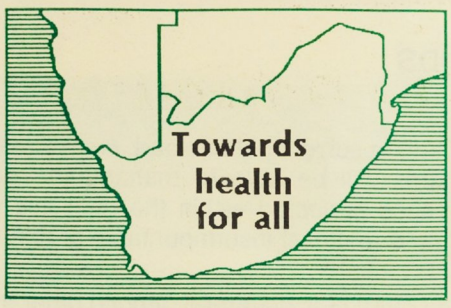
The National Medical & Dental Association



NAMDA NEWS

OFFICIAL NATIONAL NEWSLETTER OF NAMDA VOL 3 NO 2, JUNE 1989

FOCUS: DETENTIONS AND RESTRICTIONS

DELEGATION MEETS MINISTER OF HEALTH

The recent widespread hunger-strikes by South African detainees have succeeded in focusing national and international attention on South Africa's security laws and have, to a large measure, secured the release from indefinite detention of many hundreds of South Africa's leading political activists. For many health workers, the hunger strikes raised important moral and ethical issues in the management of detainees and led to the formation of the ad-hoc Johannesburg Health Crisis Committee. This committee felt it important to take up these and other issues relating to the health of detainees and restrictees with the State. A delegation which drew members from NAMDA, SAHWCO, OASSSA and CSW met with Minister W. Van Niekerk to express its concern about the well-documented dangers to health of detentions and restrictions. The delegation further urged the Minister to use his influence to abolish the laws and regulations which permit these detentions and restrictions.

The delegations expressed three main areas of concern:

1. The well documented adverse effects of detentions on the mental health of detainees and their families, manifesting often in the post-traumatic stress syndrome, and the particular risks to detained children.

2. The ethical contradictions forced on doctors and health professionals treating hospitalised detainees by police regulations and actions, and the implications these ethical contradictions have for the reputation of the medical profession as a whole.

3. The role of district surgeons in promoting the health of detainees, given the excessive workloads experienced, and the interference with clinical independence presented by security legislation.

The Minister responded by outlining new departmental guidelines for district surgeons that attempt to provide more access for detainees to district surgeons, but that failed to address any of the fundamental concerns brought by the delegates.

The Minister seemed to acknowledge that detention does cause adverse psychological effects when he noted the way in which restrictions interfere with treatment of many ex-detainees, and agreed to discuss this issue with the Minister of Law and Order. However, when pressed repeatedly to state his department's position on detention without trial and restrictions under security legislation, from the point of view of health and ethical perspectives, he repeatedly avoided a clearcut statement, saying only that the Department would like the socio-political situation in the country to be such that detentions were not necessary!

It is a reflection of the graveness of our concern as health workers, that the delegation agreed to meet the Minister on June 16. The meeting will have been useful to focus ongoing attention on the adverse health effects of detention and restrictions, the ethical contradictions posed for doctors and the invidious position of district surgeons. Ultimately, no amount of tinkering with security legislation will make detention without trial any less injurious to detainees' physical and mental health any more ethically acceptable or in any way morally palatable.

RESTRICTIONS: STATEMENT FROM THE 1989 NAMDA CONFERENCE

Thus far, no detainee has died as a result of voluntary total fasting but many of those who were released following their stand are now suffering from the effects of serious restriction orders; some were unable to attend NAMDA's conference as a consequence.

The conference participants strongly condemned these restrictions which are viewed as a form of psychological torture creating prisons out of people's houses, and producing serious, harmful effects on the restricted persons and their families. The restriction orders amount to no less than an imprisonment without trial, an administrative declaration that someone is guilty without being told what they have done wrong, nor given an opportunity to defend themselves against the allegations.

There can only be one explanation for the government's action. The state knows that no charges would stand up in a court of law in spite of the unjust and undemocratic laws at its disposal. The government is furthermore afraid to allow the sincerity and wisdom of those restricted be heard in public.

NAMDA expressed solidarity with all those restricted and reaffirmed its commitment to work for the elimination of the repressive security legislation.

EPIDEMIOLOGY OF AIDS

Since the AIDS pandemic was initially recognized in 1987 it has been met by denial and a gross underestimation of its potential magnitude. At present it is estimated that over 750,000 cases of AIDS have already occurred, that between 5 and 10 million people worldwide are infected with the AIDS virus and that within the next 5 years about one million new AIDS cases can be expected.

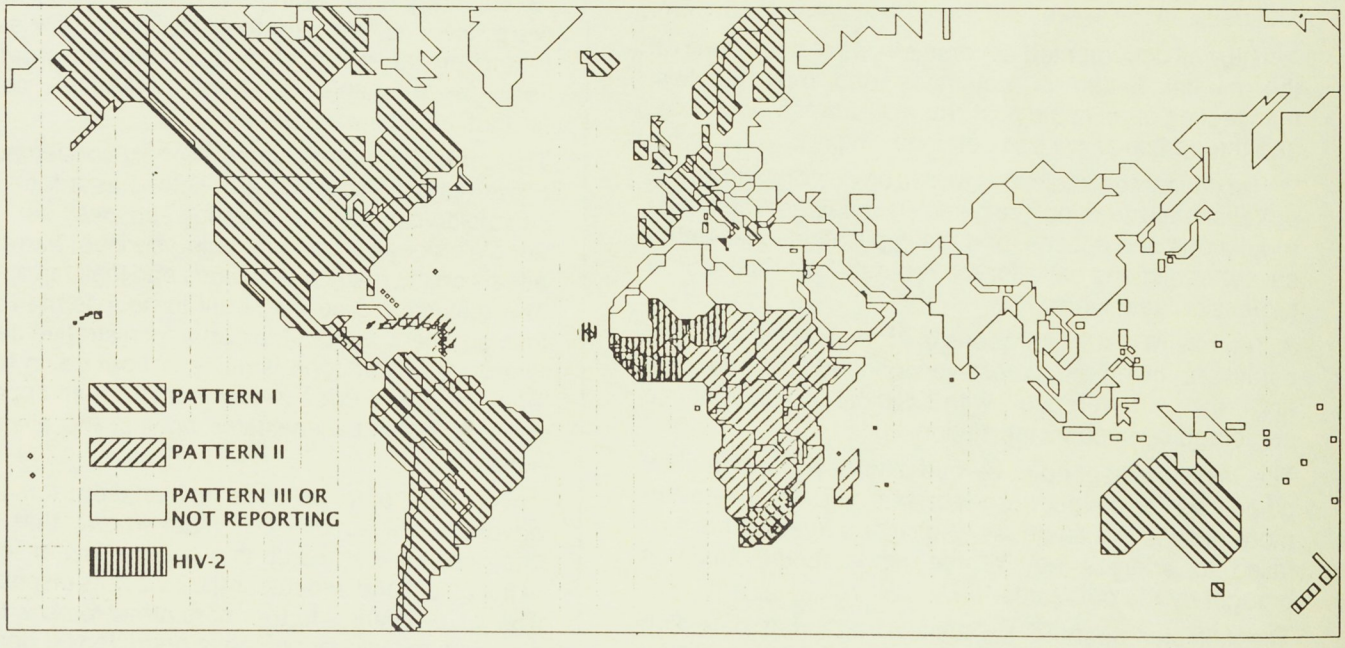
There are three different infection patterns of AIDS worldwide. These are illustrated in the figure below. Africa is the continent which has been hardest hit by the AIDS pandemic. In many of the urban centres of the Congo, Rwanda, Tanzania, Uganda, Zaire and Zambia, 5 to 29% of the sexually active age-group has already been infected with HIV. Rates of infection among some prostitute groups range from 27% in Kinshasa, Zaire, to 66% in Nairobi, Kenya and 88% in Butare, Rwanda. Close to half of all patients in medical wards of hospitals in those cities are currently infected with HIV. So are 10 to 25% of the women of child bearing age. This will mean an increase in child mortality of at least 25%. By the early 1990's the total adult mortality rate in these urban areas will have been doubled or tripled by AIDS.

The cumulative total of AIDS cases in Africa by mid-1988 was estimated at more than 100,000 and health-care systems in developing African countries are often unable to cope with the current patient load. How these health-care systems will be able to manage the additional 400,000 cases projected within the next five years in urban areas is a almost insurmountable problem.

The spread of AIDS is governed, among other things, by the probability of exposure to an infected partner. Therefore high rate of partner exchange or the frequent exposure to a relatively small number of prostitutes of many men who then return to their wives, promotes a pattern of increased heterosexual transmission. Social conditions such as migrant labour promote these patterns of sexual behaviour.

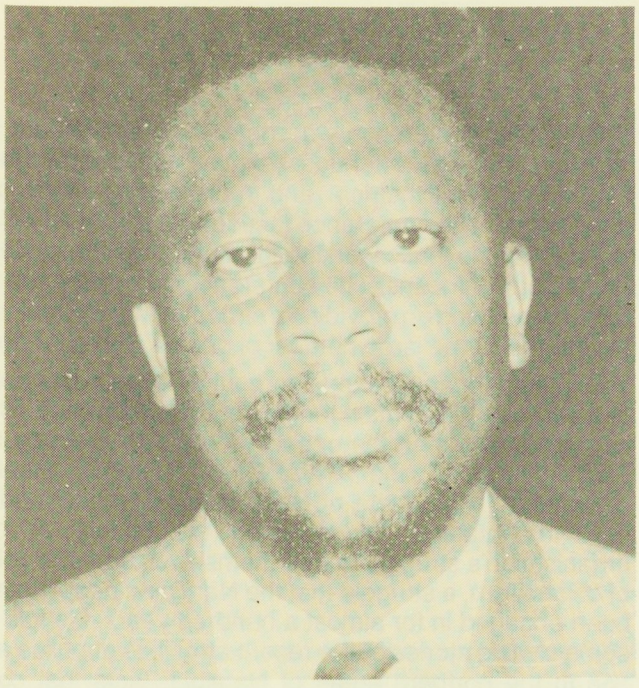
Certain aggravating factors such as the presence of chronic infections may make an individual more susceptible to HIV infection. Studies in Africa indicate that other sexually transmitted diseases, in particular those characterised by genital ulceration such as chancroid and syphilis, may increase susceptibility to infection or exposure to a partner carrying HIV or may increase the infectivity of a person carrying HIV.

Source: Scientific American Oct 1988



THREE INFECTION PATTERNS of the AIDS virus are apparent worldwide. Pattern I is found in North and South America, Western Europe, Scandinavia, Australia and New Zealand. In these areas about 90 percent of the cases are homosexual males or users of intravenous drugs. Pattern II is found in Africa, the Caribbean and some areas of South America; the primary mode of transmission in these regions is heterosexual sex and the number of infected females and males is approximately equal. Pattern III is typical of Eastern Europe, North Africa, the Middle East, Asia and the Pacific (excluding Australia and New Zealand); there are relatively few cases and most of them have had contact with pattern-I or pattern-II countries.

PROFILE: NKAKI MATLALA



Nkaki was born in 1953 in Warmbaths near Pretoria. He is currently practising as a general practitioner in Mabopane.

He first studied at the University of the North and then taught for a year before going to the USA. There he obtained an M.Sc., and qualified in medicine, at Michigan State University. He worked for a year in the States before coming back to South Africa in 1983.

While he was a student at the University of the North, he was an active member of the South African Students Organisation (SASO). But this was not his first exposure and involvement in politics. His father, a priest, was a major influencing factor during his formative and High School years.

When asked whether there was one particular incident which marked a turning point in his life, Nkaki remembered an experience which strengthened his abhorrence of the apartheid system and made him more determined to fight for the liberation of South Africa. It was an ordinary summer's day, when he was innocently sitting in a car and reading a newspaper. A White man came up to him and asked if he was able to read. Nkaki replied that he could. The man then demanded that he read to him, and proceeded to ask him what he wanted to be. Nkaki replied that he wanted to be a doctor. The White man then said that a "monkey like him" would take fourteen years to qualify and if he did qualify, he should be sure not to touch him, even if he was dying. Nkaki remembers feeling very angry at this incident. Initially as a youth his anger was against Whites as a symbol of the humiliation and oppression he had to suffer. But through practical involvement and exposure to other ideas, he realised that apartheid is the fundamental problem and Whites are victims as well.

Nkaki first heard about NAMDA at a medical discussion group meeting in the Transvaal, which was addressed by the President of NAMDA, Dr Diliza Mji. Nkaki had always felt that the health status of an individual is determined by his socio-economic conditions. After Diliza had addressed the meeting, Nkaki realised that NAMDA could provide a home and vehicle for his beliefs. He joined the Transvaal branch, and is now one of the three national Vice Presidents of NAMDA.

On the role of general practitioners in NAMDA, Nkaki feels that they can play an important role because of their contact with the communities. As primary providers of information, GPs are in a position to gain the trust and respect of their communities. It is therefore vitally important that they do not abuse their trust, but instead contribute to the upliftment of the communities they are serving.

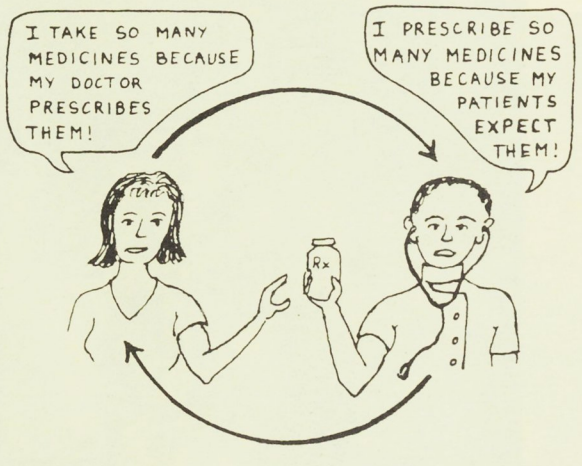
Nkaki says that the reason why he is involved in NAMDA is to fight for an equitable health system in a non-racial democratic South Africa, which will benefit not only the community he is serving, but the majority of the people in South Africa.

He believes NAMDA can play an important part in influencing health policy both at present and in the future. NAMDA can also influence attitudes of doctors to be more socially responsive.

Finally, a message that Nkaki would like to convey is that NAMDA members must get more involved in the Mass Democratic Movement, must increase their involvement in the activities of NAMDA, and persuade other doctors and dentists to join.

Nkaki is married, with two children, and his wife is studying research methods in Library Sciences at UCT.

PRACTISING PROGRESSIVE PRIMARY HEALTH CARE



THE VICIOUS CIRCLE THAT LEADS TO THE OVERUSE OF MEDICINE

EDITORIAL

Another highly successful conference marks the passage of another active year for NAMDA and its various structures. It is indicative of the organisation that the warm and comradely atmosphere that always prevails at national council meetings is that which also prevails at our major national event, the Annual Conference.

This year also marked the occasion of an evaluation of the organisation by all the branches and regions, brought together at a national retreat in Durban, to examine the directions the organisation has taken, and should be taking into the next decade.

The retreat examined NAMDA's activities and looked at ways of increasing the active participation of members. It was apparent that activities involving Progressive Primary Health Care and Detainees' care are considered high on the list of priorities for continued involvement. In this sphere, it is worthwhile mentioning a report that whilst members may subscribe to the principles of primary care and Health For All, they must also strive to practise those same principles in their daily lives.

There are, of course, many other activities of importance to NAMDA and health care in South Africa, such as NAMDA's initiatives on Community Based Medical Education, AIDS, and its involvement in various research initiatives for a future based on a non-racial democracy.

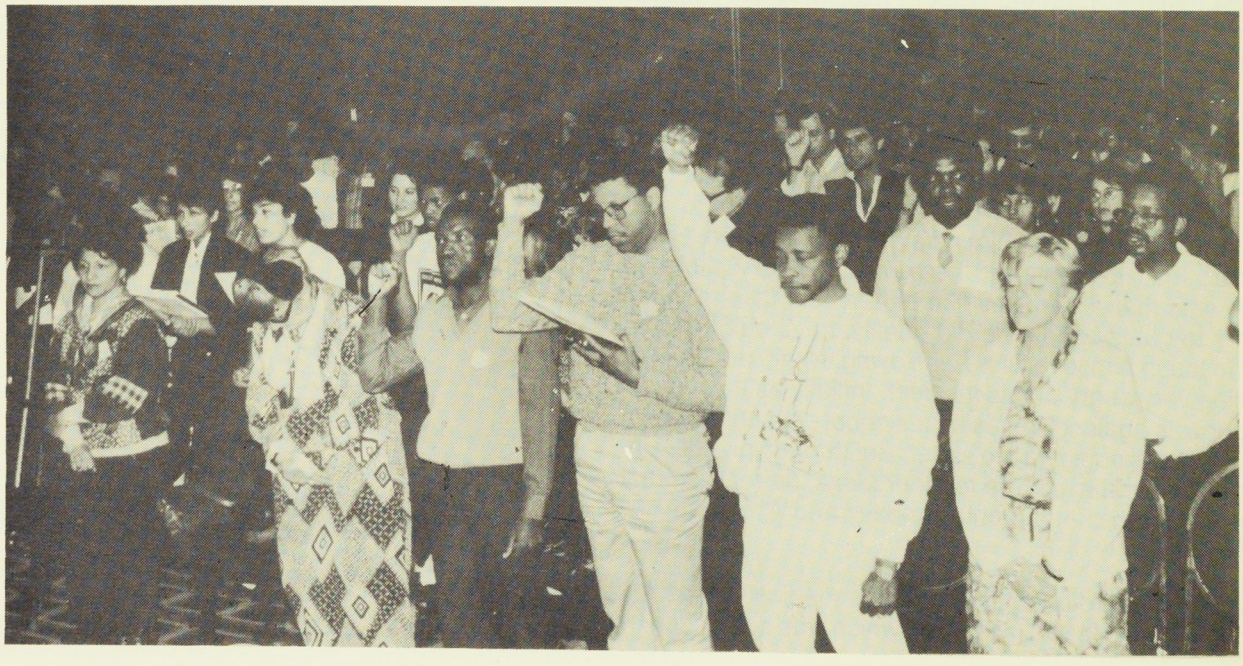
Whatever the activities of NAMDA, though, it is up to each branch and region to determine where best they can direct their energies, as priorities will differ, depending on the local membership and issues. And, hackneyed though it may be to repeat, it is still the membership that makes NAMDA. To this end, there should be a commitment by all activists within NAMDA to not only increase the (paying!) membership but also to increase the active members, by a concerted process of education about the politics of health care.

6th NAMDA A

The 1989 conference was held in Johannesburg in May, and was attended by over 400 people from throughout South Africa, and representing many organisations. The conference focused on a number of issues all vital to those working for a better health system for all South Africans. The conference committee are to be congratulated on providing a structure that maintained the interest of the large number of people who attended.

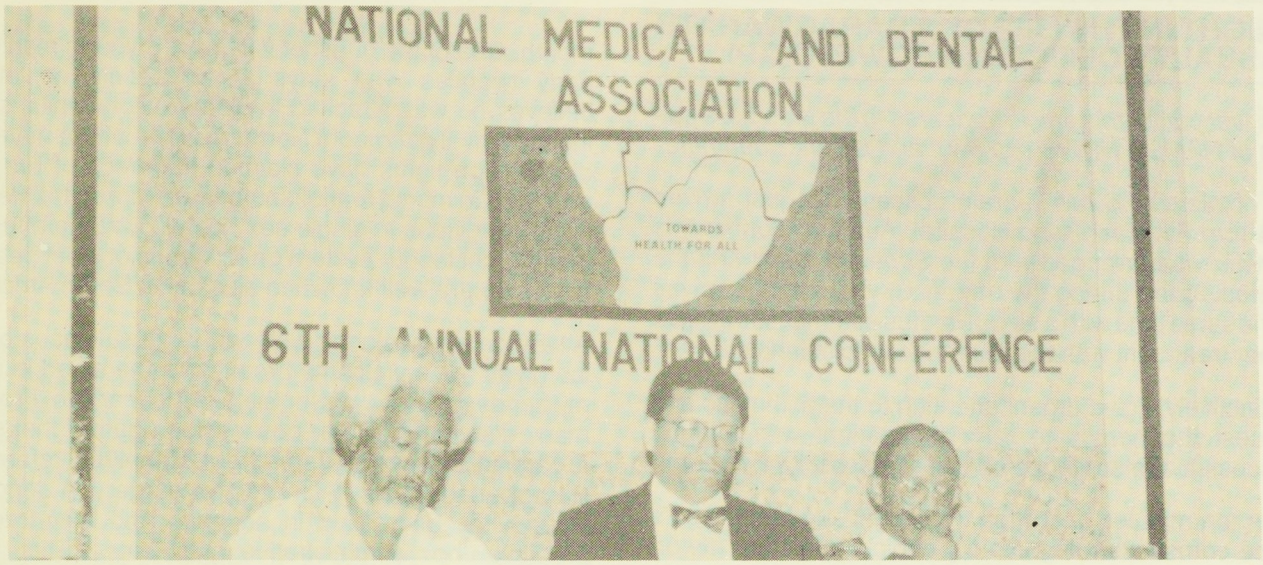
The international speakers were all working in the area of AIDS, one of the main themes of the conference. The keynote address on the opening night was given by Dr Tom Ihuhua of the SWAPO of Namibia Health Secretariat. A graduate of Natal Medical School and a G.P. in Katatura, he reviewed the history of his organisation's struggle to free themselves from the yoke of colonialism, a struggle that the Namibian people have been engaged in for almost a hundred years. He told of some chilling stories of the recent atrocities of police action in the northern areas of Namibia, facts that contrasted sharply with media reports reaching the country and the outside world. The audience warmly appreciated the opportunity to hear the other side of the story from SWAPO directly.

Mr Don Edwards, director of the Washington based National Minorities AIDS Council discussed the experiences of black Americans (whom he referred to as "African-Americans") in confronting the AIDS pandemic itself and the racism and discrimination that has accompanied it. He emphasised the dangers of viewing AIDS too narrowly as a specific disease with a specific intervention method: condoms. Instead, he explained how it could be used to focus on other directly related problems such as teenage pregnancy, drug abuse, sexually transmitted diseases and so on. More broadly, AIDS campaigns could be a tool for political mobilisation because people had to take control of the circumstances that were



Delegates sing the National Anthem at the close of the conference

NUAL NATIONAL CONFERENCE



Tom Ihuhua, Don Edwards, and Diliza Mji,

the fundamental causes of these problems. At the close of the conference, Don Edwards urged us to be mindful of the fact that the community created us, and not the other way round; we must validate the community at every step, and indeed march in step and in rhythm with the community.

The AIDS theme ran throughout the conference in a number of different workshops as well as in the plenary sessions. Dr Q.Q. Dlamini from the Swaziland Ministry of Health described the distribution and spread of AIDS in Africa, the WHO global programme on AIDS, and the programme in Swaziland. The article on page 2 summarises the epidemiology of the AIDS epidemics. Some interesting points emerged from the workshops: for example it was claimed that the South African government had sat on statistics reflecting the spread of HIV infection in this country, only releasing the figures two years later.

Another important theme of the conference was that of health planning, and local speakers provided a variety of topics, from professional education to auxiliary training.

Other major themes addressed were those of the continuing problems associated with the ominous trend towards privatisation, the need for an appropriate drugs (medicine) policy, and many issues related to occupational health.

The continued repression imposed by the State was highlighted in a section concerning issues around the hunger strikes, a subject reviewed in our last edition and, unfortunately, still present. Not least of these issues was the subsequent inhuman restrictions placed on the released detainees, a topic highlighted by our President, Diliza Mji in his speech opening the conference. The importance of this was shown by the passing of a special conference statement, summarised on page 1.

All in all the concluding sessions agreed that the conference had opened new avenues for NAMDA activities and issues to be raised and lobbied. For those of our members unable to attend this year's conference, make a resolution to attend next year's conference, which is due to be held in Durban.

Diliza Mji, Tom Ihuhua, Aron Motswaledi, Mvuyo Tom

A NIGHT IN THE LIFE OF A BARAGWANATH CASUALTY OFFICER (A SOWETO GP)

The first part of this article appeared in the March '89 edition of NAMDA NEWS (Pp 6-7), and is concluded here:

A patient who has a brain abscess has just arrived from Far East Rand Hospital. Authorisation for this transfer was arranged with the Superintendent and the neurosurgeon during the day. A 16 year old girl arrives at the same time with a severe status asthmaticus in spite of her treatment with theodur and ventolin inhaler.

Instinctively, I give urgent attention to the asthmatic and request the nurses to refer the patient with a brain abscess to the surgeons on call at Resuscitation room.

After ten minutes, a Matron from night superintendent's office comes storming into my cubicle to lecture me on why I did not remain behind after sending a patient to the Resuscitation room. I ask her politely to put herself in my shoes, and this seems to subdue her for now.

My next patient is a 40-year old man who sustained some two or three stab wounds on his way to work the previous day. The Primary Health Care Clinic nearest to his house in Zola referred him to a private hospital, Lesedi, opposite Baragwanath Hospital because he was erroneously labelled a WCA patient. Lesedi Hospital demanded an Employer's report first but advised him to see a GP when he failed to produce one. Since he did not have sufficient/enough money for GP consultation, he decided to come to Baragwanath Casualty after hours because nobody is turned away after 4pm. Fortunately sepsis in his wounds had not set in yet.

A 21 year old standard nine pupil in the company of both her parents presents next with headache, fever and rigors. The mother blames it all on cold exposure suffered during a night vigil four days ago. My assessment reveals a septic incomplete abortion as a cause of all her misery. She denies any knowledge of pregnancy because she received her menses regularly every month. After a brief explanation to the patient and her mother I refer them to the Gynaecology doctors on call: they are working in a prefab. structure just opposite the Casualty doorway.

At this stage I turned my attention to murmurs of discontent emanating from the patients seated on benches or "walking cases". A 62 year old lady (a pensioner) tells me she suspects that her "sugar" is out of control because she has been without treatment for 3 months. Her blood glucose is indeed sky high and I prepare to admit her straightaway. Her explanation for not taking treatment is that her PHC clinic has decided to withhold treatment because she is owing too much. She also feels that it would be unfair to trouble the clerical staff at the clinic. In any case, they are always seen by nurses and she feels she ought to see a doctor for a change.

The next 20 patients are victims of township violence ranging from stab wounds, gunshot wounds, blunt trauma and couples annointing each other with boiling water following disputes on how to budget for the next month. One of the gunshot victims is a young man in his early twenties who stays at Nancefield hostel. He believes he was attacked in his dormitory whilst sleeping, by a rival gang from Northern Natal where never-ending faction fights have claimed hundreds of lives. He now lives in mortal fear of another attempt on his life. The living conditions in single sex hostels and the effects of the migrant labour system on the fabric of quiet peaceful family life are well-known to all of us in South Africa.

A lady on a wheelchair with two large suitcases on her lap gives me a welcome break from the blood in which my hands were soaked for the past hour or two. From the many documents in her possession I gather that she is a cardiac disease sufferer from Mannitrus referred to Baragwanath hospital for elective surgery. A deposit of R2000 has been paid in advance and therefore she presents no administrative problems. The major obstacle, though, is language. She speaks only french and this is foreign to us. Naturally, we search for a french speaking doctor in all the corners of Baragwanath and luckily we find a surgical registrar who acts as an interpreter for a short while. We reassure her that all will be well once she is in the ward.

At 4am I take a short break for a cup of coffee. This is a favourite beverage for all those who wish to stay lucid for the night. The meals supplied are nothing more than dog's delight. The doctors' rest room is a stuffy little dungeon at the end of this long corridor called Casualty. A few mice in this room seemed quite thirsty also. This is enough to propel me back to my crowd which seems to be static in number in spite of everything.

The reception sister shouts "urgent epileptic" in reference to a patient who has just been wheeled in on a stretcher. The whole stretcher shakes with each convulsive jerk. History from the escorts reveals that this patient took ill soon after taking a concentrated love potion. As a young man he routinely cleanses his blood with herbal medicines sold at Ikhwezi railway station in Soweto. I naturally advise the others to refrain from taking medicines and herbs and to try to stick to the prescribed dose.

There has been a noticeable increase in the number of patients diagnosed as having Pulmonary TB over the past few years. A doctor from the medical admissions comes charging at me demanding to know why I admitted a patient suffering from TB Bronchopneumonia at an unholy hour like 4am. I have no difficulty in convincing him that Casualty stretcher area is not a ward. He is subdued to the extent of asking me to be reasonable and admit only those patients who need emergency care.

Just before going off at 8am I'm presented with a group of patients anxiously waiting for medical certificates to prove to their employers that they were treated at Baragwanath hospital. This is done by Booking clerks upon written request by the Casualty officer.

I then drive home to rest my aching bones, freshen up, and prepare for a normal day in my rooms.

ABOUT THE BRANCHES

WESTERN CAPE MEDICAL BRANCH

The Western Cape Medical branch has been more active than ever this year. Interest was reflected in several ways, including good attendances at (most) meetings, active participation in projects, and (not least) a paid-up membership of nearly 100 people for 1989 which is definitely a record for this time of year (although we would like the figure doubled before the year is over!).

A new feature of our general meetings has been the introduction of joint meetings with the Academy of Family Practice/Primary Care. We started off the year with a very worthwhile meeting on Tuberculosis in the Western Cape, and another joint meeting on the care of the disabled patient in the community is scheduled for late July. There can be no doubt that these meetings have helped to increase interest in NAMDA amongst G.P.'s. A meeting on Child Abuse and Violence Against Women was told, amongst other things, about an innovative community project in Atlantis, training women and children in self defence. For the first time, we joined with NADEL for a meeting on Capital Punishment, which was addressed by Miss Julia Sloth-Nielsen of the Society for the Abolition of the Death penalty. A highlight of our year was a meeting addressed by our national president, Diliza Mji, the topic "Why NAMDA?"

Our region recently held a workshop on Evaluation of NAMDA and the future direction of NAMDA. It proved to be a most worthwhile opportunity for people to exchange ideas on the workings of our organisation.

An outstanding feature of our region has continued to be our excellent monthly newsletter produced by Max Bachman.

The detainee clinic continues to function well with the involvement of several NAMDA doctors, including some new NAMDA recruits.

PPHC continues to be very active on the Western Cape and holds regular workshops on topics like TB, Nutrition etc.

A new sub-group has been formed to investigate ways of implementing Community-Based Medical education (CBME) in the Western Cape.

In addition to the above activities, our region has made every effort to respond to calls for participation in campaigns such as the call for support of the hunger strikes, the campaigns for the Abolition of the Death Penalty etc.

It must be borne in mind that all these activities have been carried out in spite of the lack of an office or a full-time secretary as is the case with other regions. This has necessarily placed a great burden on the shoulders of the few committee activists and it is hoped that more and more "new blood" will be injected not only into our membership but also into active involvement in our organisation in the near future. This will be the best possible way of maintaining the exciting momentum that has been achieved in our region.

This poem appeared in "Progress Notes", the journal of the Medical Action Group of the Phillipines.

What is terrible
is not when they suddenly arrest you
and torture you,
that one night they might execute you.

Those walls
which perhaps await you
are not what is terrible.

It is not terrible
to have to leave forever
those whom you love
and be sent far away.

What is terrible,
What is truly terrible
is to let fear win.

Not to understand
that the price of freedom
is not free.

Compared to the oppression
what is terrible is not to fight
for your dignity
to be a worm
which lets itself be crushed

What is terrible is indifference
to live only for oneself
not to have hope

WHAT IS TERRIBLE IS NOT TO DREAM

Oscar Fuentes

CHILD ABUSE

CHILD ABUSE IS THE DIFFERENCE BETWEEN A HAND ON THE BOTTOM AND A FIST IN THE FACE

HENRI KEMPE

The problem of child abuse in South Africa is one that has become more apparent over the past few years. While there may be an increase in the incidence of child abuse, the increased awareness of the problem on the part of the parents, public and the professionals who care for children has also raised the numbers of children seen.

Child abuse is a problem that occurs in all societies and is not unique to South Africa. It is clear, however, that in societies in which there is a failure to implement basic human rights, the rights of children are even more neglected. Apartheid does not necessarily cause child abuse - the problem exists in the absence of apartheid. However the inherent inequalities of our society are an added impetus. Organisations such as NAMDA must place the rights of children as a priority and should be in the forefront in the defence of children from all types of abuse. This should include cooperation with other organisations concerned with the welfare of children, the monitoring of the effects of inequality on the health and welfare of children, and the training of health professionals to deal with child abuse. It is important that the child does not become lost in rhetoric.

Recognition Of The Problem

The methods employed in the detection of abuse must suit the community, though the framework of prevention, detection, investigation, intervention and protection will be universal. The role of the health worker will be related to the resources available, but protection and detection are the two areas of importance.

Prevention involves education of parents and children and the empowerment of children to say no to abuse and to seek help if it occurs. Awareness of the problem is a start and we must all deal with the prejudices that we all possess when it comes to abuse. Health care workers should help organise the key people in their region to promote prevention programmes and must be ready to respond appropriately to the abused child and to the abuser.

Progressive health workers need to recognise that abuse occurs in their own backyards. Therefore there must be a constant watch for the symptoms, and knowledge of what abuse entails. Abuse can be difficult to detect and without a clear idea of the problem, can be missed. The detection of abuse does not start with the health care worker, but rather with the parent or adult who cares for the child. Detection therefore also involves ongoing education of parents and the opening of channels for the reporting of abuse.

What Does One Do?

The health worker must be available as a person whom children, parents and concerned individuals can approach for help. He or she must have a clear idea of what to do once an abused child presents. The most important factor is the safety of the child. Welfare organisations are required legally to investigate abuse, as are social workers and the police. However not all cases of abuse need referral to the police. Accurate documentation is mandatory as legal evidence may be necessary. It is important to have a close working relationship with a social

worker who is experienced in the investigation of abuse. This may not always be possible and the health worker must then play a role in investigating the circumstances surrounding the alleged abuse and facilitate the correct handling of the problem. It is important for every health worker to develop a procedure for the handling of child abuse in consultation with parents, children, and other health, education and welfare professionals in the region and the community. The protection of children must become a community priority.

Diagnostic Features

- There is a delay in seeking medical help (or medical help is not sought at all).
- The story of the "accident" is vague, is lacking in detail, and may vary with each telling and from person to person. (Innocent accidents tend to have vivid accounts that ring true).
- The account of the accident is not compatible with the injury observed.
- The parents' affect is abnormal. Normal parents are full of creative anxiety for the child. Abusing parents tend to be more preoccupied with their own problems - for example, how they can return home as soon as possible.
- The parents' behaviour gives cause for concern - for example, they soon become hostile, they rebut accusations that have not been made, and they leave before the consultant arrives.
- The child's appearance and his interaction with his parents is abnormal. He may look sad, withdrawn, or frightened. There may be visible evidence of a failure to thrive. Full blown frozen watchfulness is a late stage and results from repetitive physical and emotional abuse over a period of time. The absence of frozen watchfulness does not exclude the diagnosis of non-accidental injury.
- The child may say something. Always make a point of interviewing the child (if old enough) in a safe place in private. This is one of the virtues of admission to hospital. Interviewing the child as an outpatient may fail to let the child open up as he is expecting to be returned to the custody of the abusing parent in the near future.

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