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Statements made in the USA by the President of the National Medical and Dental Association (NAMDA) regarding the MASA and health services and conditions in the RSA

Statements made by Dr Diliza Mji, President of NAMDA, during a recent visit to the USA, were reported in *The Chicago Sun-Times* of May 24 and in *American Medical News* of June 6, 1987. The MASA believes that it is important that not only its members but all other doctors and the public should be made aware of some of these statements, as reported, while they should at the same time be provided with the facts, and with the Association's comments. A selection of such statements, accompanied by the facts and explanatory comment, where indicated, follows.

A. *Chicago Sun-Times* (24 May 1987)

1. **STATEMENT:** 'Dr Diliza Mji, President of the National Medical & Dental Association of South Africa . . . said MASA is an integral part of apartheid . . .'

   FACTS AND COMMENT: This is a transparent attempt to politicise the MASA by identifying it with the universally rejected 'apartheid' policy. This can be compared with saying: 'The AMA is an integral part of the Republican Party and its policies' because it does not oppose the Reagan administration's policy in Nicaragua or Cuba, etc. It must be stressed that the MASA, unlike the NAMDA, does not discriminate between members on the basis of race, colour, creed or *political persuasion* and is therefore truly representative of all doctors in South Africa.

2. **STATEMENT:** Reference was made to '. . . the international isolation of MASA . . .' and to the '. . . white dominated MASA . . .' while it was also stated by Dr Mji that '. . . the facts don't justify AMA endorsement of MASA.'

   FACTS AND COMMENT: The MASA has *never* been officially isolated internationally, although attempts have been made to do so. Such attempts have invariably been politically motivated, with complete disregard for the role actually played by the MASA, its aims and objects, and its composition. The MASA was a founder member of the WMA and voluntarily resigned from the latter in 1976 due to political discrimination, *inter alia* against the MASA. The MASA was *requested* to rejoin the WMA and was *given the assurance* that the events which had led to its resignation would not occur again.

3. **STATEMENT:** '. . . MASA has failed to condemn the mass detentions that took place under the year-old state of emergency.'

   FACTS AND COMMENT: The MASA deplores the unrest and violence which led to the declaration of a state of emergency on 12 June 1986, and the detentions necessarily associated with it. The MASA finds it strange, however, that the NAMDA is more than ready to condemn alleged cruel treatment of detainees but does not see fit to substantiate their allegations or to condemn or even mention the barbaric atrocities committed in the name of 'true democracy'. This includes the role played by the ANC in this connection, the fact that most such violence (including death by the so-called 'necklace' method) has mainly been by blacks against blacks, and the fact that there has been a drastic reduction in the number of incidents of violence since the declaration of the state of emergency.

4. **STATEMENT:** '. . . the vast majority of detainees had been physically and mentally abused . . .'

   FACTS AND COMMENT: It is significant that NAMDA has not to date issued any statement deploring the barbaric killings of blacks by blacks, *inter alia* by means of the gruesome necklace method developed by the ANC, despite the fact that this far exceeds the number of deaths due to action by the security forces. They are, however, quick to allege police brutality, maltreatment and torture of political prisoners and detainees in terms of the Regulations applicable under the state of emergency. However, when asked to substantiate such allegations by providing names, dates or places, so that appropriate steps could be taken to punish those responsible and to ensure that it could not occur again and that detainees would receive adequate care and protection, they hide behind the different international ethical codes, *inter alia* that of the WMA, stating that this is privileged information which cannot be divulged. The MASA, on the other hand, believes that they have a moral and ethical duty to provide such information in order that steps can be taken to see to it that these practices are ceased forthwith and that appropriate steps are taken to punish those responsible and to ensure that such unacceptable practices will not occur again and that detainees will receive adequate care and protection. NAMDA apparently has no hesitation at all in so far as making allegations of this nature available to the media, especi-

ally foreign media, and to other national medical associations, but is merely unwilling and/or unable to substantiate them.

5. **STATEMENT:** '. . . MASA in the 1960's was a progressive force that fought "Nazi-like" laws prohibiting whites from receiving blood from blacks. But during the 1970's . . . MASA became "indistinguishable" from the government and its legalized racism . . .'

FACTS AND COMMENT: These allegations have no basis in fact and would be laughable if it were not for the deliberate attempt to malign and discredit the MASA. If anything, the MASA's present Council is more liberal in its views than any previous Council and is doing everything that could be expected of a national medical association to see to it that the highest possible standards of medical training, practice and ethics are maintained. There has *never* been a law or regulation to prevent whites from receiving blood transfusions from blacks, or vice versa.

6. **STATEMENT:** 'MASA has been a pillar of the apartheid system.'

FACTS AND COMMENT: There is no truth to this statement, which must be seen as a deliberate attempt to tar the MASA with the 'apartheid' brush. The MASA has *never* discriminated between members on any basis and has consistently and actively opposed discrimination in health services. The MASA's position is straight and clear: it is a professional association for doctors and does not have any affiliation with political interest groups, unlike NAMDA. The MASA does not support apartheid, nor does it support any political organisations or parties. The MASA is totally opposed to all violence and therefore condemns terrorism and revolution, and especially maltreatment of detainees.

B. *American Medical News* (6 June 1987)

1. **STATEMENT:** '. . . The National Medical & Dental Association (NAMDA), an interracial organization formed in 1982 to draw physicians into active opposition to apartheid . . .'

FACTS AND COMMENT: The reasons provided by NAMDA for this organisation's establishment would appear to vary according to the audience they wish to impress. Apart from this statement in *AMN*, it has also been variously described as having been established '. . . as an alternative to the white dominated MASA' (*AMN* 6 June 1987), '. . . due to failure of the MASA to deal effectively with the ethical issues arising from the death of Steve Biko . . .' '. . . Our primary aim is to promote the attainment of HEALTH-FOR-ALL within a unitary democratic South African state' (NAMDA policy statement — undated), and '. . . NAMDA was formed in 1982 as a forum for medical and dental professionals wishing to challenge the appalling health conditions of the majority of South Africa's population'.

2. **STATEMENT:** 'The group, whose 1 000 members include roughly 5% of the nation's 20 000 physicians . . .'

FACTS AND COMMENT: According to NAMDA's own newsletter of January 1987, the membership statistics at the end of 1986 were as follows:

Full members	444
Associate members	135
	579

'Full members' are either doctors or dentists while 'Associate members' are from allied health professions, e.g. nurses, physiotherapists. With approximately 400 doctors, a more accurate assessment of the percentage of 'the nation's 20 000 physicians' would therefore be about 2%.

STATEMENT: 'The group has 1 000 members, 60% of them black.'

FACTS AND COMMENT: If all doctors who are not white were to be classified as 'black', Dr Mji's statement that '60% of them are black' would probably be correct. The fact, however, is that more than 50% of NAMDA's members are of Asian (Indian) origin, the next largest group is white or coloured, while the smallest group is actually black (i.e. of African origin).

The MASA does not classify its members according to race or skin colour, so that accurate statistics of this nature are not to hand. It can safely be said, however, that the MASA has more than 1 000 members who would not classify as 'white' (i.e. Asian, coloured and black): in other words, probably 3 to 4 times as many members from this category as NAMDA — should this, for some reason or other, be regarded as a criterion.

3. **STATEMENT:** 'South Africa's health profile has two faces', said Dr Mji, 'a good one for the minority (white) population, which enjoys a health status comparable to the best in the world, and another face for blacks, who are exposed to health conditions like those in some of the poorest countries in the world.'

FACTS AND COMMENT: No credit is given for what has already been achieved in the provision of health services to blacks, nor is any mention made of the tremendous health problems facing this country. Everything that is wrong and all the shortcomings are simplistically ascribed to a particular policy, viz. apartheid. No mention is made of the fact that infant mortality rates (IMRs) are dropping and that the overall IMR for blacks in South Africa is at least 37% better than in the rest of Africa. Nor is mention made of the fact that the crude mortality rates in all population groups are dropping fairly rapidly while average life expectancy is rising.

4. **STATEMENT:** 'Dr Mji . . . is a graduate of the University of Natal, one of two medical schools — of seven nationwide — that accept black students.'

FACTS AND COMMENT: One must assume that Dr Mji is ignorant of the fact that the medical faculties at all the other black universities in South Africa have no objection to admitting black students, especially since the permit system was abolished in 1986, but even prior to that, otherwise the statement attributed to him cannot be regarded as anything other than a deliberate attempt to mislead. At two of the other five faculties there has never been any restriction on the admission of black students, other than those previously imposed by law, while the other three have no objection in principle to the admission of non-white students. The method by which this is done differs from faculty to faculty and while some set aside a certain number of vacancies specifically for non-white

students, others are only prepared to admit students on the basis of academic merit. All medical faculties in South Africa at present have non-white students, at least at postgraduate level. According to Prof. G. Dall, Dean of the Faculty of Medicine at the University of Cape Town, black, coloured, Indian and Chinese students comprised one-third of the total student body in the first and second years of study (*Medical Chronicle,* May 1987). It also bears mentioning that the policy at MEDUNSA is to give preference to black or non-white students and that a white student will not be admitted, regardless of merit, if there should be a black or non-white applicant who qualifies for admission.

5. **STATEMENT:** 'We don't have a death wish for MASA . . . if only MASA would take up the issues we have taken up, we would close up shop and join them.'

FACTS AND COMMENT: This statement is strangely at variance with the repeated calls made by NAMDA for the expulsion of the MASA from the WMA and also with the continuing attempts to discredit the MASA, e.g. by describing it as 'a pillar of apartheid', by alleging that 'the WMA, by accepting MASA . . . has condoned exploitation and oppresssion . . .' or that 'the relationship between MASA and the WMA is opportunistic and has little to do with the promotion of health . . .'

The MASA is not aware of any attempts made by the doctors who established NAMDA to take up the issues rather vaguely referred to by Dr Mij *by becoming members of the MASA,* which they could have done and still can do. It would rather appear that NAMDA chose the path of confrontation right from the start and assumed that MASA would not take up the issues espoused by them, such as public support for a call for the unbanning of the ANC (advertisement, *Sowetan,* 2 January 1987), a call for an end to the state of emergency (*The New Nation,* No. 10/1987), a statement that 'the House of Delegates does not represent the Indian community' (*The New Nation,* April 1987), and a statement expressing support of workers dismissed by NCD/ Clover dairies in Pietermaritzburg during June 1986, claiming that they had been 'unfairly dismissed'. The MASA believes that issues such as those mentioned above do not fall within the ambit of activities of a professional organisation such as the MASA.

6. **STATEMENT:** 'Blacks in South Africa are confined by law to 10 rural homelands or to ghettos adjoining white towns and cities. Dr Mji described rural areas without running water, sanitation, adequate housing or medical facilities, where residents contract infectious diseases that have been eradicated in other countries through simple public health measures.'

FACTS AND COMMENT: This must again be seen for what it is, viz. a deliberate attempt to mislead by providing incomplete and/or incorrect information. Blacks are *not* 'confined' to particular areas although they can only exercise the vote in their own national states or 'homelands'. The pass laws have been abolished and they can move freely anywhere in South Africa while they have total freedom to seek work in any urban area. The government has officially accepted the permanence of black urban areas and blacks are now allowed and encouraged to purchase homes in such areas.

In describing black 'ghettos' no mention is made of the fact that black housing in South Africa is unequalled anywhere else in Africa, and that 92% of urban blacks receive government assistance in housing. The fact that between 1975 and 1986 homes have been constructed for urban blacks at the rate of approximately 100/day is ignored. No mention is made of the fact that the average GNP in the 10 national states is higher than in 33 of the 55 other countries in Africa. The fact that there are more black graduates in South Africa than in the rest of the African continent is ignored. So is the fact that the national health team (doctors, dentists, pharmacists, nurses and associated health service professions) is 480 per 100 000 of population — more than 300 better than the average for the Third World.

It is true that urban areas are more generously endowed with health facilities than many rural areas. This is not, however, peculiar to South Africa. Attempts to streamline the health care infrastructure in rural areas have already been very successful in certain areas while others are, unfortunately, still lagging behind. In Venda, for instance, the IMR is 36/1 000 and in the Gelukspan area of Bophuthatswana, 14/1 000, a rate which cannot be achieved by any other country in Africa. The SA Government's commitment to improving health care is convincingly illustrated by the allocation of 5,4% of the GNP for this purpose. Few, if any, developing countries use more than 2% or 3% of GNP for this purpose and even in highly developed industrialised countries it varies between 6% and 10% of GNP. Community involvement is a concept central to community health and is emphasised in South Africa, but it is an arduous undertaking indeed to convince people, many of whom are still steeped in superstition and subject to a particular cultural heritage, that disease is caused by bacteria and viruses, and not by evil spirits.

7. **STATEMENT:** 'The segregated society has one white physician for each 300 white citizens . . .compared with one black physician for each 91 000 blacks.'

FACTS AND COMMENT: This has to be regarded as a deliberate attempt to mislead in order to influence world opinion against South Africa. The fact of the matter is that by far the greater part of the medical attention received by black, Asian or coloured patients is provided by white doctors — for the simple reason that at the present time white doctors represent the majority of the country's medical force. It must be stressed that the medical care provided by the great majority of these white doctors to their non-white patients is of the same high standard as for their white patients.

Statistics regarding the 'national health team' have already been provided in B(6) above. In 1986 there were approximately 20 000 doctors in South Africa, i.e. 1 for every 1 500 of total population, which is more than 6 times better than the figure for all of Africa. For every 100 000 of the population there are 295 nurses — the highest ratio by far in the developing world. For every 1 000 of all blacks, coloureds and Asians, there are 5,2 state and private hospital beds. The comparative figures in other regions are: South-East Asia 1,7; Eastern Mediterranean 1,2; Africa 2; Western Pacific 2,9 (WHO statistics).

8. **STATEMENT:** 'In 1984, South Africa spent about eight times as much on education for whites as for blacks . . .'

FACTS AND COMMENT: That more was spent on education of whites, coloureds and Indians than on black education is undoubtedly true. It should, however, be noted that the groups mentioned above are largely responsible for paying for their own education, *as well as for most of black education.* It should further be noted that South Africa has the highest rate of black literacy on the African continent and that 80% of black children are at school, compared with 65% in Zambia, 43% in Tanzania and 44% in Nigeria.

9. **STATEMENT:** 'The infant mortality rate among whites is 9,7 for each 1 000 births, compared with 34,4 deaths for urban blacks and an estimated 120 to 150 deaths for homelands blacks.'

FACTS AND COMMENT: This must again be regarded as a deliberate attempt to mislead. Attention is again directed to the statistics provided in the comment under item B(6) above. It should further be pointed out that there has been a vast improvement in the IMR of the different population groups. The average South African IMR of 55 brings some interesting facts to light: white and Asian rates are respectively 11 and 16 (both much better than the best of the six WHO health regions). The black IMR is difficult to determine exactly due to under-registration of births and deaths, but estimates vary between 80 and 90/1 000, compared with the WMA estimate of 116/1 000 for Africa. Although this is higher than that of the other population groups, it is still 37% better than that for the rest of Africa. What is even more significant, is that black IMRs have declined rapidly in certain urban areas and are now well below the national average, e.g.:

IMR PER 1 000 FOR BLACKS

City/Town	*1970*	*After 1980*
Bloemfontein	130	43 (1983)
Cape Town	90	32 (1983)
Durban	89	30 (1982)
Johannesburg	100	26 (1983)
Pretoria	173	43 (1981)
Port Elizabeth	119	55 (1984)

The above rates are comparable to those which were found in Europe during the 1970s among the unskilled classes.

10. **STATEMENT:** 'Average life expectancy is 71 years for white females and 61 years for white males; the comparable figures for blacks are 47 and 41.'

FACTS AND COMMENT: The average life expectancy is rising fast for all population groups. The national average is 63 years, which is 13 years more than the mean for Africa. The position is as follows for the different population groups: whites — 71 years (up from 67 in 1950); Asians — 66 years (55 in 1950); coloureds — 58 years (46 in 1950); blacks — 57 years (45 in 1950 and 51 in 1970). It is significant that even in the USA the difference in life expectancy between whites and blacks is 7 years, while the difference between whites and Aborigines in Australia is 20 years. It would be interesting and important to know the source of Dr Mji's statistics as they would appear to be at least 30 years out of date.

11. **STATEMENT:** '. . . 40% of the nation's black children are malnourished despite the fact that South Africa exports food.'

FACTS AND COMMENT: The problem of malnutrition certainly exists among the developing sections of South Africa's population, as it does in developing populations elsewhere. However, the problem is extremely difficult to quantify. The final figures arrived at when such quantifications are attempted, depend very strongly on the definition of malnutrition used. Many anthropometric studies have been done in South Africa in recent years to address this problem but there are great variations in the estimates of malnutrition, depending on the measure used and the cut-off value employed.

The following are the results of three independent anthropometric studies (percentage children malnourished according to different measures and different cut-off points):

	Weight for age	*Height for age*	*Weight for height*
Boys[1]	17,4	22,4	13,3
Girls[1]	15,5	26,7	11,1
Boys and girls[2]	5,3	26,0	0,5
Boys and girls[3]	48,4	24,6	44,4

Sources:

1. Krynauw JD, Fincham RJ, Kotzé JP. An anthropometric survey of the nutritional status of black preschool children in the Dias Divisional Council area, May 1981. *S Afr Med J* 1983; **64:** 1095-1098. 1 468 black preschool children in rural Eastern Cape area. Cutoff point is 3rd percentile NCHS values.
2. Kustner HGV. *Epidemiol Comments* 1984; **11:**(7). 600 black children 0 to 5 years in Inanda, Natal. Cut-off point is 2 standard deviations below the median NCHS values.
3. Lazarus T, Bhana K. Protein-energy malnutrition and associated variables among Indian preschool children in a selected area of Natal. *S Afr Med J* 1984; **65:** 381-384. 126 Indian children 2 to 5 years in a selected area of Natal. Cut-off point is 5th percentile NCHS values.

12. **STATEMENT:** '. . . he called on the American Medical Association to actively oppose apartheid as a signatory to the Tokyo Declaration, which encourages national medical organisations to support physicians who oppose the use of torture or other inhuman or degrading treatments.'

FACTS AND COMMENT: Attention is directed to the comments and facts provided under items A3 and 4 above. The MASA's commitment towards ensuring the best possible health care for all detainees should be more than evident from:

(a) the Report of the Ad Hoc Committee appointed by it to consider the ethical issues which were raised as a result of the medical care received by the late Mr S. B. Biko (1981);
(b) the report of the Ad Hoc Committee appointed to institute an inquiry into the medical care of prisoners and detainees (1983);
(c) the agreement reached after protracted negotiations with the relevant authorities for the appointment of panels of doctors from whom a detainee would be able to select a practitioner of his own choice if, for some reason or other, he required an opinion other than that of the district surgeon (government medical officer), and the subsequent appointment of such panels in the main centres throughout South Africa (1985/86); and
(d) the compilation of a code for the handling of children in detention by the SA Paediatric Association (a group of the MASA), discussion and negotiation of such code with the relevant government departments and authorities and its subsequent publication in the *South African Medical Journal* on 20 June 1987.

From the above it should be clear that the MASA, unlike its critics or those who only make unsubstantiated allegations, has taken positive action to ensure that detainees receive the best possible health care.