was a separate sphere and area of responsibility, a livelihood only incidentally connected with their activities as politicians and party leaders.

For others, health activism was to be confined to health issues; they aimed to ameliorate conditions but skirted direct politics. Sidney Kark's movement, about which I will say more in a moment, called for careful epidemiological studies but stopped short of addressing the problems at their source in political economy and power relations. The view of health was holistic, but action was limited to the health field itself.

They had a highly developed idea of social medicine.

Lastly, there was the option which I myself followed. We too regarded health in a comprehensive, unified way as a facet of society; but we assumed that health was unattainable without political change. Thus, there had to be a direct and analytical connection made between health, economic, and political life. (The position, unified in conception but dual in action, could not be sustained without constant attention to competing imperatives, an openness to multiple forces and a willingness to contend with them.)
An important intellectual contribution to my realization that medicine might be a social service to people and communities was the writing of Henry Sigerist who had visited South Africa not long before. Sigerist was the founder of the modern history of medicine that first placed the field in its social, economic and political context. He did not hesitate to apply this broad vision of medicine to the health needs of contemporary society. For me, medicine became a possible instrument for social and political change through measures taken to raise the consciousness of health needs among the people and to stimulate their demands for care.

A Global Vision of Social Medicine
I entered the Witwatersrand Medical School in late 1945. Concerns for health in the larger sense were hardly to be found in the formal curriculum. Soon, through some fortunate contacts, we discovered Sidney and Emily Kark, who had a highly developed, comprehensive idea of what social medicine was and should be about. Theirs was an original idea and a global one which excited my friends and myself. We students went down in groups to his training center for health personnel in Durban and absorbed this comprehensive vision; we saw in the work the concrete interrelationship of health, culture and society. The scientific fruit of the work was well-illustrated in a paper by Sidney Kark on the introduction, spread and transmission of syphilis in South Africa. In it he showed how the disease in the African population was tied to the developing economic system. That paper still bears reading.*

As Zena Stein and I entered our later years at medical school (by then intending to be married), we teamed up with another already married couple, Michael Hathorn and Margaret Cormack, to make a plan for a health center following the principles we had learned from the Karks. Because we were politically active, we felt we could not join the Kark organization. As much as we subscribed to its principles, it was a government enterprise. We could not enter the government service and expect to survive unless we remained politically quiescent.

Inquiries into Health Behavior
At the end of our internships an opportunity arose in Alexandra, then a township on the periphery of Johannesburg containing some 80,000 people in about one square mile. While we were students, Alexandra and its clinic had come to our attention as a project of the University, built on the vision of the health service begun by a single nurse of the American Board Mission, Sister Ruth Cowles.

Although there were private practitioners as well, the clinic was the main service for the township. It provided 24-hour emergency service. (Given the conditions of the times, the casualties over weekends were many and bloody.) There was an obstetric service run by a dozen midwives. There were special services for tuberculosis and venereal disease. There was a home visiting program, both for acute care and the chronic sick. Finally, there was a teaching program which brought medical students for three weeks at a time to participate in all the clinic activities.

We tried to keep a total view of the social and economic context and wrote papers trying to put across that approach. At the same time we tried to discover the grassroots needs of the people and encourage them to translate their consciousness of those needs into demands. We also had carried out some of the first systematic, random sample health surveys in a Third World setting to inquire not only after certain diseases but also about attitudes and health behavior.

Our activities in health and politics were undertaken with our eyes open about the dangers that lay ahead for us. After the Nationalists came to power in 1948, they had passed several repressive laws besides those that created apartheid, for example, the suppression of

Eventually, as the idea was rounded out, this team ranged from doctors and nurses to health educators and lab technicians and health assistants (both specialized and all-purpose), all mobilized in the interests of community health. One of Kark's early projects, undertaken while he was still a medical student in the early to mid-1930s, was a survey he conducted in association with Harding le Riche in Alexandra Township. It began with an anthropometric study of African school children in the township, followed up with comparisons in the rural areas. That was a remarkable undertaking for medical students without outside guidance. They were seeing child health in a social context, trying to measure it, and assembling their data to point to rational health policies.

Sidney Kark joined the Department of Health of the Union Government shortly after he graduated in about 1939. Sidney and his wife, Emily, also a graduate of Witwatersrand Medical School, went to work in Pholela, a rural area of Natal. The best description of the project is by John Cassel and Sidney Kark in the *South African Medical Journal* of 1952. The project followed through on Kark's ideas: A health center took on the services for a population of about fifteen or twenty thousand, with an intensive area containing a group of some five thousand that became the target for comprehensive health care in a broad sense. In the intensive area, they did everything: health education, nutrition and garden programs, and complete vital statistics. And outside it, they surveyed what they could. The Karks understood that they needed correct demographic data in order to make sensible policy and judge the outcome of what they were doing, so they did their own census and kept their own registers.

His program was too social to survive in South Africa.

In 1943 and 1944, there was optimism about the chances for reform in health services. The new Minister of Health, Henry Gluckman, provided the resources for a training institution to develop personnel for a network of health centers. It was to re-educate existing health professionals, both doctors and nurses, to the new principles and broad aims of comprehensive health. For the new roles called for by the health team approach—health educators, health assistants, and others—the education had to begin de novo.

The Nationalists Rise to Power

Later when Kark became director of the training institute he developed his ideas further. Doctors, nurses, lab workers, health inspectors, and health educators were
all to be shaped by a common philosophy and sense of cooperative teamwork. Before long, a number of health centers in various parts of the country were staffed, maybe fifteen or twenty at the height of the program. Not all of these centers managed, or even wished, to translate Kark's ideas into practice, but some did and did so very well.

Sidney Kark is one of the most single-minded individuals I've ever met. My father-in-law, Philip Stein, a noted South African mathematician of broad interests, used to say that you could always have a good talk with Sidney Kark, but you knew what it was going to be about. The subject was bound to be social medicine. The theory and practice of social medicine was his all-absorbing interest. He was not involved in politics. As a government employee he had to be very careful in order to further his projects. Nonetheless, politics came to him.

In the watershed year of 1948, the Nationalists acceded to power. The official philosophy, aims, and will changed sharply. There was an internal investigation within the Department of Health, taking seriously accusations that Kark and the people he had recruited and with whom he was working were Communists. The allegations arose from white farmers and others, who lived and worked near a certain rural health center. Children suffering from severe malnutrition (kwashiorkor) were being treated with high protein supplements of dried skim milk. Although skim milk was a food-like the bananas also given for the diarrheal symptoms which often accompany malnutrition -it was actually medicinal. They took a step beyond medicines, perhaps, when they used the dried skim milk preventively in children with milder forms of malnutrition. That turned out to be the sum of the evidence of Communism that brought on the investigation. Nonetheless, the program was halted.

The training institute collapsed when in 1954 Kark was recruited as a department head for the new Natal University Medical School at Durban. With a substantial grant from the Rockefeller Foundation, they established an innovative Institute of Family and Community Health. The Medical School at Durban was founded in due course, with one concession; it would not be segregated de jure and would, if appropriate, take in white students. (More than 30 years later, one has not yet been admitted.)

The new Institute of Family and Community Health was one of its crown jewels. However, given the political developments in South Africa, even such a purely educational venture could not last. Kark, this single-minded and persistent man who after 50 years has still not given up his vision, was finally driven out. Around 1957, the Government started to apply the Bantu Education Act of 1955 in a truly systematic way. They planned to remove the Medical School from Natal University and make it one of the Bantu Universities, subject as they were to the direct authority or intervention of the Minister in hiring, firing and curriculum.

The Karks Leave for Jerusalem
The authorities' move was so strong, frightening, and, indeed, intimidating, that the faculty in Family and Community Medicine did not think it was worth going on. Beginning in about 1959, Sidney and Emily Kark left, John Cassel left, Harry Phillips and Eva Salber left, dispersing to various places around the world. Most of the remaining members eventually joined the Karks in Jerusalem to form a Department of Social Medicine supported by the World Health Organization. As pragmatic and as non-political as the program was, it was too comprehensive and social to survive in South Africa under the Nationalist government, just as our own more activist work in Alexandra could not be sustained. The moral of this cautionary tale I shall leave for you to think about.

The export of people committed to this broad view of epidemiology and its associated philosophy of public health has had an impact, especially in America, and I believe the ideas greatly influenced the WHO policy developed a few years ago at Alma Ata. What happened in South Africa? Alexandra Township is a nightmare, still full of fight and resistance, but battered and in some ways a wasteland, the half of it destroyed to set up single-sex hostels in a project that was eventually halted while still incomplete. The Health Center continued as a type of polyclinic, a philosophical shadow of its former self. It does what most polyclinics do elsewhere in the world. With the recent appointment of Tim Wilson as Superintendent, however, we may soon again see new and original things happening, even in the face of adversity.
 Bearing Witness

Witness to Apartheid, produced and directed by Sharon I. Sopher. Distributed by the South Africa Media Center, San Francisco. 58 minutes.

CHISA Newsletter (occasional), published by the Committee for Health in Southern Africa, Box 11, 630 West 168 St., New York, N.Y. 10032. Available by contribution.

By David Steinhardt

Sharon I. Sopher’s Witness to Apartheid is a splendid documentary about some of the specific, outrageous cruelties of the current South African regime. It is also the work of an outsider with a political agenda.

Witness provides important documentation of conditions in South Africa, particularly of the horrifying medical situation for those detained by the security police, and of the courageous health workers who dare to care for those who are released. It is doubly uncomfortable to watch, for the vivid pain shown on the screen, as well as the political message Sopher implicitly conveys: that it is now time for a bloody revolution in South Africa.

For the approximately 30,000 who have been detained by the police since the state of emergency was declared in June 1986, medical conditions are dismal. The vast majority, many of them children, are physically abused, and the official medical care is perfunctory at best. At the worst, it is in itself torture.

Footage of otherwise peaceful gatherings show security police who are unrestrained in dealing with demonstrators. Only a brave few physicians offer complete, responsible treatment to those who have been tear-gassed, clubbed, or shot. Health workers who speak out face great risks.

The barbarism of the security police and army at first seem incomprehensible. Confronted with a barrage of disturbing images of sadism and brutality, I recalled my childhood response to hearing about the Holocaust: “Why didn’t everybody just say they wouldn’t go to Auschwitz?”

Such questions are sincere, but too narrow. So is Sopher’s apparent judgment that it is incumbent upon South African blacks to bring down apartheid immediately. The only major failing of this film is that it fails to explore the implications of such a revolution on those who would fight and die in it.

From teenaged torture victims to healers providing services for former detainees, to callous, indifferent whites Sopher interviewed on city sidewalks, her lens refracts a vile and ruthless regime utterly contemptuous of the black majority,
which is seen only as threatening a colonial paradise.

The Anglican Archbishop of South Africa and Nobel Laureate, Desmond Tutu, is shot in such tight close-up that we can see he is missing several back teeth. He speaks of his attempts at peaceful change. He wonders aloud why the nation’s blacks still listen to him, because, after all, “I have not delivered the goods!” His wife, Leah Tutu, remembers her son Trevor’s arrest: “If I’d have had a hand grenade, I would have blasted that policeman to pieces!” Sopher has excerpted their words to great effect.

Johnny Mashiane is the first victim we see, a recent survivor of two weeks of torture during detainment. A friend speaks for him, because his own words are too garbled to be understood. His thinking and movements are slowed. He has been horribly brutalized and we see him dazed and depressed. He says he is ready to die. The regime has taken his soul and he is only fifteen years old.

Dr. Don Foster is one of several medical witnesses (who are each labeled—in freeze frame—with stenciled captions, giving the film the appearance of a military trial). Eighty-three percent of all people detained are physically abused, he informs us, listing some of the methods: “Petrol poured over the body and set alight; electric shocks . . . very frequently applied to the genital areas.”

Dr. Clifford Goldsmith displays the wounded head of a patient named Jackie; no anesthetic had been applied there to sew up the gash he received from a rifle butt. Dr. Goldsmith concludes: “Stitching up is being used as a form of torture.”

Dr. Fabian Ribeiro, who provided free medical services to detainees, reports that the police shoot to kill. Later, in December 1986, he and his wife Florence were shot to death (see “Killing the Healers” in this issue).

The South African regime, now moving even further to the right, is thorough in its barbarism, and Sopher, a former NBC producer, put herself at risk to expose this (she was briefly detained during the filming). As her Oscar-nominated film makes clear, South Africa is not the firm yet yielding willow that Morley Safer and his 60 Minutes crew have presented to U.S. viewers in its reporting from South Africa.

Sopher reaches witnesses whom “safer” reporters never bother to meet. An undertaker, whom we hear in a pre-interview over a black screen because the authorities prevented his being filmed, describes the dead: “Most have several bullet wounds. Very few have one.”

What is the culture these killer-policemen belong to? Most of the whites interviewed run from right wing to right off the spectrum. We are left to wonder how many think as one Mrs. H. Botha (a common last name among Afrikaaners), who recalls the 1960 Sharpeville massacre of 69 blacks approvingly. Sopher shows us file footage of the aftermath as this deeply racist woman speaks. Perhaps it is time for another wipeout of that kind to quiet all the unrest again, Mrs. Botha calmly muses. Precisely in sequences such as this, it seems that Sopher is prompting her viewers to speculate whether it isn’t time for such a despicable minority to be similarly massacred.

Sopher’s manipulation of such images is disturbing. It is easy to use the powerful medium of film to argue that it is time for war. Surely those resisting apartheid need our support, encouragement and solidarity—but the fate of South Africa is for the majority, not U.S. filmmakers, to decide.

Sopher sometimes appears more impatient than those she interviews. As Bishop Tutu reminds us over images of a lush suburban town: “Parkview . . . is paradise! . . . We are asking a great deal in human terms.” And that, buried in the harsh images of Witness to Apartheid, is what the struggle is all about: humans behaving humanly and in terrible, tragic conflict—conditions which have brought out the worst in many and the best in a precious few. Witness to Apartheid is less a documentary than a call to arms, but I will leave you with the words of a witness named Curtis Nkondo, of the United Democratic Front: “Remove injustice, then you will have peace.”

The CHISA Newsletter is a compilation of general announcements, editorials, calls to action, clippings, bibliography and anything else of significance regarding health in Southern Africa.

Each photocopied issue has the look of a very long letter from a dear friend who is compulsively dedicated to the cause and reads every English-language publication on South Africa from here to Johannesburg. The dear friend is in fact Dr. Mervyn Susser, an expatriate South African who co-founded the Committee for Health in Southern Africa in mid-1984, in response to a call from the National Medical and Dental Association (NAMDA) to help block the World Medical Association from holding a conference in Cape Town.

CHISA has a small membership, primarily made up of concerned health professionals who want to help their counterparts in South Africa. In addition to publishing the newsletter, they meet with visiting South Africans to hear first hand about problems and victories on health care’s front line. Incidentally, as a recent newsletter pointed out, chisa boy is slang for one who lights the dynamite fuses in South Africa’s mines.

The newsletter’s editorial range is eclectic and has included a poem by Dennis Brutus (the exiled South African poet whom the U.S. tried to deport in 1985), anti-Nazi satire, and news of the work of activists around this country. Its language speaks to the heart, as well as the head. Susser’s prose is always direct, economical and aimed at people of action. He writes: “As always, it is dangerous to be a victim. Now the police and the security forces invade the hospitals...
seeking the victims of their own violence."

The newsletter’s most frequent clippings are from the Weekly Mail. This daring South African newspaper features courageous reporting in the face of severe press restrictions. It puts to shame American news organizations, which, although they face far fewer risks, have backed off covering the heightened police repression. In a regular section called the "Apartheid Barometer," typical topics include listings of "Emergency Detentions," "Detention of Children," "Whippings" and "Hangings."

For insights into the imbecility of a repressive culture (and even a bit of comic relief), one can look to the headings "Banned" and "Unbanned." The subjects are publications and objects. (Banned: Political Trials in South Africa—May 1986, London; glass beer mug with penis-shaped handle. Unbanned: Amateur Photographer, Nov. 30, 1985; God’s Little Acre, by Erskine Caldwell).

All in all, the newsletter (which has a planned frequency now of something less than twice per year) has the feeling of a David group against a Goliath regime. Reading this scrappy newsletter, one never gets the sense that the odds are against them. The CHISA Newsletter gives the perspective of the stronger side. Amandla!

David Steinhardt is a fiction writer and former member of Health/PAC’s staff.
Health/PAC Honors Health Activists

Health/PAC presented its Fourth Annual Samuel Rubin Awards for Health and Social Justice on May 1st to South African health care leader Dr. Diliza Mji and Georgianna Johnson, President of Local 1199, New York City's largest union of health care workers.

The New York City event highlighted the link between two of Health/PAC's most fundamental goals: health care rights and racial equality. The evening paid tribute to Dr. Fabian and Florence Ribeiro, anti-apartheid activists who were murdered outside their home in the black township of Mamelodi last December, and celebrated the 30th anniversary of the Committee of Interns and Residents (CIR), the 5,000-member union of salaried physicians which has fought tirelessly for the rights of all health care workers and their patients.

Close to 400 trade unionists, health and anti-apartheid advocates heard Stanley Hill, Executive Director of District Council 37, AFSCME, introduce Georgianna Johnson as an inspiration to the labor movement who has restored democratic leadership to the 80,000 member union. Johnson, a former social work assistant who unseated the incumbent president, Doris Turner, in 1986, spoke proudly of the union's struggle on behalf of New York's exploited home health care workers and of 1199's fight for justice in South Africa and Central America. She received a lengthy standing ovation.

Cora Weiss, daughter of the late philanthropist and Health/PAC supporter Samuel Rubin, praised the courageous work of honoree Diliza Mji, the president of South Africa's National Medical and Dental Association (NAMDA), the nation's only nonracial, anti-apartheid organization of dentists and physicians. Weiss cited NAMDA's diverse health activities on behalf of the struggle for a free and democratic South Africa. Dr. Mji called on the audience to help his organization publicize the health crisis under the Pretoria regime. "Do not be duped by the apologists of apartheid, like the Ronald Reagans of this world," he said.

Dr. Fabian Ribeiro (see "Killing the Healers"), a founding member of NAMDA, who treated victims of police violence in Mamelodi township, was remembered by Nonceba Lubanga, a South African nurse and public health expert, who spoke of Ribeiro's fearless commitment to change in their troubled land.

Progressives on Surrogacy

How should progressives approach the issues raised by surrogate parenting? A recent forum cosponsored by Health/PAC's Women and Health Work Group showed that there is a significant variety of opinion among progressive women on the subject. "I'm against it for the same reason I'm against slavery," said panelist Dr. Wendy Chavkin, while writer Letty

Georgianna Johnson, president of Local 1199, New York City's largest health workers union, being introduced by Stanley Hill, executive director of DC 37, at Health/PAC's Samuel Rubin Health and Social Justice Awards Celebration.
Cottin Pogrebin came down solidly in favor of the practice: “It promotes new families.”

What is needed, they agreed, is to insure that those women who do bear children for others be protected, at least to the same extent as mothers who give up their children for adoption. None of the speakers favored a legal climate that could lead to marshalls spiriting away newborns into the hands of those who had contracted for them. The battles for such protections will likely be waged in state legislatures, as well as the courts.

The second hour of the forum was devoted to taking comments from the large audience at New York City's Judson Church. Class issues were foremost in the minds of most of the commenters; many feared that we may be heading toward a society where those who bear children and those who raise them will live on different sides of the tracks. Several adult adoptees expressed concern that far too little attention has been given in public discussions as to how all this wheeling and dealing over babies affects the lives of those who have been brokered and contracted for. And one birth mother of an adopted child made a linguistic point with symbolic importance: “What is this word surrogate?” she asked rhetorically. “They’re mothers.”

A Milestone for Medical Consumers’ Right to Know

A milestone for medical consumers was set this spring when California’s peer review organization released hospital-specific death rates for Medicare beneficiaries.

California Medical Review, Inc. (CMRI) of San Francisco, released the mortality rates for the 50 most common diagnoses of Medicare patients at the state’s 543 hospitals. The figures included statewide and regional averages. Mortality rate statistics provide the public with one of the few available measures of quality in hospital care. While far from adequate as a direct indicator of good or bad medical care, death rates are currently the main objective measure by which consumers can compare the quality of care in different hospitals.

Many other factors besides quality of medical or nursing care can influence patient outcomes, such as the severity of a patient’s illness or the presence of other health problems. But, given the paucity of measures available to determine quality of care, mortality rates are an important first step in allowing hospitals and consumers to evaluate medical care and identify problem areas.

Home Health Workers Seek Gains

New York City employs more than 70,000 home health care workers through contracts with more than 60 nonprofit agencies. They serve 48,000 clients, the largest group of home care recipients in the nation.

Most of these workers are women of color who earn less than $7,000 a year. More than half receive no health benefits, and none have pensions or job security. More than three-quarters are their families’ principal breadwinners.

In May, Jesse Jackson came to New York to address the plight of these workers who must struggle to stay above the poverty line. Jackson addressed a crowded rally outside City Hall and then paid a visit on New York’s John Cardinal O’Connor, who joined him in calling for higher wages and improved health benefits for home health care workers.

The rally, organized by Local 1199 of the Hospital and Health Care Employees Union and District Council 1707 of the American Federation of State, County and Municipal Employees, was timed to precede the expiration date of home health care agency contracts with the City, set for June 30. Georgianna Johnson, President of Local 1199 and recent Health/PAC honoree, said the unions were seeking to raise the starting salary of home health care workers from $4.15 to $6.00 an hour and to get improvements in health benefits and training. She warmly greeted Jackson, who told the workers, “Our government must assume some responsibility for health care, for the workers and for the quality of life in our country.”
Body
English

Immunization Policy: A Shot in the Dark?
by Arthur A. Levin

To most people, fall is a time leaves changing color and days getting shorter. To public health experts like those at the Centers for Disease Control (CDC), however, fall is the season for large-scale immunization efforts against influenza and pneumonia.

While flu is not much more than an inconvenience for most people, there have been thousands of flu-related deaths over the last several decades. CDC considers adults and children with chronic heart or lung problems as being at "greatest risk" for flu-related complications and recommends flu shots for them.

The same goes for older persons living in nursing homes and the institutionalized chronically ill.

One preventive health expert, Dr. Paul Frame, reported in The Journal of Family Practice (May 1986) that 95 percent of flu-related deaths occur among the chronically ill, particularly those with heart or lung problems. Frame advises that the benefits of flu immunization probably outweigh the risks for this group, regardless of age.

CDC also recommends flu shots for those at "moderate" risk, namely healthy people over 65 and those of any age recently treated for diabetes, other chronic metabolic disorders, kidney problems, anemia, suppressed immune systems and asthma. Additionally, CDC encourages any healthy person who wants the vaccine to get it.

Questions nonetheless remain about the benefits and risks of such widespread immunization. A study of healthy 65-year-olds in a Kaiser Health Plan during flu epidemics in 1968-69 and 1972-73 found no evidence that vaccination reduced flu complications. Citing this and other studies, Dr. Frame found insufficient evidence to support routinely vaccinating healthy persons of any age.

Furthermore, there are people for whom flu shots may be dangerous or even fatal. Those allergic to eggs, the flu vaccine's base, could die from an anaphylactic (allergic) reaction to the vaccine. The shots may also be harmful to patients with high fever, a history of Guillain-Barre syndrome, an active infection or respiratory disease.

Flu vaccinations don't necessarily guarantee protection against the flu. In 1985-86, for example, the vaccine was designed to ward off three viral strains, only one of which ended up being prevalent that winter, and many of those vaccinated got the flu since they were not protected against two new strains.

The 1986-87 vaccine was formulated to protect against the three viral strains experts believed would be prevalent in the U.S. last winter. Then a new virus, A/Taiwan/1/86, appeared on the scene. A single vaccine was rushed into production to be given in addition to the vaccine already being used. Despite the concerns of experts, dire warnings in the media and the small percentage of the population actually vaccinated against A/Taiwan flu, it did not turn out to be a major epidemic.

As for pneumonia vaccines, the story is much the same. Public health agencies recommend pneumococcal pneumonia vaccine for all "high risk" people over age two and all healthy people over age 50. The vaccine is seen as an example of "successful" medical technology that is relatively inexpensive and significantly reduces deaths, disability and costs associated with pneumonia and its complications. Unfortunately, it may be less successful than public health campaigns have led us to believe.

Dr. Frame agrees that persons at "high risk" (anyone with lung disease, congestive heart failure, sickle-cell anemia, diabetes, alcoholism, liver or kidney problems, and anyone without a spleen or who is entering a long-term care facility) should be immunized. He concludes, however, that "because of the unproven benefit of the vaccine in older persons and the easy treatability of pneumococcal disease with antibiotics, routine vaccinations are not recommended."

A study published in The New England Journal of Medicine (Nov. 20, 1987) even questions the value of immunization for those at high risk. The study randomly divided 2,295 persons suffering chronic kidney, liver, lung or heart diseases, diabetes and alcoholism into two groups: one was given vaccine, the other a placebo. The vaccine did not appear to prevent pneumonia more effectively than the placebo. The researchers suggest that those at high risk may actually have an impaired immune response to vaccination.

Technology that prevents disease is the most desirable accomplishment of public health research. However, questions remain about these vaccines' effectiveness and safety. Until more is known, our immunization policies should not be a shot in the dark. The public should know the limitations of these technologies.
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Health Care Is Fine in St. Louis

I am in receipt of the article entitled “Health Care is Sick in St. Louis” by Peter Downs in the June 1987 (Vol. 17, No. 3) issue of the Health/PAC Bulletin. I have reviewed this article and find it to be totally lacking in objectivity, slanted, and very negative, not only in tone, but in the use of its graphics. It uses pictures that have a 19th century appearance and gives the reader the impression that services provided by the St. Louis Regional Medical Center relate to 19th century conditions.

It is true that the government of the City of St. Louis, under the leadership of Mayor of St. Louis, Vincent C. Schoemehl, has been looking for and examining alternative mechanisms for the provision of health care services in the City of St. Louis. The St. Louis City Hospital was an aging institution that needed a major infusion of multi-million dollars in order to bring the physical plant to acceptable hospital facility standards.

The citizens of the City of St. Louis did, in fact, turn down the opportunity for passage of a bond issue that would have infused monies into Homer G. Phillips Hospital to renovate and reopen this facility. After the realization that the opening of the hospital was no longer a viable option, it became obvious that the physical plant deficiencies at St. Louis City Hospital must either be dealt with, or relocate the facility through building a new facility or buying an existing institution.

Mr. Downs fails to mention a very important issue that occurred in 1984. That issue was the receipt of a letter from Doctor George Thoma, St. Louis University Medical School, informing the Mayor that St. Louis University Medical School would end its affiliation with St. Louis City Hospital effective June 30, 1985. St. Louis University Medical School had been affiliated with St. Louis City Hospital for over half a century. Now the citizens of the City of St. Louis were faced with St. Louis University Medical School’s abandonment of St. Louis City Hospital and their previous commitment to providing medical services to the poor and indigent of our City.

Therefore, faced with the major issue of the loss of a medical staff and questionable accreditation by the Joint Commission on Accreditation of Hospitals, Mayor Schoemehl reached out into the community and brought together the business and political support necessary to put together a workable option in the creation of a private not-for-profit organization called the St. Louis Regional Health Care Corporation. This Corporation would be responsible for providing inpatient and outpatient medical care for our citizens. At the same time, St. Louis County Executive Gene McNary joined with Mayor Schoemehl in this venture since St. Louis County was faced with an outdated facility and low utilization of that facility by County residents.

The contracting with St. Louis Regional Health Care Corporation by the City of St. Louis and St. Louis County was approved by the Board of Aldermen of the City of St. Louis and the County Council of St. Louis County. These two legislative bodies are elected to represent the will of the people of both jurisdictions.

What has been created is a health care system that is truly unified and is based on the private not-for-profit models throughout the country. By contracting for inpatient and outpatient services, the City of St. Louis offers its residents the same opportunities for an integrated health care system that exists in the not-for-profit hospital environment of our metropolitan area.

That there were start-up difficulties in the transition, there is no doubt. The final evaluation, after two years of operation, indicates that more patients are using our contract facility than previously. That the cost has not risen as dramatically as it would have risen if multi-million dollars had been invested in the outdated St. Louis City Hospital, and the commitment by Washington University Medical School to participate in the physician group providing services for the St. Louis Regional Medical Center complex, enhances our commitment to providing quality care medical services to our patients.

I would take issue with Mr. Downs’ conclusion, I quote, “Mayor Schoemehl’s attempt to cool a political fire by transferring the city’s responsibil-
A Second Opinion from St. Louis

Much has been written about the crumbling health care system of St. Louis City and County, but none as comprehensive and as factual as Peter Downs' account in the June Health/PAC Bulletin. However, there are several considerations we would like to add:

Much blame for the failure of the antecedent system has been placed on the fact that Washington University pulled out in 1980 and St. Louis University in 1985, after giving the City and County run for the City's Health Care System. A Second Opinion from St. Louis City and County, but none as comprehensive and as factual as Peter Downs' account in the June Health/PAC Bulletin. However, there are several considerations we would like to add:

Much blame for the failure of the antecedent system has been placed on the fact that Washington University pulled out in 1980 and St. Louis University in 1985, after giving an ultimatum to the Mayor to appoint a qualified Director.

Privatization has resulted in fragmentation rather than integration of our public health care systems. Regional provides hospitalization for City and County patients, and it has jurisdiction over the City's clinics. County retains jurisdiction over its clinics. A separate private entity runs the long-term care facility. And the city and county run separate operations with respect to other public health activities. And yet it is claimed that we have a regional system.

There are incredible conflicts of interest, the most blatant of which are the sale of Regional Hospital, a corporation with which a co-chair of the St. Louis Regional Health Care Corp. has recently been linked. And our hotline continues to receive complaints about indigent patients being billed, long waits for treatment, abusive language, and poor or even inappropriate medical care.

Almost from the very beginning our coalition has claimed that Regional Hospital, licensed for 300 beds, is too small to provide for the needs of the indigent. We have based this, in part, on the fact that the co-chairs of the Regional Health Care Corp. also co-chaired a 1982 Task Force which recommended a new 500 bed hospital for the City alone. There have been all sorts of rationalizations to refute our claim, but a June 11 report in The St. Louis Post Dispatch states:

"The sheer demographics of north St. Louis suggest there is a need for more than one hospital to serve that community. . . ." Like the claim that privatization saves money, the claim that Regional Hospital is sufficiently large to provide for all of the indigent has also been abandoned.

In his notebook section of March 1987 Harper's Lewis Lapham notes that "the business of the state is theft (converting public money to private use) . . . ." Perhaps that's what the privatization of our health care system is all about. Never mind its effect on the sick indigent.

The editors welcome letters from readers. Letters should be typewritten and double-spaced, and are subject to editing for clarity and space.

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