HEALTH & DISEASE— MISCELLANEOUS diseases

1989

Measles: Parents urged to immunise

ARGUS 10/11/89 89

Staff Reporter

STEPS should be taken to ensure all children aged nine months or more are immunised against measles as soon as possible, city Medical Officer of Health Dr Michael Popkiss has warned.

Commenting on the recent rash of cases — 40 last November as opposed to 14 in November 1987 — Dr Popkiss said while this was not necessarily cause for panic it showed a "steady increase" in the incidence of the disease in the greater Cape Town area.

"Measles occurs in two cycles, one being over an annual period and another in a 12- to 18-month cycle."

It was therefore misleading to compare last November's figures with those of the year before.

"But the seasonal decline we were expecting hasn't started yet. We hope we'll soon see this year's peak tailing off."

BE ON LOOK-OUT

Dr Popkiss said the past five years had seen a marked rise in the incidence of measles in Cape Town.

"This is partly due to increased migration to the cityand partly a result of parents neglecting to have their children immunised."

He urged parents to be on the look-out for tell-tale signs of measles — such as irritability, constant crying, being off-colour and the development of fever and rashes.

"With some children complications can occur so it's best to catch the disease in the early stages — or better still, take steps to prevent it."

The age recommended by the World Health Organisation for immunisation against measles in a country like South Africa was nine months.

The weather

Cloudy and mild

The DEPUTY MINISTER OF TRANSPORT AFFAIRS:

(a) Eight.

(b) R24 100.

(c) 1 February 1988 to 31 January 1989.

†Mr J J S PRINSLOO: Mr Speaker, arising from the hon the Deputy Minister's reply, may I ask him whether the Government intends reducing the number of coaches and if not, what exactly is the plan with these coaches that are specifically reserved for this purpose?

†The DEPUTY MINISTER: Mr Speaker, there are eight of these coaches that are used for judges, the State President and Ministers. At present there is no intention to put the coaches to any other use.

†Mr J J S PRINSLOO: Mr Speaker, further arising from the reply of the hon the Deputy Minister, I should like to ask for what purposes coaches are specifically reserved for the use of judges. Why are the ordinary railway coaches with the necessary facilities not used?

†The DEPUTY MINISTER: Mr Speaker, the hon member will know that it is a very old custom in South Africa to make the coaches available to judges. There are three such coaches — one for the western part of the country, one for the eastern part and a spare coach in case something goes wrong with the other two. [Interjections.]

Mr Patrick "Dex" Dukashe killed in Khayelitsha

*4. Mr J VAN ECK asked the Minister of Law and Order:

(1) Whether a certain detainee, whose name has been furnished to the South African Police for the purpose of the Minister's reply, was killed in Khayelitsha Township on or about 23 January 1989; if so, (a) on what date was (i) this person detained by the Police and (ii) his wife-to-be notified of his detention or arrest and (b) what are the circumstances surrounding his death;

(2) whether, while visiting the KTC squatter camp and Khayelitsha Township in the company of members of the Police on or about 23 January 1989, any death threats were directed at this person; if so, (a) by whom and (b) what was the purport of these threats?

The MINISTER OF LAW AND ORDER:

(1) Yes

(a) (i) 16 January 1989 on five charges of murder.

(ii) The detainee did not request the Police to inform his wife-to-be of his arrest.

(b) The death of the detainee is being investigated and is the subject of a judicial process which I do not want to anticipate at this stage.

(2) No

(a) and (b) Fall away.

†Mr J VAN ECK: Mr Speaker, arising from the reply of the hon the Minister, I should like to ask him whether the late Dex Dukashe said, when the police were with him, in the presence of people in KTC including the woman he would have married, that those policeman had threatened to shoot him that day. Has this aspect been investigated?

†The MINISTER: Mr Speaker, obviously I do not have that detailed information available now. I ask the member to table the question and I will then answer him.

Sgt W J Beyleveldt charged, acquitted in Kimberley

*5. Mr J VAN ECK asked the Minister of Law and Order:†

(1) Whether a certain member of the dog unit of the South African Police in Kimberley, whose name has been furnished to the Police for the purpose of the Minister's reply, has beem charged as a result of certain events in Kakamas on or about 13 February 1988; if so, (a) what was the nature of the charges against him, (b) with what result and (c) what is the name of this member;

(2) whether the Police has taken or is considering disciplinary and/or other steps against this member; if not, why not; if so, what steps?

†The MINISTER OF LAW AND ORDER:

(1) Yes

(a) He stood trial on two charges of murder and thirteen charges of attempted murder.

(b) He was acquitted on all the charges.

(c) Sergeant W J Byeleveldt.

(2) No. Because he purchased his discharge before any further steps could be considered.

Mozambique: visit by MP's

*6. Mr F J VAN DEVENTER asked the Minister of Defence:†

(1) Whether a group of members of Parliament visited Mozambique round about the middle of December 1988; if so, (a) which parties did they represent, (b) what was the purpose of the visit, (c) at whose invitation did the visit take place and (d) who paid for the visit;

(2) whether the South African Defence Force made transport available to this group?

The DEPUTY MINISTER OF DEFENCE:

(1) and (2) Yes. A SA Air Force aircraft was supplied to a group of the Governing Party, consisting of six members of Parliament and four members of the Presidents' Council, to visit Mozambique and to conduct, on a confidential basis, discussions between the Governing Parties on the political, military and economical situation there. The cost was carried by the Mozambicans and the members of the visiting group.

Black schools: qualified teachers retrenched

*7. Mr K M ANDREW asked the Minister of Education and Development Aid:

(1) Whether any qualified teachers employed in schools for Blacks in the Cape Peninsula were retrenched in 1988; if so, (a) how many, (b) why in each case, (c) what subjects were they qualified to teach and (d) at which schools were they teaching when they were retrenched;

(2) whether any qualified teachers employed on a temporary basis at such schools in 1988 were not re-employed when they re-applied for their posts; if so, what are the relevant details?

†The DEPUTY MINISTER OF EDUCATION:

(1) No
(a), (b), (c) and (d) fall away.

(2) Yes
Eight (8) teachers who were appointed in a temporary capacity for the period 1 January 1988 to 31 December 1988 at the Intshukumo Comprehensive School, Guguletu, and the Malizo Secondary School, Khayelitsha, respectively, were not re-appointed for 1989. Due to the fact that the appointments of the teachers concerned, would expire on 31 December 1988, the vacant posts were advertised by the management bodies of the schools. All the applications received for the posts, including those of the eight teachers mentioned, were considered on merit by the management bodies taking into account their qualifications, previous teaching experience and their service records. The applications of the eight teachers concerned were not successful.

Hydroquinone: manufacture/importation of products stopped

*8. Dr M S BARNARD asked the Minister of National Health and Population Development:

Whether the manufacture and/or importation of products containing hydroquinone is to be stopped; if so, when; if not, what steps are to be taken to warn the public against the harmful effects of this product?

The DEPUTY MINISTER OF NATIONAL HEALTH:

Yes, 1 January 1991

Measles: immunisation to be made compulsory

*9. Dr M S BARNARD asked the Minister of National Health and Population Development:

(1) Whether immunisation against measles is to be made compulsory; if not, why not; if so, when;

(2) whether he will make a statement on the matter?

†The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) No,
the World Health Organisation has no fixed ruling regarding compulsory immunisation. The enforcement of compulsory immunisation may be counter-productive and would virtually the unattainable. Per-

suasion is therefore better than compulsion;

(2) no.

Executive education departments: subsidy formula determined

*10. Mr R M BURROWS asked the Minister of National Education:

(1) Whether he has determined a subsidy formula for the financing of South African executive education departments; if not, why not; if so, (a) what is this formula and (b) when was it determined;

(2) whether provision has been made for the *a* factor to be greater or less than one in the case of any education department; if so, (a) what provision, and (b) why, in each case;

(3) whether he has determined a timetable for the progress of the *a* factor for all education departments ultimately to reach one; if not, why not; if so, what is this timetable?

The MINISTER OF NATIONAL EDUCATION:

(1) No. Although these financing formulae have already been drafted, no general policy has been tabled yet under section 2(1)(a) of the National Policy for General Education Affairs Act, 1984 (Act No. 76 of 1984), as certain interested parties still have to be consulted. The formulae together with a strategy for their implementation will be announced as soon as general policy has been determined.

(2) Lapses

(3) Lapses.

Mr R M BURROWS: Mr Speaker, arising from the reply given by the hon the Minister, could he please give the House an indication of whether his reply to this question has changed over the three years I have asked it, and if it has not changed during these three years, how long he expects those who have to be consulted need to be consulted on this matter?

The MINISTER: Mr Speaker, I firstly refer the hon member to his supplementary question and my reply thereto as recorded in Hansard, Questions and Replies, Column 2151, on Tuesday, 23 August 1988. He is well aware that I took the matter further in that reply than I had done in previous replies. Today I can again take the matter further. I can now tell the hon member that I have the consent of the hon the Minister of Finance. I have also succeeded in obtaining the consent of the SA Council for Education. Furthermore I have taken the matter further by giving certain information and background material to the organised teaching profession.

At the moment the problem is that because of economic uncertainties greater clarity is needed with regard to global expenditure on education over the next number of years. Greater clarity is also needed in relation to what can be accomplished in that regard.

†I am negotiating with the State President's Committee on National Priorities, as well as with the hon the Minister of Finance.

Mr R M BURROWS: Mr Speaker, further arising from the reply given by the hon the Minister, could he give us a clear indication in connection with when he anticipates the formula will be announced, and secondly, whether the formula makes provision for diffential payments of amounts to the different population groups?

†The MINISTER: Mr Speaker, in the first instance, the hon member for Pinetown has asked me that same question in the form of a written question. Only today I signed the reply to it. He will therefore receive his reply to it.

Secondly, I cannot commit myself to a specific date because the uncertainties to which I have referred, exist. What the hon member does know, but he does not appear to take into account is that this formula is already being applied as a framework, and that we are gaining valuable experience by this application. The existence of the formula as a framework, although it has not yet been announced as official policy, therefore already arranges the allocation of funds to education to such an extent that I can say with confidence that we are making sure, in a very scientific way, and within the framework resulting from the formula, of fairness to all population groups according to the State's capabilities at a particular time.

†Mr A GERBER: Mr Speaker, further arising from the hon the Minister's reply, I understood, if I heard correctly, that economic uncertainties exist and that in the light of those uncertainties he could not give a final reply. Now I should like to

ask the hon the Minister whether he thinks that he will ever be able to give the House a reply during his lifetime if he has to meet this requirement.

†The MINISTER Yes, Mr Speaker, because this Government has specific economic aims, we are achieving a greater degree of certainty by restructuring the economy, which will result in better planning. Just as I have confidence in the country's future, I am confident that our education spending will continue to be reasonable and carried out on a set basis in the future. [Interjections.]

Open settlement areas: Department responsible for Black education

*11. Mr R M BURROWS asked the Minister of Education and Development Aid:

(1) Whether he or his Department is responsible for the provision of education facilities for Black persons residing in *de facto* open settlement areas; if not, which department is responsible; if so, (a) what is his policy regarding the provision of such facilities and (b) what facilities have been provided;

(2) whether he will make a statement on the matter?

†The DEPUTY MINISTER OF EDUCATION:

(1) Yes, the Department of Education and training is responsible for the provision of education facilities for Blacks in all areas of the RSA except for TBVC countries and Self-Governing Territories.
(a) and (b) education facilities for Black persons will be determined according to need.

(2) No.

Mr R M BURROWS: Mr Speaker, arising from the reply of the hon the Deputy Minister, can he give us an indication as to whether his department has investigated the provision of schooling facilities for Black pupils in the Hillbrow area?

†The DEPUTY MINISTER: Mr Speaker, to the best of my knowledge we have not yet identified this need and as I have said in the reply, if that need is brought to our attention, naturally we shall pay attention to it.

†Dr W J SNYMAN: Mr Speaker, further arising out of the hon the Deputy Minister's reply, I am asking whether his Department intends to establish schooling facilities for Blacks in legally established free settlement areas.

†The DEPUTY-MINISTER: Mr Speaker, apparently the hon member does not listen when I am replying to questions! In my reply I clearly said that if a need for Black schooling facilities were to arise in free settlement areas I should supply such facilities.

Mr R M BURROWS: Mr Speaker, further arising from the reply of the hon the Deputy Minister I would like to know if he could give us an indication as to whether his department consults with the department of the hon the Minister of Education and Culture of the House of Assembly concerning the number of Black persons who are applying to get into White schools in the Hillbrow area?

†The DEPUTY MINISTER: Mr Speaker, I think that reply is rather far removed from the question originally put, and I should appreciate it if the hon Member would table that question.

Mr H H SCHWARZ: Mr Speaker, further arising out of the hon the Deputy Minister's earlier reply, he indicated that if the demand for Black education in the Hillbrow area was drawn to his attention, it would receive his attention. Is he now suggesting that he is not aware of the conditions which are prevailing in Hillbrow and of the people and children who are living in Hillbrow? Is the hon the Deputy Minister not aware of that?

†The DEPUTY MINISTER: Mr Speaker, what I am saying is that the need that could arise in this area has not yet been brought to my attention. The fact is that there are many other schooling facilities at present. There are many private schools which are attended by many of these Black pupils. There are also other schools in the Hillbrow area. All I am saying is that the need has not yet been brought to my attention and I want to invite the hon Member to come and discuss the problem with me if he is aware of it. My door is wide open to him and I am prepared to discuss the problem with him. [Interjections.]

†Mr SPEAKER: Order! Time for oral questions on general affairs has now expired.

Business interrupted in accordance with Rule 180C (3) of the Standing Rules of Parliament.

CPPE Trials 24/2/89

Measles kills 1 000 a year in SA

89

By ANTHONY JOHNSON
Political Correspondent

MINISTER of Health Dr Willie van Niekerk suffered from an "obvious lack of understanding" of the devastating effect of measles in South Africa, PFP health spokesman Dr Marius Barnard said yesterday.

He was responding to Dr Van Niekerk's statement to Parliament earlier this week that compulsory immunisation against measles "may be conterproductive and would virtually be unattainable."

Dr Van Niekerk went on to say: "Persuasion is therefore better than compulsion."

Dr Barnard said the minister's lack of understanding of the problem was illustrated by the fact that more than 1 000 people in SA die each year of measles.

About 22 000 cases of measles were reported in South Africa in 1987 and an average of 14 000 cases each year for the last decade.

"After smallpox, measles is probably one of the most eradicable medical conditions, and in the Americas this eradication has nearly been achieved.

"The problem in South Africa, and the major reason why measles is such a frequent and serious condition, is that there is no overall policy to eradicate it."

Dr Barnard said the PFP would fully support a committee of authorities with a target of 90-95% immunisation of all South Africans against measles by 1995.

Cape TB cases on increase — expert

Cape Times 24/2/89

89

Staff Reporter

THE incidence of tuberculosis (TB) among coloured people in the Western Cape will continue to climb for several years despite large-scale action to improve living conditions and fight the disease.

The reason, said Department of Health and Population Development epidemiologist Dr Neil Cameron yesterday, is that TB has a lengthy incubation period which means that children who contracted primary symtoms 30 years ago might present with the disease only today.

About 16 000 more people in the Western Cape will be treated for TB this year — a figure 28% higher than in 1985 and rising.

Aggravating factors in the spread of the epidemic are socio-economic problems associated with urbanisation and overcrowding on the Cape Flats.

While the number of TB beds in Cape Town is expected to rise by 80% by the end of the coming financial year, experts believe this will contribute to only a small part of the solution.

Managements will be encouraged to strike a blow in the TB war by not discharging workers who are being treated with the disease as medication eliminates the danger of spreading infection.

Barnard hits at Minister over measles

Star 24/2/89

By Peter Fabricius, Political Correspondent

CAPE TOWN — The Government's refusal to make measles immunisation compulsory has been criticised by Progressive Federal Party medical spokesman Dr Marius Barnard.

He said yesterday that Dr Willie van Niekerk, the Minister of National Health, had an "obvious lack of understanding of the devastating effect of measles in South Africa".

Dr van Niekerk told Parliament this week that no compulsory immunisation was planned and "persuasion is better than compulsion".

Dr Barnard said more than 1 000 people died every year from measles in South Africa.

An average of about 14 000 cases a year had been reported over the last decade.

"The PFP would fully support a committee of authorities which sets a target that by 1995 there be a 90 to 95 percent immunisation of all South Africans against the disease," Dr Barnard said.

Malaria is big killer — doctor

Own Correspondent

DURBAN — Malaria remained one of the biggest killers in Africa and the pre-occupation with finding a cure for AIDs must not be allowed to reduce spending on malaria research, Medical Research Council president Philip van Heerden said yesterday.

He told a malaria symposium more than a million African children died of malaria every year, and of the 300-million people annually infected by the disease, 90% were Africans.

Researchers were still working on a (malaria) vaccine but this might prove too expensive to help the Third World.

Van Heerden said: "We are emotionally carried away by AIDS at the moment. But we also have other big problems and we must not allow our scarce financial resources to channelled into only one area."

Drug-resistant malaria on the increase in SA

Star 27/2/89

89

Own Correspondent

DURBAN — Drug-resistant malaria appeared to have a firm foothold in South Africa, delegates at a symposium on the disease were told.

In his opening address over the weekend, Dr Phillip van Heerden, president of the Medical Research Council said malaria was still rife in large parts of the country — in spite of extensive research into the disease.

"The malaria case rates seem to be increasing," he added. "Even in kwaZulu, for example, the prevalence has increased quite considerably over the last few years."

This was due to the tremendous number of people from neighbouring states, particularly Mozambique, who brought their infections with them.

Good rainfall and the increasing occurrence of drug-resistant malaria had also played a part.

Dr van Heerden said that according to the World Health Organisation, the disease was still claiming lives of more than one million children each year in Africa.

Of the 300 million people living in the world's tropical and sub-tropical zones who became infected annually with malaria for the first time, 90 percent were Africans.

"Researchers are working on a vaccine, but many specialists think that even if it could be proven effective, it would be too expensive to help the Third World," he said.

"Unfortunately, the malaria parasite knows all the tricks of the trade to confuse the body's immune system."

He said that in South Africa a substantial part of the country's health budget was spent annually on the control of malaria: "Research objectives should therefore be not only to find more effective methods of control or to improve the exisiting ones, but also to devise less expensive methods."

COLLABORATION NEEDED

He said the Medical Research Council was as concerned as the health authorities about the malaria situation and gave high priority to research on the disease.

"I believe we in South Africa have the manpower, facilities and the expertise and I am convinced we are capable of solving not only our problems with regard to malaria; we can also make a contributions to solving the malaria problem worldwide."

However, he added, it was vital that all those involved in the problem joined forces and collaborated.

HOUSE OF ASSEMBLY

QUESTIONS

†Indicates translated version.

For written reply:

General Affairs:

State hospitals: integrated wards

20. Dr M S BARNARD asked the Minister of National Health and Population Development:

(1) Whether any wards in hospitals administered by the State are integrated; if so, how many in each specified hospital; if not, why not;

(2) whether his Department intends to desegregate wards in State hospitals; if not, why not; if so, when;

(3) whether any studies have been carried out into the cost implications of desegregating wards in State hospitals; if not, why not; if so, (a) when, (b) by whom and (c) what were the findings;

(4) whether any wards in State hospitals are under-utilized; if so, (a) in which specified hospitals and (b) to what extent;

(5) whether any wards in State hospitals are overcrowded; if so, (a) in which specified hospitals and (b) to what extent?

B74E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

The honourable member is referred to my written reply to Question 404 on 30 March 1988.

Typhoid: cases reported

175. Dr M S BARNARD asked the Minister of National Health and Population Development:

How many (a) cases of and (b) deaths from typhoid were reported in respect of each race group in each province in 1988?

B410E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a)	Indians	Blacks	Coloureds	Whites
Transvaal	6	2 636	4	24
Natal	14	719	7	4
Orange Free State	0	31	0	0
Cape Province	1	123	15	3

(b)	Indians	Blacks	Coloureds	Whites
Transvaal	0	32	0	0
Natal	0	2	0	0
Orange Free State	0	1	0	0
Cape Province	0	1	0	0

Cholera: cases reported

176. Dr M S BARNARD asked the Minister of National Health and Population Development:

How many (a) cases of and (b) deaths from cholera were reported in respect of each race group in each province in 1988?

B411E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a)	Blacks
Natal	3
Transvaal	3
Orange Free State	0
Cape Province	0

Above-mentioned cholera cases reported, were not bacteriologically proven. There were no bacteriologically proven cases of Cholera in South Africa in 1988. No cases reported regarding other race groups.

(b) None.

quently not pre-empt the Commission's Report.

SADF personnel: smuggling of rhinoceros horn

*10. Mr R J LORIMER asked the Minister of Defence:

Whether, in view of charges that were laid in the United States of America against two South African Defence Force members (whose names have been furnished to the Defence Force for the purpose of the Minister's reply), he has initiated or intends to initiate an inquiry into the possible smuggling of rhinoceros horn from South West Africa by Defence Force personnel; if not, why not; if so, (a)(i) what were these charges and (ii) when were they laid and (b) what are the names of the persons involved?

B453E

The DEPUTY MINISTER OF DEFENCE:

No, because the South West Africa Police confirmed that an official investigation was instituted by them. As far as could be ascertained the matter is at present with the Attorney General of South West Africa to decide about a possible prosecution.

Expansion of Old Crossroads and Kwanonqaba Township

11. Mr J J WALSH asked the Minister of Constitutional Development and Planning:

Whether, with reference to his reply to Question No 966 on 1 June 1988, further details regarding the expansion of (a) Old Crossroads and (b) Kwanonqaba Township are now available; if so, what are the relevant details in each case; if not, why not?

B455E

†The DEPUTY MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

This matter vests in the Administrator of the Cape Province and he has furnished the following information:

Yes.

(a) The area referred to in the reply to Question 966 was declared a development area by Government Notice 2258 of 4 November 1988. The Cape Provincial Government is at present in the process of purchasing and planning the approximately 219,4 ha of land concerned.

(b) The area referred to in Question 966, approximately 141,7 ha in size, was declared a development area by Government Notice 1417 of 15 July 1988. The Cape Provincial Government is at present finalising the purchasing and planning of the area.

Social pensions to Black persons

*12. Mr K M ANDREW asked the Minister of Constitutional Development and Planning:

(1) Whether any progress has been made in the paying of social pensions to Black persons (a) on a monthly basis and (b) by way of transfers into savings accounts; if not, (i) why not and (ii) when are changes due to occur; if so,

(2) (a) what progress has been made and (b) what percentage of pensioners is now (i) being paid monthly and (ii) having such pensions paid directly into savings accounts?

B456E

The DEPUTY MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING (Reply laid upon the Table with leave of House):

This matter vests in the Administrators of the different provinces and they have furnished the following information:

(1) (a) and (b) Yes.

(i) and (ii) Fall away.

(2) Transvaal

(a) As from 1 April 1989, pensions will be paid on a monthly basis in Soweto, Deepmeadow, Dobsonville and Alexandra. This represents 22% of the total number of pensioners in Transvaal.

(b) (i) 6%

(ii) 3%

Cape Province

(a) Social pensions will be paid on a monthly basis to all Black pensioners in the Cape Province with effect from 1 April 1989.

The facility to have a social pension paid into a savings account already exists for a considerable time.

(b) (i) Only those Black pensioners who prefer to have their pension paid into a savings account receive their pension at present on a monthly basis. The number of these pensioners at present stands at 8 432 which represent 7,4% of the total number of pensioners.

(ii) Refer to paragraph 2(b)(i).

Orange Free State

(a) With effect from 1 March 1989 pensions are paid monthly in respect of the magisterial districts of Bloemfontein, Welkom, Odendaalsrus, Kroonstad and Sasolburg. It is planned to make monthly payments in the remaining districts as from 1 July 1989.

All pensions can be paid into savings accounts on request.

(b) (i) 26%

(ii) 2,4%

Natal

(a) In urban areas, where beneficiaries so desire, they will be paid on a monthly basis from 1 April 1989. Further research is being undertaken in the rural areas, as the possibility exists that some beneficiaries may not wish to change from the existing bi-monthly payments, due to high transport costs, etc.

(b) (i) 17,8%

(ii) 17,8%

Rabies: cases reported in human beings

*13. Mr R J LORIMER asked the Minister of National Health and Population Development:

Whether any cases of rabies in human beings were reported to his Department in 1988; if so, (a) how many, (b) where did these cases occur and (c) what steps were taken in each case?

B457E

†The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

Yes.

(a) 28 cases,

(b) Natal	Inanda	1
	Durban	1
	Empangeni	1
	Botha's Hill	1
	Verulam	1
	Unknown	17
	Total	22
KwaZulu	Ndwedwe	1
	KwaMashu	1
	Total	2
Orange Free State	Bloemfontein	1
	Fouriesburg	1
	Total	2
Eastern Transvaal		1
KaNgwane	Shongwe Hospital	1
	Grand Total	28

(c) It is departemental policy that if there are human contacts of a rabies case, they must be accurately identified and the nature of the exposure (e.g. bite, lick, scratch) specified. All such cases receive antirabies serum.

The treatment of patients with rabies is carried out in provincial hospitals.

Mr D J N MALCOMESS: Mr Chairman, arising out of the hon the Minister's reply, could he perhaps inform us how long he spends each Tuesday, or prior to that, memorising the answers to the questions? [Interjections.]

The MINISTER: Mr Chairman, two minutes!

Mr R J LORIMER: Mr Chairman, further arising from the reply of the hon the Minister could I ask him how many of the cases reported in this instance were fatal?

The MINISTER: Mr Chairman at the present moment none of the cases has been fatal but there is an interesting aspect to this which I would like to elaborate on and that is the difference between Natal and the rest of the South African situation. We have two epidemiological areas, the one being the Orange Free State and the Transvaal where rodents are the most common cause, whilst in Natal stray dogs are the biggest problem, and I think that we should use the opportunity of asking all people to inoculate their dogs with anti-rabies serum.

HOUSE OF ASSEMBLY

QUESTIONS

†Indicates translated version.

For written reply:

General Affairs:

Reigerpark: boycott action meeting

10. Mr C J DERBY-LEWIS asked the Minister of Law and Order:

(1) Whether the South African Police have been informed of and/or any members of the Police were present at a meeting held in the community hall at Reigerpark on or about 30 November 1988 during which a boycott action was propagated against the business community of Boksburg; if so,

(2) whether this boycott action was propagated by a certain person, whose name has been furnished to the Police for the purpose of the Minister's reply; if so, what is the name of this person;

(3) whether any charges have been laid as a result of this meeting; if not, why not; if so, what are the relevant details;

(4) whether any members of the Reigerpark Management Committee were present at this meeting; if so, what are their names?

B59E

The MINISTER OF LAW AND ORDER:

(1) No.

(2) to (4) Fall away.

Black residential areas: mayors/town committees

132. Mr J VAN ECK asked the Minister of Constitutional Development and Planning:†

(1) Whether any of the (a) mayors and/or (b) town committees in Black residential areas in the Western Cape falling under his Department have (i) any say or (ii) the final say as to who (aa) may live and/or (bb) purchase houses in the residential areas falling under their jurisdiction; if so,

(2) (a) which (i) mayors and (ii) town committees and (b) in terms of what statutory provisions and/or regulations they have been granted these powers?

B295E

The MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

This matter vests in the Administrator of the Cape Province and he has furnished the following information:

(1) (a) (i) (aa) to (1) (a) (ii) (bb)
No. Mayors have no authority to act of their own accord without the approval of the relevant town council/committee.

(b) (i) (aa) No.

(bb) Yes, but only if it is the property of the local authority.

(b) (ii) (aa) No.

(bb) Yes, but only if it is the property of the local authority.

(2) (a) (ii) All local authorities established in terms of the Black Local Authorities Act, 1982 (Act 102 of 1982).

(b) Local authorities are in terms of section 23(1)(1)(i) and the Schedule to the Black Local Authorities Act, 1982 (Act 102 of 1982) read with Proclamation 150 of 1986 and the notice whereby the local authority was established, authorised and empowered to allocate houses and premises.

Local authorities are in terms of section 52(1)(a)(i) of the Black Communities Development Act, 1984 (Act 4 of 1984) empowered in respect of land of which it is the owner or land which vests in it or has been made available in terms of Section 34(9) of the Act, to issue a right of leasehold to any competent person as defined in Section 1 of the Act.

Constitution Act: registration of teachers

140. Mr R M BURROWS asked the Minister of National Education:

(1) Whether his Department is responsible for the registration of teachers in terms of Schedule 1 of the Republic of South Africa Constitution Act, No 110 of 1983; if not, which Government Department is responsible for this matter;

(2) (a) how many teachers of each population group are registered in terms of current legislation and (b) in respect of what date is this information furnished?

B339E

The MINISTER OF NATIONAL EDUCATION:

(1) Yes, to the extent that it is a general affair.
Provision was made in the National Policy for General Education Affairs Act, 1984 (Act No 76 of 1984), that general policy may be determined in this regard but it has not yet been done. At present negotiations are under way with a view to establishing a professional council for teachers on the general level.

(2) (a) and (b) fall away as far as registration on the general level is concerned.

Rape: persons convicted

169. Mr D J DALLING asked the Minister of Justice:

How many persons in each race group were (a) charged with and (b) convicted of rape in 1985, 1986, 1987 and 1988, respectively?

B404E

The MINISTER OF JUSTICE:

The undermentioned statistics were obtained from the Central Statistical Services and are only available for the periods as indicated.

1 July 1984 till 30 June 1985

	Total charged	Total convicted
Whites	243	164
Coloureds	2 537	1 471
Indians	79	36
Blacks	6 957	3 367

1 July 1985 till 30 June 1986

	Total charged	Total convicted
Whites	289	93
Coloureds	2 478	1 431
Indians	77	30
Blacks	6 212	3 039

1 July 1986 till 30 June 1987

	Total charged	Total convicted
Whites	225	121
Coloureds	2 672	1 503
Indians	84	26
Blacks	6 658	3 334

1 July 1987 till 30 June 1988

	Total charged	Total convicted
Whites	213	122
Coloureds	2 744	1 518
Indians	60	22
Blacks	7 407	3 581

National servicemen: infectious diseases

174. Dr M S BARNARD asked the Minister of Defence:

Whether any national servicemen were admitted to hospital with infectious diseases in 1988; if so, (a) to which hospitals, (b) how many were admitted with each specified infectious disease and (c) how many died of each such disease?

B409E

The MINISTER OF DEFENCE:

Yes.

(a) 1, 2 and 3 Military Hospitals and also various sickbays.

	(b)	(c)
Bilharzia	1	0
Hepatitis	106	0
Malaria	277	0
Measles	9	0
Meningitis	15	2
Tuberculosis	5	0

Strikes: Black workers

179. Mr P G SOAL asked the Minister of Manpower:

(a) How many strikes involving Black workers occurred in 1988, (b) in how many cases did the strikes arise out of wage demands and (c) what were the main causes of the remainder of the strikes?

B416E

The ACTING MINISTER OF MANPOWER:

(a) 363

Quarry workers health shock

50 workers 28/3/89 89

THE Community Health Awareness Project conducted two free health clinics for scores of people in different areas at the weekend.

One clinic was conducted in KwaThema township in the East Rand while the other was held at Mmakau near Pretoria.

Projects co-ordinator

By MOKGADI PELA

for CHAP, Dr Oupa Mpe, said more than 100 patients were treated for various ailments in KwaThema.

Thereafter a lecture on preventive medicine was delivered by the medical team.

Emphasis was placed on how women can detect early symptoms of breast cancer. Dr Mpe said all patients were examined for high blood pressure, diabetes and breast lumps.

In Mmakau one of the doctors who treated close to 64 patients, Dr Gomolemo Mokae, said most of those he examined were found to have chronic chest problems.

This resulted from their work at a quarry where they inhaled silica dust emitted by rocks they crushed. The workers went on to develop silicosis, he added.

CHAP said other free health clinics would be conducted soon.

Trials held up by meningitis scare

89

DANIEL SIMON

AN OUTBREAK of meningitis at Diepkloof Prison forced authorities to cancel the scheduled court appearances 97 prisoners yesterday, the Prison Services said.

This is the second outbreak of the disease at the prison's Medium A section since August, when hundreds of trials were postponed for nearly a week because of one case.

Prison Service spokesman Maj Dave Smith confirmed that two cases of meningitis were diagnosed at the prison on Wednesday and that immediate precautionary measures were implemented to prevent a spread.

He said C block in Medium A prison was placed under quarantine by the Department of National Health and that no visits would be allowed for the forseeable future. He did not know how many prisoners were held in Medium A or how long the quarantine would last.

Smith added that one prisoner was being treated at Baragwanath Hospital and the other at Hillbrow Hospital.

A Rand Supreme Court employee yesterday said four murder trials involving seven accused was postponed because of the outbreak.

89

Huge rise in number of cases of hepatitis B

By Helen Grange

The incidence of hepatitis B (HB), a contagious liver disease, has risen dramatically in southern Africa over the past eight years.

Figures quoted by Dr H J Steyn, Deputy Director-General of National Health Planning, show that incidence of the disease rose from 0,04 per 100 000 people in 1980 to 1,11 per 100 000 last year.

Dr Steyn said there were about 2 million carriers of the HB virus in the region, of whom about 20 000 died annually from the disease.

It is estimated that 5 percent of the world's population are carriers.

Dr Steyn said the apparent lack of impact of the HB vaccine on the incidence of Hepatitis B is attributable to the high cost of the vaccine. In addition, the majority of acute Hepatitis B cases occur in homosexual men, intravenous drug abusers and people acquiring disease through heterosexual exposure.

"None of these groups is being reached effectively by current HB vaccine programmes," Dr Steyn said.

Less than 10 percent of reported cases occurred among health-care workers.

"Increased efforts must be made to extend HB immunisation programmes beyond the current levels to all high-risk groups.

"These include health-care workers exposed to blood or needle pricks, inmates or the staff of institutions for the disabled, homosexually active men, illicit intravenous drug users, people exposed to HB virus carriers and travellers to HB virus endemic areas."

Black rhino killings on the increase

Own Correspondent

CAPE TOWN — Several black rhino were killed in the Etosha National Park last week and Namibian conservationists believe poachers could be taking advantage of the administration's heavy involvement in the independence proceedings.

More of the threatened black rhino have been killed in northern Damaraland this year, and "crisis management" techniques — including dehorning and large-scale relocation — are being considered to save the species.

This has emerged from discussions between Namibian authorities and members of the "Namibia Trek" — three women and nine men who are hiking 750 km through the territory to raise funds for conservation there, in association with the Rhino and Elephant Foundation.

The hikers have completed about three quarters of their journey.

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six years in Taipei, eight years in London.

exporters provided [illegible] for this spring-cleaning.

[illegible] Africa and even East Bloc countries.

SA warned of hepatitis virus

(87)

DIANNA GAMES

THE number of cases in SA of the highly infectious and often fatal virus, hepatitis B, was rising alarmingly and there could be as many as two-million carriers in SA and its homelands, 40% of whom could die from the disease.

Professor of medicine at Johannesburg Hospital Michael Kew said this yesterday at a mass immunisation of more than 200 employees of multinational Smith, Kline and French, developers and producers of a hepatitis B vaccine, outside Johannesburg.

Kew said the virus often caused permanently damaging liver cirrhosis or liver cancer which led to death, usually within weeks, or cirrhosis which permanently damaged the liver. Even where people did recover, this could often take years.

The virus was 10 times more infectious than the AIDS virus, he added.

As with AIDS, the most important transmission was by blood and, thus, the high risk groups were largely the same — homosexual men, intravenous drug users, medical personnel and young children whose parents were carriers.

Tested

It can also be passed on by heterosexual contact.

Kew said children who contracted the virus remained carriers, without showing symptoms, their whole lives and added significantly to the already huge pool of carriers.

Blood donations had been tested for the virus for many years, he said.

He added that there was no connection between this virus and the Hepatitis A virus which was more common and curable.

Deputy director-general of the National Health Department Dr Hans Steyn said there were 400 reported cases of Hepatitis B in SA last year.

The number has risen from 0.04 per 100 000 people in 1980 to 1,11 in 1988.

Steyn said because of the high cost of the vaccine — between R35 and R40 — none of the high risk groups had yet been effectively reached by immunisation programmes.

He said only 10% of affected people were medical workers.

these incidents occur and (b) what steps were taken by this Department as a result of these incidents?

B809E

The MINISTER OF EDUCATION AND DEVELOPMENT AID:

(1) Yes, but only injured

(a) (i) (1) 20 April 1988
(2) 14 September 1988
(3) 1 October 1988
(4) 19 January 1989
(5) 1 February 1989

(ii) (1) Inanda residential area
(2) Inanda residental area
(3) Imbali residental area
(4) Vryheid (Northern Natal Collieries)
(5) Inanda residential area

(b) (1) Case reported to the SAP.

(2) Six pupils suspended from school; SAP was called in.

(3) Two guilty pupils suspended from school; hostels searched. Action was taken against pupils possessing sharp instruments (arms).

(4) Corporal punishment administered to guilty pupils, with the consent of their parents.

(5) Security measures were itensified.

Natal: treatment of leukemia

*15. Mr M J ELLIS asked his Minister of National Health and Population Development:

(1) What facilities are there in Natal for the treatment of children suffering from leukemia;

(2) whether any hospitals in the Republic have a full range of facilities for the treatment of this disease; if so, which hospitals; if not, (a) why not and (b) what is being done to rectify this situation?

B810E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) All major hospitals, academic and regional hospitals in Natal are able to treat children suffering from leukemia; the hospitals concerned are:

Addington Hospital, Durban
R K Khan Hospital, Durban
Clairwood Hospital, Durban
King Edward VIII Hospital, Durban
Grey's Hospital, Pietermaritzburg
Northdale Hospital, Pietermaritzburg
Eshowe Hospital
Ladysmith Hospital
Port Shepstone Hospital
Newcastle Hospital

Patients from community country hospitals who require treatment are referred to the above hospitals when necessary,

(2) yes, the following information is furnished by the provincial administrations:

NATAL

The hon member is referred to my reply to point one.

TRANSVAAL

H F Verwoerd Hospital
Kalafong Hospital
Ga-Rankuwa Hospital
Johannesburg Hospital
Baragwanath Hospital
Hillbrow Hospital

ORANGE FREE STATE

Pelonomi Hospital
Universitas Hospital

CAPE PROVINCE

Tygerberg Hospital
Groote Schuur Hospital
Red Cross Hospital

(a) and (b) fall away.

Aids in RSA

*16. Mr M J ELLIS asked the Minister of National Health and Population Development:

How many cases of Aids were identified in the Republic, (a) excluding and (b) including the independent Black states, in 1988?

B811E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a) 89 cases of AIDS have been identified of which 84 were South African cases and the balance from four foreign countries.

(b) The Republic of South Africa does not report on data pertinent to the independent National States.

Members of Parliament: visit to foreign countries

*17. Mr D J N MALCOMESS asked the Minister of Foreign Affairs:

(a) How many members of Parliament visited foreign countries at Government expense in the (i) 1987-88 and (ii) 1988-89 financial years and (b) what are their names in each case?

B812E

The MINISTER OF FOREIGN AFFAIRS:

(a) (i) Excluding myself and the Deputy Minister of Foreign Affairs, three members of Parliament visited foreign countries at the expense of my Department in the 1987-88 financial year, and

(ii) twenty-three in the 1988-89 financial year;

(b) The members of Parliament visiting foreign countries in 1987-88 were:

Dr S G A Golden
Dr J N Reddy
Mr A Williams

The members of Parliament visiting foreign countries in 1988-89 were:

Mr A S Akoob
Mr H J Bekker
Mr D de V Graaff
Mr J Douw
Mr A Fourie
Mr T George
Dr S G A Golden
Mr N Jumuna
Mr N E Khan
Mr A E Lambat
Mr J J Lemmer
Mr D Lockey
Rev E J Manikkam
Prof N J J Olivier
Mr M Rajab
Mr C R Redcliffe
Mr J L Retief
Mr I Richards
Mr G Shah
Mr H A Smith
Mr C J van R Botha
Dr J Vilonel

Katlehong: investigation into death of a certain person

*18. Mrs H SUZMAN asked the Minister of Law and Order:

(1) Whether there has been an investigation into the cause of death of a certain person, whose name has been furnished to the South African Police for the purpose of the Minister's reply, on or about 21 March 1989 at Katlehong; if not, why not; if so, (a) what were the findings and (b) what is the name of this person;

(2) whether a post-mortem has been held; if so, what were the findings; if not, why not?

B813E

The MINISTER OF LAW AND ORDER:

(1) and (2)

Yes, the cause of death of the person whose name had been furnished by the hon member, is being investigated. As soon as the investigation has been completed, the docket will be submitted to the Public Prosecutor for an inquest to be held. No particulars are therefore furnished at this stage because it may prejudice the investigation and anticipate the findings of the inquest.

Additional classrooms

*19. Mr S S VAN DER MERWE asked the Minister of Education and Development Aid:

Whether any additional classrooms were built in 1988 at schools falling under the control of his Departmentl if not, why not; if so, (a) how many additional classroom places were provided in that year and (b) what was the total cost of providing these additional classrooms?

B815E

The MINISTER OF EDUCATION AND DEVELOPMENT AID:

Yes.

(a) 88 865.

(b) R147 004 697.

Shortage of classroom places

*20. Mr K M ANDREW asked the Minister of Education and Development Aid:

Whether there was any shortage of classroom places in 1988 at (a) primary and (b) secondary schools administered by his Department; if so,

Skin cancer prevalent in SA

By Toni Younghusband,
Medical Reporter

Skin cancer is by far the most prevalent form of cancer among men and women in South Africa, the country's first national cancer registry has shown.

Figures for 1986 show there were more than 9 000 recorded cases of skin cancer among males and females. Most sufferers were white males.

Cervical cancer was of particular concern among black females, of whom there were more than 2 200 sufferers.

Black males showed a high incidence of cancer of the oesophagus.

The cancer registry, the first of its kind in the country, recorded more than 36 000 cancer diagnoses for 1986.

The information contained in the registry comes from pathology laboratories in both the public and private sector and was released to the medical profession late last year.

The least dangerous form of skin cancer — basal cell which is sun-related — accounted for the majority of skin cancer reports in this country, but the most dangerous form — melanoma — showed a high incidence among women.

President of the National Cancer Association, Professor J D Anderson, said the registry was a major breakthrough in combatting cancer.

CITY NATIONAL

Smoking blamed for huge Groote Schuur intake

89

NKGS 9/5/89

Staff Reporter

ALMOST half the patients at Groote Schuur Hospital got there because of smoking, according to an editorial in the latest South African Medical Journal.

In an edition carrying several articles on the costs — physical and financial — of smoking, the editorial calls on doctors to be in the forefront of the fight against the habit.

Smoking-related diseases are the single most avoidable cause of mortality in this country, says an article.

In an article on the economic effects of smoking, Dr S P Taylor and Mr D E McIntyre of UCT's department of community health said the available information suggested that the costs of the tobacco industry to society at present, and particularly in the future, outweighed the economic benefits.

The conservatively estimated costs of smoking to South Africa in terms of health care and lost productivity in 1985 were between R362,3-million and R396,9-million — more than the entire budget of the Natal Hospitals Service in the same year.

Smoking costs money in terms of health care, productivity losses, the actual price of the tobacco, disability grants, fire hazards (to both property and to forests), the health costs of passive smoking, implementation of legislation and anti-smoking campaigns.

A total ban on smoking would mean more money would have to be spent on pensions (because people would be likely to live longer), increased health costs in geriatric care, loss of excise duty, dislocation costs of changing crops, manufacturing plants, and the costs associated with increased obesity.

Another editorial suggests it is time to ban all tobacco advertising — in 1987 R55-million, or five percent of all advertising expenditure in South Africa — was spent on tobacco advertising.

Studies showed "an alarming" 56,3 percent of all cinema advertising came from tobacco and associated products.

"Despite the tobacco industry's denials that they encourage children to smoke, its targeting of cinema advertising suggest this is cearly the case."

The editorial suggested excise tax on cigarettes be increased by 25 percent to offset a loss of revenue to the media, and this money would be used to fund advertising promoting health.

The editorial also suggests the price of cigarettes be linked to the consumer price index (CPI).

● In a study on smoking habits in Langa, Khayelitsha's Site B and the more settled areas of Khayelitsha, researchers from the Centre for Epidemiological Research at Parow found that 60 percent of men and seven percent of women smoked, while 23 percent of boys in three schools also smoked. All preferred manufactured cigarettes.

ME sufferer can't cope with calls

Staff Reporter

A woman suffering from the debilitating disease ME (Myalgic Encephalomyelitis), has been inundated with calls for advice after the plight of ME sufferers was publicised in *Sunday*, The Sunday Star magazine, this weekend.

However, given the ravages of the disease, sufferers cannot cope with calls from the public despite the desparate need to combat ignorance of the illness.

A spokesman for a local ME awareness group has appealed to the public to write to either of two support groups, using stamped, self-addressed envelopes, should they wish to make inquiries. The ME sufferers manning the support groups say they simply cannot afford stamps and envelopes. ME has ravaged their finances.

There are at least 6 000 ME sufferers in South Africa, and numbers are growing, according to the two local ME support groups.

The disease, which was once dubbed "yuppie flu", can affect anyone. It is not restricted to young urban professionals.

A primary symptom of the disease, chronic exhaustion, makes it difficult for ME sufferers working in the support groups to cope with apparently simple tasks.

Among their many tasks, the groups try to help ME sufferers who have found themselves destitute due to the symptoms of the illness, which include acute fatigue, memory loss, and a severe sense of panic.

The spokesman said any kind of assistance for the two local ME support groups would be welcomed.

● For more information, or to render assistance, contact The ME Awareness Group, P O Box 87538, Houghton, 2041 or The ME Society of South Africa, 16 Oakley Drive, Howick.

HOUSE OF ASSEMBLY

QUESTIONS

† Indicates translated version.

For written reply:

General Affairs:

Poliomyelitis: cases

369. Mr M J ELLIS asked the Minister of National Health and Population Development:

(1) How many (a) cases of and (b) deaths from poliomyelitis were reported in respect of each race group in each province in 1988;

(2) how many persons of each race group were immunized against poliomyelitis in each province in 1987?

B771E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) (a) and (b)

Province	Population Group				
	Indian	Black	Coloured	White	Total
Cape Province					
cases	0	11	4	0	15
deaths	0	0	0	0	0
Natal					
cases	1	109	0	1	111
deaths	0	4	0	0	4
Orange Free State					
cases	0	0	0	0	0
deaths	0	0	0	0	0
Transvaal					
cases	0	45	0	0	45
deaths	0	0	0	0	0
Total					
cases	1	165	4	1	171
deaths	0	4	0	0	4

Self Governing National States are included. The information is given as at 20 April 1989.

(2)

Province	Population Group			
	Indian	Black	Coloured	White
Cape Province	426	40 043	68 377	14 818
Natal	16 817	73 551	2 348	7 034
Orange Free State	44	27 415	1 339	4 629
Transvaal	3 642	112 818	7 861	38 181
Total	20 929	253 827	79 925	64 662

The best estimate of the number of persons immunized against poliomyelitis in 1987, is provided by the number of third doses administered according to returns received from the four health regions of the RSA. No such data are available in respect of the National States.

National Cancer Association: grants from Government

395. Mr C B SCHOEMAN asked the Minister of National Health and Population Development:

(1) Whether any grants were made by the Government to a certain association, the name of which has been furnished to the Minister's Department for the purpose of his reply, over the latest specified period of 10 years for which figures are available; if not, why not; if so, (a) what is the amount of each such grant and (b) on what date was each made;

(2) what is the name of this association?

B699E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) (a) Yes, a contribution of R200 per annum, later increased to R1 000 per annum, was made during the past 10 years.

(b)

Financial Year	Amount
1978/79	R200
1979/80	R200
1980/81	R200
1981/82	R200
1982/83	R200
1983/84	R200
1984/85	R1 000
1985/86	R1 000
1986/87	R1 000
1987/88	R1 000

The contributions were stopped with effect from 1 April 1988 because of the curtailment of state expenses.

(2) National Cancer Association.

Airports: runways/facilities closed

413. Mr P C CRONJÉ asked the Minister of Transport Affairs:

Whether any (a) runways and/or (b) other facilities have been or are to be closed at any airports in the Republic in 1989; if so, (i) what facilities, (ii) on what dates, and (iii) why, in respect of each such airport?

B834E

The MINISTER OF TRANSPORT AFFAIRS:

(a) and (b) No, as far as State airports are concerned.

(i), (ii) and (iii) Fall away.

Government: amounts owing to private bodies/persons

478. Mr H H SCHWARZ asked the Minister of Finance:

What amounts were owing to private bodies and persons by the Government, other than on bank facilities and stock issues, as at (a) 31 December 1988 and (b) the latest specified date for which figures are available?

B916E

The MINISTER OF FINANCE.

(a) As at 31 December 1988	R
Indefinite Period Treasury Bonds	484 391 000
Bonus Conversion Bonds	80 591 185
Indefinite Period National Defence Bonds	197 515 000
Indefinite Period Senior Citizen Savings Bonds	739 936 844
Loan Levy	4 538 662
Tax Redemption Certificates	154 264
Total	1 507 126 995

(b) As at 30 April 1989	R
Indefinite Period Treasury Bonds	478 718 050
Bonus Conversion Bonds	77 617 075
Indefinite Period National Defence Bonds	171 308 400
Indefinite Period Senior Citizen Savings Bonds	691 466 744
Loan Levy	4 294 375
Tax Redemption Certificates	154 264
Total	1 423 558 908

Land and Agricultural Bank: amount outstanding

527. Mr J B DE R VAN GEND asked the Minister of Finance:

(a) What is the amount outstanding on the largest loan made by the Land and Agricultural Bank to a member of its staff and (b) in respect of what date is this information furnished?

B988E

The MINISTER OF FINANCE:

(a) R108 751,52

(b) 31 December 1988.

Land and Agricultural Bank: persons employed

528. Mr J B DE R VAN GEND asked the Minister of Finance.

(a) How many (i) White, (ii) Black, (iii) Coloured and (iv) Indian persons were employed by the Land and Agricultural Bank, (b) how many loans had been issued to employees in respect of each race group, (c) how many loans of (i) over R100 000 and (ii) between R50 000 and R100 000 had been made in respect of each race group, and (d) what rate of interest was being charged in respect of these loans, as at 31 December 1988?

B989E

The MINISTER OF FINANCE:

(a) (i) 1 017

(ii) 151

(iii) 25

(iv) None

(b) Whites — 501
Blacks — 8
Coloureds — 8
Indians — None
} Number of accounts in operation

(c) (i) Whites — 2
Blacks — None
Coloureds — None
Indians — None

(ii) Whites — 314
Blacks — None
Coloureds — None
Indians — None

(d) 3%.

Own Affairs:

Parow School Board area: capacity/number enrolled

56. Mr K M ANDREW asked the Minister of Education and Culture:

(a) What was the (i) capacity of and (ii) enrolment at (aa) each specified school, and (bb) in total, in the Parow School Board area in 1988 and (b) (i) what are the corresponding figures for 1989 and (ii) in respect of what date are these figures furnished?

B928E

The MINISTER OF EDUCATION AND CULTURE:

(aa)	(a) (i) *	(b) (i) *	(a) (ii)	(b) (ii)
Aristea Primary (Kraaifontein)	750	750	641	648
Bastion Primary (Brackenfell)	700	700	542	601
Bellpark Primary (Bellville)	600	600	733	738
Bellville Hoër	700	700	818	807
Bellville Hoër Tegnies	700	700	703	701
Bellville Laer	700	700	322	284
Bellville-Noord Laer	550	550	470	481
Bosmansdam Hoër (Bothasig)	650	650	564	501
Bosmansdam Lae (Bothasig)	650	650	449	457
Boston Primary (Bellville)	700	700	660	619
Brackenfell Hoër	700	700	705	706
Brackenfell Primary	600	600	924	968
De Kuilen Hoër (Kuilsrivier)	500	500	756	754
De Kuilen Laer (Kuilsrivier)	900	900	755	748
De Ruyter Hoër (Ruyterwacht)	500	500	353	328
De Tyger Laer (Parow)	600	600	501	543
De Vrije Zee Primary (Vrijzee)	700	700	398	406
De Waveren Laer (Ruyterwacht)	600	600	357	324
Durbanville Hoër	650	650	836	738
Durbanville Laer	1 000	1 000	573	586
Durbanville Voorbereiding	400	400	397	441
D F Malan Hoër (Bellville)	800	800	1 098	1 060
Eben Donges Hoër (Kraaifontein)	600	600	1 224	1 097
Kraaifontein No 2 Hoër (Nuut)	0	850	0	222
Edgemead High	850	850	371	533
Edgemead Primary	700	700	937	948
Eversdal Primary	750	750	926	951
Excelsior Laer (Bellville)	700	700	540	551
Fairbairn High (Goodwood)	800	800	661	656
Fairmont High (Durbanville)	700	700	925	876
Fanie Theron Primary (Kraaifontein)	750	750	761	791
Gene Louw Laer (Amanda Glen)	850	850	800	893
Goodwood Voorbereiding	450	450	332	367
Goodwood-Park Laer	750	750	820	837
J G Meiring Hoer (Goodwood)	700	700	724	735
J J du Preez Hoër (Parowvallei)	600	600	484	482
Kenridge Primary	700	700	703	739
Koos Sadie Laer (Goodwood)	650	650	487	433
Labiance Laer (Bellville)	150	150	240	213
Mikro Laer (Kuilsrivier)	700	700	545	570

31 fatal heart attacks daily

High death rate due to 'pig-like living'

By Winnie Graham

Thirty-one people died of heart attacks in South Africa each day, Dr Marius Barnard, the heart surgeon, said at Sun City this week.

Speaking at Convention 89, a conference organised by a direct selling organisation, he estimated 45 000 people in South Africa would have a coronary thrombosis this year. About 11 000 would die of heart-related diseases.

He estimated there would be 70 000 new cancer cases this year, of whom 6,5 percent would die.

Science had made enormous strides in preventive medicine since the turn of the century and had literally taken people "from the grave". People, however, were not looking after themselves.

Man had become a walking disaster because he had started "living like a pig".

In 1900 heart attacks were responsible for 8 percent of all deaths. This figure had grown to 48 percent in the eighties. Then, cancer killed 3,7 percent of the population. Today it kills 20,9 percent.

"Humans must be the only mammals which continue to provide milk in their diet after weaning. They guts all the chops and boerewors they want when a piece of fish would be so much better for them.

"And, worst of all, there is too much smoking. Smoking causes heart disease, cancer, baldness, ingrown toenails — everything possible that is bad for you."

He described it as the biggest health hazard in the world.

89

ME sufferers seek recognition

Medical Reporter

Sufferers of the mysterious ailment, Myalgic Encephalomyelitis (ME), have established a national research foundation in an attempt to gain professional medical recognition of the illness.

The administrative director of the National Institute for Virology, Dr Alan Smith, has been elected president of the ME foundation and a panel of concerned doctors will serve on the committee.

Dr Smith was one of the first among the medical profession to research the illness.

The disease has gained widespread recognition in Britain and America but most South African doctors regard it as nothing more than "neurotic nonsense".

It is not known how many ME sufferers there are in this country but it is believed there are hundreds.

Symptoms of the illness, which usually follows a viral infection and can last for many years, include extreme fatigue, loss of memory, eyesight difficulties and muscle weakness.

A member said the foundation was established with the chief aim of collecting funds for further research and to send Dr Smith to an international ME congress in Cambridge next year.

The foundation also hopes to assist ME sufferers by providing them with a list of sympathetic doctors and information obtained from all over the world.

Anyone interested in more information can send a self-addressed stamped envelope to the National ME Research Foundation, P O Box 72371, Parkview 2112. Please include a telephone number if possible.

Soweto clinics stop cervical cancer tests

(89) wheal

By THANDEKA GQUBULE

SOWETO health authorities have withdrawn the Pap smear — the only test for cervical cancer, one of the biggest killers of black South African women.

A paper delivered at the conference of the National Medical and Dental Association (Namda) this week said that municipal health structures in Soweto, such as clinics, no longer offered the test.

According to Namda's Dr Helen Randeira, a screening scheme was set up in 1984, but was closed this year because it was under-utilised.

Randeira pointed out that there had been no accompanying programme to educate the community on the vital importance of the Pap smear.

She added that Baragwanath Hospital provided the test only on request. As a result, Soweto had the lowest level of testing of any major centre in the country, despite its high population density.

Commenting that this was a direct consequence of the "apartheid health system", she said the situation was aggravated by a shortage of cancer specialists for black patients.

The public relations department at Baragwanath denied the allegations, claiming that many Pap smears were done at the hospital. But the spokesman confirmed that the test was no longer performed at local clinics.

The Pap smear is particularly important because it makes it possible to detect cancer at a pre-malignant stage. It can then be more easily treated.

According to Namda doctors, cancer of the cervix is the most common form of the disease among black South African women, and the fourth most common form of cancer among white women. They stress, however, that it is difficult to determine the true mortality rate from the disease, as many black people suffering from the disease in its advanced stages are sent back to the homelands.

They point out that homeland mortality figures are not included in official South African statistics.

In their paper, the doctors say: "If we look at all these figures, we see that there is a four to six percent abnormality in the screened population. However very few people are being screened and ... the wrong people are being screened."

task. Members of the Force who would have carried out the task, already perform long hours of duty under difficult circumstances. They can only perform this task at the cost of other important police functions. Such a task can, in addition, not be accounted for economically. On these grounds the furnishing of the requested information can therefore not be justified.

(2) and (3) Complaints and charges lodged against members of the South African Police are fully investigated. In the case of departmental investigations, the commanding officers of those members decide whether there is sufficient evidence available to institute departmental steps. In the case of criminal charges, the case dockets are referred to the various Attorneys-General for a decision.

I wish to point out to the honourable member that the South African Police maintain strict discipline. Offences are not tolerated and suitable steps are taken without hesitation against members who commit departmental and/or criminal offences.

SAP: members suspended/dismissed

303. Mr P C CRONJÉ asked the Minister of Law and Order:

Whether any members of the South African Police were (a) suspended and (b) dismissed in 1988 as a result of arrests, interrogations, detentions or other unrest-related activities; if so, how many in each case?

B643E

The MINISTER OF LAW AND ORDER:

(a) 35 members

(b) 25 members

Grey's Hospital: non-Whites

346. Mr C J DERBY-LEWIS asked the Minister of National Health and Population Development:

(1) (a) How many non-Whites were admitted to Grey's Hospital, Pietermaritzburg, in each of the latest specified three years for which figures are available, (b) what was the average length of their stay and (c) for what reasons were they admitted;

(2) whether equivalent facilities were available to the non-Whites so admitted at hospitals allocated to their own race groups; if so, why were they not treated at these hospitals?

B703E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) (a) and (b)

	Patients	Average length of stay
1986/87	88	12,19 days
1987/88	645	5,11 days
1988/89	939	4,32 days

(c) The general admission policy of the Natal Provincial Administration is that emergency treatment is rendered at the nearest hospital irrespective of the race of the patient and, in regard to extremely expensive specialist treatment, such treatment is rendered at the hospital that has the facility, in this regard the race of the patient is not a consideration.

It is for this reason that there is an escalation in the number of non-white patients treated at Grey's Hospital as this hospital has over recent years increased its capability of providing sophisticated expensive specialist treatment which is not readily available at the non-white hospitals from where the patients were referred;

(2) no.

Lung cancer

370. Mr M J ELLIS asked the Minister of National Health and Population Development:

How many persons in each race group in each province died of lung cancer in 1988?

B772E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

Province	Population Group				
	Indian	Black	Col.	White	Total
CP	3	52	176	134	365
Natal	16	8	7	84	115
OFS	0	0	0	0	0
Transvaal	2	15	2	48	67
Total	21	75	185	266	547

Information in respect of the Self Governing National States is included.

SAP: colleges for training

380. Mrs H SUZMAN asked the Minister of Law and Order:

(1) (a) How many colleges for the training of (i) policemen and (ii) policewomen were there in the Republic, (b) where were they located in each case, and (c) how many (i) Whites, (ii) Coloureds, (iii) Asians and (iv) Blacks were on the teaching/instructor staff of each of these colleges, as at 31 December 1988 and the latest specified date for which figures are available, respectively;

(2) how many (a) Whites, (b) Coloureds, (c) Asians and (d) Blacks were trained at each of these colleges in 1988?

B782E

The MINISTER OF LAW AND ORDER:

(1) (a) (i) and (ii) 4

(b) Pretoria
Bishop Lavis
Wentworth
Hammanskraal

(c)

	31 December 1989	30 April 1989
(i)	193	193
(ii)	34	35
(iii)	13	14
(iv)	101	101

(2) (a) 4 201 students

(b) 905 students

(c) 246 students

(d) 2 522 students

Persons under 18: awaiting trial

383. Mr R A F SWART asked the Minister of Law and Order:

How many persons under the age of 18 years were awaiting trial in police cells as at 31 December 1988?

B785E

The MINISTER OF LAW AND ORDER:

841 persons at 810 police stations countrywide.

Black spots

436. Mr P G SOAL asked the Minister of Education and Development Aid:

(1) (a) How many Black spots were removed in each (i) magisterial district and (ii) province in 1988, (b) what was the (i) name and (ii) population of each such Black spot and (c) where were the inhabitants of each such spot resettled;

(2) what was the total (a) amount paid out in compensation for, and (b) cost of removing, each of these Black spots in that year?

B857E

The MINISTER OF EDUCATION AND DEVELOPMENT AID:

(1) (a) None.

(b) and (c) Fall away.

(2) Falls away.

Resettlement of persons

437. Mr P G SOAL asked the Minister of Education and Development Aid:

Whether any officials attached to his Department helped to resettle any persons in 1988; if so, (a) on what dates, (b) from what specified areas were persons moved, (c) in what specified areas were they resettled, (d) why was it necessary to resettle them and (e) how many persons were resettled in each case?

B858E

The MINISTER OF EDUCATION AND DEVELOPMENT AID:

Yes.

(a) On a continuous basis.

(b) (i) Zaaiplaats, District Groblersdal

(ii) Cornfields, District Estcourt.

(iii) Inanda Dam Basin, Ndwedwe, KwaZulu.

(c) (i) Langkloof, District Witbank.

(ii) Boschhoek/Craig, District Estcourt;

CAPE TIMES 30/5/89



BALANCE OF LIFE . . . One-year-old Vuyiswa is weighed by Sister Miriam Gekisani at the new Shawco nutrition clinic at Nyanga. Looking on is her mother Mrs Nothandekili Ngalo. Picture: ANNE LAING

Clinic to treat malnutrition, killer of the Flats

Staff Reporter

MALNUTRITION on the Cape Flats is turning normal childhood diseases into killers.

Measles, which is common among children and easily treatable, is taking its death toll because emaciated childrens' bodies have no resistence, says Dr Trudy Thomas of the Child Health Unit at the University of Cape Town.

About 40 children are being treated at a nutrition clinic recently opened by Shawco in Nyanga, and that figure is believed to be the tip of the iceberg. One 11-month-old baby is blind, also possibly because of malnutrition.

According to Sister Miriam Gekisani, who runs the clinic, the major problem is to make people aware of the clinic's existence. "We had to go to the people and find mothers with malnourished children to persuade them to come for help," she said.

Dr Thomas, who says that there are no real statistics for the area, believes that there are many cases of severely malnourished children who "never" have medical help.

She says that it is impossible to keep track of people because of the shifting and temporary nature of the population.

Shawco, which gives out 25 000 meals daily at schools on the Cape Flats, is battling to keep up with inflation and the expanding population. Costs are rising all the time and it is becoming more difficult for people to give to charity, according to the student president, Mr Graham Herbert.

Margarine backing of TV heart series stirs major row

Star 2/6/89

OWN CORRESPONDENT

A retired professor from Medunsa is infuriated because a health programme which SABC ran recently was sponsored a margarine firm.

DURBAN — The heart attack series shown on SABC's "Good Morning South Africa" programme was sponsored by a margarine manufacturer — and this type of endorsement infuriates Professor Jack Booyens, recently retired head of the physiology department at the Medical University of Southern Africa (Medunsa).

While at the university, Professor Booyens did research into the effect of various Western dietary ingredients and came to the conclusion that, rather than helping in the prevention of coronary diseases, margarines high in unsaturated fatty acids actually promoted heart attacks.

In short, he says margarine is bad for you.

There is a body of scientific opinion which supports Professor Booyens, and also a weighty body which disagrees.

So annoyed was Professor Booyens by what he describes as the "perpetuation of gross misinformation" about the healthy effects of margarine, that he has decided to speak for the first time outside the confines of the specialised medical profession about his research findings.

Heavy smoker

Professor Booyens, incidentally, smokes cigarettes heavily, but he does not eat margarine.

When he had a paper published on the harmful effects of unsaturated fatty acids in the international *Medical Hypotheses Journal* last year, it caused an international stir.

He had generally assumed that, rather than causing heart problems, polyunsaturated fats in margarine contributed to a lowering of the incidence of heart disease.

But his paper set out to show that the opposite was true, and that margarine possibly increased the incidence of coronary heart disease.

Requests for more detail flooded in from around the world. They came from Spain, Britain, the United States, Czechoslovakia, Poland, Japan, Cuba, Bulgaria, Germany, Russia and Canada — including such august bodies as the Mayo Clinic, the US Environmental Protection Agency, and the National Cardiology Research Centre in Moscow.

The essence of Professor Booyens's research (conducted together with Mr C Lourens, also from Medunsa, and Dr I E Katzeff of the University of the Witwatersrand) was that passing hydrogen through natural vegetable oils to make margarine creates a large quantity of unnatural "weird" substances — for example, "trans" fatty acids — substances which Professor Booyens claims are harmful to man.

And, citing earlier research into infant deaths, he says pregnant mothers can pass on coronary artery disease to the unborn children, a view which suggests that woman with high consumptions of the "weird" substances in margarine can permanently affect the health of their babies.

Professor Booyens also notes that there has been research done which links the "trans" fatty acids to cancer, and yet, in spite of the suggested detrimental effects of this substance, "very little is known about the amounts consumed by our population".

But he says the public is being subjected increasingly to "health type" advertising campaigns by margarine companies, and what he calls the "outdated" thinking of some sectors of the medical profession. These factors are increasing rather than decreasing the risk of heart disease.

Professor Booyens's findings are strongly supported by Dr Wayne Martin of the United States, who, also in a paper published in the *Medical Hypotheses Journal*, said "orthodox medicine is fostering a principle cause of myocardial infarction (heart attacks)" by supporting the consumption of margarine over butter.

He notes that the US diet in 1920 was rich in cholesterol and fat, yet in that year "death from myocardial infarction (MI) was so rare that it had no name or recognition".

But in 1920 a "new, unnatural dietary fatty acid" was introduced in margarine. This, he claims, produces blood clots.

Since that time, MI-related deaths have soared and "orthodox medicine" has attributed the deaths to cholesterol and saturated animal fat rather than to what he says is the true culprit: the "trans" unsaturated fatty acids which are found in margarine.

Finding challenged

A spokeswoman for Unilever, whose subsidiary, Van den Bergh and Jurgens, is South Africa's largest margarine producer (Floro, Rama, Stork, Country Spread) said it was aware of Professor Booyens's claims, and they "could not be taken seriously".

She also questioned acceptability of the *Medical Hypotheses Journal* as a serious publication.

"He would not get his paper published in an accepted medical journal," she said.

She added that the journal was not refereed independently.

"It was founded, and is edited and published by Dr Horrobin, head of the Efamol Research Institute, which is associated with Oil Of Evening Primrose. These capsules ae marketed internationally as a remedy for many illnesses, including cholesterol control."

She also noted that several years ago the then chairman of the scientific committee of the Heart Foundation stated that the paper by Professor Booyens — which had been "rejected by the South African Medical Journal", was "biased and speculative".

Malaria risk despite cold

Star 23/6/89

89

Medical Reporter

Winter holidaymakers heading for the lowveld need to take malaria precautions despite the cold weather, Dr Celia Young, medical adviser to a pharmaceutical company, has warned.

"Although the mosquito challenge is lower in winter, only one bite by a malaria-infected mosquito is necessary to contract the disease," she said.

Dr Young said malaria was always present in endemic areas such as the eastern Transvaal lowveld, the northern Transvaal and northern Zululand.

She advised holidaymakers to take two anti-malarial tablets before leaving, two tablets once a week while in the malarial area, and two tablets once a week for four weeks after returning.

"This regimen is very important as it is possible to develop malaria up to four weeks after having been bitten," said Dr Young.

The Star Tue

'Flu bug' is not flu at all, say doctors

Contagious infection can lead to pneumonia

Star 27/6/89

Medical Reporter

The "flu bug" sweeping Johannesburg may not be flu at all, according to health experts.

Johannesburg's Acting Medical Officer of Health, Dr Nicky Padayachee, says city health clinics and general practitioners have reported quite a number of cases of upper respiratory tract infection in recent weeks.

Symptoms include a sore throat followed by laryngitis, an infection of the pharynx and, if not treated, pneumonia.

"I would advise anyone who has these symptoms to see their doctor as soon as possible.

Malaise

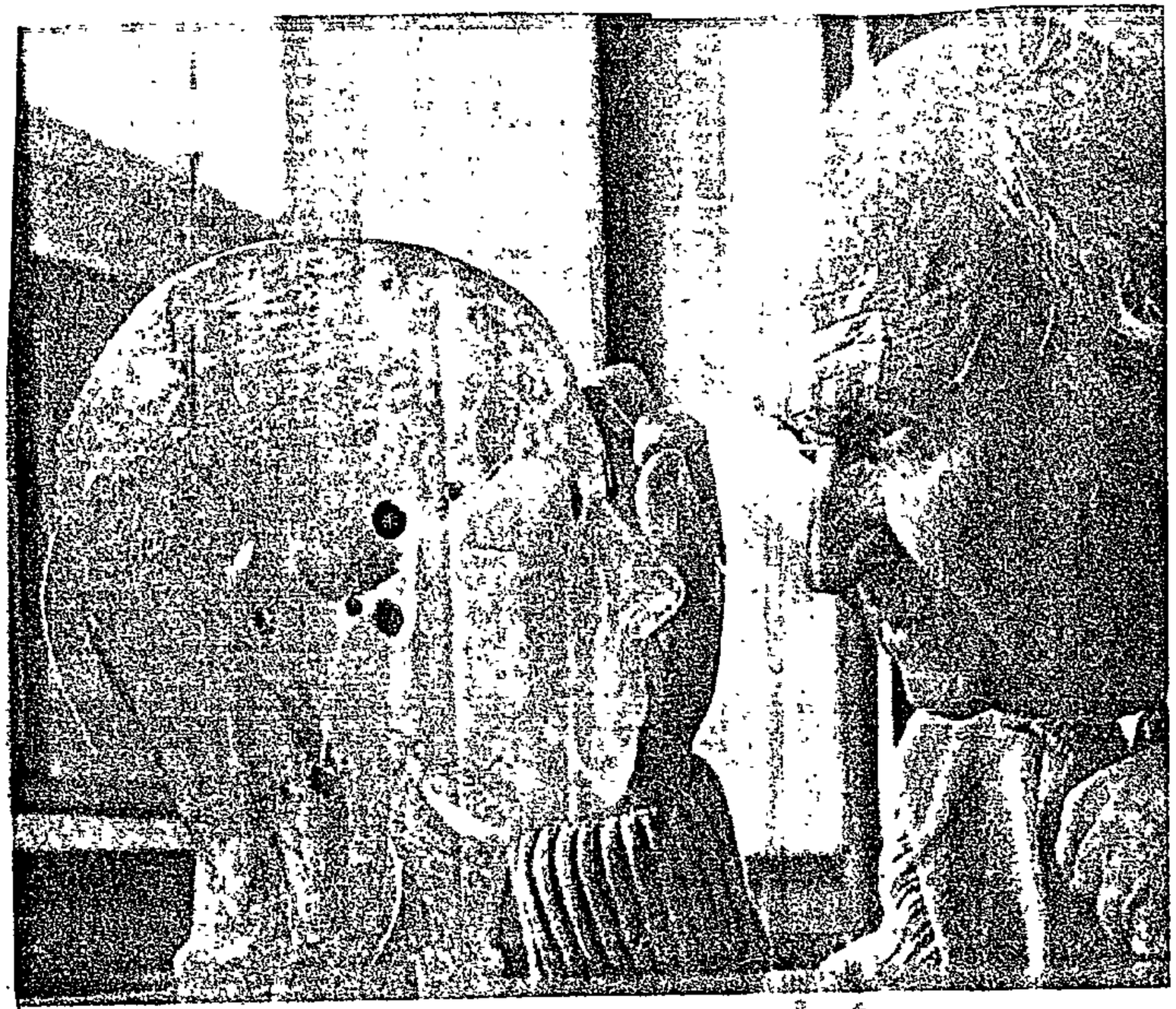
"Untreated, these people could develop pneumonia," Dr Padayachee said.

He said the virus differed from flu in that flu symptoms included muscle aches and pains, a runny nose and a general malaise.

"You can also be vaccinated against flu but there is no vaccine for upper respiratory tract viruses," he said.

Professor Barry Schoub, head of the National Institute of Virology, said relatively few cases of flu had been identified in Johannesburg this winter.

He said upper respiratory tract infections were quite common at this time of year.



HEAD TO HEAD . . . Professor Laurie Adams and Tom, the plastic head used in the experimental phase of a new tumour-location system. Picture. RICHARD BELL

World first at UCT

One Times 6/7/89 89

By MALCOLM FRIED

TWO UCT researchers claim to have made an international breakthrough with a technique which will allow brain tumours to be located without conventional, invasive surgery.

Professor Laurie Adams and Associate Professor Heinz Ruther, of the Department of Surveying, have designed a measuring system to precisely pinpoint tumours, making traditional probes into the skull defunct.

A plastic head, dubbed Tom, has been used in the experimental phase of the new system. "He's been our 'patient'," said Prof Adams.

The prototype, completed over the past three months, is the result of years of research.

It had to be demonstrated by the end of October for the project sponsors, the Cape Provincial Administration, Prof Adams said yesterday. Health authorities have contracted to spend R400 000 on the development.

"But we now have a working apparatus. It is the first of its kind in the world."

At least two overseas universities, a range of academics and many doctors had shown intense interest in the system, said Prof Ruther.

It is based on "real-time" photography — which produces an instant, computer-interpreted image — and measuring principles.

The system maps the location of a tumour in the brain and directs a proton beam on to the malignant spot, which is then destroyed.

Surgeons had not been able to bring brain tumours exactly into line with the proton beam and a number of holes had to be drilled in the skull to properly position the patient.

A CAT-scan used to be the most effective way of directing surgeons to the affected tissue.

The professors have now ensured that five or six cameras, two computer programmes and several pieces of mechanical equipment will enable a medical

To page 2

From page 1

UCT One Times 6/7/89

technologist to scan the brain as if playing a video game.

The patient will go through far less trauma — not being cut open or fastened into uncomfortable devices — and the operation will be many times faster and more accurate than before.

The patient's body will be manoeuvred by means of robotics and links to the computer directing the proton beam.

Prof Adams said the Department of Surveying had been approached to solve the problem of finding tumours "because it is really a question of measuring — and that's our field".

Sowetan 10/8/89 Page 3

Flu virus sweeps Natal

89

MORE than 100 patients and staff a day are being treated at Northdale Hospital in Maritzburg and at least three patients hospitalised each day for a virulent strain of influenza that is sweeping Natal.

The superintendent of the hospital, Dr Lal Dwarkapersad, said the strain of flu, identified as Taiwan, started to show up at the hospital from about June 13, and that 25 percent of the patients have been children.

"We thought the number of patients would start to ease off from August 4, but there seems to be a relapse and we are back to treating about 100 patients a day," said Dwarkapersad. - Sapa.

ed to the new extension to the admissions ward at Baragwanath.

Flu strikes Natal

Sterl 11/8/87 — Medical Reporter — 89

The wave of A/Taiwan flu sweeping across the country has struck Natal, laying off hundreds of factory workers and municipal employees.

At least 10 percent of deaths from natural causes in Maritzburg last month were blamed on flu-related complications. At Addington Hospital in Durban, 60 nurses have been booked off.

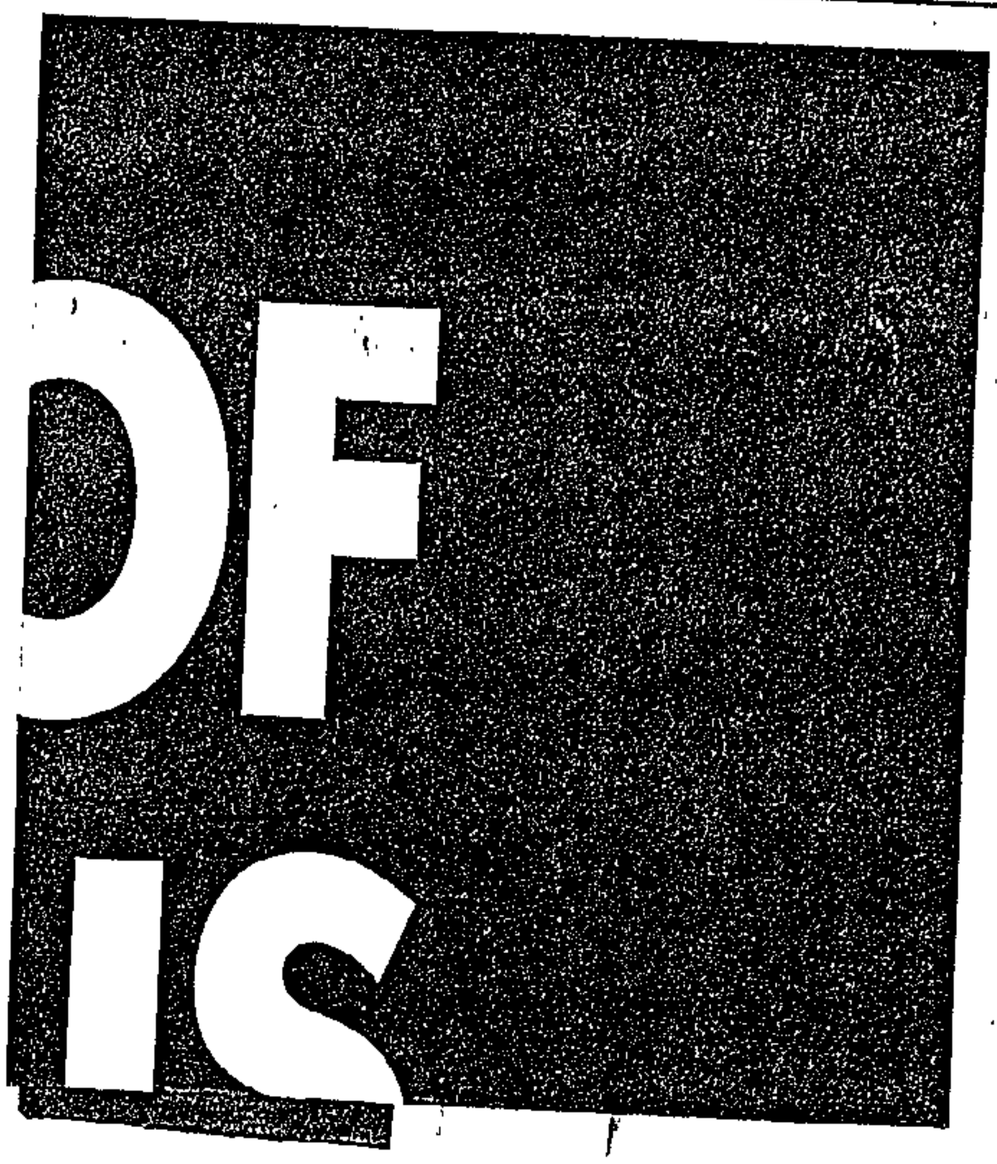
In some factories entire shifts have had to be cancelled. School have postponed rugby and hockey matches.

Employee absenteeism has risen quite steeply in the Cape but in the Transvaal and Free State the virus has proved less virulent.

Factories and businesses in and around Johannesburg report no more than the usual winter ailments among staff.

Doctors believe many people may be confusing the flu with upper respiratory tract infections.

● See Page 13.



No prevention, no cure for mystery ME disease

89
Star 24/8/89

Nearly everyone knows someone who has it, but few truly understand it and most doubt its seriousness. Myalgic encephalomyelitis (ME), better known as "Yuppie Flu" has already claimed dozens of victims yet South African medicine remains reluctant to acknowledge the disease. **By TONI YOUNGHUSBAND, The Star's Medical Reporter.**

Two years ago The Star interviewed a young university graduate claiming to have ME. A previously active, outgoing woman in her 20s, she was unable to spend more than a few hours a day out of bed. She could not find a single doctor to treat her although each time she made an appointment to see one she took along copies of lengthy medi cal articles on ME published in Britain and the US.

Her story prompted a flood of calls from fellow sufferers desperate to find medical help.

Dr Alan Smith, of the National Institute of Virology, sat up and took notice. Last year he opened an ME clinic and to date has had 140 patients.

His research has provided a number of clues to the mystery illness but there is still no prevention and no cure.

"I think that most people are coming around to the idea that it is not a specific virus that causes ME but a number of them."

Never gets well

It can affect any age group and people of any social standing. Dr Smith is treating a mother and child, a husband and wife, academics and housewives.

ME usually follows an identifiable viral illness of some sort. The sufferer just never gets well.

A Johannesburg mother-of-two believes she has had ME for four years.

"It started when our whole family came down with a tummy bug. A week later I contracted a cold and never really got well again. Doctors first called it echo flu and to date I haven't found a single one who can tell me what's really wrong with me. However, knowing the symptoms, I am convinced I have ME," she says.

She was extremely fit, running 10 km a day, at the time of contracting the illness and persisted exercising even after she fell ill, not knowing that this was the worst thing to do.

ME patients suffer extreme fatigue, depression, memory loss, eyesight disturbances, aching muscles and in some cases bizarre nightmares.

Dr Smith has a patient, an academic, who struggles to walk up the one flight of stairs to his office each day. Another patient cannot stand the noise the clasp on her husband's briefcase makes when he snaps it open and a university professor is suffering extreme memory loss.

Mild forms of the illness last a year or two but one of Dr Smith's patients has had ME for 30 years. He believes it is not contagious yet incidences of epidemics have been reported. Whether or not this was truly ME has not been proved.

In an attempt to ascertain the incidence of ME, Dr Smith asked some 30 general practitioners to report possible cases to him. Only a few complied.

He believes modern medical teaching, which trains doctors to respond to laboratory tests, is to blame. ME cannot be diagnosed through a laboratory test but requires hours of painstaking research, a process of elimination and careful investigation.

A working woman, who has had ME for a few months, was told by her general practitioner she had a viral infection which was probably flu-related. Her symptoms of lethargy, swollen glands, muscular pains and mouth ulcers persisted and she visited a second GP. He did blood tests and although three viruses were detected he could not pinpoint the cause.

A third doctor suspected ME and sent her to Dr Smith.

For the patients, ME is a dreadful illness. The symptoms cannot be seen with the naked eye and most sufferers are scorned as neurotics or lazy. There is to date very little treatment, no cure and no prevention.

For the families, it is even harder to accept.

Supportive

"ME is something that can break up a family, can cause a divorce. It is impossible for someone who has it to explain what it's like, just how awful you feel.

"The family of an ME sufferer must be incredibly supportive and sympathetic, it's very difficult for them sometimes," one sufferer pointed out.

The only advice Dr Smith has to offer is that sufferers beware of quack remedies. "They must avoid charlatanism. I don't agree with things like colonic washouts, they won't help at all," he says.

A good balanced diet, a positive attitude and daily exercise (not too strenous) is recommended.

And, of course, the sympathy of employers would help. Dr Smith says there is a lot of resistance from employers which may not be too serious if the employee is near retirement age, but if he is in his 30s he needs all the support he can get. He has a whole career ahead of him.



Sowetan reporter Mathatha Tsedu (right) discussed the condition of cancer patient Lucky Masuku (in bed) with a doctor at St Rita's Hospital at Glen Cowie, south of Pietersburg, on Thursday. By Friday, Masuku was dead.

Heed cancer's early warning signs - prof

Sowetan 25/9/89.

89

No organ is free from its spread

By MOKGADI PELA

FOCUS

ALTHOUGH not the leading cause of death in this country, cancer is among the top killer diseases and possibly the most feared.

This emerged at a lecture delivered by Professor Barry Mendelow on the disease at the South African Institute for Medical Research last week.

The fear for cancer is according to Mendelow, aggravated by ignorance, conjecture and thousands who have died from this disease.

Mendelow was quick to point out that no organ was free from its spread.

"Cancer arises from the body's own cell and the basic problem is that those cells do not know when to stop growing.

"The result is that tumours will form consisting of millions of these cells which destroy the function of the organ they arrive in.

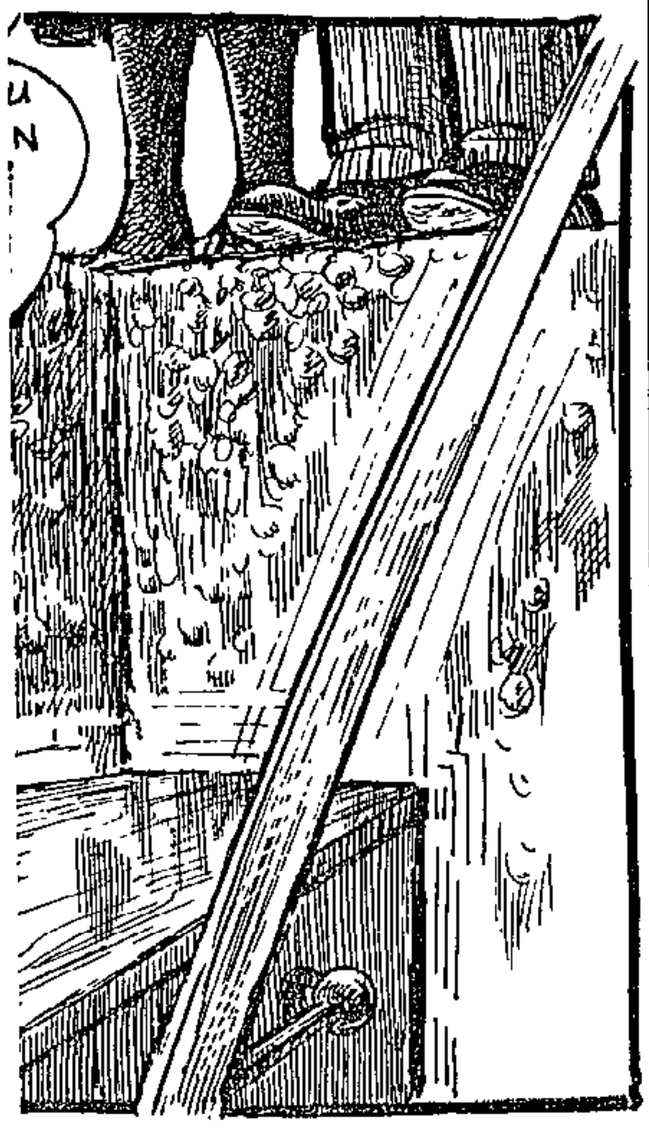
"Because they arrive in the body's own cells, the immune system does not recognise them as foreigners.

"Therefore, they are able to escape the immune system," Mendelow said.

Some kinds of leukaemia (blood cancer) are very difficult to cure while others are easier to manage

However, because of advanced medical treatment, early detection offers hope for cure.

The most common symptoms of cancer are unusual bleeding or discharge from anywhere, a swelling, a sore that does not heal, hoarseness of the voice or cough, difficulty in swallowing or indigestion, a change in bowel or bladder movements, satellite nodules and an unexpected new lump.



The most frequent cancer conditions in the country are cancer of the skin, this is very common among white people.

Mendelow said some of the skin cancers would generally cause damage where they arrive.

Ozone

He therefore, advised against the destruction of the ozone layer, adding that the removal of the ozone layer would destroy skin tissues.

The most common types of cancers among blacks include cancer of the oesophagus cancer of the cervix, breast cancer and bone cancer

Breast cancer could be avoided by constantly checking whether there is a change in shape or size of their breasts.

As far as cervical cancer is concerned, the National Cancer Association (NCA) reported 2 274 cases in 1986 among the blacks.

Women

This type of cancer mostly affects women of late child-bearing age and middle-aged women who have had children in their early teens

Early warning signs are: watery discharge generally followed by a secondary infection which becomes offensive; irregular vaginal bleeding and vaginal bleeding after sexual intercourse.

"Because these are not usually accompanied by pain many women ignore these clues - and forget to have their pap smears-resulting in the serious, life-threatening disease which could easily have been arrested

Cancer of the liver has claimed many lives.

SA scientists have made a great contribution in the study of this disease.

It is normally associated with hepatitis B virus, which causes jaundice.

Mendelow said a national vaccination programme was underway to try to combat its spread.

Gastrointestinal cancer is recognised by a change in bowel habits and weight loss.

Masuku

Tumours may also cause bone cancer.

The case of Lucky Masuku who died on Friday at St Rita's Hospital at Glen Cowie, about 150km south east of Pietersburg is the most recent example.

His bone cancer had reached a terminal stage that manifested itself in a 15kg growth.

Mendelow said the hallmark of cancer was the excessive unregulated growth of cells

Mendelow said cancer's treatment lay in its removal by surgery, radio-therapy and chemotherapy.

"All these will only be possible if cancer is detected early," he said.

Political comment in this issue by Aggrey Klaaste and Joe Thloloe. Sub-editing, headlines and posters by Sydney Matlhaku. All of 61 Commando Road, Industria West, Johannesburg

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Drug users 'now as young as 5'

Cape Times 26/9/89 87

By PETER DENNEHY

ANTI-DRUG counsellor Mr Rudy Nadler-Nir told a conference of child-care workers yesterday that anti-drug campaigners were "losing the battle" and that users were becoming younger and younger.

He said there were known cases of drug users as young as five years old who were "solvent abusers", inhaling thinners and petroleum, among other products.

Five years ago, one in eight young people in the 16-26 age group would "have exposure to a drug", said Mr Nadler-Nir, who works for the Drug Counselling Centre in Observatory.

Three years ago it was one in five, and today it was one in three or four in the age group 13-23.

Treatment usually started with a detoxification of the body, along with or followed by counselling and therapy.

Mr Nadler-Nir said drugs were among the most profitable businesses in the world. Up to 8 000% profits were known to have been made, and these were tax-free.

Behind the flow of drugs in the streets were "excellent business people" who realised that their products differed from many others in that people of all social classes could buy at least some kinds of them.

Existing anti-drug programmes were not working, Mr Nadler-Nir said. Drugs had to be considered as commodities, and those who bought them must realise that they were making choices in a market, just like the buyers of any other commodity.

"Designer drugs" such as crack were already available in Cape Town, and somebody would soon set up a crack factory in Cape Town, just as had been done with mandrax, he predicted.

● More reports, picture — Page 2

Offers to help cancer victim

MEMBERS of the community - black and white - have responded with sympathy to the plight of the man who is slowly rotting to death from cancer.

The story about 42-year-old Mr Herman Thebe Madimabe who is terminally ill from cancer of the throat appeared in *Sowetan* yesterday.

By THEMBA MOLEFE

Among responses to the story were strong calls from medical experts for a health awareness campaign among blacks.

There is no black hospice in South Africa where Madimabe can be admitted and given appropriate care.

Sister Patricia Chakane, an official of the National Cancer Association of South Africa, said she would visit Madimabe at his brother's home, 258 B Zone 2 Meadowlands, Soweto, with a doctor today.

The aim is to assess the seriousness of his ailment and determine whether he needs immediate

● To page 2

Cancer victim

● From page 1

confinement.

She said the Hillbrow Hospital which has a unit for terminally ill patients has shown interest in Madimabe's plight.

Chakane said plans to have him treated by qualified staff from a clinic nearest to him would be made.

Other offers from as far as Brits in the Western Transvaal are of food. A Johannesburg woman has pledged to pay all medical costs and hospital accommodation fees.

Madimabe's brother Mr Meleko Madimabe is an epileptic and cannot work. His wife is the sole breadwinner who supports the family which includes five children and the sick man.

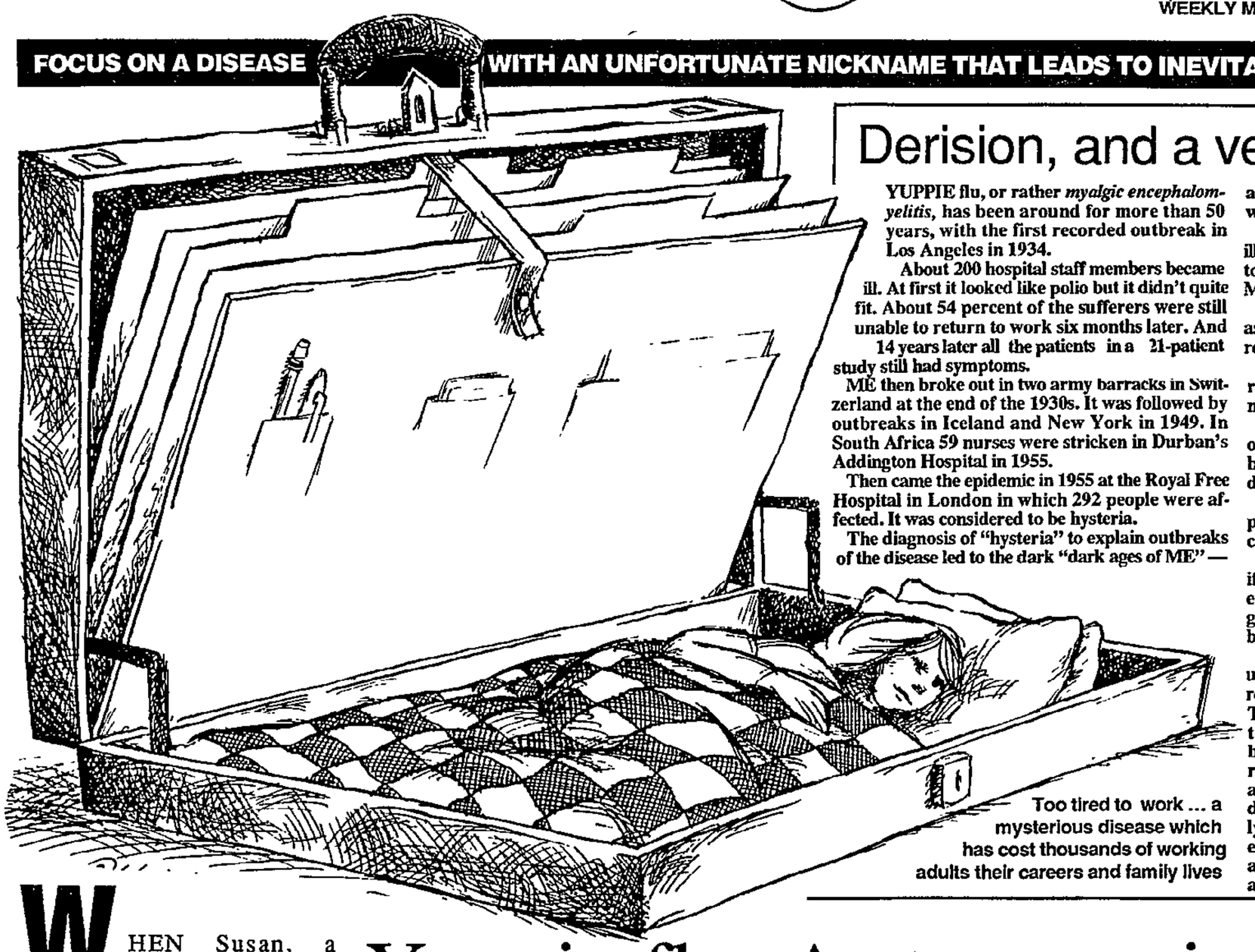
Sowetan editor Mr Aggrey Klaaste said the grey newspaper would, in line with its Nation Building campaign, get involved in relieving Madimabe's circumstances.

A Pretoria practitioner, Dr Gomolemo Mokaetsi said a health awareness campaign among blacks and started among blacks should be called on the Government to reinstate pap smear tests at its clinics.

The authorities had stopped the screening of women for cervical cancer about eight years ago, he said.

Sowetan 2/11/89

FOCUS ON A DISEASE WITH AN UNFORTUNATE NICKNAME THAT LEADS TO INEVITABLE RIDICULE ...



Too tired to work ... a mysterious disease which has cost thousands of working adults their careers and family lives

Yuppie flu: A strange virus that's neither yuppie nor flu

WHEN Susan, a healthy 24-year-old who led an active life was given progesterone for menstrual problems she was "thrust into a nightmare, a holocaust, which has persisted for four years" with no end in sight.

Forty-eight hours after taking the hormone, which seemed to suppress her immune system, Susan (not her real name) developed allergies to numerous types of food and to different environmental factors although she had no previous history.

The illness — diagnosed as *myalgic encephalomyelitis* (ME) — has left her so exhausted and weak that on some days she couldn't turn on the bath tap.

ME, which causes extreme tiredness, mental confusion and muscle weakness, is known by different names, such as chronic fatigue syndrome. But the most widely used label is "yuppie flu" — an unfortunate tag which many view as a bandwagon for any tired, depressed hypochondriac to crawl on to. Yet behind this tag is a mysterious disease which has devastated the lives of thousands of sufferers around the world, reaching beyond the young professional to the whole spectrum of society.

ME has the medical profession baffled, and the only certainty at present is there is no cure other than rest.

For years sufferers have had to battle for the recognition that their illness is organic and not emotional.

Dr Frank Spracklen of the department of medicine at the University of Cape Town, and president of the ME Association of South Africa, says the disease is now understood as a chronic fatigue syndrome with muscle pain which lasts at least six months. "The classical view of it is that it includes fatigue brought about by the slightest exertion, physical or emotional. It is extremely variable, present or absent at times.

"We have to exclude other factors of fatigue and of any other disease. There must be an absence of bad family, social, medical and psychiatric histories. Patients must be previously normal and have no alcohol and drug problems.

"Patients typically develop disturbances of balance, writing, production, reading, concentration, headaches and problems with sleeping. The major factor is fatigue, with or without muscle pain."

The exact causes of the disease are not known. According to Spracklen "the basic concept is that it is a persistant viral infection, which could involve more than one virus, together with a decreased immune system which renders one liable to a mental state of depression".

It is a triangle of not knowing which of these three factors comes first — the virus, the immune system or the depression.

ME was virtually unknown in South Africa four years ago when Susan first contracted it and she "staggered from doctor to doctor trying to maintain my life and trying to get a diagnosis". She was "shunted off to a number of psychiatrists" as doctors struggled to find any organic problem — "although many (psychiatrists) believed my problem was organic".

Says Susan: "I had to plead my sanity. Medicine revolves around many myths and one of them is that any pathology will show up on the tests doctors have at hand. It is a statement of profound arrogance that doctors believe that if they can't find it on their tests, it doesn't exist or is psychosomatic.

"But I refused to lie back and be shunted off to Tara (a leading psychiatric hospital), and to be told I was suffering from 'occult illness' and 'hysteria'. I had to fight back."

It was by chance Susan finally came across a doctor who had access to literature on ME and she became the first person in South Africa to be diagnosed as suffering from it.

Spracklen says: "ME first surfaced in South Africa in 1955 at Addington Hospital. It was labelled as hysteria and set the investigation back two decades. In the last two or three years doctors have taken an interest in overseas publications."

It appears to be incurable, yet Spracklen believes it may seem so devastating because only chronic cases are seen and many patients have received bad advice from doctors. He estimates between 5 000 and 15 000 people in South Africa have it.

Susan believes ME is one of the most difficult of illnesses to live with "because of the ignorance and suspicion which surrounds it.

"It's an invisible illness, and that makes it more difficult for people to understand. You are also intermitently disabled so people can't understand when one day you're mobile and the next day you're bedridden.

Any disease which immobilises its victims for months or years, would seem deserving of sympathy. Instead, 'yuppie flu' sufferers have to endure public ridicule ('you're just bone idle') and medical ignorance ('we can't find it, so it doesn't exist').
By KATHY STRACHAN

"My bottomline existence is that I'm teetering on the brink of death. I have a minimal amount of energy that rapidly fizzles out. By 5pm I'm incoherent."

Because of her experiences Susan mounted a campaign "to protect herself and thousands of others" and get the disease recognised in South Africa. She says: "It was a battle to get recognition from the media and doctors, who didn't want to be seen given credibility to this 'neuroses'."

The campaign which began in Susan's small bedroom, expanded into the national ME Association run by Belle Alker, of Howick. Alker, who also has ME, took over reigns when Susan grew too weak to carry on.

Susan spends the little energy she has left counselling sufferers and their families. Her phone never stops ringing and she gets "thousands and thousands of letters from people who can't get diagnosed".

The association, formed at a meeting in Pietermaritzburg earlier this year, was attended by more than 200 people. About 20 000 inquiries have reached the organisation, which has developed a network in Zimbabwe.

Although the ME Association aims to disseminate information to doctors and the public, its main aim is to support sufferers. It deals with their rights and attempts to educate companies on the causes and effects of the illness. Many of the lessons have been learnt from Aids organisations.

Letters are being received from the black community and Alker believes "we have only seen the tip of the iceberg in the black community".

"We've had desperate appeals from sufferers. One man lost his job and his house as he was too fatigued to work. He had no way of supporting his blind wife and his kids. He travelled from Ellisras to Howick to find help. He now gets a pension after being diagnosed as an ME sufferer."

Ignorance of the illness in the medical field is another major problem faced by ME sufferers.

According to Spracklen the medical profession is still split between hardcore disbelievers who are convinced it is a psychological problem, and an increasing number of doctors who are more open to it.

"Some doctors dismiss it outright, so encouraging suicides, which are not uncommon, and suggesting the wrong treatments, such as exercise, which is the most damaging thing an ME sufferer can do."

A major area of controversy is: who is affected by the disease?

The common view is it affects women between the ages of 25 and 40. Yet Spracklen says: "When it comes to ME we're dealing with a lot of myths. More and more black people are coming forward with the same condition, which shows it's a myth that it affects only white women.

"If a 'coloured' labourer complains of fatigue, he loses his job. If a white professional woman complains, she gets investigated.

ME has been nicknamed "yuppie flu" by the media because in the United States it was originally thought to affect mostly young, successful professionals in their 20s. But it is not exclusively a yuppie disease.

Dr Paul Cheney, who practised in Incline, Nevada, where an outbreak affected 200 people, says: "I don't think the virus can distinguish whether you are a yuppie or not. Yuppies get the diagnosis because they have the wherewithal to stand up to physicians and say 'You are wrong — I'm not crazy. It requires persistence and the ability to challenge medical authority."

Another problem area is how funds should be spent. Spracklen says South Africa should rely on Britain and America, with their expensive laboratories and high technology, "to crack the nut" while the money should go towards care and support of sufferers and the education of doctors and the public.

Derision, and a verdict of 'hysteria'

YUPPIE flu, or rather *myalgic encephalomyelitis*, has been around for more than 50 years, with the first recorded outbreak in Los Angeles in 1934.

About 200 hospital staff members became ill. At first it looked like polio but it didn't quite fit. About 54 percent of the sufferers were still unable to return to work six months later. And 14 years later all the patients in a 21-patient study still had symptoms.

ME then broke out in two army barracks in Switzerland at the end of the 1930s. It was followed by outbreaks in Iceland and New York in 1949. In South Africa 59 nurses were stricken in Durban's Addington Hospital in 1955.

Then came the epidemic in 1955 at the Royal Free Hospital in London in which 292 people were affected. It was considered to be hysteria.

The diagnosis of "hysteria" to explain outbreaks of the disease led to the dark "dark ages of ME" — a period between 1970 and 1986 when patients were treated with disbelief and derision.

In 1986 the medical profession began to take the illness seriously after there was widespread reaction to a letter written to a British newspaper from an ME sufferer.

ME is usually triggered by a viral infection, such as glandular fever, hepatitis or influenza. Instead of recovering, ME sufferers retain the symptoms.

It is now thought to be caused by a persistent virus in the body and the effects of the body's immune system fighting that virus.

ME is not infectious. It is probable that the virus or other agents that may trigger ME is transmitted, but whether a person succumbs to ME apparently depends on how their immune system responds.

There is no cure and no primary treatment has proved effective in alleviating the symptoms which can change in the course of the disease.

Some patients recover; others are prone to relapse if they are too physically active; in others the disease remains severe. Sufferers who rest stand a greater chance of fuller recovery. Exercise should be avoided.

The traditional treatment is complete rest, as the use of various dietary measures and immunoglobin remains at the experimental level.

These are the most common symptoms: extreme fatigue, muscular and joint aches, headaches and blurred vision, mental confusion, decreased memory and concentration, light and noise sensitivity and a new sensitivity to foods, constant sore throat, dizziness, disturbed sleep, swollen glands and lymph nodes, fever, depression, general malaise, emotional lability, gastro intestinal problems, cardiac and respiratory problems, intolerance to alcohol and anxiety.

[redacted]

HEALTH & DISEASE — MISCELL. DISEASES

1990

Cholera: 10 die in Zambia

The Star's Africa News Service

LUSAKA — At least 10 people have died and 53 have been admitted to hospital in an outbreak of cholera in Lusaka's townships.

The Ministry of Health said markets and schools had been closed and social gatherings banned in affected areas.

The Health Ministry has set up 10 treatment centres and the government has appealed to the international community for help.

Because of the outbreak, the government has postponed a convention of the ruling United National Independence Party scheduled to start tomorrow in Lusaka.

CAA Times 14/2/90 89

Nationwide anti-measles war starts

Staff Reporter

A NATIONWIDE immunisation campaign is to be launched against measles, one of the country's major preventable causes of sickness and death, the Advisory Committee on Health Affairs announced yesterday.

Measles claimed 290 lives last year, when there were 13 629 notified cases, and represents the highest incidence of reported sickness per year after tuberculosis, Dr P Vugarellis of the Department of National Health and Population Development told a Civic Centre press conference.

The Western Cape campaign will be a co-ordinated by the government, the Cape Town City Council and the Western Cape Regional Services Council.

One child dies every 20 hours of measles in South Africa, and one every 15 seconds worldwide, according to World Health Organisation figures.

The Western Cape recorded 591 cases and three deaths in 1989, and 95% of the ill were under five years old.

In spite of these facts, "many parents believe that measles is not really a serious disease", Dr Vugarellis said.

RSC medical official Dr Stewart Fisher said 30 000 children would have to be immunised in the RSC area — which includes Khayelitsha and Crossroads.

The anti-measles campaign, which begins in the Western Cape this month, aims mainly to achieve a 95% immunisation level in children under five years, promote the concept of immunisation, and keep the public informed, Dr Vugarellis said.

"Particularly in South Africa's Third World communities, the immunisation leaves much to be desired."

The Western Cape campaign will be divided into two week-long immunisation programmes, the first in February/March and the second in April/May, Dr Vugarellis said.

The services will be advertised in advance and provided free of charge.

CAPE TIMES 14/2/90 (89)

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Forester spots elephant calf

KNYSNA. — An elephant calf born more than a year ago in the Knysna forest was observed for the first time yesterday.

A forester with the Department of Environment Affairs at Diepwalle, Mr Elfen Jansen, spotted the calf late yesterday morning close to the elephant hiking trail near Knysna.

The calf's mother was also in the vicinity, but the pair fled when they became aware of Mr Jansen's presence.

There are apparently four elephants left in the Knysna forest: The cow, the year-old calf, a bull and another calf of about 15 years. — Sapa

Detention rules not obeyed, inquiry told

CAPE TIMES 14/2/90

JOHANNESBURG. — Regulations on the detention conditions for Section 29 detainees were not obeyed at John Vorster Square security cells because they were impossible to implement, the Goldstone Commission of Inquiry has heard.

General Gert Erasmus, Regional Commissioner of Police for the Witwatersrand, was giving evidence this week before the commission appointed to inquire into the death in detention of Mr Clayton Sizwe Sithole.

Mr Sithole was found hanged in a shower room in John Vorster Square on January 30.

General Erasmus said all new police stations had exercise areas, but John Vorster Square did not have enough facilities for the regulation exercise periods to be enforced.

Mr Chris Loxton, for Mr Sithole's family, said evidence had been that detainees were locked in a shower room for about an hour, during which time they could do as they pleased. They could exercise, wash clothes or shower and were not watched at this time.

He said he accepted that Mr Sithole's death was by his own hand. But he criticised the system, which had failed to prevent the suicide. — Sapa

Teleletters

PW should have

Star 24490 (89)

Campaign to control measles on cards

By Norman Chandler,
Pretoria Bureau

A huge anti-measles campaign is to be launched soon by the Department of National Health and Population Development in a bid to control the disease.

The Minister of National Health, Dr Rina Venter, said in a statement issued in Pretoria yesterday that measles, a notifiable disease, continued to be one of the major causes of infant mortality in South Africa — "it is of grave concern as a cause of infant mortality, and children between the ages of 0-4 years constitute a high risk group".

IMMUNISATION

According to Dr Venter, measles is a disease which can be prevented through effective immunisation. The department had decided to launch an extensive immunisation programme.

"The programme will be called the Measles Campaign and will be implemented in collaboration with other health authorities," Dr Venter said.

The aims of the campaign include the immunisation of all children under the age of five years, the updating of growth and immunisation cards for each child and the provision of information regarding immunisation and health care.

From the latest figures available, there were 14 000 measles cases each year in South Africa between 1980 and 1987, excluding the TBVC countries.

According to Professor Barry Schoub, the director of the National Institute for Virology, "undoubtedly the true incidence is substantially higher, as shown by a survey in the Western Cape which revealed that 60 percent of 59 general practitioners interviewed were not even aware that measles was notifiable".

He said that in South Africa black and coloured people were worst affected by the disease, and that the major cause was rapid urbanisation and inadequate housing.

meet (94)

Swazi PM warns on crime

MBABANE — Swaziland was in the grip of a fright-

Feel like you've got flu? Then see a doctor

Sowetan 23/2/90 (8 9)

PEOPLE in South Africa suffering symptoms of influenza have been warned to see a doctor without delay.

SABC radio news reports the warning follows reports of a deadly virus in other countries.

A number of people in the United States and Europe have died of Shanghai flu, the radio said. They add that the head of the Department of Virology at the University of Pretoria, Professor Willie Grapouw, said it was difficult to distinguish between Shanghai flu and ordinary flu.

Advisable

This made it advisable to see a doctor without delay.

He said vaccines to counter the virus were available, and the best time to be vaccinated was late February and early March.

Aged people in particular should be vaccinated. - Sapa.

Sowetan 21/3/90

Strikes and typhoid rock PE townships

89

TYPHOID has broken out in Port Elizabeth's black townships where garbage and nightsoil have not been collected for a week because of a strike by municipal workers.

Ten cases have been reported and urgent warnings have been issued by local authorities.

Mr J Pozyn, deputy-chief municipal health inspector, said: "We are worried about this situation. It could become epidemic."

Mr Flip Alberts, Town Clerk of Ibhayi, a black area, said: "There is an escalating health threat."

Pamphlets are being distributed describing precautions that can be taken.

Six of the notified cases are in the Ibhayi area, four in Motherwell.

They were confirmed by Dr A Brazdley, of the Port Elizabeth Municipal Cal Health Office yesterday.

He said four of the Ibhayi cases were in New Brighton and one in Zwide.

"We will be going out now to visit the homes of these people to see whether the non-removal of sanitation and refuse has anything to do with this," he said.

Mr Pozyn said there was a fear of a typhoid epidemic breaking out in Port Elizabeth. He said typhoid could be spread by contact if proper hygiene rules were not applied.

He thought it was quite possible the outbreak was due to the uncollected waste and he said it was imperative the authorities resolve the wage dispute so workers could go back to cleansing the townships.

"We are concerned with the situation. If the strike continues for long it could be a disaster," he said, adding that his office had distributed the advice pamphlets urging people to bury nightsoil and not throw it in the streets, yards or streams.

The office was also distributing black bags in which refuse could be kept until it was collected.

- Sapa

Hepatitis B — a killer virus

89

South 11/4 – 18/4/90

By Heather Robertson

LAST year, about 20 000 people died of hepatitis B in South Africa. About two million African people — 10 percent of the African population — are permanent carriers of the virus.

Each year the disease infects about 50 000 more.

The symptoms of hepatitis (commonly known as yellow jaundice) are jaundice, tiredness, poor appetite and listlessness. Many people have mild symptoms, which doctors incorrectly diagnose as flu.

"The milder the initial illness, the more likely it is to develop into the chronic stage," says Professor Michael Kew of the Department of Medicine at the University of the Witwatersrand.

Spread

Speaking at a recent seminar, he explained that — like AIDS — hepatitis B can be spread through sexual intercourse or intravenous drug use.

Unlike AIDS, it can also be transmitted by kissing or sharing a toothbrush. It is thus more infectious than AIDS.

The disease can also be spread through blood transfusion.

"Getting a bottle of blood is dangerous because blood is full of 'dinosaurs'," says Professor Kew.

With the hepatitis B virus, blood on the tip of a needle is enough to infect an individual.

Hepatitis is remarkably persistent and can survive outside the human body, in dried blood or secretions, for days.

If you are found to be a carrier, what should you do?

Carriers have to be careful, particularly with blood.

"If a husband is a B virus carrier and he scratches himself while shaving, the blood on a shaving blade is enough to infect any member of his family who touches it," says Professor Kew.

"If someone in a household is a carrier, he or she may have to make adjustments in lifestyles.

Treatment

"If you find that you have hepatitis, you should find out what type it is. If it's hepatitis B, you become a carrier and must do something to kill off the virus."

A carrier has to be injected three times a week for 16 weeks with Inferon, the virus-killing drug — although there is only a 30 percent chance that the treatment will have been successful.

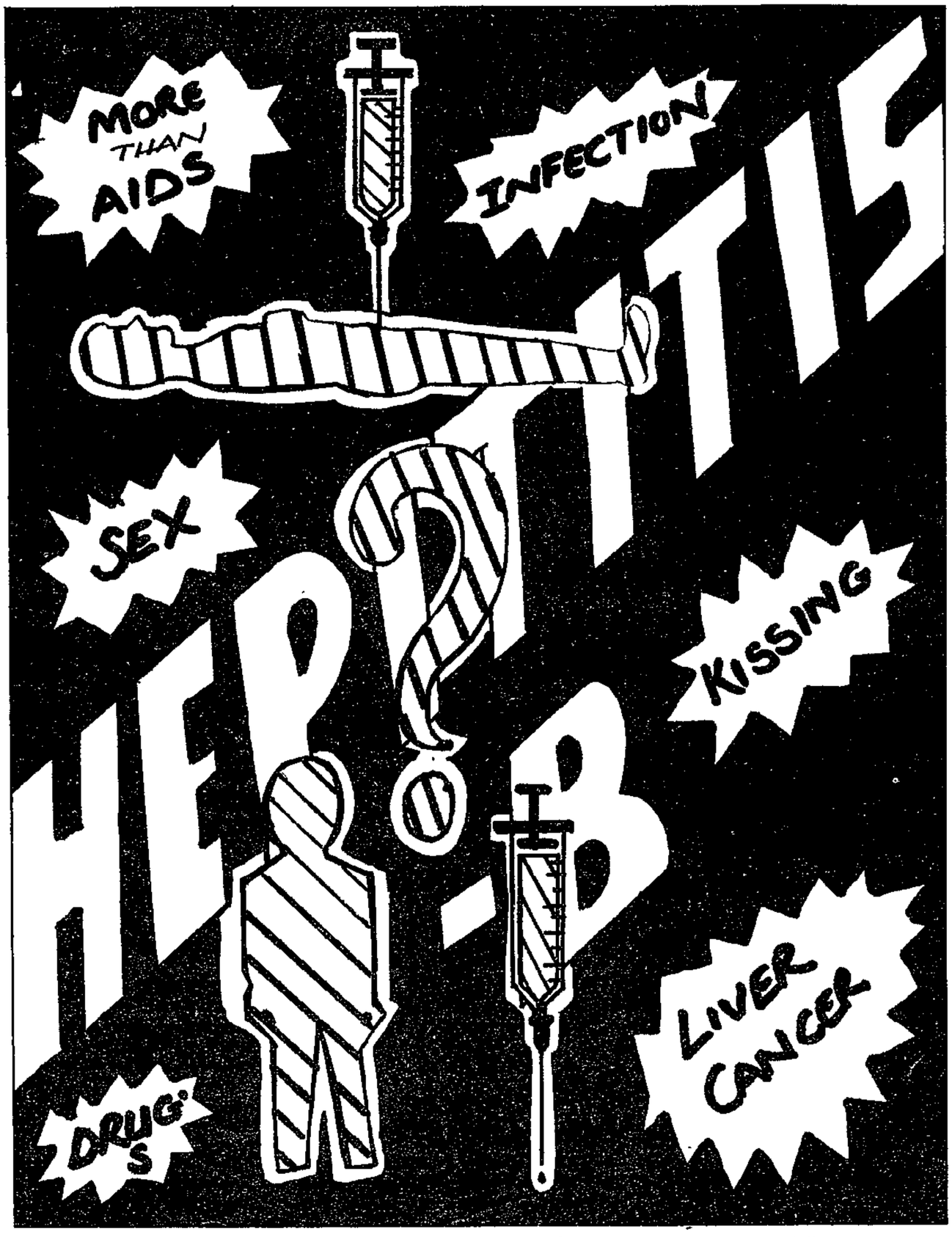
"The most shocking aspect of the spread of hepatitis B is that it is preventable," says Professor Kew.

Vaccine

An effective vaccine has been available since 1981, but few of those most at risk have been inoculated.

The vaccine was originally developed from the blood plasma of carriers. It is now possible to harvest the plasma and to produce the vaccine in laboratories

Professor Kew advises people to have their blood checked



"It becomes cost effective to test blood in high-risk areas. Because there are 2,5 million carriers in the country, we need a programme to vaccinate every newborn black baby." he says.

Professor Ralph Kirsch, head of liver research at the University of Cape Town, says: "Hepatitis B is ravaging the country, but nobody seems to be taking it seriously. We would certainly not be faced with such apathy if there was an AIDS vaccine. Yet hepatitis B is much more widespread."

Some doctors feel the virus is spreading so rapidly that most children are already, or soon will be, at risk — if not from infection in their families, then from their playmates.

In Taiwan, hepatitis is the primarily public health problem. Every new-born baby in Hong Kong is vaccinated.

Inoculation

The private cost of inoculation is high. It would cost a person R60 to have three vaccination injections. If the government vaccinated on a national scale, this amount would be reduced to R20.

The spread of the disease is an urgent national problem. The responsibility for solving it rests squarely with the Minister of National Health and Population Development.

Prof Kew has called on the government to:

- institute a mass immunisation programme immediately for all new-born babies in rural areas identified as having the highest carrier rates;
- include hepatitis B inoculations as part of the normal immunisation of all infants;
- budget a substantial sum to educate the public about the disease and how it is spread;
- introduce compulsory immunisation for all health care and rescue workers.
- The Health and Population Development Department failed to respond to SOUTH requests for comment.

Pharmacist seeks right to help fight hepatitis

PHARMACISTS should be given authority to administer immunisation injections against hepatitis, which cost SA R120m a year in manpower productivity, Pharmacy Council member C J de Bruin said at the Pharmaceutical Society of SA conference in Bloemfontein yesterday.

De Bruin said about 2,5-million of the 50-million hepatitis carriers lived in SA. Almost 20 000 South Africans died of the disease last year.

Measles — one of the most preventable diseases in SA — was another strong case for legislation to be overhauled to allow pharmacists to administer injections.

More than 21 000 cases of measles had been reported in 1987, when 424 people died of the disease. According to the World Health Organisation, a child died from measles every 15 minutes somewhere in the world.

Yet a dramatic decrease in the number of measles cases in the US resulted

Reports by TANIA LEVY

from an extensive immunisation programme in 1975.

De Bruin said the pharmacist was in a key position to educate the community about the importance of immunisation and to encourage widespread participation in public health programmes.

Educate

Pharmacists could also increase their contribution to family planning programmes by being authorised to supply certain schedule three oral contraceptives.

De Bruin said they were in a key position to educate people in birth control, which was becoming more important as SA's population was rapidly approaching 50-million, with a baby being born every 26 seconds.

Industrial pharmacy consultant Val Beaumont said the key to survival of the profession lay in concentrating on preventative health care.

Beaumont said there were 2 700 retail pharmacists in SA compared with 3 200 dispensing doctors. Besides the surge in trading doctors, trade unions were evaluating the merits of setting up their own health services, potentially reducing pharmacists' customer base.

Ethical rules had to be amended and relevant legal issues properly addressed to release pharmacists to freely practise preventative health care.

Cholesterol and diabetes screening, drug abuse monitoring and prevention and family planning were important preventative health care areas where pharmacists could play a role, Beaumont said.

At least 80% of chronic ambulatory patients in SA were hypertensives. Hypertension was a "disease state" lacking overt symptoms yet, left untreated, it could result in a number of costly diseases such as cardiovascular, cerebrovascular and renal conditions.

Home care services expansion essential, delegates told

THE home health care market in the US would be worth more than $18bn this year, Pretoria College of Pharmacy head Prof Hugo Durrheim said in Bloemfontein yesterday.

Addressing about 200 delegates at the Pharmaceutical Society of SA (PSSA) national conference, Durrheim said it was time SA pharmacists applied their full knowledge base to the problem of the home health care patient and the care-giver.

Although they had been successful in the use of their professional skills in this field, an expansion of services provided was now essential.

With his complex knowledge of drugs, patients, drug-response, therapeutic drug monitoring and the provision of medical equipment and services, the pharmacist could contribute strongly in pain management.

Drugs were probably the most cost-effective elements in chronic disease management. The pharmacist's role in chronic disease management could include the monitoring of side effects. Lack of supervision was one of the three major reasons for adverse drug reactions in the elderly.

The profession could help improve patients' self-care, facilitating adherence to long-term drug regimens, he said. Drugs could be targeted for removal from the regimen with the pharmacist consulting with the primary provider.

Pharmacists could also establish new patient records, listing side effects of all drugs used by a patient that might cause gastric erosion or mental-status changes. Adverse effects could then be anticipated and forestalled.

Durrheim said home health care was a more psychologically desirable form of health care because patients felt better and got better sooner when treated at home. This applied particularly to conditions of minor illness and during periods of recuperation.

Enforce measles jabs, say specialists

By CLAUDIA KING

CITY specialists say immunisation against measles should be made compulsory.

In South Africa, measles accounts for more deaths than all the other childhood infectious diseases combined.

Although a major immunisation campaign was launched by the state this year the influx of unimmunised Transkeian children to the Cape makes it an extremely difficult disease to control.

Paediatrician Dr Max Klein, of the Red Cross Children's Hospital, said yesterday that measles was the most infectious disease known to man and killed two million children each year.

"Making it compulsory to be immunised against the disease would place a compunction on health authorities to provide the vaccination," he said, adding that an unimmmunised person coming into contact with measles would most definitely contract the disease.

He said measles effectively depressed the immune system — in a similar way to Aids — opening the way for other infections to strike.

The Medical Officer of Health for the Regional Services Council, Dr Stewart Fischer, said the state could save thousands of rands and many children's lives if compulsory measles immunisation was introduced.

He said the current measles epidemic in Transkei threatened the Cape as the constant influx of unimmunised Transkeian children made it difficult to maintain a good immunisation cover.

Rapid influx

"It was discovered during a recent campaign that only 50 to 60 percent of children in some areas had been immunised against measles, which is just not good enough," he said.

Eighteen thousand children were immunised over three weeks at the beginning of the year, compared to around 3 000 normally, bringing the average immunisation cover from 52% to 78%.

"I know from past experience,though, that with the rapid influx of unimmunised children to the Cape the figures will drop within the next few months if the campaign is not repeated."

He said immunisation in Transkei should be increased.

A letter in the most recent edition of the South African Medical Journal says the South African Paediatric Association is strongly against the legal enforcement of any vaccination for a variety of reasons.

It would violate the principle of individual free choice, it was not advocated by WHO or Unicef and local authorities were mandated to vaccinate and the state could act against any who did not perform this function effectively.

● Reports from Transkei say that a measles epidemic sweeping the country is killing about one in four afflicted children.

Complications from measles include pneumonia, severe chronic lung infections and in rare cases encephalitis, resulting in permanent brain damage.

Clewlow to succeed Rosholt at Barlow Rand

Star 24/4/90 (3) (89)



Mike Rosholt

By Sven Lünsche

Warren Clewlow takes the helm at Barlow Rand at a time when political developments will demand almost as much from the chairman of South Africa's leading industrial conglomerate as will business growth.

Barlow Rand announced yesterday that Mr Clewlow, currently vice chairman and chief executive of the group, will take over the chairmanship from the charismatic Mike Rosholt with effect from January next year.

Mr Clewlow said yesterday that he would be taking over the group at a time when South Africa was undergoing rapid political change.

"We will have to read these developments well and adapt the group to the changing circumstances."

"I would like to carry on with the low political profile of my predecessors, but given the strong link between the economy and politics, this will not be an easy task.



Warren Clewlow

"It is one of the major challenges not only for Barlow Rand, but for the business community as a whole, to convince people that the free market system offers the best growth potential for South Africa," he said.

Mr Clewlow joined Barlows in 1963 and was appointed a director of the board in 1974.

His position as vice-chairman of Barlows will be filled by Mr Derek Cooper, at present a deputy chairman of the group.

	(a)	(b)	(c)	(d)	(e)
Osindisweni Hospital	387	6	14	33	259
Orthopaedic Services				9	76
Provincial Medical Rehabilitation Services			1	1	6
Provincial Medical Supply Centre				24	58
Port Shepstone Hospital	234	5	19	29	157
Regional Laboratory Services			35	39	517
Richmond C H C	17		1	1	7
R K Khan Hospital	671	21	72	123	402
R K Khan C H C	17				10
Regional Laundry Durban and Coastal				8	268
Regional Laundry Northern Natal				4	108
Regional Office	550	1	28	69	374
St Andrew's Hospital	132	1	4	10	54
St Appollinaris Hospital	246	3	6	15	106
Stanger Hospital	262	3	18	37	180
Tayler Bequest Hospital	129		4	12	98
Tongaat C H C	38		2	9	19
Underberg C H C	17			1	7
Usher Memorial Hospital	108	3	6	14	101
Umzinto C H C	17				
Utrecht Hospital	33	1	2	6	36
Vryheid Hospital	152	3	8	23	137
Wentworth Hospital	493	20	37	48	430
TOTAL	12 548	492	1 189	1 626	10 257

(2) yes,	(a)	(b)	(c)	(d)	(e)
Osindisweni	107	0	0	0	11
St Appollinaris	11	3	1	5	6
TOTAL	118	3	1	5	17

(3) (a) none,

(b) (i) and (ii) fall away.

Notifiable diseases: cases

461. Mr M J ELLIS asked the Minister of National Health and Population Development: How many cases of each notifiable disease were notified in respect of each race group in 1989? B1082E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

Number of notified cases of all the notifiable medical conditions in the RSA (excluding TBVC), 1989 (as on 18 May 1990)

Condition	*Indian*	*Black*	*Coloured*	*White*
Cholera	0	2	1	0
Typhoid fever	1	28	0	0
Paratyphoid fever	0	0	0	0
Tuberculosis (all forms)	611	44 520	17 197	697
Plague	0	0	0	0
Anthrax	0	1	0	0
Brucellosis	0	3	5	10
Leprosy	0	33	0	0
Diphtheria	0	6	3	0
Meningococcal infection	21	358	414	75

Condition	*Indian*	*Black*	*Coloured*	*White*
Tetanus	0	119	3	2
Poliomyelitis	0	8	3	0
Smallpox	0	0	0	0
Measles	49	8 676	468	191
Yellow fever	0	0	0	0
Haemorrhagic fevers of Africa	0	1	2	9
Rift Valley fever	0	0	0	0
Viral hepatitis	63	816	561	656
Rabies	0	6	0	1
Psittacosis	0	1	0	2
Trachoma	0	300	2	0
Typhus fever	0	0	0	0
Malaria	3	6 030	18	193
Trypanosomiases	0	0	0	0
Leptospirosis	0	0	0	0
Toxoplasmosis	0	2	0	0
Primary malignancy, Bronchus	22	98	131	169
Primary malignancy, Lung	32	49	42	83
Primary malignancy, Pleura	0	16	14	10
Poisoning from agricultural remedies	0	67	42	24
Lead poisoning	0	5	1	0

OFS Region: farm schools for Blacks

473. Mr R M BURROWS asked the Minister of Education:

(1) How many (a) primary and (b) secondary schools for Blacks were located on farms in the Orange Free State Region in 1989;

(2) how many pupils were attending such (a) primary and (b) secondary schools as at the latest specified date in 1989 and 1990, respectively, for which figures are available? B1098E

The MINISTER OF EDUCATION:

(1) (a) 1 053

(b) none.

(2) (a) 1989 — 61 395
1990 — 59 830

(b) 1989 — none
1990 — none.

Own Affairs:

Teachers/administrative staff employed

87. Mr J J WALSH asked the Minister of Education and Culture:

How many (a) teachers and (b) administrative staff were employed by each of the provincial education departments as at 31 December 1989? B644E

The MINISTER OF EDUCATION AND CULTURE:

	(a)	(b) *
Cape	16 522	2 002
Natal	7 357	953
Orange Free State	5 050	627
Transvaal	30 462	4 449

* excluding professional, technical and scheduled departmental personnel.

Cape Province/Natal: school attendance/absenteeism

130. Mr R M BURROWS asked the Minister of Education and Culture:

Whether, with reference to his reply to Question No 18 on 28 February 1990, the 1989 statistics relating to school attendance and absenteeism for the Cape Province and Natal are available as yet; if not, why not; if so, what was the daily average (a) number of pupils attending (i) primary and (ii) secondary school, and (b) percentage absentee rate at (i) primary and (ii) secondary schools, in (aa) the Cape Province and (bb) Natal in that year? B1220E

QUESTIONS

†Indicates translated version.

For oral reply:

Own Affairs:

Questions standing over from Tuesday, 5 June 1990:

Cape Province: hospitals for Whites only

*1. Mr K M ANDREW asked the Minister of Health Services, Welfare and Housing:

(1) Whether there are at present or were in May 1990 any hospitals for Whites only in the Cape Province; if so, (a) which hospitals and (b) why;

(2) whether all the services provided by these hospitals are now available to all races; if so, since when; if not, why not;

(3) whether any change is planned in regard to such hospitals; if so, what change?

Hansard 12/6/90 B1161E

†The MINISTER OF HEALTH SERVICES, WELFARE AND HOUSING:

(1) (a) and (b) No.

Four provincial hospitals in the Cape Province were transferred to the Administration: House of Assembly in terms of the Republic of South Africa Constitution Act, 1983.

(2) Yes. All the services provided by these hospitals have always been available to all races subject to the availability of funds.

(3) No.

Mr K M ANDREW: Mr Speaker, arising from the hon the Minister's reply, is he aware that as recently as this month people phoning Conradie Hospital in Cape Town for information about admission have been asked what their colour is? [Interjections.]

†The MINISTER: Mr Speaker, to the best of my knowledge, the four hospitals that are under discussion here are the Volks Hospital, William Slater Hospital, the Port Elizabeth General Hospital and the Walvis Bay Hospital. It seems to me that the hon member for Cape Town Gardens directed his question to the wrong address.

*2. Mr K M ANDREW — Health Services, Welfare and Housing. [Question standing over.]

New questions:

White teachers' colleges: persons of colour

*1. Mr A GERBER asked the Minister of Education and Culture:†

Whether it is his Department's policy that persons of colour be permitted (a) to receive education and (b) to reside in hostels at White teachers' colleges; if not, why not; if so, how many persons of colour are currently (i) studying, and (ii) residing in hostels, at teachers' colleges under his Department's control?

Hansard 12/6/90 B1185E

†The MINISTER OF HEALTH SERVICES, WELFARE AND HOUSING (for the Minister of Education and Culture):

(a) Yes, in terms of Items 2 and 14 of Schedule 1 of the Constitution, service is rendered at three teachers' colleges,

(i) 285 distance teaching students at the Natal College of Education, 11 B Prim Ed students at the Edgewood College of Education and 53 B Prim Ed students at the Johannesburg College of Education;

(b) no, because the Department does not render a service in this respect,

(ii) falls away.

†Mr A GERBER: Mr Speaker, arising out of the hon the Minister's reply, can he tell us whether tuition at the teaching college and residency in hostels of that teaching college are also regarded as services to persons of colour?

†The MINISTER: Mr Speaker, the hon member for Brits will surely not take offence if I do not reply to his supplementary question. I believe he must utilise the opportunity and put the question to my hon colleague, the hon the Minister of Education and Culture. [Interjections.]

Business interrupted in accordance with Rule 180C (3) of the Standing Rules of Parliament.

Homes for the aged: already non-racial

*2. Mr H D K VAN DER MERWE asked the Minister of Health Services, Welfare and Housing:† Hansard 12/6/90

Whether the homes for the aged falling under his Department are non-racial already; if so, from what date; if not, why not?

Hansard 12/6/90 B1187E

The MINISTER OF HEALTH SERVICES, WELFARE AND HOUSING:

The Department at present subsidises 428 homes for the aged. The policy in respect of admittance to these homes is determined by the managements and owners of the homes concerned. The Department subsidises only Whites who are admitted to these homes.

The Department of Health Services and Welfare controls and operates four homes for the aged, namely Tini Vorster Home, Sonop, Karatara and Silwerkroon. At present only Whites are admitted to these homes as they are community orientated.

Lumpy-skin disease: shortage of vaccine

*3. Mr W L VAN DER MERWE asked the Minister of Agricultural Development:†

(1) Whether any shortage of vaccine supplied by Onderstepoort for the combating of lumpy-skin disease has been experienced since 1 January 1989; if so, why;

(2) how many doses of vaccine have been provided (a) in the Republic and (b) to African states and other countries since that date;

(3) in respect of what date is this information furnished? Hansard 12/6/90 B1226E

The MINISTER OF AGRICULTURAL DEVELOPMENT:

(1) Yes, a shortage of lumpy-skin disease vaccine was experienced due to the fact that the disease took on epidemic proportions at the end of 1989. One of the reasons for this is that farmers neglected to immunise their stock the preceding period. The supply and production of vaccine coincided with the demand because the vaccine does not have a long shelf-life.

There has not been a shortage of lumpy-skin disease vaccine since mid-April 1990.

(2) (a) 4 409 900 doses were supplied in the RSA between 1 January 1989 and 31 May 1990.

(b) 144 900 doses (that is 3,18% of the total 4 554 800 doses manufactured) were supplied to foreign countries (including African states) during the same period. Hansard 12/6/90

(3) The period in respect of which this information is supplied is 1 January 1989 to 31 May 1990.

For written reply:

General Affairs:

Harms Commission: counsel for SAP

299. Mr S S VAN DER MERWE asked the Minister of Law and Order:

(1) (a) (i) What are the names of the senior and junior counsel appearing for the South African Police before the Harms Commission and (ii) how many years has each such counsel been in practice and (b) what arrangements have been made between the Police and such counsel regarding remuneration to be paid to them;

(2) whether any counsel are being paid retainers; if so (a) to whom are such retainers being paid and (b) (i) how much is being paid, and (ii) why, in each case;

(3) whether any arrangement has been made between the Police and any counsel regarding the (a) duration of services and (b) length of notice required for the termination of such services; if so, (i) what are these arrangements, and (ii) why were they made, in each case?

Hansard 12/6/90 B776E

The MINISTER OF LAW AND ORDER:

(1) (a) (i) Advocate L Visser (SC)
Advocate S J Maritz (SC)
Advocate M D Du Preez
Advocate P Kemp

(ii) 20 years
17 years
14 years
11 years

(b) The fee structure of the advocates was compiled beforehand by way of agreement.

(2) No.

(a) and (b) Fall away.

(2) (a) 25 764

(b) 4 320

(c) 1 535

NOTE: A large number of the stolen vehicles are taken to countries such as Mozambique, Zimbabwe, Zambia, Zaïre, Tanzania, Malawi, Botswana, Swaziland and Lesotho. Although some of these vehicles are identified in the countries concerned, it is difficult to retrieve them as the co-operation of the authorities of these countries cannot be obtained.

Police Force: resignations/shortage

501. Mr S S VAN DER MERWE asked the Minister of Law and Order:

(1) (a) How many policemen of each rank resigned from the Police Force (i) in 1989 and (ii) from 1 January 1990 up to the latest specified date for which information is available and (b) how many new recruits were there during each of these periods;

(2) what was the shortage of policemen of each rank in each province as at (a) the latest specified date for which figures are available and (b) 31 December 1989?

B1155E

The MINISTER OF LAW AND ORDER:

(1) (a) (i) 3 048 in 1989.

(ii) 2 589 until 31 May 1990.

(b) (i) 3 716 in 1989.

(ii) 4 154 until 31 May 1990.

(2) (a) On 31 May 1990, 4 925 posts were vacant country-wide.

(b) On 31 December 1989, 5 304 posts were vacant country-wide.

PE area: technikons

505. Mr E W TRENT asked the Minister of National Education:

(1) (a) How many technikons for (i) Whites, (ii) Blacks, (iii) Coloureds and (iv) Indians are there in the Port Elizabeth area and (b) in respect of what date is this information furnished;

(2) what was the (a) capacity of and (b) enrolment at each such technikon as at the latest specified date in 1990 for which information is available;

(3) whether there are any plans to build additional technikons in this area; if not, why not; if so, (a) when, (b) where and (c) who will be allowed to attend such technikons?

B1172E

The MINISTER OF NATIONAL EDUCATION:

(1) (a) The Port Elizabeth Technikon is the only technikon which serves the Port Elizabeth area. Students of all population groups are registered at this technikon which falls under the Department of Education and Culture, Administration: House of Assembly

(b) 1990

(2) (a) 3 000

(b) 3 975.

(3) The Department of National Education does not initiate the planning and building of technikons. The State Departments responsible for education should be approached in this regard.

Unemployment Insurance Fund benefits: OFS

519. Mr L FUCHS asked the Minister of Manpower:

(1) What total amount was paid out in Unemployment Insurance Fund benefits in the Orange Free State in the 1988-89 and 1989-90 financial years, respectively;

(2) in respect of each of these financial years, (a) how many (i) Blacks, (ii) Whites, (iii) Coloureds and (iv) Indians received such benefits and (b) what was the total amount involved in each case?

B1218E

The MINISTER OF MANPOWER:

(1) 1988 — R21 518 683
1989 — R30 336 445

(2) (a) and (b) Figures for the different population groups are not readily available.

NOTE: The figures are for the period 1 January to 31 December of each year concerned.

Clinics for termination of pregnancies

531. Mr A J LEON asked the Minister of National Health and Population Development:

Whether there are any clinics for the termination of pregnancies in South Africa; if so, (a) (i) what are their names and (ii) where is each located and (b) in respect of what date is this information furnished?

B1266E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

No, there are no specific clinics for the termination of pregnancies but abortions are carried out at provincial hospitals and some private hospitals

(a) (i) and (ii)

provincial hospitals,
Sandton Clinic,
Louis Leipoldt Hospital, Bellville, and
Poli Clinic, Port Elizabeth

(b) 11 June 1990.

Diarrhoea/dysentery: child deaths

541. Mr M J ELLIS asked the Minister of Home Affairs:

Whether the Central Statistical Service keeps statistics of the number of (a) White, (b) Coloured, (c) Indian and (d) Black children who died of (i) diarrhoea and (ii) dysentery; if not, why not; if so, what are the relevant statistics for 1989 or the latest specified year for which they are available?

B1276E

The MINISTER OF HOME AFFAIRS:

Statistics on children who died of diarrhoea and dysentery are not kept separately. In the compilation of statistics on deaths, the Statistical Classification of Diseases, Injuries and Causes of Death (which is based on the International Classification of Diseases) is used to distinguish the different causes of death. Diarrhoea and dysentery are not identified separately but fall under Ill-defined Intestinal Infections in the group Intestinal Infectious Diseases. Child deaths in this category during 1988 (the latest year for which such statistics are available) were:

	*Children**
(a)	15
(b)	805
(c)**	11
(d)	3 892

* Children under one year of age. This age group is normally used to calculate the infant mortality rate.

** Asians are shown. Data on Indians are not separately available.

Killer measles hits Kei

(89)

June 1990

UMTATA - A measles epidemic is sweeping Transkei, with about one in four afflicted children dying, the head of paediatrics at Umtata General Hospital, Professor JW Owange-Iraka, said this week.

Iraka said about 50 children had been treated at the hospital in the last two months, with babies of between nine months and two years being the most susceptible age group.

He said doctors in Cape Town had also voiced concern that Transkeians travelled there on buses to be treated and were spreading the disease in the city.

"Polio is no longer our main fear. It's measles," he said.

"In South Africa and the First World, measles is no longer a problem because babies have been immunised and over-crowding does not exist."

But the disease was rife in Transkei because of over-crowded living conditions.

This meant the contagious virus was easily transmitted from one person to the next and caused malnutrition, which meant decreased immunity in the body.

"Here, we only need one case of measles to infect 50 others in the location," Iraka said.

He urged mothers to take their babies to clinics or hospitals for vaccination. - Sapa.

4. Remainder of Groendraai 117, Subdivision 1 of Kleinpan 183, Remainder of Majoorskraal 757	J C M Naudé	1-7-89 to 30-6-90	R 7 650 pa
5. Remaining Portion of Voorspoed 772, Remaining Portion of Groenvallei 741	J C M Naudé	1-7-89 to 30-6-90	R12 700 pa
6. Remainder and Subdivision 2 of De Kamp 1294	J C M Naudé	1-7-89 to 30-6-90	R 8 850 pa
7. Diepfontein 1263	K J Kirchner	1-1-90 to 31-12-92	R 9 900 pa
8. Subdivision 2 of Davelsrust 1131	J G Blignaut	1-7-89 to 30-6-90	R 8 450 pa
9. Remaining Portion and Portion of Prins 1738, Welverdiend 1804	Paul Farrell Boerdery	1-7-89 to 30-6-90	R15 450 pa
10. Subdivision 5 and Subdivision 6 of Bramleyshoek 52	A Grobbelaar	1-5-89 to 30-4-91	R12 250 pa
11. Sterkfontein 118, Remaining Portion of Gegund 739, Hawee 1203, Remaining Portion of Groenhoek 1190, Anna's Hope 1257	L M Blignaut	1-7-89 to 30-6-90	R 7 550 pa
12. Onssaam 1741, Waterval 290	C A van Niekerk and L M Blignaut	1-7-89 to 30-6-90	R 6 100 pa
13. Remainder of Welgedacht 189, Welgedacht 1740, Portion 1 of Betsemes 1346, Hoogte van Pisga 1537, Subdivision 1 of Letsewaan 1213, Remainder of Letsewaan 1213, Remainder of Betsemes 1213, Remainder of Betsemes 1346, Subdivision 1 of Bosch-en-Dal, Remaining Portion of Bosch-en-Dal 1217, Bosch-en-Dal 1217, Bosch-en-Dal 1739	C A van Niekerk	1-7-89 to 30-6-90	R 9 650 pa
14. Mooigelegen 115	W D F Viljoen	1-3-89 to 31-8-90	R 1 710 pa

Bloemfontein/Dewetsdorp

1. Remaining Portion of Palmietfontein 67 (326 ha)	C A van der Linde	14-9-89 to 13-9-90	R 3 850 pa
2. Ramalitze 22	G Hendriks	1-9-89 to 31-8-90	R 1 850 pa
3. Portion of Remainder and Portion 2 of Ramahutshe 47 (400 ha), Remainder of Travalgar 2 (662, 2066 ha)	Ds J Mohapi and J Mfokasie	1-11-89 to 31-10-90	R 850 pa
4. Portion of Remainder and Portion 2 of Ramahutshe 47 (375 ha)	N J A Henning	31-8-89 to 30-8-90	R 750 pa
5. Remainder of Travalgar 2	J A van der Linde	14-9-89 to 13-9-90	R 550 pa
6. Melville 768 (100 ha)	STK	1-11-85 continuously	R 150 pa

Nurses: applications not accepted

495. Mr M J ELLIS asked the Minister of National Health and Population Development:

Whether any applications to train as nurses at institutions for the training of (a) White, (b) Coloured, (c) Indian and (d) Black nurses were not accepted in 1989; if so, (i) how many, and (ii) why, in each case?

Hansard 22/6/90 B1149E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a), (b), (c) and (d) Yes.

(i) During 1989, 45 172 persons applied at institutions for training as nurses of which 2 598 reported for training.

(NB Records are not kept according to population groups.)

The number of applications received does not reflect the actual situation as often one person applies to more than one training school. There is no way to verify these numbers.

(ii) Definite guidelines are applied when selecting the candidates. The number of candidates accepted also depends on the availability of funds for posts, clinical facilities, accommodation and other infrastructural restraints.

Many candidates were not suitable for nurse training because of inadequate educational qualifications. During the past two years, the colleges of nursing and universities experienced that selected candidates do not report for training. In some instances 25% of selected candidates did not report for training.

As records are not kept according to population groups, the information cannot be given in the format requested.

Typhoid

497. Mr M J ELLIS asked the Minister of National Health and Population Development:

How many (a) cases of and (b) deaths as a result of typhoid were reported in respect of each race group in each province in 1989?

B1151E

Hansard 22/6/90 (89)

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a) Notified cases of typhoid fever in the Republic of South Africa by population group, 1989 (as on 25 May 1990):

Province	*Population Group*			
	Indian	*Black*	*Coloured*	*White*
Cape	2	52	11	5
Natal	15	408	1	4
Orange Free State	0	29	0	1
Transvaal	2	1 466	3	19

(b) Notified deaths as a result of typhoid fever in the Republic of South Africa by population group, 1989 (as on 25 May 1990).

Province	*Population Group*			
	Indian	*Black*	*Coloured*	*White*
Cape	0	0	0	0
Natal	0	10	0	0
Orange Free State	0	1	0	0
Transvaal	1	17	0	0

Notifications received by the Department of National Health and Population Development.

Vista University

506. Mr E W TRENT asked the Minister of Education:

(1) Whether there are any plans to extend Vista University; if not, why not; if so, (a) when, (b) at what cost and (c) (i) what is the nature of the proposed extensions and (ii) how many additional students will such extensions be able to accommodate;

(2) (a) what is the (i) capacity of and (ii) enrolment at this university and (b) in respect of what date is this information furnished?

B1173E

The MINISTER OF EDUCATION:

(1) Yes. The Vista University is a developing university with eight campuses in metropolitan areas. Academic expansion and growth in student numbers will result in the expansion of the University.

(a) No dates have been fixed for the establishment of further campuses.

(b) The cost of a new campus in the Rand of 1989 is approximately R21 500 000.

(c) (i) The areas presently being investigated for establishing new campuses are Northern Natal, South East Rand and Zuurbekom.

The introduction of Physics and Chemistry is also being considered at campuses with permanent buildings (Soweto and Port Elizabeth (in 1992) and Mamelodi (in 1993)).

(ii) To date campuses have been established for a minimum number of 500 FTE students and new campuses will probably provide for a maximum of I 500 FTE students per campus.

(2) (a) (i) 5 600 (contact tuition)
No limit (teletuition)

(ii) 5 564 (contact tuition)
18 142 (teletuition)

(b) 6 June 1989.

Malaria/typhoid/cholera

511. Mr M J ELLIS asked the Minister of National Health and Population Development:

(1) Whether there was any increase in the incidence of (a) malaria, (b) typhoid and (c) cholera in the Republic in 1989; if so, (i) to what extent, (ii) in which areas and (iii) how many cases of each disease were diagnosed in each area;

(2) whether any persons died of these diseases during this period; if so, how many in each race group in each area in respect of each disease;

(3) whether any steps are being taken to combat the spread of these diseases; if so, what steps in each specified area?

B1201E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) (a), (b) and (c) No.

(2) Yes; notified deaths of malaria in the RSA, 1989. Data are still incomplete.

Health Region	*Population Group*			
	Indian	*Black*	*Coloured*	*White*
Eastern Cape	0	0	0	0
Western Cape	0	0	0	0
Northern Cape	0	0	1	0
Natal	0	0	0	0
Orange Free State	0	0	0	0
Southern Transvaal	0	0	0	3
Northern Transvaal	0	3	1	1
Gazankulu	0	5	0	0
KwaZulu	0	3	0	0
Lebowa	0	3	0	0

Qwaqwa	0	0	0	0
KaNgwane	0	2	0	0
KwaNdebele	0	0	0	0

Notifications received by the Department of National Health and Population Development.

Notified deaths of Typhoid Fever in the RSA, 1989. Data are still incomplete.

Health Region	*Population Group*			
	Indian	*Black*	*Coloured*	*White*
Eastern Cape	0	0	0	0
Western Cape	0	0	0	0
Northern Cape	0	0	0	0
Natal	0	5	0	0
Orange Free State	0	1	0	0
Southern Transvaal	1	2	0	0
Northern Transvaal	0	1	0	0
Gazankulu	0	4	0	0
KwaZulu	0	5	0	0
Lebowa	0	5	0	0
Qwaqwa	0	0	0	0
KaNgwane	0	4	0	0
KwaNdebele	0	1	0	0

Notifications received by the Department of National Health and Population Development.

No deaths due to Cholera were notified to the Department of National Health and Population Development.

(3) *Malaria*:

yes,
- surveillance,
- active case finding,
- vector control,
- education: usage of prophylactic drugs and personal preventive measures,
- treatment of cases,
- notifiable disease;

Typhoid and Cholera:
yes,
- surveillance
- case findings: treatment and isolation of cases to prevent and reduce spreading of the diseases,
- tracing of contacts: to prevent infections and to prevent and reduce the spreading of the diseases,
- health education,
- advice with regard to environmental factors,
- participation in interdepartmental committee providing advice to authorities responsible for the service,
- notifiable diseases.

Cholera

512. Mr M J ELLIS asked the Minister of National Health and Population Development:

How many (a) cases of and (b) deaths from cholera were reported in respect of each race group in each province in 1989?

B1202E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a) Notified cases of cholera in the Republic of South Africa by population group, 1989 (as on 30 May 1990):*

Province	*Population Group*			
	Indian	*Black*	*Coloured*	*White*
Cape	0	0	1	0
Natal	0	2	0	0

Orange Free State	0	0	0	0
Transvaal	0	0	0	0

(b) No deaths due to cholera were notified to the Department of National Health and Population Development during 1989.

* Notifications received by the Department of National Health and Population Development.

Poliomyelitis

513. Mr M J ELLIS asked the Minister of National Health and Population Development:

(1) How many (a) cases of and (b) deaths from poliomyelitis were reported in respect of each race group in each province in 1989;

(2) how many persons of each race group were immunised against poliomyelitis in each province in 1988? B1203E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) (a) Notified cases of poliomeylitis received by the Department of National Health and Population Development in the Republic of South Africa by population group, 1989 (as on 30 May 1990):

Province	*Population Group*			
	Indian	*Black*	*Coloured*	*White*
Cape	0	3	3	0
Natal	0	2	0	0
Orange Free State	0	1	0	0
Transvaal	0	2	0	0

(b) No deaths due to poliomyelitis were notified to the Department of National Health and Population Development during 1989.

(2) Number of children under one year who received at least three doses of poliomyelitis vaccine in the seven health regions of the Republic of South Africa, 1988.

Province	*Population Group*			
	Indian	*Black*	*Coloured*	*White*
Cape	345	43 819	71 168	19 319
Natal	16 029	78 765	2 212	7 240
Orange Free State	55	15 976	472	1 754
Transvaal	3 356	108 474	6 946	40 980

Sentences for murder

522. Mr A J LEON asked the Minister of Justice:

(1) In respect of sentences handed down by the Supreme Court for murder, how many persons were sentenced to (a) a fine without the option of imprisonment, (b) a fine with the option of imprisonment, (c) up to 5 years' imprisonment, (d) 6 to 10 years' imprisonment, (e) 11 to 15 years' imprisonment and (f) other specified punishments in 1985, 1986, 1987, 1988 and 1989, respectively;

(2) what total number of persons was convicted of murder in each of the above years? B1230E

The MINISTER OF JUSTICE:

The required information is not readily available. To obtain it all court records pertaining to the crime concerned will have to be scrutinised which is not economically feasible.

Unrest-related deaths in Cape Town area: inquests

523. Mr P G SOAL asked the Minister of Justice:

Whether any inquests have been held into the deaths of any of the persons who died in the (a) Cape Town, (b) Wynberg, (c) Goodwood, (d) Bellville and (e) Simon's Town magisterial districts as a result of unrest on or about 6 September 1989; if so, in respect of each such person, (i) when and (ii) what were the findings of the inquest; if not, why not? B1253E

The MINISTER OF JUSTICE:

(a) CAPE TOWN
No.
As far as could be established no persons died in this magisterial district as a result of unrest on or about 6 September 1989.

(b) WYNBERG
No.
The persons who caused the death of 9 persons at Khayelitsha on or about 6 September 1989, have been charged. The deaths of 2 persons at Grassy Park and Mitchells Plain on or about 6 September 1989 are still being investigated.

(c) GOODWOOD
No.
The person who caused the death of 1 person at Elsies River on or about 6 September 1989, has been charged. The dockets in connection with the death of 3 persons on or about 6 September 1989 at Bishop Lavis are with the Attorney-General, Cape Town, for a decision.

(d) BELLVILLE
No.
As far as could be established no persons died in this magisterial district as a result of unrest on or about 6 September 1989.

(e) SIMON'S TOWN
No.
As far as could be established no persons died in this magisterial district as a result of unrest on or about 6 September 1989.

SA Development Trust: future of land

524. Mr P G SOAL asked the Minister of Development Aid:

(1) Whether the Government has taken a decision regarding the future of land currently held by the South African Development Trust; if not, (a) why not and (b) when can such a decision be expected; if so, (i) when was this decision taken and (ii) what is the purport of the decision;

(2) whether he will comment on whether certain reports concerning such land which appeared in newspapers on or about 3 May 1990, copies of which have been furnished to the Minister's Department for the purpose of his reply; if so, what is his response to these reports? B1254E

The MINISTER OF DEVELOPMENT AID:

(1) Yes.

(a) and (b) Fall away.

(i) In the court of March 1990.

(ii) The land shall be administered by the South African Development Trust for the benefit of Blacks, which may include the disposal thereof to Blacks. The land shall further only be included in the areas of jurisdiction of independent states and self-governing territories if the inhabitants concerned agree thereto.

(2) The Government announced that the Black Land Act, 1913 (Act 13 of 1913) and the Development Trust and Land Act, 1936 (Act 18 of 1936) are receiving attention with the view to possible revision. These Acts effect *inter alia* the vested interests of a large variety of people and instances. It is therefore an extremely complex matter. No decision has as yet been taken in this regard.

HSRC: investigations for Bureau for Information

525. Dr F H PAUW asked the State President:†

Whether the Bureau for Information requested the Human Sciences Research Council (HSRC) over the past four years to carry out investigations for the Bureau; if so, (a) (i) how many and (ii) what investigations, (b) what was the cost involved, (c) to whom was the information gathered by means of these investigations made known and (d) in respect of what period is this information furnished? B1256E

The STATE PRESIDENT:

(a) Yes.

(i) 25.

(ii) On various matters of current interest to the Government.

(bb) None

(cc) None

(dd) None

(ee) None

(b) It is unfortunately not possible to determine the number of commuters involved in each of the relevant financial years, but the numbers mentioned below are calculated according to the number and type of subsidised bus tickets which were sold at Harrismith and Bethlehem and there are no other commuters involved —

	Harrismith	*Bethlehem*
1980/81	1 514 326	Nil
1981/82	1 724 564	33 630
1982/83	2 151 198	69 952
1983/84	2 117 388	100 194
1984/85	2 912 572	187 538
1985/86	3 289 060	121 436
1986/87	3 839 804	151 024
1987/88	3 969 196	164 358
1988/89	4 571 006	184 272
1989/90	4 180 716	148 824

(c) Qwaqwa Bus Service (Pty) Ltd which traded under the name of Setsokosana Bus Service (Pty) Ltd until the end of 1985/86 financial year.

Lung cancer

539. Mr M J ELLIS asked the Minister of National Health and Population Development:

How many persons in each race group in each province died of lung cancer in 1989?

B1274E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

Number of lung cancer deaths in the Republic of South Africa by Population Group, 1989 (as on 11 June 1990)

Province	*Population Group*			
	Indian	*Black*	*Coloured*	*White*
Cape	2	41	187	98
Natal	20	3	12	54
Orange Free State	0	1	0	0
Transvaal	1	27	0	55
Total	23	72	199	207

Notifications received by the Department of National Health and Population Development.

Marasmus/kwashiorkor: cases

540. Mr M J ELLIS asked the Minister of National Health and Population Development:

How many (a) cases of (i) marasmus and (ii) kwashiorkor were reported, and (b) children were treated in clinics for each of these diseases, in 1989?

B1275E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a) (i) and (ii) Marasmus and kwashiorkor are not notifiable diseases. Accurate incidence figures are thus not available for these two conditions.

(b) During 1989, 3 045 children were treated for marasmus and 7 672 for kwashiorkor through the departmental scheme.

Public Service Staff Code: housing subsidies

545. Mr R M BURROWS asked the Minister for Administration and Economic Co-ordination:

(1) Whether the Commission for Administration recently effected alterations to the Public Service Staff Code relating to the housing subsidy scheme for State employees; if so, (a) what is the purport of the alterations and (b) when will they come into effect;

(2) whether a costing has been done of the effect of these alterations; if so, what are the relevant details?

B1289E

The MINISTER FOR ADMINISTRATION AND ECONOMIC CO-ORDINATION:

(1) Yes.

(a) The purport of the most important changes are as follows:

* The revised allowance scheme does not provide for the continued subsidisation of additional capital redemption.

* In terms of the revised allowance scheme, employees will only be paid an allowance until they reach the age of 65 years whereas no age restriction existed under the previous scheme for the payment of subsidy to employees.

* Under the previous scheme participants were penalised in terms of shortening the period for which they could participate in the scheme as a result of some or other action (eg the net profit realised from the sale of a previously subsidised dwelling was not utilised as payment for a next dwelling). Under the revised scheme, penalisation will be effected by means of decreasing the amount of the monthly allowance payable.

* Participants in the previous scheme were divided into two percentage groups, namely the 3% group and 4% group with the salary notch R29 205 as division point between the two groups. In the case of the 3% group, the interest above 3% up to and including the average building society interest rate was subsidised whilst in the case of the 4% group, the interest above 4% was subsidised. The new allowance scheme will only cater for one percentage group namely a 3% group.

* The previous scheme permitted a person to buy (or own) only two dwellings consecutively while stationed at the same headquarters. Furthermore, he could in respect of the first dwelling for which he received a subsidy, raise his registered mortgage more than once in order to obtain funds for immovable improvements/alterations to such first dwelling. In the revised scheme, no such limitations exist.

* If a person under the previous scheme, in addition to the dwelling which he occupied, owned another —

  (i) paid-off dwelling in respect of which he previously received a housing subsidy, he was excluded from participation in the scheme; or

  (ii) not paid-off dwelling in respect of which he previously received a housing subsidy and if such other dwelling had a smaller mortgage bond than the bond on the dwelling which he occupied, the subsidy payment period (in respect of the house he occupied) was shortened according to a prescribed formula.

In terms of the revised allowance scheme if a person owns another (paid-off or not paid-off) dwelling, he will qualify for participation in the scheme but a reduced monthly allowance is payable in respect of the dwelling he occupies.

* Under the previous scheme a person who sublet his dwelling was penalised in terms of the period for which he qualified for the payment of subsidy. In terms of the revised allowance scheme, no penalisation for subletting takes place.

(b) 1 August 1990.

(2) An accurate costing was not undertaken. Care has however been taken to ensure that the expenditure resulting from the revised allowance scheme does not exceed that of the previous scheme.

Brandvlei area, NW Cape: Radio SA transmissions

552. Mr J VAN ECK asked the Minister of Home Affairs:†

With reference to his reply to Question No 448 on 28 May 1990, (a) how many radio listeners are detrimentally affected by the fact that the English service of Radio SA is not transmitted

Measles: R11m saved

Cape Times 7/7/90 89

A SAVING of more than R11 million in the hospitalisation of children due to complications caused by measles has been attained during the first three months of 1990.

This was achieved by intensified immunisation, Dr Hans Steyn of the Department of National Health and Population said yesterday.

Speaking at a primary health care conference in the city, Dr Steyn said preliminary figures indicated that compared with the first quarter of 1989, 30% more children were immunised against measles in the same period this year.

The intensified campaign against measles was part of the government's determined effort to promote primary health care services in the community.

Dr Steyn said that involvement based on a partnership between the government, the private sector and the community in particular was imperative in order to fulfil this ideal.

Measles is one of South Africa's most important preventable causes of child mortality.

It is also the disease with the most notified deaths after tuberculosis and cancer. Though measles is a notifiable disease in South Africa, a recent survey in the Western Cape revealed that 60% of the general practitioners were unaware of the fact. — Sapa

FEATURE (39) Star 17/1/90

Maximum effort to halt deadly measles

By Marguerite Moody

Measles is regarded by most people as a childhood illness, yet 321 children died in South Africa as a result of the disease last year, according to the Department of National Health and Population Development.

According to the deputy director-general of health planning at the department, Dr Hans Steyn, this was the highest death rate of any disease after tuberculosis and cancer.

The World Health Organisation has estimated that worldwide about 2 million people die from measles annually, meaning a child dies every 15 seconds from a disease that could have been prevented.

Conservative

Dr Steyn said that these may even be very conservative figures, as many deaths resulting from measles were not reported to the authorities.

Nearly 18 000 cases of this contagious disease were reported in South Africa last year.

To combat the disease, the department has launched an extensive programme to immunize children. The programme forms an integral part of the department's primary health care plan this year, in accordance with the WHO's campaign to control the disease.

"It is not an experimental programme, it is directed towards preventing mortality and morbidity," Dr Steyn said.

He said a recent survey in the Western Cape had revealed that 60 percent of general practitioners had not even been aware that measles was a notifiable disease.

"Most people do not realise the illness is very dangerous, and as well as causing death, it can lead to severe complications and permanent disabilities."

Complications varied from bronchitis, pneumonia, infection of the middle ear, and infection of the cornea which could lead to blindness, to meningitis and encephalitis.

Dr Steyn said the main cause of measles was overpopulation, which was "a typical result of rapidly expanding urbanisation and insufficient housing facilities".

"An improvement in socio-economic circumstances, and especially the provision of adequate housing, will play a significant role in the control of measles.

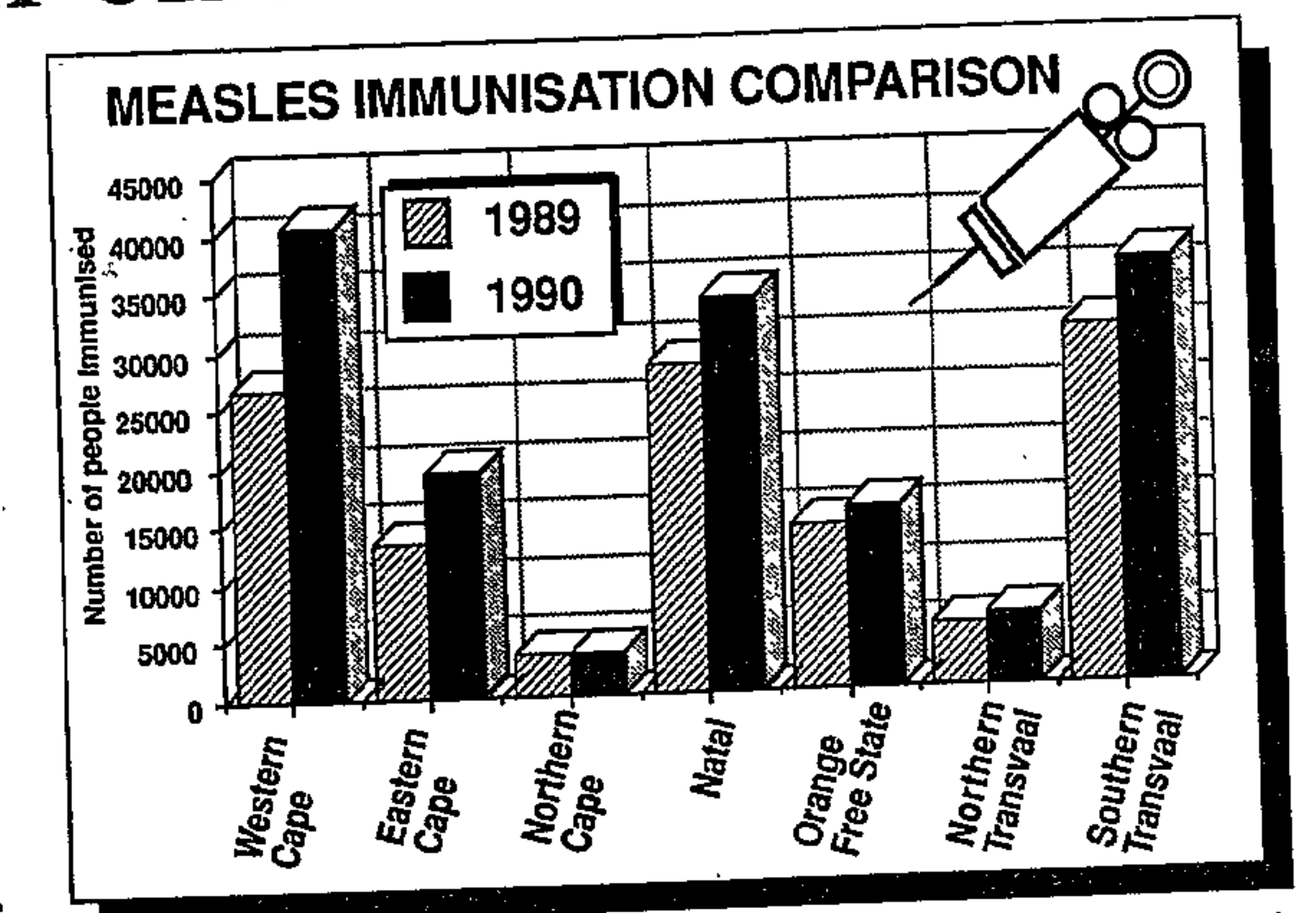
"Nevertheless, the responsibility of controlling the disease depends primarily on immunization."

He said the department's immunization drive, undertaken in co-operation with other health authorities, had already achieved considerable success.

"The intensified campaign has led to more than R11 million being saved in the hospitalisation of children due to complications caused by measles during the first three months of 1990," he said.

Preliminary figures indicated that during this period, about 30 percent more children had already been immunized than in the same period last year.

In the Western Cape, the increase in immunization for the first three months was more than 50 percent, in the Eastern Cape it was 45 percent, in Natal 20 percent and in the Free State it was 10 percent. In the Northern Transvaal nearly 15 percent more children were immunized, while in the Southern Transvaal about 20 percent more children attended immunization clinics.



The immunisation campaign by the Department of National Health and Population Development against measles has already achieved considerable success. This graphic shows the increase, on a regional basis, of the number of people immunised in the first three months of this year, compared with the same period last year.

Community

The cost of the vaccine used in the first three months amounted to about R45 000, each dose costing the authorities only 30 cents.

The vaccine is free to the public.

The acting medical officer of health for Johannesburg, Dr Nicky Padayachee, told The Star that, at a local level, authorities were promoting community involvement in the campaign.

Church groups, women's organisations and social welfare agencies were being contacted to spread information to communities, and the health department's nurses were informing mothers of the 60 vaccination points in the city and the times they were open.

Natal rabies spreads as violence halts vets

Own Correspondent

Township violence in Natal has contributed to an "alarming" increase in the incidence of rabies in the province because vets are not always able to enter strife-torn areas to inoculate pets.

Maritzburg and Durban vets, who made this claim today, have already destroyed more rabid animals in the first six months of this year than in the whole of last year.

When they are given official permission to enter townships it is without Government number plates on their cars and without police escorts.

The State vet for Maritzburg, Dr Max Bachmann, said that violence was a "major complicating factor" in the rabies inoculation programme.

Ten cases of rabid animals from areas south of the city and from areas around Durban and on the coast have been positively identified as rabid this month.

Durban's State vet, Dr Robin Thorogood, has reported 39 cases of rabies this year, compared to 45 cases for whole of last year.

City medics make breakthrough

GM Times 20/7/90

Measles cure in vitamins?

By PETER MALBIN

A NEW study by two Cape Town doctors shows that children with severe measles should be given vitamin A supplements.

The doctors, Dr Max Klein and Dr Gregory Hussey, published a scientific report in the prestigious New England Journal of Medicine yesterday that demonstrates the efficacy of giving vitamin A to children with measles. They are both members of the Department of Paediatrics and Child Health at the University of Cape Town and started their research on measles in early 1987.

In the doctors' study, a group of children infected with measles given large doses of vitamin A had fewer complications and fatalities than a group not given vitamin A.

"Our study shows that vitamin A is a very potent substance," Dr Klein warned. "If you take excessive amounts of vitamin A when you don't need it you can suffer severe side effects and die. It should only be taken when a child is sick with measles.

"The only reason our study is important is because there are huge numbers of children in South Africa and elsewhere in the world who have not yet been immunised."

'Gross underestimate'

"Measles is the most severe infectious disease in childhood, the most infectious disease known to man," Dr Hussey said.

"And in South Africa, every year there are 30 000 reported cases of measles — outside the homelands — and about 300 cases of children dying, which is a gross underestimate," Dr Hussey said.

"More kids die of measles in one year in South Africa than in one decade in the United States. The reason is that in the States they have a comprehensive immunisation programme: Children won't be allowed into pre-school without being immunised."

The uniform immunisation policy in South Africa is for children to be vaccinated at nine months. The World Health Organisation recommends that children in areas of risk be immunised at six months.

"At the section for infectious diseases at a city hospital we see on average over 500 cases a year, and a number of those children develop severe complications and die," Dr Hussey said.

"Obviously the vaccine is not getting to where it should."



MEDICAL BREAKTHROUGH ... Doctors Klein (left) and Hussey, who have published a significant scientific report on the efficacy of giving vitamin A to children with measles. The doctors, both members of the Department of Paediatrics and Child Health at UCT, stressed that vitamin A is a very dangerous supplement when given to healthy children or those with other illnesses.

Picture: GLENN SHERRATT

All you need to know about deadly cancer

CANCER is the second major cause of death in South Africa, affecting one out of every four people.

Recent studies and statistics reveal that malignancy contributes to the morbidity and mortality rates of all population groups.

The incidence of types of cancer varies from different regions and among different population groups, even in the same geographical areas.

Cancer is generally understood as a "typical degenerative condition" that can be found in all age groups. It is regarded as a disorder of cell growth and the result of immune system dysfunction.

Cancers are often classified according to the embryonic tissue they resemble although they arise from normal, differentiated adult cells that have changed from their nature. Cancer begins in a group of cells, or perhaps, even a single cell, that divides, regardless of need.

Descendants

The change is fixed and it persists in the descendants of the affected cells.

It can be said that cancer is a parasite formed from the patient's own tissues and draws on the general supply of nutrients of the body.

The alienated cancerous tissue cells are not subject to cell growth control and reproduce themselves proliferatively until they finally outnumber the healthy and normal cell count of the body.

The following types of cancers have been proved statistically in South Africa:

* Cancer of the respiratory tract occurs more frequently among white and coloured men;

* Breast cancer has the highest incidence among white women;

* Black people, especially those from Transkei and Swaziland, have a higher incidence of cancer of the mouth cavity, paranasal sinuses and oesophagus;

* Black and coloured women have a higher incidence of cervial cancer;

* Cancer of the stomach is most frequently found among the coloureds, followed by whites and Asians;

* Skin cancer is found more often among whites; and

* White men are the most frequently affected by cancer of the prostate gland.

Symposium

A symposium on learning about and understanding cancer has been organised by the Institute for Complementary Health in association with the Training and Communication Forum on August 11.

The seminar, to be held at Eskom Training College, Dale Road, Halfway House, will deal with the causes, treatment, nutrition and prevention of cancer and various other aspects including the understanding of the dying process.

Medical and paramedical professionals, nurses, pharmacists, health care workers, cancer patients and their families and any interested persons are welcome to attend.

"The symposium will enable all delegates to become more familiar with the concept of accepting more responsibility for their own health and that of their families," says the institute.

Booking is essential. Telephone 805-1842 in Johannesburg.

Change in SA is permanent - bishop

SOUTH Africa is moving irreversibly towards democracy and an end to apartheid and minority rule, Archbishop Mzilikazi Masiya, coordinator of Chrisitian Peace and Reconcilliation for Southern Africa, said yesterday.



DE KLERK

He said in a statement that the establishment of the South African Communist Party was a "sure sign" that the reforms of President FW de Klerk were irreversible.

"Sanctions and disinvestment should then also be called off now for the sake of peace, stability and growth in South Africa," he said. - Sapa.

Disease scare at 'Sun City' jail

c/from 5/8/90 (89)

By SOPHIE TEMA

A SECTION of Johannesburg Prison has been placed under quarantine after one inmate had been diagnosed as having meningitis – a highly contagious disease.

The liaison office of the South African Prison Service confirmed that one case of meningitis had been diagnosed at the prison commonly known as "Sun City".

They said the matter was brought to the attention of the district surgeon and measures had been taken to prevent the spread of the disease.

Visits to awaiting-trial prisoners were cancelled from Tuesday.

A medical doctor said meningitis brought on many complications. The disease could lead to an abscess forming in the brain.

He said the patient would have to be monitored and transferred to hospital. The rest of the inmates should be closely watched and the prison authorities would have to make sure steps were taken to protect them.

Prisoners have the right to demand the help of independent doctors.

If steps were not taken to protect the inmates, it could be very dangerous, he said.

This is the second case of meningitis in Johannesburg Prison.

In 1988 hundreds of trials had to be postponed when 796 prisoners in the Medium A section were placed under quarantine after an inmate contracted the disease.

This week, hundreds of people who arrived to visit friends and relatives were turned away from the prison without explanation.

Smuts Mokoena said he went to the prison on three different days to visit his son, only to be kept waiting outside from morning until visiting time was over.

He said no explanation was given to the waiting crowds and most of them were angered by the authorities' refusal to tell them what the problem was.

Lethal skin cancer on increase

THE most lethal form of skin cancer - malignant melanoma - has increased 1 000 percent in 50 years, according to the National Cancer Association.

According to the Cancer Registry, there are 10 000 reported cases of skin cancer in South Africa, making it the most common form of cancer among the white population. Sowetan 13/8/90 (89)

The president of the NCA Prof J D Anderson said figures were growing exponentially because damage done years ago was only now becoming apparent.

Contrary to popular opinion, skin cancer could lead to death.- *Sapa*

Women want return of tests

Sowetan 15/8/90

WOMAN

AMONG the many meetings and marches to mark National Women's Day, one stood out in that it was not a cry for the freeing of women from male bondage but concern for their survival.

About 100 women in Soweto, Dobsonville, Johannesburg and Mamelodi marched to their local clinics and provincial hospitals in protest against the stopping of pap-smear tests in most township clinics and hospitals.

Pap-smear tests help in the early diagnosis of cervical cancer, the most common cancer among black women.

The march was organised by the Advice Centres' Association which, according to women's desk coordinator Yvonne Ngakane, has been campaigning for the reinstatement of the service since it was stopped several years ago.

Ngakane said the issue, along with abortion and sex education, had been dealt with as a priority by the community-based organisation.

They sent a petition to the Department of Population and Health expressing their grievances about the stoppage. The only reply they received was that their complaints were being looked into.

"Stopping pap-smear tests puts a lot of women's lives in danger, especially those who do not have money to pay for them in institutions that offer them for a fee," Ngakane said.

"We hope that with this action the Government will realise our concern for our health and be prompted to take immediate action.

"We feel it is taking them too long to decide on this matter and to come up with constructive solutions."

Funding

Chairman of the southern Transvaal region of the National Cancer Association Dr M Gordon-Grant said the reason the State had terminated the service was lack of funds.

He said some hospitals were now offering the service for about R10. The NCA was also offering it in factories but could not afford to do the tests on everybody.

The South African Association of Obstetrics and Gynaecology had written to the Department of Health on several occasions for the reintroduction of the service but had not received a reply. They wrote two months ago to Minister of Health Dr Rina Venter.

"One out of every four black women die from cervical cancer every year. There are tests that could stop these deaths but they are not available to people who need them," Gordon-Grant said.

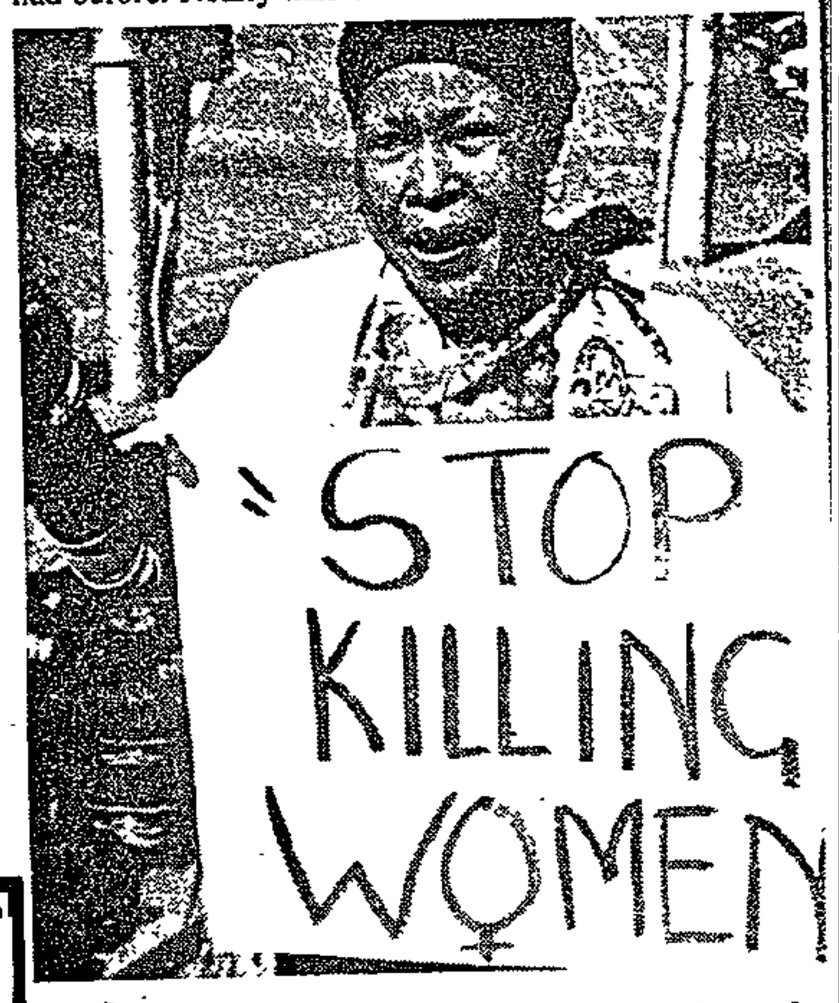
He said the cancer, also prevalent among coloured and other women in the lower socio-economic group, could be detected and eradicated if early diagnosis was made of the abnormal cells that caused it.

"Any woman who is sexually involved is at risk. The disease is transmitted sexually and infects the cervix. It spreads into the bladder, the bowel and to the bones and kills the sufferer once it reaches this stage.

"Last year our hospital detected 553 new cases of the cancer, which was more than we have had before. Nearly half of the cases were advanced," he said.

The cancer is symptomless at an early stage when the cure rate is 100 percent.

Intramenstrual bleeding, contact bleeding, foul smelling watery discharge, dysuria and pain are some of the symptoms.



Yvonne Ngakane is campaigning for the reintroduction of pap-smear tests for women.

Skin cancer sufferers in SA number 9 420

B (Day 10/8/90 (89)

TANIA LEVY

MORE THAN 9 000 people in SA have skin cancer, the most prevalent form of the disease in the country.

The latest Cancer Registry shows that the 9 420 reported skin cancer cases outstrip the 1 087 reported lung cancer sufferers and 764 people with cancer of the colon.

National Cancer Association (NCA) president John Anderson said tens of thousands more skin cancer sufferers could be expected in future if the public was not alerted to the dangers of sun exposure.

Because of SA's close proximity to the equator, the sun shone overhead for many months of the year and ultraviolet radiation was intense, he said.

Many South Africans were unaware or ignored this risk, even though skin cancer had reached epidemic proportions worldwide. Since 1930 the lifetime risk of developing skin cancer had increased ninefold and malignant melanoma, the most dangerous form of skin cancer which could spread to the rest of the body, had increased 1 000%.

There were 602 cases of malignant melanoma in SA and the total incidence of skin cancer was increasing by 5% a year, he said. Figures increased exponentially as sun damage from years ago became apparent.

There were an annual 600 000 skin cancer cases in the US, including 27 600 melanoma patients expected this year.

The US Environmental Protection Agency predicts that a 1% drop in the thickness of the ozone layer would lead to an extra 20 000 cases in the US alone.

Contrary to popular belief, skin cancer could be fatal and about 8 800 deaths from the disease were predicted in the US for 1990, said Anderson.

A sunscreen was essential but users had to be careful that manufacturers' claims of products' sun protection factor (SPF) were not misleading, he said.

There were no regulations requiring substantiation of claimed SPF's and a survey had shown that while 90% of products claimed an SPF, only 56% were tested.

Cholera [illegible] (89)
Argus 13/9/90

JOHANNESBURG. — More than 1 100 cases of cholera have been reported in four provinces of Mozambique since June. At least 59 people have died since the outbreak. — Sapa.

Shock health conditions in Far North

Sowetan 1/10/90

89

NINETEEN percent of all Mozambican refugees who cross into South Africa have malaria, the regional head of the Department of National Health and Population Development in the Northern Transvaal announced last week.

Speaking at a Press conference in Pietersburg, Dr NG Crisp said 20 people had died of the disease in the Lowveld and other areas of the Northern Transvaal.

Last year 894 cases of malaria infection were detected among Mozambican refugees who came into the country during 1989.

A total of 673 South Africans were also found to be infected by malaria during the same period, he said.

Crisp said a regional measles vaccination campaign carried out in May this year had revealed that more than half a million children had never been vaccinated against the disease.

Of these, the campaign had reached more than 430 000 children in Lebowa, Gazankulu and areas served by the South African authority.

The success of the programme was also attributable to the high media co-operation in publicising the activities. he said.

By MATHATHA TSEDU

He said a survey done by his department in the region on 20 162 rural dwellings had revealed that 57 percent had no toilets, while nine percent had "an unacceptable quality of water".

About 19,5 percent did not have "ready access to water within a reasonable distance", while 13,5 percent of those polled were over crowded with 6,6 percent living in shanty accommodation.

He said an inspection of all black farm schools in the area of jurisdiction had shown that in one area 32 percent of all schools "had no access to water at all", while 50 percent in another area had "grossly inadequate sanitation facilities".

Succeed

"In order to succeed in promoting a health environment and lifestyle, with the ultimate aim of health inhabitants, it is essential that this basic needs be addressed", Crisp said.

Crisp said the region had to deal with nine first tier goverments and 36 local authorities.

These included fully fledged bantustan government such as Lebowa, Gazankulu, KaNgwane and KwaNdebele.

The proliferation of these government and SA authorities sometimes caused friction, he said.

He announced that the focus for the 1991 year will be a campaign to highlight nutrition, growth monitoring and prevention of diarrheal disease.

This will take the form of guidance on breast-feeding and procedure for weaning babies.

An Aids seminar was been planned in conjunction with the Aids counselling centre in Pietersburg to coincide with the international Aids Day on December 1, Crisp added.

Heart ailments linked to high blood pressure

(89)

80 welton 8/11/90

By PEARL MAJOLA

THERE is a relationship between diabetes, hypertension (high blood pressure) and coronary heart disease, three dangerous ailments which are becoming increasingly common among South Africans.

Medical experts speaking at the 30th Annivesary of the Pretoria Medical Discussion Group held in Johannesburg at the weekend, agreed that wrong diet, excess weight and smoking were among the primary causes of these diseases.

Professor HC Seftel of the University of Witwatersrand, spoke on the Management of Diabetes in General (medical) Practice.

Focusing on non-insulin dependent diabetes (NIDD), he said the disease was not simply a sugar disorder.

"It is a complex, multi-faceted disorder characterised not only by excess sugar in the blood (hyperglycaemia), but also by obesity, too much insulin (hyperinsulineamia) which causes low blood sugar level, hypertension, cardiovascular disease and other complications," he said.

"The major challenge facing the therapist of this type of diabetes is to prevent or reduce the incidence of coronary heart disease."

The correct diet would be the easiest treatment for diabetes as well as heart disease, where it developed from diabetes and high blood pressure.

Township sewage flows into spruit leading to Vaal

Star
3/12/90

By Therese Anders
Highveld Bureau

BETHAL — Raw sewage from Emzinoni township, where doctors report an outbreak of dysentery, is flowing directly into a spruit which eventually leads into the Vaal Dam.

Emzinoni administrator Neels Malan said he was "very much perturbed" about the growing health hazard.

The crisis comes three months after the Government stopped bridging finance to townships involved in rent and service boycotts.

Sewage from Emzinoni (population 40 000) began seeping into the nearby Blesbokspruit two weeks ago when Bethal's Conservative Party town council cut water and electricity to the township for failure to pay bulk service arrears.

After 10 days without water, two Bethal doctors reported an outbreak of dysentery and gastro-enteritis among township residents. They pleaded with the Bethal council to restore the water supply before a major outbreak of diseases such as typhoid and cholera swept the township and other communities.

"If dysentery gets into the river you'll never stop it because people are using that water for their personal needs all the way downstream to the Vaal, and beyond," one doctor warned.

Four days ago the water service was reconnected after a private donation of R15 000. This will pay for a supply until Wednesday.

Mr Malan said there was no chance of reconnecting the township's electricity in the near future and that without power, sewage could not be pumped up to the treatment station. This meant all the township's sewage was flowing out of manholes near residential areas and into the Blesbokspruit.

Mr Malan asked local industries to consider lending Emzinoni two large generators "to avert a worsening health crisis".

The newly appointed administrator disclosed that Emzinoni was technically bankrupt.

"The township has debts of R2,2 million, of which R500 000 is owed to the Bethal council."

HEALTH AND DISEASE - MISCELLANOUES diseases

1991

(2) yes, (a) the only formal request for notifiability has come from the community health group of the Medical Association of South Africa and (b) this group is of the opinion that AIDS should be made notifiable.

†Dr W J SNYMAN: Mr Speaker, arising out of the hon the Minister's reply, I wish to ask him whether the Government, owing to the seriousness of this threat, intends making a negative HIV-test a prerequisite for any immigrant or person who applies for permanent citizenship.

†The MINISTER: Mr Speaker, once again I do not want to venture into my colleague's field who, owing to circumstances relating to Parliament, has not been able to attend.

†Mr J H VAN DER MERWE: You do not know!

†The MINISTER: I do not know and therefore I request that this matter again be placed on the Question Paper so that the hon members can be furnished with a reply.

SADF: alternative service

*3. Mr L FUCHS asked the Minister of Defence:

Whether some form of alternative service (a) exists and/or (b) is envisaged for persons refusing to serve in the South African Defence Force; if so, what is the nature of such alternative service? B147E

The DEPUTY MINISTER OF DEFENCE:

(a) Yes. A member can do community service after having been classified as a Religious Objector by the Board for Religious Objection.

(b) No other form of alternative service is envisaged.

†Mr J H VAN DER MERWE: Mr Speaker, arising from the hon the Deputy Minister's reply, I would like to know whether any legislation is envisaged to amend the existing legislation regarding the evasion of national service.

†The DEPUTY MINISTER: Mr Speaker, the reply to that is an unequivocal no.

†Mr J H VAN DER MERWE: That is a good reply.

†Dr W J SNYMAN: Mr Speaker, further arising from the hon the Deputy Minister's reply, may we ask him whether the Government will leave the national service system unchanged in the future?

†The DEPUTY MINISTER: Mr Speaker, several statements in this connection have recently and in the past week been made by the hon the Minister, and the reply to that is again no.

Mr R V CARLISLE: Mr Speaker, further arising out of the hon the Deputy Minister's reply, does he not accept that there will be inevitable changes with the scrapping of the Population Registration Act? Secondly, does he intend to deracialise compulsory military service?

†The DEPUTY MINISTER: Mr Speaker, I want to say to the hon member that national service, as it presently exists for the specific race group, is of course irreconcilable with a new constitutional dispensation, and it is the Government's full intention that the national service system will remain as it is at present, because in this transitional period, in this period in which we will discuss and negotiate the formation of a new South Africa, we will also address these matters and all matters resulting from the scrapping of the Population Registration Act will naturally also be addressed when the time comes.

Business interrupted in accordance with Rule 180C (3) of the Standing Rules of Parliament.

Trade unions: legislation

*4. Mr L FUCHS asked the Minister of Manpower:

(1) Whether it is envisaged to introduce legislation to make trade unions, vicariously liable for the acts of their members; if not, why not; if so, when;

(2) whether it is envisaged that the rules of the Industrial Court will be amended so as to allow costs orders to be given in certain circumstances; if not, why not; if so, when? B148E

The MINISTER OF MANPOWER:

(1) The Labour Relations Act, 1956, as part of the consolidation process, is at present being investigated in its entirety which

specifically includes trade unions, employers' organisations, strikes and lockouts. Future amendments to the Act will be considered on the grounds of the investigation and recommendations.

(2) The Labour Relations Act, 1956, at present provides in section 17(12)(a) for the granting of costs orders according to "the requirements of the law and fairness" in the case of urgent interim applications for legal aid as well as in the case of section 46(9) determinations. The Act also provides in section 43(4)(c) for the granting of a costs order in the case of a section 43 (status quo) application, but it may only be granted by the Court "on the ground of unreasonableness or frivolity on the part of a party". In terms of section 17(22)(c)(vi) of the Act the Rules Board may make rules "as to the taxation of bills of costs" only.

Withholding tax on interest

*5. Mr J J WALSH asked the Minister of Finance:

(1) Whether he is considering the introduction of a withholding tax on interest; if so, (a) how will such a tax be applied and (b) when is it to be introduced;

(2) whether he will make a statement on the matter? B161E

The MINISTER OF FINANCE:

(1) (a) and (b)

As mentioned in the Budget Review of last year, the real return on interest-bearing investments is very low or even negative, and the existing taxation of interest discourages saving. It was considered that a withholding tax, imposed on interest received by individuals, would have made a positive contribution to the encouragement of savings, but that the implementation of such a system could only be accomplished after several obstacles had been investigated and eliminated. It was envisaged that the tax would be a final tax, at a low rate, deductible at source and payable to Inland Revenue.

(2) As mentioned during the introduction, on 19 February, of the Part Appropriation Bill, 1991, the Committee regarding the Advancement of Equal Competition for Funds in Financial Markets (the Jacobs Committee) gave serious consideration to this matter. Their investigation brought to light numerous problem areas, of which the most crucial is the reclassification of other income and the practice of so-called arbitrage, for which solutions have not yet been found. It has, therefore, been decided not to proceed with the implementation of such a tax at this stage.

Leprosy

*6. Dr F H PAUW asked the Minister of National Health:†

(1) What is the latest information on the incidence of the various forms of leprosy among the population groups in the Republic;

(2) whether her Department regards leprosy as a highly contagious or deadly disease;

(3) (a) what is her Department's standpoint on the (i) notifiability and (ii) isolation of cases of this disease and (b) what is the motivation for the removal of lepers from their social environment? B172E

The MINISTER OF NATIONAL HEALTH:

(1) Notified cases of leprosy in the Republic of South Africa by population group, 1990 (as on 11 February 1991) are as follows:

Asian	0
Black	31
Coloured	1
White	0

No information regarding the various *forms* of leprosy is available;

(2) no;

(3) (a) (i) leprosy is a notifiable disease and

(ii) patients are not isolated and

(b) leprosy patients' are referred to Westfort Hospital in Pretoria for confirmation of the diagnosis and stabilising of the treatment. As a rule patients are then referred back to their place of origin for continuation

and follow up of their treatment. The policy is thus not to take patients out of their social environment for long periods. Over the past year the average stay of leprosy patients at Westfort Hospital was 66 days.

Robertson: SAP action

*7. Mr J VAN ECK asked the Minister of Law and Order:†

Whether, with reference to an incident at Robertson on 11 April 1990 (in which, allegedly, more than 140 people were injured during police action), the South African Police (a) has instituted a second investigation into the incident and/or (b) is still conducting such an investigation at present; if so, (i) why was it decided to institute the present investigation, (ii) who is in charge of the investigation and (iii) what progress has been made to date? B178E

The MINISTER OF LAW AND ORDER:

(a) Yes.

(b) Yes.

(i) After the docket, which was investigated as a result of the occurrence at Robertson on 11 April 1990, was referred to the Attorney-General, and he had refused to institute any prosecution, the Commissioner of the South African Police instructed that the evidence in the docket be analysed and further investigation instituted into matters arising therefrom, also with a view to possible departmental steps, so that the unfortunate incident that occurred could be settled to the satisfaction of all the parties.

The honourable member was also requested to render any such assistance that he could give in the further investigation. All indications are that the matter will be settled to the satisfaction of all the parties.

(ii) Major-General R N van der Westhuizen.

(iii) The investigation has already been completed. Only medical reports are still outstanding. The docket will soon be resubmitted to the Attorney-General.

Police training colleges

*8. Mr K M ANDREW asked the Minister of Law and Order:

(1) Whether all police training colleges train recruits of all race groups; if so, since when; if not, (a) why not and (b) for which race groups does each such college cater;

(2) whether any changes are being considered in this regard; if so, what changes? B185E

The MINISTER OF LAW AND ORDER:

(1) and (2)

The Police Colleges in Pretoria, Hammanskraal, Wentworth (now Chatsworth) as well as Bishop Lavis, have, as a result of tradition, but also for practical considerations such as religious practices, food preferences and customs, language preferences and location, until now trained only students belonging to the same population groups respectively.

Advanced training at the College for Advanced Training in Paarl; internal protection courses at Maleoskop and Verdrag; training for dog handlers at the South African Police Dog School in Pretoria and Appingendam; management development training at Silverton and courses offered by the South African Police Mechanical Training Centre in Benoni, have already been integrated.

The reason why this is being done here is because:

courses are presented for older members, who are more proficient in the official languages;

members are accommodated for shorter periods of time and the sacrifices with regard to food, etc, are therefore not as disruptive; as during basic training.

A thorough and urgent investigation is at present being carried out in order to determine how students will, in respect of their basic training, in future be grouped and a statement in this regard will be made shortly.

Commercial concerns: concessions

*9. Mr R M BURROWS asked the Minister for Regional Development:

(1) Whether any concessions have been paid to commercial concerns in respect of industries located in terms of the regional industrial development programme; if so, (a) what amount was paid in total in respect of the 1989-90 financial year and (b) what amount is expected to be incurred in respect of the 1990-91 financial year;

(2) whether he will make a statement on the matter? B207E

The MINISTER FOR REGIONAL DEVELOPMENT:

(a) No commercial concerns receive concessions under the Regional Industrial Development Programme (RIDP). Only secondary industries qualify for concessions. An amount of R780 249 000 was paid to approved regional industries under the RIDP in the 1989/90 financial year. An amount of R916 506 000 is budgeted for the 1990/91 financial year.

(b) None.

Aids programme: funds

*10. Mr M J ELLIS asked the Minister of National Health:

(1) Whether her Department allocated any funds to an Aids programme recently; if so, (a) what total sum of money was allocated during the latest specified period of 12 months for which information is available and (b) what were the main areas of expenditure in this programme;

(2) whether the money initially allocated to this programme was sufficient; if not,

(3) whether additional money was allocated for this purpose; if so, from what source? B212E

The MINISTER OF NATIONAL HEALTH:

(1) (a) The Department of National Health and Population Development allocates funds to AIDS prevention through a number of different channels. This is a reflection of the polycentric nature of the HIV (Human Immunodeficiency Virus) pandemic. It is not possible to determine the exact funds that have been spent on the combating of AIDS, because the combating of AIDS, a multidisciplanary responsibility is also narrowly entwined in the total Primary Health Care Programme and

(b) the Department has a specific AIDS unit based in Pretoria which has been involved in setting up and supporting the AIDS Training and Information Centres (ATICS), of which there are now ten in the country. The AIDS unit has been responsible for updating the National AIDS strategy and for promoting and developing educational interventions for young persons. The sum allocated for this unit for 1990/1991 was R5,4 million. The allocation for 1991/1992 has not been made public yet.

For nearly 6 years the administration has encouraged the screening for HIV antibodies of all donated blood. This small, but important part of HIV prevention costs about R10 million a year;

(2) in no country are there sufficient funds for all aspects of HIV prevention and this country is no exception. The Department of National Health and Population Development will continue to try and use such resources as we have in an efficient way and look for ways of mobilising further resources to meet the ongoing challenge of AIDS prevention,

(3) yes, additional funds for 1991/1992 have been diverted from the new allocation to the Primary Health Care budget.

AK 47 rifles

*11. Mr A J LEON asked the Minister of Law and Order:

(a) How many AK 47 rifles have been (i) seized in the course of police action and (ii) voluntarily surrendered to the South African Police for reward since 1 January 1991 and (b) in respect of what date is this information furnished? B215E

The MINISTER OF LAW AND ORDER:

(a) (i) 106.

Johannesburg Hospital	R189 164 900
Coronation Hospital	R49 474 500
Grey's Hospital	R39 005 000

Medical waste: disposal

86. Mr M J ELLIS asked the Minister of National Health:

Whether any changes were introduced in the 1990-91 financial year by hospitals falling under the control of the provincial administrations in the system used to dispose of medical waste; if not, why not; if so, what are the relevant details? B211E

The MINISTER OF NATIONAL HEALTH:

Although the disposal of hospital waste (medical and clinical waste) is considered to be reasonably satisfactory, all provincial administrations undertook investigations to identify portential problems during the past year. These resulted *inter alia*, in the introductin of more uniform methods of disposal, increased use of standardised containers, renovation of incinerators and contracting professional firms for waste removal and disposal. However, most improvements planned are subject to the availability of funds.

Johannesburg North: service applications

106. Mr P G SOAL asked the Minister of Mineral and Energy Affairs and Public Enterprises:

Whether any applications for (a) telephone services and (b) private post boxes were outstanding in the Johannesburg North constituency as at the latest specified date for which figures are available; if so, (i) how many in each suburb falling within this constituency and (ii) when is it anticipated that the backlog will be eliminated? B291E

The MINISTER OF MINERAL AND ENERGY AFFAIRS AND PUBLIC ENTERPRISES:

(a) Yes, 512 as at 28 February 1991;

(i) and (ii) In addition to applications that are met on demand on a continuous basis where telephone numbers and cable leads are available, service will be provided as follows to waiting applicants in the areas indicated:

Exchange area	*Number of waiting applicants*	*When services are to be provided*
Bramley (includes the suburbs of Eltonhill, Winston Ridge, Kentview and Birnam)	77	Within the next three months as cable works are completed.
Rosebank (includes the suburbs of Fairway, Illovo, Melrose, Melrose North, Melrose Estate, Birdhaven, Dunkeld West, Parktown North, Parkhurst and Craighall Park)	209	Within the next five months as cable works are completed
Randburg (includes the suburbs of Craighall and Blairgowrie)	178	Within the next five months as cable works are completed.
Linden (includes the suburbs of Victory Park, Pierneef Park, Pine Park, Blairgowrie and Beaconsfield Estate)	48	Within the next five months as cable works are completed.

(b) Yes;

(i) 76 as at 25 February 1991 (Birnam Park 28 and Parkhurst 48).

(ii) The installation of additional private post office boxes at Birnam Park and Parkhurst is not possible because of the structure of the buildings. The waiting applicants at these centres can only be accommodated as and when existing boxes become vacant. Specific dates for the elimination of the backlog cannot, therefore, be furnished. It should be mentioned

that vacant private post boxes exist at Saxonwold (28), Northlands (54), Bramley (449), Parklands (300) and Pinegowrie (975). The number of vacant post boxes at Northlands has increased since last year because some renters were allocated post boxes at the more conveniently situated Pinegowrie Post Office. By arranging that a number of renters at Craighall be provided with private boxes at more conveniently located offices, it was possible to provide all waiting applicants at that office with private boxes.

Immunisation programmes

123. Mr M J ELLIS asked the Minister of National Health:

(1) (a) What sum of money was allocated to immunisation programmes in the 1990-91 financial year and (b) what immunisation programmes were undertaken;

(2) whether these programmes could be implemented fully out of the sum so allocated; if not,

(3) whether additional funds were allocated for this purpose; if so, from what source? B213E

The MINISTER OF NATIONAL HEALTH:

(1) (a) R4 150 500 and

(b) expanded immunisation programme against tuberculosis, poliomyelitis, diphtheria, pertussis, tetanus and measles,
immunisation of contacts of rabies and
immunisation against yellow fever for international travel purposes;

(2) yes;

(3) falls away.

Tuberculosis

129. Mr M J ELLIS asked the Minister of National Health:

In respect of each race group in each province in 1990, (a) how many cases of tuberculosis were (i) reported and (ii) hospitalised and (b) how many tuberculosis patients died? B361E

The MINISTER OF NATIONAL HEALTH:

(a) (i) Notified tuberculosis cases in the Republic of South Africa by Population Group and Province, 1990. (As on 27 February 1991. Notifications for 1990 are still incomplete.)

POPULATION GROUP

Province	*Indian*	*Black*	*Coloured*	*White*
Cape	32	13 587	16 960	411
Natal	453	9 247	196	75
OFS	1	9 481	633	130
Transvaal	52	13 462	487	228

(ii) Admission in a hospital with tuberculosis

POPULATION GROUP

Province	*Indian*	*Black*	*Coloured*	*White*
Cape	0	2 430	2 724	2
Natal	183	9 273	97	15
OFS	0	3 031	75	0
Transvaal	13	1 922	142	62

(b) Notified tuberculosis deaths in the Republic of South Africa by Population Group and Province, 1990. (As on 27 February 1991. Notifications for 1990 are still incomplete.)

POPULATION GROUP

Province	*Indian*	*Black*	*Coloured*	*White*
Cape	0	571	485	12
Natal	4	46	1	0
OFS	0	110	10	3
Transvaal	1	492	12	7

Own Affairs:

Sea Point: rent-controlled premises

11. Mr C W EGLIN asked the Minister of Welfare, Housing and Works:

(1) How many rent-controlled premises were there in the Sea Point constituency as at 31 December 1990;

(2) (a) how many such premises were decontrolled in 1990 and (b) what is the (i) address and (ii) description of each of the properties concerned? B154E

HEALTH

Nearly Autumn, time to consider flu vaccination

89

Star 29/3/91

Difficulties still exist in finding an effective means of treating and curing influenza.

This is because of its viral origin and the fact that antibiotics remain ineffective in combating viruses.

Some anti-viral products do protect against influenza, but research has shown that these only have a temporary action and often require a twice-daily dosage during several weeks of treatment.

It is widely accepted, therefore, that vaccination is still the only route to take against influenza.

But just how effective is this and who — that is, what types of patient — should be vaccinated?

Acording to data released by the Institut Merieux in Lyons, France, the influenza treatment problem would be simplified if there were only one stable agent causing influenza. Unfortunately, this is not the case.

When the first viral culture on an embryonated egg was effected 55 years ago, two key facts were established:

- Influenza may be caused by several viruses.
- These viruses could change with time, thus acquiring new antigenic determinants.

Owing to its effective antigenic power, the influenza virus confers good protection against the agent responsible.

But given that the virus has changed in the interim, the immunity acquired against the previous virus is no longer effective against the new variant and infection may occur.

Although the influenza virus is prevalent throughout South Africa for most of the year, the winter months are still generally accepted as "influenza season" — and autumn is not far off!

The French institute researchers stress that it is necessary on every occasion to prepare a vaccine which is adapted to recent epidemiological experiences.

This assumes that the antigenic structure of the mutant is known and an international network is in place to supply the formula of the next vaccine in good time.

Who should be vaccinated?

Influenza vaccine should be administered first and foremost to "at-risk" subjects in whom complications may be feared during the course of influenza. These are:

- **Subjects with a pre-existing disease,** particularly of a bronchopulmonary nature (chronic bronchitis, asthma, emphysema, etc) or of a metabolic nature (diabetes).

Certain cardiac patients also fall into this category, provided that the cardiopathy is not decompensated.

- **The elderly.**
- **In children, those who are debilitated by a long illness.**

Children with cardiopathies, respiratory deficiencies, muscoviscidosis and metabolic disorders can and should be vaccinated. This very well-tolerated vaccine scarcely influences the weight curve.

- **Those living in communities.**
- **Pregnant women,** because of the pulmonary risks and the risks of miscarriage which can be caused by influenza when it takes a serious turn.

It must be remembered that as this vaccine is composed of inactivated viruses, it is not contraindicated in pregnant women.

However, in order to forestall any psychological anxiety concerning the hypothetical risks to the embryo, it is recommended to administer this vaccination in the second half of the pregnancy.

- **Those having recently undergone surgery,** transplant patients, and people undergoing haemodialysis.
- In healthy subjects, vaccination of **people in very close contact with the public,** such as those working in a hospital environment could be envisaged (doctors, nurses, paramedical staff), or those particularly exposed to contagion (teachers), administrative workers (those in contact with a large number of the general public), etc.

When should the vaccination be done?

Vaccination is highly recommended at the beginning of autumn, thus allowing immunity to be well established before the start of the winter season.

The fact that obtaining this immunity requires around two weeks to build up should not be overlooked.

From "Medicine Today", Vol 1, No 9 (February 1991.

TOMORROW – The job interview. Tips on how to make a good impression.

Professor warns on measles

Sowetan 22/3/90

89

By MOKGADI PELA

MEASLES is among the most preventable causes of child mortality in the country, a leading virologist has said.

Professor Barry Schoub, head of the department of virology at the University of the Witwatersrand, said there were 17 890 measles diagnoses and 321 resulting deaths in 1989.

He said measles was, together with tuberculosis and cancer, among the most fatal diseases in South Africa.

Many people were disabled because most did not realise that measles was dangerous.

"Measles causes death, severe complications and permanent disabilities. It varies from bronchitis, pneumonia, infection of the middle ear, infection of the cornea which may lead to blindness, to meningitis and encephalitis," Schoub said.

Contagious

"Measles is also highly contagious. It can take the form of high fever, which is followed by a reddish spotty rash. In the case of the ebony-skinned, the rash is not easily noticeable," he said.

The rash normally appears on the stomach or groin and under arms.

According to the World Health Organisation, about two million people die annually from measles. Thus a child dies every 15 seconds.

However, measles can be effectively prevented by immunisation. Since the beginning of 1990, the Department of National Health and Population Development said it immunised 30 percent more children than in 1989.

Schoub added that the main cause of measles was overpopulation.

He suggested that an improvement of socio-economic circumstances would play a significant role in controlling the disease.

The silent killers: Fear, ignorance and superstition

By PHILIPPA GARSON

A TIRED woman walks into the Hillbrow Hospital's breast clinic and patiently takes her place in the queue. Her face is drawn, she has travelled miles and she is ill — very ill.

She has a lump in her breast so big that a mastectomy is surgically impossible. And the cancer has spread to other parts of her body.

She discovered the lump in her breast a long time ago but thought it came from keeping coins in her bra. She visited a sangoma who gave her a poultice. By the time she visited the clinic the cancer had spread dangerously.

Research shows this to be a typical case study among black women living in rural areas.

Breast cancer has become a killer because of a lack of knowledge about the essentially curable disease.

Medical practitioners say most black women with breast cancer wait until the disease is advanced before they seek medical help, do not return for follow-up treatment and are thus less likely to be cured.

Dr Lesley Seymour, based at the breast clinics at Hillbrow and Johannesburg hospitals, sees a marked difference between the patients at the two hospitals. "At Johannesburg (with mainly white and Asian patients) it is unusual to find women who have not had mastectomies. At Hillbrow, the disease has spread to the extent that it is too late for surgery."

Most of the Hillbrow patients arrive with cancer that has reached stage three (the lesion in the breast is over 5cm) or stage four (the cancer has spread to other parts of the body).

"Sometimes they have enormous tumours in the breast which are difficult to treat as they have grown into the chest wall, even through into the lung."

Seymour describes this condition as a "surgical nightmare".

Seventy percent of breast cancer sufferers at Hillbrow Hospital do not return for follow-up treatment due to socio-economic conditions. People from outlying areas are too poor to pay for transport and would rather not come for treatment than risk losing their jobs. Others think they are cured after a couple of treatments.

Sister Joyce Lehoka started the breast cancer clinic at GaRankua Hospital eight years ago and says only 10 percent of their patients come while the disease is at an early stage. The hospital services mainly rural areas.

Two years ago Lehoka researched the prevailing attitudes of 100 breast cancer patients.

Almost half of them thought the lump in their breast was an abscess which "would open up, release puss and heal". Roughly 35 percent were "unalarmed", taking no immediate action. The rest saw the lump as either caused by their baby burping on the breast during feeding, keeping coins inside their bra, or a witch's curse.

One woman, who had fought with her in-laws, believed they had sent the lump to her breast. She paid a diviner to remove the lump.

Ninety of the 100 patients first consulted traditional healers, churches or the clinics when the cancer was at an advanced stage. The clinics were often slow to refer patients to hospitals with cancer-treating facilities.

Many women believed their "abscesses" had to be "doctored" by traditional healers or home-made potions which would "spit out" the pain and poison.

They are loath to have mastectomies, fearing the ancestors will not accept them if they are buried without parts of their bodies or that the removal of the left breast will affect their hearts, says Lehoka. And Venda women often bare their breasts in the hot climate and during traditional dancing.

(c) Indian
(i) 5 (ii) 5
(d) Black
(i) 179 (ii) 179

(bb) LEGAL TRAINING
(a) White
(i) 195 (ii) 175
(b) Coloured
(i) 5 (ii) 3
(c) Indian
(i) 3 (ii) 3
(d) Black
(i) 6 (ii) 5

Sterkfontein Psychiatric Hospital: patients missing

239. Mr P G SOAL asked the Minister of National Health:

(1) Whether any patients went missing from the Sterkfontein Psychiatric Hospital during the latest specified period of five years for which information is available; if so, (a) how many (i) male and (ii) female patients and (b) how many such patients were classified as (i) dangerous and (ii) aggressive;

(2) whether any steps have been taken to ensure that patients do not go missing from the said hospital; if not, why not; if so, what steps;

(3) whether she will make a statement on the matter?

B624E

The MINISTER OF NATIONAL HEALTH:

(1) (a) Yes,

(i) 443 male and

(ii) 70 female

The above include patients who have escaped, broken out, absconded and ones that were allowed to go out on leave, but did not return and

(b) (i) and (ii) the relevant information is not readily available;

(2) yes, dangerous patients are locked up. All others are attended to in open wards and may move about freely. The hospital has no guards patrolling the grounds; neither does it have security fencing or gates. The reason for this is that hospitals must not be looked upon as prisons;

(3) no.

Academic hospitals: bed occupancy rate

251. Mr M J ELLIS asked the Minister of National Health:

What is the annual bed percentage occupancy rate at each academic hospital in South Afria?

B658E

The MINISTER OF NATIONAL HEALTH:

Provincial Administration of the Cape of Good Hope:	*Percentage Bed Occupancy*
Groote Schuur	95,21
Tygerberg	107,93
Provincial Administration of Natal:	
King Edward VIII	91,20
Provinial Administration of the Transvaal:	
Baragwanath	86,40
Coronation	83,50
Ga-Rankuwa	86,40
HF Verwoerd	63,80
Hillbrow	80,10
JG Strijdom	31,70
Johannesburg	80,80
Kalafong	76,00
Provincial Administration of the Orange Free State:	
Pelonomi	91,57
Universitas	65,89
National	60,14

Malaria/typhoid/cholera

255. Mr M J ELLIS asked the Minister of National Health:

(1) Whether there was any increase in the incidence of (a) malaria, (b) typhoid and (c) cholera in the Republic in 1990; if so, (i) to what extent, (ii) in which areas and (iii) how many cases of each disease were diagnosed in each area;

(2) whether any persons died of these diseases during this period; if so, how many

in each race group in respect of each disease;

(3) whether any steps are being taken to combat the spread of these diseases; if so, what steps in each specified area?

B674E

The MINISTER OF NATIONAL HEALTH:

(1) (a), (b) and (c) No;
(i), (ii) and (iii) fall away;

(2) yes,
notified deaths of Malaria in the Republic of South Africa by Population Group, 1990 (as on 20 March 1991)

Population group	*Number of deaths*
Indian	0
Black	27
Coloured	0
White	3
TOTAL	30

Notified Deaths of Typhoid fever in the Republic of South Africa by Population Group, 1990 (as on 20 March 1991)

Population group	*Number of deaths*
Indian	0
Black	28
Coloured	0
White	0
TOTAL	28

(3) yes,
Malaria:
— Disease surveillance.
— Case finding.
— Health Education.
— Encouragement to take prophylactic treatment.
— Vector control.
— Treatment of persons suffering from malaria.
— Notifiable disease.

Typhoid:
— Disease surveillance.
— Case finding: Treatment and isolation of cases to save lives and reduce further excretion of organisms.
— Tracing of carriers and contacts to prevent infections and reduce further excretion of organisms.
— Immunisation is indicated in certain circumstances, examples being exposure to a carrier, outbreaks of typhoid in a community or institution and in the case of groups such as military forces in field conditions.
— Health Education.
— Advice with regard to environmental factors
— Participation in Interdepartmental Committee, providing advice to the authorities responsible for service.
— Notifiable medical condition.

Cholera:
— Disease surveillance.
— Tracing of source.
— Case finding.
— Health Education.
— Treatment of cases.
— Notifiable medical condition.
— Co-ordinated action with all health services to prevent crossborder spread of cholera.

Care of patients by community health workers

259. Miss M SMUTS asked the Minister of National Health:

(1) Whether a senior official of the Department of National Health and Population Development stated in June 1990 that up to 60 per cent of patients treated at hospitals in South Africa could be cared for by community health workers; if so, (a) on what evidence was this statement made and (b) what is the rank of the official concerned,

(2) whether she will make a statement on the matter?

B685E

The MINISTER OF NATIONAL HEALTH:

(1) (a) and (b) Dr H J Steyn, Deputy Director-General of the Department of National Health and Population Development, said, during a seminar in June 1990, that the work load of a clinic nurse, could be alleviated by up to 60% by the use of community health workers and voluntary workers. This statement was based on a study carried out at a clinic where community health workers did the follow-up visits at the homes of tuberculosis and family planning clients so that the nurse could carry out her clinic functions;

(2) no.

Killer disease reaches Natal

Star 19/11/91

DURBAN — A new killer disease desribed as far more infectious than Aids has been detected in Natalians and drastic measures have been taken to prevent the spread through blood products.

Natal's Blood Transfusion Services have started testing for Hepatitis C, which is transmitted via blood transfusions and infected body fluids, and kills slowly by destroying the liver.

NBTS director Professor Francisco Costa said his service was the first in the country to start testing for Hepatitis C, which was similar in symptoms to the deadly Hepatitis B, but caused by a different virus.

The latest equipment for testing for Hepatitis C was recently acquired from abroad and installed at NBTS. — Own Correspondent.

Severe cancer service cutbacks

Medical Reporter

The present harsh economic climate in South Africa is forcing the National Cancer Association (NCA) to make severe cuts in the services it offers, president Professor Douglas Anderson said this week.

Professor Anderson was making the NCA's first national television broadcast on M-Net in which he disclosed the NCA's plan to raise R50 million over the next five years, with an immediate target of R1,5 million.

He said the NCA's budgeted income of R11,2 million for the current financial year will still leave the association with a deficit of R1.5 million.

Apart from the cutbacks, certain services would also have to be curtailed in some cases.

The NCA is funded by public donations. State assisstance amounted to less than one percent of the annual budget.

NCA southern Transvaal regional director Monica Perold told a press conference in Johannesburg that the incidence of cancer had risen from one in four people to one in three.

This meant the demand from people in need of the association's services increased while financial resources dwindled.

Professor Anderson and Mrs Perold said the NCA had an obligation to offer all South Africans the best chance " to beat cancer", but this cost money.

"The tremendous demand for our community services is a clear indication of just how sorely needed they are," Professor Anderson said.

SOME HEARTBREAKING FACTS



Businessmen under stress are major candidates for heart disease. Dr Nick Lee, editor of the *SA Medical Journal*, takes a tough look at the reasons why South Africans are in the top bracket of heart sufferers.

Faced with a loaded gun pointed at their heart most people would have the commonsense to take some prompt steps to reduce the risk to their continued presence on this planet. But this is just what South Africans are not doing, according to the Heart Foundation.

SA enjoys the dubious distinction of being in the world's big league when it comes to coronary heart disease; but attempts to get the dismal message across to a population which seems hell-bent on self-destruction continue to fall on deaf ears. Part of the problem may be that the message itself may at times be less than clear to those unused to the Talmudic hair-splitting which characterises scientific medical research. For instance, it is beyond doubt that what furs up the coronary arteries is a cheesy substance called cholesterol.

How it comes to get there in some people and not others is still something of a mystery. The message gets more complicated when the cognoscenti start indulging in such jargon-ridden diagnoses as high-density (good) and low-density (bad) lipoproteins, and how they relate to each other, and start arguing among themselves about how it happened. Stripped of all its mystery, however, is a simple basic message: if your total blood cholesterol level is too high, then your life is in danger from coronary artery disease. If you are also a cigarette smoker and weigh too much for your height and age, then you are really well launched down the slippery slope.

As far too many South Africans, particularly whites, meet all three criteria, it is small wonder that deaths from heart disease top the mortality charts. Some Afrikaners are at even greater risk because of an hereditary disorder which gives them a high blood cholesterol level even early in life. Those at highest risk though are often those who the country can ill-afford to lose — usually at the height of their intellectual powers and capabilities. They are top executives and managers living a pressured, stressful life, affluent, unfit, overweight and overindulged.

What is the danger level for blood cholesterol? Again, answers vary depending on which population group you belong to and how old you are. But as the cholesterol level increases, so does the risk.

Knowing that a high blood cholesterol level is a major risk factor for heart disease is one thing. Getting people to have themselves tested is another. Some experts believe that whole population groups should be screened, but government health authorities have usually balked at such a suggestion, mainly on grounds of cost.

A more practical approach would be to test individuals known to be at risk, such as those from families with a history of heart attacks. Another approach would be for commercial firms to set up executive health programmes which would include regular monitoring of blood cholesterol levels in their top management, coupled with a compulsory intervention programme for those caught in the net to get the flab off and the cholesterol down.

Ideally, from a medical viewpoint, the general public should be educated into awareness of the dangers of a high blood cholesterol level, and encouraged to get themselves tested. This is now much easier than it was a few years ago — new, compact test machines have become available, and the cost of screening has fallen dramatically.

But before it happens on a large scale, South Africans are going to have to get used to the idea of taking charge of their own health instead of expecting others to do it for them. Living a destructive lifestyle and then screaming for help when the body's wheels start falling off is about as intelligent as locking the stable door after the horse has dropped dead.

What is so frustrating to bodies like the Heart Foundation, now celebrating its 10th birthday, is that once an individual is known to have a high blood cholesterol level, a great deal can be done to cut down the risk of sudden death and to reduce the need for highly expensive surgery on the coronary arteries later.

Cutting down the amount of animal fat in the diet, stopping smoking, taking regular exercise and getting the body weight down are all effective ways of reducing blood cholesterol levels and reducing the risks of a heart attack. For those whose cholesterol level stubbornly refuses to come down, effective cholesterol-lowering drugs are now available — at a price.

The take-home message which comes across loud and clear from the Heart Foundation is that not only is prevention better than cure — it's a lot cheaper.

Hearty advice to send the Grim Reaper running

9/5/91 Star

In South Africa, 48 000 people have heart attacks each year. Of these, 12 000 will die immediately or shortly thereafter, but the remaining 36 000 will have a second chance at a healthy life, if they — and their doctors — heed some simple advice from former South African Dr Neil Gordon, who now lives and works in Dallas, Texas.

Coronary heart disease is the leading cause of death in Western industrialised countries.

But the real tragedy of this disease, which was virtually unknown at the turn of the century, is that it's not something you catch, like a common cold, or typhoid or tuberculosis; it's mostly a self-inflicted malady.

The heartening news is, however, that once you've got this serious disease, death is not necessarily around the corner: there's a lot you can do to halt the Grim Reaper in his tracks and even point him in the reverse direction.

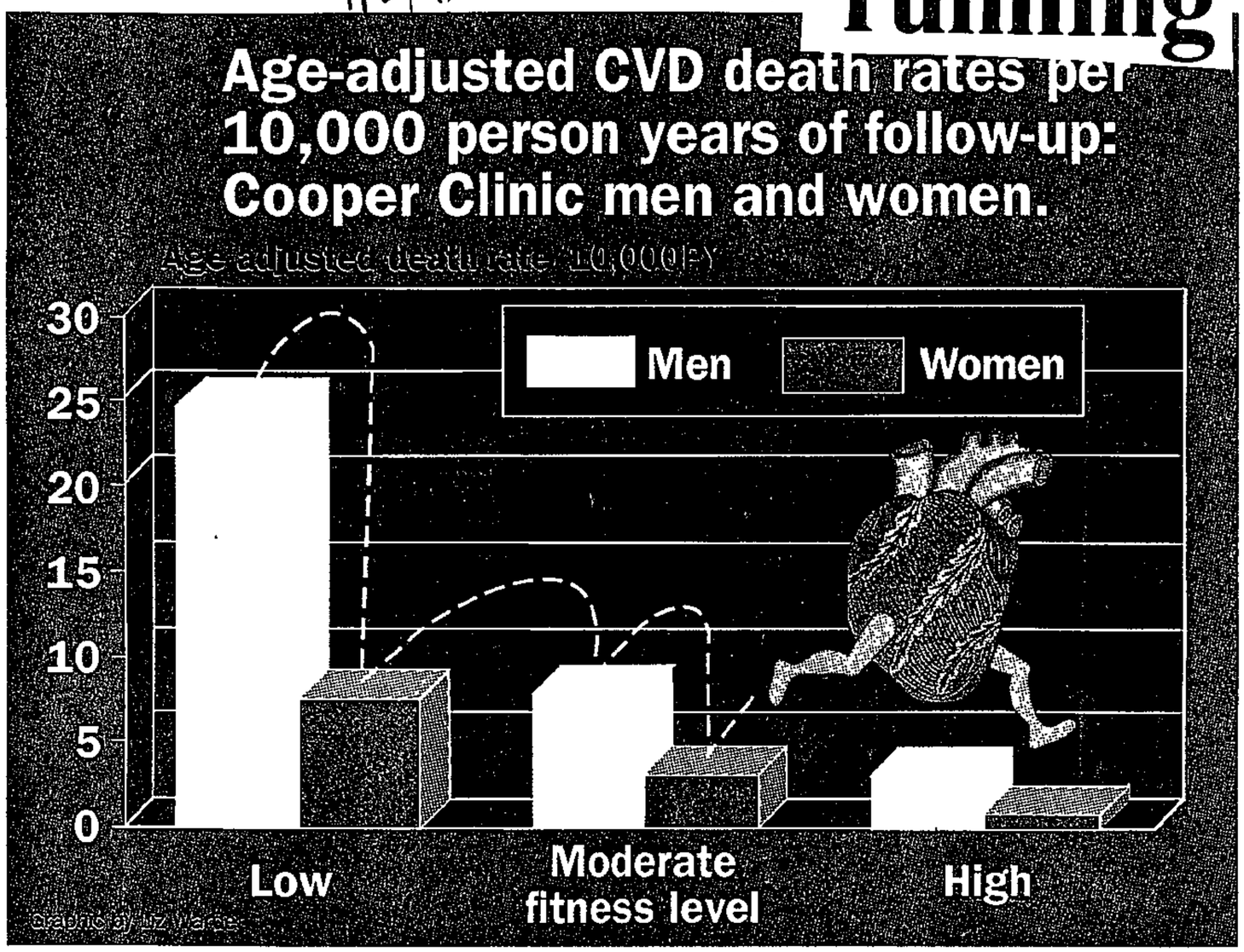
In South Africa, 48 000 people have heart attacks each year. Of these, 12 000 will die immediately or shortly thereafter, but the remaining 36 000 will have a second chance at a healthy life, if they — and their doctors — heed some simple advice from former South African Dr Neil Gordon, who now lives and works in Dallas, Texas.

Dr Gordon is director of exercise physiology at Dr Kenneth Cooper's Institute for Aerobics Research and director of the Aerobics Centre Cardiac Rehabilitation Programme.

He visited South Africa last week to attend the SA Physiotherapy congress in Pretoria, and the SA Sports Medicine Association's biannual congress at Sun City, where he spoke on cardiac rehabilitation in the 1990s, as well as exercise and health updates.

Major studies in the past two or three years show that people with heart disease who participate in a comprehensive cardiac rehabilitation programme reduce the risk of dying from the disease by as much as 25 percent, says Dr Gordon.

There is ample evidence to show that cardiovascular disease can be reversed by modifying the major risk factors: smoking, high blood pressure, high levels of "bad" cholesterol, obesity and physical inactivity.



Fighting the odds . . . from research done at Dr Kenneth Cooper's Clinic in Dallas, statistics show that even moderate fitness substantially reduces the risk of death from heart disease.

A programme for cardiac rehabilitation may sound like a mouthful, but it can be bitten off and chewed in easily digested portions, by even the most sceptical of patients, says Dr Gordon. And the benefits are not just to prolong life, but to improve the quality of those extra years as well.

His advice on diet is aimed at teaching patients about the fundamentals of food, enough for them to "navigate the aisles of the supermarket with confidence and to sit down to eat, knowing they are not promoting coronary heart disease", he says.

There is convincing evidence, says Dr Gordon, that exercise training can reduce the risk of dying from heart disease, even when the person has already had a heart attack.

And that doesn't mean that the unhealthy couch potato must suddenly become a chip off Comrades king Bruce Fordyce's marathon block.

Studies have shown that ordinary physical activities, such as gardening, dancing and walking, when performed regularly and for at least 30 to 45 minutes nonstop, three to five times a week, are enough to reduce significantly the risk of death from heart disease.

It's important, too, that patients realise that biology is not destiny, says Dr Gordon.

"The fact that heart disease runs in a family does not necessarily mean that the increased risk is genetic in origin," he points out.

"It can simply be a matter of passing unhealthy habits and lifestyles around within a family."

It has been shown, he points out, that wives of heart attack victims are at increased risk, even though women have a lower incidence of the disease.

He puts this down to the fact that men and women resembling each other in lifestyle are more likely to marry each other, and that people who are close to each other are likely to mimic each other's habits, both good and bad, in many years of most marriages.

One major hurdle that faces the successful implementation of state-of-the-art cardiac rehabilitaion programmes in South Africa, according to Dr Gordon, is that medical aid companies have been exceptionally slow in responding to the many documented benefits. Unlike the American counterparts, they generally do not provide any reimbursement for cardiac rehabilitation.

The high incidence of heart disease in rich nations is compounded by the fact that many doctors are still unaware of the benefits of rehabilitation programmes for sufferers of heart disease, says Dr Gordon.

"It's easier for a doctor to write out a prescription than to start advising about diet, stress management and exercise."

Dr Gordon would like to see South African doctors as well as patients following the trend of their American counterparts in becoming actively involved in preventive medicine.

He has written a comprehensive and readable book on the subject along with collegue Dr Larry Gibbons, "The Complete Heart Recovery Guide" (Oxford University Press, Cape Town), which is recommended by The Heart Foundation of Southern Africa.

The book explains simply what a heart attack is, how it happens, what the many myths surrounding the disease are (a major one being that sex after a heart attack is dangerous: Dr Gordon reassures sufferers that heart disease should have minimal negative impact on sexuality), and what can be done to prevent a recurrence and reverse the disease.

The first part of the book involves education, helping the patient understand why change is necessary; the second part involves action, giving the patient simple guidelines to make that change a healthy reality.

The book is intended for use only in close consultation and collaboration with the patient's personal physician.

MARIKA SBOROS

Cancer services crippled by shortage of finance

wl mail 10/5 – 16/5/91

89

By CARMEL RICKARD: DURBAN

THE National Cancer Association, crippled by a severe shortfall in funds, faces the grim prospect of closing its laboratory, leaving many thousands of women around the country without access to early, affordable cervical-cancer tests.

Director of the Natal branch of the association, Theony Szidat, said this week that the region was operating on a budget R1,5-million less than was needed. Only a skeleton staff could be employed to offer the hospicare, education and self-help programme services for which the association has become known.

Szidat said one of the services most threatened was the laboratory to screen papsmears, based in Durban but serving family-planning clinics around the country and Namibia. Until recently the test was offered free of charge, but the association has been forced to charge R3 a slide. As a result, 20 000 to 30 000 fewer women had the test because they could not afford it.

This was cause for great concern since the family-planning clinics tended to serve women from lower-income brackets, who were most at risk from cervical cancer, she said.

If they did not have regular papsmear tests — which detect pre-cancer changes in the cells — they ran the risk of detecting the disease too late.

"Closing down our laboratory would put some 50 000 to 60 000 women at risk every year."

Szidat estimates the association needs about R150 000 to keep the laboratory going. The funds would have to come from the public since the Natal Cancer Association does not receive any state funds.

A number of other projects of the association are also under threat, or are being put on hold until the financial situation improves.

For example, the budget for grants to families of cancer victims decreased from R40 000 last year to R12 000 this year.

"This is alarming, because very often these people lose their jobs after being diagnosed as having cancer," Szidat said.

"We have tried to provide them with bridging finance until they can obtain a government disability grant. We used to be able to give them a grant for three months. But because of the shortfall in our finances, we can now give grants only for one month — and then only if we feel they are desperate cases, if they really have no other financial resources to can call on.

"For most, all we can offer is a food parcel and then refer them to the social welfare department for further help."

Concern over diabetes toll worldwide

89

Sowetan 17/5/91

GROWING concern among national health officials about the escalating incidence and toll of diabetes throughout the world has compelled the International Diabetes Federation and the World Health Organisation to declare June 27, 1991 the first ever Diabetes-Day.

World Diabetes Day has influenced an unprecedented union of organisations, government health bodies and industry leaders to reach out to an estimated 120 million people with diabetes throughout the world, says IDF president-elect Wendell Mayes.

"Our objective is to garner long overdue and meaningful attention to this deadly killer among the public and the media, so we can begin to educate people about the symptoms and treatment of diabetes".

Exciting lives

The IDF and WHO are also mounting a historic week of diabetes-related events, including scientific presentations by experts, international health ministers and well-known public figures who enjoy exciting lives despite their diabetes.

Dr H Nakajima, director general of WHO, said: "For good reasons, Aids, cancer, and heart disease have captured the public's attention. Now it's time to focus on another insidious killer: diabetes. It's astonishing and unacceptable that people do not know that diabetes is responsible for heart disease, stroke, nerve and kidney damage, blindness and amputation among millions of people.

"World Diabetes Day will provide the needed platform to educate the world about diabetes and more importantly, what can be done to control it," he added.

Threat of heart disease lower in Western Cape

BLACKS living in the Western Cape have a lower risk for coronary heart disease than other population groups, according to the results of a recent study.

The Medical Research Council conducted a study involving 1 000 subjects to determine risk factors for blacks which showed that more than 30 percent of males had at least one reversible risk factor for ischaemic heart disease.

Although South Africa has one of the highest heart attack rates in the world, with about 12 000 people dying annually, the percentage of black who have at least one major risk factor is about half the figure for white, Asian or coloured males.

The study showed that 52 percent of males smoked compared with eight percent of women. However, 25 percent of the women had cholesterol levels which posed a risk to heart disease, as opposed to 16 percent of the men.

Higher than recommended blood pressure levels were found in 14 percent of the males and 13 percent of the females.

Smoking 10 or more cigarettes per day was defined as imparting a high level of risk. Of the males, nearly 25 percent smoked 10 or more cigarettes a day.

The study was initiated because reliable data of heart disease deaths among blacks is not available.

Researchers feared that increasing urbanisation could lead to a change in diet and lifestyle which could contribute to early heart attacks.

Of the minor risk factors, the high level of obesity among black females was an outstanding feature, with 44 percent classified as obese.

The researchers believe the prevalence of obesity has partially contributed to the development of hypertension in this group.

More than a third of both men and women took no exercise outside working hours.

The co-ordinator of the study, MRC senior researcher Dr Kristela Steyn, said the fact that so few black women smoked was encouraging. The researchers were however, concerned about the high rate of smoking among black men. - *Sowetan Reporter.*

SABC: pirate viewing/annual loss

376. Mr L F STOFBERG asked the Minister of Home Affairs:†

(1) Whether he has been informed that the SABC annually loses an amount of approximately R150 million as a result of pirate viewing; if not, why not; if so, (a) what was the amount of this loss during the latest specified financial year for which figures are available and (b) what percentage did it constitute of the SABC's total revenue from licence fees for that financial year;

(2) whether he intends granting the SABC a further increase of licence fees; if so, (a) why, (b) when and (c) by what percentage?

B969E

The MINISTER OF HOME AFFAIRS:

(1) No. The amount the SABC loses annually as a result of pirate viewing is difficult to ascertain, since accurate statistics in respect of television ownership are not available. Television set movements arising from private transactions are also not easily ascertainable. The estimated amount of money lost through pirate viewing may be as high as R100 million. Assuming this amount to be accurate, this would constitute about 28,6% of the estimated potential revenue from licence fees.

(2) No request for a further increase has been received from the SABC.

Public telephones: cost of repairs

406. Mr P G SOAL asked the Minister for Economic Co-ordination and Public Enterprises:

What was the estimated cost of repairing public telephones in the Republic (a) in 1987 and (b) during the latest specified 12-month period for which information is available?

B1071E

The MINISTER FOR ECONOMIC CO-ORDINATION AND PUBLIC ENTERPRISES:

(a) R12 976 007,64 during the 1987/88 financial year; and

(b) R23 953 734,81 for the period 1 April 1990 until 31 March 1991

Note:
The figure against (a) does not include the cost in respect of the Western Cape, as it is not readily available.

Average value of rand: changes

410. Mr J CHIOLÉ asked the Minister of Finance:†

How has the average value of the rand changed on a year-to-year basis over the past 10 years in respect of the basket of currencies of each of the six most important trading partners of South Africa?

B1083E

The MINISTER OF FINANCE:

Statistics for 1981 is not readily available. The annual percentage change since 1982 is as follows:

Year	Germany	France	Japan	Switzerland	UK	USA
	Mark	Franc	Yen	Franc	Pound	Dollar
82	−13,4	−2,5	−9,1	−17,1	−6,9	−19,6
83	2,4	13,0	−6,9	0,9	12,3	−2,8
84	−14,4	−11,9	−23,1	−14,2	−12,8	−22,6
85	−30,9	−31,3	−33,2	−30,0	−30,6	−34,4
86	−29,4	−26,3	−32,2	−29,9	−16,2	−3,5
87	−7,9	−3,3	−4,7	−7,9	−0,11	11,5
88	−12,3	−11,1	−20,2	−12,0	−17,3	−10,0
89	−7,3	−7,2	−7,1	−3,2	−6,2	−13,6
90	−13,0	−13,6	6,3	−13,9	−6,6	1,2

Foreign currency unit per rand — middle rate index (1979 = 100)

Notifiable diseases

414. Mr M J ELLIS asked the Minister of National Health:

How many cases of each notifiable disease were notified in respect of each race group in 1990?

B1092E

The MINISTER OF NATIONAL HEALTH:

Notified cases of each notifiable medical condition in 1990 RSA (as at 28 May 1991)

Disease	Population Group					
	Unknown	Indian	Black	Coloured	White	Total
Cholera	0	0	1	0	0	1
Typhoid fever	1	10	1 541	25	19	1 596
Paratyphoid fever	0	0	1	0	0	1
Food poisoning	0	0	295	80	127	502
Tuberculosis	44	575	49 663	19 568	879	70 729
Brucellosis	0	1	2	0	6	9
Leprosy	0	0	35	1	0	36
Diptheria	0	0	7	3	8	18
Meningococcal infection	0	4	434	355	56	849
Tetanus	1	2	96	5	0	101
Legionellosis	0	1	1	0	0	2
Poliomyelitis	0	0	2	0	1	3
Measles	5	32	4 828	299	490	5 654
Crimean-Congo Haemorrhagic fever	0	0	1	0	3	4
Viral Hepatitis	3	73	855	406	1 128	2 465
Rabies	0	0	15	1	0	16
Trachoma	0	0	3	0	1	4
Malaria	3	2	6 028	7	231	6 271
Encephalitis	1	0	2	6	50	59
Acute rheumatic fever	0	15	44	20	2	81
Rheumatic heart disease	1	0	65	5	1	72
Pesticidal poisoning	0	2	55	32	16	105
Plague	0	0	0	0	0	0
Anthrax	0	0	0	0	0	0
Smallpox	0	0	0	0	0	0
Yellow fever	0	0	0	0	0	0
Other haemorrhagic fevers	0	0	0	0	0	0
Typhus fever	0	0	0	0	0	0
Lead poisoning	0	0	0	0	0	0

Population Development Programme

416. Mr J A JORDAAN asked the Minister of National Health:†

(1) How much money was spent in her Department on the Population Development Programme in the latest specified financial year for which information is available;

(2) what total amount was spent on the Population Development Programme in each financial year since the inception of this programme:

(3) what are her Department's future plans regarding this programme?

B1097E

Breast, cervix cancer kill thousands a year

(89) ARGUS 18/6/91

By VIVIEN HORLER
Medical Reporter

CANCERS of the breast and cervix, the two cancers which most frequently affect women worldwide, each killed about 1 300 South African women in 1988, the latest year for which figures are available.

According to a report by the Department of Health on health trends in South Africa, breast cancer is the most common female cancer worldwide, but cancer of the cervix is more common in developing countries.

Breast cancer trends in South Africa have remained almost unchanged over the past 10 years, with white women most affected and black women least.

In 1988 about 29 white women in every 100 000 women died of breast cancer, about 13 coloured women, about eight Asian women and less than five black women.

About one in 11 women in industrialised countries will develop breast cancer. Once she is diagnosed, she has about a 65 percent chance of surviving for the next five years. But her chances depend on how soon the cancer was diagnosed.

If the cancer is contained within the breast, she has an 85 percent chance of surviving for five years, but if it has already spread to the lymph nodes or beyond, her five-year survival rate drops to 50 percent.

Risk factors include exposure to radiation, a history of breast cancer in close relatives, early onset of periods and late menopause, no children and late child-bearing.

Other possible risk factors are still controversial, and include the consumption of animal fat and alcohol, no breastfeeding, use of oral contraceptives and oestrogen replacement therapy.

Cervical cancer, the most common cancer in women in the developing world, is strongly linked to early onset of sex and many partners. Male promiscuity also appears to increase the risk in the female partner, and could be as important as female sexual behaviour.

Other risk factors include low socio-economic status and smoking. In the United States almost 29 percent of cervical cancer deaths are related to cigarette smoking.

Protective factors against cervical cancer include barrier methods of contraception such as the condom and the diaphragm, and spermicidal contraceptives.

Although mortality rates are high if the cancer reaches an advanced stage, it is nearly always curable by surgery or radiotherapy if caught early, usually after a pap smear.

80% have the 'silent killer'

AFCMS 18/6/91 (89)

By VIVIEN HORLER
Medical Reporter

EIGHT out of 10 westernised South Africans have the "silent killer" — raised blood cholesterol, believed to be the single most important risk factor for a heart attack, according to the Heart Foundation of Southern Africa.

Now a pharmaceutical company has launched a screening programme to identify those people most at risk.

Ms Rika de Ruiter of the Heart Foundation believes everyone should know their cholesterol level, because if it is too high a combination of diet and exercise can reduce it, and minimise the risk of a heart attack.

High blood cholesterol is known as the silent killer because it is symptomless at even dangerously high levels. Often the first a patient knows of it is a heart attack.

With the corporate screening programme companies and organisations will be able to have a nurse and several cholesterol-testing machines on the premises for as long as it takes to test the employees.

The service will be free of charge, although the company will have to pay for the chemical strips used in the blood-testing, which cost R7 a test.

The test takes about three minutes and involves a finger-prick.

Miss Alyson Prowse, product manager for Logos Pharmaceuticals, which is sponsoring the tests, said an insurance company had estimated it cost between R375 000 and R850 000 to replace a senior executive who had died of a heart attack.

"And a coronary bypass operation can cost R50 000 in direct medical costs."

The cholesterol tests are accurate to within 10 percent either way, said Miss Prowse.

"We measure the total cholesterol levels, and recommend that if the person's level is high they should see their doctor for a more comprehensive test performed after a 10-hour fast."

Cholesterol is a fatty substance carried in the blood. High levels clog the arteries, which can lead to a heart attack.

By reducing cholesterol levels by 25 percent you can reduce the risk of a heart attack by up to 50 percent.

Blood cholesterol can be reduced by changing eating patterns, cutting down on fat and dietary cholesterol (found in eggs, prawns and shrimps, liver and kidneys) and increasing fruits, grains and vegetables.

Regular exercise also helps to reduce blood cholesterol levels.

The other two main coronary heart disease risk factors are high blood pressure and smoking.

(iv) 328 and

(b) 21 May 1991.

Harms Commission: amounts paid for transcription

408. Adv C D DE JAGER asked the Minister of Justice:†

With reference to his reply to Question No 89 on 8 May 1991 and the amounts paid to Vlok Recordings for the transcription of the proceedings of the Harms Commission with regard to its investigation into certain alleged murders, (a) at what rate did Vlok Recordings tender for the work (i) per day for an operator, (ii) per day or per month for the provision of recording machines and (iii) per folio for transcription and (b) how is the amount of R7 370,20 made up, regard being had to the basis of tender?

B1075E

The MINISTER OF JUSTICE:

(a) (i) R50 per day per operatrix.

(ii) R25 per day or portion thereof plus R6 per cassette.

(iii) R3,04 per page plus R1,66 per page additional in respect of a running transcript.

(b) The amount is made up as follows:

(i)	Operatrix for the making of the recording	55 days at R50 per day	R2 750,00
(ii)	Hiring of Lanier recording machine and 10 microphones	55 days at R25 per day	R1 375,00
(iii)	Cassette tapes for recording	119 cassettes at R6 per cassette	R714,00
(iv)	Copy of transcriptions: Pretoria and London proceedings (2 free copies supplied)	4 052 pages at 30 cents per page	R1 215,60
(v)	Additional copies of certain volumes	656 pages at 30 cent per page	R196,80
(vi)	Original typing, checking and binding of the report	170 pages at R5,00 per page	R850,00
(vii)	Six copies of the report	1 020 pages at 12 cents per page	R122,40
(viii)	Computer discs	6 discs at R2,75 each	R16,50
(ix)	Certified copies of volumes 26, 27, 28, 29 and 30 of the record for the Commercial Crime Unit, the South African Police and John Vorster Square	433 pages at 30 cent per page	R129,90
			R7 370,20

Education budget: details

422. Mr J H MOMBERG asked the Minister of Education and Training:

(1) What (a) amount and (b) percentage of the education budget of his Department was spent in the Republic on (i) pre-primary, (ii) primary, (iii) secondary and (iv) tertiary education during the latest specified 12-month period for which figures are available;

(2) whether any part of his Department's education budget was spent on pre-primary, primary, secondary and tertiary education in (a) Qwaqwa and (b) KwaZulu during the period referred to above; if so, (i) what were the relevant amounts and (ii) what percentage of his Department's total expenditure on education for the period concerned did each such amount constitute;

(3) whether his Department has statistics on the amounts spent on pre-primary, primary, secondary and tertiary education by the (a) Qwaqwa and (b) KwaZulu Department of Education and Culture during the above period; if so, (i) what were the relevant amounts and (ii) what percentage of each of these Departments' total expenditure on education did each such amount constitute? B1105E

The MINISTER OF EDUCATION AND TRAINING:

Since the Department's accounts for 1990/91 have not yet been finalised, accurate amounts for 1990/91 cannot be submitted at this stage. Information figures for the 1989/90 financial year are supplied:

		(a)	(b)
(1)	(i)	R695 936,30	,04%
	(ii)	R970 395 069,95	49,61%
	(iii)	R590 184 613,99	30,17%
	(iv)	R281 015 748,53	14,37%

(2) No.

(3) No.

Management training: amount spent

423. Mr J H MOMBERG asked the Minister of Education and Training:

What (a) amount and (b) percentage of the education budget of his Department was spent on management training during the latest specified 12-month period for which figures are available?

B1107E

The MINISTER OF EDUCATION AND TRAINING:

(a) R4 380 188,16

(b) 0,22%

Note:

The information is based on the estimated expenditure for the 1990/91 financial year.

Cholera: cases/deaths

424. Mr M J ELLIS asked the Minister of National Health:

How many (a) cases of and (b) deaths from cholera were reported in respect of each race group in each province in 1990? B1108E

The MINISTER OF NATIONAL HEALTH:

(a) Notified cases of cholera in 1990 RSA (as on 3 June 1991)

Province	Population Group Indian	Black	Coloured	White
Cape Province	0	0	0	0
Natal	0	1	0	0
Orange Free State	0	0	0	0
Transvaal	0	0	0	0 and

(b) no deaths due to cholera were notified in 1990.

Note:

This case was not bacteriologically proven.

Poliomyelitis: cases/deaths

425. Mr M J ELLIS asked the Minister of National Health:

(1) How many (a) cases of and (b) deaths from poliomyelitis were reported in respect of each race group in each province in 1990;

(2) how many persons of each race group were immunised against poliomyelitis in each province in 1989?

B1109E

The MINISTER OF NATIONAL HEALTH:

(1) (a) Notified cases of poliomyelitis in 1990 RSA (as on 3 June 1991)

Province	Population Group Indian	Black	Coloured	White
Cape Province	0	0	0	0
Natal	0	0	0	0
Orange Free State	0	0	0	0
Transvaal	0	2	0	1 and

(b) no deaths due to poliomyelitis were notified in 1990.

(2) the total number of children less than one year of age who received a third dose of poliomyelitis vaccine in the RSA, 1989

Province	Population Group Indian	Black	Coloured	White
Cape Province	581	58 649	108 129	21 013
Natal	15 402	68 672	2 431	6 426

	Population Group			
Orange Free State	12	41 552	2 312	7 910
Transvaal	3 672	154 277	7 654	38 566

Lung cancer: deaths

426. Mr M J ELLIS asked the Minister of National Health:

How many persons in each race group in each province died of lung cancer in 1990? B1110E

The MINISTER OF NATIONAL HEALTH:

As of 15 December 1989 lung cancer has no longer been listed as a notifiable medical condition. There are therefore no notifications of deaths because of this disease available for 1990

Amounts spent

428. Mr R M BURROWS asked the Minister of Education and Training:

(a) What was the amount spent by his Department on (i) salaries of teachers and principles, (ii) salaries of administrative staff, (iii) salaries of inspectorate and executive officials, (iv) salaries of any other specified staff, (v) capital expenditure, (vi) supplies and services, (vii) equipment and (viii) other items and (b) what percentage of the total education expenditure by his Department in 1990 does each of the above amounts constitute? B1113E

The MINISTER OF EDUCATION AND TRAINING:

The information as requested in a(i) to (iv) is not readily available and a total amount for personnel expenditure is supplied:

	(a)	(b)
(i)—(iv)	R2 089 420 423	71,38%
(v)	R316 283 686	10,80%
(vi)	R172 270 023	5,88%
(vii)	R29 384 570	1,00%
(viii)	R320 231 776	10,94%

Note:

The accounts for the 1990/91 financial year have not been finally closed. The information is therefore based on the estimated expenditure.

Vote: Finance

431. Mr C UYS asked the Minister of Finance:†

(1) Whether, with regard to Vote No 12—Finance, he will furnish further information on the amount in interest of R12 738 512 000 appearing under the item "Commitments in respect of the State debts"; if not, why not; if so, what are the details of the (a) capital sum to which the interest relates and (b) amounts per foreign exchange unit;

(2) whether in respect of the above-mentioned vote he will furnish further information on the amount of R2 741 000 000 appearing under the item "Commitments in respect of loans by community councils"; if not, why not; if so, what are the details of the (a) capital sum to which the cost of concluding loans relates and (b) amounts per foreign exchange unit? B1136E

The MINISTER OF FINANCE:

(1) (a) The capital amount to which the interest relates to is as follows:

— State debt as at 31 March 1991:		R94 283 439 560,51
— Expected increase in State debt to finance the deficit before borrowing during the 1991/92 financial year:		R11 740 000 000,00
— Expected State debt as 31 March 1992:		R106 023 439 560,51

(b) The amounts per exchange unit are as follows:

— Internal debt:			R105 302 090 351,12
— Foreign debt at book value:			
USA Dollars	256 303 483 =	R381 735 446,30	
German Mark	250 000 000 =	R148 782 955,42	
Swiss Franc	141 349 065 =	R168 850 756,15	
European Currency Units (ECU)	20 946 000 =	R21 980 051,52	
		R721 349 209,39	R721 349 209,39
			R106 023 439 560,51

(2) (a) and (b) The amount of R2 741 000 000 does not appear under the Main division "Commitments in respect of loans by community councils". Abovementioned amount represents the estimated amount of the discount with which the gross amount to be borrowed by means of Government Stock issues will be reduced during the 1991/92 financial year. In accordance with section 20 of the Exchequer Act, 1975 (Act 66 of 1975) discount costs shall be deemed to be expenditure chargeable to the State Revenue Account and the nett amount so borrowed shall be increased by the amount of such costs in the State Revenue Account. Since the discount therefore realizes as an expenditure as well as an income in the State Revenue Account during a financial year, it is, for the sake of completeness, shown as expenditure under the item "Cost of raising loans" and deducted under the item "Discount" so that only the nett amount to be borrowed is eventually budgeted for in the State Revenue Account.

Commitments in respect of loans by community councils therefore only amounts to R73 496 000 whilst the capital amount to which this cost relates to will amount to R16 891 000 000 during the 1991/92 financial year. Seeing that the amounts will be borrowed locally the exchange unit will only be that applicable to the Rand Monetary area, i.e. Rand.

Vote: Manpower

435. Mr P J PAULUS asked the Minister of Manpower:†

Whether, with regard to Vote No 15—Manpower, he will subdivide the amount of R110 607 000 under Main Division 4—"Training", according to aims; if not, why not; if so, what are the relevant details? B1141E

The MINISTER OF MANPOWER:

Yes.

OBJECTIVE	BUDGET
National Training Board:	
Administration	R566 000
Internal Research	R782 000
External Research	R301 000
Regulation and promotion of training:	
Centres and schemes	R1 446 000
Financial assistance to certain schemes:	
South African Agricultural Union	R1 500 000
Cash Allowances	R3 350 000
Training in Labour Relations	R650 000
Rebate Training	R4 500 000
Manpower Development Fund	R1 000
Regulation of apprenticeship training	R4 392 000
Regulation of artisan training	R4 317 000
Training of workseekers:	
Establishment and regulation	R3 719 000
Contributions to fund for training of unemployed persons	R75 000 000
Training in certain occupations	R1 000
Central Organisation for Trade Testing	R9 505 000
Administrative auxiliary services	R568 000
Training and development of personnel	R9 000
Total	R110 607 000

Special Defence Account: details of budget

450. Adv J J S PRINSLOO asked the Minister of Defence:†

Whether, with regard to Vote No 6—Defence Force, he will subdivide according to aims the amount of R4 173 538 under Main Division 7—"Special Defence Account" for the financial year ending 31 March 1992; if not, why not; if so, what are the relevant details? B1165E

the KTC-case on the days on which he worked on other cases. For other cases in which he acted on behalf of the Minister of Law and Order or the South African Police he naturally, also did not charge a higher fee than that which he could charge according to the fees agreed upon for the KTC-case.

For some of these cases he, in fact, charged a fee which was less than the fees agreed upon.

(a) and (b) Fall away.

Government Service Pension Fund: interest rate

447. Mr P J PAULUS asked the Minister of Finance:†

(1) What interest rate did the Government Service Pension Fund receive in each financial year from 1984-85 up to and including 1990-91 in respect of funds invested in (a) Government securities and (b) semi-Government securities;

(2) whether a change of policy regarding investment possibilities is being considered; if not, why not; if so, what are the relevant details?

B1162E

The MINISTER OF FINANCE:

(1) (a) and (b)

Interest rates in respect of funds invested in Government securities and semi-Government securities, are not individually available.

1984-85	11,5%
1985-86	12,5%
1986-87	13,3%
1986-88	13,7%
1988-89	13,9%
1989-90	14,8%
1990-91	14,8%

(2) I recently announced that a Committee of experts in the private sector had been appointed to advise the Government on the future structure and siting of the Government Pension Funds. The investment policy inevitably forms part of the Committee's assignment and until such time as it has finalised its business and the Government has considered its recommendations, no conclusive answer can be given.

Squatters in Germiston: attack by Whites

448. Mr D H M GIBSON asked the Minister of Law and Order:

(1) Whether he or the South African Police have been informed of an alleged attack by a group of Whites on squatters at Old Goedehoop High School in Railway Street, Germiston, on or about 2 June 1991; if not, why not; if so,

(2) whether an investigation into this incident is taking place; if not, why not; if so, what progress has been made in this investigation;

(3) whether any (a) suspects have been identified, (b) arrests have been made and (c) charges have been laid in connection with this incident; if not, why not; if so, (i) how many in each case and (ii) what is the nature of the charges;

(4) whether any squatters were injured in this attack; if so, (a) how many and (b) what was the nature of the injuries;

(5) whether he or the Police intend taking any action to prevent further similar attacks; if not, why not; if so, what action?

B1163E

The MINISTER OF LAW AND ORDER:

(1) Yes.

(2) Yes, the matter is being investigated and numerous arrests have already been made.

(3) (a) Yes.

(b) Yes.

(c) Yes.

(i) and (ii)

The case is still being investigated, but six identified suspects have already been arrested for public violence.

(4) (a) and (b).

Yes, 5 squatters sustained superficial wounds.

(5) Yes, the functions of the South African Police are, inter alia, the maintenance of law and order and the prevention of crime. This implies that the task of the South African Police is at all time directed at, inter alia, protecting all persons against attacks by other persons, irrespective of who may be responsible for such attacks. This principle is applied consistently.

Should law and order be disturbed in any manner—also attacks on civilians—the Police will take steps to act against any transgressions of the law.

Note:

The squatters have already vacated the Ou Goedehoop High School in terms of a court order, in that the Messenger of the Court acted in terms of an eviction order to remove them.

Newlands police station: child abuse reported

449. Mrs C H CHARLEWOOD asked the Minister of Law and Order:

(1) Whether a case of alleged child abuse involving a 9-year-old girl and a White couple was reported at the Newlands police station; if so, when;

(2) whether an investigation into this incident is taking place; if not, why not; if so, what progress has been made in this investigation;

(3) whether there are any suspects in this case; if so,

(4) whether any arrests have been made in connection with this incident; if not, why not; if so, (a) how many, (b) when, (c) what are the names of the persons so arrested and (d) what is the nature of the charges being laid against them?

B1164E

The MINISTER OF LAW AND ORDER:

(1) No, but there was a case of alleged rape reported at the Parkview Police Station on 19 March 1991, which was investigated by the Child Protection Unit at the General Johan Coetzee Police Station.

(2) Yes, after conclusion of the investigation the case docket was submitted to the Senior Public Prosecutor in Johannesburg.

(3) Yes.

(4) Yes.

(a) 2 Persons.

(b) 11 April 1991.

(c) Since the Senior Public Prosecutor has declined prosecution, it is not regarded to be in the interest of these persons to make their names known.

(d) A charge of alleged rape was investigated.

Infant mortality rate

451. Mr M J ELLIS asked the Minister of National Health:

What was the infant mortality rate for (a) Blacks, (b) Whites, (c) Coloureds and (d) Indians in (i) urban and (ii) rural areas in South Africa in 1990?

B1166E

The MINISTER OF NATIONAL HEALTH:

Infant mortality rates for 1990 are not yet available. The following table contains infant mortality rates for 1988 and 1989. The Department of National Health and Population Development has no seperate rates available for urban and rural areas in South Africa.

Infant mortality rates (per 1 000 live births)
South Africa

Year	*Population Group*			
	Indian	*Black*	*Coloured*	*White*
1988	17,4	57,4	57,5	13,2
1989	12,2	n/a	35,1	8,6

Note: n/a = not available.

Typhoid: cases of/deaths

452. Mr M J ELLIS asked the Minister of National Health:

How many (a) cases of and (b) deaths from typhoid were reported in respect of each race group in each province in 1990?

B1167E

The MINISTER OF NATIONAL HEALTH:

(a) Notified cases of typhoid fever in 1990 RSA (as on 7 June 1991)

Province	Population Group: Indian	Black	Coloured	White
Cape Province	0	34	23	6
Natal	8	338	1	2
Orange Free State	0	16	0	1
Transvaal	2	1 153	1	10

and

(b) Notified deaths from typhoid fever in 1990 RSA (as on 7 June 1991)

Province	Population Group: Indian	Black	Coloured	White
Cape Province	0	1	0	0
Natal	0	2	0	0
Orange Free State	0	0	0	0
Transvaal	0	25	0	0

Black townships: kilometres formal/informal roads

453. Mr A J LEON asked the Minister of Planning, Provincial Affairs and National Housing:

(1) How many kilometres of (a) informal and (b) formal roads are there in each Black township in the Republic;

(2) in respect of what date is this information furnished?

B1170E

The MINISTER OF PLANNING, PROVINCIAL AFFAIRS AND NATIONAL HOUSING:

Cape Province

(1) (a) 536 kilometer

(b) 1 888 kilometer

(2) 12 June 1991.

The information for each Black township is not readily available and can only be obtained at high costs.

Natal

(1) Town:	1(a) Informal Estimated	1(b) Formal
Bhongweni	3	15.980
Bhekuzulu	2	23.010
Bruntville	1	13.360
Dumbe	3	27.940
Enhlalakahel	2	15.610
Hamabanti	1	12.580
Itsokolele	2	4.850
Kwamevan	—	4.186
Mzingizi	—	1.560
Ningizimu/Chesterville	2	25.080
Ningizimu/Lamontville	2	24.660
Inkanyezi	1	6.200
Shakaville	2	12.100
Shayamoya	—	2.330
Sibongile	2	19.460
Sithembile	1	12.370
Sobantu	1	11.860
Steadville	1	28.910
	26	262.046

(2) 12 June 1991.

Orange Free State

(1) Black Township	Kilometres (a) informal roads	Kilometres (b) formal roads
Allanridge (Nyakallong)	5,6	18,7
Arlington (Leratswana)	1,1	8,5
Bethlehem (Bohlokong)	8,7	69,2
Bethulie (Lephoi)	1,2	14,0
Bloemfontein (Mangaung)	18,5	227,2
Boshoff (Seretse)	Nil	7,1
Bothaville (Kgotsong)	6,4	83,1
Brandfort (Majwemasweu)	Nil	19,0
Bultfontein (Phamameng)	Nil	9,9
Clarens (Kgubetswana)	Nil	6,1
Clocolan (Hlohlolwane)	2,6	14,3
Cornelia (Ntswanatsatsi)	Nil	4,2
Dealesville (Tswaraganang)	Nil	14,8

(1) Black Township	Kilometres (a) informal roads	Klometres (b) formal roads
Deneysville (Refenkgotso)	0,99	20,1
Dewetsdorp (Morojaneng)	0,2	13,5
Edenburg (Ha-Rasebei)	0,3	11,0
Edenville (Ngwathe)	0,1	10,3
Excelsior (Mahlatswetsa)	Nil	10,7
Fauresmith (Ipopeng)	0,2	6,6
Ficksburg (Meqheleng)	0,4	29,6
Fouriesburg (Mashaeng)	Nil	9,2
Frankfort (Namahadi)	0,7	41,5
Harrismith (42nd Hill)	0,5	32,2
Heilbron (Phiritona)	1,4	24,1
Hennenman (Phomolong)	13,5	20,0
Hertzogville (Malebogo)	1,1	4,8
Hobhouse (Dipelaneng)	Nil	4,4
Hoopstad (Tikwana)	Nil	5,7
Jacobsdal (Ratanang)	0,3	3,2
Jagersfontein (Itumeleng)	0,6	14,7
Kestell (Thlolong)	0,4	7,3
Koffiefontein (Ditlhake)	1,8	12,3
Koppies (Kwakwatsi)	9,7	11,4
Kroonstad (Maokeng)	0,9	74,1
Ladybrand (Manyatseng)	1,2	50,6
Lindley (Ntha)	1,5	11,4
Luckhoff (Relebohile)	Nil	1,5
Marquard (Moemaneng)	0,8	12,4
Memel (Zamani)	Nil	5,1
Odendaalsrus (Kutlwanong)	56,3	48,6
Oranjeville (Metsimaholo)	0,8	3,4
Parys (Tumahole)	26,3	37,8
Paul Roux (Fateng-Tse-Ntsho)	0,9	6,0
Petrusburg (Bolokanang)	Nil	9,2
Petrus Steyn (Mamafubedu)	0,7	12,9
Philippolis (Poding-Tse-Rolo)	0,1	6,4
Reddersburg (Matoporong)	0,8	12,4
Reitz (Petsana)	0,3	20,9
Rosendal (Mautse)	Nil	4,2
Rouxville (Rweleleyathunya)	Nil	23,0
Sasolburg (Zamdela)	2,7	36,5
Senekal (Matwabeng)	6,0	22,1
Smithfield (Mofulatshepe)	0,5	17,2
Soutpan (Kgomotseng)	Nil	5,8
Springfontein (Maphodi)	Nil	10,0
Steynsrus (Matlwantlwang)	1,1	9,3
Theunissen (Masilo)	0,7	51,8
Trompsburg (Madikgetla)	0,4	9,0
Tweeling (Mafahlaneng)	Nil	7,2
Tweespruit (Borwa)	0,3	5,8
Van Stadensrus (Thapelang)	Nil	3,5
Ventersburg (Mmamahabane)	2,6	14,4
Verkeerdevlei (Tshepong)	0,4	8,3
Viljoenskroon (Rammulotsi)	18,7	24,5
Villiers (Qalabotjha)	Nil	18,0
Virginia (Meloding)	3,0	28,3
Vrede (Thembalihle)	Nil	15,8
Vredefort (Mokwallo)	2,9	14,0
Warden (Ezenzeleni)	1,5	8,5
Welkom (Thabong)	22,5	92,2

Knocking the spots off measles

(84) ARG 17/7/91

. . . and Natal identifies new flu vir

HANS-PETER BAKKER
Staff Reporter

DEATHS from measles in South Africa dropped from 137 in 1989 to 49 last year, following an intensified immunisation campaign.

Dr Leon du Toit, chief director primary health care of the Department of National Health and Population Development, said the figures were "proof of the successes which can be achieved with primary health care".

He said the incidence of measles had decreased from 11 868 in 1980 to 5 976 cases in 1989 and, after an "intensified immunisation campaign" in 1990, decreased to 3 823.

"The aim is to decrease this figure even further, since complications from measles is an important cause of preventable death among children," Dr Du Toit said.

He said the immunisation campaign was done with the help of local health authorities and parents and in the Western Cape immunisation increased from 115 960 in 1989 to 154 711 in 1990.

"If this level of immunisation had not been achieved the incidence and deaths among children as a result of a preventable disease would have been significantly higher," Dr Du Toit said.

He said the level of immunisation should remain high, to allow health authorities to pay more attention to other serious health problems.

Meanwhile, The Argus correspondent in Durban reports that the first 'flu virus to be isolated in South Africa this winter has been isolated in Natal - and it is the A virus which is highly infectious and can spread to epidemic levels.

A spokesman for the National Institute of Virology in Johannesburg said that an influenza A virus had been isolated very recently at the Virology Laboratory at the Natal Medical School.

This is the first positive identification of a 'flu virus this year.

"Most doctors don't bother to send in specimens for identification because with any 'flu or respiratory virus there is no specific treatment except to relieve the symptoms," said the spokesman. This means that very few specimens are available for identification and isolation.

"Influenza A is more infectious than the influenza B and mutates (changes) which means that vaccinations do not always cover it," he said.

A virus symptoms include hot and cold shivers, sore chest and throat, severe body pains and a general malaise.

A virologist said that 'flu could only be treated symptomatically while bedrest was advised for a few days until the symptoms had cleared up.



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Pneumonia now major baby-killer

89

VIVIEN HORLER
Medical Reporter

ARG 31/7/91

PNEUMONIA is now the major infectious cause of infant death in South African cities, overtaking diarrhoea.

Doctors say children of all races in South Africa are far more likely to develop pneumonia than children in Western Europe.

White children are seven times more at risk of death than children in France and the Netherlands, while coloured South Africans of the same age are 11 times more likely to die of pneumonia than whites.

Now the doctors who have produced these horror findings have called for urgent studies to discover why South African children are so at risk.

Dr Yasmin von Schirnding of the Medical Research Council, Dr Derek Yach of the Red Cross Children's Hospital and Dr M Klein say the figures for black children are "likely to be a considerable under-estimate because of under-reporting of deaths in this group".

An average of 2 157 black infants died of pneumonia every year between 1980 and 1985.

Writing in the latest SA Medical Journal, the authors say deaths from pneumonia and other acute respiratory infections have declined substantially in the past 18 years for whites, coloured people and Asians, although the figures for black children are unknown.

The scarcity of accurate black statistics is "a glaring deficiency".

Coloured and Asian infants show a marked increase in respiratory infections in winter.

The authors say that prevention of acute respiratory infections needs attention.

Lentegeur: nine people have died of dysentery

HOW DID IT HAPPEN?

South 15/8 – 21/8/91 (89)

By Heather Robertson

AT least four of the dysentery patients at the Lentegeur Psychiatric Hospital in Mitchells Plain died before the various "own affair" health departments linked up to identify and curb the disease.

Allegations were also made this week of a cover-up by the authorities of the outbreak of the disease among patients in the hospital's mental wards.

The disease, caused by the shigella bacteria, claimed its ninth victim on Wednesday.

The hospital's "silence" has drawn strong criticism from community organisations and medical bodies.

According to sources at the hospital, the first signs of the disease were evident in April this year.

The first death from shigella — a highly contagious bacteria which causes stomach cramps and severe diarrhoea — occurred on 23 June. Doctors said the crisis at Lentegeur pointed to the disastrous effects of state fragmentation of the health services.

A source, who cannot be named for professional reasons, claimed that officials at Lentegeur were hamstrung in dealing with the crisis because of the "bumbling" of various medical departments.

Lentegeur is unique in that it is the only hospital that falls under the jurisdiction of the House of Representatives.

A source said one of the patients afflicted with shigella had been turned back from a provincial hospital because Lentegeur was considered an "own affairs" institution.

It was also feared that patients at the provincial hospital would be infected.

Lentegeur, as a psychiatric hospital, did not have the facilities to treat the disease.

When the provincial authorities did not respond promptly, the Medical Research Council (MRC), which is not a service organisation, took the initiative to investigate the epidemic on 1 August.

The symptoms of diarrhoea had already been noticed in mid-May but some members of staff and the public were only informed last week after eight patients had died.

A private general practitioner disclosed that he had attended to a Lentegeur patient who had diarrhoea last week.

He had not known about the epidemic until it was revealed in the press at the end of last week.

"I saw my patient last week and I didn't believe her when she spoke of some unnamed 'mystery disease' at the hospital where seven people had died.

"I feel very angry that the hospital has covered up the epidemic for so long because it's shocking and irresponsible not to notify the general public when so many people had already died."

It was found that his patient did not have shigella."The best way to end an epidemic is to notify the public as soon as possible", he said. But he

● TURN TO PAGE 3

'My night of AWB terror in Ventersdorp'



MACABRE SHOOTING: Ventersdorp victim Tyekeza Myaka this week told of his night of terror after driving into a rightwing mob. **See page 3**

PIC: DYNAMIC IMAGES

FROM PAGE ONE

Lentegeur

added that health workers in the community should have been informed so that they could deal with the disease adequately, he said.

The Lentegeur Hospital authorities had held meetings with the Cape Town City Council, the South African Institute of Medical Research and the Department of Health and Population Development since July 28.

The first meeting, however, to ensure effective co-ordination was convened by Dr Peter Vurgarellis, director of the Western Cape Region of the Department of National Health, only held this week.

The meeting occurred virtually four months after the first cases of dysentery were reported at Lentegeur.

"Very little co-ordination has been necessary because the disease has been contained in the hospital and hasn't spilled into the community," said Dr Vurgerellis when approached for comment

"The main problem is when there are complications and we have to then involve teaching hospitals.

"We met on Monday to streamline the referrals from the community hospitals to the teaching hospitals."

Dr Vergarellis claimed that in spite of fragmentation, the various departments of health "worked as a team during crises".

Problem

He conceded, however, in a unitary health system there would be "less treading on toes"

A spokesperson for the National Medical and Dental Association (Namda) said the shigella outbreak was a "public problem" and should not have been "kept under wraps" for so long

"The public should have been informed about what was going on By covering up, the hospital has posed a health risk."

The secretary of the Mitchells Plain Co-ordinating Committee, Mrs Theresa Solomon, has urged that a proper investigation be undertaken

"We demand to know how, in these days of high-technology medicine, people could have died of shigella, and what conditions in the hospital led to the origin and spread of the disease."

Dr Ahmed Gamieldien, the medical superintendant at Lentegeur, has refuted the allegations against the hospital.

In an interview, he gave the assurance that "everything is under control"

"Shigella has been with us for centuries It is endemic which means the causative organism (Shigella Flexneri) is always present in the community

Visit to hospital of fear

South 15/8-21/8/91

By Heather Robertson

I VISITED the Lentegeur Hospital and was allowed to enter the clinic where 27 of the most severely hit patients are kept in isolation.

I had to be sprayed with disinfectant and draped in layers of protective clothing as the sister in charge of the clinic led me into each of the rooms

The most severely affected patient appeared to be comatose, struggling to breathe. I heard the next day that he had died in the early hours of the morning.

The sister, who had admitted to fearing for her own safety, was at pains to ensure that "our morale is high"

"Can you hear the music. We're feeling much better now," she assured me.

She said she had been depressed when the death rate increased and the number of patients in the clinic rose from 15 before the weekend to 28 on Monday

"But we have adapted well with support groups," she assured me.

Another nurse revealed that families who had not contacted patients for years had called to find out if they could take their relatives out of the hospital for good

"This is one of the positive spin-offs of the epidemic Families hardly keep in touch with these long-term mentally handicapped patients," she said.

There are no hand basins at the entrance to the hospital but antiseptic sprays are situated at the entrance to each ward

Many patients, particularly the severely mentally impaired, do not have control over their bowels which makes combatting the disease even more difficult. Some patients are wearing nappies.

Dr Derek Yach, of the Medical Research Council, says shigella is resistant to existing antibiotics. When these failed, the hospital had to use a new drug, Oflaxin.

Since the introduction of Oflaxin, staff report that the condition of most of the patients has improved, although one more death was reported on Wednesday. Three more cases of diarrhoea among staff were reported.

Yach explained that shigella is one of the most infectious dysentry bacteria "You can catch it from a toilet seat," he said

According to Yach, there are two different forms of the disease

The first is a large mass-based food associated outbreak "In the USA, 3 000 women at a pop concert contracted it This was traced to salad which was sold at the concert"

The MRC investigation into the food and stools of kitchen staff at Lentegeur revealed that this was not the cause of the outbreak

Overcrowding

"The second outbreak, which is what occurred at Lentegeur, commonly occurs in conditions of overcrowding and poor sanitation like jails, asylums, ships — basically confined settings," said Yach

Speaking about the nine patients that died he said it was probable that they had other diseases and their immune system was weak

A physiotherapist at the hospital revealed that the outbreak has affected more long-term patients because "good care has been given to severely mentally handicapped patients and short-term patients."

The main mode of spreading shigella is through faecal or oral transmission It can be passed on by people who do not properly wash their hands after defaecating and spreads through physical contact and shaking hands

The initial symptoms are stomach cramps, watery stools with traces of pus and blood

"To control the disease you have to focus on very rigorous handwashing and have to make the ward as antiseptic as possible That is not so easy in a hospital like Lentegeur," said Yach

But the staff at Lentegeur are working around the clock — armed with antiseptic sprayguns — staving off panic and paranoia with a good dose of toilet humour Hand washing has become a new form of therapy



HOURS after an ANC commission investigating violence in Crossroads and a police delegation visited the area on Tuesday, renewed clashes occured in the area leaving one person dead, a policeman wounded and four houses petrol-bombed

The commission, which was established by the national executive committee of the ANC, has alleged that police have not acted fast enough to solve cases where evidence was submitted by residents

After a two-hour meeting on Tuesday, the commission and the police decided to establish a liaison committee to deal with township violence and assist in solving cases.

Touring Crossroads were, above from left, Mr Andile Sindelo of the Unathi Residents Committee, Colonel Jan Benadie, Athlone district commissioner of police, Mr Sindiso Mfenyana, of the ANC commission, Mr Vincent Diba, ANC, and Mr Patrick Mathanjana



DONOR AWARENESS . . . Mr Tony Rischbieter (left) presents a video to Professor John Odell (right) to mark the launch of the Organ Donor Week in Cape Town yesterday. With him are Ms Carola Koblitz (second from right) and Ms Daphne Moses, a kidney recipient. Picture: STEWART COLMAN

(89) CT 20/8/91

1 000 await organ transplants

Staff Reporter

MORE than 1 000 critically-ill patients are desperately waiting for kidneys, hearts and livers throughout South Africa, Professor John Odell said yesterday.

Speaking at the launch of the Organ Donor Week in Cape Town, he added that less than 300 transplants are performed annually.

Prof Odell, chairman of the SA Organ Donor Foundation partly attributed the significant drop in organ donor referrals this year to the severe cost-saving measures enforced in provincial hospitals.

"The medical profession still has many sceptics with regard to transplantation, particularly now when financial constraints are being considered," he said.

The number of transplants done this year was far less than previous years and this was possibly the result of a perception by doctors that if donors were not referred then money was being saved, Prof Odell said.

"This is not true. In fact, during the recent restrictions on admissions by the administrator in order to save money, transplantation was not restricted."

So far this year a total of 60 heart, liver and kidney transplants have been performed in the Western Cape, which is lagging far behind the total of 147 in 1990, he said.

Vaccine to help kids in homeland

Sowetan 28/8/91

A LEADING pharmaceutical company has donated a Hepatitis B vaccine, Engerix B, to Tintswalo Hospital in Gazankulu to benefit 600 children in the area.

The donation is part of an awareness drive by SmithKline Beecham Pharmaceuticals because of their concern over the lack of knowledge about the infectious disease among the general public.

The donation has been made to Tintswalo Hospital on recommendation of the University of the Witwatersrand's Department of Community Health.

"The donation of the vaccines is a move in the right direction towards achieving the ideal (of providing protection from Hepatitis B) at the grassroots level," said the head of Tintswalo's Community Health Department, Dr Alan Pugh.

"It now needs to be taken further by making it a routine infant immunisation programme."

Hepatitis B is a highly contagious disease accounting for some 15 000 deaths a year in South Africa.

It is responsible for more deaths than measles and mumps during pre-immunisation days.

According to Professor Barry Schoub, head of Virology at Wits University, the best way to combat the disease is the incorporation of Engerix B into routine infant immunisation programmes in line with recommendations of the World Health Organisation.

Smithkline Beecham's awareness campaign is to include pamphlets, posters and editorial about the dangers of the disease.

Hay fever threatens Reef health

Star 30/8/91

By Brian Sokutu

Witwatersrand hospitals are bracing for a hay fever epidemic as the level of airborne pollen yesterday soared to six times more than the safe level set by the World Health Organisation (WHO).

The University of the Witwatersrand's pollen laboratory yesterday recorded a count of 362 pollen grains in a cubic metre of air. According to the WHO, counts higher than 50 are hazardous to health.

Dr Ann Cadman of the palaeontology department, who is a researcher at a pollen laboratory, said the spread of hay fever could be traced to trees, mainly those imported from the northern hemisphere, which relied on wind-blown pollen for fertilisation.

Few indigenous trees relied on wind pollination.

Hay fever spread rapidly when dry winds spread windborne pollen.

Dr Cadman said a pollen count was taken daily.

"In spring, the spread of pollen, particularly in the urban areas where many of these imported trees are planted, is worse.

"The only way out for us is to avoid planting imported trees such as ash, plane and cypress, which are wind-pollinated."

There were ways of minimising pollen-related allergies.

"People should take antihistamime medication or have desensitisation treatment if they prefer not to move to Namibia or the Karoo."

In summer and autumn, grass pollen caused itching eyes, she said.

Concern as meningitis strikes Tvl

(89)

STV 3/9/91

By Carina le Grange
Medical Reporter

A meningitis outbreak in the Transvaal, which has resulted in at least 11 victims being admitted to hospital, is believed to have originated in Mozambique, say medical experts.

Six people are being treated in the Leratong Hospital on the West Rand and another two in Rietfontein Hospital's isolation wards.

The disease is not restricted to the Reef.

The head of medical microbiology at the University of the Witwatersrand and the SA Institute for Medical Research, Professor Keith Klugman, said there had also been an outbreak in the eastern Transvaal, with people being treated at Shongwe Hospital.

He said meningitis was a contagious, life-threatening disease.

Rietfontein spokesman Dr Bernie Miller said five men had originally been treated for meningococcal meningitis after they were transferred from Leratong Hospital. Three had been discharged and the remaining two were doing well and might be discharged soon.

The patients were former Mozambicans.

One of the six under treatment at Leratong may be discharged soon.

An SA Institute of Medical Research spokesman said the institute had typed the strains now present as falling into a group associated with epidemics. "This is especially so in South Africa and is of great concern," he said.

Professor Klugman said he was aware of one person being treated at Baragwanath Hospital and of an outbreak in an unnamed prison recently, although in these instances there was no further spread of the disease.

Indications were that there was an epidemic of meningitis in Mozambique at the moment which had spread to South Africa through refugees.

There had been no cases of people infected by the original group at present infected.

He said, however, that most adults, and even children from as young as two years old, developed an immunity against the disease. Exposure to the disease did not mean a person would contract the disease.

The danger was that it was a disease of overcrowding which could easily spread in hostels, prisons, among military recruits and in hospitals.

Babies between three months and two years were at risk as this was the time during which they were not protected by immunity through breast-feeding and before they developed their own immunity.

Medical taxation slammed

THE introduction of VAT on health services means that black people are being taxed for suffering from diseases that are caused by the political deprivations, a doctor has said.

Dr Aaron Motsoaledi, vice-chairman of the Northern Transvaal region of the ANC, was addressing a fundraising dinner of the organisation on Saturday night and told the gathering that 80 percent of black people were not on medical aid, while 80 percent of whites were.

Unfair

"This means that 80 percent of the entire nation is not on medical aid and are therefore going to be taxed each time they go to a doctor or to hospital.

By MATHATHA TSEDU

"When we look at the diseases that black people suffer from, you find that they are tuberculosis, cholera and kwashiokor.

"All these are related to the lack of clean water and food.

Hospital

"The responsibility to provide purified water is with the Government but many areas in the rural areas have no water at all, let alone clean water.

"These are the people who get sick and are going to be taxed for being ill due to the deprivation by Government," Motsoaledi said.

"It is all so unfair," he said, adding: "We are fighting against this but who will help us?"

Beating cancer

(89) (89) 12/9-18/9/91 South (Southside)

UNTIL VERY recently, black people in the Western Cape had no access to any special cancer facilities. Often cancer victims did not know what was wrong with them until it was too late.

This situation began to change in 1987, with the opening of a cancer centre in Langa called Philani. Philani is a health education project which was established by the National Cancer Association (NCA) in order to educate the community about cancer.

It is the only cancer centre in the Western Cape which runs in an African township.

The NCA is now running six centres in each province in the country wich are open to all races.

According to NCA public relations officer Mrs Theresha Hanekom, Philani was established in January 1987 by a group of interested volunteers from a cross-section of the black community. She said the NCA became concerned about the number of black patients who presented themselves at a very late stage to hospital for treatments.

"It was then that we realised that there was an urgent need for education about cancer," she said.

The project has a multi-disciplinary team that includes health educators, social workers, ministers of religion, traditional healers, clinical psychologists, nursing sisters and medical doctors.

Ms Lindi Langalibalele's aims, an education officer, said Philani are to educate the community, students and teachers about the prevention of cancer and its early detection and treatment.

Ms Linda Gqiba, a nursing sister at Philani, said the NCA also render assistance to existing cancer patients by providing health education and day care free of charge to their families.

"Should the cancer prove to be ongoing, we provide expert nursing assistance, including pain control, for those who can no longer be nursed at home," she said.

The NCA is now celebrating its 60th anniversary with a Cancer Expo from 11 to 15 October in the Good Hope Centre in Cape Town.

According to Hanekom, the aim is to show the public how the NCA plans to cater for future requirements. Two shows of one and a half hours each will be held at 9am and 11.30am. Entrance of R2 per child will be charged.

An educational variety show for youth is planned for Tuesday 15 October in the main hall at the Good Hope centre with the theme "Cancer can be beaten by healthy living". Choirs from the townships and from Faure school will also form part of the show.

● The Philani Centre is at 22 Merriman Street, Langa. The telephone number is 694-1841. □

Move to combat diarrhoea deaths

16/9/91

EVERY year, worldwide, more than 3,5 million children under five die as a result of illnesses caused by diarrhoea. (89)

In South Africa, the problem is also critical. It has led to the launch of an intensive prevention and educational programme, according to the Minister of National Health Services Dr Rina Venter.

Venter said diarrhoea and the dehydration that arises from it was one of the largest causes of disease and death in developing countries.

In 1988, 6 693 deaths, all attributable to diarrhoea, were recorded on children in the age of four and under.

The deaths represent 20 percent of all deaths in that age group.

Venter said research had shown that many of the deaths could be prevented with the use of a simple and economical oral rehydration therapy (ORT), consisting of a solution of salt and sugar in water.

Soweto air puts children at risk

By ISAAC MOLEDI

CHILDREN born in Soweto risk developing respiratory illness because of high levels of sulphur dioxide and particles from burnt coal, wood and oil.

A new study of air pollution levels in Soweto reveals that the area is three times more polluted with sulphur dioxide and other particles than suburbs and areas near big power stations.

The study, believed to be the first of its kind, was conducted by the Soweto branch of the National Association for Clean Air and the University of the Witwatersrand's Research Centre during August and September 1990.

The associate professor at the Wits Research Centre and secretary of NACA's Soweto branch Mr Harold Annegan said women and children were most affected.

He suggested alternative energy sources be found to curb the trend.

"Fuel burning and dust are the major source of air pollution in Soweto.

"Although more than 90 percent of Soweto houses are electrified, people still use coal."

HEALTH

Early signs of childhood cancer

Star 24/9/91. (89)

After accidents childhood cancer remains the chief cause of death in children between the ages of one and 14. The National Cancer Association of SA, discusses cancer in children and symptoms that parents need to look out for.

The National Cancer Association of South Africa says there are at least 600 new cases of childhood cancer every year.

Dr Richard Cohn, of the Department of Paediatrics at Johannesburg Hospital, says cancer is second only to accidents as the biggest cause of death among children under the age of 16.

"One in every 600 children nationwide is diagnosed with cancer each year, as opposed to an average of one in three adults," says Dr Cohn.

And because cancers in children are often difficult to recognise, NCA President, Professor J D Anderson said parents should ensure their children have regular medical check-ups and be alert to any unusual symptoms.

Symptoms to watch out for include:

- Unusual mass or swelling.
- Unexplained paleness and loss of energy.
- Sudden tendency to bruise, bearing in mind the child who never has a bruise is the exception rather than the rule.
- Persistent, localised pain or limping, prolonged, unexplained fever or illness.
- Frequent headaches, often with vomiting.
- Sudden eye or vision changes, and excessive, rapid weight loss.

The most common childhood cancer is leukemia which accounts for about one-third of all childhood cancer deaths annually.

There are a number of different types of leukemia and over the last 30 years there has been a dramatic improvement in the survival of patients with the most common form of the disease, acute lymphocytic leukemia — from about four to 73 percent..

The prognosis for other rarer types of leukemia is less positive.

Early signs of leukemia include:

- Fatigue.
- Paleness and weight loss.
- Repeated infections, bruising easily and nosebleeds or other haemorrhages.

Other main childhood cancers are:

- Osteogenic sarcoma and Ewing's sarcoma, both of which are bone cancers.

There may be no pain at first but swelling in the area of the tumour is often a first sign.

Five-year survival rates average around 54 percent.

- Neuroblastoma — a tumour of the kidney. There may be no symptoms until a swelling develops in the child's abdomen.

About 56 percent of patients survive five years.

- Brain cancer in early stages may cause headaches, blurred or double vision, dizziness, difficulty in walking or handling objects and nausea.

Five-year survival rates are around 59 percent.

- Lymphomas and Hodgkin's Disease are cancers that involve the lymph nodes and may also invade bone marrow and other organs. They may cause swelling of lymph nodes in the neck, armpit or groin and other symptoms may include general weakness and possibly fever.

About 85 percent of children with Hodgkin's Disease survive for five years.

- Retinoblastoma, or an eye cancer, usually occurs in children under the age of four. When detected early, cure is possible with appropriate treatment.
- Wilms' tumour, a kidney cancer, may be recognised by a swelling or lump in the abdomen. Here, about 83 percent of children survive for five years.

New heart drug for SA

B Day 7/10/91 (89)

TANIA LEVY

A NEW drug which manufacturers claim will prevent thousands of deaths caused by heart failure is to be made available in SA.

Enalapril makes it easier for the heart to pump blood through the body by inhibiting the production of a hormone which constricts blood vessels.

Although forecasts for SA have not been made, the drug is expected to prevent 20 000 deaths and 100 000 hospitalisations a year in the US.

Logos Pharmaceuticals spokesman Terry Raats said the exact incidence of heart failure in SA was unknown but it could be expected to be on the increase as people lived longer.

Heart failure is suffered by about 1% of people in their 50s and rises with age to affect about 10% of people in their 80s.

Raats said that unlike a heart attack, heart failure was almost always terminal.

SA medicine 'harmed by isolation'

SA's academic isolation of the past 10 years had taken its toll on medical standards, according to international neurologist Prof Ottar Sjaastad of Norway.

Speaking before his return to Norway last week after a 10-week lecture and research tour, he added that it appeared there had not been sufficient financial resources available to support advanced research.

This was a tragedy, as there were top quality people in the neurology field and SA was clinically up to international standards.

He said standards in neurology would drop if sufficient money was not found for academic research.

"Funding is poor, and salaries are poor. Young doctors prefer private practice to doing research."

Sjaastad, one of the world's foremost experts in migraine research, worked with Medunsa neurology department's Prof Jacques Joubert and gave lectures on successfully diagnosing migraines as opposed to other headaches.

He also assisted Joubert in interviewing more than 800 migraine sufferers in Zululand.

He said up to 6% of people suffered migraines, which was often a hereditary disease.

DAVE LOURENS

Meanwhile, Glaxo pharmaceuticals corporate affairs manager Martin Jennings announced this week that an innovative drug was in the pipeline for migraine sufferers.

It had already been introduced in Britain, New Zealand and Holland, and was planned for introduction in SA early next year, subject to registration.

Jennings said Sjaastad's lectures had been invaluable in raising consciousness of migraines among general practitioners and opinion leaders.

Jennings said much pain was needlessly endured because sufferers were reluctant to consult doctors with "mere headaches".

Whooping cough vaccine here again

(89)

ARG 18/10/91

VIVIEN HORLER
Medical Reporter

A SHORTAGE of whooping cough vaccine has caused many babies to be turned away from Cape Town health clinics.

The supply of the vaccine, which comes from the Department of Health, has been erratic for some time and eventually it ran out, said Dr Michael Popkiss, Cape Town's medical officer of health.

But the shortage was now over.

"We apologise and regret the delay caused to mothers, but we have been entirely powerless. The department have had all our requirements in advance, but they haven't been able to supply everything.

"It has been most upsetting, but the new supplies which arrived this week mean we should be able to meet their needs."

Whooping cough vaccine is usually given in a combined dose with a vaccine against diphtheria and tetanus at three months, four and a half months and again at six months.

But in the past few weeks babies have been vaccinated against diphtheria and tetanus only, and their mothers asked to bring them back later for the whooping cough vaccination.

Dr Popkiss said a couple of months' delay in vaccination was unlikely to cause any health problems among individual babies, but he regretted the disruptive effect of the shortage.

"Mothers take the trouble to come to the clinics and then can't have the full dose. It may mean we miss some babies altogether."

A Department of Health spokesman was unavailable for comment.

When cancer attacks (89)

Sowetan 24/10/91.

Every Thursday in *Sowetan* a doctor from Alexandra Health Clinic gives advice on medical matters. It would be a good idea to cut these articles out and keep them in a safe place so that you can use them when you need them. Also, you can write to the doctor at A Healthy Nation, PO Box 6663, Johannesburg 2000. He might not be able to deal with every question individually, but he will do his best to deal with most of them in this column.

Many people ask what is cancer?

Our bodies are made of millions of cells. Every minute of every day these cells grow and divide in an orderly manner so that just enough cells are made to replace those which die because of ageing.

Cancer begins when the cells start to divide without order. Instead of being normal they form growths. These cells can spread to other parts of the body and form growths there.

It is similar to people in a demonstration. If they remain orderly there is no problem, but if they become disorderly the demonstration could turn into a riot and people may be killed.

So when cells divide in order there is no problem. It is only when they lose their sense of order they cause cancer and perhaps death.

Are there different types of cancer?

There are many different types of cancer, depending on where the growth is in the body. In South Africa, the following types of cancer are the most common among the black population:

MALE	FEMALE
Foodpipe	cervix
prostrate	breast
mouth	mouth
lips	lips
tongue	tongue
pharynx	foodpipe
lung	uterus
larynx	womb
liver	liver

What causes cancer?

Often it is difficult to know what causes cancer. We do know that what we eat, drink, breath in and how we live can affect our chances of getting cancer.

This is very true for some kinds of cancer such as cancer of the foodpipe. With this cancer, smoking and not having a good diet make it more likely for a person to get it.

Smoking may also cause cancer of the lungs, mouth and stomach.

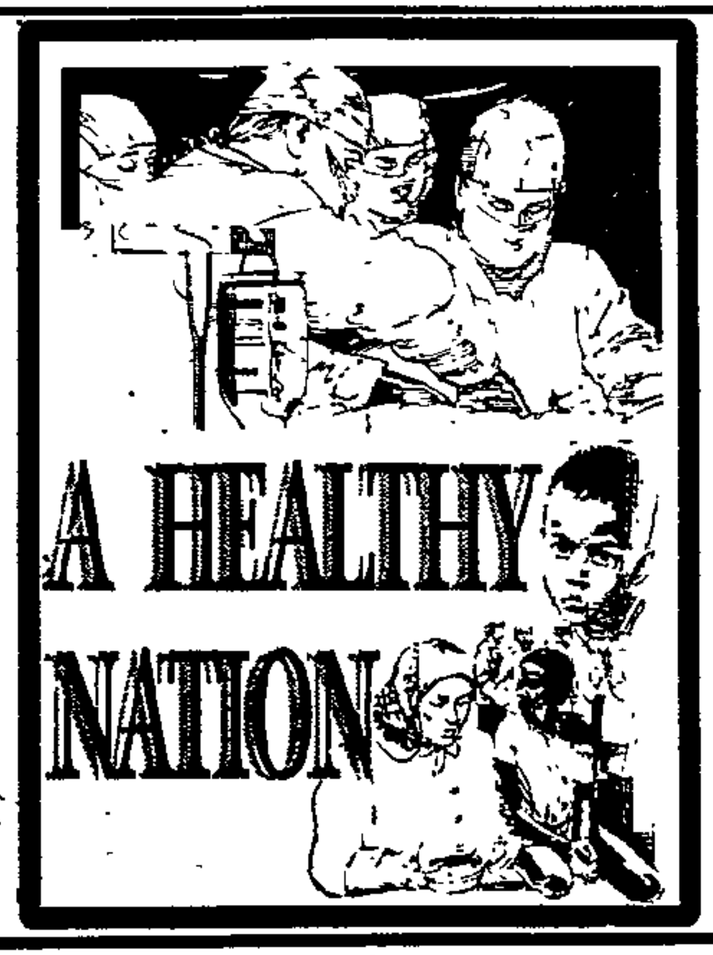
What can I do not to get cancer?

Our lifestyle is very important. The following simple rules can help you.

- Do not smoke.
- Do not drink too much.
- Do not be overweight.
- Eat lots of fruit and vegetables.
- Eat less smoked, cured or heavily spiced food.
- Eat less fat in margarine, butter, oil and red meat.
- Eat more fibre in wholewheat bread and fresh fruit and vegetables.
- Know the warning signs of cancer and see a doctor if the signs are present for longer than two weeks.
- If you are a woman, have a pap smear regularly and do monthly breast self-examination.

Can cancer be treated and cured?

Yes, and the sooner it is found, the better the chances of cure are. Cancer is usually treated through cutting out the growth (surgery), giving anti-cancer drugs (chemotherapy) or radio therapy (high energy rays like X-rays).



Natural fertiliser from lightning

Science Watch, a new column by Professor Samuel Israelstam, is designed to keepyou up to date with what is happening at the frontiers of science around the world. Israelstam is Professor Emeritus of Chemistry at Wits University.

AT first sight, the heading above may sound rather strange but lightning could become more important to our lives than we perhaps think.

Many fertilisers contain compounds of the elements nitrogen, and as we all know, fertilisers help crops to grow and the various crops which are grown, provide the necessary food for man and beast.

The element, nitrogen, is a colourless, odourless and tasteless gas and is the most plentiful element in the Earth's atmosphere, and an important part of living matter.

It occurs in air to the extent of 78 percent by weight, with oxygen, about 22 percent by weight. It is the main constituent of proteins contained in many of our foods and is found in the nucleus of living cells.

However, ordinary nitrogen gas in the air is chemically unreactive - it does not combine easily with other elements such as hydrogen and oxygen to form the compounds from which fertilisers are made.

Nevertheless, chemists have found ways of making nitrogen to combine with hydrogen to form ammonia and nature has a way to make nitrogen to combine with oxygen to form oxides of nitrogen which, with water, forms nitric acid.

This process of getting nitrogen to combine is called "the fixation of nitrogen". It is found in a combined form in coal and in certain naturally occurring chemicals such as saltpetre and ammonia and in all fertile soil which is a source utilised by plants.

Convert

In nature, nitrogen from the air is "fixed" by conversion to ammonia by certain soil bacteria, then other soil bacteria convert the ammonia to nitrates which are utilised by plants.

In industry, nitrogen from the air is "fixed" by conversion to ammonia by the Haber-Bosch process such as the one at the Modderfontein factory, not far from Johannesburg.

This ammonia is used as a raw material in many manufacturing operations such as the production of other chemicals such as fertilisers, plastics, resins, dyes and explosives.

So we all can see that nitrogen fixation is a very important process. It has been known for a long time that, when lightning struck, some of the nitrogen in the air combined with the oxygen and any water in the air, such as rain, to form nitric acid.

But it was considered that this did not take place to any extent. The nitric acid then falls to the Earth as a very dilute solution, combining in time, with the alkali in the soil to form nitrates. It was always thought that the major process of the fixation of nitrogen was that soil bacteria was the greatest source of nitrogen fixation.

A few years ago, at a conference of the American Chemical Society, Dr Edward Franzblau maintained that lightning may well be the major source of fixed nitrogen in the world.

He has based this statement on experiments he carried out in the chemistry department of the New Mexico Institute of Mining and Technology under Professor Carl Popp.

They have found that lightning accounts for about half the world's supply of fixed nitrogen. This is nearly 10 times more than most other scientists have found. It is hoped that further experiments will confirm their statements.

Relief in sight after shortage of whooping cough vaccine

(89)
ARGUS 24/10/91

VIVIEN HORLER
Medical Reporter

THE nationwide shortage of whooping cough vaccine should be over by mid-December, says the Department of Health.

The shortage has been caused by a delay in the importation of ingredients needed by the South African Institute for Medical Research, which makes the vaccine.

Dr H Steyn of the Department of Health, which supplies local authorities around the country with the vaccine, said new supplies had been sent to centres, including the Western Cape.

"These supplies should reach their destination within the next several days."

He said he was confident the situation would be back to normal by mid-December.

The whooping cough vaccine is given to babies as part of the three-in-one diphtheria, tetanus and whooping cough vaccination at three months, four-and-a-half months and six months.

The Medical Officer of Health in Cape Town, Dr Michael Popkiss, said supplies of the three-in-one had been erratic lately and on several occasions had run out altogether.

In some cases babies had been turned away from clinics. Dr Popkiss said a delay of a couple of months in a vaccination was unlikely to cause any health problems.

"But the interruption of the vaccination routine is more serious. We may find that some of the babies are not brought back and miss their shots altogether."

When cancer attacks (89)

Sowetan 24/10/97

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So when cells divide in order there is no problem. It is only when they lose their sense of order they cause cancer and perhaps death.

Are there different types of cancer?

There are many different types of cancer, depending on where the growth is in the body. In South Africa, the following types of cancer are the most common among the black population:

MALE	FEMALE
Foodpipe	cervix
prostrate	breast
mouth	mouth
lips	lips
tongue	tongue
pharynx	foodpipe
lung	uterus
larynx	womb
liver	liver

What causes cancer?

Often it is difficult to know what causes cancer. We do know that what we eat, drink, breath in and how we live can affect our chances of getting cancer.

This is very true for some kinds of cancer such as cancer of the foodpipe. With this cancer, smoking and not having a good diet make it more likely for a person to get it.

Smoking may also cause cancer of the lungs, mouth and stomach.

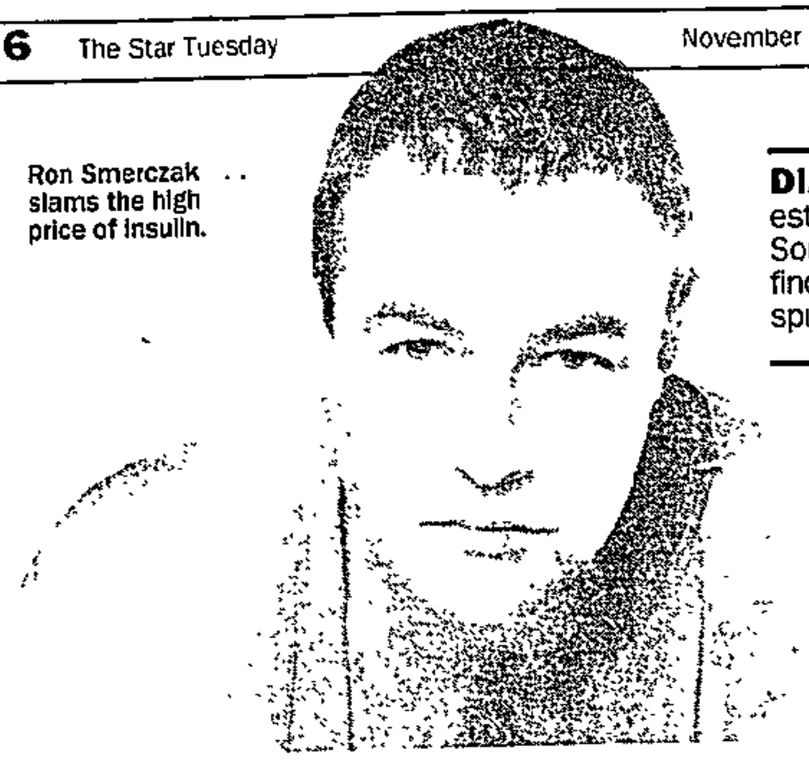
What can I do not to get cancer?

Our lifestyle is very important. The following simple rules can help you.

- Do not smoke.
- Do not drink too much.
- Do not be overweight.
- Eat lots of fruit and vegetables.
- Eat less smoked, cured or heavily spiced food.
- Eat less fat in margarine, butter, oil and red meat.
- Eat more fibre in wholewheat bread and fresh fruit and vegetables.
- Know the warning signs of cancer and see a doctor if the signs are present for longer than two weeks.
- If you are a woman, have a pap smear regularly and do monthly breast self-examination.

Can cancer be treated and cured?

Yes, and the sooner it is found, the better the chances of cure are. Cancer is usually treated through cutting out the growth (surgery), giving anti-cancer drugs (chemotherapy) or radio therapy (high energy rays like X-rays).



Ron Smerczak .. slams the high price of insulin.

DIABETES affects an estimated five percent of South Africans, but many find they cannot afford the spiralling costs of insulin.

Time to sweeten health dilemma

Star 19/11/91 (89)

SOUTH African actor Ron Smerczak is a normal, productive person, who takes special care with his diet and lifestyle. He has to because he is a diabetic.

But he is deeply concerned about the spiralling cost of insulin which, he says, is threatening to become unaffordable for many insulin-dependent diabetics.

It is estimated that at least 5 percent of South Africans are diabetic, and 20 percent of those are insulin dependent. Diabetes is particularly prevalent in the Indian community, where some entire families are diabetics

Smerczak says it costs him and thousands of other diabetics R10 000 to R12 000 a year to buy phials of insulin to stay alive.

He spoke on a radio station this week about the "morally iniquitous" exploitation of a captive market.

Huge bill

He says that figures in his possession show the wholesale price of a phial to retailers was R61,86 The retail price was R102,07 including VAT.

"If a diabetic is not wealthy, the State does provide insulin. But those who are not impoverished, but not wealthy, end up with a huge bill which is not tax deductible," he says.

"This is discrimination against people with a life-threatening disease They cannot live without their insulin, although diabetics are normal, productive people. They are often healthier than others because they take great care with their diets and lifestyles."

He adds: "We are facing a brick wall — not the drug companies or pharmacists, but a government which doesn't care about people."

Dot Shuttleworth, SA Diabetes Association Natal branch secretary, says the price of insulin is "ridiculous".

"Some Durban diabetics get treatment at the diabetes clinic at Addington Hospital. But many diabetics' medical aid funds run out by May or June. Some are lucky and get an extension from their medical aid society, but others have to foot the bill.

"Insulin dependent diabetics cannot do without their doses even for a short time. Within four days of not taking insulin, a person can slip into a coma and die I remember a little boy saying his family could not afford holidays or toys because their first consideration was to buy insulin to keep his mother alive."

Natal University Medical School's Professor Y K Seedat, a recognised world authority on diabetes and hypertension, says the cost of drugs for such chronic conditions as diabetes, hypertension and heart disease is escalating to the extent that medical aid societies are increasingly unable to cover the costs

"There is little doubt that this is all leading to one important fact we will have to face a national health insurance scheme."

Doctors must be educated on the correct usage of drugs so that the "more cost effective drugs in a Third World environment" are used.

Cheaper drugs

"If one needs insulin, that is what one needs But when dealing with high blood pressure, for instance, which is often associated with diabetes, cheaper drugs can be used," he says.

Chris Lund, marketing manager of Novo Industries (Pharmaceuticals) which is the country's major insulin manufacturer, agrees that the price is high, but says: "The price we sell insulin at is one of the lowest in the world. But once it goes through the various channels, mark-ups and tax, it becomes higher than the average world price."

He says Novo had increased the cost of insulin by 15 percent in August, below the real inflation rate.

JANETTE BENNETT

Bill of Rights doubt delays smoking law

DARIUS SANAI

GOVERNMENT's anti-smoking legislation, whose passage has been delayed since July, is being held up because of doubts about whether it would conflict with a proposed Bill of Rights, informed sources said yesterday.

The publication of the Control of Smoking and Advertising of Tobacco Draft Bill was first delayed in July after National Health Minister Rina Venter met senior representatives of the tobacco industry.

The anti-smoking legislation would enable Venter to impose widespread restrictions on the advertising of tobacco products.

But sources within the National Health Ministry and in the Tobacco Action Group (TAG) — which consists of representatives of the National Cancer Association, the SA Heart Foundation and the National Council Against Smoking — agreed yesterday that the current delay was not because of pressure from the tobacco industry.

National Council Against Smoking executive director and TAG committee member Yusuf Saloojee said publication of the legislation had been delayed because the Justice Department had been scrutinising the Bill to see whether it would infringe laws enshrined in any future Bill of Rights.

Saloojee said he was confident the delay was only temporary because he believed the Bill would not impose illegal restrictions on personal freedom.

National Health Ministry spokesman Coenie Oberholster said the anti-smoking Bill would "definitely be tabled during the coming session of Parliament".

Man dies of Congo Fever

(89)

CT 6/12/91

Staff Reporter

A 48-YEAR-OLD Montagu farmworker died in Tygerberg Hospital yesterday of the highly contagious Congo Fever, a Department of National Health and Population Development spokesman said.

As a result of their contact with the man, 398 people have been placed under surveillance which will continue until the end of next week, the spokesman said. They are "all well" at this stage, he added.

The man, who has not yet been identified, died at 10.15am yesterday after being ill since November 23 with the raging fever.

There is no antibiotic to fight the fever, which is transmitted by the bite of a tick.

In 1984 a Mr Frans Theart and the doctor who treated him died in Tygerberg Hospital.

The disease first reared its head in 1944 in the Russian Crimea and in tropical African countries such as Zaire, Tanzania and Kenya.

In the Crimea about 800 people die of the disease every year.

Congo Fever: 400 monitored

(89)
CT 7/12/91

BY IVOR CREWS

NEARLY 400 people who came into contact with a 48-year-old Montagu farmworker, Mr George Mgcamga, who died of the highly contagious Congo Fever on Thursday, are being closely monitored to ensure that the killer disease does not turn into a full-blown epidemic.

"Only those who have come into direct contact with someone suffering from Congo Fever's contaminated blood can be affected," a spokesman for the National Health and Population Development said yesterday, warning the public "not to panic".

Frantic members of the public, the spokesman said, had expressed concern about holidaying in the Montagu area and wanted to cancel their trips after reading about the farmworker contracting Congo Fever in the area.

Mr Mgcamga, who was initially thought to have contracted pneumonia, had been in contact with about 398 people including farmworkers, ambulance staff and hospital workers after he became ill on November 23.

Contacts showing any symptoms of Congo Fever will be immediately transferred to Tygerberg Hospital and placed under strict observation.

"The patient was initially taken to the Montagu Hospital, transferred to Worcester and then admitted to Tygerberg on December 1 where he was diagnosed as having Congo Fever by the National Institute of Virology," the spokesman said.

Congo fever strikes fast and kills fast

STAR 10/12/91

A Montagu farm labourer died of suspected Congo fever last week and almost 400 associates, doctors and nurses are now under observation for two weeks. CARINA LE GRANGE looks into the background of this deadly disease.

THE FIRST time Congo fever was diagnosed and recorded in South Africa was in February 1981. Since then 95 other cases have been diagnosed and recorded — and 25 of those patients died.

Annually between 150 and 250 people are suspected of having contracted haemorrhagic fevers such as Congo fever — but only about 10 people are diagnosed as having the disease.

Special Pathogens Unit chief at the Institute of Virology, Professor Bob Swanepoel, said about 30 percent of people who contracted Congo fever died from it.

He spoke after the death of the Montagu man, but said that by Friday it had not yet been conclusively determined that the man died from Congo fever.

He said the institute was responsible for diagnosing the fever countrywide, but that patients were treated at 12 select hospitals, most notably Kimberley Hospital, where three people — who never came to the attention of the media — were successfully treated last month.

He explained that Congo fever belonged to the viral haemorrhagic fever group of diseases which both caused and were characterised by bleeding.

People could contract Congo fever directly from tick bites (particularly the bontlegged tick with the scientific name Hyalomma) or from contact with blood of infected cattle and sheep, Professor Swanepoel said.

The animals themselves, however, were not prone to the disease. The animals simply contracted an infection, after which they were immune. People became infected through blood contact when dehorning, inoculating, castrating or slaughtering the animals.

Because the virus did not live long in meat due to the meat's acidity, meat did not pose a danger.

The third source of infection was through contact with blood of patients who had the disease.

Professor Swanepoel said the 30 percent death rate was very high in comparison with other diseases — except Aids.

What made the disease more frightening — in comparisen even with Aids — was the quick onset and progression.

"It happens within a very short time — within a couple of weeks people can be dead. The virus disturbs the clotting of blood, causing internal and external haemorrhaging. There is also damage to the liver and other vital organs."

He said that if it were contracted from a tick bite, the incubation period was very short — one to three days — while infection from animal blood led to the onset of the illness within five to six days, with severe headaches, fever and muscle pains similar to influenza. By the third day a rash could develop.

Haemorrhaging could start between three and five days after the onset. The patient then slipped into a coma and died unless the treatment was started very early.

Professor Swanepoel said a drug to combat the disease on trial at the Kimberley Hospital appeared to be very promising — but treatment needed to be started within the first five days of illness. The major reason for the high percentage of deaths was the fact that most people were diagnosed relatively late.

It was because of this — and the quick onset of the dangerous disease — that contacts of diagnosed patients were tracked down fast and kept under observation until the danger period in which they might show symptoms had passed. □

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Congo fever threat averted

(89) CT 27/12/91

Staff Reporter

THE threat of a highly-contagious Congo fever epidemic has been averted.

None of the almost 400 people who had come into contact with Congo fever victim Mr George Mgcama, who died in the Tygerberg Hospital on December 5, had developed the fever, a spokesman for the Department of National Health said.

A surveillance programme had been mounted to monitor the 398 people who had come into contact with Mr Mgcama, a farm labourer from the Montagu district, who had been struck down by the disease on November 23.

The disease, which is transmitted by a tick bite, has a 14-day incubation period. There is no antidote.

"All contacts have been followed up and none of them has shown any symptoms of the disease," the spokesman said.

The disease first emerged in the Cape in 1984 when a Mr Frans Theart and the doctor who treated him died in Tygerberg Hospital.

Mr Mgcama, who was originally thought to have contracted pneumonia, was initially taken to Montague Hospital, transferred to Worcester and then admitted on December 1 to Tygerberg, where he was placed under intensive care in isolation before he died.

Doctors warned on insulin test

S/Times [CM] 29/12/91

SOUTH African doctors have been warned to be "extremely" careful when they use an insulin test to explore growth hormone functions which has resulted in the death of at least five children in Britain.

By EVELYN HOLTZHAUSEN

In the "Insulin Hypoglycaemia Tolerance Test" (IHTT), children suspected of being growth hormone deficient are injected with insulin to stimulate its production.

If the insulin makes the blood sugar level fall too low, they may sometimes require the injection of small amounts of glucose.

But in the case of five children in Britain too much insulin was injected, with fatal results.

In the most recent tragedy Dr Eugene Panieri, a South African registered doctor who is visiting Britain, is alleged to have "overdosed" a young boy who recovered.

Five days later, in June this year, at St Alban's City Hospital, Hertfordshire, he apparently administered the test to a second child, four-year-old Bethan Little, who died.

St Albans police are investigating the case.

Dr Panieri could not be contacted for comment this week at an address in Queenstown, provided by the South African Medical and Dental Council, with whom he is registered.

"The test is done in South Africa," confirmed Prof Francois Bonnici, Head of the Endocrine Diabetics Unit at the University of Cape Town.

"It is a standard test but an extremely dangerous one if not properly supervised and not done by a doctor qualified and trained to administer it."

He said that as far as he knew there had been no fatalities in South Africa resulting from the test.

"We are so careful that we have only used it twice on children this year, and our unit is the biggest in the country," he said.

A Deparment of Health spokesman said the department was "not in a position to comment" as specialists who had knowledge of the test were "all on leave".

Prof Bonnici said even though the test was not often performed in South Africa, he welcomed any warning about its dangers.

"When it is done, the patient must be monitored all the time, there must be qualified staff on hand to deal with an emergency and the doctor must be trained in the test — specially in how to deal with complications," he said.

Meanwhile, health authorities in Britain are in the process of writing to paediatricians practicing in Britain to warn them that the test should be done only in "exceptional circumstances" and under proper supervision.

The warning follows an official inquiry into Bethan Little's death and the death, as a result of the test, of four other children.

The inquiry was set up to investigate how a healthy child could have been killed by a "simple diagnostic test."

Bethan was taken to hospital by her parents, Bob and Helen Little of St Albans, because of her short stature to examine whether she was producing growth hormone in the normal way.

Now, British doctors have been told to use alternative tests wherever possible, to make sure highly qualified staff are on hand to monitor the test an ensure they have the training to cope if the test goes wrong.

"The problems that have arisen have not come from the test itself, but from what has happened when the child has become hypoglycaemic," Dr Peter Swift, consultant paediatrician at the Leicester Geneneral Hospital and secretary of the British Society for Paediatric Endocrinology told reporters in Britain.

According to reports, several hospitals in Britain have stopped using the test in favour of other tests known as the glucagon, clonidine and arginine tests.

All the tests apparently have certain "hazards" which need monitoring but British doctors have been told they should now be used in preference to the IHT test, unless the circumstances are exceptional.

Incidence of flu declines

89 SUSAN RUSSELL

THE number of South Africans falling prey to winter ailments, such as colds and flu, is declining, a survey has found. BIDay

The four-year study by consumer research company Research Surveys has monitored the use and awareness of a comprehensive range of cold and flu remedies among 800 black and 800 white women over the age of 18 in major metropolitan areas. 31/12/91

Research Surveys director Binky Kellas said the incidence of colds and flu among white respondents had decreased from 58% in 1988 to 51% in 1991. While the incidence of winter ailments was generally higher among black respondents, there had also been a decline in this group.

"In 1988 about 66% of black female respondents suffered from winter related illnesses, compared with 55% in 1991."

Generally the winter of 1991 was not severe and "it is hypothesised that the severity of the symptoms of the ailments was lower".

Squatters must go, says mine hostel's owner

BDay 31/12/91

ABOUT 700 squatters due to be evicted this week from Durban Roodepoort Deep gold mine's A hostel had appealed to government for a reprieve, a spokesman for the group said yesterday.

However, a Durban Deep spokesman said the mine needed the accommodation for its own employees and their families and had told squatters it would stand by an eviction order awarded by the Supreme Court.

Vulindlela United Community of SA president Eric Ntshigela said his organisation — established in 1989 as a result of mass demolition of shacks in the PWV area — was acting on behalf of squatters and had asked for the deadline to be extended to January 31.

Intervene

It had appealed to Local Government and National Housing Minister Leon Wessels, Justice Minister Kobie Coetsee and Law and Order Minister Hernus Kriel to intervene in postponing the eviction.

The squatters — among them a small percentage of miners — had to leave the mine premises by January 2 in terms of the court order granted to the company on December 4, Ntshigela said. He said the organisation was only informed of the eviction date two weeks before Christmas and had been unable to make arrangements to help people due to be evicted.

VERA VON LIERES

The Durban Deep spokesman said the squatters "took it upon themselves to occupy the hostel when a Mr Jack Morebudi approached the mine about a year ago to purchase the hostel". The sale had not materialised.

The building had been extensively vandalised and numerous attempts by the mine management to solve the problem had failed. Overcrowding and unhygienic conditions had left management with no alternative but to approach the court for relief, the spokesman said.

"Management is prepared to provide transport for A hostel occupants and their belongings to within a radius of a 100km in order to facilitate a smooth evacuation."

The judge had asked the mine to defer eviction until the beginning of January because of the approaching Christmas season, the spokesman said. Although management had been asked for a further deferment it had indicated to the squatters that it would stand by the court order.

"The mine intends to repair the damage and convert the hostel into married accommodation for its own employees as soon as it is practically possible."

Ntshigela said possible options available to squatters included accommodation in Nigel and in Pootjie, near Lenasia.

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HEALTH & DISEASES — MISCELLANEOUS DISEASES

1992 — 1993

Health

TRENDS

DIET:

Many people, especially vegetarians, suffer from flatulence. Sufferers should eat slowly, avoid fizzy drinks and chewing gum and reduce their intake of cabbage, onions, cauliflower, beans, peas, wholemeal cereals and bread. — The Independent.

Polio may soon become extinct

STAR 2/1/92 (89)

DISEASE CONTROL
Polio may soon be eradicated, just as smallpox has been removed from the face of the Earth.

POLIOMYELITIS may soon join smallpox on the list of the world's eradicated diseases, says the Department of Health's epidemiology director, Dr Horst Kustner.

The idea first raised eyebrows in many quarters and was branded sheer speculation and ambition gone wild, but it has become an achievable dream: "Polio may soon be eradicated just as smallpox has for all practical purposes been removed from the face of the Earth," he says.

The global smallpox eradication programme of the World Health Organisation and the local Primary Health Care Programme has led to a new era of disease control.

The same principles and techniques are being applied to polio control.

The drop in the incidence of polio is already evident: in 1972 almost 900 cases were reported. But between 1980 and 1989 an average of 120 cases were reported per year.

In 1990 this dropped to five cases — and to date no cases have been reported for 1991.

Dr Kustner said a two-fold strategy applied to the eradication of polio: vaccination and surveillance and containment.

"Whenever a case of polio is reported or a person is suspected of harbouring the disease, health services must be notified fast, the patient isolated and all susceptible contacts of the patient vaccinated."

He says polio is a vaccine-preventable disease and immunisation must be maintained since humans are the only hosts for the polio virus.

CARINA LE GRANGE

Skin cancer: Computer's warning

PATRICK FARRELL
Weekend Argus Reporter

(89) ARG 1/2/92

FAIR-SKINNED people can take only 10 minutes of the midday sun in Cape Town in midsummer without protection before ultra-violet rays begin to damage their skin.

This is the finding of two researchers, Dr Charles Musil and Mr Neresh Bhagwandin, who have developed a computer programme to work out UV levels from the sun anywhere in the world.

Even though the Cape Town figures are disturbing, they are lower than for the rest of the country. Pretoria's critical time is eight minutes and Durban and Bloemfontein are between eight and nine minutes.

In midwinter the figures for Cape Town are 100 minutes and Pretoria 34 minutes.

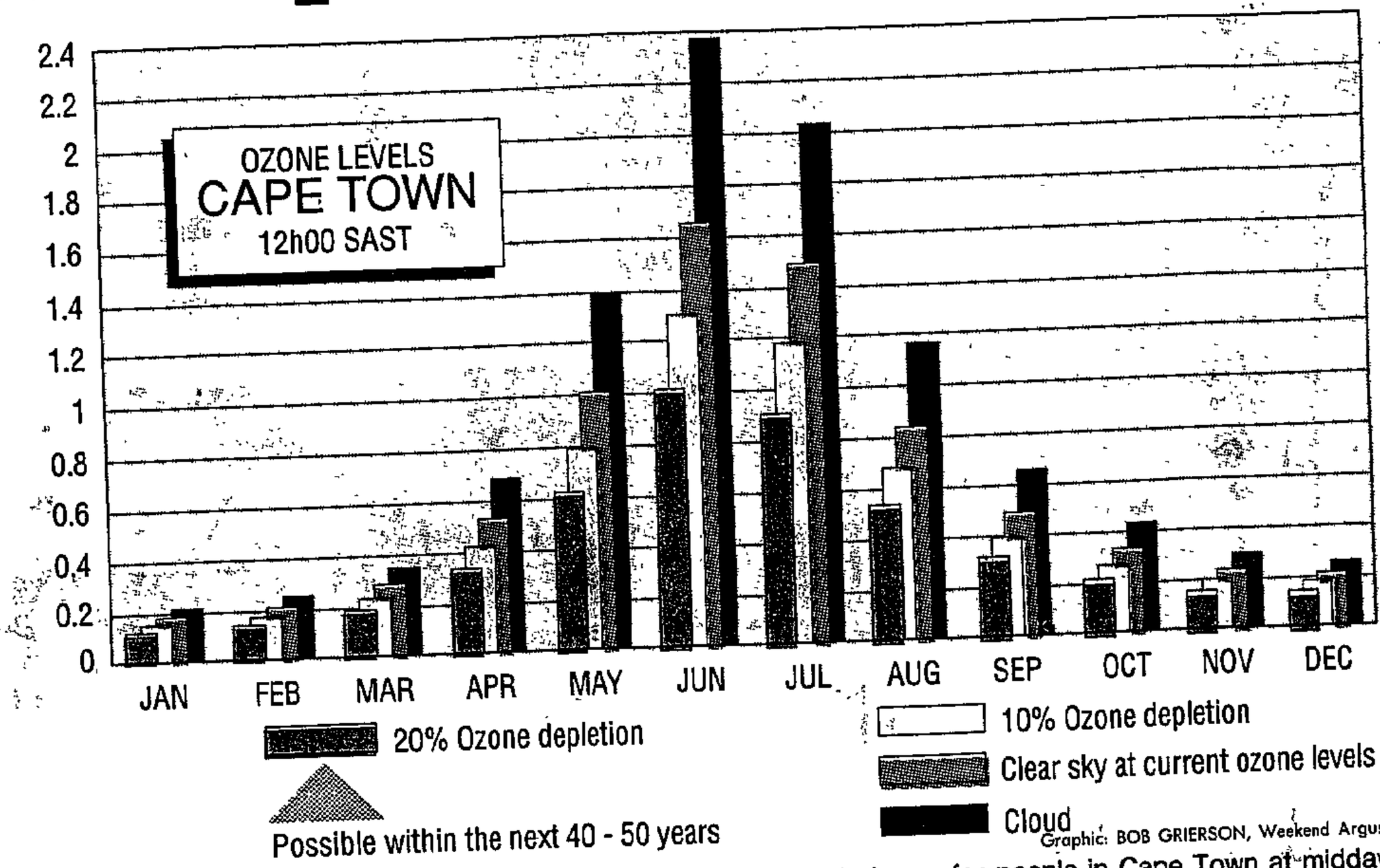
But according to a manuscript the researchers have prepared for the South African Journal of Science, if the accumulation of chloroflurocarbons (CFCs) continue at the presently monitored rate of 3,8 percent a year off Cape Point, then by the year 2050 the ozone layer above Cape Town could be expected to be reduced by between 20 and 30 percent.

If this happens then fair-skinned people in Cape Town will be able to take less than seven minutes of sun at midday without protection.

Dr Musil said the permissible exposure times were worked out for "an average caucasian skin".

"The permissible times will be even less for people with more sensitive skins and longer for darker-skinned people."

Research has proved there is a link between over-exposure to the sun and increased chance of skin cancers and tumours. A 1983 study in America found more than 400 000 new cases of skin cancer every year.



□ **SUNTIME:** This graph shows the permissible exposure time in hours for people in Cape Town at midday without protection.

Dumped toxic waste burns children

STAR 6/2/92.

By Carina le Grange

At least 15 Alexandra children received medical treatment yesterday after they suffered serious chemical burns on Tuesday as a result of illegal and dangerous dumping in the township.

It was later established the burns were caused by a substance called Xylol

One child, six-year-old Thomas Mabhena, was admitted to Tembisa Hospital.

The other children, and at least one mother, were treated at the Alexandra Health Clinic. More children, with less serious chemical burns, were expected to come for treatment yesterday afternoon.

The chemical burns were suffered after a truck illegally dumped tins of a paint-related substances on an empty site — near to a children's informal playground — in Alexandra on Monday. Residents believe the truck came from Wynberg.

An official of the Department of National Health and Development said last year, during a visit to Alexandra by the director-general Dr Coen Slabber, that it was known "agents" from outside dumped refuse in the township.

While The Star visited the site yesterday, another unmarked truck arrived to illegally dump its cargo of waste.

Moses Sedane, who works for excavators on the site, tried in vain to stop the driver and three passengers.

Sandton Environmental Health Services officer I P Ferreira, yesterday assisted the Alexandra Health Centre to establish the identity of the substance to expedite the correct treatment.

He said the area fell outside the jurisdiction of Sandton.

He said the substance had been identified as Xylol and it was a member of the benzine family. Xylol was used for purposes similar to paint stripping and was very dangerous.

Among other things, it could penetrate soft tissue, cause respiratory failure and lead to cancer and toxic dementia.

He said Sandton was investigating the matter and would take the necessary steps via the Department of National Health when they had established the origin of the substance.

Alexandra medical manager Dr Pascal Ngakane said his staff had been told that children had come into contact with the dangerous substance on Tuesday, and that they woke up yesterday with blisters over large parts of their bodies and suffering burning sensations.

He said the clinic would monitor the children's condition over the next 48 hours.

Monica Rakoma, whose son Josiah (19) sustained burns, said the children were playing on a small soccer field when they were told by men on the unmarked truck that dumped the dangerous cargo that they could help themselves to the "paint".

"The children got excited and played with the paint," she said

Among the other injured children were Grant Mbedze (8), Arnold Mbedze (13), Justus Mponyane (13), Siphiwe Janji (11), and brothers John (9) and Bongani (3) Mabhena.

Mothers of the children expressed anger about what had happened, and said if white people had lived nearby the dangerous waste would not have been dumped.

"There have always been strange things dumped in Alex .. at times food which had gone off is dumped and the children, being children, would eat it and become ill," one mother said.

Regional Services Council chief executive officer Len de Wet said the responsibility for preventing illegal and dangerous dumping usually lay primarily with the local management who could contract with other bodies to execute the task.

It was not possible yesterday afternoon to establish who was responsible for environmental safety in Alexandra.





Picked up on the playground . . . six-year-old Thomas Mabhena (above left) shows the chemical burns he sustained while his friend, who also sustained burns, looks on. (Right) A truck dumps its waste illegally in Alexandra yesterday. ● Pictures: Herbert Mabuza.

Educate parents to cut hospital costs

PARENTS should be taught how to recognise and deal with acute respiratory infections in children, thus avoiding unnecessary hospital visits.

Dr Karen Wolmarans, who won the Triomed Scholarship for Medical Research, says about 20 percent of the out-patients who visited the Red Cross Children's Hospital in Cape Town could have been managed at home without medication.

"Acute respiratory infections, particularly pneumonia, are very serious in children and the death rates in South Africa are up to 270 times higher than those recorded in Western Europe.

"At the same time, many of the out-patient visits are for trivial infections which could be managed without antibiotics at home," Wolmarans said.

Managing director of Triomed Dr Pietman Botha said Wolmarans' suggestion was important to child health in the country. - *Sowetan Reporter.*

Cut drug costs to developing countries - plea

89

Sowetan 12/2/92

MANUFACTURERS of the hepatitis-B vaccine should make the drug available to developing countries at an affordable price, according to an article in the latest issue of the *South African Medical Journal.*

Experts at an international conference on the control of hepatitis-B in developing countries, which was held in Yaounde, Cameroon, said the virus was afflicting more than 300 million people worldwide.

The conference further called on countries to:

* Recognise the significance, especially to children, of hepatitis-B infection;

* Recognise the right of all children to protection from hepatitis-B infection;

* Support the development of hepatitis-B vaccines combined with other childhood drugs;

* Establish a global fund for vaccine purchase and delivery; and

* Provide hepatitis-B vaccine to children in all countries as part of the expanded programme for immunisation.

The experts said the burden of the disease exceeded that of diphtheria, Aids, cholera and polio.

Quiet tragedy envelops maiming fever's victims

STAR 20/2/92.

(89)

PITILESS POLIO
The maiming fever that laid low multitudes before the coming of the preventive vaccines has an aftermath that no one foresaw.
PERCY BANESHIK reports.

A NEW phrase is making an appearance in the language of the medical world "Polio the Pitiless". It reflects the growing realisation that poliomyelitis, the maiming fever that laid low multitudes in sweeping epidemics before the coming of the preventive vaccines, has an aftermath that no one foresaw at its onset, anything up to 60 years ago.

Recent reports rejoice in the news that polio has been virtually eliminated from the greater part of the world, thanks to the wide adoption of anti-polio vaccines But that triumph of medical science has little bearing on this problem. It is a new problem, affecting all those who have already (perhaps half a century ago) experienced the massive destructive effects — greater or lesser, according to individual fortune — of the polio virus, and who have made a partial recovery.

What is happening is that as they grow older, they become increasingly disabled ... new disability piled on old. This comes after a lifetime of overcoming the physical handicaps.

It is not necessarily a weakening of the muscles as a normal manifestation of age; it is at least *additional* to the condition common to everyone, the accepted decline in muscle-power and brain of the elderly.

The irony is that the patient's efforts to beat the disability resulting from the polio attack long ago are now found to be *contributing* to his or her new distress.

Simply stated, what the doctors believe to be the rationale of the post-polio syndrome (sometimes referred to as the "late sequelae of polio") is that the nerve-paths first affected by the paralytic virus were obliged by the struggling patient to do work (convey the nerve signals) that they were never equipped to do.

They were called to carry the signals the totally destroyed nerve-paths no longer could.

In other words, when the branches (or network of nerves) that were put out of action by the virus — resulting in disuse and atrophy of the muscles they normally served — made a partial recovery, they were called on to do more than nature intended them to do in the first place.

THEY stood up to the demands valiantly. But eventually they wore out. Thus "old polios" (a semi-affectionate term used by concerned doctors) are finding the partially restored function they acquired by applying grim determination is now deserting them.

It is a poor reward for all those decades of denying that they were unable to proceed in life at a normal pace, and all those years of asserting that they were able to deal with the world on its own terms.

Scientists are studying the syndrome with some diligence, and have come up with an array of theories as to why and how the condition proceeds. But their approach so far has been essentially diagnostic, and none appears to have come up with an answer as to how to stop the process, so lately discovered.

Moreover, why should they? Polio is a disease of the past (so the world reports adumbrate), so the urgent necessity that brought about the development of the Salk and Sabin vaccines in the 1950s is no longer called for.

Remember, it was America's panic at the growing incidence of polio epidemics in that country in the 1930s that inspired the "March of Dimes" campaign, a crash fund-raising effort that swept the country and resulted in speedy development of the preventive vaccines.

And it may be remembered that here in South Africa, at about the same time, polio hit often enough to spark a much-publicised effort that raised hundreds of thousands of rands for the South African Polio Research Foundation, a brand new institution, purpose-built, equipped and staffed in the name of polio. (Now renamed the National Institute for Virology, it develops other anti-viral vaccines against such diseases as Lassa fever or Green Monkey fever).

The number of ageing polio "survivors" grows fewer with the passing years. Of course, medical science is alert to their needs, but to no urgent degree.

This is the quiet tragedy of polio survivors of advanced years. As one elderly veteran of the fray has put it, "I have served one life sentence. Now I am to serve another".

Warned of black 'contamination'

THE STILFONTEIN City Council has sent 40 000 letters to white residents, warning that they could be "contaminated" by their domestic workers.

Following a disconnection of water and electricity to the Western Transvaal township of Khuma, white Stilfontein residents have been told they are in danger of catching "cholera, dysentery, diarrhoea etc." from domestic workers living in Khuma.

In response to the letters, the South African Council of Churches (SACC) said: "What can bring people to this place of such inhumanity when one group is warned of health hazards while at the same time another group is placed in a position where the chance of such health hazards are increased?

"Are black lives still of less value than white? It seems as if the Stilfontein council thinks so," the SACC said in a press release.

The letters say white residents should "ensure" a domestic worker did "not prepare any foodstuffs or handle any utensils unless she has washed herself properly".

Sowetan 14/2/92 - 2pp

Great hope that cancer can be beaten

(89) Sowetan 21/2/92

By MOKGADI PELA

THE general message on cancer this week has been one of hope - cancer can be beaten.

This was done through Cancer Awareness Week on the Radio 702 helpline and pamphlets focusing on the educati n and prevention aspects of the disease. The idea of the Cancer Awareness Week was summed up by the National Cancer Association's education director, Mrs Sonja Oudtshoorn: "We wanted to reach thousands of people and make them think about cancer, find out about it, talk about it and talk to us."

According to the NCA there are more than 200 cancers. The most prevalent among black males are: oesophagus, prostrate, mouth, lip, tongue and pharynx, lung and liver while females suffer cervical cancer, breast cancer, cancer of the uterus, lip and liver.

Physical factors

Ninety percent of cancers are linked to environmental factors. Tobacco smoke, diet, asbestos, physical factors such as sunlight and nuclear radiation are linked to the development of cancer.

There is overwhelming scientific evidence linking smoking with cancer of the lungs, larynx, kidneys and stomach.

The NCA lists the following rules to reduce cancer:

- Ceasing to smoke;
- Moderation in the consumption of alcohol;
- Avoiding becoming overweight and reducing fatty foods;
- Eating fruits and vegetables with a high fibre content;
- Limiting the intake of heavily spiced food;
- Knowing the warning signs of cancer and consulting a doctor if the signs persist for more than two weeks; and
- Females should regularly have pap smear tests and do monthly breast self-examinations.

The warning signs of cancer include unusual bleeding or discharge, a lump or thickening in the breast, a sore that does not heal, change in the normal bowel or bladder habits, persistent cough, indigestion or difficulty in swallowing and sudden unexplained weight loss.

Cancer is usually treated through drugs and radiotherapy. The success of the treatment greatly depends on the type of cancer, the amount of spread and early detection. The NCA this week reminded people that heeding its advice was a sure way of proving that cancer can be beaten.

Decrease in heart disease in SA

23/3/92 (89)

Own Correspondent

DURBAN. — The prevalence of coronary heart disease among white South Africans has decreased over the past 11 years but is still very high, according to international standards.

Dr Krisela Steyn presented figures which showed the decrease in heart disease in both white men and women at a talk at the Lipid and Atherosclerosis Society of Southern Africa's second annual congress at the Elangeni hotel here yesterday on risk factors for coronary heart disease in South Africa.

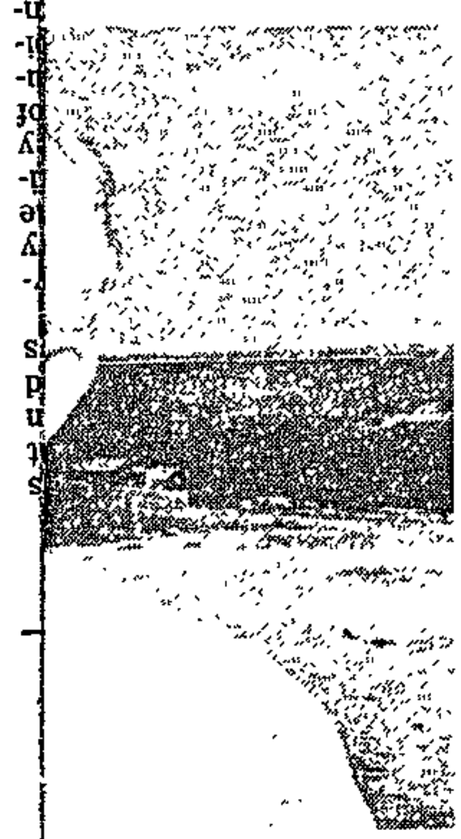
Dr Steyn, the chief specialist scientist of the South African Medical Research Council's centre for epidemiological studies, said the main risk factors remained smoking, high blood pressure and cholesterol.

"Anyone who smokes has an increased risk of heart disease. Between 1979 and 1990, the number of white people smoking actually decreased. However, more urban black women and urban Indians are taking up smoking."

According to the 1990 figures Dr Steyn presented, 4,8 million South Africans of all races between the ages of 15 and 64 smoked. The total number of people suffering from hypercholesterolaemia (high cholesterol level) is also 4,8m.

Similarly there are 5,4m South Africans of all races between 15 and 64 years of age who suffer from high blood pressure.

Dr Steyn said the best way to change this trend is lifestyle modification in the form of not smoking, adapting eating habits and taking moderate exercise.



Picture: ROBERT BOTHA

Cholera rumour quashed

KATHRYN STRACHAN

REPORTS of a cholera outbreak in the Zevenfontein squatter community were yesterday dismissed by Bryanston DP MP Rupert Lorimer as right-wing rumours spread to create fear among whites ahead of the March 17 referendum.

Transvaal Provincial Administration (TPA) representative Zakkie Lombard and squatter spokesman Pinky Moloi confirmed there were no incidences of cholera.

TPA liaison officer Magda du Toit said the administration's clinic had found eight cases of diarrhoea.

Lorimer said it was surprising there had not been a cholera outbreak, given the squatters' living conditions. Better toilet facilities and more water were needed to ensure that disease did not break out, he said.

The biggest problem was that the camp, being so near the Klein Jukskei river, posed the threat of sewage seeping into the water — which put the squatters at great risk of contracting diseases such as cholera, he said.

The TPA said the Department of National Health and the Randburg Town Council were being called in.

Inkatha and police hold talks on violence

THE Inkatha Freedom Party held discussions with the police yesterday, Soweto police liaison officer Lt-Col Tienie Halgryn has confirmed.

He said if the party wished to release a statement on the matter, "then we have no comment".

Inkatha central committee member Themba Khoza released a statement last night saying further discussions would be held within six days.

"The SA Police undertook to invite an ANC delegation to attend," he said.

Khoza said yesterday's meeting was called after the latest attack on Soweto train commuters and the "shooting of IFP members by the police at Inhlazane station on February 27".

Khoza was referring to an incident when a group of armed men, apparently from the Jabulani single-sex hostel, attempted to board a train at the Inhlazane railway station.

Police refused to allow the men on the train, and then used teargas to disperse the group. Three people were injured. — Sapa.

prisoners are not tolerated either and offenders are dealt with severely.

(b) (i) and (ii)
63 Members were charged in public courts due to complaints of assault on prisoners. Of these, 39 members were found not guilty whilst 24 members were found guilty.

(2) (a) 200 Members stood trial in terms of Prisons Regulation 71(1)(hh) read together with Section 53 of the Correctional Services Act, 1959 (Act 8 of 1959) on counts of assault on prisoners. Of these, 144 members were found not guilty whilst 56 members were found guilty and were sentenced in terms of Section 53(2) of the Correctional Services Act.

In respect of 889 complaints, no substance could be found after thorough investigation to lay charges against any member of the Department. Furthermore, the Attorney-General refused to prosecute in 153 cases. On 31 December 1991, the remaining cases were still being dealt with.

(b) Inquiries in terms of the stipulations of Prisons Regulation 77(1) to determine the suitability of members to remain in service, inter alia led to the dismissal of one member against whom an offence of assault on a prisoner was recorded.

(c) Besides sentences imposed in terms of Section 53 of the Correctional Services Act, 1959 (Act 8 of 1959) during departmental trials, members were seriously warned against such actions and were made aware of the implications thereof on their careers. Furthermore, such inadmissible conduct is duly considered in the competence evaluation of such members.

Insulin: representations

107. Mr M J ELLIS asked the Minister of National Health:

(1) Whether she has received any representations from individuals and/or organizations with regard to the high cost of insulin required for the treatment of diabetes; if so, (a) from whom or what organizations and (b) what was the nature of these representations;

(2) Whether she has been notified of any medical aid schemes that do not cover the cost of insulin required for such purposes; if so,

(3) whether she will furnish the names of these medical aid schemes; if not, why not; if so, what are their names;

(4) whether she intends taking any steps to make insulin more freely available to diabetics; if not, why not; if so, (a) what steps and (b) when;

(5) whether she will make a statement on the matter?

B267E

The MINISTER OF NATIONAL HEALTH:

(1) Yes,

(a) four members of the public and the South African Diabetic Association, and

(b) the excessive increase in the price of insulin and requests that

(i) diabetics without a medical aid scheme may purchase the medicine at cost price at the provincial hospitals;

(ii) diabetics with a medical aid scheme who exceed the maximum may purchase the medicine at cost price at the provincial hospitals;

(iii) price control on medicine be instituted;

(iv) a maximum limit on life-saving medicine be instituted; and

(v) insulin be exempted from value added tax;

(2) no;

(3) falls away;

(4) no, insulin is but one of a variety of life-saving medicines and to exclude insulin at this stage is not appropriate. There was, however, a forum on the high cost of medicine on 28 February 1992. It is expected that steps which flow from the forum will address this type of problems;

(5) (a) and (b) fall away;

(5) no.

Prison warders: killed/injured

111. Mr D J DALLING asked the Minister of Correctional Services:

(1) Whether any prison warders were (a) killed and (b) seriously injured by prisoners in 1991; if so, (i) how many and (ii) in which prisons;

(2) whether any prisoners were (a) killed and (b) seriously injured by fellow prisoners in that year; if so, (i) how many and (ii) in which prisons?

B275E

The MINISTER OF CORRECTIONAL SERVICES:

(1) (a) No.

(i) No member of the Department of Correctional Services was killed by prisoners during 1991.

(b) Yes.

(i) and (ii)

Fifteen (15) members of the Department of Correctional Services were seriously injured by prisoners during 1991 at the prisons mentioned below and a further twenty five (25) members received medical treatment, consultations for minor injuries sustained as a result of assaults by prisoners:

Barberton
Beaufort West
Brandvlei
Durban
Groenpunt
Losperfontein
Middelburg (Cape)
Modderbee
Robben Island
St Albans
Victor Verster
Voortrekkerhoogte

(2) (a) Yes.

(i) and (ii)

Available information indicates that twelve (12) prisoners were killed by fellow-prisoners at the following prisons: Bethal, Goedemoed, Groenpunt, Johannesburg, Krugersdorp, Modderbee, St Albans Maximum, Pretoria, Stellenbosch, Leeuwkop and Pollsmoor. However, these inquests have not yet been finalized.

All deaths in prisons in respect of which a medical practitioner is unable to certify that the prisoner died as a result of natural causes, are reported to the South African Police or a magistrate for the necessary investigations. Inquests into every case where death is ascribed to unknown or unnatural causes, are instituted in terms of the stipulations of the Inquest Act, 1959 (Act 58 of 1959) and at the same time departmental investigations are also undertaken.

(b) Yes.

(i) and (ii)

The Department of Correctional Services regards every complaint of an assault, no matter how petty, in a serious light. Prisoners are daily given the opportunity to lodge any complaint or request, and preventative measures, for example the reallocation of sleeping quarters or working places, are instituted should it appear that there is reason to believe that a prisoner is threatened.

In cases of injuries which are related to complaints of alleged assault, a suitable entry is made in a complaints register and/or a register of injuries and in addition to the necessary medical treatment which may be administered or prescribed by the medical officer, a departmental inquiry is instituted into the alleged assault. Where such a complaint is substantiated suitable disciplinary action is taken in terms of Prisons Regulation 99 in the case of minor assaults, while complaints of serious assault are reported to the South African Police without delay for investigation in order that the legal process may take

Cont....D

HOUSE OF ASSEMBLY

QUESTIONS

†Indicates translated version.

For written reply:

General Affairs:

Telephone services/private post boxes: Johannesburg North

154. Mr P G SOAL asked the Minister of Posts and Telecommunications:

Whether any applications for (a) telephone services and (b) private post boxes were outstanding in the Johannesburg North constituency as at the latest specified date for which figures are available; if so, (i) how many in each suburb falling within this constituency and (ii) when is it anticipated that the backlog will be eliminated?

B373E

The MINISTER OF POSTS AND TELECOMMUNICATIONS:

(a) Yes, 1 802 as at 29 February 1992;

(i)

Bryanston	133
Farmall	17
Fourways	144
Diepsloot	28
Lanseria	13
Olivedale	48
Randburg	101
Bromhof	165
Rosebank	350
Parkview	92
Sandton	0
Benmore Gardens	172
Kelvin	189
Sunninghill Park	350
TOTAL	1 802

(ii) it is expected that 667 of the waiting applicants will be provided with telephone service by the end of April 1992 and the remaining 1 135 in the course of the 1992/93 financial year. At this stage it is not possible to indicate a definite or anticipated date when the backlog will be eliminated as the execution of planned projects is entirely dependent on the availability of sufficient funds for the 1992/93 financial year.

(b) Yes;

(i) 224 as at 11 March 1992 (Birnam Park 55, Parkhurst 49 and Craighall 120).

(ii) 250 additional boxes will be installed at the Birnam Park Post Office during the course of 1992. The installation of additional boxes at the Parkhurst and Craighall Post Offices is not possible because of the structure of the buildings. The waiting applicants at these offices can only be accommodated as and when existing boxes become vacant. Specific dates for the elimination of the backlog cannot, therefore, be furnished. It should be mentioned that vacant boxes exist at Pinegowrie (537), Saxonwold (4), Northlands (13), Bramley (772) and Parklands (300).

PE Provincial Hospital: beds

178. Mr E W TRENT asked the Minister of National Health:

What, in respect of the Port Elizabeth Provincial Hospital, was the (a) total number of beds, and (b) number of beds not utilized, in 1991?

B421E

The MINISTER OF NATIONAL HEALTH:

(a) 722 beds and

(b) average of 338 beds.

Notifiable diseases

181. Mr M J ELLIS asked the Minister of National Health:

How many cases of each notifiable disease were notified in respect of each race group in 1991? B424E

Cont - - D

The MINISTER OF NATIONAL HEALTH:

(89)

Notified cases of each notifiable medical condition
Republic of South Africa, 1991
as on 23 March 1992

Disease	*Indian*	*Black*	*Coloured*	*White*
Cholera	0	2	0	0
Typhoid fever	16	1 045	35	20
Food poisoning	0	74	1	50
Brucellosis	0	3	0	12
Leprosy	0	21	0	0
Diptheria	0	9	3	0
Meningococcal infections	4	385	271	36
Tetanus	0	61	5	1
Legionellosis	0	7	2	4
Poliomyelitis	0	1	0	0
Measles	25	1 791	129	143
Haemorrhagic fevers of Africa	0	0	3	1
Rabies	0	5	0	2
Trachoma	0	0	0	0
Typhus fever	0	1	1	0
Malaria	0	4 194	8	140
Congenital syphilis	0	64	19	0
Acute rheumatic fever	4	14	12	5
Tetanus neonatorum	0	7	0	0
Lead poisoning	0	9	0	2
Pesticidal poisoning	1	73	43	7
Tuberculosis	521	47 233	18 554	748
Viral hepatitis	54	757	421	1 188
Anthrax	0	0	0	0
Paratyphoid fever	0	0	0	0
Plague	0	0	0	0
Smallpox	0	0	0	0
Yellow fever	0	0	0	0

Livingstone Hospital: beds

183 Lt-Gen R H D ROGERS asked the Minister of National Health:

What, in respect of the Livingstone Hospital, was the (a) total number of beds, and (b) number of beds not utilized, in 1991? B434E

The MINISTER OF NATIONAL HEALTH:

(a) 793 beds and

(b) none.

Own Affairs:

Subsidized school buses

40. Mr R M BURROWS asked the Minister of Education and Culture:

(a) (i) How many pupils were transported daily in subsidized school buses, and (ii) what was the total net annual cost of such transport, in each province in 1991 and (b) what is each provincial education department's policy regarding the transportation of pupils? B353E

The MINISTER OF EDUCATION AND CULTURE:

(a)	(i)	(ii)
Cape	9 493	R6 501 120
Natal	6 692	R6 520 000
Orange Free State	3 145	R3 565 665
Transvaal	54 382	R49 062 660

(b) All provinces are moving towards a self-supporting school bus transport system. At present, preference is given to pupils who live farther than 3 km from their nearest school and where public transport or hostel accommodation is not available

QUESTIONS

†Indicates translated version.

For written reply.

Own Affairs.

Training of teachers: cost

5. Mr M RAJAB asked the Minister of Education and Culture:

What is the estimated cost to the State of training a teacher at a (a) university and (b) teacher-training college on a non-residential full-time basis for four years? D42E

The MINISTER OF EDUCATION AND CULTURE:

The lowest estimated cost to the State of training a teacher on a non-residential full-time basis for four years is as follows:

(a) at a University, say University of Durban Westville, the State subsidy of R7 371,00 p.a. × 4 which is R29 484,00 (minimum).

(b) at a teacher-training college, say Springfield College of Education, R11 283,39 p.a. × 4 which is R45 133,56 (minimum).

Mass protests: Indian schools

6. Mr M RAJAB asked the Minister of Education and Culture:

(1) Whether teachers in Indian schools staged any mass protests during 1991; if so, (a) when, (b) where, (c) why and (d) what amount of teaching time was lost as a result;

(2) whether he will make a statement on the matter? D43E

The MINISTER OF EDUCATION AND CULTURE:

(1) Yes

(a) From 5 February 1991 to 8 February 1991.

(b) Staged "sit-in/chalk down" in most schools.

(c) Protest against implementation of rationalization of staff as per E.C. Circular 2 of 1991.

(d) Approximately eight hours in total per school in 90% of the schools. The "chalk down" was spread over four days.

(2) No.

Teachers: retrenched/made redundant/retired early

7. Mr M RAJAB asked the Minister of Education and Culture:

(1) How many qualified teachers were made redundant, retrenched or retired early because of a surplus of teachers during or at the end of 1991;

(2) How many teachers who qualified at the end of 1991 were unable to obtain posts from the beginning of 1992;

(3) (a) how many Indian student teachers have bursaries from the State at present and (b) (i) what is the annual cost to the State of such bursaries and (ii) in respect of what year is this information furnished? D44E

The MINISTER OF EDUCATION AND CULTURE:

(1) There are no surplus teachers according to the needs of the Department. However, in terms of the SANEP formula, the basis on which funding for Education is provided, 2 743 teachers were regarded as additional to the establishment. 509 Educators were granted early retirement in terms of rationalization measures adopted by the Department

(2) 22—declined to take up posts away from home districts.

(3) (a) 574

(b) (i) R1 524 400

(ii) 1992 (as at 4 March).

Subsidized school buses

8. Mr M RAJAB asked the Minister of Education and Culture:

(1) (a) How many pupils attending schools falling under his Department were transported daily in subsidized school buses,

cont--p

(90)

Nutrition aid spending

HALF of the R220m allocated by government for its Nutrition Development Programme in 1991/92 had been spent in the first three months, National Health Minister Rina Venter, said yesterday.

Since the inception of the NDP, 270 groups had applied for funds and 194 had received them. The balance of R110m would be paid out this year. BIDay 1/4/92

'Hunger tragedy weeks away'

(90) ET 9/4/92

Own Correspondent

JOHANNESBURG. — Operation Hunger is in desperate need of funds as an estimated 3000 to 5000 starving people approach the organisation every week, executive director Mrs Ina Perlman said yesterday.

She said there had to be a greater awareness "of the hunger tragedy that is a couple of weeks away".

"We need your money now, as we have never needed it before," Mrs Perlman said.

She added that past funds from the government — R10 million over three months — only covered a fraction of Operation Hunger's needs.

The organisation requires R9m a month for the next nine months, and presently spends R7m a month feeding just under two million people, but fears that there might be 2,25 million people by the end of June.

Mrs Perlman blamed the problem on the slave wages paid to farm labourers and domestic workers and said it made it impossible for workers to maintain their families in reasonable health.

"We must accept that we will never wipe out chronic malnutrition in this country until there is a minimum wage for farm and domestic workers; anything less is bandaging open sores," she said.

Mrs Perlman said Operation Hunger would soon approach the government for more money, and would also travel to Europe and the United States on a "begging bowl" trip. She said she did not think the country's political leaders knew how bad the problem is.

Appeal to combat poverty

A STRONG appeal to the Government for urgent and decisive action to combat poverty and malnutrition in South Africa has been made by Independent Development Trust chairman, Mr Jan Steyn.

He was speaking on behalf of the Nutrition Society of Southern Africa and the IDT.

Steyn urged the Government to adopt a committed and co-ordinated approach to malnutrition on a short as well as long-term basis.

"The present ravages of the drought and rapidly escalating levels of unemployment are the recipe for a nutritional catastrophe of unprecedented proportions," he told the congress.

Steyn pointed out that the most basic survival needs of food and safe shelter, including safe water and sanitation, were inadequate for a large proportion of the black population.

At least 12 per cent of black pre-school children suffered from chronic protein energy malnutrition, while 31 percent of rural children and 10-15 per cent of children in urban areas were underweight, Steyn said.

He said certain key issues which had to be addressed included:

- The establishment of a directorate of nutrition within the health department; and
- The appointment of an advisory council to advise the Government. - *Sapa*

Waiting for food or death

C/Press 12/4/92 (90)

By SOPHIE TEMA

SOUTH AFRICA's shame is hidden away from us in the hills and desolate places.

Here the "matchstick people" sit about in silence – waiting for food or death.

They need R81-million to get through the next nine months, according to the organisation on the frontline of the issue, Operation Hunger.

The victims in these areas are those least able to fend for themselves – mainly infants, little children and the aged.

Ina Perlman, head of Operation Hunger, said to feed (keep alive) the present starving masses would cost R9-million a month for the next nine months.

City Press visited some sites in the Orange Free State last week with Perlman where we saw shocking scenes of little children with bulging, staring eyes, puffy faces, distended bellies and reed-thin legs.

They sat rigidly and in silence. One could almost feel the life draining out of the place, like a clock winding down.



STAYING ALIVE . . . An old couple eats to survive. ■ Pic: EVANS MBOWENI

Perlman said this tragedy was heightened by the fact starvation is taking place in obscure rural areas, especially in the homelands. The drought was the "last straw".

Chronic malnutrition, she said, would be with us as long as there is no minimum wage for farm and domestic workers.

F Diale (not his real name) said he worked for seven years on a farm for R60 a month until paralysed down one side by a stroke.

He was instantly dismissed and no attempt was made by the farmer to assist him in obtaining his disability pension.

I was shocked to see that Diale and 19 others live in one room in an abandoned farmhouse.

I spoke to Mapule, a stunted six-year-old girl, who lives in a shack with three younger brothers and a baby sister. Their mom recently picked up a job as a domestic worker in Bloemfontein and can only visit on Sundays.

So little Mapule cooks, cleans and takes care of four younger siblings . . .

Mapule said a dozen potatoes used to be their only food, but Operation Hunger arranged that one of the neighbours come to their soup kitchen for a daily ration for the little ones.

I looked around. A lifetime spent working on a farm had resulted in one bed, one table and three beat-up chairs.

Perlman said squatters' numbers were swelling as destitute, dislocated people set up hovels and prepared to battle for their lives.



HARDEST HIT . . . Will this child make it? (90) ■ Pic: EVANS MBOWENI

C/Press 12/4/92 (298)

Diet boost for Bishop Lavis mums, babies

ANDREA WEISS
Medical Reporter

(90) ARLG 22/4/92

A PILOT project to supplement the diets of mothers and babies in Bishop Lavis could be the beginning of a national health revolution.

Funded from the government's food aid programme, the project is based on dramatic success achieved in Chile over the past 30 years.

In Bishop Lavis, the objective is not merely to provide food parcels, but to cut the vicious cycle of poverty created by under-nourishment which stunts physical and intellectual development.

Mothers will be required to attend clinics regularly to qualify for food parcels. The spin-off is that the clinic will be a forum for education on breastfeeding and weaning practices and ensure full immunisation of children.

Dr Spinnie Benadé, who heads the Medical Research Council's new National Programme: Nutritional Intervention, is enthusiastic about its prospects.

"We can make nutritional miracles happen before socio-economic miracles," he maintains.

Chile has achieved remarkable success with its nutritional supplementation programme, political upheaval notwithstanding.

In the past 30 years the country has gone from a Marxist government to a military dictatorship and now is ruled by an elected government of Christian democrats.

The country, which once had the highest infant mortality rate in South America, now has the lowest, a drop from 200 a 1 000 people to 15 a 1 000.

Further evidence of this success story is that the average Chilean height has increased by 12cm.

Dr Benadé says he was "converted" when he visited Chile a few years ago and believes it is time to depart from the traditionally held view that the problems of poverty are outside the ambit of scientists.

The MRC is the guiding force behind the Bishop Lavis scheme and is seeking to "go into partnership" with anybody able to set up nutritional intervention projects elsewhere in the country.

Dr Benadé is adamant that the MRC does not wish to duplicate services but to provide scientific backing to ensure that the limited money available is spent most effectively.

He says under-nourishment is costing the country an enormous amount in lost human potential.

He points out that no scheme in South Africa can be universally applied because of regional and cultural differences in diet, and different models will have to be developed for different parts of the country.

Models are in the pipeline for Stellenbosch, Lebowa in the Northern Transvaal and Namaqualand.

Bishop Lavis has been chosen for the pilot because a high percentage of babies born there are underweight, indicating that the mothers are undernourished.

Work on establishing a scientific basis for the project has already started.

From July, women in their last three months of pregnancy will be given appropriate food parcels when they visit the clinic. The only requirement will be that they attend the clinic every month until their children are two.

Dr Fernando Monckeberg, brainchild of the Chilean programme, is visiting South Africa and has a special interest in the Bishop Lavis project.

He puts Chile's success down to dramatic improvements in feeding, education and sanitation.

Dr Monckeberg says a project of this nature takes at least a generation to show results. Because of political changes, an "institution with prestige" is needed to elaborate the policy and keep it running for a long time. In Chile's case it was a university that played this role.

"It takes a whole package to improve the quality of life of the total population. The results are not short-term. The most difficult thing has been to keep the equilibrium."

"Poverty is not just a question of social justice. It doesn't just damage the individual but the whole country."

Cape cancer body targets townships

ANDREA WEISS
Health Reporter

89 ARG 7/5/92

CANCER is still significantly more prevalent than Aids, says the National Cancer Association.

It is estimated that one in three South Africans will have some encounter with cancer, be it a mild form of skin cancer or something more serious.

The Cape Western branch of the association is actively engaged in a programme to reach people with cancer in the townships of the Western Cape, an area which has largely been ignored in the past.

Among the difficult tasks it has set itself is to establish exactly how many people in the townships are affected and which cancers are prevalent.

At present, most cancer statistics for these areas come from hospitals where people who are seriously ill present themselves.

But this obscures the real picture which has yet to be established in the mushrooming new settlements of the Western Cape.

Mr Jo Lazarus, assistant director of the branch, believes it is "crucial to establish the scale of needs" to provide the right kind of services.

Philani project in Langa is actively engaged in tackling this task.

Target areas include an educational and information service aimed at preventing cancers, 75 percent of which are caused by environmental and lifestyle factors.

The association also wants to expand its patient care into these areas. This includes screening services, referrals and setting up home care for cancer patients.

Warning on Vitamin K injections

STAR 11/5/92

By Marika Sboros (89)

A vitamin injection routinely given to South African babies at birth may double the risk of cancer in childhood.

Fears about injections of Vitamin K surfaced in Britain last week after a study by Jean Golding, professor of paediatric and perinatal epidemiology at the Institute of Child Health in Bristol, found a statistical link between Vitamin K given by injection and leukaemia. There was no link found between Vitamin K given by mouth and any cancer.

The Independent newspaper reported that the British Department of Health was taking advice on its recommendation that all new-born babies should be given Vitamin K in the light of the new study's findings.

A spokesman for the South African Department of National Health said the department was unaware of the new findings, and would not reconsider its recommendations on Vitamin K injections at birth until "more insight" was gained into the study and its implications.

Unaware

Dr Harm Pretorius, chief director of the department's Advanced health section, said he had consulted a number of professional bodies, including the UCT Centre for Safety of Medicines, all of whom were unaware of the British findings.

The injections had been used routinely at birth for 40 years, he said, and he would be surprised if there were a link with increased risk of cancer.

All new-born babies are low in Vitamin K, which is essential for the blood-clotting mechanisms. Vitamin K is given to prevent bleeding, which can cause brain haemorrhage, disability or even death.

Professor Golding reportedly found an association between Vitamin K injections and childhood leukaemia two years ago, but believed it could have been a chance finding.

However, her new survey, which involved a much larger group of children, has confirmed the earlier results.

Professor Golding said cause and effect still had to be proved. While she now felt it "might not be a good idea to give Vitamin K by injection", it should still be given orally.

Cases of flu on the decline in SA

THEO RAWANA

FEWER South Africans are getting flu, and indications are that this slide will continue this winter, researchers have found.

Conducted by research company Research Surveys among 800 white and 800 black women in major metropolitan areas, the survey found that the incidence of winter ailments such as coughs, colds and flu decreased from 58% of the population in 1988 to 51% last year.

The Wintercheck study monitored awareness and usage of a comprehensive range of cough, cold and influenza remedies and other associated products.

The Researchers said although whites on average used more boxes of tissue paper than blacks, significantly fewer respondents of both races used tissues last winter.

Binky Kellas, director of the company's Omnichek division, says: "The incidence of winter ailments (coughs, colds and flu) has decreased from 58% in 1988 to 51% last year."

The downward trend is particularly clear in the case of husbands of white respondents — from 51% in 1988 and 1989 to 43% in 1990 and 41% in 1991.

"The drop over the past three years in the incidence of coughs, colds and influenza is also apparent among white and black respondents' children aged 16 and under," the survey says.

In 1988, about 66% of black women suffered from winter-related illnesses compared with 55% last year.

"However, the incidence of winter ailments for every year of the study was higher among blacks than whites — and particularly among adults."

First aid for skin harmed by bleaching

STAR 20/5/92

(89)

THE "Black is Beautiful" message appears to be falling on deaf ears. If black women were hearing it, they wouldn't still be using skin-lightener creams, and be in desperate need of help to repair the damage caused by the creams' bleaching chemical.

Most skin lighteners contain hydroquinone — an active colouring chemical that bleaches skin. Local skin specialists say the damage caused by the cumulative use of hydroquinone is irreparable, but Dr Danne Montague-King, an American biochemist who visited South Africa recently, is confident that there is a treatment that can remove those blemishes, ugly spots and dark patches of damaged skin.

He claims that his treatment, which is available over the counter in South Africa, will "give you back the skin you had when you were born".

For many years, black women have eroded, damaged, and burnt their skin with products that were not meant for them, says Dr Montague-King, who claims to have pioneered the first effective treatment for black skin in the United States.

He says facial creams with more than two percent of hydroquinone are banned in the US. In South Africa, skin lighteners that contain hydroquinone used to be sold over the counter, but are now available only on prescription, says a local dermatologist.

Dr Montague-King's research in this country has led to a a "botanical breakthrough of natural enzymes and acids" which he claims can help repair damage caused by hydroquinone. Through a three-stage treatment, products can "bring life back to a dead skin".

The treatment involves a cleanser which removes ashy, dead dark skin cells and excess oils. It also controls acne, blackheads, whiteheads and prepares skin for the next product that fades dark spots and uneven colouring naturally, he says. A sun block is used to protect the skin against the harmful rays of the sun.

Black skin has certain advantages, says Dr Montague-King: black people have more epidermal (outer) layers of the skin, and larger oil and sweat glands that moisturise the skin; also, black skin has the ability to reproduce new skin cells faster and therefore does not visibly age as fast. But these "pluses become minuses if the wrong chemistry is used", he says.

Sceptical

However, two prominent dermatologists — who cannot be named for ethical reasons — are sceptical of Dr Montague-King's claims.

A Bedfordview dermatologist says there are a number of products derived from natural acids that are currently available in South Africa. These superficial peeling agents, he says, can heal acne, blemishes and other pigmentation problems.

But the damage caused by hydroquinone is deep within the skin. Treatment applied on the outside of the skin cannot penetrate deeply enough to repair damage. Says one dermatologist: "There is no cream that can shift the permanent pigmentation damage from the use of hydroquinone."

...ancer patients

A new oncology day clinic for the treatment of cancer in patients was recently opened in Morningside, Sandton.

The Sandton Oncology Centre caters for all non-surgical therapies in one location. In the past, cancer patients often had to travel to different locations for the various components of their treatment.

It comprises advanced diagnostic facilities as well as comprehensive paramedical services ranging from clinical psychology to dietary advice and physiotherapy.

STAR 21/5/92.

Clinic a boon for cancer patients

Woodstock alleys a health hazard

ST Times (Cape Metro) (89) 31/5/92 31/5/92

By KURT SWART

THE lanes and alleys of Woodstock have become a health hazard with uncontrolled dumping of refuse threatening typhoid and other diseases as well as causing a large rat influx to the area.

And the main culprits in the dumping of household waste are the residents themselves, says Mr David Oliver, a city council environmental health officer.

Mr Oliver is also a B Admin (Development Studies) honours student at the University of the Western Cape and is researching community partipation in the maintenance of Woodstock's alleys.

"Every day a council team cleans the lanes. On Wednesday the whole labour force is used to clear the lanes. For health inspectors dirty lanes are a priority, but not it seems for the residents," Mr Oliver said.

He said the problems with the lanes, particularly in lower Woodstock, were increased rodent activitity in the form of rats, bad smells emanating from the lanes because of the amount of refuse dumped there, and a large vagrant population, many of whom defecated in the lanes.

"The rats are brought to the lanes by the refuse. Despite being cleaned every day, the refuse in the lanes contains enough food for the rats to be there on a daily basis. We have free rodent control for residential premises and we have received quite a number of complaints.

"Flies breed in faeces and in refuse. For example when a rotten fish lies in the lane for a day, flies will breed in it, bad smells will emanate, and the risk of disease is increased.

"Children are vulnerable to diseases like typhoid and diarrhoea carried from the refuse into households by flies who settled on food and babies' milk."

Residents were largely to blame for the situation, said Mr Oliver.

"Residents know council will do the cleaning-up, so they just throw their garbage over the walls of their property into the lanes.

"When a law enforcement officer goes along to enquire who has dumped the refuse, nobody knows."

Perils of travel through Africa

Sowetan 5/6/92 (6) (89)

Sowetan Correspondent

SOUTH Africans travelling in Africa have been warned by a medical expert to take precautions against certain diseases, some of which are potentially fatal.

"The major risk which faces any business person in Africa is contracting numerous infectious diseases," Dr Simon Robson, deputy director of the Medical Research Centre of the University of Cape Town, told members of the South African Foreign Trade Organisation.

He said the major diseases were malaria and cholera, but there was a growing danger from hepatitis-B.

"Looking at hepatitis-B, the facts for Africa are frightening," he said. "Estimates are that between eight and 15 percent of all Africa's inhabitants are chronically infected with it. However, between 70 and 95 percent of the continent's inhabitants have been exposed to the virus."

The disease, which affected the liver, was transmitted through human body fluids and could be contracted from inadequately sterilised hypodermic or surgical needles, he said.

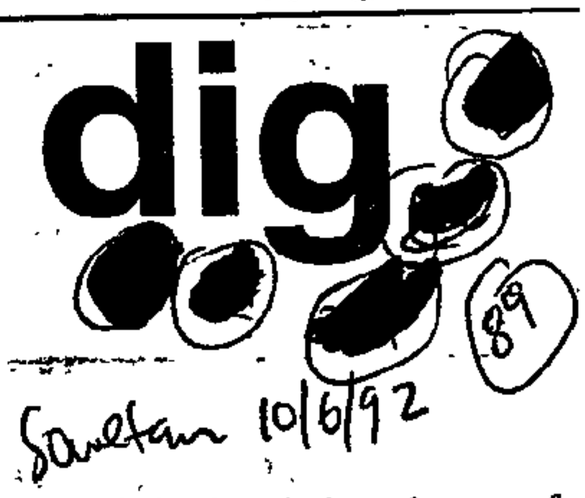
It was now suspected that it might also be transmitted by blood-sucking insects such as bedbugs.

Robson advised business people to try to travel in pairs or groups and arrange for a member of the party to see that any needle or syringe that was about to be used on another member of the party came from a sealed pack.

Travellers should have themselves vaccinated against hepatitis B before going to a part of Africa where there was a high risk of infection, he said.

sdav June 10 1992

Bara strikers dig in their heels



By KENOSI MODISANE

THE NATIONAL Education and Health Workers Union yesterday vowed to defy a court interdict and continue with their strike and pickets over wage grievances at Baragwanath Hospital.

A Nehawu spokesman yesterday said the union members from 10 other clinics in Soweto were expected to join the strike.

A *Sowetan* team which visited the hospital yesterday found workers at the kitchen preparing food.

The workers, as well as those in the theatres and mortuary, are exempted from the strike.

Nurses and doctors have to fetch the food from the kitchen for distribution to patients.

"We are operating normally although the floors and other areas are not clean. Nurses fetch the food for patients in the wards," a chef said.

Some workers at the theatre were found performing their normal chores, though one said: "It is a bit slow since Monday. But we are all the same on duty and exempted from joining the picket."

Nehawu spokesman Mr Chicks Moletsane yesterday accused the hospital authorities of unfairness and said: "They asked the TPA to apply for an interdict restraining us from picketing in the hospital instead of solving the problem."

Baragwanath officials yesterday locked doors leading to the administration block and security personnel barred reporters from entering.

An attempt to reach the hospital spokesman for comment through the telephone also drew a blank.

It was yesterday reported that student nurses at the hospital held a meeting on Monday where a decision was taken to picket daily for an hour in sympathy with the striking workers.

"We are prepared to resume our duties as soon as the authorities respond to our demands," Moletsane said.

Cancer, birth defects most controversial

89

STAR 18/6/92

ILLNESSES attributable to chemicals used in agriculture vary widely.

Of possible long-term effects, the potential of agrichemicals to cause cancer and birth defects has aroused the most controversy, says Dr Lesley London of UCT's department of community medicine.

Despite the controversy, evidence is accumulating for an association between cancer and TCDD, a contaminant of some herbicides and present in the defoliant (Agent Orange) used extensively in the Vietnam conflict, says Dr London, writing in the South African Medical Journal.

TCDD has been shown to cross the human placenta and to cause foetal abnormalities in laboratory animals.

Impairment of the immune system has also been associated with agrichemicals.

As well, Dr London notes the following:

- Paraquat exposure has been implicated in the development of early onset Parkinson's disease.
- Skin problems may be caused by a wide range of agrichemicals, including paraquat, organophsophates and organochlorines.
- Dizziness, blurring of vision, increased secretions and ultimately muscle paralysis and respiratory failure are associated with organophosphates and carbamates.
- The development of central nervous system damage is associated with organochlorines.
- Recent interest has focused on the contribution of organophosphate exposure to the development of neuropsychological problems.
- Organochlorine pesticides have been implicated in liver and renal damage in experimental animals; kepone is known to be toxic to the liver in humans.



An African village ... where malaria often stalks.

Malaria fight is made to order

Sowetan 22/6/92

Diversity the key in the WHO's battle

(89)

GENEVA - Conceding that one grand strategy can't defeat malaria, the World Health Organisation is preparing to fight one of the world's great killers with tactics tailored to the locale.

For instance, health care workers in an African village may be able to reduce malaria deaths by getting families to use bed nets. Workers in a Thai village, meanwhile, may have more success distributing anti-malaria drugs.

Malaria is the leading killer of children worldwide. It is endemic in 100 countries, said Dr Pieter de Raadt, WHO director of the Division of the Control of Tropical Diseases.

He said that at least 25 countries will reorganise their malaria control efforts in the next five years.

"Every minute two children worldwide die of malaria," said Dr Craig Wallace, who is organising the official launch of the WHO project at an international meeting in Amsterdam in October.

"I am very enthusiastic about the WHO programme. This is the way to go," said Dr Thomas Wellems, head of genetics and pharmacology of the malaria section of the US National Institutes of Health in Bethesda, Maryland.

All too often people think of malaria as the same disease wherever it strikes, Wellems said. "But in reality malaria depends on the nature of the mosquito in each locality, the living conditions of the population, and the virulence of the parasite in that particular region."

In the past few years, the WHO has collected data from villages about the extent of disease, access to anti-malaria drugs, and capabilities of local health care systems.

The last major WHO initiative in the 1950s, a global campaign aimed at wiping out malaria, failed because communities in poor countries lacked the money, people, or health care systems once foreign help ran out.

The new approach seeks to work within existing health care systems so programmes can be maintained long after international experts leave. Success relies on co-operation of local health care workers. - Sapa-AP.

Pneumonia still lethal among SA infants

SOUTH 20/6-24/6/92 (89)

Pneumonia is the major cause of infectious deaths among infants in many South African cities, including Cape Town.

But MRC researchers say pneumonia deaths among black children are probably under-reported and the data therefore unreliable.

Among coloured children under the age of one year, pneumonia accounted for 14,5 percent of deaths and among white and Asian children, 6,7 percent last year.

While the pneumonia mortality rate among whites, coloureds and Asians has declined substantially in the past 18 years, it is still at least seven times higher than the death rate in developed countries such as France and the Netherlands.

The researchers recommended that attention be given to the prevention and early treatment of pneumonia.

Factors that need to be considered include malnutrition and indoor pollution, both from tobacco smoke and the burning of domestic fuel.

Concern as Govt puts out tender for banned DDT

STAR 27/6/92 (89)

JULIENNE DU TOIT

THE Government has put out a tender for 213 tons of DDT insecticide, a banned substance in South Africa and most other countries.

Although it is banned, the banning notice makes provision for its use in malaria control, as long as it is not used outdoors where it can harm the environment.

But according to a recent thesis done through the University of Potchefstroom, it has been detected in the environment, and in the breast milk of mothers living in the areas sprayed.

Since the 1950s the insecticide, which stays in the food chain almost indefinitely and causes cancer and deaths in certain animals, has been used against malaria-carrying mosquitoes in South Africa.

It is sprayed in the mud huts of people living in northern Natal and KwaZulu and northern Natal by authorities linked to the Department of National Health. "DDT has never killed a single person," said Dr Edmund Hartwig, specialist scientist at the Department of National Health.

He said it was essential to use DDT because it was the best alternative and, if it was not used, the incidence of malaria would shoot up.

High levels in breast milk

But Dr Henk Bouwman at the University of Potchefstroom has just done research on DDT levels in humans and nature in KwaZulu, and has found very high levels in breast milk and babies' blood serum, and lower levels in the region's fish.

He acknowledged that no human had ever died of DDT poisoning since no one could ingest enough of it. And it did not cause cancer in humans.

But it does cause liver damage in children and adults very similar to that caused by alcohol. And the effects on babies, whose neurological functions are not fully developed, has not been studied.

DDT is used because it is cheap and because it breaks down extremely slowly. This is bad news for the environment, because it persists in the food chain and becomes more and more concentrated as it passes through the different animals, until there is a lethal dosage and predators start dying.

According to Hartwig, DDT is the only substance effective in mud huts, because all other insecticides soak in, while DDT eventually crystallises out of the mud.

But new research, being done overseas and in Natal by the Medical Research Council, is showing that synthetic pyrethroids could be the answer.

Towards a super-vaccine at birth

STAR 6/7/92. (89)

BETTER THAN CURE

Although 80 percent of the world's children are immunised against major childhood diseases, the search goes on for a genetically-engineered formula which will speed up the World Health Organisation's drive towards universal childhood vaccination.

VACCINE production, for long a sleepy sideline of the pharmaceutical industry, is being rejuvenated through a combination of new technology and corporate restructuring.

With the help of biotechnology, researchers are working to develop vaccines for diseases against which there is as yet no vaccine protection, such as malaria and Aids.

At the same time, they are searching for ways to combine existing vaccines into one super-vaccine which would deliver immunity against all serious childhood illnesses in a single dose soon after birth.

The corporate background to vaccine development is changing as fast as the science, through mergers and alliances which are transforming a patchwork of national vaccine companies into a handful of global players.

Institut Merieux of France and Merck of the United States recently signed a letter of intent to co-operate on developing and marketing combined childhood vaccines for the US market. There is speculation in the pharmaceutical industry that Lederle and SmithKline Beecham are planning a vaccines alliance to balance the link-up between Merieux and Merck.

The primary reason for these alliances, according to Merieux chief executive Alain Merieux, is that the future lies in combined vaccines with multiple antigens. (Antigens are the proteins produced by viruses and bacteria which stimulate the immune system to make protective antibodies.)

No single company has enough antigens to make a good all-in-one vaccine on its own.

Two triple childhood vaccines are already used routinely: DTP, against diphtheria, tetanus and pertussis (whooping cough); and MMR, against measles, mumps and rubella.



This won't hurt . . . drug companies are striving for an all-in-one vaccine.

STAR 6/7/97 (89)

Jacques Armand, Merieux's vaccine development and production director, says it will be feasible within two years to expand DTP into a six-fold vaccine, by adding polio, hepatitis B and haemophilus influenzae b (the latter is a relatively new vaccine which protects against a common form of bacterial meningitis).

A more serious obstacle to combining childhood vaccines is that the current strains need to be given at different ages to provoke the best immune response.

It would be impossible, for example, to add the current measles vaccine, given at 12 to 15 months, to DTP, which is generally given in three doses at two, three and four months.

So the search is on for new strains that will confer immunity soon after birth.

Non-genetic techniques will also improve existing vaccines. The World Health Organisation (WHO) is particularly keen on micro-encapsulation, a new delivery system based on tiny biodegradable capsules which release vaccine slowly into the bloodstream in a way that mimics repeated injections.

Goal

The worldwide effort to produce a vaccine against malaria — which kills about 2 million people a year, mostly African children — will be successful within five years, Merieux believes.

Multiple vaccines will help the WHO and Unicef (United Nations Children's Fund) to achieve their goal of universal childhood vaccination. Already 80 percent of the world's children have been immunised against the six main childhood diseases — measles, diphtheria, whooping cough, tetanus, polio and tuberculosis — compared with only 10 percent a decade ago.

Only about 20 diseases have commercially available vaccines. There is none yet for many diseases that cause widespread death, including dengue, rotavirus diarrhoea, hepatitis A and E, acute respiratory infections, meningococcal meningitis, malaria and Aids.

FINANCIAL TIMES

ing enrolled at Tembisa Hospital.

protest at Medunsa University in solidarity with striking Nehawu

[illegible] march would be held in sympathy

[illegible] future."

Gluckman made his allegations. Picture: CATHERINE ROSS

Blacks hate the police, says PAC

RAY HARTLEY

THE PAC blamed the growing number of police deaths on a general climate of hatred and mistrust of the security forces, PAC publicity secretary Barney Desai said yesterday.

"The black population has a very poor impression of the SAP. You cannot isolate 1 700 blacks killed since the signing of the peace accord from the killing of policemen," he said.

He said he condemned all killings, but while they did not have the ballot, the bullet could not be abandoned.

Desai said he could not speak for the PAC's military wing Apla. People claiming to be members of Apla recently claimed responsibility for the campaign to kill policemen.

But Desai said he could not understand why the PAC had been accused of being behind the so-called "Kill-a-Cop-a-Day" campaign.

He said ANC supporters had been seen carrying placards with the slogan, but the ANC had not been blamed for the campaign.

Desai said recent revelations of police complicity in the death of prisoners were evidence of how the police raised the anger of blacks.

"Against that background, how must the people feel when they think about this?" he asked.

Sapa reports that police commissioner Gen Johann van der Merwe said individuals or organisations threatening or harming policemen would be prosecuted to the full extent of the law. B1DAY 28/7/92

Reacting to a claim purportedly made by "the national commander of the Azanian Peoples Liberation Army in SA", one Karl Zimbiri, Van der Merwe said the SAP had no evidence Apla had been responsible for the killings. "But an intensive investigation into the murder of each and every policeman is taking place.

"I want to warn those individuals and organisations concerned to refrain from making such threats (against policemen). Members of the SAP will defend themselves, and those who encourage or attempt to carry out such attacks will have to bear the consequences of their actions," Van der Merwe said.

18 people die in weekend unrest

RAY HARTLEY

POLICE reported yesterday that 18 people died in unrest in Natal and the Transvaal at the weekend.

Five people were killed near Heidelberg in the southeastern Transvaal, while another five died in the Vaal Triangle. B1DAY

Eight people were killed and three were injured after violence broke out between residents and taxi operators at Folweni near Umbumbulu on the Natal South Coast on Sunday.

The bodies of two men who had been stabbed and shot were found in the East Rand squatter camp of Zonkeziswe on Sunday. 28/7/92

The body of a 21-year-old man who had been shot was found in an outside room of his parents' house in Sharpeville yesterday morning, police said.

In Sebokeng the body of a municipal police constable who had been shot was found on Saturday, while in Orange Farm a man was shot dead.

Two men were killed — one shot and the other burnt — in Boipatong on Saturday night.

Cholera threat to Vaal Triangle

ADRIAN HADLAND

AN OUTBREAK of cholera was imminent in the Vaal Triangle following the vandalism of municipal water mains and sewers, Vaal Triangle Negotiating Forum secretary Nigel Mandy said yesterday.

An urgent meeting of the forum this week will discuss the services crisis in the region together with possible measures to prevent vandalism to municipal installations. B1DAY 28/7/92.

The forum's activities were suspended recently following the withdrawal of the Vaal Civic Association but the calling of an urgent meeting had been authorised, Mandy said.

Mandy said about R8m, "which the councils do not have", was required to repair damaged water mains, sewers and roads.

He said all services in Sebokeng, Sharpeville, Bophelong and Boipatong would continue to deteriorate and break down, while money to pay municipal workers was running out.

Electricity supplies in virtually every township in the region were likely to be disconnected following the continuing non-payment of services levies, Mandy said.

Levy payments for June in the Vaal Triangle had dropped to below 20%.

Sapa reports the Vaal Civic Association agreed to attend the forum meeting tomorrow..

But the civic body was prepared to discuss only a resumption of sanitation services and repairs to mains, said association general secretary Talitha Jona.

The ANC-linked civic group, through its contacts in Vaal townships, was prepared to ensure the safety of workers brought in to make repairs and to resume the services. "But the same does not apply to the collection of refuse, which has not been done since 1984," said Jona.

Meanwhile, DP spokesman Douglas Gibson yesterday blamed the ANC's mass action for the breakdown of the townships' essential health services.

He said the ANC leadership should ask itself which was more important — their political agenda or the health and perhaps the lives of ordinary people.

"The ANC will have to learn the responsibilities of power — power can be abused and political mass action, which harms the people instead of helping them, is surely an abuse of power."

Flu virus danger

A DANGEROUS flu virus is sweeping through the greater Maritzburg area in the Natal Midlands, leaving a number of people dead. Sowetan 30/7/92

A Maritzburg health department spokesman Dr John Esstratiou said several deaths had been reported, but he could not provide statistics. (89)

All age groups, he said, had been affected. But young children and old people were more susceptible to infection. Smokers and asthmatics had been most affected. - *Sapa.*

Fighting diarrhoea

JOHANNESBURG's City Health Department has launched a campaign to tackle the high incidence of child deaths caused by acute diarrhoea.

"Each year, thousands of children under the age of five years die from acute diarrhoea in South Africa," the city's director of community health, Dr Eric Buch, pointed out in a statement. "Almost three quarters of these deaths are due to dehydration which can be prevented by the application of a very simple and cheap remedy."

The campaign will encourage the use of oral rehydration therapy by families in the home through the distribution of pamphlets, posters, an intensification of health education for mothers at health clinics and possible television and radio advertising. ORT consists of giving the child a solution of sugar, salt and water to drink to replace the body fluids lost through diarrhoea. - *Sapa.*

Sowetan 31/1/92

Stinking disgrace!

By MOSES MAMAILA

BATTLE-WEARY Vaal residents could soon find themselves engaged in a war of a different kind – the one against disease.

Squalor and filth are everywhere in the Vaal townships, threatening a possible outbreak of disease such as cholera as every open space in the area is being turned into a dumping zone and streets into streams of sewerage.

Maintenance has come to a standstill in the area and there is no clear reason why this is the case.

Sebokeng administrator Herman Immelman blames the township youths for the mess.

"The boys who have taken control of the townships practically prevent our personnel from going into the area and cleaning up," he said.

But this is strongly denied by residents who maintain that the authorities stopped providing essential services long before violence erupted in the area.

Authorities claim that street barricades erected by youths as defence units since violence erupted in the Vaal township were preventing municipal workers from doing their job.

Speaking about the breakdown of services in the troubled townships, Immelman said about R8-million would be required for the reconstruction of damaged roads, water and sewerage pipes.

"But we would have to wait for the youths to remove the barricades and fill up the trenches. Our men cannot move into the township. Some who have defied warnings were assaulted, robbed and threatened with burning if they ever returned.

"We cannot repair the sewerage pipes and now the area is a mess. But what can we do if we are barred from entering the area?" asked Immelman.

Residents dismissed Immelman's comments as cheap propaganda.

"The council stopped providing the services in November last year. The story that they were intimidated in the townships is just a silly excuse," said ANC Sebokeng vice-chairman Watch Mothibeli.

"The authorities told us they had a critical shortage of trucks. They also claimed that residents were not paying rent.

"The council officials are able to move around in Sebokeng, switching off lights. But when they are called upon to repair damaged pipes they are afraid to enter the area," he added.

Mothibeli's claims were confirmed by a plumber employed by the council. He categorically stated that all the trucks meant to remove refuse were out of order.

The plumber, who refused to be named for fear of losing his job, denied that council workers were intimidated by the youths.

"The truth is that the authorities say there is no money because the residents are not paying their rent," he said.

Denying this, Immelman challenged the plumber to come forward and he would send him to work in the township without delay.

He added that although there was a shortage of trucks there were still some operating.

Approached for comment, Vaal Civic Association spokesman Paul Sithole said he doubted if the main reason for the authorities not providing services in the township was alleged intimidation by the youths.

VCA had never received reports that the council workers were harassed in the locations.

"Besides, these workers stay in the townships. Why are they not harassed when they return to their homes?" he asked.

While the residents and the authorities continue to trade accusations, the kids are playing in the streets polluted by rubbish and sewage with little knowledge of the health risks involved.

Toddlers scavenged from the heaps of refuse which litter the townships.

Medical experts have expressed fears of an outbreak of water-borne diseases such as cholera if no drastic measures are taken to normalise the conditions.

A Red Cross doctor said that clinics and health services were functioning under a lot of strain, adding that mobile units could no longer operate in the area because they were intimidated.

Elderly people who were too sick to come to the clinic could not be assisted as "our cars are in danger of the youths who have no respect for the Red Cross".



WASTELAND OF NEGLECT ... These kids have to live with streets of filthy water and rotting rubbish as their playground. They also run the risk of catching cholera. ■ Pic: TLADI KHUELE

'Trenchtown' ruled by thugs

By STAN MHLONGO

AN ANC call to throw up the barricades has been taken up so enthusiastically in Orange Farm that the ANC is having second thoughts.

The Vaal town, called "Trenchtown" by residents, sports a host of diggers so dedicated that nobody – not even the lumbering security force vehicles – can navigate their deep slashes in the earth.

And the digging goes on relentlessly – as if the act of digging itself has some kind of curative power.

Trenchdiggers at work sound like old, weary miners with their deep, soulful chanting.

Resident Motsumi Ramola said the trench-digging campaign started two months ago after anonymous gunmen opened fire on bystanders.

Now the situation is out of hand. Most services have broken down.

Garbage was piled up high and the place stank.

Two weeks ago the Evaton ANC branch asked residents not to "burn private cars or vehicles taking food into the townships" and to stop "charging" at the barricades.

But many residents feel anarchy has set in and hooligans rule the roost.

Danger on the Vaal this time from disease

89

Cipher 2/8/92

POLLUTION

Pollution, respiratory tract illnesses link investigated

STAR 18/8/92

89

Data collected on more than 10 000 children between the ages of eight and 12 as part of the Vaal Triangle Air Pollution Health Study (Vaps) have indicated that up to 70 percent of the children suffer from respiratory tract illnesses during the year. **Pharmacy Today** reports.

The Vaps project was set up two years ago by the Medical Research Council (MRC) to establish the levels of air pollution in the industry-intensive Vaal Triangle and whether these levels are affecting the health of residents.

The respiratory conditions reported in children include sinusitis, earache, hayfever and chronic runny noses.

"The high levels of particular matter and pollen measured in the region could be an explanation for these conditions and are being investigated further," Dr Petro Terblanche of the MRC explains.

Asthma

The prevalence of lower respiratory tract illnesses (bronchitis, pneumonia, wheezing, chronic cough), was 29 percent in the Vaal Triangle population. The normal distribution of this in the South African population is not known.

The prevalence of asthma was 7,7 percent, which is similar to what is expected in the general South African population.

Significant risk factors for respiratory illnesses in the Vaal Triangle children are the period of residency (the longer the residency, the bigger the risk), maternal smoking, younger age and female gender. The study also found that there is a strong correlation between the mother's concern about air pollution and the prevalence of respiratory illnesses.

It is assumed that because the child is ill, the mother is aware and concerned about air pollution rather than the opposite. This hypothesis is currently being tested.

The preliminary results of the Vaps have now enabled the project to focus on specific problems. The top priorities of the study for the next two to four years are:

- To determine the relative contributions of pollen and man-made air pollution to the high percentage of children suffering from upper respiratory illnesses.

This data is crucial in decision-making regarding control priorities.

Evaluate

- To closely evaluate the levels of gaseous pollutants to ensure that the levels are acceptable and are not a health risk to the population.
- To characterise risk factors such as maternal smoking and coal-burning better and to communicate the results to the Vaal Triangle residents.

Sanitation needed for 18-million

HALF the population does not have access to adequate sanitation, the Water Research Commission said yesterday.

The commission found in its investigation into sanitation that in urban and rural areas, 18-million people lived without proper sanitation.

In urban areas a third of the people do not have adequate sanitation. In addition, about 9-million people (one in every four) do not have access to a safe water supply.

"This involves major health hazards as diseases relating to human waste and impure water are the cause of the majority of infant deaths in developing countries," the commission warned.

Gastric disease was a major cause of death and permanent disabilities among infants.

The commission said it was engaged in a programme aimed at addressing the problem of inadequate sanitation.

Its objectives included:

- ☐ Establishing the number of people with access to safe sanitation;
- ☐ Testing the efficiency of current systems; and
- ☐ Developing a strategy to improve the situation and developing guidelines for the provision of sanitation.

The investigation has found the cost of providing urban dwellers with waterborne sewerage by 2000 to be R11bn. — Sapa.

Measles outbreak

STAR 20/8/92

By Louise Marsland
Municipal Reporter

(89)

An outbreak of measles has occurred in Johannesburg, with more than 40 cases reported to City Health in the past two days — compared to the 50 cases a year usually reported.

Several other centres, such as Port Elizabeth, Pretoria, Springs and Bloemfontein, have reported a higher than usual incidence of measles.

Two high schools in Johannesburg's north-western suburbs have confirmed that about 20 children have been diagnosed with measles and City Health is aware of about 20 other cases in the city.

Johannesburg's acting medical officer of health, Dr Eric Buch, said a team of senior health workers were sent out yesterday to investigate.

"The cases we are aware of are mostly in teenagers who did not have their measles immunisation as children."

Dr Buch said the situation was not as serious as first thought as, apart from the two schools, other incidences of measles were scattered around the city.

"We are keeping a close eye on the situation and are continuing with our investigation to clarify the pattern."

He said there seemed to be a heightened incidence of measles in certain areas of the country. This could not be attributed to any one factor, but was a "cyclical phenomenon".

In Port Elizabeth, the health department is also investigating an increase in measles in the city.

Spokesman Sheila van der Merwe said the number of cases reported for last month exceeded the figure for the previous year ending in June.

Mrs van der Merwe said, however, that the cases reported could not be pinned down to one specific area in the city.

A Bloemfontein health worker said more than 50 cases of measles had been reported between April and June in nearby townships. "We expect to have more than 100 cases by the end of the year," she said.

In Pretoria a spokesman said there were more cases of measles recorded this year and the city would be embarking on an immunisation programme next week.

Durban and Cape Town health authorities say they have had no problems with measles outbreaks this year.

All children at the affected schools in Johannesburg will now be immunised.

Dr Buch asked that all doctors, school principals and parents notify Johannesburg's health department at 407-7139 on any measles cases, on the first day the rash appears.

"This allows us to keep track of the situation and to take the necessary action to protect the health of the community."

Scientists in search of a 'Christmas tree' vaccine

STAR 20/8/92

(89)

VACCINE production, for long a sleepy sideline of the pharmaceutical industry, is being rejuvenated through a combination of new technology and corporate restructuring.

With the help of biotechnology, researchers are developing vaccines for diseases against which there is no protection today, from malaria to Aids.

They are working to combine existing vaccines and ultimately achieve the World Health Organisation's goal of an ideal children's vaccine which would deliver immunity against all serious childhood illnesses in a single dose shortly after birth.

The corporate background to vaccine development is changing as fast as the science, through mergers and alliances which are transforming a patchwork of national vaccine companies into a few global players.

The primary reason for these alliances, says Alain Merieux, head of the major French pharmaceutical company, Merieux, is that the future lies in combined vaccines with multiple antigens. (Antigens are the proteins produced by viruses and bacteria which stimulate the immune system to make protective antibodies.) No single company has enough antigens to make a good all-in-one vaccine on its own

Two triple childhood vaccines are already used routinely: DTP against diphtheria, tetanus and pertussis (whooping cough) and MMR against measles, mumps and rubella. Jacques Armand, Merieux's vaccine development and production director, says it will be feasible within two years to expand DTP into a six-fold vaccine, by adding polio, hepatitis B and haemophilus influenzae b (a relatively new vaccine which protects against a common form of bacterial meningitis).

A more serious obstacle to combining childhood vaccines is that the current strains need to be given at different ages to provoke the best immune response.

In the long run, the best hope for a multiple vaccine may lie in genetic engineering. The favourite approach is to add antigen genes from several different germs to a single Christmas-tree microorganism.

Most researchers are using viruses of the pox family, which contain large amounts of genetic material and are therefore attractive targets for genetic manipulation. Animal tests show that a genetically engineered pox vaccine can induce immunity against several diseases, though the approach is unlikely to produce a commercial human vaccine for several years

Multiple vaccines will help the WHO and Unicef (the United Nations Children's Fund) to achieve their goal of universal childhood vaccination Already 80 percent of the world's children have been immunised against six leading childhood diseases — measles, diphtheria, whooping cough, tetanus, polio and tuberculosis — compared with only 10 percent a decade ago.

Although the first priority is to improve and combine existing vaccines, new vaccines are a close second priority, says Hiroshi Nakajima, WHO director-general. Only about 20 diseases have commercially available vaccines. There are none yet for many diseases that cause widespread death.

Charles Merieux, honorary chairman of Institut Merieux, says an Aids vaccine is the most exciting scientific challenge and malaria is most important.

The worldwide effort to produce a vaccine against malaria — which kills about 2 million people a year, mostly African children — will be successful within five years, Merieux believes.

Although genetic engineering plays a vital role in making new vaccines, there is still plenty of juice left in classical vaccine development, says Stanley Plotkin, Merieux medical and scientific director.

In the industrialised world, a priority is to produce a new whooping cough vaccine. The existing one is more likely to provoke damaging side-effects.

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'Immunise, or measles could spread'

Municipal Reporter (89)

Investigations by Johannesburg health officials have shown that the city is not suffering a measles epidemic, but the disease could spread if people do not have their children immunised, acting medical officer of health Dr Eric Buch said yesterday.

An unusually high outbreak of measles was reported to city health last week and 60 cases had been recorded this month, compared with the usual 50 cases a year.

Dr Buch repeated his call to doctors, school principals and parents in Johannesburg to inform the council on 407-7139 of any measles cases.

Star 24/8/92

SUNRISE | SUNSET | MOONRISE

Tomorrow 6.48 am | Today 5.52 pm, Tomorrow 5.52 pm | Today 3.05 am

Farcu

Two PE babies die of measles

PORT ELIZABETH. — Two babies have died from measles here, and in Durban an entire class of pupils at a primary school has contracted the disease.

In the past 6½ weeks 80 cases have been reported in Port Elizabeth, prompting fears of an epidemic. — Sapa



Testing for diabetes . . . Johannesburg branch chairman Verle Smit tests a volunteer's blood.
Picture: Gary Bernard

Bid to boost diabetes association

STAR 21/9/92

By Paula Fray
Medical Reporter (89)

Greater Johannesburg diabetics have injected new life into the local branch of the South African Diabetes Association (Sada) in a renewed bid for the body to gain a higher profile in society.

Sada national executive Josina Barnes said yesterday that it had to create public awareness and educate diabetics.

She said there were between 500 000 and a million diagnosed diabetics in South Africa.

Johannesburg Sada chairman Verle Smit said the branch had been quiet for nine months with little interest and participation. But an offer of assistance by a drug company could strengthen the group.

There are about 12 Sada branches in South Africa — some of them run by volunteers, said Mrs Barnes.

Among the suggestions the regional branch will look at is a call to negotiate lower costs for insulin for members

Other suggestions include a discount card for members and a supportive social club. Members will also be informed of facilities available, including a counselling toll-free line. The number is 0800-121-555.

Local diabetics who are interested can call Mrs Smit for more information at (011) 462-3223.

Measles death

(89)
APG 4/9/92

PORT ELIZABETH. — The measles epidemic in Port Elizabeth has claimed the life of a third baby.

The city's medical officer of health, Dr Ettienne du Plessis, said, however, that the epidemic appeared to be easing off with fewer cases being reported.

The latest victim, a four-month-old baby from the Ibahyi area, was the third baby under a year-old to die from measles in the past month. — Sapa.

Measles cases cause concern

Staff Reporter (89)

HEALTH authorities are concerned about an increase in cases of measles in the Peninsula.

"Since the beginning of August, up to September 4, 18 cases of measles have been notified and the majority of these were residents in the northern parts of greater Cape Town," said Dr S A Fisher, chief director of health services for the Western Cape Regional Services Council.

Dr Fisher said parents should ensure their children were adequately immunised. CT 11/9/92

SA on brink of allergy crisis

(89)

ET 25/9/92

By IVOR CREWS

SOUTH AFRICA is on the brink of an allergy explosion, with about six million people already suffering from allergic diseases, health experts warned yesterday.

Leading international and local experts in allergy treatment are attending the first Allergy Congress at a Sea Point hotel held by the Allergy Society of South Africa (Allsa), focusing on diagnosis and management of allergic diseases.

According to congress convenor Dr Paul Potter, the dramatic increase in allergies is closely related to industrial air pollution.

"It has been shown in Japan that diesel exhaust fumes, car exhaust fumes and sulphur dioxide released from refineries enhance the allergic response."

Dr Potter said allergic diseases were an important cause of absenteeism from school and jobs and contributed significantly to medical aid bills.

He said six million South Africans are currently affected by allergic diseases, hayfever being the most common.

He added that the incidence of asthma in Cape Town schoolchildren is about 8%, compared with 0,14% in rural Transkei

Estimates are that about two million South Africans have asthma.

Dr Potter said that experts believed that the urban environment, particularly at the coast, is highly conducive to the development of allergies.

One reason is that the house-dust mite, which is an important cause of asthma and hayfever, exists at very high levels in Cape Town and other coastal cities

Secondly, the cities have a number of naturalised grasses such as Bermuda grass and rye grass, which are more allergenic than indigenous grasses.

All possible steps should be taken to avoid exposure to house-dust mite. Carpets and matress covers should be vacuum-cleaned and acaricides applied to kill the mites.

BLBM 25/9/92

Migraines 'cost SA millions'

KATHRYN STRACHAN

MIGRAINES cost the SA economy more than R800m a year through lost productivity, yet the problem was largely ignored by researchers and doctors, a Glaxo Pharmaceuticals spokesman said recently.

Nick Wells, a British pharmaceutical expert who advises Glaxo on health economics, said on his visit to SA last week there was a tendency to focus only on the costs of illness to the health care system and to overlook the other costs involved. BLBM 25/9/92

"We need to look across the spectrum and understand the broader economic and personal costs involved. But people in health care have their budgetary contraints to consider rather than taking a comprehensive view," he said.

This included getting away from focusing only on the cost of treatment, to investigating its cost-effectiveness instead.

Although there was great emphasis on reducing the costs of medicines, Wells said it was not necessarily the best approach. Investing more in medicines, thereby increasing the price, could prove to be more cost-effective than other forms of treatment such as hospitalisation.

Migraines were a classic example of this bias, he said. Although it caused tremendous pain to sufferers and amounted to millions of rands in lost productivity, very little research had been done into the problem because its cost to the health care system was minimal.

Unlike migraines, illnesses such as flu could cause further complications if not treated, and could eventually result in expensive hospitalisation.

Glaxo MD Martin Jennings estimated that more than 10% of the population suffered from migraines.

City vaccine could end cervical cancer

NDREA WEISS.
lealth Reporter

A CAPE TOWN-based research roject aimed at developing a accine to prevent the commonest ancer in South Africa could all ut eliminate deaths from the isease.

Professor Basil Bloch, vice presi-ent of the National Cancer Associa-on, said cervical cancer was the ommonest cancer in South Africa — ecounting for 14 000 new cases a ear.

According to Professor Bloch, an nportant factor in the development cervical cancer is the human papil-ma virus, a common sexually trans-itted virus which sometimes causes enital warts. A vaccine against the rus would greatly reduce the risk of eveloping the cancer.

If caught early, the cancer is easily eated. However, if it is allowed to lvance beyond the early stages the rvival rate drops dramatically.

At present, the best way of detect-g the cancer is by pap-smear tests. it in this country, there is no nation- screening programme and many omen present themselves at hospital th the cancer so far advanced there little that can be done.

Professor Bloch said 70 percent of e patients treated for cervical cancer at Groote Schuur Hospital already had advanced cancers of the cervix and had only a 30 percent chance of surviving five years down the line.

The aim of the research project, which has been funded to the tune of R300 000 by the National Cancer Association, is to develop a vaccine against the strains of the virus which are linked to cancer.

Once developed, the vaccine could be incorporated into a national health-care programme and routinely administered to women before they become sexually active.

The vaccine project follows another South Africa first when Professor Michael Kew of the University of the Witwatersrand led a project to develop a vaccine against Hepatitis B which is linked to liver cancer.

Doing the scientific legwork for this project is Dr Annelize Williamson, a senior specialist scientist in the department of medical microbiology at UCT.

● The human papilloma virus is not the only trigger in cancer of the cervix, thus it does not necessarily follow that a woman infected by it will develop cancer. Other risk factors are smoking, other viral infections such as herpes, an unspecified hormonal link and a suppressed immune system.



BUSKING BUDDIES: Mr Hubert Ngqola of Nyanga, left and Mr Sammy Gomo, right, of Khayelitsha sing and play guitar in St George's Mall. "I'd rather busk than steal," says Mr Gomo, who began busking after losing his job a year ago.

Picture: DOUG PITHEY, The Argus.

Strike, slump hits Powertech

89E

CT 28/9/92

JOHANNESBURG. — Difficult economic conditions, exacerbated by a protracted strike in the steel and engineering industry, saw Powertech post a 9% decline in earnings a share to 13,8c (15,2c) for the six months ended August 31.

Its attributable earnings dropped from R20,4m in the six months ending August 31 last year to R18,7m for the same period this year.

Powertech executive chairman Peter Watt on Saturday blamed the negative effects of the mass action campaign and the drawn-out labour disruptions which followed for the earnings results.

Recessionary conditions were partially countered, he said, by a successful refocusing of target markets, the introduction of new products and technologies, and a continued control of expenses and working capital.

Powertech's cash position was reinforced by the sale of the industry division of former Brown Boveri Technologies (BBT) to the Swiss-based Asea Brown Boveri (ABB). Renamed ABB Powertech, the remaining portion was restructured to continue as a joint venture with ABB.

Watt said the single biggest boost to the productive power of the country would come from unequivocal agreement by all political parties on constituional transition.

But he cautioned that, "by the time political aspirations have been met, damage to the economy by political action may be irreversible".

Watt did not expect an upturn in the economy or in trading conditions for the second half of the year. — Sapa

news in brief

6 die in unrest

SIX people died and at least 10 were wounded in unrest-related incidents on Monday and early yesterday, police reported. Sowetan

At Tokoza in Alberton gunmen firing from a vehicle killed four people and wounded seven. 14/10/92.

In Alexandra on the Witwatersrand police found the bodies of a man and a woman. Both had been shot.

Gunmen opened fire on a man at Wembezi, Estcourt, seriously wounding him.

Explosives were detonated at homes in Ratanda, Heidelberg, and at Khuma, Stilfontein. There were no injuries in the Ratanda explosion but the blast at Khuma early yesterday injured two people.

2 Durban suicides

A POLICE constable shot and killed himself in his flat in Overport, Durban, on Monday night. Police said Constable TM Shangase (30) was found with a bullet wound to his head in a flat in South Road. Foul play is not suspected.

In another incident, Mr J Govender of Chatsworth was found hanging from a tree.

Cop shot four times

AN off-duty municipal policeman, Sergeant Robert Khatshelo (39), was shot and wounded on Monday night.

Soweto police liaison officer Lieutenant Eugene Henning said Khatshelo went to investigate a noise at a neighbour's house in Generator Street, Power Park, at about 7.40pm when he was confronted by three men, one with a firearm.

During an ensuing argument four shots were fired, wounding the policeman twice in the right arm and twice in the left leg.

The suspects fled on foot.

Khatshelo was admitted to the Garden City Clinic. His condition is stable.

Mental health care

Sowetan 14/10/92

THE South African Federation for Mental Health launched its public awareness campaign for October at a two-day conference in Johannesburg last week (Oct 6 and 7).

The conference, which focused on mentally handicapped children, resolved to reduce the incidence of mental handicap in children.

Driver dies in hijack

A TRUCK driver has been shot dead near Dundee in what police believe to be an attempted robbery and hijacking, SABC radio news reported yesterday.

Church discriminates against blacks, claim

Sowetan 14/10/92

■ BLACKS EXPELLED: 300 members bring accusations against church:

By Mandla Zibi

A GROUP of 300 people who were allegedly expelled from the Old Apostolic Church of Africa's Transvaal region have accused the church of discriminating against black members.

This was said at a Press briefing in Carletonville at which representatives of the fired members expressed their dissatisfaction about the church administration headed by Apostle JJ Boshoff.

The group's spokesman, Mr Theophilus Mahlatshana, said the church had promised to build creches, old people's homes, schools and other projects but only white members's needs had been met so far.

Mahlatshana claimed about 300 members had been expelled.

"For example, we have long been asking for an old people's home but only white church members have one in Johannesburg, and yet everyone of us contributes 10 percent of their monthly salary to the church," Mahlatshana said.

Another major grievance was that blacks were denied top positions in the church.

Measles attacks older kids

Sowetan 14/10/92.

■ Outbreak in Johannesburg also emphasises need for immunisation:

By Mokgadi Pela

THE Department of Health has reiterated the importance of early immunisation against measles in the wake of recent outbreaks of the disease in Greater Johannesburg.

Dr Coen Slabber, director general of the department, said 40 cases were reported to the Johannesburg City Health Department in one week. This indicated a sharp increase in the incidence of the disease compared to the same period last year.

The Johannesburg outbreak came largely from high school pupils who were not immunised as children. According to Slabber, such outbreaks can only be prevented by the early immunisation of children and by maintaining vaccination levels.

Most children in South Africa received the measles vaccine but a small proportion did not develop immunity.

MOH calls on UCT in outbreak of measles

(89)
ARG 5/10/92

ANDREA WEISS
Health Reporter

AN "unusually" high number of schoolchildren have measles, and Cape Town's MOH Dr Michael Popkiss has called in UCT's community health department to monitor the outbreak.

Dr Popkiss said 64 cases of measles had been reported in the council's area over the past month, with many more school-going children than normal being affected.

The Regional Services Council has reported 57 cases of measles in its area, which stretches as far as Stellenbosch and Paarl.

Dr Popkiss said because cases were spread across the board from pre-school to matric, this did not indicate any large-scale vaccine failure.

Also the source of vaccinations varied from clinics to general practitioners. Among the first 15 cases of measles at Bishops were children who had been vaccinated in the United States, Britain, Zimbabwe and Ghana, he said.

The measles vaccine was 90 percent effective, which meant that where more people in the community were immunised, the 10 percent failure rate would become more evident.

Dr Popkiss said the situation was being monitored and at this stage no major re-immunisation programme was being considered. But parents of children who had not been immunised were advised to do so.

Dr Stewart Fisher, Regional Services Council MOH, said he was not "overly concerned" about the outbreak, which was not as severe as "in the bad old days".

He said the phenomenon of measles affecting older children was worldwide where there was reasonably good immunisation cover.

NEWS SA lifestyle not conducive to longevity ● Organisations unite to ensure commuter safety

Beating chronic diseases

Sowetan 12/10/92

■ **New study shows South Africans are extremely vulnerable to deadly illnesses:**

By Mokgadi Pela

NEARLY a quarter of all deaths in 1988 were from chronic diseases like stroke, heart disease and cancer, according to the results of a newly released study.

Researchers at the Medical Research Council say the deaths resulted from tobacco smoking, an unhealthy diet and lack of exercise.

These habits can cause the development of conditions such as tobacco addiction, hypertension, heart disease, high blood cholesterol, obesity and diabetes.

Nearly half

The researchers found that nearly half the South African population must improve their lifestyles in order to reduce risk factors for chronic diseases.

The researchers tested five communittees totalling 10 000 people.

They found that 4,88 million South Africans, mostly black males, are smokers. Nearly five million South Africans have high cholesterol levels and carry the associated risk of heart disease while 5,5 million have high blood pressure.

HEALTH

Smoking and diet have links to cancer

Cancer is the destruction of normal bodily tissues or organs by the abnormal, uncontrollable division and multiplication of cells.

How does cancer develop? Simply put: a cancer provoker (initiator) changes a cell irreversibly. It can, however, take up to 10 or 20 years before a tumour is formed, and then only when other substances (promoters) are present, which promote cancer growth.

Ingredients in the diet may serve as promoters. Abnormal cell division is prevented, delayed or stopped when the promoters are decreased and anti-promoters or inhibitors are included in the diet.

Which cancers are diet-related?

Risk

There is a link between diet and cancer of the digestive tract (oesophagus, stomach, colon, liver and pancreas), lungs, breast and prostrate.

A diet containing lots of fat and/or little food fibre, or the excessive intake of smoked, salted or pickled food, shows a clear link with the above-mentioned cancers.

There is no single particular food that is able to cure cancer, but a prudent diet decreases the risk of cancer.

Possible ways of inhibiting cancer:

● A high fat intake causes an increased bile secretion for the digestion of fats. The excess bile acids combine with the bacteria normally found in the colon to form potential cancer-causing substances. A diet containing a lot of food fibre increases the volume and moisture content of the stool and dilutes the concentration of bile acids. A soft stool is evacuated faster and the intestinal canal is therefore exposed to harmful substances for a shorter period.

The food fibre itself also serves to bind the bile salts.

● A high fat and energy intake may cause increased hormone levels, which in turn may lead to cancer of the breast or prostate.

● Obese people are more inclined to develop cancer of the gall bladder or prostate. Obesity as such does not cause cancer but a desirable weight reduces the risk of cancer.

● Nitrates added to meat products such as bacon and ham during processing are changed in the digestive tract into harmful substances (nitrosamines) which are possible promoters of cancer. Vitamin C prevents this conversion.

● Small amounts of substances known as "free radicals" are normally formed during digestion. Cigarette smoke and air pollution give rise to the formation of large numbers of "free radicals" (initiators) which may cause cell damage. Certain nutrients in the diet, namely beta-carotene and vitamins C and E together with selenium, inhibit the formation of "free radicals".

Hints

● Eat at least four to five portions of fruit or vegetables daily. Eat cabbage, broccoli or cauliflower regularly.

Fibre

Bright yellow and dark green vegetables (such as pumpkin, carrots, spinach, broccoli) and yellow fruit (such as pawpaw, and pineapple) are good sources of beta-carotene, while citrus fruit, tomatoes, guavas, and raw cabbage are rich in vitamin C. All fruit and vegetables provide valuable amounts of food fibre.

● Give preference to brown or wholewheat bread and unrefined grain products to ensure an adequate intake of vitamin E, selenium and food fibre.

● Limit the fat intake by making use of low—fat dairy products and eat fried foods only occasionally.

● Don't indulge in smoked, salted, pickled or processed meat products such as ham, bacon, corned beef, polony, salami, Viennas and Russians.

Department of Health Services and Welfare.

Cancer is one of the main causes of death in our society. There is a significant correlation (up to 40 percent) worldwide between eating and smoking habits and all forms of cancer.



Stirring the pot . . . the food you eat and even the way it is prepared can have an influence on your health. Too much fat is bad for the digestive system, as is too little fibre. By watching your diet, it is possible to reduce the risk of cancer.

Asthma lurks in the cities



DANGER IN THE AIR: Children in squatter areas are the worst hit by the increase in respiratory diseases

South 24/10 – 28/1992 (89)

DANGER: Breathing can seriously damage your health. Respiratory problems caused by allergies affect the lives of one in four South Africans. A decade ago it was less than one in 10, and the increase seems related to the fact that more and more of us live in cities.

"While this increase has been reported from all over the country, in the developing cities there are very obvious trends related to the dynamics of urbanisation," says allergy specialist Dr Matt Haus.

A startling 60 percent of all children born in squatter areas develop asthma to a degree. Most are the children of people who moved from the rural areas, where asthma is virtually unknown. This is in spite of the fact that rural people live in dusty conditions, close to crops which add large quantities of pollen to the air, in homes which have indoor fires without proper ventilation, and in close proximity to animals.

Dust, pollen, smoke and animals are all irritants that can trigger allergic reactions. Yet when the same people move to cities they develop allergies with remarkable speed.

To understand this change it is necessary is look at what makes a person develop asthma. The onset of the disease requires three sets of circumstances: an inherited, genetic predisposition towards the disease; the presence of the particular allergen (for example, pollen), which triggers an allergic reaction; and what doctors call "non-specific enhancement factors".

These "enhancement factors" do not trigger allergies directly, but increase the sufferer's predisposition to allergic diseases, including asthma.

Many of these factors are part of city life, and changes in lifestyle which occur when people move from rural to urban areas.

Urban dwellers breathe in car exhaust fumes and cigarette smoke. A typical urban diet includes a high proportion of processed foods that include chemical preservatives and colourants, which researchers suspect may be linked to respiratory diseases. Filling a home with furniture and carpets provides a breeding gound for house dust mites, one of the most common causes of allergy.

South Africa faces an "explosive epidemic" of asthma and other respiratory diseases, owing to rapid urbanisation and the social changes that go with it, Haus says.

How then to face this impending epidemic?

Treatment of athsma has previously been plagued by prejudice and ignorance about the disease. It is commonly thought to be psychologically linked, or to occur only in overweight and spoilt children.

The explosion of asthma among working-class people should finally put paid to this myth.

"The biggest problem is underdiagnosis — and therefore undertreatment," says Professor Eugene Weinberg of Red Cross Children's Hospital.

People may suffer from chronic symptoms which they do not report to a doctor because they feel nothing can be done.

In fact, most cases of asthma are curable.

"Most experts see only the very worst cases, which represent only five percent of all asthma cases," Weinberg says.

"This leads to a biased view of the whole picture of athsma sufferers.

"Children who have mild or moderate asthma (95 percent of asthma cases) have an excellent chance of outgrowing the illness as they mature. Only the more severe cases require continuous treatment."

Dr Cas Motala, also from Red Cross Hospital, believes the first step to combatting asthma is educating the public, especially in regard to the sharp increase in the occurence of the disease. People also need to be made aware of how medication can help. Having medicine available is one thing — ensuring people take it correctly is another.

Asthma sufferers and, just as importantly, their families, need to learn what aspects of their lifestyles are aggravating the disease. Giving up smoking is a particularly important step to take, both for sufferers and those who live with them.

Community health workers have a role to play in keeping an eye on how people are living, and how appropriately they are using medicine.

Doctors agree self-help is important in treating allergies. A worldwide trend that may be followed here is towards self-monitoring — patients adjusting their own treatment in accordance with clear protocols. This has been extremely effective, doctors say.

The Allergy Society of South Africa intends launching a national asthma campaign, targetting families of asthma sufferers, the public at large, and employers.

By Justin Pearce

6,5-m have blood pressure

Sowetan 28/10/92

89

■ Heart disease differs in ethnic groups:

By Mokgadi Pela

MORE than 6,5 million South Africans have mild high blood pressure levels, a recent study has shown.

The results came from a three-day meeting of experts from varying disciplines related to hypertension control. The meeting was organised by the Heart Foundation of Southern Africa and the Medical Research Council.

Hypertension is one of the major risk factors for cardiovascular disease sufferers in all ethnic groups in Southern Africa.

Reversible risk factors are smoking, high blood cholesterol and diabetes. Irreversible factors are age and family history.

Elevations of blood pressure increase the risk of a stroke, renal impairment and heart failure. The researchers say heart disease appears to differ according to ethnic groups. In blacks, renal failure and strokes are of particular concern, while in other groups coronary heart disease predominates.

Effective ways of reducing blood pressure are weight loss, limiting alcohol intake, salt restriction, physical exercise and increased potassium intake.

The researchers made the following recommendations:

- The impact of hypertension on heart disease, particularly in the black population, is not known and follow-up studies should be conducted;
- Education materials need to be developed and tested in the appropriate target populations;
- The needs of health care providers regarding the diagnosis and management of hypertension should be assessed.

NEWS IN BRIEF

B | TODAY 11/11/92

SA faces cholera threat

THE National Health Department warned yesterday of a possible cholera threat in SA following the recent heavy rains. (89)

There was still no effective vaccine against the disease, the department said, adding that the threat of cholera was greatest in areas without tap water.

News in brief

Kwashiorkor cases rise (89)

THE number of children admitted and treated at various Lebowa hospitals for kwashiorkor and other malnutrition-related diseases had increased significantly. Sowetan 11/11/92

Despite the food aid programme introduced by the department of health and social welfare, the situation in rural communities such as Sekhukhune and Matlala was deteriorating. - *Sapa*

'SA must help fight malaria'

Southern Africa needed to strengthen applied research and exchange information to combat malaria which kills more than 1 million people worldwide each year, the Medical Research Council (MRC) said this week.

According to the World Health Organisation (WHO), 80 percent of the 1 million malaria fatalities occur in Africa.

MRC's National Malaria Research Programme head Dr Brian Sharp, who recently returned from a WHO and World Bank-funded malaria workshop in Madagascar, said it was clear South Africa could make a valuable contribution.

South African authorities were efficient in controlling the seasonal transmission of the disease.

"The incidence of malaria in South Africa is low compared to many other African countries," he said. "In a bad year we might have 10 000 cases with fewer than 20 deaths, compared with countries such as Mozambique or Kenya where up to 30 percent of hospital outpatients have malaria."

The meeting was attended by over 50 delegates from 13 African countries. — Medical Reporter.

Vaccines send polio into decline in Western world

STAR 21/12/92 (89)

Medical Reporter

High levels of routine polio vaccination and the absence of any reported polio cases in the western hemisphere during 1992 have marked the first step towards the eradication of the crippling childhood disease.

According to the United Nations Children's Fund (Unicef) "1993 State of the World's Children" report released at the weekend, there have been no polio cases in the western hemisphere since September 5 last year.

However, while vaccines have cut the toll by 80 percent in the other half of the globe, polio still paralyses more than 100 000 children each year.

This tragic figure, said Unicef, actually represented remarkable progress.

A decade ago, when only about 20 percent of the world's children were immunised, polio struck at the lives of more than half a million children a year.

Since then, immunisation levels have leapt up to 85 percent worldwide. In some countries, polio's decline has been nothing less than spectacular; reported cases in the Philippines fell from 1 422 in 1988 to just 82 in 1990.

This success has raised hopes that polio could become the second major disease — after smallpox in 1977 — to be eradicated.

Careful watch for cholera outbreaks

(89) DIRK HARTFORD

FEARS are growing of cholera outbreaks in SA following scores of deaths from the disease in recent weeks in Swaziland, Zambia and Zimbabwe.

A source at the Health and Population Development Department said yesterday there had been only one reported case of cholera in recent months, and that was "imported". The person had been cured.

One sample of cholera had also been found in a southern Natal river, but it seemed to be an isolated case.

The situation was being monitored closely with the co-operation of health officials in all southern African countries. Places where cholera could break out — such as the northern borders, rivers, prisons and camps — had been under surveillance for malaria and cholera for the past 18 months. B1 DAM 24/12/92

The source said the situation had been complicated by the drought as there was more surface pollution than usual, which could flow into rivers when it rained.

The department has warned people living in rural areas to boil water before use and to be strict about hygiene. The Natal Parks Board has also warned holidaymakers gathering shellfish from rocks on the Natal coast to cook it thoroughly to avoid possible contamination by cholera and typhoid organisms.

Cholera has claimed 60 lives in the Zambian capital of Lusaka in the past two weeks and more than 850 people have been treated in the squatter settlements around the city. In Swaziland 13 cases of cholera have been reported in one village alone. And in Zimbabwe, 37 people have died recently from cholera. A further 1 000 cases have been confirmed.

Cholera epidemic spreads

Sowth 23/11 – 27/11/93. (89)

CHOLERA in eastern Zimbabwe has been killing about three people a day since the end of November last year.

It is Zimbabwe's first cholera epidemic in 12 years and the disease is spreading fast, reportedly as a result of the influx of Mozambican refugees.

The first victims were at Tongogara refugee camp near Chipinge. New cases are being reported from all over Zimbabwe in a scenario that has kept local health authorities on their toes. But there is little hope of containing the disease.

A campaign has been launched, but poor hygiene standards, food mismanagement and lack of co-ordination between government ministries appear to be sabotaging efforts to contain the epidemic.

In addition, the state says people are not allowed to leave or enter refugee camps, but no one seems to be enforcing the ban.

"We have agreed that the movement of people to and from refugee camps should be monitored and controlled. These places should be protected villages. We don't seem to succeeding," says a desperate Mr Timothy Stamps, Zimbabwe's Minister of Health.

While it is known that food, vegetables, fish and fruit help transmit the cholera bacteria, Zimbabwean border posts have not been checking on food being brought into the country by either visitors or returning residents.

"I find it extremely shocking that people are being let in with food when such a serious outbreak has been reported," says Stamps.

Zimbabwean laws allow border guards to seize food from travellers if it has been screened and cleared by health officers.

Zimbabwe is host to more than 250 000 Mozambican refugees who fled the hunger and the civil war that ravaged the country for 17 years.

Following the Mozambican peace accord signed in October, the influx of new arrivals declined from about 9 000 to 2 000 a month. Food is reported to be reaching most parts of Mozambique which were inaccessible because of the war.

But despite the peace, Mozambicans still come into Zimbabwe daily using bush paths to barter fish, game meat and vegetables for maize meal and beer.

In one recent incident, ten people, six from the same family, died in Mount Darwin, north-eastern Zimbabwe, after eating contaminated fish brought by traders.

Some of the food, particularly prawns, has reached Harare where authorities have set aside two big hospital wards for possible cholera cases.

Dr Maureen Wellington, Harare's acting director for health services, says there is an increase in diarrhoea in the city. "We are checking every case, and so far our tests have shown that none of the patients had cholera," she says.

Private doctors say that unless border controls are improved, especially between Mozambique and Zimbabwe, cholera is there to stay.

— AIA

Academics to contest deportation

B1 Rand 12/1/93

DIRK HARTFORD

THREE University of Bophuthatswana (Unibo) academics — deported from the homeland on Friday for their alleged "radical" activities — will challenge their deportation orders in the Supreme Court in Mmabatho on Thursday.

None of the three — Roy Williams, Charl Williams and Jaya Ruthman — will be able to attend the court hearing because of their deportation orders.

Roy Williams — Unibo's communications department head until his deportation — said they would have to apply for visas and were unlikely to obtain these in time.

He said the Bophuthatswana government had alleged they were involved in a sustained plot to disrupt education in the region and that staff, students, parents and the university's management wanted them out.

However, he believed he was deported because of his membership of the ANC.

He believed he and his colleagues had "a lot of support" at the university and their deportation would cause further disruption on the troubled campus.

He had a "very positive" testimonial from a senior person in university management which he believed reflected the opinion of staff on the campus.

The deportation was a case of victimisation for political reasons, said Williams.

SA on alert as cholera rages through region

B1 Rand 12/1/93

THE Department of Health has stepped up measures to prevent a local outbreak of the cholera epidemic which has already claimed hundreds of lives in neighbouring countries.

The department said it was concerned that the epidemic could spread to SA, but there was no cause for alarm at present.

A department spokesman said there were presently only 11 "imported" cases of cholera. The infected people were either mine workers from neighbouring countries or people who had visited Mozambique shortly before falling ill, he said, adding that the cases had all responded well to treatment.

But, to be prepared, the department had alerted health authorities to the possibility of an outbreak and had launched cholera awareness campaigns at a local level, informing people of preventative measures such as boiling or chlorinating water.

It had also increased surveillance of sewage effluent with regular tests, and by increased monitoring of rivers and dams.

Although cholera could be spread through contaminated food, most epidemics occured from contaminated drinking water. The people most at risk were those who did not have access to chlorinated and filtered tap water, the spokesman said.

He added that cholera germs had recently been detected in the sewerage system in western Transvaal mine hostels, but no cholera cases had been reported in the area.

KATHRYN STRACHAN

This was not surprising as most people who were infected did not become ill even though they were excreting cholera germs, he said.

As the water supply and sanitation of these hostels was reticulated, major problems were not expected.

The germs had been found at these mine hostels during previous epidemics in the country without outbreaks in the hostels, he said.

Sapa reports that the Zambian government has postponed the opening of all schools in Lusaka for the first term because of the epidemic which had claimed 200 lives since November.

Zimbabwe had requested Z$7m from the international donor community to deal with its cholera outbreak which had claimed 105 lives so far, Ziana national news agency reported yesterday.

Acting World Health Organisation representative to Zimbabwe Dr Nicholas Chitimba said the WHO supported Zimbabwe's request and had agreed to provide the country with "emergency materials worth Z$150 000.

Inkatha and Azapo end feud

PEACE prospects in the West Rand township of Bekkersdal were improved yesterday when feuding organisations Inkatha and Azapo resolved to bury their differences.

The organisations told journalists in Johannesburg they had identified reasons for their feud, which had claimed at least five lives this year. These included:

- A lack of political tolerance among members;
- Declaration, by members, of certain areas as strongholds; and
- The involvement of a third party in the conflict.

WILSON ZWANE

The organisations said they had agreed on steps to restore peace in the township. These included ensuring that everyone had free access to public facilities, encouraging interaction where the two organisations co-existed and creating a forum at which political debates would be held.

The organisations also resolved to "expose" the involvement of a third party in their feud. Inkatha Transvaal organiser Themba Khoza and Azapo deputy national organiser Monwabisi Duna would not say who the suspected "third party" was.

A peace rally would be held at the weekend.

Last week Inkatha, Azapo, the PAC and the ANC formed a joint committee to monitor the return of pupils to schools.

- Sapa reports that the Goldstone commission in Port Shepstone heard yesterday that there had been a dramatic decrease in political violence in the area since a peace initiative was facilitated by a Commonwealth observer last month.

Typhoid fears in E Cape

CT 30/11/93

TYPHOID may have broken out in drought-stricken Adelaide in the Eastern Cape.

Municipal health inspector Mr Kobus Marais said yesterday tests had been done on two suspected cases of the disease. Typhoid can be fatal if it is not diagnosed quickly.

"We expect the results back next week," Mr Marais said.

● Water is running a metre deep on a section of the R74 along the Oliviershoek Pass between Natal and the Orange Free State. The road on the OFS side of the border has been closed.

Heavy rain is also falling in the Lions River and Balgowan area.

● Good showers began falling countrywide in Namibia this week — bringing some relief from the drought. — Own Correspondent, Sapa

Potential cancer victims

ONE out of every four South Africans is a potential cancer victim, according to statistics released by the National Cancer Association of South Africa (NCA)

Sowetan 4/2/93

The NCA said yesterday 90 percent of cancers were linked to dietary factors and certain living habits. A healthy, balanced diet with low fat, a moderate intake of alcohol and no smoking were indispensable in the fight against cancer. *Sapa*

(89)

the nation in brief

'Govt involved in violence'

THE delegation of the International Confederation of Free Trade Unions (ICFTU), on a one-week fact-finding mission to South Africa, said yesterday that it had discovered that the Government was directly and indirectly involved in violence.

Speaking at a Press briefing in Durban, ICFTU secretary-general Enzo Friso claimed the security forces were exploiting political differences to destabilise democratic forces in the black community. He said he wondered why the security forces were unable to curb the violence because they had been able to crush black political organisations when they were still banned.

Sowetan 4/2/93

Boesak not quitting ANC post

Sowetan 4/2/93

THE chairman of the ANC's Western Cape regional executive, Dr Allan Boesak, is not resigning his post or returning to the ministry.

Boesak ended speculation about his resignation and friction within the regional executive committee at a media conference yesterday by announcing that he had decided to stay in office. He had postponed his return to the ministry and would stand for future elections if nominated as an ANC candidate.

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Sowetan 4/2/93

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89

...it was part of its commit- phasis is not on playing policeman."

No VAT on food — TAU

GERALD REILLY

PRETORIA — The Transvaal Agricultural Union (TAU) has made an urgent appeal to Finance Minister Derek Keys to free certain basic foods from VAT.

In a statement yesterday, TAU president Dries Bruwer said the TAU's general council believed this would be in the interests of the vast majority of the population.

It was vital that basic foods be maintained at affordable prices.

Essential foods such as meat and dairy products, as well as staple grain products, should be relieved of the price-boosting influence of VAT.

Aside from the fact that VAT on these foods would place a heavy additional burden on consumers, it would also place producers under further pressure because buying power would be reduced and demand would shrink.

Housewives' League immediate past president Lyn Morris said if basic foods were not zero-rated it would be a blow to lower income groups as well as producers.

"However, to be realistic government needs to boost its income and — provided it is not squandered — it is difficult under current conditions to argue for VAT concessions."

Inbreeding cited for high number of heart attacks

KATHRYN STRACHAN

SA HAS the world's highest incidence of a genetic cholesterol disease — and medical experts claim it is caused by inbreeding in some communities.

SA also had the second highest number of fatal heart attacks worldwide with high cholesterol levels being one of the major causes, Logos Pharmaceuticals spokesman Alyson Prowse said yesterday.

She said heart attacks were the primary cause of early death in SA, killing 31 people a day. Most of these deaths could be prevented.

Statistics showed that one in three men and one in four women would develop heart disease before they reached the age of 60.

"According to medical experts, the three groups most affected are the Jewish, Afrikaner and Asian communities most given to intermarriage," said Prowse.

"These groups suffer from a condition known as familial hypercholesterolaemia, and there are frequent early deaths from heart attacks — often striking people in their early teens and 20s."

Prowse said in order to reduce the incidence of coronary heart disease, a concerted effort to reduce cholesterol levels was needed. Other controllable risk factors were blood pressure and smoking.

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Plea for kidneys

89

Soweten 22/2/93

■ Many patients waiting for ops:

By Mokgadi Pela

TWO hundred and twenty five black patients are waiting for kidney transplants at five teaching hospitals in Johannesburg.

The hospitals are Baragwanath, Hillbrow, Johannesburg, Coronation and JG Strijdom.

Professor Anthony Meyers of the University of Witwatersrand's renal unit told about 60 participants at the Dorothy Suskind Memorial Lecture at the weekend that these patients were living on dialysis machines.

He made an impassioned plea to the black community to allow surgeons to remove kidneys from their relatives who died in accidents.

"If there are religious problems, we will be happy to remove one kidney," Meyers added.

The cost of putting a single patient on dialysis for a year is R14 000.

The causes of kidney failure include diabetes and hypertension.

STAR 22/2/93.

Boost for treatment of malaria

89

OVERCOMING a series of difficulties that have frustrated other malaria researchers, scientists at New York's Sloan-Kettering Institute have become the first to clone an entire chromosome of the organism that causes malaria.

The achievement, one of the most dramatic breakthroughs in the evolving science of DNA, is expected to provide a major boost to the prevention and treatment of malaria, which affects nearly 300 million people a year, of which two million a year die from the disease, most of them in Africa.

The Sloan-Kettering team had to use an unusual technique to clone the chromosome because of the genetic makeup of the organism, known as *Plasmodium falciparum*.

The organism alternates between two hosts — mosquitoes and primates — making genetic crosses long and difficult.

The breakthrough was achieved by a team of scientists led by Dr Jeffrey Ravetch. — The Star Bureau. □

By Paula Fray
Medical Reporter

Star 14/1/93

Cholera outbreak in SA possible

89

An outbreak of cholera in South Africa was a "definite possibility" and the Department of National Health has already taken all preventive measures, it was confirmed yesterday.

Zimbabwe made an urgent appeal to the international community this week for help in dealing with a cholera outbreak which has so far claimed more than 100 lives.

In Zambia, the government postponed the opening of all schools in Lusaka on Monday for the 1993 first term due to a cholera epidemic which has claimed 200 lives since November. It is understood a South African medical team is in Zambia to assess ways of helping.

Cholera — one of the first signs is diarrhoea — is spread through contaminated water sources.

According to a Health Department spokesman, four cholera cases have been reported in South Africa during the past two months.

"In November 1992 reports of positive sewer findings were received from closed communities such as gold mines. Since then, three miners have been admitted to mine hospitals with confirmed cholera." On January 2 another miner was diagnosed as having the disease.

These cases were not unusual and had been expected for some time, the spokesman said.

South African border areas were particularly prone to cholera since it was possible for people travelling across the borders to spread the disease.

The department said there had been an increase in environmental surveillance of sewage effluent, rivers and dams.

briefs

Cancer on the rise (89)

OESOPHAGEAL cancer, formerly prevalent in the Transkei, was now on the rise among urban blacks, a study just released by the Medical Research Council has shown.

The 10-year study was headed by Professor Walter Marasas, who is chief specialist scientist at the MRC's programme on mycotoxins and experimental carcinogenisis. His study has shown a direct link between oesophageal cancer and home-grown maize. Sowetan 31/3/93.

The prevalence was 100 in 100 000 blacks a year and five in 100 000 whites.

Marasas said the rates were on the increase in people who eat maize as their staple food. He said all maize was deficient, whether commercially produced or home-grown.

vision. This member sees to it that all prescribed directives regarding the care of the children are strictly adhered to and that the children's general health and well-being are promoted.

In general it can be mentioned that the Department of Correctional Services places a high premium on the medical treatment of all persons entrusted to its care. In this regard the nursing staff of the Department of Correctional Services are guided by the medical officer (district surgeon) and his prescriptions and directives are meticulously carried out. This includes general treatment which can be provided in the prison and prison hospitals, hospitalization in private or provincial hospitals and treatment by specialists.

SADF officer attached to State Security Council

*24. Mr J A JORDAAN asked the Minister of Defence:†

(1) Whether, with reference to his replies to Question No 28 on 17 February 1993 and Question No 21 on 3 March 1993, a former senior officer of the South African Defence Force, whose name has been furnished to the South African Defence Force for the purpose of the Minister's reply, was employed by the Defence Force during the period in which he was attached to the Secretariat of the State Security Council; if so, what is the name of this officer;

(2) whether this officer made direct or indirect contact with any chief ministers or governments of the self-governing areas at any time during the above-mentioned period; if so, what was the (a) nature and (b) extent of this contact;

(3) whether he will make a statement on the matter? B508E

The MINISTER OF DEFENCE:

(1) and (2)

The former senior officer whose name has been furnished to me was functionally in the employ of the Secretariat of the State Security Council and only fell under the SA Defence Force administratively. The finer details of the contacts he may have made during this period are consequently not known to my department.

(3) No.

Press freedom

*25. Mr P G SOAL asked the Minister of Home Affairs:

Whether, with reference to the free flow of information and reporting by the Press, any further steps have been or are being taken or are being contemplated in respect of the repeal of the 11 Acts referred to in the reply to Question No 7 on 18 March 1992; if not, why not; if so, (a) what steps and (b) when? B509E

The MINISTER OF HOME AFFAIRS:

As stated in the reply to Question No 7 of 18 March 1992 (Hansard: Column 419), of the 11 Acts referred to, the Department of Home Affairs administers only the Electoral Act, 1979 (Act 45 of 1979), and for the reason furnished in the aforesaid reply, it is still not the Department's intention to repeal the provision concerned.

I further recommend that my colleagues who administer the other Acts concerned be consulted by the hon member in that regard.

TBVC states: pension funds

*26. Mr P G SOAL asked the Minister of Foreign Affairs:

(1) Whether he will furnish information on whether pension funds in the TBVC states are being monitored in any way; if not, why not; if so, (a) in what way are these funds monitored and (b) what is the state of each of these funds;

(2) whether any large payments were made by any of these funds to any individuals in the past 18 months; if so,

(3) whether he will furnish details of such payments; if not, why not; if so, what are the details? B510E

The MINISTER OF FOREIGN AFFAIRS:

(1) Yes, but it is primarily not my function.

(a) On the one hand, pension funds in the TBVC States are administered by the independent state in question and monitoring occurs in terms of the pension and financial instructions as well as through auditing by the Auditors-General of those states. On the other hand, it is monitored in terms of Structural Adjustment Arrangements if actions regarding the pension funds have a fiscal impact on the adjustment measures. In such cases the Chairman of the Structural Adjustment Committee, in accordance with the agreement, would take the matter up with the two governments.

(b) I refer the hon member to the latest reports of the Auditors-General of the various states.

(2) Yes.

(3) According to available information the Venda Government decided to privatise its pension fund and in the process amounts were paid to financial institutions on behalf of individuals. Members of the pension fund were unhappy about this and this led to strikes. To solve the crisis the Venda Government appointed the Venda Pensions Crisis Committee to investigate all payments made from the pension fund. The Venda Government is assisted by Dr J de Loor in the investigation. The Committee has made good progress with its investigation and according to Dr De Loor a report will soon be submitted to the Venda Government.

Regarding the pension funds of the other States, the calculations of the amounts were made in accordance with the formulae laid down in the laws of the respective countries.

It must be stressed that the various TBVC States, as independent states, administer their own pension funds.

SADF: legal fees

*27. Mr D H M GIBSON asked the Minister of Defence:

What was the total amount paid by the Government during the latest specified period of 12 months for which information is available for the legal fees incurred by members of the South African Defence Force in respect of (a) defence in (i) criminal and (ii) civil cases, (b) inquests, (c) commissions of inquiry and (d) other legal actions? B513E

The MINISTER OF DEFENCE:

R2 907 389,53 since 1 April 1992. The figures are unfortunately not available in the cost components specified and the time and effort required to calculate them thus cannot be justified.

Reply substituting reply to Question No 9 on 17 March 1993, put by Dr F H Pauw (col 592):

National Cancer Association: funds

*9. Dr F H PAUW asked the Minister of National Health:†

(1) Whether the State makes any funds available to the National Cancer Association; if not, why not; if so, (a) what was the total amount so made available during the latest specified period of 12 months for which information is available and (b) on the budget of which State Department or Departments are donations to this association indicated;

(2) whether it is required of this association to apply the above-mentioned donations on a racial basis; if not, what is the position in this regard; if so, (a) why and (b) what procedure is being followed? B397E

The MINISTER OF NATIONAL HEALTH:

(1) Yes,

(a) R465 000 for the financial year 1992/93 and

(b) Administration: House of Representatives,
Administration: House of Delegates,
Provincial Administration of Transvaal,
Provincial Administration of the Orange Free State,
Provincial Administration of the Cape of Good Hope;

(2) no, the Association applies for subsidy at different State institutions who subsidise social worker posts for Blacks, Coloureds and Indians. The application of these personnel is not prescribed.

(b)	(c)	*Finding/Action*
20 May 92	Assault	Member awaiting trial.
20 May 92	Assault	Member awaiting trial.
20 May 92	Assault	Members awaiting trial.
04 Jun 92	Assault	No grounds found for complaint.
19 Jul 92	Murder	Member awaiting trial.
19 Jul 92	Murder	Charge withdrawn.
03 Aug 92	Rape	Case still under investigation.
18 Aug 92	Murder	Charges withdrawn.
15 Oct 92	Misconduct	Member tried, found guilty and disciplinary action taken.
06 Dec 92	Shooting incident	Case still under investigation.
21 Dec 92	Shooting incident	Case still under investigation.

Aids: HIV-positive statistics

184. Mr M J ELLIS asked the Minister of National Health:

(1) How many (a) White, (b) Black, (c) Coloured and (d) Indian persons in the Republic tested HIV-positive in the latest specified calendar year or 12-month period for which statistics are available;

(2) whether she will furnish the House with corresponding statistics in respect of each of the (a) independent Black states and (b) self-governing territories; if not, why not; if so, what are the relevant statistics? B369E

The MINISTER OF NATIONAL HEALTH:

(1) (a) 230,

(b) 18 201,

(c) 368 and

(d) 78

for the period 31 January 1992 to 6 January 1993;

(2) (a) yes, Transkei 0
Bophuthatswana 1
Venda 0
Ciskei ..... 0 and

(b) no, furnishing of statistics is voluntary and no statistics have been received.

Children: places of safety

199. Mr R M BURROWS asked the Minister of National Health:

(1) (a) How many places of safety other than police cells and prisons were there in South Africa for children of each race group, and (b) what was the total number of children who (i) could be accommodated and (ii) were being held in each of these places of safety, as at the latest specified date for which information is available;

(2) whether her Department has statistics on the number of children of each race group being held in police cells as places of safety; if so, (a) what are the relevant statistics and (b) in respect of what date is this information furnished? B447E

The MINISTER OF NATIONAL HEALTH:

(1) (a) Whites: 7
Coloureds: 9
Asians: 1
Blacks: ..... 13 and

(b) (i) Whites: 487
Coloureds 845
Asians: 75
Blacks: ..... 1 749 and

(ii) Whites: 467
Coloureds 623
Asians 84
Blacks 1 339

[Information furnished on 4 February 1993.]

(2) no, not per race group, but globally,

(a) under 14 years: 249
15 to 18 years: ..... 662 and

(b) 15 March 1993.

Immunization programmes: money allocated

216. Mr M J ELLIS asked the Minister of National Health:

(1) (a) What sum of money was allocated to immunization programmes in the 1992–93 financial year and (b) what immunization programmes were undertaken;

(2) whether these programmes could be implemented fully out of the sum so allocated; if not,

(3) whether additional funds were allocated for this purpose; if so, from what source? B452E

The MINISTER OF NATIONAL HEALTH:

(1) (a) R5 818 000 [vaccines only] and

(b) — the Expanded Programme on Immunisation [EPI] makes provision for vaccination of children against tuberculosis, poliomyelitis, diphtheria, whooping cough, tetanus and measles. It also makes provision for the vaccination of pregnant women against tetanus in order to prevent neonatal tetanus [protection of the newborn]

— the prevention of yellow fever in order to comply with the International Health Regulations Act, 1974 [Act 28 of 1974]

— post-exposure prophylactic treatment against rabies

— prevention of typhoid epidemics;

(2) yes;

(3) falls away.

Own Affairs:

Additional staff at schools

22. Mr R M BURROWS asked the Minister of Education and Culture:

(1) Whether he or his Department has agreed to supply additional staff, according to existing staffing quotas, to Model B, C and D schools whose 1993 enrolment is greater than that of 1992; if not, why not; if so, how many additional teachers were made available;

(2) whether he will make a statement on the matter? B280E

The MINISTER OF EDUCATION AND CULTURE:

(1) Yes, 739 additional posts were allocated;

(2) no.

Loss of permanent/temporary teachers

23. Mr R M BURROWS asked the Minister of Education and Culture:†

How many (a) permanent and (b) temporary teachers did his Department lose in each province in 1992 (i) on account of (aa) marriage, (bb) retirement, (cc) ill health, (dd) termination of service, (ee) death, (ff) the acceptance of non-teaching posts and (gg) further study and (ii) for other reasons? B281E

The MINISTER OF EDUCATION AND CULTURE:

			Cape	*Natal*	*OFS*	*Transvaal*
(a)	(i)	(aa)	38	7	7	62
		(bb)	209	71	29	325
		(cc)	74	18	21	228
		(dd)	1 121	216	118	3 695
		(ee)	8	4	2	31
		(ff)	345	24	47	101
		(gg)	9	4	2	34
	(ii)		48	134	22	769
(b)	(i)	(aa)	1	2	0	3
		(bb)	47	7	3	5
		(cc)	0	0	7	0
		(dd)	0	91	40	161

cont'd

Tens of thousands doomed by virus

(89) (85) ARGUS 27/3/93

LOUISE MARSLAND
Weekend Argus Reporter

BEFORE the end of the decade tens of thousands of black South Africans will die of liver cancer caused by the hepatitis B virus — and many thousands more will contract the disease — simply because there is no effective vaccination programme.

According to Professor Micheal Kew, director of the new molecular hepatology research unit, the way to combat the full-blown disease, for which there is no cure, is through the mass vaccination of newborns.

Yet, he says, South Africa cannot afford to inoculate all its black children against hepatitis B.

"Regrettably the vaccine is still very expensive" — it costs R48 a person.

The World Health Organisation has stipulated that by 1995 all babies throughout Africa and the Far East should be vaccinated against the virus.

South Africa would not meet this target as there was no active programme to inoculate babies against hepatitis B, Professor Kew said.

The hepatitis B virus, which is 10 times more infectious than Aids, will kill one million people in South Africa in the next two decades.

In South Africa, there are two million carriers of hepatitis B, which causes liver cancer and subsequent death in one out of two adult carriers of the disease.

The new Medical Research Council/University of the Witwatersrand molecular hepatology research unit was opened a week ago. The unit will carry out fundamental research on the cause and related aspects of primary liver cancer, with the long-term goal of prevention and control of this fatal disease in southern Africa.

Professor Kew is a leading international figure in the field of research on liver cancer, having devoted most of his research career to the subject. He has published more than 300 papers and received many awards, the most recent one being the 1991 Wellcome/MRC Medal for Medical Research.

Professor Kew said hepatitis B and liver cancer was endemic in Africa. "People are dying every day from cancer of the liver."

The two areas in the world where liver cancer is a big problem are Africa south of the Sahara and the Far East.

"There are about 50 million carriers of hepatitis B in Africa and 300 million carriers throughout the world. Half of them are expected to die of liver cancer," Professor Kew said.

Hepatitis B carriers infected within the first six months of their lives are the mostly likely to die of liver cancer in adulthood. The disease is not fatal to adults who contracted chronic hepatitis B but were not carriers of the virus.

"The incidence of infection in children is mostly through adult carriers. Although adults are infecting each other, they're not the ones going to get liver cancer."

Professor Kew said children as young as five had been diagnosed with liver cancer.

Hepitatis B is transmitted through contact with a carrier's blood. In Africa possible causes of transmission are tribal rites such as circumcision where non-sterilised instruments are used, the bites of mosquitoes, bedbugs and ticks.

Liver cancer is also caused by chemical afflatoxin found in fungi and mould on staple crops such as maize and peanuts.

The symptoms of liver cancer are abdominal pain, weight loss and weakness. The disease is particularly virulent with patients dying an average of 11 weeks from the onset of symptoms.

Liver transplants are not very successful because the cancer recurs in the transplanted liver very quickly.

Professor Kew said a short-term goal would be to raise the level of awareness of the virus and its causes and a long-term goal to vaccinate all children against the virus and improve storage methods of staple foods in rural areas.

"There is no cure and no effective treatment once the virus has entered the body's DNA. One cannot use radiation or chemotherapy and sufferers die within 11 weeks of the first symptoms.

"We have to work out how the virus and chemicals cause cancer — to work out an effective treatment."

vision. This member sees to it that all prescribed directives regarding the care of the children are strictly adhered to and that the children's general health and well-being are promoted.

In general it can be mentioned that the Department of Correctional Services places a high premium on the medical treatment of all persons entrusted to its care. In this regard the nursing staff of the Department of Correctional Services are guided by the medical officer (district surgeon) and his prescriptions and directives are meticulously carried out. This includes general treatment which can be provided in the prison and prison hospitals, hospitalization in private or provincial hospitals and treatment by specialists.

SADF officer attached to State Security Council

*24. Mr J A JORDAAN asked the Minister of Defence:†

(1) Whether, with reference to his replies to Question No 28 on 17 February 1993 and Question No 21 on 3 March 1993, a former senior officer of the South African Defence Force, whose name has been furnished to the South African Defence Force for the purpose of the Minister's reply, was employed by the Defence Force during the period in which he was attached to the Secretariat of the State Security Council; if so, what is the name of this officer;

(2) whether this officer made direct or indirect contact with any chief ministers or governments of the self-governing areas at any time during the above-mentioned period; if so, what was the (a) nature and (b) extent of this contact;

(3) whether he will make a statement on the matter? B508E

The MINISTER OF DEFENCE:

(1) and (2)

The former senior officer whose name has been furnished to me was functionally in the employ of the Secretariat of the State Security Council and only fell under the SA Defence Force administratively. The finer details of the contacts he may have made during this period are consequently not known to my department.

(3) No.

Press freedom

*25. Mr P G SOAL asked the Minister of Home Affairs:

Whether, with reference to the free flow of information and reporting by the Press, any further steps have been or are being taken or are being contemplated in respect of the repeal of the 11 Acts referred to in the reply to Question No 7 on 18 March 1992; if not, why not; if so, (a) what steps and (b) when? B509E

The MINISTER OF HOME AFFAIRS:

As stated in the reply to Question No 7 of 18 March 1992 (Hansard: Column 419), of the 11 Acts referred to, the Department of Home Affairs administers only the Electoral Act, 1979 (Act 45 of 1979), and for the reason furnished in the aforesaid reply, it is still not the Department's intention to repeal the provision concerned.

I further recommend that my colleagues who administer the other Acts concerned be consulted by the hon member in that regard.

TBVC states: pension funds

*26. Mr P G SOAL asked the Minister of Foreign Affairs:

(1) Whether he will furnish information on whether pension funds in the TBVC states are being monitored in any way; if not, why not; if so, (a) in what way are these funds monitored and (b) what is the state of each of these funds;

(2) whether any large payments were made by any of these funds to any individuals in the past 18 months; if so,

(3) whether he will furnish details of such payments; if not, why not; if so, what are the details? B510E

The MINISTER OF FOREIGN AFFAIRS:

(1) Yes, but it is primarily not my function.

(a) On the one hand, pension funds in the TBVC States are administered by the independent state in question and monitoring occurs in terms of the pension and financial instruc-

tions as well as through auditing by the Auditors-General of those states. On the other hand, it is monitored in terms of Structural Adjustment Arrangements if actions regarding the pension funds have a fiscal impact on the adjustment measures. In such cases the Chairman of the Structural Adjustment Committee, in accordance with the agreement, would take the matter up with the two governments.

(b) I refer the hon member to the latest reports of the Auditors-General of the various states.

(2) Yes.

(3) According to available information the Venda Government decided to privatise its pension fund and in the process amounts were paid to financial institutions on behalf of individuals. Members of the pension fund were unhappy about this and this led to strikes. To solve the crisis the Venda Government appointed the Venda Pensions Crisis Committee to investigate all payments made from the pension fund. The Venda Government is assisted by Dr J de Loor in the investigation. The Committee has made good progress with its investigation and according to Dr De Loor a report will soon be submitted to the Venda Government.

Regarding the pension funds of the other States, the calculations of the amounts were made in accordance with the formulae laid down in the laws of the respective countries.

It must be stressed that the various TBVC States, as independent states, administer their own pension funds.

SADF: legal fees

*27. Mr D H M GIBSON asked the Minister of Defence:

What was the total amount paid by the Government during the latest specified period of 12 months for which information is available for the legal fees incurred by members of the South African Defence Force in respect of (a) defence in (i) criminal and (ii) civil cases, (b) inquests, (c) commissions of inquiry and (d) other legal actions? B513E

The MINISTER OF DEFENCE:

R2 907 389,53 since 1 April 1992. The figures are unfortunately not available in the cost components specified and the time and effort required to calculate them thus cannot be justified.

Reply substituting reply to Question No 9 on 17 March 1993, put by Dr F H Pauw (col 592):

National Cancer Association: funds

*9. Dr F H PAUW asked the Minister of National Health:†

(1) Whether the State makes any funds available to the National Cancer Association; if not, why not; if so, (a) what was the total amount so made available during the latest specified period of 12 months for which information is available and (b) on the budget of which State Department or Departments are donations to this association indicated;

(2) whether it is required of this association to apply the above-mentioned donations on a racial basis; if not, what is the position in this regard; if so, (a) why and (b) what procedure is being followed? B397E

The MINISTER OF NATIONAL HEALTH:

(1) Yes,

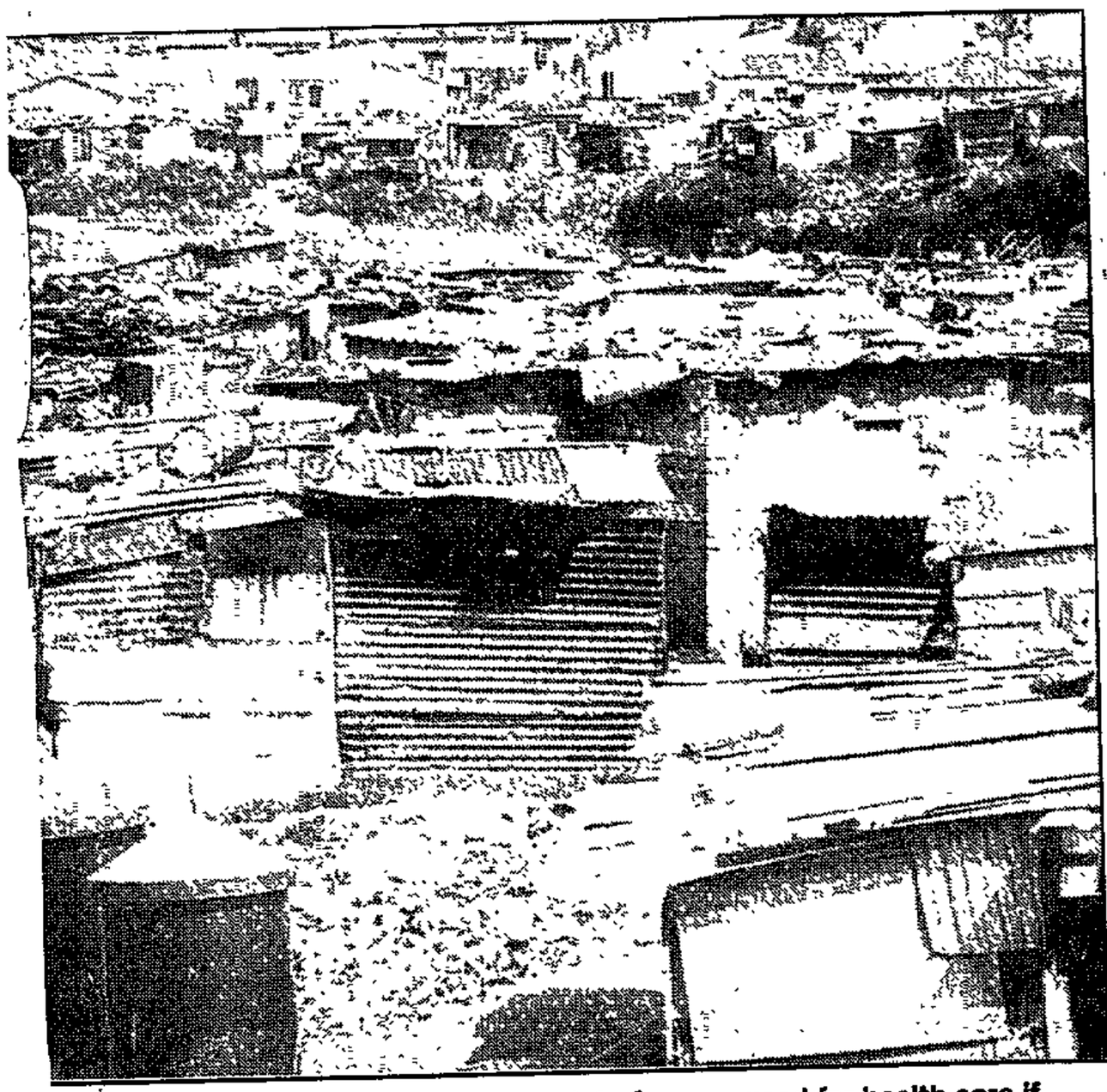
(a) R465 000 for the financial year 1992/93 and

(b) Administration: House of Representatives,
Administration: House of Delegates,
Provincial Administration of Transvaal,
Provincial Administration of the Orange Free State,
Provincial Administration of the Cape of Good Hope;

(2) no, the Association applies for subsidy at different State institutions who subsidise social worker posts for Blacks, Coloureds and Indians. The application of these personnel is not prescribed.

HEALTH FOR ALL SUPPLEMENT Diabetes can lead to serious health complications

Diabetes is a big menace



, of ill-health. This country could save a lot of money used for health care if

■ More than 120 million people suffer from diabetes worldwide; 500 000 of them are South Africans:

Sowetan 7/14/93.

By Musa Zondi
Health Reporter

(89)

DIABETES is a serious and growing health problem.

In this country, an estimated half a million people are diabetic. Worldwide, this figure stands at 120 million.

This disease can, if it is left uncontrolled, lead to other complications, like blindness, kidney failure, amputation, heart disease and poor pregnancy, says the South African Diabetes Association.

"Diabetes is a condition of the body where sugar is not used correctly to provide energy for living and growing.

"Insulin carries sugar from the blood to the cell to provide energy to the body. In diabetes, the pancreas fails to supply enough effective insulin", Sada says.

Symptoms include continuous thirst, frequent urination, weight loss, hunger, tiredness, changes in vision, numbness in the hands and feet, slow healing of cuts and bruises and itchiness.

However, in other people, there are no symptoms at all.

If you're not well

- Contact your doctor for a check-up
- Ask him to check your blood sugars (This involves a little prick of the finger, a drop of blood)
- Then you will know if further investigation is required.

If you have it

- You must understand your condition by asking your doctor thoroughly
- Accept the fact that you have the disease
- Be disciplined and responsible because in many cases, you have to change your life style if you want to live longer

Star 16/3/93

Hotline for SA's diabetics

South Africa's one million diabetics, their nurses and doctors, can now use a toll free hotline to obtain the latest information about diabetes care and support. The 24-hour line will be manned by two qualified educators.

(89)

Skin cancer in SA could rise by 20 percent

(Cape metro) ST Times 14/3/93 (89)

SKIN cancer in South Africa could rise by 20 percent over the next decade, dermatologists believe, unless some lifestyle adjustments are made.

Dr Mark Jury, climatologist in the University of Cape Town's Oceanography Department said many people are worried about the effect of the ozone hole on solar radiation levels which cause sunburn.

"The media-driven emphasis on the ozone hole is somewhat misleading since ozone is only one of the many atmospheric components which can usefully absorb the solar radiation which causes sunburn. We have found that water vapour and clouds contribute most to absorbing solar radiation."

"Ozone contributes less than one third to the absorption of solar radiation, while water vapour accounts for more than half. Clouds, oxygen and carbon dioxide absorb the remainder. This explains why people in humid climates such as Durban obtain a darker tan. Cape Town's dry summers on the other hand, are not conducive to a "good" tan and visitors to the Western Cape who enjoy the outdoors should take suitable precautions against sunburn," said Dr Jury.

"As most of us suntan at the coast during summer, it is interesting to look at the distribution of solar radiation over South Africa. Water vapour and clouds are minimal over the west coast in summer, and some of the highest solar radiation levels world-wide are found there."

"What is not fully appreciated is that the ozone hole remains to the south of 50 degrees south latitude. The ozone hole is kept there by the circumpolar jet stream of westerly winds in the upper atmosphere. It is therefore not necessary to worry about sun tanning in the ozone hole, unless you are planning a trip to Antarctica.

South Africa's summer radiation distribution indicates that we have our own "ozone hole" located somewhere near Ai-Ais in southern Namibia but this "hole" is caused by the dry weather and not ozone depletion, said Dr Jury.

Albinism is often seen as a curse

STAR 27/2/93

ALBINOS have started an organisation to fight their cause, reports JOE LOUW.

JEFF was 11 when he first thought about killing himself because of the relentless teasing he suffered from other children and the shame his parents seemed to feel every time they looked at him.

His problem was that he was white in a black world.

Jeff, now a fully grown man with a family of his own, was born with a hereditary genetic condition known as albinism. He is pure white with deep red patches scattered about his face, his hair is yellowish and since boyhood he has worn a deeply furrowed brow — developed from constant squinting to protect his weak and sensitive eyes.

Insulting names

He walks with a stoop, wears a big floppy hat, his teeth are bad and he is deeply shy.

As a child, he played a lot by himself. The children in his neighbourhood called him all kinds of insulting names — from "white man" to "amper baas" (almost "baas") to unprintable ones.

Even his parents seemed to be deeply disappointed and puzzled by his condition. "I used to run crying home to my mother and would ask her why I wasn't like other children, and she would say she didn't know and would tell me to go out and play. When I was a kid I always thought about killing myself. I still don't know why I didn't do it."

His neighbours in the township had a simple explanation. It was a curse, they said.

Most albinos have heart-rending stories to tell, and the theme that runs through them is of deep prejudice and suspicion, even of wanton cruelty, in a society scarred by an over-sensitivity to skin colour.

Now these abused people have formed an organisation to protect and promote themselves. More than 250 albinos from all walks of life — teachers, housewives, professionals, labourers — met in Soweto to form the Soweto Albino Society with Sonti Mazibuko as chief executive.

"We launched our society to alleviate the trauma suffered by people with the condition of albinism, to combat the prejudices faced by them and to educate the public to the idea that albinism is not a curse but a genetic disorder," Mazibuko says.

"People with the condition are shy, withdrawn, angry and bitter. Many albino children are abandoned at birth because the mothers may not be able to deal with the so-called shame. Families are torn apart as couples blame each other for the 'curse' or 'affliction', and society blames their parents, other races and even almighty God himself."

She says albinos are doubly discriminated against: they are not integrated socially or in work situations.

Research has shown that one person in 17 000 has some type of albinism and that it is caused by genes that do not make the usual amounts of a pigment called melanin. Most albinos suffer serious eye problems because of a lack of pigment in the retina.

Mazibuko herself was one of 10 children — five were born albino and five were normally pigmented — yet four of her five own children are normally pigmented.

"There is an appalling amount of cruelty against people with albinism — especially children," she says.

Mazibuko, a strong, proud woman who has overcome her shyness, is determined to make a success of the albino society. She wants the organisation eventually to cover most of South Africa and to help carry out research on ways of alleviating the condition.

Help needed

"Like many other groups in this country who are fighting this kind of prejudice we need help — help with setting up an office, help to educate the public through the media and through public awareness programmes. But most of all we need help to restore the self-esteem of our people and to help them confront and overcome the afflictions society heaps on them daily."

Minister warns on school invasions

BIDAY 30/4/93.

KATHRYN STRACHAN

THE threat to occupy white schools and universities could delay change in SA, Education Co-ordination Minister Piet Marais said yesterday.

Marais said the threats — aimed at forcing government to address the crisis in black schools and to establish a national education forum — were misdirected and irresponsible.

The southern Transvaal regions of the National Education Co-ordinating Committee (NECC), the SA Students' Congress and the Congress of SA Students have said they will disrupt classes and bring education to a halt at white institutions from May 26.

The CP and white parents have warned that such action will be met with force. The ANC, in turn, has distanced itself from the plan, and has urged students instead to step up constructive campaigns to open schools to all.

Marais said the threats were inappropriate as government had repeatedly committed itself to "meaningful advisory structures" and had held preparatory talks to this end.

But National Education Conference (NEC) spokesman Ahmed Essop dismissed Marais's promises. The NEC conference had held meetings on the issue with government for almost nine months, he said, and had failed to extract an agreement.

Marais claimed he needed time to consult various players, such as homeland education ministers, before making such a commitment. But Essop argued that these consultations had taken place months ago.

At the centre of the controversy lies the role of such a structure.

Government refuses to move from the concept of an advisory forum made up of experts, while the NEC demands a representative body of all stakeholders, including students.

Marais said government could not agree to anything which was tantamount to abdicating its responsibilities during its term of office. Although there were negotiating forums on housing and economics, he said education was a far more sensitive issue and had to be handled sensitively. But Essop said the NEC envisaged a forum which made decisions on the basis of consensus.

"The forum will work co-operatively with government to attain its objectives, and will not force any decisions on Parliament," he said.

Meanwhile, opposition to the threat of occupation grew yesterday.

Transvaal Education Department executive director Ken Paine said the necessary steps would be taken in conjunction with the police should any attempt be made to disrupt schools.

Free State executive director of Education Gert Heyns said all schools in the province had discussed plans to deal with any emergency situation arising from the NECC threat.

CP youth leader Andre Vorster said the party's youth council would act with other right-wing organisations to stop the proposed invasion.

Sapa reports the right-wing Boere Weerstandsbeweging (BWB) warned yesterday occupying white schools would cause a civil war. BWB leader Andrew Ford said "boers" would protect their children "to the death".

● Comment: Page 8

Drugs 'useless' in malaria battle

(89) KATHRYN STRACHAN

MEDICAL science is making little progress in its battle against the deadly malaria epidemic sweeping across Africa.

The greatest obstacle for researchers is the drug resistance emerging throughout the continent, says Medical Research Council malaria reseach programme leader Brian Sharp.

Although there are four strains of the virus, more than 90% of cases are cerebral malaria — falciparum plasmodium which does not recur.

Falciparum plasmodium has become resistant to chloroquin, the standard drug used for all four strains, says Sharp, and other drug combinations.

A new drug, mefloquine, is used in Europe but has not yet been approved by local health authorities.

It must be taken under medical supervision and is not prescribed for children or pregnant women, says Sharp.

The MRC believes the drug has been insufficiently studied, and cases of resistance have also been reported.

Sharp says the drugs, not only often ineffectual, can mask infection and complicate the disease. If malaria is diagnosed early it can be cured easily, but it kills if left too late.

ADRIAN HADLAND reports that about 30 patients in the Pretoria region are receiving treatment for malaria.

Namibian health authorities yesterday warned tourists and residents to take precautions against malaria, which had killed 27 people in the territory this year.

Health Ministry Internal Medicine Department head Prof Ockie Oosthuizen said laboratories were diagnosing up to 60 new cases every day. On Wednesday, 57 people were admitted to two Windhoek hospitals suffering from the disease, he said.

Sharp's advice to travellers is to see a doctor even if only flu-like symptoms and diarrhoea are experienced, as they could be symptoms of malaria.

Travellers to north return with malaria

Star 28/4/93

89

By Julienne du Toit

The increased incidence of people with malaria in South Africa is a result of more people travelling to other African countries, according to the Department of Tropical Diseases at the SA Institute for Medical Research.

Another reason is that Anopheles gambiae, the mosquito that carries the parasite that causes malaria, Plasmodium falciparum, appears to be developing an increased resistance to preventative drugs.

In fact, mosquitoes all over the world in tropical regions appear to be more resistant against drugs, said Dr John Frean at the Department of Tropical Diseases.

Sometimes they are resistant to new drugs, simply because they work on a similar system to older drugs, said Dr Frean.

Dr Isak Joubert, superintendent at the Rietfontein Hospital in Edenvale, said they had nine malaria admissions on the weekend alone. He confirmed this was an unusually high number, and that all the patients had recently travelled to Zimbabwe or Mozambique.

The Star's journalist Peter Davies fell prey to the disease after travelling in Malawi. He did not take his prophylactics because he had a reaction to them, he said.

"The malaria is horrible. It starts off like flu, with aching bones, sore throat and night sweats. It gets worse, and you feel so nauseous you can't keep anything down. Then when you're being treated, the quinine makes your ears ring, and you sweat and have hallucinations at night."

Travellers have been warned by tour operators that a particularly virulent strain of malaria is emerging in northern Zimbabwe and Zambia.

There were rumours of a woman near Kariba complaining of a severe headache in the morning who died in the evening of malaria.

The rumour has never been confirmed.

● The malaria parasite is only passed on through the female mosquito. She sucks blood, essential for egg-laying. The males have to be content with plant juice.



Malaria bugs SA businessmen in search of trade

THE hidden costs of doing business with Africa are permeating through to the business community.

Dozens of businessmen venturing into Mozambique, Zambia, Kenya and Malawi have been laid low by malaria and hepatitis, forcing some companies to rerate the risk of sending executives to these areas.

Clinics in upmarket suburbs confirm an increase in the number of hospital cases of malaria. Many patients were bitten by mosquitoes while on business trips. The increase in the incidence of malaria follows good rains in Southern Africa.

By CHERILYN IRETON

A Sandton Clinic spokesman reports an increase in the number of malaria patients in the past few months. "Many people contracted the disease in neighbouring countries where there are poor controls."

If not recognised and treated within a few days, complications, including cerebral malaria, can develop, often with fatal results, says a physician.

South African Foreign Trade Organisation (Safto) spokesman Andrew Mags advises businessmen to observe health regulations when going to African countries.

Safest

"In addition to taking prophylactics against malaria it is advisable to get hepatitis shots — three over six months — and to check whether cholera and yellow fever have been prevalent in the area to be visited. In the case of malaria it is essential to continue treatment on return to South Africa."

Sales of prophylactics have risen sharply, says Anja Gruttke, manager of Wellcome's over-the-counter products division. Wellcome makes two commonly used anti-malaria prophylactics, Maloprim and Daraclor.

However, these drugs are not recommended by the Department of National Health. Daraclor is ineffectual against chloroquine resistant parasites and Maloprim's efficacy is in doubt.

But the department says chloroquine is still one of the safest, most effective antimalarials. Where there is resistance to chloroquine, a cocktail of chloroquine (sold under the brand name of Nivaquine) and Proguanil — not registered in South Africa — is recommended. Proguanil can be bought in most Southern African countries.

Maloprim, a combination of pyrimethamine and dapsone, is recommended by the Zimbabwe health authorities.

Because of the emergence of resistant strains, Wellcome advises travellers to check the best preventative medicine with the health authorities of the country they are visiting.

The Department of National Health says malaria usually develops 10 to 30 days after a bite by an infected mosquito. The period can be longer if the parasites are resistant to prophylactics.

The initial symptoms are a flu-like illness with shivering, headache, fever, muscular pains, sweating, nausea, diarrhoea and fatigue.

The World Health Organisation says 110-million clinical cases of malaria occur each year. Most cases are in sub-Saharan Africa.

How to halve cost of bond

By TERRY BETTY

PLANNING can almost halve the cost of a property buyer's bond.

Financial consultant Faizel Mahomed says the buyer can make regular payments over 20 to 30 years, or the bond can be paid off faster than necessary.

Other options are paying only interest and taking out an endowment policy or buying into a unit trust to redeem the capital amount on maturity.

A person can redeem a R100 000 bond in 10 instead of 20 years if he pays an extra R284 a month.

The bond will cost R201 000 instead of R333 840 if only regular payments were made.

Pumping extra money into a bond is one of the best investments. To beat it, one would have to find an after-tax return of 18%. A person paying the marginal tax rate of 43% would need an investment yielding more than 32% a year.

Mr Mahomed says making only the scheduled payments is sensible if a person has a subsidised bond. It would be better for him to invest excess cash elsewhere because the bond costs less than normal.

Paying only interest on the bond and subscribing to a unit trust or endowment policy to redeem the capital amount is a popular option.

Fraught

Mr Mahomed says endowment policies are advisable in only a few cases.

The benefits are that if the policy grows faster than the bond rate, the borrower will make money or pay off the bond earlier.

But if the policy does not perform well, the investor will lose money.

Most endowment policies guarantee a return of about 5% a year and are performing at 10% to 20% a year over 10 years.

Mr Mahomed says this option is fraught with problems, mainly because it lacks flexibility.

Another option is paying only interest on the bond while contributing to a unit trust. They have generallly shown a return of 20% to 30% a year in the past 15 years.

Although they have higher historic returns, they also bear a higher risk.

The advantages are that they are flexible and contributions can be increased or decreased. They can be cashed in at any time without incurring a tax liability.

Malaria rampant

OF THE 100-million cases of malaria reported annually, 80% occurred in Africa, Health and Population Development northern Transvaal director Dr Nicholas Crisp said yesterday after attending a World Health Organisation meeting in Brazzaville, Congo.

About 275-million Africans, or more than half the continent's 500-million people, were infected. The disease was responsible for 1-million deaths a year, he said.

Star 6/5/93

Travellers warned to take precautions against malaria

Staff Reporter (59)

The Department of National Health has warned prospective travellers to neighbouring states to take precautions against malaria because of a reported increase in the number of people being exposed to malaria-carrying mosquitoes in these countries.

The department said in a statement that these visitors also run the risk of getting malaria which is resistant to certain preventative medicines.

Prospective visitors to malaria areas have been advised to consult a pharmacist, physician, health clinic or one of the regional offices of the department.

The correct medicine must be taken according to the instructions. It is important that it is taken for a period of four to six weeks after leaving the malaria area.

Central Economic Advisory Service

Capacity	*Number of retrenched public servants*	*Number of retired public servants*
State Accountant		1
Total		1

South African Communication Service

Capacity	*Number of retrenched public servants*	*Number of retired public servants*
Principal Communication Officer		1
Industrial Technician	1	
Total	1	1

Schools: number of classrooms

323. Mr R M BURROWS asked the Minister of Education and Training:

(a) What is the (i) total number of classrooms in (aa) primary and (bb) secondary schools administered by his Department and (ii) average number of classrooms in each case and (b) in respect of what date is this information furnished? B744E

The MINISTER OF EDUCATION AND TRAINING:

(a) (i) (aa) 43 509.

(bb) 14 849.

(ii) (aa) 5,8.

(bb) 23,2.

(b) 3 March 1992.

Notifiable diseases in each race group

331. Mr M J ELLIS asked the Minister for National Health and Welfare:

How many cases of each notifiable disease were notified in respect of each race group in 1992? B745E

The MINISTER FOR NATIONAL HEALTH AND WELFARE:

Disease	*Population Group*					
	Unknown	*Asian*	*Black*	*Coloured*	*White*	*Total*
Brucellosis	1	1	6	7	24	39
Cholera	1	0	13	0	0	14
Congenital syphilis	83	0	423	288	1	795
Congo fever	0	0	7	0	2	9
Diphtheria	0	0	2	0	0	2
Food poisoning	2	7	21	51	1	82
Lead poisoning	0	0	1	0	1	2
Legionellosis	0	0	1	0	1	2
Leprosy	2	0	69	1	0	72
Malaria	42	2	2 540	5	188	2 777

Disease	*Population Group*					
	Unknown	*Asian*	*Black*	*Coloured*	*White*	*Total*
Measles	910	340	12 677	2 117	4 304	20 348
Meningococcal infection	9	3	258	291	32	593
Pesticidal poisoning	3	1	68	50	20	142
Rabies	0	0	15	2	10	27
Rheumatic fever	0	2	15	12	1	30
TB bones & joints	0	3	99	34	6	142
TB genito-urinary system	0	0	34	13	20	67
TB intestines	0	3	50	8	5	66
TB meninges, CNS	3	5	237	98	14	357
TB miliary	1	1	117	48	7	174
TB other organs	34	17	1 653	354	97	2 155
TB other respiratory	0	2	476	373	33	884
TB primary infection	1	1	1 892	2 705	31	4 630
TB pulmonary	247	506	47 608	19 054	782	68 197
Tetanus	1	1	74	2	4	82
Tetanus neonatorum	0	0	15	1	0	16
Trachoma	0	0	7	0	0	7
Typhoid fever	10	8	1 084	8	37	1 147
Viral hepatitis A	138	40	164	215	825	1 382
Viral hepatitis B	27	36	330	175	52	620
Viral hepatitis non-A, B	1	0	25	0	9	35
Viral hepatitis unspecified	0	5	212	56	38	311

Western culture is a health risk

By SIPHO KHUMALO

BLACKS who have embraced Western culture are paying an increasingly high price in obesity, heart attacks and other related diseases, medical experts have warned.

Instead of taking only the good out of Western culture and leaving out the bad, blacks have taken both, said Professor Yacoob Seedat of Natal University Medical School.

"Hypertension, a constant companion of heart disease, is fast becoming a way of life among black women," said Seedat.

One in three black women in urban centres in Natal is obese and suffering from hypertension, he said.

Figures released by the Heart Foundation paint a gloomy picture with more than 24 percent of all deaths in SA being caused by heart related diseases. This rate, said the Foundation, is higher than anywhere in the world.

The Foundation added that the incidence of heart disease in this country is increasing proportionally as blacks become more westernised.

Blacks start getting the diseases which are rampant among whites when they abandon their healthy lifestyle in favour of the western way of life.

Lack of exercise, cigarette smoking and unhealthy diet have been identified as the chief culprits on the new life style of blacks.

Blacks used to walk miles and miles to go and buy brown bread, thus getting a combination of exercise and good food in one stroke, comments Ningi Ngcobo, a nutritionist at Umlazi's Prince Mshiyeni Hospital.

"These days they buy canned fruits and white bread, both low in fibre," she said.

White bread, which is inferior to brown, is wrongly considered a status symbol by blacks, she added.

Ngcobo said when black people ate ground mielies, which was rich in roughage, as their staple diet with sour milk and wild vegetables, heart attacks were very rare and diabetes non-existent.

She said the number of obese people – mostly women – attending the hypertension clinic at her hospital were increasing daily.

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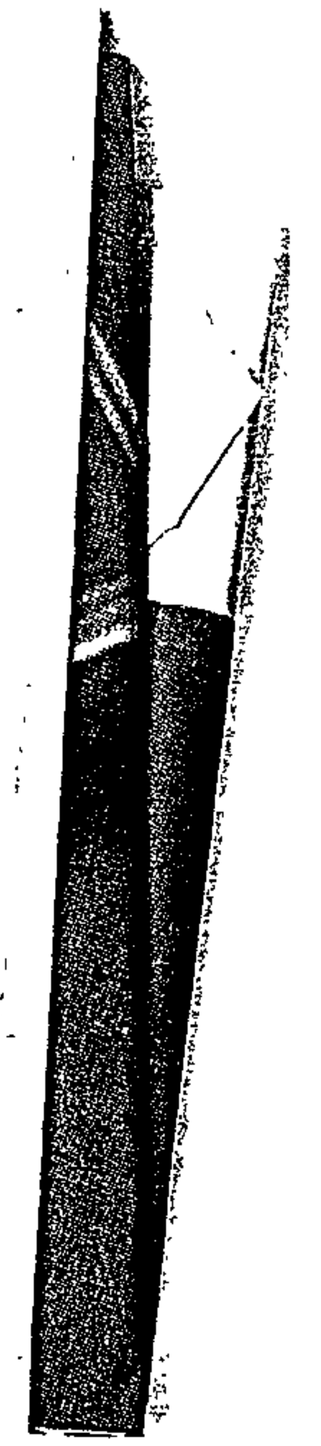
Professor Seedat also blamed the tobacco industry for the increasing heart attacks among blacks.

He said as people in Europe became aware of the dangers of smoking, the tobacco industry was now dumping its product on Third World countries such as mainland China and Africa.

Seedat said the World Health Organisation (WHO) has advised countries to introduce primordial prevention programmes among those communities which had not yet developed destructive lifestyles.

He called on the government to introduce health education in black schools.



Mandela from jail

Provincial Administration of the Orange Free State

(a) 80 and 2

(b) Black—40; White—38; Coloured—2

Other Provincial Administrations

The Provincial Administration of Transvaal, Natal and the Cape of Good Hope do not keep statistics of causes of death.

Lung cancer: deaths

314. Mr M J ELLIS asked the Minister for National Health and Welfare: (89)

How many persons (a) in total and (b) in each race group died of lung cancer in each province in 1992? B706E

The MINISTER FOR NATIONAL HEALTH AND WELFARE:

Provincial Administration of the Orange Free State:

(a) 80 and

(b) Blacks: 40 Whites: 38 Coloureds: 2

Other Provincial Administrations:

The Provincial Administration of the Transvaal, Natal and the Cape of Good Hope do not maintain statistics on causes of deaths.

***Per capita* allocation of health funds**

316. Mr M J ELLIS asked the Minister for National Health and Welfare:

(1) Whether her Department has made any calculations regarding the *per capita* allocation of health funds for 1991–92 in the four provinces of the Republic; if so, (a) which (i) census year's statistics and (ii) financial year's expenditure were used as the basis for these calculations, (b) what allowance was made for rapid urbanization, (c) how was the expenditure per province calculated and (d) what factors were taken into account in reallocating funds between provinces;

(2) whether the independent Black states (TBVC states) were included for the purpose of these calculations; if so, as part of which provinces; if not, what allowance was made for cross-border flows;

(3) whether the (a) self-governing territories and (b) various departments of health in the (i) Republic, (ii) self-governing territories and (iii) TBVC states were included for the purpose of these calculations; if not, why not; if so, in what way;

(4) whether provision was made in these calculations for (a) health facility planning, (b) construction expenditure, (c) expenditure on equipment and (d) extraordinary expenditure; if not, why not; if so, (i) what items of extraordinary expenditure were provided for and (ii) how did their inclusion affect the *per capita* allocations;

(5) whether the figures derived from these calculations are updated annually; if not, why not; if so, what are the most recent estimates? B708E

The MINISTER FOR NATIONAL HEALTH AND WELFARE:

(1) Yes,

(a) (i) 1985, as adjusted and

(ii) 1991/92 budget allocations,

(b) none,

(c) the total budget allocations to the town affairs administrations, provincial administrations and the self-governing territories within each of the geographic regions of Transvaal, Cape Province, Natal and the Orange Free State respectively, are divided by the total populations in each of the mentioned geographic regions.

The budget allocation of the Department of National Health and Population Development is not included in the allocations mentioned above because the Department—

— has a national overall responsibility in respect of health services which can only with great difficulty be divided into regions; and

— has limited responsibility for the delivery of health services and

(d) the Department divides the national health budget on the basis of a financing formula which has been approved by the Cabinet. The relative need for health services in the different geographic regions is the principle on which the formula is founed. The need for health services is determined by the size of the population in a specific geographic region, as well as the health status of the population. The latter takes mortality rates, loss of potential years of life and utilisation rates of health care facilities into consideration;

(2) no, accurate figures are not available;

(3) (a) yes, as stated in paragraph 1 (c) and

(b) (i) yes, as stated in paragraph 1 (c),

(ii) yes, as stated in paragraph 1 (c) and

(iii) no,

the TBVC States are excluded because of the fact that the health services of these states are not funded from the national health budget. The Department of National Health and Population Development carries no responsibility for allocation of the budget for health services in these states.

Regarding the health departments which are included, refer to paragraph (1) (c);

(4) (a), (b), (c) and (d) yes,

(i) the total allocations to each of the health authorities are used in the calculations. Specific items are not referred to and

(ii) because specific items are not referred to in the calculations, the per capita effect of the allocations cannot be determined;

(5) yes,

1993/94 (provisional estimates)

	Rand *per capita*
Cape Province	401
Orange Free State	293
Transvaal	266
Natal	235

In an effort to establish the *per capita* allocation in the four geographical regions on a more comparable basis, steps have been taken to improve the backlog in the Natal region. The results are as follows:

Percentage disparity in the *per capita* allocation between the Cape Province (highest) and the Natal region (lowest)

1991/92	85,9%
1992/93	76,6%
1993/94	70,6% (provisional figure)

Political violence in Natal Midlands: inquests

324. Mr W U NEL asked the Minister of Justice:

(1) How many inquests pertaining to death resulting from political violence were conducted in each magisterial district in the Natal Midlands (a) in 1992 and (b) during the period 1 January 1993 up to the latest specified date for which information is available;

(2) in how many of these inquests (a) was death attributed to persons unknown and (b) were findings referred to the Attorney-General for his decision;

(3) in how many cases (a) did the Attorney-General decline to prosecute and (b) were prosecutions instituted? B748E

The MINISTER OF JUSTICE:

The required information is not readily available. In an effort to be of assistance to the hon member, a few magistrates of districts (Pietermaritzburg, Glencoe, Howick and Estcourt) in the Natal Midlands were requested to furnish information regarding inquests pertaining to deaths flowing from violence. The following information for the period 1 January 1992 to 31 December 1992 is available.

(1)	Pietermaritzburg	745
	Glencoe	39
	Howick	53
	Estcourt	74
(2) (a)	Pietermaritzburg	459
	Glencoe	37

cont—D

125 cases of cancer a day in SA

(89) ARG 27/5/93

JOHANNESBURG. — An average of 125 cases of cancer are being reported in South African every day, according to a senior researcher, who warned that the number was bound to increase.

Dr Freddy Sitas, head of the National Cancer Registry of the South African Institute for Medical Research, said smoking, diet, lifestyle, pollution and infectious agents were responsible for 80-90 percent of cases.

Inherited cancers contributed only 5 percent, he said in the latest National Cancer Registry report.

Dr Sitas said there had been a 30 percent increase in smoking in South Africa between 1975 and 1986, and that cancers in 40,4 percent of males and 15,2 percent of females aged between 15 and 64 were associated with the habit.

"Cancer is bound to increase, given current trends in South African society," Dr Sitas said in his report.

He said one in eight blacks had a lifetime risk of being stricken by cancer "although the figure was more likely to be one in five or worse".

For whites, the risk was about one in four for males and one in five for females. Rates for coloured and Asians ranged from one in five to one in 10, but Dr Sitas said rates for these two population groups could be much higher.

He said annual cancer cases reported had risen to 46 500 by 1989. This compared to 35 498 in 1986, 38 027 in 1987 and 45 570 in 1988.

In black males, cancer of the oesophagus was the most common, he said, adding that one in 32 black males had a lifetime risk of developing this cancer.

Cancer of the cervix was most common in black and coloured females, and at least one in 21 black females had a lifetime risk of developing this cancer.

"These South African rates rank among the highest worldwide," Dr Sitas said in his report. — Sapa.

Incidence of cancer rising

BJDAM 27/5/93

KATHRYN STRACHAN

THE incidence of cancer is increasing, with one in four men and one in five women at risk, the latest figures on the disease indicate.

Presenting the National Cancer Registry's statistics yesterday, Dr Freddy Sitas said an average of 125 cases of all types of cancer were reported daily — and the figure continued to rise each year.

Almost 47 000 cases had been reported since 1989.

Sitas cautioned that the figures were conservative because access to pathology services in SA's rural areas was rare, compounding the problem of developing accurate figures.

Smoking, diet, occupation, lifestyle, pollution and infectious agents were responsible for 80%-90% of all cancers.

Inherited cancers made up only 5% of the total.

Changes in SA's society during the past two decades which had contributed to the escalation of cancer cases included a 30% increase in tobacco consumption — from 34-million tons in 1975 to 44-million tons in 1986 — and the arrival of AIDS.

About 25 000 people were infected with HIV, he said. Such people were more at risk of developing cancers caused by other viruses.

(89)

"We know from data in developed countries that HIV causes dramatic increases in some of these cancers," said Sitas.

"It is important to monitor all cancers associated with infection.

"Health planners need to know whether to expect even small increases in certain cancers because these could cause an increased burden in an already overcrowded public health service."

More than 40% of cancers in males and 15% in females were associated with smoking, he said.

Increased exposure to ultraviolet radiation caused by the "hole in the ozone" was also cause for concern, as excessive exposure led to an increase in skin cancer.

"Cancer is bound to increase, given the current trends in SA society.

"For this reason we need to measure the burden of cancer, especially in black rural areas, by establishing environmental-population-based cancer registries where all forms of cancer diagnosis are taken into account," said Sitas.

Incidence of cancer rising

BJDay 27/5/93

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Children don't have to die — doctor

Dirty water and open fires are child killers. These and other aspects of impoverished living conditions, coupled with a lack of primary health care facilities, are responsible for most deaths of South African babies.

Dr Marian Jacobs of the Child Health Unit at the University of Cape Town points to the statistics on the causes of infant mortality.

"The top killers are preventable causes," she points out.

Infant mortality is generally taken to mean the number of babies dying before their first birthday — in 1989 more than 36 000 children died in the first year of life.

Of the babies who die before their first birthday, 56 percent are perinatal deaths: that is, occuring during labour or within the first four weeks of life. Jacobs says most of these deaths could be prevented by a proper system of pre-natal, obstetric and post-natal care.

A further 17.3 percent of infant deaths are the result of intestinal infections, with diarrhoea a common symptom — these infections are largely the result of unsanitary living conditions. Respiratory diseases account for another 10 percent of child deaths — electrification of homes could help prevent such diseases, which are most common when children are living in smoke-filled houses or shacks.

Diseases caused by inadequate nutrition account for three percent of infant deaths.

Among older children, deaths caused by traffic accidents and drowning could be reduced with better road planning and recreation facilities in townships.

These findings are part of a report which Jacobs has compiled on child health as part of the Situation Analysis of Children and Women in South Africa, which the National Committee on the Rights of Children (NCRC) is to present to the United Nations Children's Education Fund in June.

The report also illustrates how strongly the infant mortality rate is linked to socio-economic status. Babies whose families can provide private medical care, and who live in clean, electrified houses, are more likely to live past their first birthday.

In South Africa, racially skewed health services mean that race as well as income group has an effect on whether a child can expect to survive the first year of life.

While the infant mortality rate among high-income white communities is 7.3 a thousand, among low-income black communities it is as high as 25.2 a thousand.

Concentration of health care facilities in urban areas means that rural children are more likely than urban children to die during infancy.

"The infant mortality rate is the most sensitive indicator of children's well-being," Jacobs says.

She also suggests the mortality rates for African children, especially in rural areas, may be even higher than reported, owing to unreliable registration and census data.

SA gets vaccine to protect babies

By Zingisa Mkhuma Star 3115193

A vaccine to protect infants against the relatively unknown Hib disease which claims the lives of thousands of children worldwide, and leads to meningitis, has been made available in South Africa for the first time.

The vaccine, called HibTITER, is specifically designed to protect infants from as young as two months against the highly contagious Haemophilus influenzae typ-b bacterial infection which causes Hib disease.

Disabling

Toddlers and infants infected with the virus may suffer from spinal meningitis, often with severely disabling side effects such as deafness, seizures, paralysis, hearing and vision impairment. and mental retardation in infants and toddlers.

According to Dr Lyne Leibowitz, a microbiologist from the SA Institute for Medical Research, 95 percent of the cases of this invasive disease are children under the ages of five. Sixty percent of victims develop meningitis, 6 percent die and up to 30 percent suffer permanent disabilities.

Hib disease is very contagious and is easily spread through casual contact. Researchers have found that infants attending play schools have a significantly greater risk of infection from the disease than other children in the community.

The risk is even greater in lower socio-economic population groups because of overcrowding and the general absence of preventive primary health care.

Leibowitz said 23 cases of meningitis linked to the Hib virus were reported at the Johannesburg Hospital between January 1992 and March this year in children between the ages of three months and three years.

Overseas studies have indicated that children have a 1:200 chance of developing some form of invasive Hib disease before their fifth birthday. In South Africa the figure is 1:250.

A spokesman for the company that imports the vacaccine, Neville Huxam, said that very litle research has been conducted to determine prevalence of the disease in South Africa.

Widespread

However, Huxam said, preliminary data indicated that the incidence of the disease may be more widespread than was suggested by officials.

South Africa has joined group of over 14 countries that are using the HibTITER vaccine to protect infants from the age of two months against the disease.

The vaccine is available on demand and at a cost from chemists and doctors.

SA-made KlinoLab 'major step forward'

BLOOM 4/6/93 ADRIAN HADLAND (89)

PRETORIA — A revolutionary SA-developed medical instrument, the KlinoLab, was unveiled by the CSIR yesterday.

Designed to detect congenital metabolic disorders, the instrument was the first of its kind in the world and represented a "major step forward in the diagnostic field", CSIR executive vice-president of operations Daan Toerien said.

Where conventional testing for metabolic disorders — believed to be a major cause of infant mortality — required a sophisticated laboratory, cost around R1 000 a test and had to be conducted by an experienced analyst, KlinoLab was a single, easy to operate unit which could complete the scan in six minutes for around R75, Toerien said.

As global interest was expected, international distributors were currently being approached to handle the product, valued at R157 000.

Thought up by a student in 1988, the KlinoLab was developed jointly by the CSIR, Potchefstroom University's biochemistry department and Lektratek Instrumentation.

A CSIR statement said up to 94% of patients screened in the conventional way for metabolic disorders were diagnosed as negative. This cost the same as a positive test, putting tremendous strain on resources.

The KlinoLab, while unable to diagnose the specific disorder, could nonetheless screen out the negative patients, streamlining the process considerably.

In Europe, genetic defects were viewed as the most frequent cause of baby deaths, the statement said. The invention of the KlinoLab would allow significantly more children in SA to be tested. In some instances, early diagnosis contributed to a successful cure.

"If a metabolic disorder is not diagnosed within the first 90 days after birth, it leads to retardation in the child," the CSIR said.

Malaria: 'local drugs powerless'

Star 7/16/93

(89)

By David Robbins
Health Writer

Thousands of South Africans risk becoming victims of the worsening malaria epidemic because the protective medicines used locally have lost their power.

This warning comes from a prominent haematologist (blood disease specialist) at the Insitute of Medical Research at Baragwanath Hospital.

The prophylactic drugs recommended by the World Health Organisation (WHO) for use in Africa are not even licensed in South Africa, and the drugs which are available — and widely used — are considered by experts to be inferior.

Refusal

They also carry a higher risk of side effects.

It has been estimated that there are about 300 million malaria infections globally, most of them in sub-Saharan Africa. Especially with the opening of South Africa's northern borders, increasing numbers of South African travellers are at risk.

"The continued refusal of the Medicines Control Council to license the recommended prophylactics is a grave disservice to travellers from this country," said Alan Fleming, professor of haematology at the institute and at Wits University.

For several decades now, malaria parasites have shown an increasing tendency to resist drugs designed for their control.

For this reason new drugs have periodically appeared, and new combinations of drugs are recommended for prophylactic and curative use.

The WHO's recommended prophylaxis for Africa is chloroquine and proguanil taken together, but proguanil is not licensed in South Africa. Most widely used is pyrimethamine combined with chloroquine.

As long ago as September 1991, however, a group of local scientists was saying that due to resistance by malaria parasites to pyrimethamine, its combination with chloroquine "is no longer generally recommended as it is thought to confer only marginal, if any, benefit over the use of chlororquine alone".

Proguanil, on the other hand, appears to be a superior drug. Although widespread resistance has developed here too, proguanil is still effective in com bination with chloroquine.

Even more effective is another drug, mefloquine, but under certain conditions it produces neuro-psychiatric side effects, and it is not recommended for children or pregnant women. It's a good drug for short-term travellers, but like proguanil it's not licensed here.

"I am not willing to put my family or myself at risk by relying on the prophylactics currently licensed in South Sfrica," said Fleming.

Professor Peter Folb, chairman of the Medicines Control Council, is currently overseas, but has been quoted recently as saying that the council's decisions are "continually under review as circumstances change".

FOCUS: *Immunising young children against the killer Hib disease*

Serious gap in routine shots

W Mail 18-24/6/93

(89

CRITICAL CONSUMER

Pat Sidley's weekly column on controversial issues



PARENTS of young children, who can afford to, should be asking their doctors to immunise their children against Haemophilus Influenzae B. This is *not* the flu we know but is called "Hib disease", which kills many children annually.

It hits children aged mainly between six and 12 months, though there have been some cases involving children as young as two months. Mostly, it affects children before they are five years old.

It may cause the deadly, infectious and notifiable meningitis, as well as specific types of ear infections which lead to deafness, arthritis, septicaemia and pneumonia.

In the United Kingdom, according to the *Drug and Therapeutics Bulletin,* the newer vaccines should prevent the deaths of 55 children annually and prevent serious illness in another 1 100.

In South Africa, the problem is a great deal more serious, as it is known to affect poorer populations more seriously.

In other words, the vaccine ought to be given to all black children, along with other routine vaccinations, like those against measles, tuberculosis, etc. But, because of the costs involved — a private shot will cost around R50 — it is not yet supplied by local authorities.

In the UK, it has recently been introduced along with all the other routine innoculations.

Research shows that children under five years in South Africa have a one in 250 chance of falling ill with the disease. According to the research, black male children are most at risk.

It is a highly contagious disease, easily spread in schools, creches and the like.

In the UK, two types of vaccine are available — here so far, only one, known as HibTITER and made by Lederle. According to local doctors, the vaccine is safe and effective, and it eliminates a major cause of child deaths.

The *Drug and Therapeutics Bulletin* says when it is given with the usual diphtheria, tetanus and pertussis shots, and then with polio shots, it will provide protection to children from four months old. And according to studies in the UK, no booster shots are needed afterwards.

The *Bulletin,* which is an independent and authoritative publication, says that large field studies "show a rapid and marked reduction" in the incidence of the disease as a result of the vaccination. And in one pilot immunisation programme in the UK, the incidence dropped to zero.

According to the *Bulletin,* there are few side effects from the vaccination.

The conclusion of the *Bulletin* — which mirors what the drug company says, and gives it more weight — is that immunising against Hib disease "saves lives and reduces serious morbidity (deaths) in very young children. We welcome its inclusion in the routine vaccination programme."

Naturally, the drug company would like to see its product included in local-authority health programmes as this would represent a great deal of cash for the company. But, it seems, as usual, money and other problems will delay this.

Taking the overseas evidence into account, along with the advice of local doctors this Critical Consumer spoke to and the South African research which shows we are at greater risk than European groups, the obvious conslusion is that the health authorities ought to introduce it as soon as possible and parents should ask their doctors for protection as soon as they are able.

Malaria: a growing menace

Malaria is on the increase throughout the world as malarial parasites become increasingly resistant to the armoury of drugs which medical science has developed to combat this deadly disease. What is the situation locally, and what impact will new research have on the world epidemic? Health Writer DAVID ROBBINS reports.

MORE THAN 300 million people will contract malaria worldwide this year and up to 2 million will die.

In Africa, it is estimated that 100 million people — one in three — have the disease and about 1 million of them will die.

Apart from northern Natal and KwaZulu, the Transvaal lowveld and the Limpopo basin, South Africa is not malaria country. We're certainly not in the same league as the rest of sub-Saharan Africa. Nevertheless, the incidence of malaria is increasing dramatically here.

More than 2 500 cases were reported in the first three months of this year, compared to 1 017 cases for the same period in 1992. The incidence of malaria has been dropping steadily since 1987, but if the present trend continues, 1993 could see the highest figure over the past 30 years.

Even on the Witwatersrand, the figures give cause for concern, although it is not possible to acquire malaria here. Johannesburg health officials report a sharp increase of the disease among the white population.

Drought

The weather is partly to blame for these increases, in particular the breaking of the drought which afflicted much of southern Africa during the first years of the present decade.

But the increases also illustrate South Africa's closer relationship with the rest of the subcontinent since 1990, and also the decreasing efficacy of the prophylactic drugs taken by South Africans travelling into high-risk malaria areas like the Zambezi basin, Mozambique, Madagascar, and Zambia.

The most effective drugs for these countries are not registered here. The World Health Organisation (WHO) recommends a combination of chloroquine and proguanil as the most effective prophylactic for use in Africa. This includes northern Natal, but not the eastern Transvaal lowveld where chloroquine alone is still considered sufficient protection.

But proguanil is not licensed by the Medicines Control Council. Neither is mefloquine, a more recent drug.

The truth is that even proguanil and mefloquine are losing their potency as malaria parasites show increasing resistance to them. The same must be said about chloroquine. The parasites are even learning to resist quinine.

Since malaria exists in a broad band along the equator, the worst affected countries are all Third World. Put another way, from the point of view of major Western pharmaceutical manufacturers, there's not a lot of money to be made in attempting to research more effective anti-malarial drugs.

The cynics say we need another war, since most major advances were made in an attempt to protect Western soldiers fighting in malaria-ridden countries like Vietnam.

The Third World says otherwise, however, and scientists in China and Colombia are coming up with research in which Western scientists are now taking a keen interest. Two advances are worth mentioning.

The first is qinghaosu or artemisinin. Derived from a Chinese herb which has been used for medicinal purposes since before Christ, artemisinin was found in the early 1970s to have anti-malarial properties.

Artemisinin drugs were also tested on 141 cases of cerebral malaria, a complication which normally ends in death. Mortality was reduced to 7 percent.

According to medical scientists writing in The Lancet in March this year, two more years of tests will be necessary before the efficacy of artemisinin is fully established.

The scientists also warn that the build-up of resistance to the drug is a distinct possibility. "Since these (Chinese) drugs are such valuable alternatives to quinine for severe malaria, it would be disastrous if their unlimited use for uncomplicated malaria and availability in the marketplace led to the rapid development of resistance."

The second advance from the Third World is SPf66, a chemically synthesised vaccine developed by Manuel Patarroyo in Colombia.

Patarroyo's approach to the problem of producing a vaccine against an organism which is in a constant state of mutation was, in simple terms, to create a chemical caricature of a basic malaria parasite in all its life-cycle mutations against which the vaccinated person can build up some resistance.

Tests so far have shown fair results, with average efficacy during tests 33 percent.

Gone is the optimism of the 1950s and 1960s when it was thought that widespread spraying with DDT would eradicate the disease entirely. Indeed, malaria experts now agree that eradication is impossible.

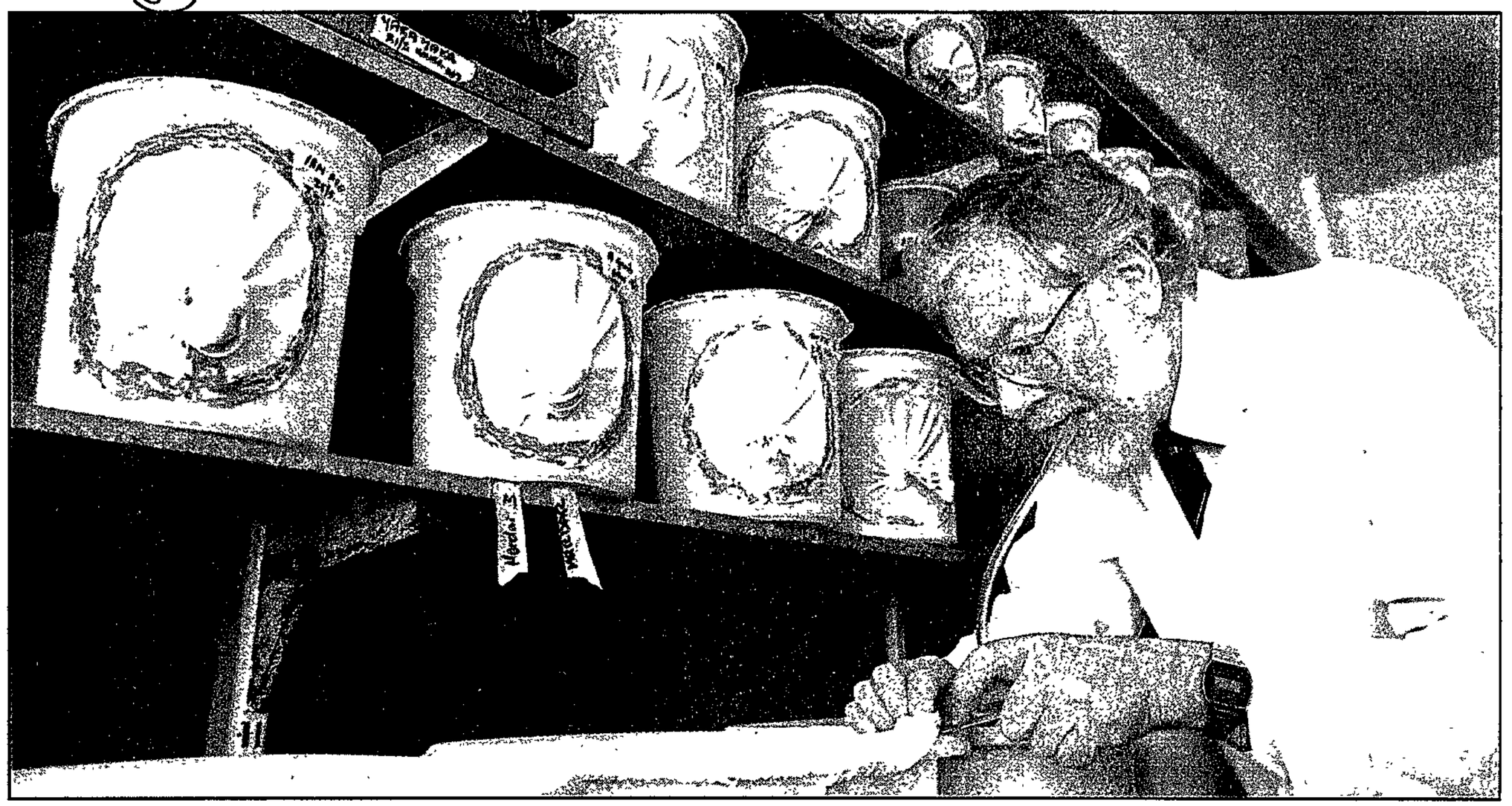
Ideal conditions

Learning to live with the disease and with the 30 different species of *Anopheles* mosquitoes which transmit it is not easy. Some of the classic activities of developing countries actively promote malaria. Forest clearing for agriculture and the untidiness of urbanisation and informal settlements create conditions which are ideal for the rapid breeding of mosquitoes.

To fight the disease, attention is shifting from prophylaxis to avoidance of contact with the mosquito. Clean environments and the prompt treatment of water pools are now being encouraged, as is the wearing of clothing which adequately protects the limbs.

Most important of all in the fight against mosquitoes which feed at night is the good old-fashioned bed net, but these days soaked in insecticide.

Most South Africans are not in the direct firing line, but enough of us are, and our borders are sufficiently close and open to one of the major centres of malaria for all of us to take the disease very seriously indeed. □



Delving . . . Dr Richard Hunt, head of medical entomology at the SA Institute of Medical Research, collects mosquitoes from larval bowls. Lining the shelves are containers of adult mosquitoes, among which are two of the most dangerous carriers of malaria in Africa. Picture: Ken Oosterbroek

Research now uses DNA technology

'A LOT of people think that the solution to malaria is to kill off all the Anopheles mosquitoes," says Dr Richard Hunt. "But it's not as simple as that."

Hunt is head of the Department of Medical Entomology at the South African Institute of Medical Research.

"The point is they're not all deadly," he explains. "Take *Anopheles gambiae*, Africa's most dangerous group of species. It's composed of no less than six morphologically identical species, some of which carry the malaria parasite, some of which don't."

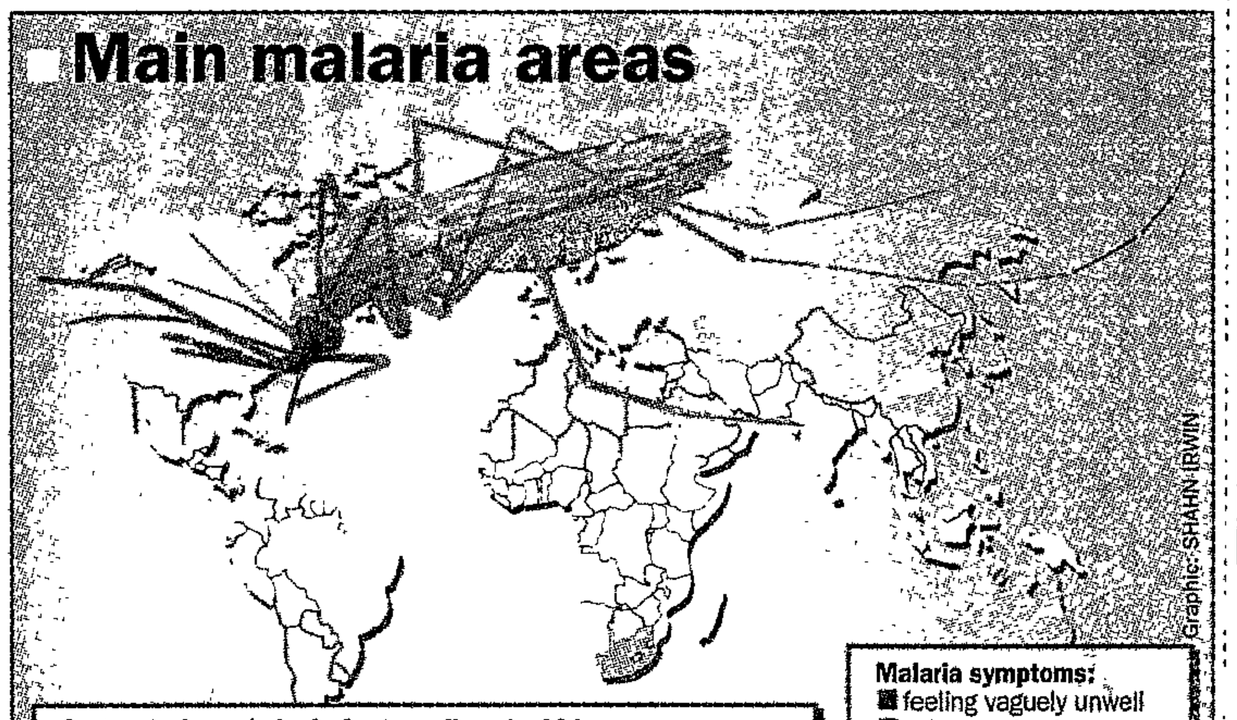
The accurate identification of malaria-carrying mosquitoes occupies most of Hunt's time, and is the main thrust of the research taking place in his department.

He explains the stages through which this research has developed. First mosquitoes were cross-mated and their offspring examined, but this was a tedious procedure.

Then an Italian discovered that identification was possible by comparing the banding patterns on the mosquitoes' chromosomes. In more recent years, chemical methods of identification were developed.

"Now we're using DNA technology for the identification process," says Hunt. □

Main malaria areas



Graphic: SHAHN IRWIN

Suggested prophylaxis for travellers in Africa:

- Kruger Park: chloroquine between November and May.
- Ingwavuma, Ubombo and Swaziland lowveld districts, also Angola, Kenya, Madagascar, Malawi, Mozambique and Zaire: chloroquine with proguanil, or doxycycline, or mefloquine throughout the year.
- Zimbabwe, Botswana, Namibia, Zambia: chloroquine with proguanil, or doxycycline, or mefloquine between November and June.

The main malaria-carrying mosquito is the Anopheles gambiae seen here. *Source: SA Institute of Medical Research.*

Malaria symptoms:

- feeling vaguely unwell
- aches and pains
- headaches (like influenza)
- occasionally diarrhoea and vomiting
- fever, perspiring and cold shivers
- drowsiness
- later complications can include renal failure and coma

HOUSE OF ASSEMBLY

QUESTIONS

†Indicates translated version.

For written reply:

General Affairs:

District surgeons: salaries/allowances

315. Mr M J ELLIS asked the Minister for National Health and Welfare:

(1) Whether she will furnish information on (a) the annual salaries and (b) allowances payable to district surgeons in the employ of the State; if not, why not; if so, what are the relevant particulars in respect of the latest specified date for which information is available;

(2) whether district surgeons are employed in a full-time capacity; if so, what are the relevant details; if not, (a) why not and (b) how many hours per week is a district surgeon expected to work;

(3) how many district surgeons were employed by the State in each region as at the latest specified date for which information is available? B707E

The MINISTER FOR NATIONAL HEALTH AND WELFARE:

(1) Yes,

(a) *Full-time district surgeons*

These officers can, depending on the number of years experience gained, be appointed according to the following salary scales:

Medical Officer
R44 574–48 024–51 474
Snr Medical Officer
R55 650–59 826–64 002
Principal Medical Officer
R69 348–74 694

Part-time district surgeons

The annual salary of these personnel differ from district surgeon to district surgeon because the individual salary is calculated according to an allocated workload applicable to the session basis of medical officers/ senior medical officers (R1 764/2 340 per session per annum respectively) and

(b) *Full-time district surgeons*

Non-pensionable district surgeon allowance of R4 800 p.a.

Non-pensionable professional allowance of R15 207 p.a. if they are prepared to comply with a working week of at least 56 hours.

Part-time district surgeons

Honorarium: R3 186 p.a.
Infrastructure allowance: Can vary between 15% to 25% of the compensation package
Medicine allowance: R13,45 per prescription (issues from own stock)
Handling fee: R5,94 per item (issues from replaceable stock).

Information furnished as on 1 May 1993;

(2) yes,

Full-time district surgeons

Pretoria, Johannesburg, Louis Trichardt, Pietersburg, Durban, Pietermaritzburg, Pinetown, Bloemfontein, East London, Port Elizabeth, Cape Town, Paarl and Bellville.

Rest of the country

Part-time district surgeons.

A full-time district surgeon works 40 hours per week. If the full-time district surgeon is prepared to work a further 16 hours per week at the additional compensation of R15 207 per annum (non-pensionable allowance) it is expected of him to work 56 hours minimum per week. Full-time district surgeon services are rendered on a 24 hour basis;

(3)

	NPA	PAOFS	TPA	CPA
Full-time district surgeons	8	2	12	11
Sessional district surgeons	21	—	19	—
Part-time district surgeons	47	75	104	138

Information furnished as on 1 May 1993.

Secret funds audited: irregularities

352. Dr W J BOTHA asked the Minister of State Expenditure:†

(1) Whether he will furnish information on secret funds spent in each financial year since 1982–83; if not, why not; if so, (a) what was the amount spent (i) in total, and (ii) in respect of each State department concerned, in each of these financial years and (b) through which State departments were these funds channelled;

(2) whether this expenditure was audited; if not, why not; if so, to what extent;

(3) whether any irregularities with regard to secret funds have come to light; if so, what are the relevant details;

(4) whether he will make a statement on the matter? B827E

The MINISTER OF STATE EXPENDITURE:

(1) No. By virtue of the Secret Services Act, 1978, a secret service is of such a nature that it is in the national interest that the performance thereof is not directly or indirectly made known. The information requested will defeat this object.

Funds for Secret Services are appropriated on the Vote: State Expenditure and are contained in the printed Estimate of Expenditure (RP 2 and 4) which is tabled in Parliament.

(2) Yes. Auditing and reporting to Parliament is continously done in accordance with the Auditor-General Act, 1989 (Act No 52 of 1989) which reports are dealt with by the Joint Committee on Public Accounts.

(3) Yes. Irregularities which came to light were taken up in the various reports of the Auditor-General with due consideration to the provisions of section 6 (3) of the Auditor-General Act, 1989.

(4) No.

Cholera: cases/deaths

357. Mr M J ELLIS asked the Minister for National Health and Welfare:

How many (a) cases of and (b) deaths from cholera were reported in respect of each race group in each province in 1992? B822E

The MINISTER FOR NATIONAL HEALTH AND WELFARE:

(a) Number of notified cholera cases in the RSA, 1992

Province	*Unknown*	*Asian*	*Black*	*Coloured*	*White*
Transvaal	1	0	6	0	0
Cape	0	0	1	0	0
Natal	0	0	6	0	0
OFS	0	0	0	0	0

(b) none.

Poliomyelitis: cases/deaths/immunization

358. Mr M J ELLIS asked the Minister for National Health and Welfare:

(1) How many (a) cases of and (b) deaths from poliomyelitis were reported in respect of each race group in each province in 1992;

(2) how many persons of each race group were immunized against poliomyelitis in each province in 1992? B823E

The MINISTER FOR NATIONAL HEALTH AND WELFARE:

(1) (a) and (b) None;

(2) the data for 1992 are not yet available and are not available for each population group separately any more.

Star 11/16/93

Two malaria drugs get council's nod

89

By David Robbins
Health Writer

The Medicines Control Council (MCC) has given the green light for two important anti-malarial drugs which have been recommended for sub-Saharan Africa, but which were not registered for local use.

This news comes after The Star noted on Monday that thousands of South Africans risked becoming victims of the worsening malaria epidemic because many medicines in use had lost their power and the two drugs were not available.

"The council has taken a decision to approve both products — proguanil and mefloquine — on condition that certain provisos are met," the Registrar of Medicines, Johan Schlebusch, said yesterday.

Mefloquine, first developed in 1985, is marketed under the trade name Lariam. It is a powerful prophylactic for short-duration travellers, but has some side effects. It is not recommended for pregnant women

The wrapping must also carry warnings with regard to side effects. Lariam will be available on prescription only.

Proguanil is an older drug, to which considerable resistance has been built up. But it is extremely safe.

The long delay in its registration remains a mystery.

According to Dr Matt Haus, medical director of Zeneca-ICI SA, the company which will supply proguanil, an application for registration was first submitted to the MCC about five years ago.

"During that time we were allowed to dispense the drug only on compassionate clearance grounds, a system controlled by the MCC, and not through pharmacies.

"Finally, in July 1991, we withdrew our application and stopped importing because we couldn't keep up with the overwhelming demand," said Haus.

"Since withdrawing our application, we've been handling several phone calls a day from people asking for the drug. Now, although we have not reapplied for registration, we've been notified by the MCC that the council has decided to approve the product," he said.

Proguanil is marketed under the trade name Paludrine. Its packaging must contain the warning that resistance to proguanil is widespread, and that it must always be taken with chloroquine.

Cancer toll in SA hits the 125 new cases-daily mark

(89) ARG 14/6/93

☐ Doctor warns that varying causes on increase

ANDREA WEISS
Health Reporter

AN average of 125 cases of cancer are being reported in South Africa daily.

Smoking, diet, occupation, lifestyle, pollution and infectious agents cause up to 90 percent of all these, while inherited cancers contribute only about five percent of the total.

These figures were released by Dr Freddy Sitas, head of the national cancer registry at the SA Institute for Medical Research.

A 30 percent increase in tobacco consumption and an increase in the numbers of people with HIV have also had a significant impact.

Increased cancers due to tobacco were in the region of 40 percent for men and 15 percent for women. These included cancers of the mouth, pharynx, larynx, lung, osoephagus, stomach, kidney and bladder.

HIV could cause a dramatic increase in certain cancers which could increase the burden on already overcrowded public health service.

Increased exposure to ultraviolet radiation due to the ozone "hole" was also cause for concern. Skin cancer was already the commonest cancer in the white population.

Bacteria and viruses played an important role in cancers. The human papilloma virus was linked to cancer of the cervix while Hepatitis B had a link with liver cancer.

Dr Sitas cautioned that, because access to pathology services in certain areas was limited, accurate figures were difficult to obtain for the black population.

From the figures at his disposal, lifetime risk of cancer for blacks had been pegged at one in eight, although this could be as low as one in five if under-reporting were taken into account.

For whites, the risk was one in four for men and one in five for women.

Significant work could be done to control cancers of the cervix, oesophagus, skin and mesothelioma (caused by inhaling asbestos fibres), he said.

Cancer of the cervix was treatable if caught early, making a strong case for a national screening programme.

Cancer of the osoephagus was caused by a combination of poor diet, smoking, alcohol and the consumption of mouldy maize and was the commonest cancer in black men.

South African whites had the highest rate of mesothelioma worldwide. Black rates were lower, but this was probably because of lack of access to diagnostic facilities.

Dr Sitas made an appeal for the establishment of regional cancer registeries which would give a more accurate measure of the "true burden of cancer".

FUNDING CHALLENGE
South Africa's National Cancer Registry has begun to provide statistical information which is vital for effective health policy planning. But Health Writer DAVID ROBBINS finds this essential function to be in urgent need of increased funding.

Cancer Registry struggles to fund reliable data base

AN authoritative picture of cancer in South Africa is beginning to emerge for the first time, and some old myths have crumbled.

For example, cancer is not, as once suggested, a First World disease which afflicts only the affluent white middle-aged.

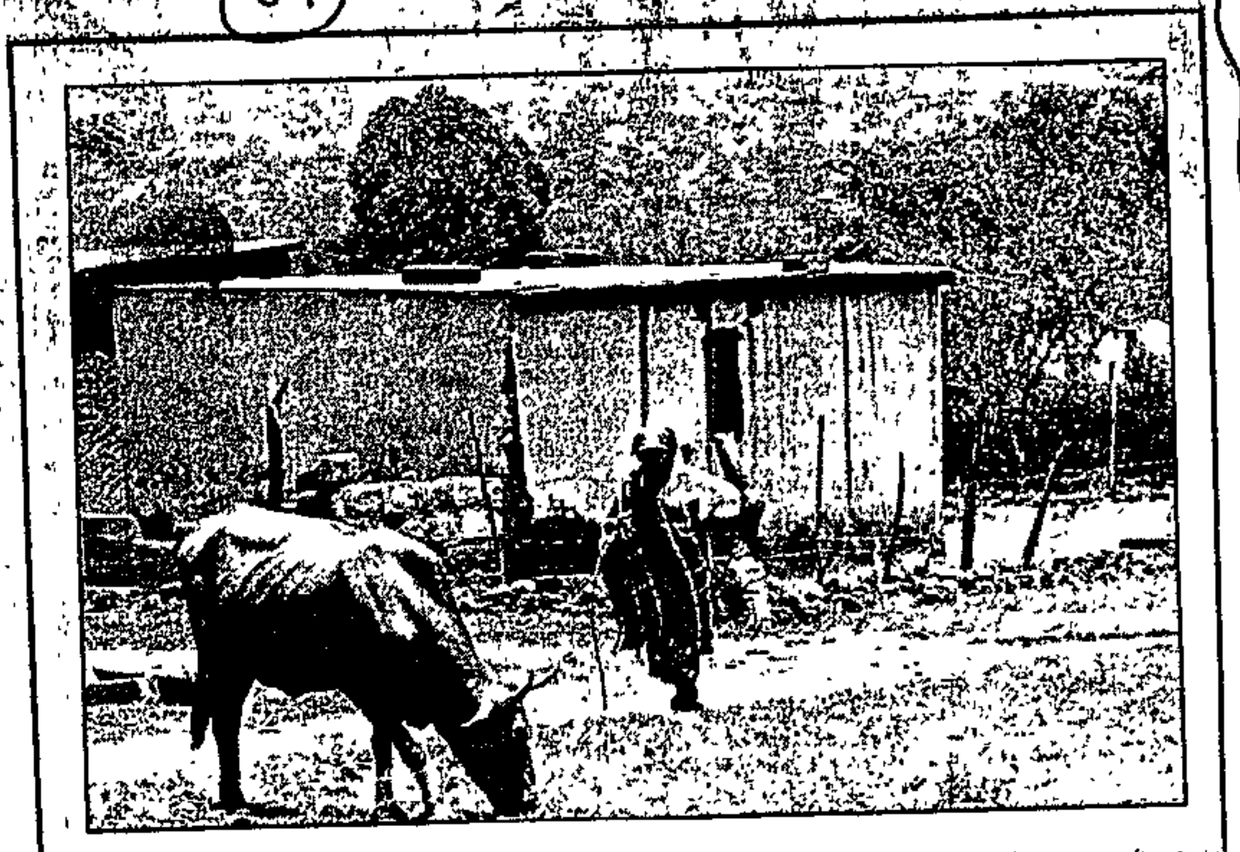
Black people appear to be equally vulnerable. And the disease is definitely on the increase.

Rates for oesophagael (part of the alimentary canal) cancer in black males, cervical cancer in black and coloured females, and certain skin cancers in whites rank among the highest in the world.

We know all this and much more, thanks to the efforts of the National Cancer Registry (NCR), which has recently published its third detailed analysis of the disease in South Africa.

Incredibly, this important institution was established only in 1986.

Before that time, South Africa lagged far behind the rest of the world — and not a few countries in Africa — in knowing just what the world's most dreaded disease was actually doing on a national level.



Spreading tentacles . . . cancer is not a First World disease which afflicts only the affluent white middle-aged people. Black people appear to be equally vulnerable and the disease in rural areas is underestimated. Picture: Etienne Rothbart

Not enough

Historical records are available only for Johannesburg (1953-55); Soweto (1966-75); Natal (1964-1966); the Cape (1956-1959); and in four districts in Transkei (1981-1984).

According to the current head of the NCR, Dr Freddy Sitas, nowhere near enough is being spent, even now, to establish a reliable cancer data base.

It operates off a minuscule budget of R236 000 (in 1992) and is housed in two rooms at the Johannesburg headquarters of the South African Institute of Medical Research.

The NCR has a staff of only three, but still copes with about 50 000 entries each year.

"It is imperative that resources are made available to improve registration of the disease and related data collection.

Ensuring accuracy

"This is the only way to ensure accuracy, without which good health planning is impossible," Sitas says.

Current method of data collection is through the voluntary co-operation of 85 pathology laboratories throughout the country.

This gives a reasonable idea of incidence in the urban areas.

"But we are almost certainly underestimating a substantial number of cancer cases in the rural areas," Sitas admits.

"We are attempting to set up regional registries in four such areas, but at the moment only one of these is working with any degree of efficiency."

Main functions

Sitas says he had been given a grant of R66 000 towards the costs of establishing regional registries.

"It's simply not enough," he says, "even for the four pilot programmes."

The four main functions of an efficient cancer registry are:

- To establish base-line trends in the disease which show regional and population group differences
- To link with the International Association of Cancer Registries, and to compare rates of incidence.
- To offer data useful in the evaluation of screening and other intervention programmes, for example with breast and cervical cancer.
- To provide information regarding the effectiveness of various cancer treatments.

"Beyond this, trends can be picked up early by those working with the data, and statistical predictions made which could be extremely useful to health policy makers and those charged with health budgets," Sitas says.

Examples of the type of predictions which could be made are: the increasing responsibility which smoking must bear for rising incidences of the disease and what this could mean in 10 or 20 years; and the linkage between HIV positivity and viral-related cancers.

Expensive business

Already, information emanating from South Africa's tiny NCR is being used by the insurance and pharmaceutical industries, as well as by various health agencies.

"There is a great deal more that can and should be done," says Sitas.

"But the reality is that data collection and analysis is an expensive business.

"And who will pay?"

Although the private sector is willing to pay R150 per copy of the NCR's published statistics, Sitas believes that the private sector contribution should be a lot more.

At the moment, the NCR's income is provided jointly by the South African Institute of Medical Research, the Cancer Association of South Africa and the Department of National Health and Population Development.

Single example

Smaller ad hoc contributions have also come from Anglo American, the South African Medical Research Council, several computer companies and private estates.

Sitas says: "With more support, we could provide a lot more urgently required data. Let me give a single example:

"It seems likely that if tobacco consumption rates among blacks reach those prevailing among whites in the 1960s and 1970s, we can expect an increase in smoking-related deaths of well over 1 000 percent in the African population by the year 2000

"With more support we could plot the probability. At the moment we can only estimate."

'Hidden' menace for asthmatics

Star 29/6/93.

TOUGHER LAWS
Lobbying for stricter food labelling laws has gained new momentum after a major allergy study, the first of its kind in South Africa, found that many asthmatic children react adversely to sulphur dioxide and that the widely used preservative can induce acute asthmatic attacks.
MARIKA SBOROS reports.

PRESERVATIVES may be a "marvel" of modern food technology, but they are not so marvellous for asthmatic children.

From time to time, children are exposed to one preservative in particular, sulphur dioxide, which can induce a severe asthmatic at tack. Some experts say inadequate food labelling is at fault. Others believe inadequate policing of food labelling and a lack of education among consumers are more to blame.

Either way, lobbying for stricter food labelling laws has gained new momentum after a major allergy study found that many asthmatic children reacted adversely to sulphur dioxide and that the widely used preservative could induce acute asthmatic attacks.

The research, the first of its kind in South Africa, was performed at the allergy clinic of the Red Cross Children's Hospital in Cape Town and published in the latest edition of the SA Medical Journal.

Higher

The study found that 43 percent of asthmatic children developed a tight chest due to sulphur dioxide; this led to acute asthma attacks requiring immediate medical treatment in 21 percent of the children. These levels are much higher than similar studies in the United States, where 10 percent of asthmatics were found to react to sulphites.

The problem is complicated be cause sulphites and sulphur dioxide may be hidden in many foods.

Dr Paul Potter, president of the Allergy Society of SA (Allsa) and co-author of the research paper, says this "inadequate food labelling practice leaves asthma patients inadvertently exposed to these preservatives".

Sulphites and sulphur dioxide are widely used as preservatives by the food industry by spraying fresh fruit and vegetables in certain supermarkets and salad bars to inhibit browning, to condition flour doughs, for their anti-microbial action in soft drinks, wine and beer, and as preservatives in certain medicines, the researchers say.

Education

Education and avoiding foods with sulphites through trial and error are the only ways of preventing the ingestion of this preservative because labelling legislation here is less stringently applied than in other Westernised countries, they say.

Dr Harris Steinman, who headed the study, says the fact that many asthmatic children are affected by sulphur dioxide but show no symptoms makes it difficult to detect foods containing these preservatives until large amounts have been ingested.

The effects of sulphur dioxide worsen as more is taken in.

Legislation stipulates that sulphites and other preservatives should be listed on the labels of all foodstuffs (except wine) containing these additives, but enforcement of food labelling laws is inadequate, he says.



Tastes good . . . and gives the inner person a nice, comfortable feeling. But some foods containing preservatives can cause trouble for asthmatic children. Picture: Karen Sandison

Also, sulphites can creep in when foods previously treated with preservatives are used in food processing.

The Allergy Society's call for stricter food labelling practices regarding sulphites and sulphur-containing foods, as well as for other common allergy-causing foodstuffs, such as milk, egg, nuts or nut oil, comes at a crucial time as new food laws are being formulated.

Jeremy Hele, executive director of the Grocery Manufacturers' Association, says present legislation is more than adequate.

He "won't argue" with the fact that asthmatics do have a problem with sulphur dioxide, but says many more people would have trouble with food poisoning if preservatives were not used.

Calling for stricter food labelling is not the answer, he says.

Intolerance

To do so would be to turn food labelling into a prescription for every different condition of food intolerance.

"Like our roads, food labels are governed by sufficient legislation, but are not adequately policed because of inadequate resources," he says.

And contrary to popular conceptions, food manufacturers are not bad guys who go around putting poisons into food and spraying sulphur dioxide all over the place.

"On most things, there wouldn't be any point, anyway," says Hele.

The preservative functions efficiently only in an acidic medium.

Sulphur dioxide is not used on flour dough in South Africa "because manufacturers have found a better preservative — calcium propionate", says Hele.

Jane Badham, public relations dietician for the Association for Dietetics in Southern Africa (Adsa), says preservatives ensure people get food in this country.

Longer

Food increasingly has to be more and more mass produced, travel long distances and have a longer shelf life.

Food preservatives pose little problem if they are a small part of a balanced diet.

If children have lots of highly coloured and preserved drinks and bright red hot dogs daily, they could run into a problem with preservatives.

But their diet would be bad anyway, Badham says.

Adsa believes that food labelling for preservatives is adequate, but is pushing for manadatory nutritional labelling.

This demand has received favourable response from the authorities involved.

However, new legislation which will be finalised soon will make the labelling of nutritional information only voluntary.

"Consumers should encourage manufacturers to put on this voluntary labelling."

Call for unity to end taxi violence

B/Day 30/6/93

ADRIAN HADLAND

PRETORIA — In a bid to end the rivalry and violence endemic to the minibus taxi industry, the creation of a single national taxi association was proposed yesterday.

National transport policy forum chairman George Negota, speaking at the 13th Annual Transportation Convention conference in Pretoria, called on all taxi operators and organisations to unite into one association.

But minutes after the call for unity, the deep rifts within the industry became evident once again as taxi association chiefs took up verbal cudgels.

SA Black Taxi Association president James Ngcoya said the newly formed marketing arm of the Pretoria United Taxi Association, Taximax, was destroying his organisation.

He accused Taximax director Enos Makena of poaching key staff, drawing away Sabta members and of sowing discord in the industry.

Makena had delivered a paper earlier in the day arguing that Taximax, at its foundation in January this year, had pledged to bring professionalism, discipline, safety and profitability to the industry. He said Taximax intended to implement driver training, establish vehicle maintenance workshops and investigate new business avenues.

But Ngcoya said: "I don't know anything about this Taximax other than that it is destroying Sabta."

Negota said the violence associated with the taxi industry, which had killed more than 50 people in Soweto alone this year, had to stop.

A national taxi indaba had been planned by the policy forum at which the question of unity would be debated.

"We want to give the people an opportunity for a new start." At the indaba, a national code of conduct for operators and drivers would be drawn up, he said.

An agenda and date for the indaba were being investigated.

Old cure-all lauded in new report

B/Dmy 30/6/93

STEPHEN COPLAN

RECENT medical studies had shown that aspirin could effectively combat migraines, heart disease and common strokes, the SA Aspirin Foundation said recently.

Aspirin, which has been in commercial use for the past 100 years, had also been found to prevent pregnancy complications, a report released by the foundation said.

The report cautioned, however, against extensive use of aspirin by high-risk pregnant women.

In two long-term studies in the US and UK it emerged that subjects who regularly received low dosages of aspirin reported a lower incidence of migraine and musculo-skeletal pain. The reason was still being investigated, a foundation spokesman said.

Aspirin's anti-thrombotic properties were responsible for its effectiveness in preventing heart attacks and common strokes, the report said.

But aspirin should not be used regularly by people with gastric problems and by younger children.

However, Kawasaki's Disease, which usually strikes infants and small children, could be countered by aspirin and gammaglobulin, the report said.

Transkei typhoid outbreak confirmed

UMTATA. — There has been an outbreak of typhoid fever in the Port St Johns area, a spokesman at the nearby Isilimela Hospital confirmed yesterday despite a government denial.

He said almost 100 cases of the infectious disease — which is spread through contaminated food and water and characterised by red rashes, high fever and bronchitis — was treated at the hospital this year. CT 17/7/93

However, Transkei's Department of Health denied the outbreak yesterday, dismissing it as "speculation".

"We have no evidence of any typhoid outbreak in the area," the department said.

The spokesman at Isilimela Hospital said they were now treating three people for typhoid and three others were transferred to Umtata General Hospital for intestinal operations.

He said at one stage as many as four patients were being admitted daily with the disease.

Children catch diseases from refuse

South : 14/8 – 18/8/93

By Sabata Ngcai

TOWNSHIP children are contracting air-borne diseases including scabies and diarrhoea.on a worrying scale from growing mounds of refuse which remain uncollected.

Mrs Anna Genu, a community health worker, said the children played in the scattered waste and contracted diseases from the contact. (89) (~~120~~)

"The situation has increased our workload," she said.

The piles of refuse are growing daily as there is no fuel for the waste disposal trucks managed by the Ikapa Town Council.

Refuse has been uncollected in Guguletu, Nyanga and Langa townships since July 5 when Ikapa Town Council employees downed tools after a wrangle with their employers over pay.

The workers said that, despite downing tools, they were prepared to remove the garbage if they could get fuel for the refuse trucks.

Cape Provincial Administration (CPA) said the situation was still under discussion by the working committee comprising representatives from workers, the union and CPA.



WASTE: Part of the refuse which is lying uncollected

Genu said dead and rotting dogs were also dumped in the refuse and the stench was overwhelming.

The elderly are also vulnerable to disease, but children are at greater risk because they play in the garbage.

"This makes our work difficult because if we say people should not throw refuse on the streets, we should give them an alternative," Genu said.

She said as a result of the "appalling conditions" their community work did not "bear any fruit because sick people could not use our advice and medicine effectively.

"There is no improvement in the health of people suffering from tuberculosis because of the refuse," Genu said.

"We give them treatment and they are affected by the refuse which is sometimes dumped in front of the houses and their health gets worse."

Govt 'committed to proper food hygiene'

DIRK VAN EEDEN

PRETORIA — Declining food hygiene standards led to lowered population health, burgeoning medical costs and poverty, Deputy Agriculture Minister Tobie Meyer said at the weekend. B1D94

The lowering of hygiene standards was thus a "luxury" South Africans could ill afford, he said. 13/9/93

Officially opening Onderstepoort Veterinary Institute's new food hygiene research centre, Meyer said government remained committed to maintaining proper hygiene standards for the whole population.

The importance of food hygiene was underscored by the high incidence of diarrhoea, a major cause of malnutrition in developing countries. (89)

About 70% of all diarrhoea cases was caused by poor food hygiene, Meyer said.

SA could no longer afford escalating public health costs and the centre, which cost R9m, had a role to play in supplying uncontaminated water, promoting hygienic living conditions and ensuring that food was safe.

Town in typhoid scare

2/11/93

ST Times

By CAS St LEGER

AN Eastern Transvaal town is preparing itself for a typhoid epidemic after dozens of residents have fallen ill with stomach complaints.

So far 15 cases of typhoid have been confirmed among residents of the black township at Delmas, near Springs.

But clinics in the town have also treated about 100 patients for what they thought was a seasonal outbreak of "apricot stomach" or gastric flu.

Town clerk Johan Luwes said this weekend he believed Delmas was in the throes of its first full-scale typhoid outbreak.

"We have prepared ourselves for an epidemic. We have made contingency plans, have medical corps staff on standby and if the hospital beds fill up, a school has been identified to provide temporary facilities for treating patients," said Mr Luwes.

Seriously ill patients, all residents of Botleng, have been transferred by ambulance to the Far East Rand Hospital, Rietfontein, and other hospitals on the Reef.

SADF personnel work around the clock to contain eastern Trans

STAR 23/11/93 (89)

1 000 treated for ty

(89)

89

EMERGENCY hospital set up to deal with influx of suspected victims

■ BY MICHAEL SPARKS

Nearly 1 000 suspected cases of typhoid have been reported from the Delmas area in the eastern Transvaal. And more patients are continuously arriving at an emergency field hospital in the area, while others are being transferred to hospitals in the PWV area and Ga-Rankuwa.

So far two people — a woman and a primary school child — have died, although it has not been confirmed that they died of typhoid.

The Delmas Town Council had set up the emergency hospital at the local airport by Saturday morning to deal with the influx of people from Botleng township who could not be accommodated in nearby hospitals. (89)

At least 50 SA Defence Force medical corps personnel are working around the clock to treat the patients at the field hospital. One of the doctors contracted the disease and was evacuated to 1 Military Hospital in Voortrekkerhoogte yesterday morning.

Discharged

Brigadier Louis du Preez confirmed there were nearly 1 000 cases of suspected typhoid, including those who had been sent to other hospitals. Over 100 were admitted to the field hospital yesterday, although more than 40 were being discharged by the end of the day, with tablets for them to continue treatment.

Du Preez said 21 cases of typhoid had been confirmed so far, but added that since the test results took 72 hours to be determined, that figure was certain to rise dramatically.

Ambulances would continue to transport people from Botleng to the nearby hospital. Loudspeakers were being used to urge all those with diarrhoea to report to the hospital, Du Preez said.

Nicknamed Groote Schuur, or "big barn", the hospital is a converted aircraft hangar, hosed down by the local fire department. Its large sliding doors stand nearly closed at one end, with the entrance at the other.

People were lying the length of the hangar, in five lines, separated by their respective conditions.

The "severe cases" line had four people in it by mid-afternoon, all waiting to be transferred to provincial hospitals when beds became available.

A drip line connected many of the patients to bags of intravenous fluid hanging from a strand of wire strung over each line.

A few fans were moving the stale air, with the faint smell of rubber from the medics' gloves permeating the gauze masks everyone wore.

The occasional crying howl indicated that another child had been diagnosed. Such children were given an intravenous drip to prevent dehydration when they felt too nauseous to eat.

Patient Eric Khanye said he had been given seven drips since being admitted to the hospital on Sunday morning, each with one litre of fluid, after first developing the symptoms of the disease nearly three weeks ago.

Like many in the hospital,

▶ To Page 3

WHAT YOU SHOULD KNOW ABOUT IT

THE DISEASE: Typhoid fever is a contagious disease picked up from eating food or drinking water which has been contaminated by faeces or urine.

THE SYMPTOMS: Many typhoid carriers are asymptomatic (do not display any symptoms). Those affected will get severe headaches, stomach cramps, become feverish and lethargic and lose their appetite. Some carriers develop a rash. Advanced symptoms include fever, vomiting and diarrhoea. If neglected, the patient may lapse into a coma and die.

THE LOCALITY: The disease is found mostly in areas which have poor sewerage facilities.

Star 23/11/93

1 000 get treatment for typhoid

◀ From Page 1

Khanye said he had visited a doctor four times, but despite the tablets and injections, nothing had helped.

"I could not eat. I felt as if something was standing in my throat," he said.

Elvis Nkosi seemed dazed by the experience and spoke through quivering lips of first feeling sick on Friday, before coming to the hospital.

Elias Msebenzi said he was feeling better after being sick for two weeks. "My body has no power and my tongue is very dry," he said.

According to acting town clerk Henre de Hart, older people and children are more likely to be affected by the highly contageous disease, which is spread through body fluids and contaminated food.

According to Delmas management committee chairman David Swanepoel the water was tested weekly in the past, but was now being analysed daily. (89)

Most cases have come from the Mandela View squatter camp on the outskirts of Botleng, although the syringe needles stuck into the map, to indicate the origin of each case, clearly show the disease has struck the entire township.

De Hart said the causes were unhealthy living conditions, which were being addressed by a R6,9 million grant for the development of 2 700 new stands.

■ BY CYRIL MADLALA

Winnie Mandela continu fightback into the politica stream when she was national deputy presiden powerful South African N Civic Organisation (Sar the weekend.

She was elected chair Transv

Deaths reported as typhoid spreads

Star 24/11/93

■ BY MICHAEL SPARKS

The typhoid epidemic which is sweeping through the eastern Transvaal township of Botleng, near Delmas, has affected more than 1 500 of the township's 85 000 residents, with four deaths reported by yesterday afternoon.

So far only one death has been confirmed as being caused by typhoid.

ANC spokesman Ronnie Mamoepa said in a statement that the rapid spread of the disease was a clear indication of the appalling conditions under which people were forced to live.

He condemned the authorities who had allowed the unhealthy living conditions to develop, adding that it was a legacy of 45 years of NP rule.

The number of people reporting sick to the field hospital at Delmas airport had dropped yesterday but, according to Brigadier Louis du Preez, who is in charge of the hospital, many people were staying in their shacks and houses because of the heavy rain.

He added that while only 95 people had reported sick yesterday — with only 30 admissions to the hospital — many of those were sicker than those who arrived at the hospital on Monday.

"A lot of people coming to us were in a more serious condition today, especially the younger children because the parents have been trying to treat them at home," Du Preez said.

He said that he did not see the outbreak of typhoid subsiding for at least another week as the disease had an incubation period of about seven to 14 days.

The field hospital discharged 51 patients yesterday, up from 41 on Monday.

Three others were transferred in a more serious condition to one of eight hospitals in the PWV which are taking the overflow of patients.

This brings to 241 the number of people in provincial hospitals with suspected typhoid.

Patients sent to provincial hospitals were in a more serious condition, but the move also helped to reduce the pressure on the facilities at the hangar of the field hospital, dubbed Groote Schuur.

Some fresh faces from the army were brought in yesterday to relieve the 150 SADF medical corps personnel who have been working around the clock to treat the patients at the field hospital.

But many of the same faces were still there among the 24 workers from the community who have volunteered their assistance. (89)

While some of them have first-aid training, many have not. But they have worked as tirelessly as everyone else, taking care of patients' needs.

Other community groups have also come forward, providing food for the volunteers, while the town council provides food for the military personnel.

Four dead following outbreak of typhoid

MARIANNE MERTEN

FOUR people have died following the outbreak of typhoid in Botleng township near Delmas over the weekend, but authorities could not confirm whether they had died of the disease. 8/1/94

The Transvaal Provincial Administration said yesterday not all of the 1 452 people treated at an emergency field hospital at Delmas airport were treated for typhoid. 24/11/93

However, provincial hospitals in Delmas, Nigel, Heidelberg, Johannesburg and Springs are still treating 241 typhoid patients.

Water Affairs assistant director Petrus Venter said the disease had probably been spread through water and the township's unhygienic conditions.

Unsanitary conditions in the Delmas township and Alexandra in Johannesburg had been discussed at a meeting between the department and area co-ordinating centres three weeks ago. (89)

Delmas town clerk Johan Louwes said a further 138 patients were yesterday admitted to the emergency field hospital set up at the local airport at the weekend after more than 350 typhoid cases were reported.

Since Saturday, 727 patients were referred from the field hospital to other hospitals in the area.

Delmas town secretary Henre de Hart said earlier this week the disease was probably spread by contaminated food prepared by a person who carried the virus. He expected the number of patients to continue increasing as typhoid symptoms appeared only 10 to 14 days after the disease was contracted.

The ANC said yesterday the fact that the disease had spread so quickly was an indication of appalling squatter living conditions.

Star 25/11/93

Botleng typhoid was predicted

■ BY MICHAEL SPARKS

The typhoid epidemic that has affected more than 1 600 residents of Botleng township, near Delmas, was predicted three years ago.

A prediction was also made that this could happen in many of the squatter settlements in the country, according to medical experts.

In a 1990 survey which was commissioned by the Botleng Civic Association, Dr Eric Buch, who is currently director of community health for the Johannesburg City Council, found that there was a "significant risk of . . . an unnecessarily high rate of childhood diarrhoea and a risk of outbreaks of polio and typhoid".

Buch said yesterday: "I am not very happy that I was right about this.

"If something had been done three years ago, an epidemic of this nature would have been prevented," he said.

ANC health department spokesman Dr Tim Wilson said: "It is outrageous that the Government could be so arrogant and incompetent as to ignore a report that warned of these dangers three years ago."

Wits University medical microbiology department head Professor Keith Klugman agreed, saying that the potential for a similar outbreak in other squatter camps was "great".

On Tuesday, Klugman began an investigation which was commissioned by the Delmas Town Council to find the source of the epidemic.

So far four deaths have been recorded in Botleng but only one of these has been confirmed as being from typhoid.

Klugman said that the very rapid spread of the disease, while remaining restricted to Botleng residents, suggested that the typhoid could have been carried in the water supply, but he added that it could also have been caused by other factors.

Chairman of the Delmas management committee David Swanepoel is convinced the disease is not from the township's water, which is purified with chlorine.

Typhoid: 'Foul play' possible

(89)
CT 25/11/93

JOHANNESBURG. — African National Congress PWV region chairman Mr Tokyo Sexwale said yesterday foul play could not be ruled out at Botleng near Delmas in the Eastern Transvaal, where more than 1 600 people have been treated for typhoid over the past few days.

Mr Sexwale made these comments while visiting the field hospital outside Delmas where victims of the disease are being treated.

Mr Sexwale said the outbreak of typhoid showed what apartheid could do to black people. The disease had not broken out in a white residential area, but in a black squatter camp.

Since the water in the Eastern Transvaal squatter camp of Botleng became "different" two weeks ago, four people have died and more than 1 500 treated for typhoid fever.

Residents blame a new reservoir.

But Mr A J Roux, administrator of the Botleng Town Council, said tests conducted on the reservoir water found it to be clean and drinkable. He said the cause of the outbreak remains unknown.

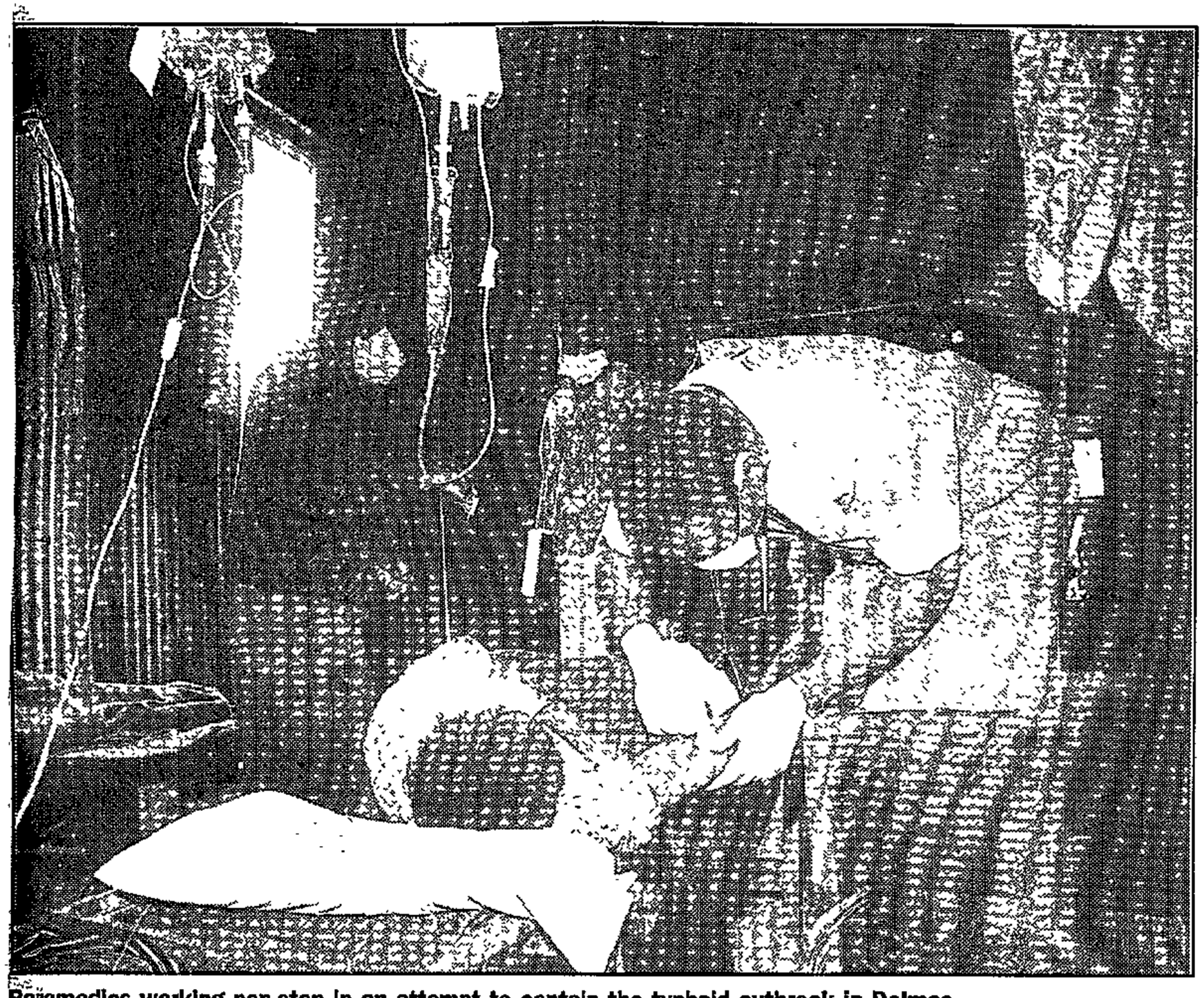
Yesterday, 124 people were in the field hospital. Others had been sent to other hospitals.

Fewer people arrived on Tuesday compared to Monday, leading officials to think the worst was over. — Sapa-AP

PEOPLE'S LIVES *Delmas's township a place that inherited the ravages of apartheid*

There's no beauty in Botleng

Sowetan 26/11/93



Paramedics working non-stop in an attempt to contain the typhoid outbreak in Delmas.

■ SUDDEN PAIN *Cause of typhoid is hotly argued as disease rages:*

Mokgadi Pela

BOTLENG — a place of beauty as the name suggests — is just another misnomer from the ravages of apartheid.

For while the inhabitants may have hoped the township would develop into a marvel, dirt and squalor in the Eastern Transvaal location is very much in evidence.

Thus, it came as no surprise when this Delmas township was struck by a typhoid epidemic late last week.

The disease has so far claimed four lives and confined more than 700 residents to beds in a makeshift emergency clinic nearby. Many other patients have been treated at the nearby hospitals of Springs, Boksburg and Benoni.

The cause or possible source of the disease is water. This view is shared by medical scientists and residents, but rejected by the chairman of the Delmas management committee, Mr David Swanepoel. He insists that the water supplied to the township is purified with chlorine.

Microbiologists, in a study commissioned by the South African Institute for Medical Research, have taken water samples from the area to determine the cause. The results, according to Dr John Frean, will be released early next week.

Experts have, meanwhile, advised residents to boil water before use.

Typhoid is a bacterial infection which infects the exposed individual through the mouth and causes a systemic illness. The responsible organism is spread in the faeces of the patient.

It is a disease common among low socio-economic groups. Its symptoms include headache, nausea, vomiting, diarrhoea or constipation, stomach cramps and fever. 89

It is these symptoms that will haunt some victims of the disease for months to come. Some have said they are unlikely to forget the sudden pains which eventually landed them in an emergency hospital.

One such person is Miss Lizzy Mqwathe (19). She was admitted to the clinic about 9am on Wednesday, together with her six-months-old daughter, Nontokozo.

"I felt terrible pains in my stomach which increased as moments ticked by. As I was cringing, Nontokozo was turning and crying and I didn't know what to do.

"Fortunately, my mother turned up and summoned help. I was rushed to the emergency clinic where I was given immediate attention by the medical staff. I won't forget this day", she said.

Nelly Zulu (61), a mother of five, also experienced stomach aches. Her condition was worsened by vomiting.

"I thought this was the end of me. I was rushed to the clinic and admitted. An intravenous drip was then administered, probably to strengthen me," says Zulu.

Among the unsung heroes of Delmas are the soldiers of the South African Medical Services, who are working round-the-clock to save lives.

Brigadier Louis du Preez, officer in charge of Witwatersrand Medical Command, said they also assisted patients with transport to and from hospitals.

The general secretary of the Botleng Civic Association Mr Bantu Mabhena said among their demands were:

- The prevention of the problem from escalating.
- Health education to residents and the construction of decent houses for shack dwellers.

Mabhena however, expressed his appreciation about the role of the Sams.

Solving such problems will obviously constitute one of the major challenges for the interim government if it wants to avoid being likened to the 45 years of National Party rule or being dubbed NP in a new form.

HE WEEKLY MAIL & GUARDIAN
lovember 26 to December 2 1993

Squatters live in filth and fear (89)

■ From PAGE 4

field hospital in a corrugated iron hangar at the Hendrik Schoeman airfield, big enough to accommodate two light aircraft. At the entrance, a big crowd waits patiently for news of relatives who have been admitted. Some are angry, demanding access; an old woman stands quietly with a rosary in her hand.

Inside, 54 patients lie on stretchers in single file; about 20 more arrive for treatment every hour. There is a sense of urgency, with civic members, first aid units, SADF members and volunteers working hand in hand.

Children sit next to their sick mothers; mothers sit next to crying babies; young men wander aimlessly through the semi-darkness.

The man in charge of the hospital, Brigadier Louis du Preez, says the community is being told how to identify typhoid. But most of the residents interviewed had little understanding of the disease or how to prevent it.

"I don't know what happened to me, but my body hurts all over," says Esther Nkosi. "I just pray to God I'll live. I'm missing my family."

WSM 26/11 - 2/12/93

Council worker Job Khumalo tosses and turns in pain: "I don't know anything, except the headaches and the vomiting when it attacks. I'm hungry, but I'm afraid to eat because it will all come back."

As eight-year-old Christina Mahlangu's condition deteriorates, an ambulance is called in. She is taken to the Far East hospital near Springs, 35 km away — despite the fact that Delmas, 5km away, has a hospital of its own.

"There is no way they will accept the child into Delmas' white hospital, even though they can see she is in a critical condition," said Sepenyane.

Delmas town clerk Luwes stressed that the Botleng town committee was "an independent local authority". It had developed its own water supply field which Delmas replenished, he said. Delmas also tested water samples.

Botleng was fully serviced, with roads, water, electricity and sanitation systems. Delmas improved services in the township "on a contractual basis as and when required by the Botleng local authority". Services could not be provided to the 3 500 squatter structures, however, as they were on land unsuitable for residential settlement.

Asked whether there were plans afoot to amalgamate the local government structures of the black and white towns, he said: "As ... the town clerk is not a political functionary, this is a question I cannot comment on."

Another typhoid victim dies

Sowetan 26/11/93

■ OUTBREAK Cause of epidemic still not known.

Sowetan Reporter and Sapa

FIVE PEOPLE HAVE died and 204 others are receiving medical treatment following the outbreak of typhoid at Botleng township near Delmas, according to the Transvaal Provincial Administration.

The TPA's communication services directorate yesterday said the fifth victim died on Wednesday night. So far, more than 1 600 people have been treated at an emergency field hospital outside the township.

The TPA said it was doing everything possible to prevent the disease from spreading to other patients at hospitals where the infected were being treated. Special measures had been taken to launder their clothes separately and to use disposable eating utensils.

Researchers had not yet determined the cause of the outbreak. (89)

The researchers, led by microbiologists Professor Keith Glugman and Dr John Frean of the South African Institute for Medical Research, believe water is the most likely cause of the epidemic.

Frean said results of laboratory tests would be disclosed early next week.

Residents point to a newly built reservoir as the likely source of the plague.

The chairman of the Delmas management committee, Mr David Swanepoel, has rejected claims and said the township's water was purified with chlorine.

Experts have meanwhile advised residents to boil water before use.

Meanwhile, a health co-ordinating committee had been established to find the quickest possible solution to the epidemic, the Department of National Health said.

A joint epidemiological survey by the universities of Pretoria and the Witwatersrand started yesterday.

Government is blamed

Sowetan 26/11/93

THE typhoid epidemic that has affected more than 1 700 residents of Botleng township, near Delmas, was predicted three years ago.

A prediction was also made that this could happen in many of the squatter settlements in the country, according to medical experts.

In a 1990 survey which was commissioned by the Botleng Civic Association, Dr Eric Buch, currently director of community health for the Johannesburg City Council, found that there was a "significant risk of ... an unnecessarily high rate of childhood diarrhoea and a risk of outbreaks of polio and typhoid".

ANC health department spokesman Dr Tim Wilson said: "It is outrageous that the Government could be so arrogant and incompetent as to ignore a report that warned of these dangers three years ago."

Wits University medical microbiology department head Professor Keith Klugman agreed, saying that the potential for a similar outbreak in other squatter camps was "great".

On Tuesday, Klugman began an investigation which was commissioned by the Delmas Town Council to find the source of the epidemic. (89)

So far five deaths have been recorded in Botleng but only one of these has been positively confirmed as being from typhoid.

Of 79 reported ill, just seven were admitted, compared to 46 on Wednesday. The others are treated and given medication.

Chairman of the Delmas management committee David Swanepoel is convinced the disease is not from the township's water, which is purified with chlorine. — *Sowetan Correspondents.*

204 treated for typhoid

(89)

PRETORIA. — Five people have died and 204 others are being treated in provincial hospitals since typhoid broke out at Botleng township near Delmas, the Transvaal Provincial Administration said yesterday.

The TPA's communication services directorate said in a statement the fifth victim died on Wednesday night.

The TPA added it was doing everything in its power to prevent the disease from spreading to other patients in the hospitals, and special measures had been taken to launder their clothes separately and use disposable eating utensils.

"The TPA wishes to express its appreciation to all the staff and others involved in helping to handle the additional workload in the affected hospitals efficiently," the statement said. — Sapa

CT 26/11/93

Typhoid outbreak believed responsible for five deaths

B1 Day 26/11/93

KATHRYN STRACHAN

ANOTHER two people had died after an outbreak of typhoid at Botleng township near Delmas, bringing the total number of deaths apparently caused by the disease to five, the TPA said yesterday. (89)

Only one of the deaths however, had been confirmed as caused by typhoid.

The flood of patients to the emergency field hospital set up at the Delmas airstrip continued unabated yesterday, with a further 150 patients coming in for treatment. Almost 2 000 patients had been treated since Saturday.

More than 200 patients were still being treated at a number of provincial hospitals in the area, but the TPA gave the assurance that it was doing everything in its power to prevent the disease from spreading to other patients in the hospitals.

Special measures had been taken to launder their clothes separately and for them to use disposable eating utensils, the TPA said.

Meanwhile, the search for the cause of the outbreak continued. Pretoria and Wits universities began their joint epidemiological survey yesterday, while the SA Institute for Medical Research said the results of an analysis of water samples would soon be available.

Following a meeting between all role players in the township yesterday, a health co-ordinating committee was established to manage the typhoid epidemic more effectively.

Six dead in typhoid epidemic

(57)

ARG 22/11/93

PRETORIA. — The death toll in the Delmas typhoid epidemic has risen to six, while 307 people are being treated in hospital, the Transvaal Provincial Administration said.

A sixth person died on Thursday night.

One of the new admissions to the Far East Rand Hospital was a white angler from Springs, who had been fishing in the Delmas area, the statement said yesterday.

The source of infection was still not known.

The statement stressed that visitors to Delmas were entering a high-risk area and urged them to take precautions.

A total of 177 patients were still being treated in provincial hospitals, 123 in the field hospital, four in Heidelberg Hospital and three in Boksburg-Benoni Hospital.

A joint epidemiological survey is being carried out by the universities of Pretoria and the Witwatersrand. — Sapa.

22 more treated for typhoid

Star 29/11/93

About 22 more people suffering from typhoid were admitted to provincial hospitals while 123 were being treated at the emergency field hospital at Delmas yesterday, a member of the SADF medical corps said.

This brings to 1 684 the number of typhoid cases reported in the area since the epidemic first broke out in Botleng township, near Delmas, more than a week ago. (89)

Only one death has been confirmed as typhoid-related.

The source of the typhoid is still unknown. However, a contaminated water supply had not been ruled out.

Professor Keith Klugman, head of the department of medical microbiology at the University of the Witwatersrand, said last week that investigators had not yet been able to find a source of the disease although they were testing water. — Staff Reporter.

(89)

Typhoid: 143 in hospitals

ST 29/11/93

DELMAS. — More than 20 people suffering from typhoid were yesterday admitted to provincial hospitals near Delmas, east of Pretoria.

Member of the SADF medical corps Mr Kobus Grobler said another 123 were being treated at the emergency field hospital here.

This brings to 1 684 the number of typhoid cases reported in the area since the epidemic first broke out in Botleng township more than a week ago.

One death has been confirmed as typhoid-related. The source of the typhoid is unknown, but a contaminated water supply has not been ruled out as a reason the epidemic is spreading so rapidly. — Sapa

Fewer typhoid patients being admitted

Star 30/11/93



Goodwill visit . . . Marike de Klerk visits patients being treated for typhoid symptoms in Botleng.

■ BY MICHAEL SPARKS

While the number of people reporting for treatment for symptoms of typhoid at the emergency field hospital in Botleng near Delmas remains high, the number being admitted to the hospital has been declining steadily. (89)

According to Colonel Piet Kilian at the hospital, the total number of patients treated since the outbreak of the epidemic 10 days ago has leapt to 2 900.

The number of deaths from the epidemic increased to six when a 31-year-old man died on Saturday. Only two of the deaths have been confirmed to have been caused by typhoid.

More than 900 people have reported for treatment since Friday morning, with 140 being admitted to the hospital since then.

During a visit to the hospital, set up in an aircraft hangar, the State President's wife Marike de Klerk gave a message of goodwill to the patients there yesterday morning. She also gave them a gift of toiletry essentials so that they could use the shower facilities set up at the hospital recently.

Local ANC Youth League chairman Victor Khanye said he was pleased that De Klerk had brought gifts to patients at the hospital, but added he was upset that she had come to visit only during a crisis.

According to Professor Keith Klugman, head of the medical microbiology department of the University of the Witwatersrand, no cause for the typhoid epidemic has yet been established.

At the hospital, patients are given medication as well as intravenous fluids.

Typhoid: No source as yet

DELMAS. — Tests on water samples taken in the Botleng area, site of a typhoid epidemic, had all been negative, Delmas town clerk Mr Johan Luwes said yesterday.

The number of deaths in the area have risen to eight and about 315 typhoid fever patients are still hospitalised (89)

Mr Luwes said an application had been lodged to start a disaster fund for victims and the community. CT 30/11/88

Investigations into the cause of the outbreak are being continued by health officials and researchers. — Sapa

Typhoid epidemic now under control

Star 2/12/93

■ BY MICHAEL SPARKS

The typhoid epidemic that struck Botleng, near Delmas, is finally coming under control after infecting more than 3 200 people in the past 10 days.

According to Colonel Piet Kilian, from the emergency field hospital set up in an aircraft hangar near the stricken township, more than 3 200 patients have been treated so far, with 1 115 admitted to this hospital and provincial hospitals by yesterday afternoon.

Kilian said that while the number of people reporting to the field hospital had declined somewhat, he was taking heart from the far lower number of people who were being admitted.

"The percentage of people admitted compared to the number we see is how we judge whether we are getting the situation under control," Kilian said.

The number of people with confirmed cases of typhoid was now 86, he said, although many more had been infected by the disease (89)

No cause of the outbreak has yet been found. A team of academics and scientists is trying to find out why the disease spread so rapidly, remaining confined to Botleng.

Botleng 'plague' abates

WM 3-9/12/93

Desmond Pitoyi

THE typhoid epidemic that claimed six lives and infected approximately one in 25 residents in Botleng township appears to be abating, say doctors, with fewer people being treated and many recovering.

The "plague" has given impetus to a Delmas City Council plan to move the residents of Welumlambo and Mandela E squatter camps to more suitable land after their bucket sewage system, rubbish heaps and overcrowded filthy streets were blamed for the epidemic.

More than 3 000 sufferers have received treatment at the nearby Hendrik Schoeman Airfield hospital since the outbreak. The last group of 1 113 patients had been treated by late on Tuesday. Colonel Piet Kilian, a medic at the makeshift hospital, said there had been a noticeable drop in the number of typhoid patients being admitted to the hospital, from 22 percent of outpatients to four percent this week "which tells us that people are getting better".

Civic and community organisations last week accused the Delmas City Council of having ignored requests to improve infrastructure, sanitation and water supply in Botleng.

This week, town clerk Johan Luwes said that before the epidemic broke out, "we were in the process of acquiring land to resettle squatters and to provide them with proper services like a water-bound sewage system. About 2 700 stands have already been acquired so far and 531 families have been resettled on that land. We intend acquiring more land for this purpose."

He added that about 3 000 squatters were presently settled on unsuitable land and "this may have led to the outbreak of the typhoid epidemic due to lack of proper hygiene. The Botleng council is doing everything to get them settled in a properly serviced area in phase two."

When news of the outbreak was first reported, Luwes said, there was a health education programme in process. "About 20 health workers in the area were going around teaching residents basic general hygiene."

However, local civic leader Bantu Mabhena refuted claims by Luwes that the council had employed health workers, saying the only health workers operating before the epidemic had been community volunteers.

He said: "The civic is still negotiating with the council to employ the 15 community volunteers who are already trained to do the job. So far, we haven't reached any agreement on the matter."

Luwes admitted the resettlement programme was beset with problems.

"There is no quick-fix solution to the squatting problem. We could resettle the whole squatter camp in one swoop, but there will still be people flocking here from other areas."

Mabhena dismissed this, saying people would not want to move to "this unsuitable place". He said his organisation was continuously alerting people to the dangers of Welumlambo squatter camp — where most of the victims of the epidemic came from.

Delmas typhoid linked to contaminated water

(89) ARG 3/12/93

PRETORIA. — Contaminated water could have been the source of the typhoid outbreak in Delmas on the far East Rand, which has claimed 11 lives in about two weeks.

"There is a possibility the water was infected at one stage. Samples of the water, however, tested negative for salmonella typhi and it cannot be determined beyond doubt how, where and when the infection took place," the Department of National Health said yesterday.

Among the latest victims of the disease were a six-month-old baby, a 43-year-old man and a 78-year-old woman, said the Transvaal Provincial Administration.

It said 226 people were being treated for typhoid, 125 of them at a field hospital and 101 in provincial hospitals.

The water was now safe and was being monitored continuously.

The provincial administration said it was taking special measures to prevent the disease's spread to other patients, including washing laundry separately and using disposable cutlery.

In addition, every patient discharged from provincial hospitals was being provided with pamphlets on measures to combat the disease. — Sapa.

Source of typhoid has experts baffled

(89) CT 2/12/93

PRETORIA. — Scores of patients have been treated for typhoid since the disease broke out in Delmas on the far East Rand two weeks ago, but its origin remains a mystery.

The Transvaal Provincial Adminstration said yesterday that there had been a decrease in the number of typhoid cases reported. About 260 patients were still in hospital.

With four confirmed cases of typhoid in the Delmas town area, it appeared the fever was prevalent in both Delmas and Botleng, the statement said.

Eight deaths apparently linked to the disease have been recorded. There are 159 patients still being treated in a field hospital in the area; 46 in Pholosong, 32 on the far East Rand, 13 in Rietfontein, six in Bernice Sameul, two in Nigel and two in Johannesburg. — Sapa

SA's typhoid scourge

Star 3/12/93

EVENTS at Botleng, outside Delmas in the eastern Transvaal, last week have brought typhoid starkly into the national consciousness, reports Health Writer David Robbins

89

The first thing to understand about the typhoid outbreak in the Delmas district last week is that it was neither unexpected nor isolated. Typhoid is endemic in many parts of South Africa.

Yet Delmas has been particularly severe, with the full consequences not yet known. So far, more than 3 200 people have been treated for the disease, 1 113 of them in hospital, although fewer than 100 of these cases have so far been confirmed as typhoid. Six people have died, two from confirmed typhoid.

Undoubtedly, these confirmations will increase as the results of the long and complicated tests become available.

What is not so widely known is that, in the first nine months of this year, nearly 1 200 cases of typhoid were notified countrywide, and nine people died of the disease. In 1992, 13 people died. New cases are reported all the time, particularly from the hot northern and eastern Transvaal and humid Natal.

To view these figures in perspective, it must be pointed out that the question of the under-reporting of notifiable diseases, especially from rural areas, remains a major problem.

According to health experts, the under-reporting of tuberculosis, for example, could be having the effect of hiding as many cases as are notified. So with typhoid.

What is this feared and, if untreated, very serious illness?

It's a bacterial disease that results in fever, weakness and, in severe cases, death. It's caused by a bacterium called *Salmonella typhi*, and is contracted via the faecal/oral route, in other words, by ingesting food or water contaminated with human excrement.

Typhoid is a systemic disease, which means that the *S.typhi* infection is capable of passing beyond the bowel to infect other organs as well. The good news is that it's treatable, if caught sufficiently early, with antibiotics.

These days, it's one of the diseases of inadequate sanitation and dirty water. The racial divide between South Africa's First and Third World components is clearly indicated by looking at the typhoid statistics.

In 1970, the notification rates per 100 000 of population ranged from 1,6 for whites, 5 for Indians, 11,1 for coloureds, and 26,6 for blacks.

By 1990, these figures had improved to 0,4 for whites, 1,1 for Indians, 0,8 for coloureds, and 7,3 for blacks. Even so, the threat of further outbreaks, especially in the informal settlements burgeoning on the perimeters of every town and city in the country, is high and increasing.

Development, coupled with good primary care and health education, is obviously the answer. Development in this context means, most importantly, the provision of sanitation and clean water.

But how close are we to providing all South Africans with these basic tools to good health? Major research in 1991 — *Water and Sanitation 2000* — gives an indication.

In the urban and metropolitan areas, 62 percent of 22 million people of all races have waterborne sewerage systems, and a further 5 percent have buckets or ventilated pit latrines. The remaining 33 percent (that's 7,3 million people) make do with what the research calls "minimal facilities". With regard to water, 18 percent of urban dwellers make use of rivers, tanks and other unreliable sources.

In the rural areas, the situation is even worse. Only 53 percent of 16 million people have a safe water supply; and a mere 14 percent have access to adequate sanitation.

More recent research emanating from the Medical Research Council has estimated that to provide basic facilities to these many millions of have-nots will cost between R15 billion and R20 billion. That's an amount to make the eyes of budget planners water. But it will have to be spent.

The consequences of not doing so, especially as South Africa's urbanisation process gets into top gear, will make Delmas look like child's play.

Water may have been source of typhoid

Star 3/12/93

Contaminated water could have been the source of the typhoid oubreak in Delmas on the far East Rand which has claimed 11 lives in about two weeks.

"There is a possibility the water was infected at one stage. Samples of the water, however, tested negative for salmonella typhi and it cannot be determined beyond doubt how, where and when the infection took place," the Department of National Health said yesterday. (89)

The water was currently safe and was being monitored continuously, the department said.

A six-month-old baby is among the three most recent victims. A 43-year-old man and a 78-year-old woman had also died recently, the Transvaal Provincial Administration said.

A total of 222 people were being treated for typhoid, 125 of them at a field hospital and 97 in provincial hospitals.

The TPA said it was taking special measures to prevent the disease's spread. — Sapa.

Typhoid crisis eases

(89) ARG 4/12/93

PRETORIA. — The number of patients being treated for typhoid fever has decreased drastically and the disease is under control, the Department of National Health said.

The number of patients in provincial hospitals dropped from 95 on Thursday to 69 yesterday, and from 135 to 55 in the field hospital established to deal with the outbreak at Botleng, Delmas, on the far East Rand two weeks ago.

There have been 11 deaths. — Sapa.

Typhoid is under control

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It said the number of patients in provincial hospitals dropped from 95 on Thursday to 69 yesterday, and from 135 to 55 in the field hospital established to deal with the outbreak at Botleng, Delmas, on the far East Rand two weeks ago. CT 4/12/93

There have been 11 deaths apparently linked to typhoid. — Sapa

Typhoid case traced to Durban camp

(89)

The Argus Correspondent

A CONFIRMED case of typhoid has been traced to a Durban squatter camp and the city health department has begun a huge health education programme in the area.

ARG 9/12/93

The camp is in Palmiet Road, Clare Estate.

But Dr Humsha Naidoo, a spokesman for the city health department, said yesterday the 12-year-old patient might have contracted the disease while visiting a rural area.

The child was diagnosed as having typhoid when she was taken to the Addington Hospital last week. The hospital in turn notified the health department.

Dr Naidoo said the child was recovering at Clairwood Hospital.

Dr Naidoo said residents from the squatter camp obtained water from a tap.

Typhoid cases on the increase

TEMBA, Bophuthatswana. — There has been an increase in the number of typhoid patients admitted to a Bophuthatswana hospital, the acting superintendent confirmed yesterday.

Dr Lumamda Mbuyamba of the Jubilee Hospital at Temba, near Hammanskraal, said about 10 patients had been admitted since November 20. — Sapa

HEALTH AND DISEASE — MISCELL. DISEASE

1994 — 1997

ST Times 23/1/94 (89)

Warning is sounded on yellow fever threat from mosquitoes

By BRONWEN JONES

MOSQUITOES carrying a disease more deadly than malaria — and much swifter to kill than AIDS — are hitching rides into South Africa in old tyres, under trains and in planes.

The disease, yellow fever, is also being brought into the country by illegal immigrants.

Direct flights from danger zones can bring in passengers unaware they are in the early stages of the fatal fever — and all it takes for the disease to start spreading is one bite from a local mosquito.

Yellow fever kills at least 30 000 people every year — and scientists warn the problem is getting worse in South Africa.

The main mosquito that carries yellow fever already exists across much of South Africa — its prime breeding sites are in the rubbish that litters squatter camps and ill-managed townships.

Danette Lombard, principal medical natural scientist at the Department of National Health, said that of a budget of R10-million for disease control, 85 percent was spent on malaria.

"We have to make it a priority. There is not enough money to tackle everything."

South Africa's malaria figures in 1993 were the worst for six years.

Years of drought had kept mosquito populations in check, but, with a lot of rain in the past 12 months, there were more than 10 000 cases in 1993 — and 22 known deaths.

The easing of travel restrictions on South Africans in Africa has led to many more people coming in from, and going to, regions where malaria is resistant to preventative drugs.

Many of the areas where malaria is endemic also harbour yellow fever.

But Miss Lombard says: "Most South African doctors haven't ever seen yellow fever."

Yellow fever is carried by a mosquito which, unlike the malaria variety, can breed in a little water in any artificial container, from discarded drink cans to old tyres.

As this kind of mosquito flies no more than 500m, it is relatively easy to keep it out of major airports.

But applying the same treatment to infected humans, or to cars and trains harbouring mosquitoes, is more difficult.

Says Miss Lombard: "A year ago, our health inspectors started checking the smaller airports, but there are too many. We haven't enough staff to check them all."

Dr K, a senior doctor who cannot be named for professional reasons, adds: "If we cannot keep illegal immigrants out, I cannot see any chance of keeping yellow fever out.

"It only takes one mosquito or one infected person to start the epidemic."

Even the SA Medical Journal warns: "If yellow fever becomes established in the sub-tropical regions of Natal and the Transvaal, it will cost the taxpayer millions of rands each year to keep it under control and to maintain immunisation campaigns."

Epidemiologists are warning the fever is staging a major comeback around the world, and David Magrath, of the World Health Organisation, believes there will not be enough vaccine to deal with big outbreaks.

South Africa stopped making its own yellow fever vaccine a few years ago, and is still using up supplies before deciding who to import fresh vaccine from.

With travellers using between 100 000 and 200 000 shots worth of the vaccine every year, the National Institute for Virology's Professor Barry Schupp says there may be only four years' supply left.

Professor Schupp says the vaccine, "which is cheap to make", is sold to the Department of National Health "for less than 50c a shot". The department provides it free of charge to the provinces.

Yet early last year, Johannesburg was charging R20 for the vaccine — and now R51 a shot. No Transvaal Provincial Administration official has yet explained how the mark-up is calculated.

While yellow fever is now only common 15 degrees north and south of the equator, the mosquitoes that carry it are moving further afield every year.

The most dangerous one, Aedes Aegypti, already exists right across the Transvaal, Natal, in a swathe from Umtata down to Port Elizabeth, and along the Orange River.

Another mosquito, Aedes Albopictus, already creates the potential for yellow-fever epidemics right into Cape Town.

Jim le Duc, a WHO virologist, says that if countries don't do more to prevent mosquitoes from hitching rides across their borders — in aeroplanes, on trains and in cargo ships — "we could be in for a worldwide catastrophe".

The pessimism of international virologists is based on the spread of dengue, a mosquito-borne disease similar to yellow fever, but less lethal. Brazil, Venezuela and Australia are seeing their first dengue epidemics.

Mr le Duc says: "Wherever dengue flares up, yellow fever could follow."

In 1985, Aedes Albopictus — also called the Asian tiger mosquito because of its striped legs — travelled from Japan to the southern United States in a shipment of tyres. Now it is common in the US and Brazil. South Africa also imports used tyres from Japan for retreading. Cargoes are checked and a soap solution is meant to be placed each tyre to kill any mosquitoes or larvae.

But, if the tyres are loaded wet or with eggs, the mosquitoes can breed on the journey. A health department document lists some of the known mosquito arrivals: "January 1992, Aedes Albopictus in tyre consignments from Tokyo.

"Live larvae (of the same mosquito) came in to Cape Town from Osaka in January 1990, from Kobe in February 1990, from Yokohama in May 1990."

Ninety-five percent of yellow fever cases reported in the world now occur in Africa. And, as the number of epidemics on the continent increases, so does the proportion of children affected.

In December, the United Nations commented that seven percent of South Africa's children died from easily preventable diseases before the age of five.

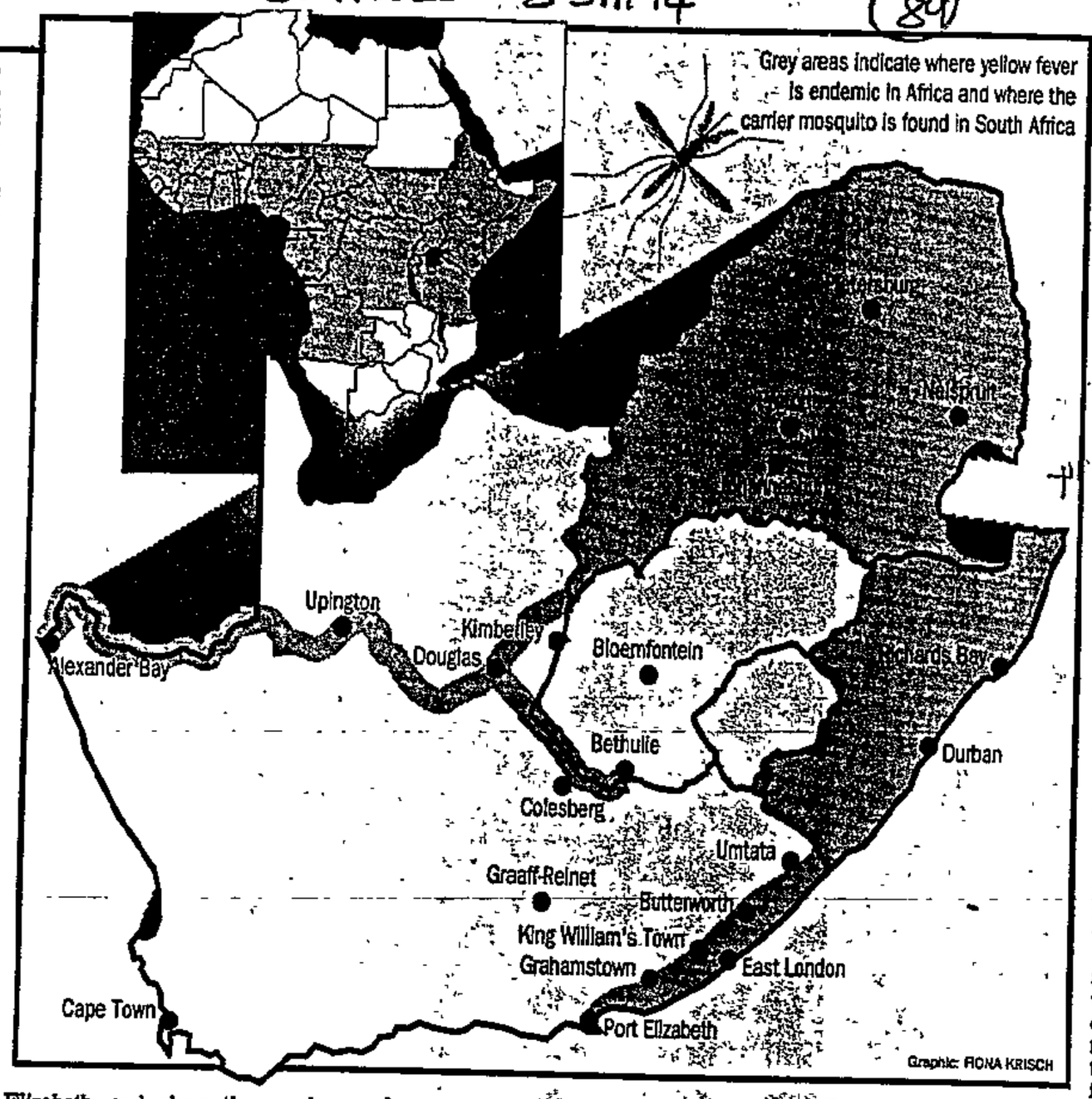
Yet health officials in SA admit to "not having considered adding the yellow fever vaccine to the immunisation package" available to all young children here.

Eleven other African countries already vaccinate children against yellow fever, and six more have plans to do so.

Preventing the arrival and spread of yellow fever would require massive campaigns to eradicate mosquitoes, improve sanitation and water supply, free immunisation and widespread education on the need to remove rubbish in which the mosquitoes breed.

"But getting rid of it once it's here will be a thousand times more difficult," says Dr K.

"And if several countries need yellow fever vaccine at the same time, I don't know what will happen."



Sunday Times
SECTION 2

Slothful South Africans sink deeper into the couch of overindulgence

ST 4/2/96 (89)

By CAS St LEGER

HE SPENDS all evening draped on the couch. When he does move, it's to light a cigarette or cram his mouth full of a hamburger and chips. Eyes glued to a television screen, the most exercise he gets is shuffling to the TV when the remote is missing.

This is a picture of the average middle-class young South African — and the warning bells are ringing.

We are a nation of junk food-eating, drinking, smoking couch potatoes who are killing ourselves by the million. Four out of 10 of us will die before we turn 60, a team of scientists has found.

Under the leadership of Dr Krisela Steyn, a team of Medical Research Council scientists including Dr Derek Yach, Professor Tim Noakes and Professor Harry Seftel has prepared the first full review of chronic diseases caused by lifestyle.

The team found that, rather than the good dying young, it is often the overindulgent who are bound for early deaths.

Only one percent of middle class men in rural areas take part in strenuous physical activity, one study found. This is common to all South African fitness and exercise studies of affluent and developed communities, says Dr Steyn. The only exceptions are the young men seen jogging along the roadsides and those whose jobs involve hard physical work.

"Where are all the middle-aged and elderly runners?" she asks.

South Africans spend more on alcohol a year than the billions the South African Defence Force spent on the war in Angola, she says.

In a study carried out in a black community in Cape Town, half of the women over the age of 40 were found to be grossly obese, while 34 percent of women between the ages of 16 and 64 were way overweight.

Among coloured women, four in 10 older than 40 were obese. A quarter between the ages of 16 and 64 were too fat.

A quarter of white women and 20 percent of white men were also rated too fat. Black men fared better, with only eight percent rated obese.

All South Africans — with the exception of some rural people with healthier traditional diets — follow "typical, unhealthy, Western lifestyles", says Dr Steyn.

South Africans cram themselves full of animal fats, red meat and soggy potato chips, heaping butter over potatoes, bread and corn on the cob.

The researchers found that four in 10 South Africans between the ages of 24 and 64 die young because of their lifestyles.

Two out of five boys now aged 15 could expect to be dead before they reached 60 — unless they changed their habits drastically. The projected premature death figure for girls now aged 15 was just over 25 percent.

"As far as lifestyle-related early deaths are concerned, South Africa is up there with the worst in the world — Scottish women and the northern Finns," says Dr Steyn.

Lifestyle diseases include high blood pressure, heart attacks, strokes, lung diseases related to smoking such as bronchitis and emphysema, diabetes and cancers caused by diet or smoking.

Dr Steyn says it is easy to avoid most lifestyle-related illnesses. "Take regular exercise, even if it is just a walk for half-an-hour a day, cut down on animal fats, stop smoking and control stress."

Ironically, says Dr Steyn, the more development there is in underprivileged communities, the faster the growth in lifestyle diseases, which she calls "the hidden epidemic".

"The more there is so-called development and industrialisation, the more disadvantaged people aspire to Western-style lives," she says.

The provinces most affected by lifestyle diseases are the more developed provinces. In the Western Cape, 57 percent of the population die early because of their lifestyles, followed by 55 percent in the Northern Cape and 36 percent in Gauteng, which still has a large poor population. By contrast, the rural provinces, which are still battling with diseases of poverty, lose fewer people to lifestyle diseases.

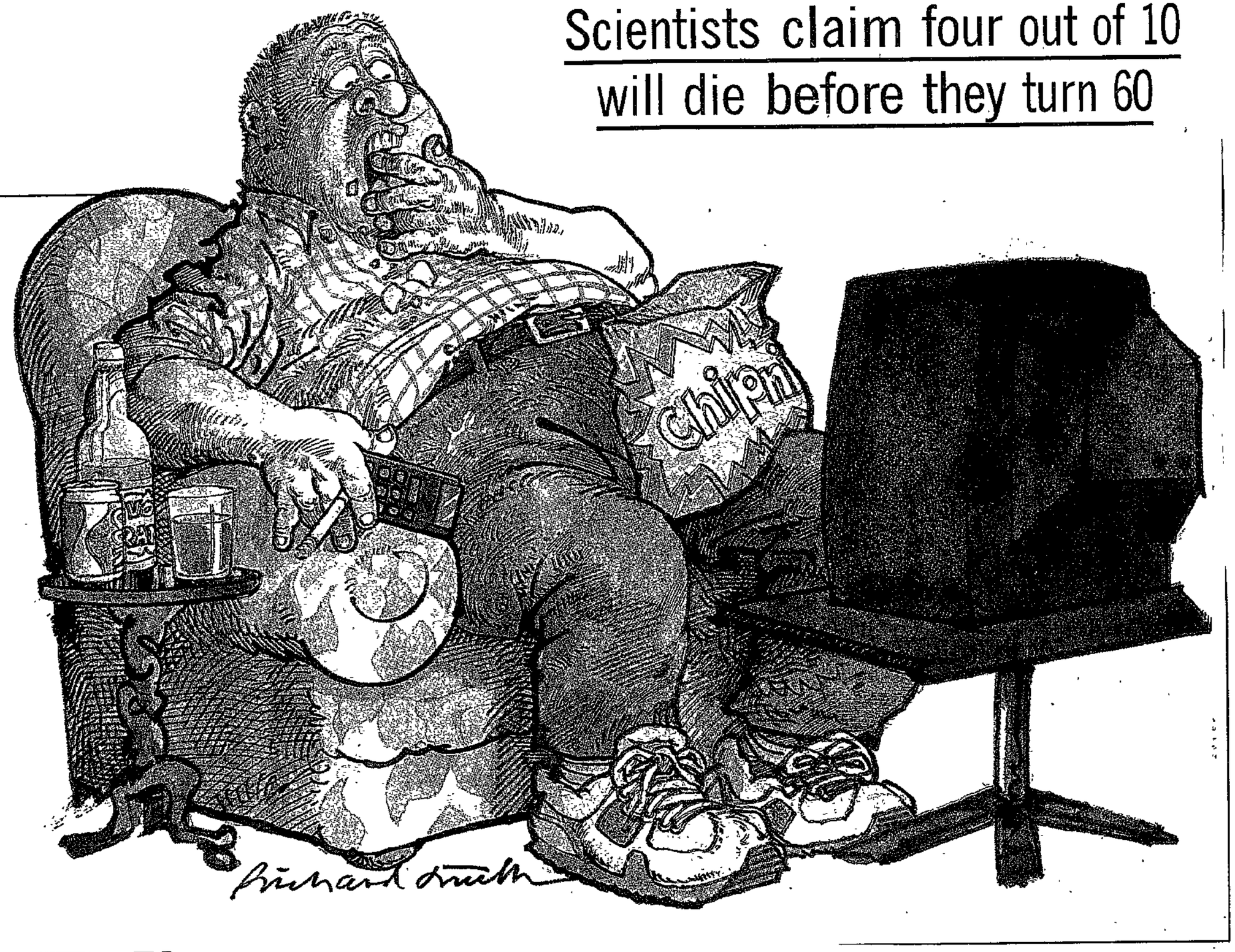
Diseases of development rarely get attention, says Dr Steyn.

"The government's health programme is now focused on poverty-related diseases such as malnutrition and infections. Once the new government succeeds in controlling and preventing diseases of poverty, we will be overcome by diseases of development."

Lifestyle diseases cost South Africa billions. One 1991 Medical Research Council study found strokes and heart disease cost the country up to R4,8-billion a year.

The director general of health, Dr Olive Shisana, has created a directorate for chronic diseases and disabilities to prevent and manage lifestyle illnesses.

Scientists claim four out of 10 will die before they turn 60



Hepatitis B a growing threat in SA

(82) (89) Star 5/2/96

In South Africa, infants, the under-fives in rural areas, and young, sexually active urban dwellers are most at risk of contracting hepatitis B.

Free routine hepatitis B immunisation for infants was introduced in April 1995. Now, private companies such as The Vaccine Bureau are offering mass hepatitis B immunisation at school, tertiary institutions and local businesses.

Here are some facts to consider when deciding whether to take up that offer:

■ Hepatitis B is a potentially serious viral infection that causes inflammation of the liver. Its symptoms can be severe or non-existent. Most people remain asymptomatic, while others develop chronic, or acute, hepatitis, which can debilitate for up to five weeks. Persistent infections are associated with fatal cancer and cirrhosis of the liver. An estimated 2 million people in South Africa carry the virus in their blood, and can infect others. It is prevalent throughout the country.

The aim of mass immunisation is to reduce the carrier pool in the country.

■ The hepatitis B virus is tougher and more infectious than the HIV virus. It is usually contracted in early childhood or young adulthood. The aged, and children between 5 and 13, are at lowest risk. The risk for the average schoolchild is relatively low, but significant: it comes from sex – there's an alarming increase of sexually transmitted diseases among teenagers; intravenous drug abuse; contaminated needles such as from careless tattooists, beauticians and acupuncturists; and there's also a risk from unknown sources, which cause up to 20% of infections.

■ The ideal age to immunise a schoolchild is between 10 and 12, just before they enter puberty. Dr Rudi Eggers questions whether it is appropriate to immunise a child between five and ten. Prof Barry Schoub says the effects of the vaccine are probably lifelong, so an earlier vaccine would make no significant difference.

■ Both forms of the vaccine – plasma-derived and synthetic – have been proved to be equally safe and effective. The vaccines are delivered in three doses, over three months, and side effects are limited. Both forms are relatively costly, though the plasma-derived vaccine is cheaper than the synthetic. The recommended retail price for the plasma-based Hepaccine B is R25,65 per single dose for an under-10-year-old and R42,75 per adult dose. The synthetic Engerix-B is R37,89 per dose for a child and R55,51 per adult dose.

Journal urges drug therapy

By Mokgadi Pela (91)

SOUTH Africa should encourage compliance with drug therapy if it is to win the war against tuberculosis, according to the latest issue of the *South African Medical Journal*.

In its opinion following results of a study conducted at Hlabisa Hospital in KwaZulu-Natal, *SAMJ* said compliance with treatment "will lead to a sustained reduction in case rates. This is the basic strategy advocated by the World Health Organisation and the International Union against Tuberculosis and Lung Disease."

Of even greater concern is the link between TB and HIV. At Hlabisa Hospital, a typical district institution, 35 percent of adults diagnosed with TB in mid-1993 were HIV-positive. Research has shown that the TB case load at the hospital has increased dramatically in recent years.

"While some of this increase reflects a higher general workload from improved staffing, referral from neighbouring districts and the impact of a more user-friendly service, the impact of HIV infection and the worsening poverty in the area probably account for the rest. It is clearly difficult for any service to cope with a 300 percent increase in workload at a time of major political and health service transition and no increase in resources," the *SAMJ* said.

13/2/96

The joiurnal said failure to control TB in South Africa largely reflected the apartheid legacy of poverty, discrimination and fragmentation of health services.

As a solution, *SAMJ* advocated a strong central management and technical expertise in TB at national and provincial levels.

Western Cape beauty pageant will aid Africa's worst TB region

(91) ARG 13/2/96

Staff Reporter

WESTERN Cape women are gearing up for a beauty pageant with a difference, which will target public awareness of tuberculosis and raise funds for sufferers.

The region is believed to have the highest incidence of TB in Africa.

Finalists in the event next month, sponsored by the South African National Tuberculosis Association (Santa), will learn about the disease, its causes, prevention and cure.

Besides having the opportunity to educate their communities, they will be eligible for prizes and become automatic semi-finalists in the Miss South Africa competition.

Ignorance about TB is appalling, even though it is the commonest infectious disease in South Africa, Santa officials say.

The Western Cape had 25 530 of the 80,000 or so cases reported last year, according to the Department of Health.

All funds raised in the competition will help communities where TB levels are worst. Santa will distribute food parcels to victims, sponsor nutrition programmes, education and support initiatives, and distribute seedlings so sufferers can grow vegetables.

Pageant organisers also hope to dispel misconceptions people may have about the disease. TB has always been associated with poorer communities, says Natalie Benard, co-ordinator of the event and a runner-up in last year's Miss South Africa pageant. But anyone can get it, she says.

Women must enter the competition before February 23. The semi-finals will be on March 2, and the finals on March 29 in Stellenbosch.

For more information, contact Ms Benard at (024) 51 1674.

Expo opens window on schools

Education Reporter

SCHOOLS Expo '96 will afford schools the opportunity to market themselves and their services to the public for the first time.

This new exhibition on the South African calendar will run alongside bition Centre in Johannesburg next month.

Schools Expo '96 has already attracted more than 50 exhibitors, including leading state and private schools in the Western Cape.

In addition, a number of these

Tuberculosis – a new threat

(91) ARLT 15/2/96

Alarm bells are ringing as tuberculosis takes on epidemic proportions in many parts of the world. Health Reporter JENNY VIALL investigates.

TUBERCULOSIS is a treatable disease, yet every year three million people die from it.

The World Health Organisation estimates that a third of the world's population is infected with TB, and the Western Cape has among the highest incidences of TB in the world.

Jonathan Youngelson, project manager of pharmaceuticals and biotechnology at the Medical Research Council, believes it is time TB was tackled head on. "TB is an international threat to humanity. The message must go out. This is a serious problem," he says.

Dr Youngelson heads a five-year research project, TB Action, which aims to find novel and enduring ways to treat the disease.

South Africa, along with the United Kingdom and Canada, was chosen to do research for TB Action, a £10-million (about R55,6-million) project funded by pharmaceutical company Glaxo-Wellcome. The project is now in mid-term.

"Our focus is fundamental, basic research to enable us to develop new drugs and therapies," explains Dr Youngelson.

There are many challenges ahead in combating TB, says Dr Youngelson. These challenges are not specific to South Africa, and solutions found here will be of value to the world at large.

The global TB picture is frightening. Thirty million people will die this decade from what is a curable disease. And more than 300-million additional people will become infected in the next decade. TB is now responsible for more adult deaths than any other infectious disease in the world.

Add to this the relationship between the Aids-causing Human Immuno-deficiency Virus (HIV) and TB, and the number of TB cases is set to rocket. No wonder then that alarm bells are ringing.

In an unprecedented move, the World Health Organisation declared tuberculosis a global epidemic in 1993.

Global it is, and it's spreading fast. While most deaths occur in developing countries, the number of TB cases in Europe and the United States is increasing. And in Africa, Asia and Latin America there's been a dramatic rise in cases.

"Tuberculosis knows no borders. Because TB is contagious through relatively casual contact there is no way we're going to contain TB in one region of the world," says Dr Youngelson.

Migration, business and tourist travel make it impossible to protect one community when an epidemic is out of control elsewhere.

Treatment, funding, education and monitoring are all areas that need to be tackled.

Why was South Africa chosen to do research? "South Africa is a meeting of two worlds," says Dr Youngelson. "We have a population with a high incidence of TB, but also the research infrastructure and credibility to do internationally acceptable research."

South Africa also has certain unique characteristics: "The Western Cape has among the highest incidence of TB in the world and definitely the highest in South Africa. But we have the lowest incidence of HIV.

"Natal with its high HIV incidence and its association with TB poses a challenging research area."

The need for new drugs is one area of research as multi-drug resistant strains of tuberculosis emerge. Already people are presenting strains of TB that don't respond to the usual drugs. Why has this happened?

"Tuberculosis has been around for a long time. It is thought that Tutankhamen died of it, and the pharaohs are the oldest recorded cases we have of tuberculosis.

After TB became treatable earlier this century, it went out of vogue, he says. It wasn't seen as life threatening – there was a cure, and it was accorded low priority.

A vaccine (BCG) was developed in the 1920s, but its efficacy is controversial. Protection is highest in preventing serious forms of TB in children, but it does not give long-lasting immunity.

In South Africa, along with other developing countries, many do not have easy access to clinics.

The World Health Organisation has proposed a strategy called DOTS (Directly-Observed Treatment, Short course), where health workers observe the patient taking medication. This may not be viable, though, in areas with few clinics.

Dr Youngelson says that with proper management of TB there is a nearly 100 percent cure rate. With bad management this is only about 50 percent.

"Bad management has many contributing factors. People need to take the medication for six months. If they don't finish the medication, which they often don't because they soon start feeling better, the residual bacteria develops a resistance and sits dormant. When TB develops again, the strain cannot be treated with the usual drugs."

Are we looking at "superbacteria" that will eventually become untreatable? Not at this stage, says Dr Youngelson.

"Multi-drug resistance is found in only a small proportion of TB sufferers. I don't know any who are resistant to all drugs. But this could happen."

Controlling TB needs a global effort, says WHO, in its 1995 report. Industrialised nations will have to contribute to efforts to fight TB in developing countries if they are to contain the spread of TB in their own countries, says the report.

Funding for TB control is less than that spent on Aids, tropical diseases, malaria and diarrhoea.

"Unfortunately, affordable life-saving health interventions for infectious diseases are often neglected in favour of large and expensive projects," it says.

WHO figures for 1990 show that $185-million (R673,4-million) was spent on Aids, $74 million (R269,36-million) on tropical diseases, $55-million (R200,2-million) on diarrhoea, $47-million (R171,08-million) on malaria and only $16-million (R58,24-million) on TB.

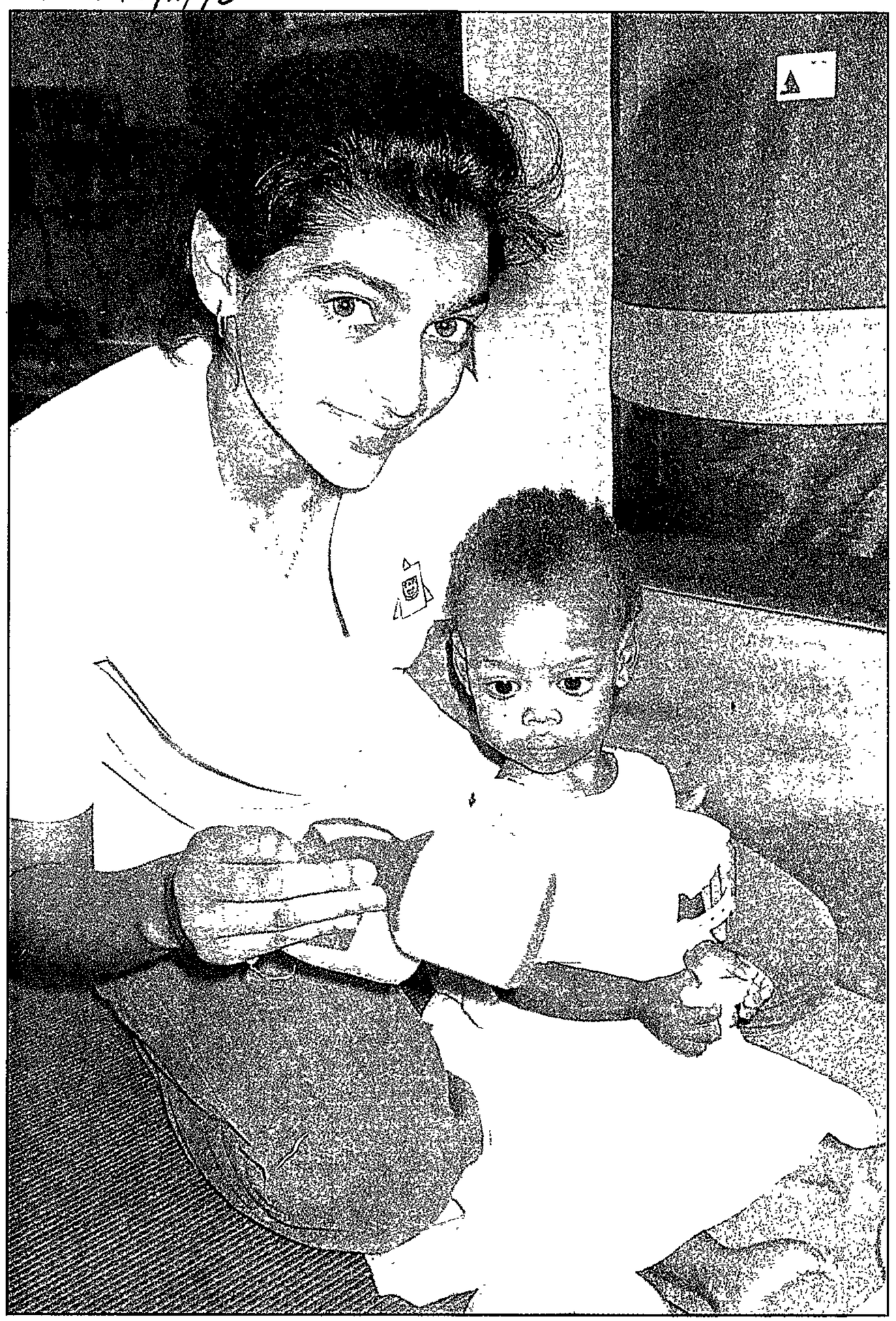
● Tuberculosis is a major cause of death in people with Aids, yet the relationship between TB and the Human Immuno-Deficiency Virus (HIV), the virus that causes Aids, is not clear says Dr Youngelson.

"An HIV-positive person exposed to the TB bacteria is at risk of rapidly developing a fatal case of TB," he says. "Conversely, TB can hasten the progression to Aids in HIV infected people."

Most of us are exposed to the TB bacteria, but we don't develop the disease because our natural immunity is well-developed.

"With HIV the dynamics change," says Dr Youngelson. "We're not sure what they are, but HIV seems to activate TB in people who are infected with it."

HIV also accelerates from years to weeks the speed at which TB progresses from harmless infection to life-threatening disease.



Picture: JENNY VIALL, The Argus

TB CARE: Many of the babies at the Brooklyn Chest Hospital have had TB meningitis, which can cause developmental problems. Here occupational therapist Shaamila Kamaloodien works with a young TB patient with poor muscle tone. The hospital is for patients with acute TB who find it difficult to get to a clinic or those with a multi-drug resistant strain of TB who need monitoring.

W strain is drug-resistant

GENETIC studies of the super-lethal W strain of tuberculosis that emerged in New York City in 1991-92 show that the first known cases of the mutant strain appeared in New York City and on Long Island in 1986, and that it has spread to other states and overseas.

Using new techniques for analysing and comparing the DNA of TB bacteria found in 273 patients since 1986, researchers from the Public Health Research Institute in New York City have managed to map the history of New York's latest tuberculosis epidemic.

Their work is to appear in the Journal of the American Medical Association.

From 1978 to 1992 the total number of tuberculosis cases in New York City tripled, jumping from 1,200 cases a year to nearly 4,000.

Many patients died because they had HIV-weakened immune systems that could not fight off the TB, or they were infected with one of the strains that was resistant to one or more of the seven leading drugs used to treat the disease.

A frightening facet of the epidemic was the emergence of the W strain of TB, which was resistant to nearly all tuberculosis drugs.

The odds of surviving W strain tuberculosis are less than 50 percent, and involve 18 to 24 months' use of three expensive drugs that can have awful side effects, including blindness and dementia.

'No concern' over alum in water

STAFF REPORTER

THE city's water is filtered with the chemical alum, which Australian scientists have discovered could be linked to Alzheimer's Disease.

City engineer Mr Arthur Clayton said yesterday alum was the most widely used water filtering chemical in the world.

"Alum is used to remove the colour and suspended particles in the water — to clear the water. The water then goes through a sedimentary process, and by adjusting the pH of the water, the alum settles on the bottom and is removed to a level well below the World Health Organisation (WHO) guidelines of 0,2mg a litre," Mr Clayton said.

He said there was no cause for concern about the alum content of the water. The latest communication from WHO had indicated that the organisation saw no need to introduce stricter guidelines.

"One cannot change an entire water industry just on the basis of anecdotal evidence," Mr Clayton said. (89) CT 12/4/95

CHRONIC DISEASES RELATED TO LIFESTYLE

More than 40% of South Africans obese

(89) CT 12/4/95

THE Medical Research Council says SA is undergoing a transition from diseases of poverty to diseases associated with unhealthy lifestyles. **MELANIE GOSLING** reports.

SOUTH Africa has one of the highest rates of obesity in the world, with over 40% of the population classified as obese, the head of the Medical Research Council's Chronic Diseases of Lifestyle Division, Dr Krisela Steyn, said yesterday.

At a lecture attended by chronic disease experts at the MRC in Parow, Dr Steyn said South Africa was undergoing a transition from diseases of poverty to the adult chronic diseases of lifestyle associated with developed countries.

These diseases included strokes, heart disease, chronic bronchitis, emphysema and various cancers related to tobacco use and overeating.

"These diseases are already the number one killer of whites and Asians in this country. The risk factors, such as high salt intake, overeating, a high animal fat diet, increased smoking rates among black men and a lack of exercise are becoming an emerging problem in urbanising communities," Dr Steyn said.

Visiting expert Dr Pekka Puska of the National Public Health Institute in Finland, who is visiting the country as part of a multi-national chronic disease prevention programme under the auspices of the World Health Organisation, spoke on the success of community-based programmes aimed at reducing chronic diseases.

Dr Puska said well-planned programmes in Finland had had a major impact on reducing lifestyle diseases.

Risk factors

A 20-year project in Finland, aimed at reducing the very high coronary heart disease death rate, had resulted in a decline in the mortality rate among males under 65 by nearly 50%.

"Research has clearly shown that cardiovascular diseases have their roots in unhealthy lifestyles, the aim of a community programme is to tackle these risk factors."

Malaria: 'Don't be complacent'

(89) ET 29/6/95

MELANIE GOSLING

THREE people have died of malaria in the Eastern Transvaal town of Nelspruit since the beginning of the year and doctors have warned the public not to be complacent when travelling north.

Nelspruit pathologist Dr Adrian Brink said yesterday a chloroquine-resistant strain of malaria had moved into parts of the Lowveld — including the Kruger National Park — over a year ago, and was also found in northern kwaZulu/Natal, near the Mocambique border.

"People are very blasé about malaria — many don't take any drugs or they take the wrong drugs or, most commonly, they don't finish the course of drugs and stop taking them when the get home," Dr Brink said.

The most recent death in Nelspruit was a local man who died four weeks ago. He had only sought medical attention when in an advanced stage of malaria.

"The problem is not the malaria so much, but that people don't get to the doctor soon enough," Dr Brink said.

People visiting malaria areas should take a combination of a chloroquine-based drug (Daramal, Nivaquine or Plasmoquine) as well as Paludrine. The combination of drugs was necessary because of the chloroquine-resistance strain of malaria.

He said a new anti-malarial drug, Larium, was the most effective against the chloroquine-resistant strain of malaria. However, this was expensive and could have unpleasant side effects.

Symptoms

"The most common symptoms are like very severe flu — muscular aches and pains, fever and a severe headache," Dr Brink said.

The warden of the Kruger National Park, Mr Harold Braack, confirmed that chloroquine-resistant cases of malaria had occurred in the park. "It's certainly not a new, deadly strain," he said.

Hepatitis B vaccine for SA's immunisation plan

KATHRYN STRACHAN

MEDICAL experts have warned against the dangers of the hepatitis B virus which infects about 5% of SA's black community.

Dr Bucs Lombard of the National Health Department said last week there was little public awareness of the potentially lethal virus, but the new government would take measures to eradicate the disease.

A vaccine was now available against the highly contagious virus, and it was hoped that by next year the vaccine would be included in the immunisation programme for children. BI Day

In the meantime, however, health practitioners were trying to get the message out that those who could afford the vaccine should get it. 11/7/94

Prof Ralph Kirsh of the Medical Research Council said the disease, which affected about 5-million people in SA, would not decrease until an effective vaccination programme was in place. Poor living conditions, overcrowding and lack of sanitation contributed to the problem, he said.

Prof Michael Kew of Wits University's medical department said while there were various strains of hepatitis, hepatitis B was the most prevalent. SA had the highest number of tumours caused by the virus in the world. (89)

Almost half those who became infected when young became chronic carriers and eventually died of liver cancer or cirrhosis. While adults displayed more severe symptoms and became more ill when they contracted the virus, most recovered and became immune. About 5% went on to become chronic carriers.

Measles kills 600 kids yearly

By Mokgadi Pela

MORE than 600 children die from measles yearly in South Africa due to deficiency of vitamin A.

According to Dr Greg Hussey, of the Department of Paediatrics and Child Health at the University of Cape Town, a national study set up by the Medical Research Council and the Health Ministry is needed to address the problem.

"Studies have shown that vitamin A reduces childhood deaths by 30 percent," Hussey said.

He adds that the World Health Organisation has recommended that all children with measles should be given vitamin A.

Hussey says measles is a preventable disease which can be stifled by immunising children at nine months.

Food with vitamin A includes margarine, vegetables and liver.

Vitamin A deficiency results in pneumonia, diarrhoea, malnutrition and mouth ulcers.

Malaria on the increase; major project to map it — then fight it

ARG 10/6/94

LIBBY PEACOCK, Staff Reporter

IN South Africa 10 000 malaria cases were reported last year, mainly in Northern KwaZulu/Natal and Northern and Eastern Transvaal — compared to an annual average of 7 500 cases in the late 1980s and early 1990s.

And before that an average of 2 900 cases a year were documented.

Now the Medical Research Council is undertaking a major research project to geographically chart the incidence of malaria throughout the country in an effort to combat the disease.

The project — which involves collaboration with local, as well as Zimbabwean and Mozambiquean health authorities — has been prompted by the higher incidence of the disease.

The growing number of cases is due mainly to the emergence of new strains of malaria parasite increasingly resistant to traditional anti-malaria drugs.

Brian Sharp of the MRC's National Malaria Research programme in Durban said more than 300 million people globally were at risk of contracting malaria, with more than 80 percent of infections occurring in sub-Saharan Africa.

The resistance of the parasite was aggravated by the migration of people from affected areas to those previously free of malaria, as communities moved in search of work, to claim land or to escape war and famine.

"Mapping the geographic occurrence of the disease and where specific preventive measures prove most effective will ensure a better targeted and more cost-effective control of the disease in the Southern African region," Dr Sharp said.

"By identifying where the parasite is distributed and the incidence of the disease, appropriate treatment and prophylactic advice can be dispensed.

"This will not only benefit communities at risk but also help business and leisure travellers within Southern Africa to decide on the best anti-malarial course of action to take."

'Affluent' diseases hitting urban blacks

(89) CT 26/3/94

BLACK people aspiring to affluence who have adopted a "Westernised lifestyle" are increasingly at risk of contracting heart disease, a leading heart specialist said yesterday.

Professor William Lore, head of the Department of Medicine at Moi University in Kenya, who was speaking at the Medical Research Council (MRC) in Parow, said people from rural areas who migrate to cities are swopping their previously healthy lifestyles for unhealthy ones, putting them at risk of contracting heart disease.

He said they did not eat their traditional foods, smoked more, did not exercise and suffered a rise in hypertension after moving to the cities.

He said migration to cities had an effect on the development of high-blood pressure and diabetes.

Dr Krisela Steyn, head of the MRC's Chronic Diseases of Lifestyle division, said heart disease among South African blacks will reach the same proportions as that among whites and Indians, unless appropriate steps are taken immediately.

"Like other developing countries, South Africa is undergoing a transition from diseases of poverty to the adult chronic diseases of lifestyle associated with development."

These included strokes, heart disease, lung diseases and cancers due to tobacco use.

"These diseases are becoming an emerging problem in South African blacks," she said.

She said 80% of blacks living in Cape Town had adopted a Westernised diet which was no longer a protective one.

Health focus:

(Suppl. to South)

Immunisation best defence against measles

CHILDREN still die of measles although it is easy to prevent the disease with immunisation, which is free.

Immunisation is the most cost-effective way to prevent disease.

Six diseases have been targeted for immunisation in South Africa —measles, tuberculosis, polio, diphtheria, whooping cough and tetanus.

Immunisation against these diseases is obtainable free of charge from municipal clinics.

Serious side effects from inmmunisation are rare. The risk of death or serious illness from the six target diseases far outweighs the risks from immunisation.

Measles is an acute childhood infectious disease. It is estimated that approximately 1,2 million children in developing countries die from measles every year.

About three-quarters of measles deaths are caused by pneumonia which follows on the weakening of the immune system by the measles virus.

Measles is probably South Africa's most important preventable cause of illness and deaths in children under five years.

The eradication of poliomyelitis by the year 2000 is one of the objectives for 1994 proposed by the Department of National Health and Population Development.

Because of immunisation the number of polio cases has dropped dramatically worldwide and the number of notifications in South Africa has been low since 1989 — making the goal of polio eradication within reach.

At maternity homes, after the birth of a baby all mothers are (89) given a letter telling them about the clinics and giving the immunisation schedule.

They also receive a "Road to Health" card on which all immunisations given can be recorded.

The first immunisation (BCG and Oral Polio) is usually given at the nursing home. Thereafter immunisations are given at the clinics.

CLINICS ON THE CAPE FLATS:

Bonteheuwel, Honeysuckle Street, 694-4116/7/8
Hazendal, Kuils Street, 696-9920
Heideveld, Heideveld Road, 637-8033/4
Honeyside, Cnr Belgravia and Honeyside Roads, 697-1922
Manenberg, Manenberg Ave, 691-0048/9
Netreg, Cnr Bonteheuwel and Jakkalsvlei Ave, 694-1733/4
Newfields Estate, Surran Road, 692-1307
Silvertown, Petunia Street, 637-1293/4
Vahalla Park, Johannes Street, 934-0101/2/3

nin A in SA

Measles a child killer

By Mokgadi Pela

MORE than 600 children die from measles every year in South Africa due to a deficiency in Vitamin A. (89)

Addressing the media in Midrand this week, Dr Greg Hussey of the Department of Paediatrics and Child Health at the University of Cape Town said a national study set up by the Medical Research Council and the department of health was needed to address the problem. Sowetan 22 6 94

Vitamin A deficiency results in pneumonia, diarrhoea, malnutrition mouth ulcers, blindness and lung disease.

(89) ET 23/11/95

Dysentery outbreak kills 10 in E Cape

QUEENSTOWN: Workers in the Eastern Cape department of health and welfare have been sent to Mount Fletcher and Flagstaff to help contain a dysentery epidemic in which 10 people have died.

The department's deputy permanent-secretary Ms Siphiwo Stamper said the epidemic was reported on November 15.

In November last year a similar outbreak was reported, and contaminated water was found to be the cause.

Ms Stamper called on people to boil water before drinking it, and to ensure food was covered between meals.

Dysentery is an infection of the intestine which causes profuse diarrhoea with blood and mucus.

Other symptoms are vomiting, high temperature, stomach cramps and dehydration. — Sapa

SA faces diseases of affluence and poverty

Star 6/12/95 - (90)

Cape Town – South Africa's poorer neighbours have far more accessible health facilities than South Africa itself, says Health Minister Dr Nkosozana Zuma.

This country, with its combination of poverty and opulence side-by-side, had more serious health problems than most other Commonwealth countries.

Zuma was speaking at a press conference at the Commonwealth Health Ministers meeting in Somerset West. She said South Africa was faced with both diseases of affluence and poverty, and solutions to these would have to include both rich and poor sections of society.

Zuma has been elected chairperson of the conference, which has as its theme "Women and Health".

Delegates from more than 30 countries will discuss the role of women in health, and will also formulate practical steps to be taken by the Commonwealth in the health field and hopefully recommend how it can facilitate these, said Zuma. – Health Reporter.

Dysentery strikes Transkei village and kills 10

(89) Star 23/11/95

At least 10 people have died and scores more have fallen seriously ill in an outbreak of dysentery in a remote Transkeian village, an Eastern Cape health official said yesterday.

"The information we have received is that 10 people died over the weekend and on Monday.

"The outbreak is in an entire village," said Eastern Cape deputy permanent secretary of health Dr Siphiwo Stamper.

"This is a serious infection. We have already sent our environmental teams over there – the thing is to prevent a further spread of the condition, treat people and educate the people on how to prevent deaths.

"We are sending tanks with water to the area to stop people from using their own water sources until those have been checked by us," Stamper added.

He said dysentery deaths were avoided if patients made up for fluid loss by drinking plenty of fresh water.

Stamper said the outbreak was first reported to his office on November 15, and scores of villagers had since been taken to Flagstaff and Mount Fletcher for treatment.

But he said total patient numbers were unclear, as the poor communications in the area delayed the information reaching him.

"This is exactly the same area where it happened last year and then the water they were using was contaminated with human faeces. This year, we believe it is the same reason.

"It's typical where you have poor sanitary conditions in remote areas," Stamper said, adding that his department hoped to prevent the infection from recurring with improved environmental and health education in villages scattered across the province. – Reuters.

PEOPLE'S LIVES *Tragedy of under-development*

Thousands die from this disease

Sowetan 25/3/94

89

By Russel Molefe

■ SEVERE PAIN

Survivors disfigured for life:

NOMA, a little known disease in Africa and Asia, is killing thousands of children each year, according to the World Health Organisation.

Hundreds of survivors become handicapped and disfigured for life. The deaths and untold suffering caused by noma are mostly avoidable, say WHO officials who are concerned about the dreaded disease.

Noma, which has also been recorded in South Africa but not given much attention, is an oral disease which begins with ulcers of the gums, a condition that takes a wide variety of forms.

If not treated, it can progress towards noma through "transmission to the soft tissues in contact with periodontal lesions".

At this very painful stage, the cheeks or lips begin to swell, oedema appears and the patient's general condition deteriorates. In a few days the swelling becomes enormous.

The gangrenous process sets in and after the scab falls off, leaves a gaping hole in the face.

Mortality rate

If the patients do not get treatment on time, the mortality rate is 80 percent, says the WHO. But if the condition is detected early, it can be prevented from progressing by simple disinfection procedures and by administering common antibiotics.

"Noma today is yet another tragedy of poverty and under-development. Does that mean we must wait until the socio-economic conditions of the countries concerned improve?" asks Dr Hiroshi Nakajima, secretary-general of WHO. With oral diseases on the increase, their treatment costs spiralling and most of them rapidly becoming fatal, the WHO has devoted World Health Day on April 7 to oral health.

Devoting the day to oral health whose theme would be *Oral Health For a Healthy Life*, Nakajima says the WHO is endeavouring to mobilise member states, the health professions and the general public so that more attention can be paid to this important aspect of public health.

Nakajima says the situation is deteriorating in many developing countries where oral diseases are on the increase and treatment costs spiralling.

"Yet oral diseases are not an inevitable corollary of development. We have the means to prevent this health and economic disaster.

"In particular, care for the elderly should be strengthened to prevent the oral health problems linked with age. At the same time, prevention among children and adolescents must continue," Nakajima says.

In South Africa, more than 90 percent of adults suffer from dental caries (damage caused by tooth decay) and 93,5 percent from periodontal diseases (diseases of the gums).

Survey

Department of National Health and Population Development spokesman Ms Tienie Holtzhauzen told *Sowetan* that a survey conducted recently involving 16 000 people recorded only one case of noma in Namibia.

Holtzhausen says not a single case of noma has been recorded in South Africa. She says experts have indicated that noma is rife in West African countries.

However, it is believed that the disease could have already started to have effects in South Africa, especially in rural areas, where drought threatened the survival of mankind in the past two years.

The Aids epidemic has also resulted in many patients suffering from oral fungal infections, destructive ulcers and untreatable cancers. Most do not even receive simple palliative care.

Sowetan has also established that only people living in major cities get reasonable treatment for oral problems. Most rural and many poor urban communities have almost no access to even basic emergency care and relief of pain.

For many, especially in rural areas, dentistry is still "pain and pay".

Then WHO has drafted a programme focusing on six areas which it is hoped will eradicate the ever increasing oral diseases described as "health and economic disaster". The six areas are:

- Ensuring that essential preventive activities are maintained so that gains already made were not thrown away;
- Demonstration of the new techniques for basic, health promoting and economically feasible oral treatment to the public;
- Preparation of learning materials such as posters, videos and computer-assisted learning packages;
- Preparation of well designed technology for the new care — basic materials, instruments and drugs;
- Building a support network to assist communities to care for and repair children maimed by destructive diseases like noma; at the same time leading a campaign, based on improved nutrition and basic child care to prevent such illnesses; and
- Bringing about a radical change in education of oral health care professionals.

wearing eastern print sarong kebaya airline uniforms and chinese "lion" dancers, right.

Heart disease 'new threat to SA blacks'

(89) (93) ARG 26/3/94

Weekend Argus Reporter

UPWARDLY mobile South African blacks are at great risk of developing coronary heart disease.

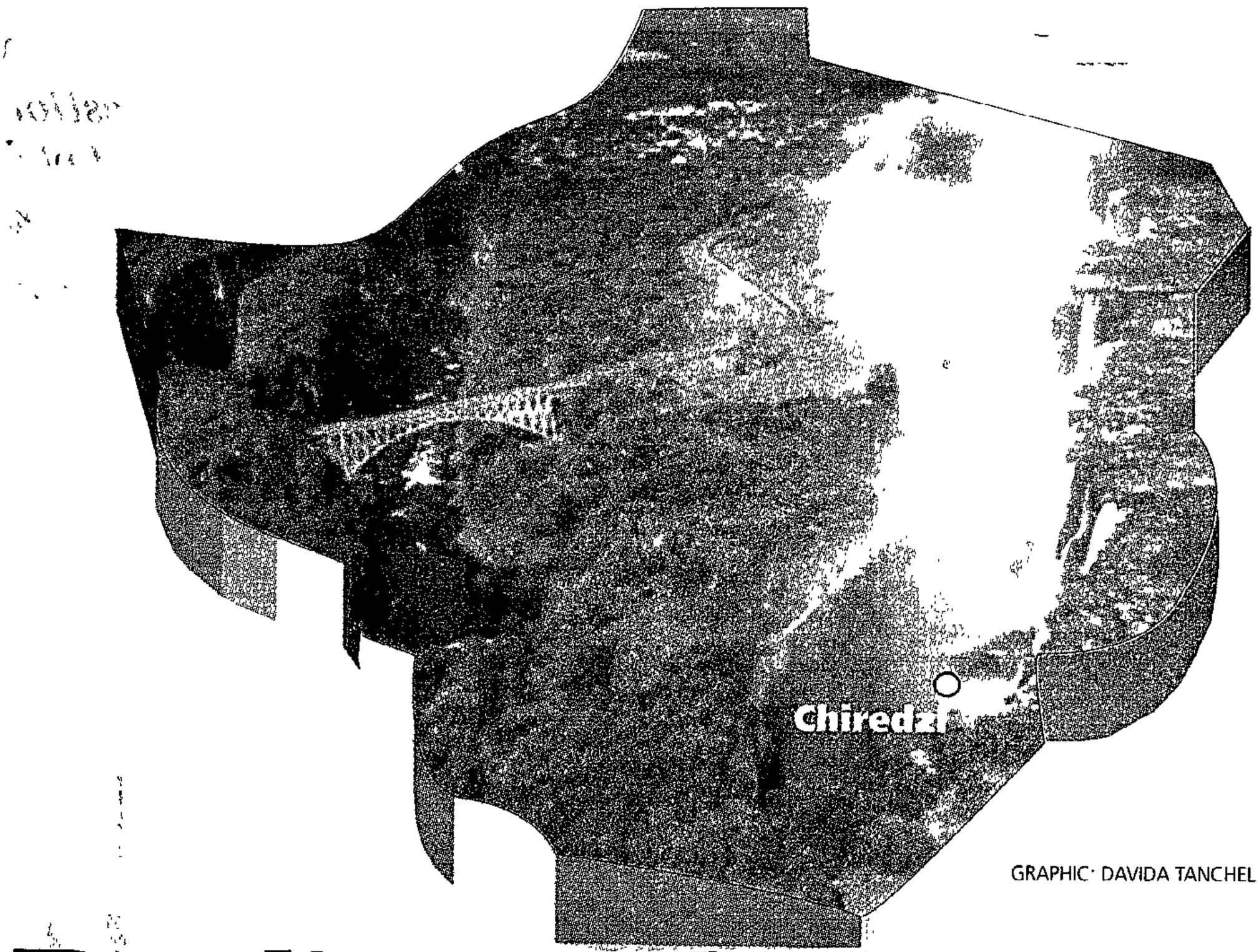
This is the opinion of national chairman of the Kenyan Medical Association William Lore, who yesterday addressed cardiovascular researchers at the Medical Research Council.

Professor Lore said that as black people gained independence and moved into higher social strata, they became more sedentary, had more stress and ate more salt and fats.

He said high blood pressure and coronary heart disease were almost non-existant among black people in Kenya at the turn of the century, but after independence health workers noticed a sudden emergence of both.

"Rural-urban migration and Westernisation have some relationship with the development of high blood pressure, diabetes, smoking and obesity," Professor Lore said.

"All of these can lead to coronary heart disease."



GRAPHIC: DAVIDA TANCHEL

Battling malaria in the Chiredzi sugar fields

Star 7/14/94

The notices by the roadside on the approach to Chiredzi are unequivocal: you are in malaria country and malaria kills.

Last month more than a dozen people were reported to have died at Mberengwa in Zimbabwe's Midlands province, and hundreds succumb to the disease nationwide each year

But the work being done at Chiredzi helps to refine the national control effort — for bilharzia as well as malaria.

What has made Chiredzi such a good research area?

Sweltering

Listen to Moses Chimbari, officer in charge of the ministry of health's De Beers Laboratory in this sweltering southern town.

"This place used to be called a wasteland," he says.

"Nothing grew here, and neither malaria nor bilharzia were much in evidence.

"There simply wasn't enough water, and rainfall was low. Then in the mid-1960s sugar-cane arrived, and with it canal irrigation."

But a lively health ministry saw the dangers immediately. Spurred by a knowledge of the water-related health problems caused by the irrigation schemes served by the Aswan Dam in Egypt, the ministry insisted that careful control and monitoring be introduced by the sugar-cane companies from the start.

The result was the erection of the De Beers Research Lab in Chiredzi which, by 1966, had been handed over to the ministry and attached to the famous Blair Research Institute of Harare.

The process of sugar-cane irrigation, via concrete canals to holding dams, and from there to the plantations where excess water often stands for some time, has created ideal conditions for the proliferation of the *malaria vector*, and the snails responsible for the spread of bilharzia.

Measures taken by the sugar estates themselves (motivated by the desirability of maintaining a healthy workforce), and careful monitoring by the ministry of health, have ensured that both diseases are controlled.

Only about 10 percent of the local population, for example, are these days affected by bilharzia; and a system of ensuring prophylaxis consumption among sugar workers and their families, and education programmes, keep malaria at bay.

89

Irrigation

"But of course the conditions created by extensive irrigation make Chiredzi an ideal place for research," Chimbari explains

"We're working in the estate villages themselves, and also in those communities in the surrounding communal land."

Research is currently going on into the effectiveness of new insecticides (for the spraying of the inside of huts) and new larvicides (for the treatment of standing water), while the nature of the relationship between malaria and Aids is also under the microscope.

Chimbari's own special interest is in the biological control of bilharzia. After taking an initial biological sciences degree in Lesotho, Chimbari is now registered with Copenhagen University for a doctorate on the possibility of using fish to control the bilharzia snail.

"I'm looking at two species which I've brought down from Kariba," he says, "one which I think will eat the snails directly, the other which prefers the weeds off which the bilharzia snail feeds."

He already has a few of the latter species in a pond in the grounds of the De Beers Laboratory. He tosses on to the surface a few blades of grass and we watch as the fish cause some turbulence in their haste to devour it.

I ask if this is original research.

"Is any research ever original?" he replies. "Everything is built on a foundation laid on the work of others. In my own literature search, I have come across useful contributions from several parts of the world, including South Africa."

TRENDS
The Star
THURSDAY APRIL 7 1994
Edited by Marika Sboros

Co-operation between departments vital

One of the most important lessons to be learnt from the introduction of major irrigation schemes in the Chiredzi area of Zimbabwe is the need for full and formal co-operation between various involved departments.

Moses Chimbari, head of the De Beers Research Laboratory in Chiredzi, cites the example of the Gezira irrigation scheme in the Sudan, designed to stimulate cotton farming, but which has caused frequent malaria epidemics resulting in serious loss of production, and which has also pushed the incidence of bilharzia to above 70 percent.

Chimbari's recommendations include:

- Specific consideration of all health implications should be a compulsory addendum to water project proposals.
- All environmental health workers should be made aware of water development-linked disease.
- The dialogue between departments should be facilitated by a special co-ordination body
- Special provisions must be made to oversee the health implications of private water schemes.
- All the costs of measures against water-related diseases must be included in all major water projects
- An awareness campaign should be launched to ensure that the proposed health impact assessments for all water projects are not seen simply as increased red tape.

HEALTH NET AFRICA

DISEASE CONTROL

Zimbabwe is benefiting from a research programme designed to help combat the spread of malaria and bilharzia. **DAVID ROBBINS** reports from Chiredzi.

TOMORROW

A fall on the head led Thomas Kgope in an artistic direction.



LONG-TERM PATIENT . . . but unlike the older lepers at Westfort, Aggie is able to lead a more normal life **Picture: JON HRUSA**

No visitors for the leper whose home is hospital

ST Times 17/4/94

By CAS St LEGER

FOR 52 years, the serenity of a turn-of-the-century hospital has been the only home that "Groen", a leper, has known.

The 77-year-old patient has not had a single visitor since he was admitted to Westfort hospital outside Pretoria in 1942.

He lost both his legs in 1958 after they went septic, and leprosy has left him with damaged facial muscles.

Before he was confined to his wheelchair, he kept himself busy by working in the hospital gardens. Then he was made "foreman" of the patients.

Groen regards the hospital as his home — he has no children, and has nowhere else to go.

Another leper, Sarah, has been a patient for 66 of her 80 years. She was cured of her leprosy many years ago, but, like Groen, she has no other home.

When Sarah arrived at Westfort hospital from Bethlehem in 1928, she was a plump, pretty 14-year-old who had lost the feeling in her hands and feet.

"I was sent here by the government," she said.

Now she spends her days dozing, her fingers reduced to stumps by the disease.

She does know, though, from radio and the hospital TV, that an election is coming up. "I want to vote," she says.

She has no family and is vague about her age. "I can't remember," she smiles.

A proud nursing sister retrieves her original file, complete with Sarah's yellowed admission photograph.

When Sarah and Groen were admitted, Westfort was a busy leprosy hospital with more than 1 000 patients.

Such is South Africa's success in treating the disease that there are now just 40 patients, with numbers dropping every year. There were 58 admissions in 1990, compared with hundreds in the 1960s.

Former leprosy wards have been filled with an overflow of about 400 mental patients from Weskoppies hospital.

As a testament to the former population of Westfort, four little churches stand empty on overgrown land. Several of the hospital buildings are in line to be declared historic monuments.

Many of the original Westfort patients came from the old leper colony on Robben Island, in the days when the disease was thought to be highly infectious.

That is one of the many misconceptions about this ancient disease. "Unlike TB, leprosy has a very low rate of infectivity," said Dr Louis Shulman, Westfort's acting superintendent. (89)

In 30 years, not one nurse has contracted leprosy.

The other misconception is that leprosy causes fingers and toes to drop off.

Dr Marie Beyers, medical officer in charge of leprosy at Westfort, points to the stumps of 41-year-old Aggie's fingers.

"Look. She still has her fingernails," she said.

Dr Beyers explained that rather than Aggie's fingers dropping off, micro-fractures of her bones had caused them to become shorter.

Unlike the older patients, Aggie, of Rustenberg, is able to live a more normal life. She has a husband, who is a mine transport officer, and three children.

She pays nothing for her treatment, and goes home "on holiday".

Leprosy is a disease of the nerves. Like tuberculosis, it is caused by bacteria. Unlike TB, the patient does not feel ill.

Today, with intense multi-drug therapy for six weeks, plus treatment and monitoring for at least two years, a 100 percent cure rate was possible, even in severe cases, Dr Beyers said.

Patients plead at hospital hit by strike

AAG 30/5/94

☐ Mediators in bid to end crisis

The Argus Correspondent

DURBAN. — Hospital authorities at Durban's King Edward VIII Hospital were this morning awaiting the arrival of two senior health officials to act as mediators in a bid to end the four-day strike by nurses and cleaners.

Patients at the hospital this morning petitioned a superintendent, pleading for medical treatment as soon as possible.

Many of the outpatients who joined the petition had appointments at the clinics run at the hospital.

But senior medical superintendent Ahmed Badat said management was unable to accede to the patients' request until those on strike returned to work.

KwaZulu-Natal's designated Minister of Health, Zweli Mkhize, and former KwaZulu health chief Darryl Hackland have been asked to negotiate between the hospital management and members of the Workers' Forum.

Most nurses, general assistants and cleaners began the strike on Friday to protest against the dismissal of four nurses from the hospital nurses' residence.

The nurses were alleged to have assaulted another nurse. Charges had been laid against the nurses, hospital sources said.

The Workers' Forum claimed the nurses were dismissed unfairly, but had not yet put their claims formally to the management, said chief superintendent Lal Dwarikarpersad.

"We would like to hear from them as soon as possible — otherwise it will be impossible to resolve the strike," he said.

Dr Badat said the strike had left the hospital "chaotic" since Friday.

"The entire hosital has been hit. Conditions have worsened as we are now entering a fourth day without essential services.

"Patient care is being compromised."

Some nurses had continued to work in "high-care" areas like the labour wards and intensive care units.

"General wards have been completely abandoned," he said.

About 200 patients had been transferred to other Durban hospitals.

Meals were being served — and general cleaning was being done — by volunteers.

Doctors were helping with feeding and providing medication, said Dr Badat.

Clinic Holdings nets healthy profit

(89)
CT 1/6/94

From MARCIA KLEIN

JOHANNESBURG. — Private hospital group Clinic Holdings (Clinics) increased its attributable profit 15,6% to R19,1m (R16,6m) for the six months to March, and announced the acquisition of two hospitals from its controlling shareholders.

Directors said the group, whose hospitals include the Park Lane, Milpark, Garden City and Rosebank, operated in a period fraught with uncertainty and a difficult trading environment.

The group was able to lift turnover 21,1% to R324,3m (R267,7m) and operating profit 18,5% to R62,4m (R52,6m), despite modest tariff increases and amendments to the Medical Schemes Act.

Changes in the structure of finance charges — with no more rent paid and higher interest — reflected the effects of the completion of the merger of the property interests and hospital trading operations.

Fully diluted earnings were 12,6% up at 18,8c (16,7c) a share. But the dividend was maintained at 6,5c in line with the intention of achieving a three times cover.

A director said the important feature of the reporting period was the acquisition of the entire shareholding of the Krugersdorp Hospital and an effective 89,2% interest in Greenacres Hospital in Port Elizabeth from the controlling shareholders of Clinics. Clinics also gets complete ownership of the properties.

The total consideration was R21,9m, of which R14,7m was payable in cash with the balance payable on December 1 1995.

The controlling shareholders — the Hurwitz family and directors — have been buying or developing hospitals, but not bringing them into the listed group until they offer a good return. This ensures there is no roller-coaster effect on earnings.

This is part of Clinics' stated policy of acquiring additional hospitals once they are fully established to generate suitable profits. The director said that, since its 1987 listing, it had been Clinics' intention to acquire the controlling shareholders' interest in seven hopitals. The acquisitions represented the first two in this process.

Directors said the new dispensation should stabilise business conditions. The private healthcare industry would "participate meaningfully in the expected new socioeconomic initiatives".

Workers toyi-toyi in support of colleague

(89) CT 3/6/94

Staff Reporter

ABOUT 150 Lentegeur Hospital staffers yesterday stopped work and toyi-toyied outside the hospital's administration block for about two hours in support of a colleague they claim was transferred without warning.

"We've had enough," workers said, expressing general unhappiness with victimisation, poor management and understaffing. One nurse said they were expected to staff a ward on their own at night "with 30 psychotics".

National Education, Health and Allied Workers Union (Nehawu) shop steward Mr Wayne Weitz said the work stoppage between 10am and noon was not a strike action but rather a supportive gesture to "make management" heed their demands.

Senior staffer Mrs Lana Maart had returned from maternity leave on May 2 to be told she would have to report for duty at the outpatients section.

According to a Nehawu and CPA recognition agreement she should have been given a 10-day warning before being transferred, Mr Weitz said.

The union discussed the issue with hospital management, but on May 30 Mrs Maart was told if she did not report for duty at outpatients by June 1, disciplinary action would be taken against her.

Lentegeur medical superintendant Dr J P Müller said negotiations with the union would continue. Only a small percentage of the hospital's workers were dissatisfied with the working conditions, he said.

Child care workers protest against conditions, R6 pay

South 3/6- 7/6/94

By Edwina Booysen

CHILD CARE workers at a place of safety are up in arms because they have to work with children — some of whom are hardened criminals — without protection and, in some cases, their take-home pay is a measly R6 a month. 355

"We enjoy our work and consider it a vocation, but we cannot work for free. We have families too and we cannot afford to get hurt," Mr Edward Cook, a child care officer at House Bonnytoun Place of Safety, said. (452)(89)

Cook and about 50 Bonnytoun child care workers held a placard demonstration outside the Wynberg school's premises on Monday morning to highlight their grievances and call on the government to guarantee their basic human rights and safety.

"We felt that this was the only way, short of a general strike, to express our displeasure at the apparent lack of concern for our needs," Cook said.

"Since 1991 we have been asking, no, pleading, for a better deal, for better conditions and compensation.

"We work in dangerous conditions with children who are sometimes hardened criminals and for our pains some of us earn less than R50 a month. Some earn less than R6 after deductions. How can you care for a family on that?"

Cook said a prison culture existed in the school because children of all backgrounds are placed together.

"Gangsterism is rife, crude weapons are manufactured and sodomy is not uncommon," he said.

"Hardened criminals are placed with those who are simply referred by the courts because their behaviour at home has been uncontrollable. And we can get hurt trying to protect the innocents."



HUMAN RIGHTS: About 50 childcare workers protest about low wages Photo: Yunus Mohamed

The workers are demanding that the government ensures their safety by providing exits within dormitories, pay night shift allowances and "danger pay", compensate them for overtime, the registration of child care workers to ensure that child abusers cannot be employed in a children's facility and that children's ages be proven upon admission.

The National Education, Health and Allied Workers Union (Nehawu) is starting negotiations with the government on behalf of the Bonnytoun workers on June 6.

The Department of Education and Culture Services had not responded to a request for comment at the time of going to press.



DRENCHED DELFT: A flooded street is an obstacle for this motorist. (89)

Health authorities probe baby deaths

ARG 22/6/94

Cold homes blamed for pneumonia toll in Delft

DAVID YUTAR and JOHN VILJOEN

Staff Reporters

HEALTH authorities are investigating claims that six Delft babies who died in the past two weeks of pneumonia became ill because they they lived in cold homes provided by the Cape provincial administration.

Meanwhile, a Delft mother has described the horror of discovering her baby daughter dead after a cold Cape Flats winter's night.

Over the past week between 50 and 60 Delft residents have occupied the offices of the provincial administration demanding an investigation of the deaths in the past two weeks of six infants aged between one and two months.

Cape Housing Minister Gerald Morkel met the residents' representatives to discuss the babies' deaths.

A spokesman for the Department of Housing said the department was trying to verify the residents' allegations and until it was able to do so it was impossible to make a statement.

He said the oldest houses in the area were no more than five years and this was the first time such complaints had been made.

The houses were erected in full compliance with the regulations of the Building Federation of South Africa and they also complied with the minimum local authority requirements, he said.

It was impossible for the department to respond to the allegations until doctors' medical reports were furnished, but these were proving difficult to obtain because at this stage the identity of the affected families had not been made known.

Chief director of health services for the Cape Regional Services Council Stewart Fisher said health inspectors were investigating the allegations.

Belinda Engeland, who lives in a part of Delft known as Eindhoven, found her two-month old daughter Charlene Esmeralda dead on the morning of June 5.

Charlene had appeared healthy and content the previous day and when she tended to her in the night, Mrs Engeland said.

But when she saw Charlene in the morning, she screamed and told her husband: "My child does not look right." The toddler was lying lifeless, her face at an odd angle, Mrs Engeland recalled. The cause of death was pneumonia.

Welcoming an Argus team into the home, which costs R221 a month to rent, Mrs Engeland said she and her husband had moved there because the alternative was a 15-year waiting list. "That's what the housing people told us."

But the Cape winters are bitter for this and other Delft families.

Part of her house was flooded after heavy downpours, Mrs Engeland said

She also complained that the house's inner walls were flimsy and gradually falling down.

A major gripe is that her home has no ceiling — whatever warmth is generated within the house escapes into the night air.

The R18 388 asking price for the house was "a lot of money" if you still had to put in a ceiling, said Mrs Engeland.

Delft resident Richard van der Byl condemned the houses as "fridges".

He was sceptical about their survival in the sandy Delft terrain.

"These houses are not going to stand here long. This is not the right place to build houses," he said.

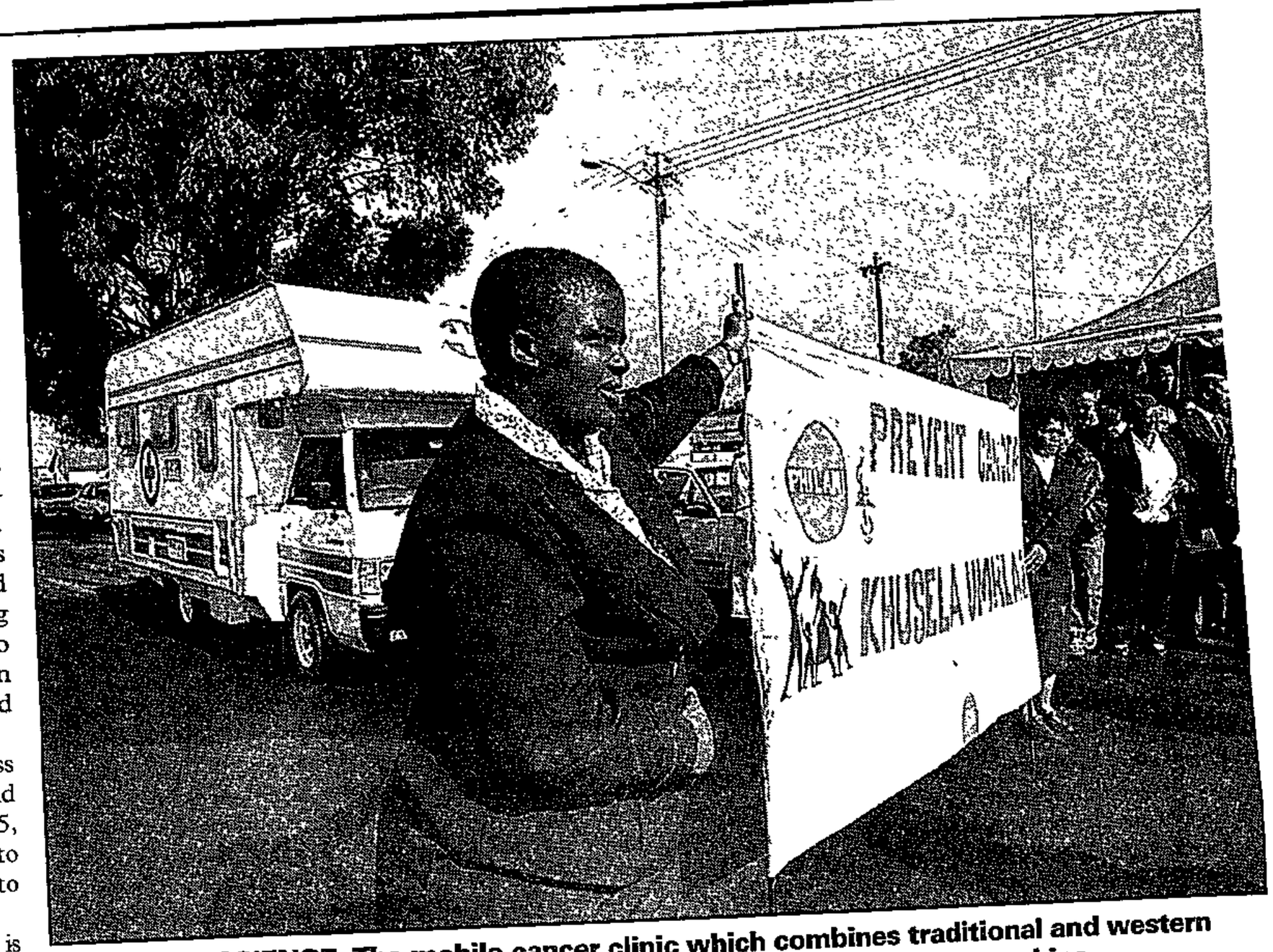


Pictures. ROY WIGLEY, The Argus.

GRIEVING MOTHER: Belinda Engeland in the Delft home where her baby daughter died of pneumonia. It's a battle for her and children Selwyn, five, and Leticia, three, to endure the cold.

South (89) 8-12/7/94

Mobilising against cancer



SANGOMA SCIENCE: The mobile cancer clinic which combines traditional and western medicine recently celebrated its first anniversary of working in the townships

AN EXCITING mobile hospital that combines the scientific medicines of the West with the traditional medicines of the sangomas to battle cancer in the townships celebrated it's first anniversary recently.

Philani is the first centre of its kind in the world and has recorded tremendous success in identifying cancer victims at an early stage so that they can be cured, and in demystifying the disease and encouraging people to seek help.

The mobile hospital travels across the Peninsula visiting townships and informal settlements from Site 5, near the tip of the Peninsula, to Imizamo Yethu in Hout Bay, to Khayelitsha.

Its advantage over day hospitals is that patients receive the results of any tests done immediately.

Spokesperson for the project, Ms Amanda Botha, said when day hospital patients were told to return in two or three weeks for results of their tests, they usually didn't turn up. And if tests had proved they had cancer, the hospital spent valuable time trying to track them down.

Co-ordinator of the project, Sister Linda Qiba, said one of the problems with cancer was that patients were usually very ill before they realised they had it.

The hospital not only to identify and cure cancer patients but also to educate people to recognise early warning signs of cancer.

She said the mobile hospital with its staff of two doctors, two sangomas and a large number of nursing sisters had a great deal of success in preventing cervical cancer which kills more women in the country than any other cancer. If women had pap smears every six months, it could be identified at an early stage and easily cured.

Sister Linda said a large part of the hospital's success could be attributed to the sangomas.

"The sangomas play an important role, not only in attracting people to the hospital but also explaining to them what cancer is.

"The people trust the sangomas and if they say the people must use western medicine then they do.

"Many people believe cancer is a 'devil' or an 'evil spirit'. The sangomas explain to them that this 'devil' can be cured with medication," she said.

Anyone interested in finding out more about Philani can phone 6841841/2. **BY SHANNON NEILL**

Keeping cholera at bay

Souku

THE Disaster Committee, chaired by regional health minister Mr Ebrahim Rasool is taking precautionary measures in flood-ravaged areas to prevent outbreaks of the killer diseases cholera and polio.

Health co-ordinator of the committee, Dr Norman Kahlberg, said although there were no problems with the diseases at present, the health services were taking steps to ensure there was no epidemic.

"In the squatter areas a lot of people didn't come for regular immunisation. The health department is to have these people immunised," he said. 8|7 - 12|7|94

He said the diseases flourished where there were problems of dirty drinking water and pools of sewerage. (89)

"The damp and wet will obviously affect any respiratory problems people have. The day hospitals have reported an influx of people with chest infections but there's been no swamping of services.

"At present the health services are functioning well. There is a shortage of doctors at some treatment centres but this is being addressed right now," said Kahlberg. **BY SHANNON NEILL**

Paraffin is main cause of poisoning

Cape Town — The drinking of paraffin is the biggest cause of poisoning among children in South Africa, according to the South African Medical Journal. 11/11/94

A report in the latest issue says the finding is a result of research by Medunsa at the Ga-Rankuwa Hospital in the Northern Transvaal and by the National Trauma Research Programme in the Cape Peninsula.

One of the main reasons was that the liquid was often stored in soft-drink bottles, resulting in it being mistaken for water or a soft drink.

The research at the Ga-Rankuwa Hospital showed that paraffin had caused 78 percent of cases of acute accidental poisoning among children entering the hospital.

The Cape research showed 436 cases of paraffin poisoning in six hospitals in 1990.

Extrapolating the figures indicates that 16 000 children a year were being treated for paraffin poisoning. — Sapa (89)

ARG. 15/11/94 (89)

WHO meets over disease crisis

☐ Africa lagging in vaccination campaign

JOSEPH ARANES
Staff Reporter

FIGHTING polio, the "silent killer" neonatal tetanus and measles, was the focus of discussion at a World Health Organisation (WHO) meeting in Cape Town.

Health officials from 15 African countries involved in the implementation of the organisation's expanded programme on immunisation (EPI) began discussions yesterday. The programme ends on Friday with a meeting of the task force on immunisation in Africa.

Nicholas Ward of WHO said the EPI prevented 3 million deaths annually and, on some continents, had effectively eradicated the spread of diseases such as polio.

"In the Americas, through the EPI, the spread of polio has been effectively beaten and we are on course to kill off the disease globally by the year 2 000.

"The number of reported measles cases has dropped dramatically since the EPI began in the 1970s and as with polio we hope to stop the spread of the disease completely.

"We have set ourselves a goal of preventing 95 percent of cases by next year, and already 90 percent of cases are being prevented," Dr Ward said.

But in Africa coverage was declining rapidly. Civil unrest and wars, logistics, reduced resources and the generally poor management of the campaign were identified as the reasons for the immunisation set back in central Africa.

Provincial Minister of Health Ebrahim Rasool, who opened the conference, called on African countries to make the EPI a major success on the continent.

He said that with the limited resources in the region, it was of great importance to continue to improve surveillance to develop the capacity to monitor disease routinely and accurately, identify risk areas and direct immunisation activities to areas of greatest need.

"Only by the joining of our efforts will we be able to reach the common goals set for immunisation in this region."

Neil Cameron, the Health Department's director of communicable disease control, said the department had recently reviewed the EPI programme in South Africa and presented its findings to the government.

"On the whole the immunisation programme is going well, but at some clinics the staff are not sensitive enough about its importance.

"We need to ensure that the national policies on the programme filter down to people working in these clinics."

Dr Cameron said the department would set up a national EPI unit and one in each province, and would implement the WHO's new EPI schedule from April.

Deadly new disease spreads in Durban

(89) Star 25/2/95

DURBAN medical teams are on the alert following the outbreak of a contagious disease which has appeared in South Africa recently. CATHY MOLONEY reports.

DURBAN — Six people have died in Durban and hundreds more have become infected with a new and highly contagious disease that is spreading through the city's informal settlements in epidemic proportions.

Lack of proper sanitation and clean water are ideal breeding grounds for the disease. Durban's growing and overcrowded squatter camps and other informal settlements could become cesspits for the deadly bacteria known as Shigella dysentery type 1.

"It causes a particularly severe bloody, mucoid diarrhoea," according to University of Natal Medical School paediatrician Dr Nigel Rollins.

Other problems associated with the disease are perforation of the bowel and kidney failure.

Resistant to conventional dysentery antibiotics, which only stem, but do not cure the disease, this is the first time Shigella has appeared in South Africa.

Rollins said the first reports of the disease came from areas around Durban, Inanda and Umbumbula, about three to four months ago but it has rapidly spread to urban areas in Durban. About 30 to 40 children have been admitted to King Edward Hospital with the disease in recent months.

Unlike other dysentery, Shigella is far more contagious and affects all age groups rather than just the old and very young.

Rollins said the disease tended to erupt in massive outbreaks, but said he did not want to cause a panic, although people did need to be made aware of how serious it was.

Epidemics of Shigella have spread through Bangladesh, Thailand, Mexico and Burundi in the past 10 years. Contamination is through contact with an infected person and subsequent contamination of food and utensils.

Infectious

"Identified originally in 1898, and in South Africa in March 1994, Shigella has commanded attention because of its particularly infectious and virulent nature.

"Basic personal hygiene, washing hands regularly, especially when preparing food will stop the likelihood of it being passed on," said Rollins.

It is essential that infected people seek medical attention immediately. Doctors or clinic staff who want further information should phone (031) 260-4348 or (031) 260-4355.

Mandela to announce plan to rid SA of polio scourge

(89)

ROGER FRIEDMAN
Staff Reporter ARG 29/3/95

STEPS to rid South Africa of polio once and for all will be announced by President Mandela on World Health Day next week.

The president will spend the day in an as yet unspecified "poverty-stricken area", health department officials said.

World Health Day, April 7, will be celebrated across the globe under the slogan: "A world without polio".

In 1988 the United Nations World Health Assembly set the year 2000 as the target date for the global eradication of polio.

Last September an international commission led by Nobel laureate Frederick Robbins officially declared the Western hemisphere polio-free.

Although there has not been a case of polio in South Africa since 1989, the infection has been encountered recently in Namibia — and it was premature to think that South Africa had seen the last of it, health department officials said at a Press conference yesterday.

As Hiroshi Nakajima, director-general of the World Health Organisation put it in his World Health Day message: "Before we can sit back and enjoy the benefits of polio eradication, the job has to be completed.

"There is a need for national immunisation days to be organised, sustainable supplies of good quality vaccine to be stocked and delivered, for personnel to be trained, and for epidemiological surveillance to be established."

President Mandela's announcement is expected to be in keeping with the needs identified by Dr Nakajima.

The MINISTER OF CORRECTIONAL SERVICES:

(1) Yes. The Department of Correctional Services has an "Aids Strategy", which was compiled in conjunction with the Department of Health, of which a copy will be provided on request.

(2) Yes.

(a) These prisoners are kept in separate sleeping quarters as a preventative measure.

(b) These prisoners are under supervision during working hours but they can mingle freely with other prisoners at work, school or recreational/social activities.

(3) No.

(a) Falls away.

(b) Testing is only done on the advice of the medical practitioner and after the prisoner has been informed and has given his written consent for the tests to be done.

(4) Yes. It was found that the testing procedures are Constitutional and also in accordance with the "Statement of Principles" of the National Aids plan as published by NACOSA and the "general principles" of the World Health Organization regarding Aids in Prisons.

Cases of typhoid fever treated at Usher Memorial Hospital (89)

118. Mr G Q M DOIDGE asked the Minister for Health: Hansard 31/3/95

(1) (a) How many cases of typhoid fever were treated at the East Griqualand Usher Memorial Hospital during the period 1 December 1994 up to and including 28 February 1995 and (b) from which districts did the patients originate in each case;

(2) whether her Department is taking any action with a view to addressing the cause of the disease in respect of these cases; if not, why not; if so, what action;

(3) whether her Department has made any investigations in respect of the water supply to the Mount Ayliff Hospital; if not, why not; if so, what are the relevant details;

(4) whether a report has been submitted in this regard; if not, why not; if so, on what date;

(5) whether such report is available; if not, why not; if so, what are the relevant details?

N209E

The MINISTER FOR HEALTH:

(1) (a) Four (4) cases.

(b) The patients originated from Umzimkulu, Mount Ayliff, Flagstaff and the address of one is unknown.

(2) The Senior Medical Superintendent of Usher Memorial Hospital notified the Eastern Cape Provincial Health Authority by letter. patients admitted to the hospital were interviewed by Kokstad Municipal Health Officials in an attempt to establish the source of the infection. Five (5) river samples were taken from local rivers—up to 35 km into the Eastern Cape. These were all negative. No clustering of cases was detected.

(3) Investigations in respect of the water supply to the Mount Ayliff Hospital were conducted by the Environmental Health Officer, Mount Ayliff, and a report was submitted to the Eastern Cape Provincial Health Authority—who is well aware of the problem and is attending to the matter—on 18 November 1994.

— The hospital receives water that is not safe for drinking purposes from the Municipality of Mount Ayliff.

— The hospital has two underground sources (boreholes), one of which was recently fitted, tested and put to use.

— Further investigations revealed that the problem of correcting the water supply lies with Local Government (Department controlling the Municipalities) and the Department of Agriculture (the water authority).

(4) A report has been submitted to the Eastern Cape Provincial Health Authority on 18 November 1994.

(5) The report is available—the details as described in paragraph (3) supra.

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Breytenbach, Mr W N—
Defence, 58

Cassim, Mr M F—
Water Affairs and Forestry, 205

Chiolé, Mr J—
Housing, 8

De Lille, Mrs P—
Land Affairs, 69

Geldenhuys, Dr B L—
Foreign Affairs, 2

Gibson, Mr D H M—
Transport, 63

Groenewald, Mr P J—
Safety and Security, 210

Jacobsz, Dr F P—
Welfare and Population Development, 382

Jiyane, Dr Z B—
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POLIO BLITZ

CP 9/4/95

SOUTH Africa could be proud that seven of out every 10 of its children had been immunised against polio, President Mandela said on Friday.

He was speaking at a World Health Day function at Sebokeng College of Education near Vereeniging. (89)

"Since 1992 we have had no cases of polio notified. This is good, but not good enough. We can and must do better. Let us join those countries which have already made history by eradicating polio altogether," he said.

"During the months of June and July we will be giving polio drops to millions of children in many parts of the country."

■ Children under the age of five will be immunised against polio at all Free State clinics in June and July, Senorita Ntlabathi, Free State MEC for health, welfare and population development, said in Bloemfontein on Friday. – Sapa.

Concern over low polio immunisation

(89) Star 7/4/95

■ BY DAVID ROBBINS
HEALTH WRITER

About 3 000 people are expected to listen to President Mandela today as he delivers his World Health Day message to the nation from the Sebokeng College of Education.

The theme this year is "Target 2000 — a world without polio".

Although no new cases have been reported in South Africa over the past five years, immunisation levels are low enough to cause concern.

"Our average immunisation coverage is around 70%," said Dr Rudi Eggers, immunisation coordinator at the Department of National Health. "This means that 30% of our children aren't immunised, and the percentage is much higher in some of the old homelands. The danger is that a single case could rapidly turn into an epidemic." The disease is rife in Angola and recent outbreaks have been reported in Namibia.

"Our target date for complete eradication is 1998," Eggers said. "This is when we hope to be certified polio free."

One of the things to be considered will be immunisation levels.

South Africa's target levels for immunisation against polio, and all other immunisable diseases, have been set at 90% by the year 2000.

Major technological advances have transformed efforts to eradicate polio, with scientists now able to analyse the polio virus in sufficient detail to draw up family trees.

Pneumonia still major child killer — Unicef

(89) CT 8/6/95

PARIS: Pneumonia still kills three million children a year, and Angola, Haiti, Somalia and South Africa have no projects to tackle it, the UN Children's Fund (Unicef) reported here today in a 1995 review.

Unicef estimated that one mother in two had lost at least one child that way in Guinea, Mali and Niger, and more than one mother in four in Ecuador, Egypt, Pakistan and Peru.

However, children's welfare and the condition of women are making progress around the world — though under-development remains a major obstacle to improvements, the report said.

Developing countries have more than 560 million children aged under five, and mortality rates remain high — 320 per 1 000 in Niger, 122 per 1 000 in India, compared with seven per 1 000 in Denmark. In Eritrea and Ethiopia, one child in five dies before the age of five.

Avoidable diseases and malnutrition are the big killers, claiming millions of lives, Unicef said.

Measles carries off between one million and two million children a year. A deficiency like lack of vitamin A handicaps more than 200 million. More than 67% of child deaths in India are linked to malnutrition, and 53% in Haiti.

On the bright side, cases of poliomyelitis (infantile paralysis) have fallen 75% in 10 years, and Unicef hopes to eradicate the crippling ailment by 2000. Anti-measles vaccinations have topped 90% in Cuba, Indonesia, Mexico and Vietnam, and nearly 50 countries are campaigning effectively against iodine deficiency.

Fertility dip

Unicef's inquiries showed that women wanted fewer children than in the past: On average 3,9 in Kenya compared with more than seven 15 years ago, 2,8 in Egypt against 4,1 a dozen years ago, and 2,7 in Peru as against the figure 14 years ago of 3,8. But sub-Saharan Africa recorded only a slight dip in fertility from 6,7 to 6,3. — Sapa-AFP

National campaign to beat polio

(89) Star 13/6/95

■ BY PAULA FRAY

Health officials in local authorities countrywide are gearing up for the start of a national polio immunisation campaign next week which targets all children under five.

The campaign forms part of the Government's commitment to eradicate polio — an infectious illness which occurs mainly in children.

The Western Vaal Metropolitan substructure alone aims to target more than 250 000 children in the area with two rounds of vaccine, according to Medical Officer of Health Dr Kobie van der Walt.

"The whole idea of the national campaign is to reach as many children as possible," said Van der Walt, explaining that the second vaccine dose was a follow-up programme.

She said the campaign in the Vaal areas would not just be at clinics: "We are going into the squatter camps ... we have developed a whole plan of action for the day and will be using volunteers."

In Greater Johannesburg, the Health and Social Services Committee has started preparations for the campaign which aims to give all children under the age of five, who are at high risk, a dose of oral polio vaccine on Wednesday; June 21 and to repeat the dose again on Wednesday August 2, according to a Johannesburg council report.

Health facilities, creches, shopping centres and community institutions have been identified as vaccine sites. Every available health worker and volunteers will be on hand to assist the local authority.

The project is of particular importance as the World Health Day message this year is "Target 2000 — a world without polio". Although no new cases have been reported in South Africa since 1989, immunisation levels are low enough to cause concern.

According to the Department of Health, immunisation coverage is around 70% — leaving 30% of South Africa's children susceptible to the disease which is rife in Angola. Recent outbreaks have been reported in Namibia and Mozambique.

■ For more information on polio immunisation in your area, contact your local authority.

be in SA, but the new publication would be tail-

Reform could save R1bn in illegal pension payouts

BD 19/6/95

Kathryn Strachan

MONITORING of the abuse of pension money, especially in poor rural services, points to government employees as the guilty parties, Natal University monitors say.

Francie Lund, a researcher at the university's centre for social and development studies, said closing up the loopholes would save R1bn from the overall social grants budget of R11,5bn.

The creation of racially separate welfare departments and the separate homelands and independent states administrations laid the foundation for the abuse, she said. Added to that was limited accountability, poor management and poor information technology.

"That was all that was needed for some people working within the systems to take advantage of loopholes and create new ones," she said.

In the past, whenever pension abuse was mentioned, fingers were pointed at the pensioners themselves. While there were cases of people managing to receive pensions before the stipulated age, or receiving double pensions, the reality for most had been difficulty in getting their legitimate pension paid regularly.

One cause of the problem had been that a number of different departments were involved in various phases of the process from application to final payment.

Death registers, for example, were kept by one department, usually justice. It was possible in principle for people in that department to register a death, but not forward the information to welfare. The payment continued to come back to justice "to deliver" — to themselves.

Officials from one department had used one fingerprint — any one would do — to apply for multiple pensions. These were processed by another department by people unskilled in fingerprinting.

Another source of abuse was the payment of government old age pensions to civil servants already receiving a civil pension.

"The good news is that the system can be cleaned up relatively easily," she said. "The main ingredients are available: the national plan for a central register of all SA citizens, the relatively low-cost technology to do the cleaning up; and — most important — the commitment of Welfare Minister Abe Williams, Deputy Minister Geraldine Fraser-Moleketi and senior officials in the welfare department to more efficient and honest governance."

Williams recently committed himself to cleaning up government's system of pensions and grants and acknowledged the possible involvement of officials in fraud.

Fears of diabetes epidemic in SA

BD 19/6/95 (89)

Kathryn Strachan

A STUDY has found that 8% of black people living in Cape Town are diabetic, sparking fears that a diabetes epidemic is emerging in SA.

Natal University diabetes unit specialist Ayesha Motala said people living in developing countries and impoverished communities were at greatest risk of developing non-insulin dependent diabetes. With the trend towards rapid urbanisation, more and more black people in SA were falling into these categories.

She said although non-insulin dependent diabetes was often regarded as less serious than insulin dependent diabetes, research had proved this was not the case.

"Ninety percent of diabetics have non-insulin dependent diabetes, and they are up to four times more prone to developing heart and kidney problems than healthy people."

Another indicator of the threatening diabetes epidemic was the high incidence of a condition known as impaired glucose intolerance.

People with this condition did not metabolise carbohydrates properly, and nutritionists believed these people would develop diabetes at a later stage.

Acquittals sh

Deborah Fine

The acquittal of eight AWB members on all counts of complicity in last year's pre-election bombings in Gauteng proved police had been "over eager to please their new ANC bosses" and had been prepared to lay charges "with absolutely no substance" against the AWB, the right-wing organisation's spokesman Fred Rundle said last week.

Rundle's comment followed a decision on Thursday by Transvaal deputy Judge President HCJ Flemming to withdraw 92 charges against AWB

How to make friends . . .



Making a splash . . . Russian far-right leader Vladimir Zhirinovsky claws his way back into the headlines, scuffling with a top talk show host and throwing orange juice into the face of regional governor Boris Nemtsov, whom he had called a 'scumbag' and 'bastard'. PICTURE: REUTER

National polio immunisation campaign under way

(89) Star 21/6/95

■ BY BONGIWE MLANGENI
CITY REPORTER

The national polio immunisation campaign, which targets children under the age of 5, took off in Soweto yesterday with about 10 children receiving their first doses of oral vaccine.

Today health workers will start with mass immunisation of children in the Greater Johannesburg area.

Local celebrities and Greater Soweto mayor Danny Kekana attended the launch of the campaign which is part of a national strategy to eradicate the illness.

To meet South Africa's target for complete eradication by 1998, all existing health facilities as well as many creches, shopping centres and community institutions have been identified as vaccination sites.

The services would also be provided at informal settlements, said TMC health and social welfare committee chairman Sizakele Nkosi-Malobane.

Soweto medical officer Dr Ngokoane Khomo pointed out that no new polio cases had been reported in Soweto for the past six years.

"By the year 2000 we want to be certified free of polio. If the advantaged people could go an extra mile to help the disadvantaged, we would be able to fight most of the [illegible] problems here," she said.

According to the Department of Health, immunisation coverage is around 70%, leaving 30% of South Africa's children susceptible to the disease which is rife in other African countries.

POLITICAL BRIEFS

New campaign to fight polio

(89)

THE Health Department launched an immunisation campaign earlier this week to eradicate polio by 1998, Health Minister Dr Nkosazana Zuma said in her budget vote speech yesterday.

● By the year 2000 the department hoped to reduce by 70% the number of deaths of children under five due to measles.

● Altogether R90 million of the RDP fund had been allocated to upgrade clinics.

● A total of 5,6 million children from 13 167 schools were being fed under the Primary School Nutrition Scheme.

CT 22/6/95

Malaria: New clue to survival

(89) CT 20/7/95

LONDON: A relatively harmless enzyme deficiency protects up to half of all people who have it against malaria, doctors report in the journal Nature today.

Researchers at Oxford University said glucose-6-phosphate dehydrogenase (G6PD) deficiency was passed on genetically.

"The common African form of G6PD deficiency is associated with a 46 to 58% reduction in risk of severe malaria for both females and males," they said.

There are up to 500 million cases of malaria a year, 90% of them in Africa. It causes between 1,5 million and three million deaths a year. — Reuter

Australian funds for diarrhoea treatments

ARG 27/7/95 (885) (89)

Health Reporter

THE Australian government has given R210 000 to the Medical Research Council for a project to train nurses at rural clinics in two methods of treating diarrhoeal disease and dehydration in babies.

Deaths from diarrhoea account for 27,7 percent of fatalities in children under five in South Africa. Causes of gastroenteritis are linked to the availability of safe water and sanitation, problems which will take some time to address.

The MRC project aims to improve the management of dehydration through two innovative devices.

The Infusofeed balloon system, an Australian invention, rehydrates babies with a nasogastric tube which drips fluid into the child's stomach. Tested in Lesotho, the method has been shown to reduce mortality. As the device does not constrain the child as an intravenous drip would, the baby can be carried and breastfed by the mother during the rehydration process.

The second device — the Manz meter, developed by the MRC's health technology research group — assesses dehydration and the process of rehydration in a safe and sensation-free procedure taking about 20 seconds.

The grant money will be used to train nurses to use these devices on site at six clinics. The nurses will then be responsible for gathering data to evaluate the effectiveness of the devices.

now Peoples Bank: AMANZIMTOTI; ATHLONE; BETHEL; BELLVILLE; BENONI; BETHLEHEM; BLOEMFONTEIN; BO
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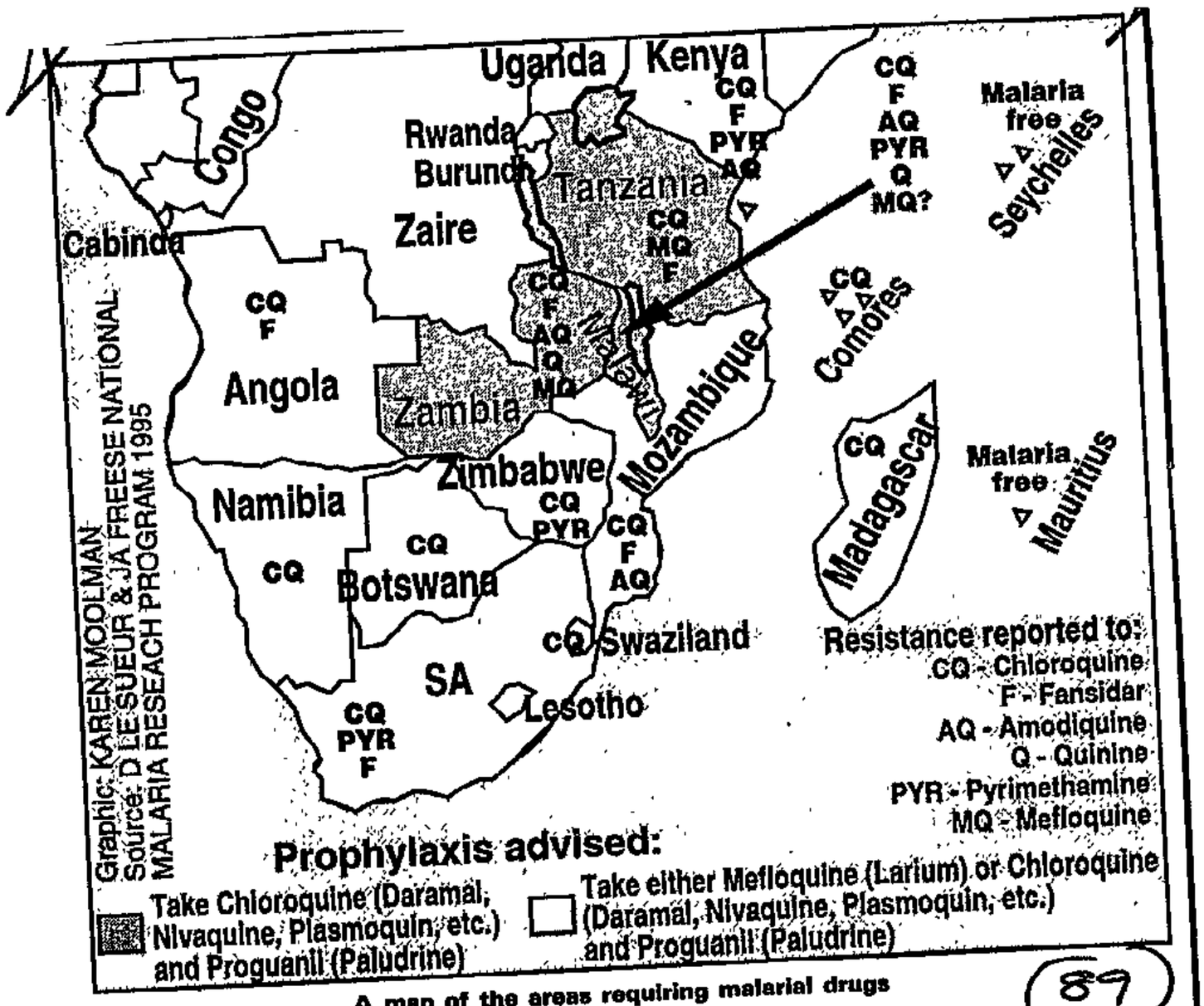


A map of the areas requiring malarial drugs

89

Medical council produces broad African malaria map

BD 16/8/95

Kathryn Strachan

THE SA Medical Research Council has produced the most comprehensive overview to date of how resistance to malarial drugs is distributed throughout Africa.

MRC researchers David le Sueur and Janet Freese, who have drawn up a map of Africa showing which prophylaxis should be taken in which areas, say malaria is not static. The disease is undergoing a period of resurgence and increasing resistance to drugs is being reported.

Even if the correct prophylaxis has been taken, a very small risk exists that a person can still become infected.

All of Africa excluding part of Egypt is now considered to be chloroquine resistant. This has made it necessary to take chloroquine in combination with paludrine. The alternative is to take Larium alone. The map opposite shows which drugs should be taken in which countries.

Above southern Africa all areas are considered high risk and visitors should take prophylaxis. There may be areas in some of these countries which are free of malaria (ie Zomba Plateau in Malawi and Kilimanjaro in Tanzania). It is only on the edge of distribution where one can become selective about taking prophylaxis, provided one is equipped with the correct information about the risk of these areas.

Within this region the disease is highly seasonal and at certain times of the year there is little or no infection.

As a result of low temperatures and low rainfall in the winter months, July to November are low-risk times in southern African countries. Le Sueur added that fever trees in many areas had the same distribution as malaria.

More than 80% of the 300-500-million cases of malaria in the world occur in Africa. The mortality rate in children below the age of five in Africa is estimated at more than 1-million a year.

Thus, from a travellers' point of view the availability of reliable information on where malaria occurs and what precautionary measures they can take is of the utmost importance.

The data for southern African countries is based on detailed information on where cases occur. This information was incorporated into geographical information system, a computer-based mapping system. The malaria cases are then superimposed on this map, and a more accurate pattern of malaria distribution emerges.

Le Sueur says that while some people are reluctant to take drugs over extended periods of time, as is the case with prophylaxis, and would rather treat any consequent infection, there are problems with this approach.

The first is there is increasing resistance being reported in eastern and southern Africa to curative drugs such as Fansidar. Another problem is, it is often difficult to diagnose malaria, especially in areas where there is no access to medical facilities, as the symptoms are similar to other illnesses.

The return of the killer mosquitoes

(89) ST 3/3/96

By CAS St LEGER

SOUTH AFRICA could be facing its worst malaria epidemic, with one hospital in Kwazulu Natal reporting a death a day.

The death toll from the disease could already be three times that for the whole of last year, according to a spokesman for the Department of Health's directorate of communicable disease control.

Last year, there were reportedly 9 247 cases and 10 deaths.

So far this year there have been 4564 recorded cases.

None of the other regions — including Kwazulu Natal — has yet calculated numbers or estimates of malaria deaths.

Worst hit is Kwazulu Natal. At least one hospital in the far north of that province is pitching army tents and has called for South African National Defence Force help to cope with the highest number of admissions of malaria patients seen in many years.

This week, Manguzi hospital in Ingwavuma was admitting more than 50 malaria patients daily, compared to the usual five to 10.

One patient has died almost every day since the beginning of the year and many patients are infected with killer strains of the disease.

The province's health minister, Dr Zweli Mkhize, said a severe strain was being placed on hospital resources in Ingwavuma and Ubombo.

There were also problems with medicine supplies, overcrowding at hospitals and a shortage of ambulances.

This month is normally peak malaria season. However, the number of cases had already begun to climb in November. Over Christmas, the figures were boosted by a suspected high number of Mozambicans visiting South Africa and falling ill, and by South Africans visiting Mozambique and returning with malaria.

The problem has also been exacerbated by the recent heavy rains, which have left behind pools of water, in which mosquitoes breed.

Some of the malaria strains in the high-risk areas to the north and east of the country and in neighbouring Mozambique are resistant to the common anti-malarial pill chloroquine.

"Ninety-five percent of the cases we are seeing are of the type that can move to complicated forms of malaria," said the directorate's spokesman. "If it is not diagnosed and treated in time, the illness can be severe or even fatal."

However, she said it would be impossible for malaria to spread across the whole country, away from areas already identified as high-risk.

The malaria-carrying anopheles mosquito cannot survive in the extreme weather conditions common in areas such as the Highveld.

There have been rare cases of people who have never visited malaria areas contracting the disease — such as a 10-week-old Meggan Jennett of Sandton, who was admitted to an intensive care ward in January.

But Dr Lucille Blumberg of the South African Institute for Medical Research said such cases were caused by "travelling" mosquitoes — insects which had hitched a ride on an aircraft or motor car from a malaria area.

Dr Blumberg said deaths from malaria were usually related to delays in diagnosis and treatment.

The Health Department advises people travelling to malaria regions to take the normal precautions, such as insect repellents and long-sleeved clothing and to take the drug proguanil in addition to chloroquine (both are available over the pharmacy counter).

However, malaria will not be the only problem following the rains.

Cases of bilharzia, which already number an estimated two million in South Africa, and tick-bite fever could also rocket.

The wet conditions followed by warmth, which cause the mosquito population to multiply, also favour the bilharzia snail and the tick.

Other, rarer, diseases could also appear.

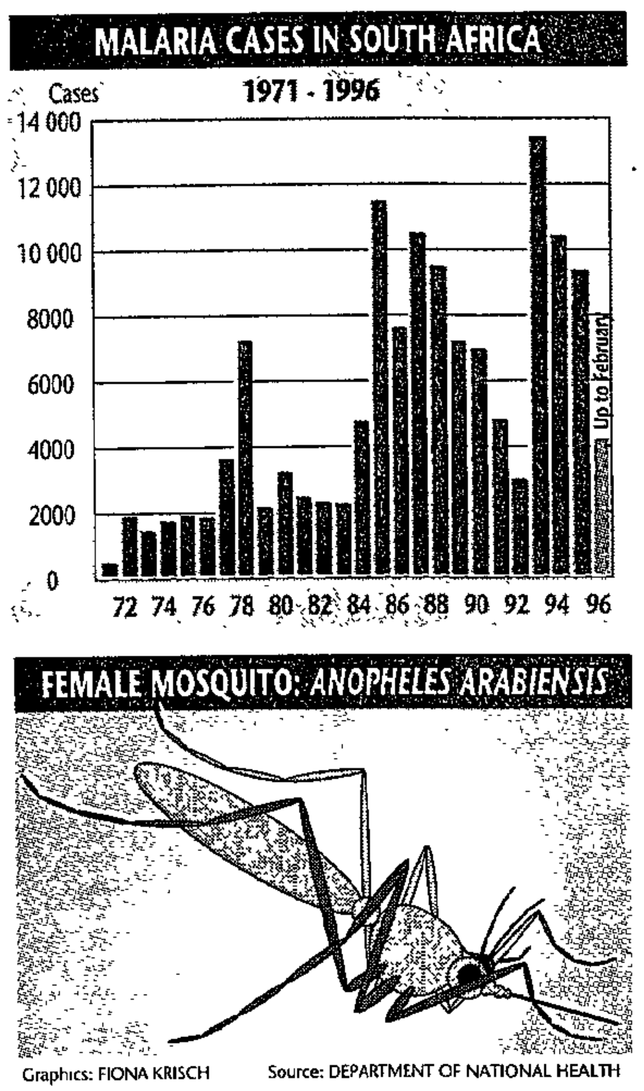
Animal plague, found mainly in the Free State, is being closely monitored in animals by the Health Department, although the last human plague case occurred in the Eastern Cape in 1982.

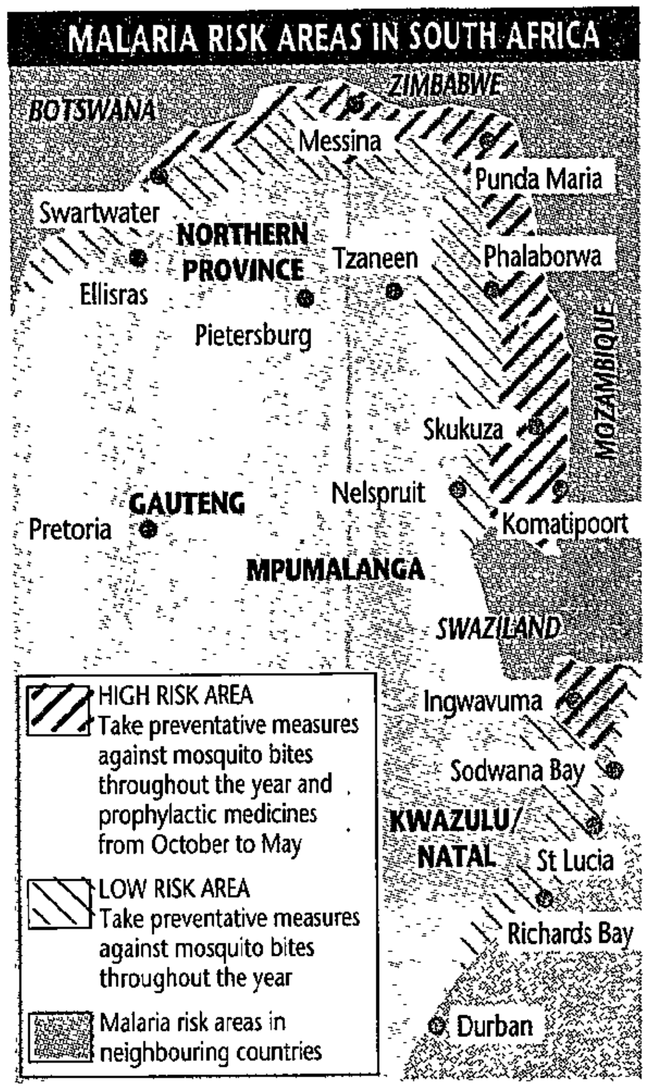
A watch is also being kept on Congo Fever, borne by cattle ticks. Normally, about 10 cases are found a year.

Malaria, tick-bite fever and Congo Fever can all start with flu-like symptoms — headaches and high temperatures.

Malaria high-risk areas stretch from Messina in the north to Ingwavuma and beyond in Kwazulu Natal. Bilharzia affects similar regions.

Ticks are active particularly in the Northern Province and along the Natal and Eastern Cape coasts.





Graphics: FIONA KRISCH Source: DEPARTMENT OF NATIONAL HEALTH

Battle to beat the whining carriers of death

By CRAIG DOONAN

WEAK and delirious, nineteen-year-old Nokuthula Khoza is helped onto a bed by nurses in the overcrowded Manguzi Hospital near the Mozambican border.

She is one of the victims of the worst outbreak of malaria in northern Kwazulu Natal in years.

The nurses insert a quinine drip into a blood vessel in Nokuthula's hand.

"She should be okay in a couple of days, but some who leave it later than her die of cerebral malaria," said one of the nurses.

"We have deaths here almost daily," she added.

Nokuthula is one of thousands of new malaria cases reported since the outbreak in the far northern region of the province last month.

Unusually high rainfall combined with temperatures of over 30°C have created ideal conditions for the anopheles mosquito, which carries the malaria parasite, to breed profusely in pools of warm water, says Jotham Mthembu, the acting chief of the Malaria Control Station in Jozini.

"We're sitting on a potential time bomb but we're going all out to try to control the outbreak and prevent it from spreading," Mr Mthembu said.

The provincial health department, armed with a R15-million budget, is trying to prevent the disease from spreading further south by rapidly identifying and treating those who contract malaria and spraying homes with insecticide.

But resources are limited for the teams of fieldworkers who have to cover rugged terrain and dense bush to reach the region's population of more than half a million people.

On top of this there is the problem of the stream of Mozambicans, many of them infected with the parasite, who cross illegally into South Africa seeking work.

Another concern is that of people moving southwards seeking jobs in the Richards Bay area and Durban.

The anopheles mosquito still occurs there, although in smaller numbers, and this raises the possibility of spreading the disease to these areas.

To prevent this, the 15 teams of fieldworkers in the Ingwavuma and Ubombo districts are working seven days a week, moving from homestead to homestead, taking blood smears from residents and handing out medication to those who show early symptoms of the disease, such as headaches and nausea. The more serious cases are referred to hospital.

"It's an epidemic. The worst we've seen in years, but we're trying to control it," said a local environmental health officer, Thandiwe Mvulane.

She says the lack of a programme to control malaria in Mozambique is one of the biggest contributors to the constant occurrence of malaria in northern Kwazulu Natal.

"Many of the Mozambicans who come to seek work here are infected. We do treat those who come to us but their presence makes it easy for the disease to spread. It's a very difficult situation."

One of the biggest hurdles is that of traditional healers, she said.

"People have a strong belief in traditional healers and some don't want to go to doctors because when they contract the disease they believe they're bewitched.

"We're trying to negotiate with traditional healers and show them the signs and symptoms of malaria.

"Now that people are dying they are starting to refer the sick to us," she said.

Provincial Health Minister Zweli Mkhize said he may have to reinforce staff in the area if the outbreak is not brought under control, and warned tourists visiting game parks and coastal resorts in the area of the danger.



JUST IN TIME . . . a malaria-stricken baby gets a life-saving dose of quinine Picture: BRETT ELOFF

All-out war on malaria

ARG 7/3/96 (89)

The Argus Correspondent

DURBAN. – KwaZulu-Natal health officials have requested the mass distribution of thousands of insecticide-treated bed nets, as they turn to extraordinary measures and a contingent of almost 50 army medics to control the province's worst outbreak of malaria since 1987.

At least 16 people have died in the north-east Ingwavuma district since heavy rains helped set off the unseasonal outbreak over two months ago.

Two big hospitals in area, which borders Swaziland and Mozambique, are treating about 60 malaria cases a day, mostly children. Five to 10 cases a day are normally treated at the start of the "malaria season" , which usually peaks in April and May.

The regional director for health, Sipho Ngxongo, said the province yesterday requested health department authorisation for the distribution of treated bed nets to about 10 000 people in high-risk areas.

These were to protect people from contact with the vector mosquito, Anopheles arabiensis. The nets would also kill any mosquitoes which landed on them.

The measure was taken because, although insecticide sprayed on walls effectively kills mosquitoes, Medical Research Council (MRC) scientist Dr Brian Sharp had shown that a percentage of mosquitoes did not rest on walls after biting people in their huts.

Thirty SA National Defence Force Medical Service members were flown to Manguzi hospital, west of Kosi Lake, and two other hospitals yesterday.

They joined 17 medics deployed in the area at the weekend, Captain Dries Erasmus said. By month end 100 medics, including nursing personnel and primary care and emergency care orderlies, will be in the area.

parties. ANC MP S. Swart said

Malaria epidemic kills 16 in KwaZulu-Natal

BD 7/3/96 (89)

Farouk Chothia

DURBAN — The malaria epidemic in remote parts of northern KwaZulu-Natal has claimed 16 lives since the beginning of the year amid indications that the under-resourced KwaZulu-Natal health department is battling to contain the epidemic.

Provincial health ministry spokesman Dave McGlew said yesterday that about 1 500 people had been admitted to the Manguzi hospital since January, and about 1 100 people to the Mosvold hospital in Ingwavuma. The hospitals were still admitting 30 to 40 patients daily.

McGlew described the situation as "acute, but under control".

SANDF Natal Command medical services spokesman Capt Dries Erasmus said the service sent an extra 30 members to the hospitals to help contain the epidemic. Seventeen medical aides had been sent earlier.

McGlew said the malaria outbreak was the result of heavy rains. Mozambicans were also arriving at the hospitals for treatment.

A "worrying factor" was the "strange" behaviour of the mosquitoes. The health department was spraying huts with the aim of killing the mosquitoes. However, the mosquitoes were not sitting on sprayed surfaces, thus evading death. They entered huts, bit patients and left, McGlew said.

Erasmus, who visited the areas earlier this week, said the hospitals were battling to cope.

McGlew said at least 20 tents had been sent to the hospitals to provide additional accommodation for patients. He said malaria could be contained in the long term only through co-operation between southern African states.

Transvaal

Killer mosquitoes creating an epidemic

(89) Star 26/3/96

Health Ministry reports large number of deaths, and the worst part of the malaria season still lies ahead

MEDICAL CORRESPONDENT

More people have died in this year's malaria epidemic than in any year since 1989 – and we've not yet reached April and May, traditionally the the peak period for reports of malaria.

Health Ministry spokesman Lulu Sebake said yesterday that more than 8 000 malaria cases and 55 deaths from the disease had been reported since the start of the year.

There were only 10 deaths, and 9 288 cases of malaria, in 1995.

According to a paper in the South Africa Medical Journal by the National Malaria Research Programme, the number of malaria deaths between 1989 and 1994 ranged between 12 and 45, and the number of cases from 13 285 in 1993 to 10 286 in 1994.

Sebake attributed the sharp increase in the number of malaria cases to high rainfall in malaria areas.

But researchers say the movement of parasite carriers into South Africa, particularly from Mozambique, is also an important factor.

Malaria distribution in South Africa had not changed and the higher incidence was reported from the low-altitude, high-risk areas of Northern Province, Mpumalanga and north-eastern KwaZulu Natal, Sebake said.

North-eastern KwaZulu Natal appears worst hit, with Ingwavuma recording 24 deaths and 3 854 cases since January.

Regional health director Sipho Ngxongo said yesterday there had been a slight decline in the daily figures from local hospitals over the past week.

Sebake cautioned the public to take precautions against mosquito bites, even in low-risk areas.

This included remaining indoors between dusk and dawn, wearing long-sleeved clothing, long trousers and socks when going out at night, and applying insect repellant to exposed skin.

Doors and windows must be fitted with screens, or closed at night, and mosquito bed nets had to be used, preferably impregnated with an insecticide registered for this purpose.

Houses, especially bedrooms, had to be sprayed with an aerosol insecticide at dusk after the windows were closed, and mosquito coils or mats should be burnt.

Visitors to high-risk areas had to take chloroquine and proguanil, both of which are available over the counter.

An alternative is mefloquine, which requires a doctor's prescription.

Sebake said there had been recent reports of serious side effects from anti-malarial drugs, but these had to be weighed against the risk of contracting malaria, which could be fatal.

Between 17 and 20% of anti-malarial drug users experienced temporary, minor side effects – insomnia, nausea and dizziness – while serious side effects – convulsions or depression – occurred in one out of every 10 000 people.

HOLIDAY-MAKERS WARNED AGAINST SPREAD OF KILLER MOSQUITOES

DRUG REGIMES FOR CHLOROQUINE-RESISTANT AREAS

mefloquine (Lariam®)
ADVANTAGES
- highly effective
-weekly regime

DISADVANTAGES
- certain contra-indications
- not yet indicated for long term use
- severe neurological S/E, although rare
- relatively expensive

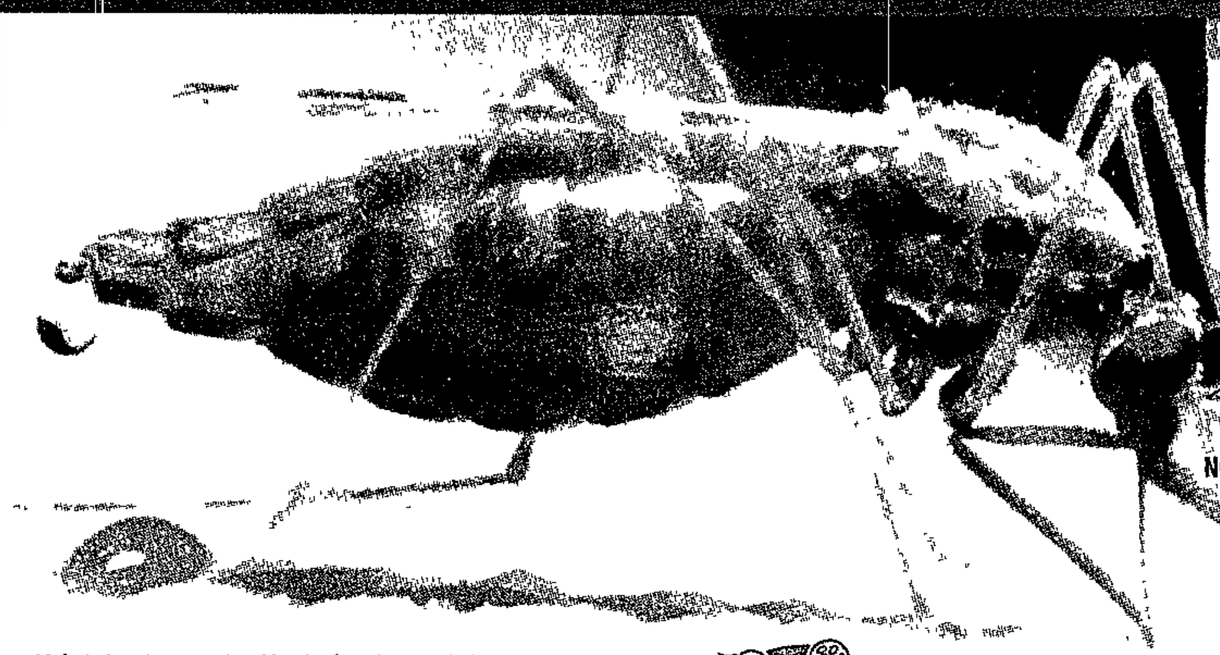
chloroquine (eg Nivaquine®, Daramal®, Plasmoquine®) **and** ***proguanil*** (Paludrine®)
ADVANTAGES
- well tolerated with a low incidence of severe S/E
- can be used long term
- available without a Rx
- relatively inexpensive

DISADVANTAGES
- widespread resistance, especially in SE Asia
- poor compliance due to complicated regime

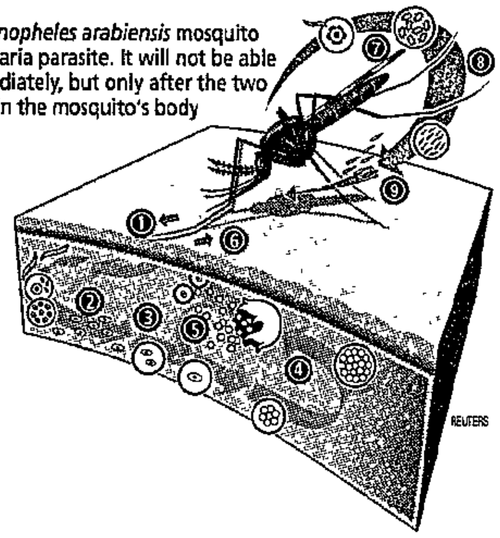
doxycycline (e.g. Vibramycin®)
ADVANTAGES
- resistance is rare
- highly effective in SE Asia

DISADVANTAGES
- relatively little experience as an antimalarial
- short term use only (<7 weeks)
- photosensitivity and candida superinfection
- relatively expensive

Source: Lee Baker, Glaxo Welcome Malaria Hotline, TPS Drug Information Centre



Malaria is only transmitted by the female *Anopheles arabiensis* mosquito which has fed off a human carrying the malaria parasite. It will not be able to pass malaria on to the next human immediately, but only after the two weeks that it takes the parasite to develop in the mosquito's body



Three week period

1: Malaria parasite injected into human body

2: Infects red blood cells and gives rise to young parasites that invade the red blood cells

3: Parasite grows and reproduces

4: Infected cell ruptures, releasing young forms which invade new red cells

5: Asexual cycle of development is repeated over and over, destroying red blood cells

Two week period

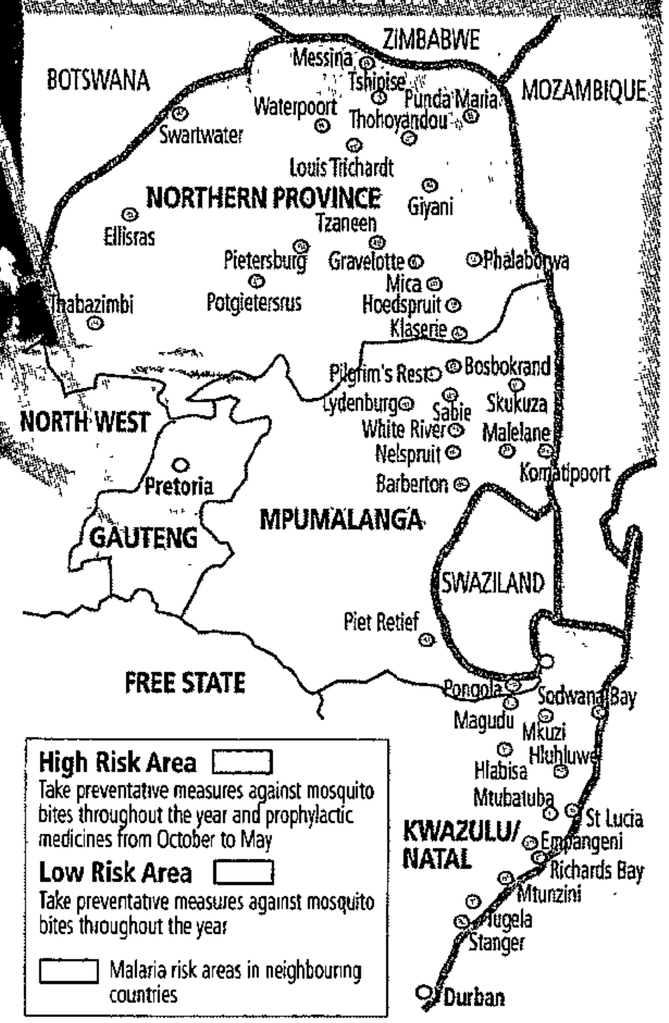
6: Mosquito sucks in infected human blood

7: Parasites mate in stomach and develop into a cyst

8: Sporozoites develop inside the cyst

9: They invade salivary glands, until injected into new human host

DISTRIBUTION OF MALARIA



High Risk Area
Take preventative measures against mosquito bites throughout the year and prophylactic medicines from October to May

Low Risk Area
Take preventative measures against mosquito bites throughout the year

Malaria risk areas in neighbouring countries

Source: Dr Dave Durrheim, Consultant, Communicable Disease Control. Mpumalanga Dept of Health

55 malaria deaths this year boost demand for prophylactics

Star 3/4/96 (89)

MEDICAL CORRESPONDENT

Travel clinics and pharmacies are reporting a surge in public interest in taking precautions against malaria, and some concern as holidaymakers try to work out whether their destinations are high-risk areas.

Heavy rains, heat and an influx of people carrying the parasite across South Africa's borders have fuelled this year's malaria epidemic, in which, according to the Department of Health, at least 8 000 cases and 55 deaths have been reported since January.

The outbreak is confined to carefully mapped high-risk areas, particularly north-eastern KwaZulu Natal and south-eastern Mpumalanga.

Johannesburg pharmacies from Rosebank to Braamfontein have reported a sharp rise in sales of anti-malaria pills.

Calls to the Glaxo Wellcome Malaria Hotline, at Braamfontein's TPS Drug Information Centre, have rocketed from six or seven a day in November to between 40 and 50 a day and are rising, says drug information pharmacist Lee Baker.

And, says Dr Isak Joubert, who runs the Travel Safe Clinic in Sunninghill, Sandton, the public is significantly more aware and concerned about getting the right information.

In Mpumalanga, according to the province's communicable disease control consultant Dr David Durrheim, there have been 5 529 cases and about 50 deaths since the malaria season started in July.

More than 100 cases of malaria among Kruger National Park staff have been reported since January, according to public relations officer Chris van der Linde.

Southern African countries, including Mozambique, Zimbabwe and Swaziland, have been worse hit.

Reuters reports that Swaziland health officials this week warned visitors that malaria had spread to Manzini, where the disease has been rare for decades.

There have been 81 deaths and about 6 000 malaria cases identified in Swaziland since January. These have occurred mostly along its northern border with Mozambique.

At a briefing in Isando yesterday to clarify recommendations on prophylaxis, Roche Products, manufacturer of the prescription anti-malarial drug mefloquine (trade name Larium), said it was vital that travellers realise that prophylaxis should be tailored to who was taking it and where they were going.

Pregnant women and children under 2 should not enter endemic areas.

Malaria could best be prevented by using long sleeves and mosquito repellants from dusk, to avoid getting bitten by the female *Anopheles arabiensis* mosquito.

▶ Anti-malaria drug side-effects not serious
Page 2

Malaria: 55 deaths, 8 000 cases reported (89)

ARG 4/4/96

The Argus Correspondent

JOHANNESBURG. – Travel clinics and pharmacies are reporting a surge in public interest in taking precautions against malaria, and some concern as travellers try to work out whether or not their proposed destinations are high-risk areas.

Pharmacies throughout the city have reported a sharp rise in sales of malaria prophylaxis.

Calls to the Glaxo Wellcome Malaria Hotline, at the Drug Information Centre, have rocketed from six or seven a day in November last year to between 40 and 50 a day, and rising, says drug information pharmacist Lee Baker.

And, says Isak Joubert, who runs a clinic called Travel Safe, the public is more concerned about getting the right information.

Heavy rains, heat and an influx of people carrying the parasite across South Africa's borders have fuelled this year's malaria epidemic.

According to the Department of Health at least 8 000 cases and 55 deaths have been reported in South Africa since January.

The outbreak is confined to carefully-mapped high-risk areas, particularly north-eastern KwaZulu-Natal and south-eastern Mpumalanga.

Hardest hit is Mpumalanga where, according to the province's communicable disease control consultant David Durrheim, there have been altogether 5 529 cases and about 50 deaths since the malaria season started in July 1995.

More than 100 cases of malaria among Kruger National Park staff have been reported since January, says public relations officer Chris van der Linde.

Mozambique, Zimbabwe and Swaziland have been hit badly by the disease.

Swaziland health officials warned visitors that malaria had spread to Manzini, where the disease had been a rare.

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Malaria could best be prevented by using long sleeves and mosquito repellents from dusk, to avoid being bitten by the female *anopheles arabiensis* mosquito seeking a blood feed.

Cancer high in S Africa

(89)

Sowetan 7/6/96

By Mokgadi Pela

CANCER associated with lifestyle in South Africa ranked among the highest in the world, results of a fresh study have shown.

In the latest South African National Cancer Registry report jointly published by the South African Institute for Medical Research, the Cancer Association of South Africa and the Department of Health, it has been reiterated that between 80 to 90 percent of cancers were caused by external factors. These could range from lifestyle, environmental to occupational.

The report, which registered 111 207 new cancer cases for 1990-91 (152 new cancer cases per day), points out that if adjusted for under-reporting, one in four South Africans will develop a cancer in their lifetime. The report said a quarter of all cancers occurred before the age of 50 and cancer was found to be the third commonest killer in black adults and the second in whites, coloureds and Asians, dispelling the myth that cancer is a rare disease which affects the oldest segment of the population.

Figures show that cancer of the cervix, caused mainly by too much sex, too early and with many partners, was the commonest among women.

Madiba to launch polio campaign

Sowetan 30/7/96 (89)

Programme aims to immunise up to 120 million children in Africa

By Mokgadi Pela

PRESIDENT Nelson Mandela will launch the Kick Polio Out of Africa campaign in Midrand on Friday.

The campaign aims to "mobilise all African nations to implement the World Health Assembly's goal of eradicating polio by the year 2000".

The Assembly has the support of the World Health Organisation, Rotary International, Unicef, the Organisation of African Unity and USAid.

The programme aims to immunise 120 million children from Cape to Cairo under the programme. And the organisers have chosen soccer as the vehicle to popularise the campaign.

Meanwhile, Messers A Wigton, G Hussey and D Fransman of the child health unit of the department of paediatrics and child health at the University of Cape Town, have cautioned that mass campaigns such as this requires "significant commitment, involvement and resources in order to be carried out successfully".

"They are expensive, labour intensive and logistically difficult. They may also have a questionable long-term impact, as has been shown in other countries."

In the latest issue of the *South African Medical Journal* they says: "The proposed mass campaign may encounter logistical problems in the setting up of vaccination points in rural areas and with other areas with limited or no infrastructure at all."

International effort to contain malaria

(89) BD 1/8/96

Kathryn Strachan

IN THE past year SA had been hit by the worst malaria epidemic since the 1930s, with more than 20 000 cases and about 124 deaths, the Medical Research Council (MRC) said yesterday.

MRC researcher Dave le Sueur said despite active controls Zimbabwe had more than1,4 million cases by May this year and more than 2 000 deaths, and Botswana had its worst year of malaria incidence in recorded history.

In response the MRC has embarked on a R1m project to plot the geographical incidence of malaria in Africa so that large scale interventions for the continent can be effectively implemented.

The project, to be known as Mapping Malaria Risk in Africa (Mara), would collate information on the severity of malaria and gather existing information on issues such as drug resistance, mosquito species and climate.

The data would then be integrated into a geographical information system by a team of five investigators who would operate throughout Africa.

Mapping the geographic occurrence of the disease and its severity would allow the most effective interventions, such as insecticide impregnated bednets, to be targeted to areas of need.

The team, consisting of researchers from Ghana, Mali, Kenya, Ivory Coast and Switzerland would meet in Cape Town over the next few days to finalise the procedures and database design before launching the project, which they estimated would take two years.

Le Sueur said more than 300 million people worldwide were at risk of contracting malaria, with more than 80% of infections occurring in sub-Saharan Africa. Worldwide about 1,5 million children under the age of five die from malaria each year.

Funding for the initiative came from Canada's International Development Research Centre, the World Health Organisation and the UK's Wellcome Trust.

Meanwhile, Sapa reports that a 50-year old postman in Switzerland died last week after being bitten by a mosquito.

Health officials said the vector (carrier) was almost certainly a mosquito that had survived the obligatory insecticide sprayed in all planes coming from risk countries in Africa and Asia. The mosquito also survived what normally would have been a fatal change of temperature, because of exceptionally warm weather in Geneva.

(89)

Plan to map out malaria

Sowetan 1/8/96

THE Medical Research Council has embarked on a multimillion rand project to plot the geographical incidence of malaria in Africa so that large-scale intervention can be effectively implemented

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The MRC says the data will be integrated into a geographical information system by a team of five investigators who will operate throughout Africa.

Funding for the initiative, amounting to R1 million, came from Canada's International Development Research Centre, the World Health Organisation and the Welcome Trust in the United Kingdom.

MRC coordinator Dr Dave le Sueur says more than 300 million people worldwide risk contracting malaria, with more than 80 percent of infections occurring in sub-Saharan Africa. Worldwide about 1,5 million children under the age of five die from malaria.

Over 20 000 cases

"Last year was the worst in South Africa since the 1930s, with over 20 000 cases and about 124 deaths," Le Sueur says.

"Zimbabwe had more than 1,4 million cases by May this year and more than 2 000 deaths, despite active control efforts. Botswana had its worst year of malaria incidence in recorded history."

"Zimbabwe had more than 1,4 million cases by May this year"

He says mapping the geographic occurrence of the disease and its severity will allow appropriate and cost-effective interventions such as insecticide-impregnated bednets to be made available in areas of need

The Mara team comprising Dr Fred Binka (Ghana), Prof Yeya Toure (Mali), Dr Bob Snow (Kenya), Dr Thomas Yeuscher (Ivory Coast) and Dr Christiaan Lengeler (Switzerland) will meet in Cape Town over the next few days to finalise the procedures and database design before launching the project, which they estimate will take two years.

● A Swiss postman has died of malaria after being bitten by a mosquito that survived airline insecticide and what would normally have been a fatal change of temperature.

The victim, about 50 years old, died recently in a Geneva hospital, according to health official Ms Letizia Toscani.

He had been admitted as an emergency case, but the disease had already undergone a long and deadly incubation period because his doctor failed to diagnose the symptoms.

In the last, nonfatal case of this "extremely rare tragedy", five people living near Geneva's international airport were infected in the summer of 1989

Toscani said the carrier was almost certainly a mosquito that had survived the obligatory insecticide sprayed in all planes coming from "risk" countries in Africa and Asia and what would generally have been a fatal change of temperature, because of exceptionally warm weather in Geneva in early July. – *Supa-AFP*



About 1,5 million children under the age of five die from malaria worldwide. Eighty percent of the infections occur in sub-Saharan Africa.

Plan to plot occurrence of malaria in Africa

(89) Star 5/8/96

By Melanie-Ann Feris

The Medical Research Council (MRC) is co-ordinating a multi-million rand project to plot the geographical occurrence of malaria in Africa, thus effectively helping contain the disease on the continent.

Dr Dave le Sueur, co-ordinator of Mapping Malaria Risk in Africa (MARA), said more than 300 million people globally were at risk of contracting the disease with more than 80% of infections occurring in sub-Saharan Africa.

"Last year was the worst in South Africa since the 1930s, with over 20 000 cases and about 124 deaths. Zimbabwe had more than 1,4 million cases by May this year and more than 2 000 deaths, despite active control efforts," Le Sueur said.

MARA is not only aimed at collating information on the severity of malaria, but will also look at issues such as drug resistance, mosquito species and climate. All the data will be integrated into a geographical information system by a team of five investigators who will operate throughout Africa.

Le Sueur said mapping the geographical occurrence of the disease and its severity would allow appropriate and cost effective intervention.

Funding for the MARA initiative has come from Canada's International Development Research Centre, the World Health Organisation and the Wellcome Trust in the United States.

The MRC will maintain the database to ensure the information is kept updated and relevant.

Maps will be made available on a public domain database on the internet and will become available on a Worldwide Web site which is currently under construction.

People travelling to other African countries will be able to access the Web site (http://www.malaria.org.za) for details about precautions to take when travelling to malaria areas.

Gauteng opens immunisation points in anti-polio campaign

(89) BS 7/8/96

Kathryn Strachan

THERE will be more than 1 000 polio immunisation points in Gauteng next week, when the province joins the rest of Africa in a mass eradication campaign.

Gauteng has allocated R2,5m to the campaign, and provincial health services are poised for an all-out offensive against polio and measles. More than 7 000 workers will immunise about 620 000 pre-school children in the space of a few days.

The "Kick polio out of Africa" campaign was launched in Gauteng yesterday by Health MEC Amos Masondo and leaders of the Munsieville community project on the West Rand. The success of the campaign, they said, depended on parents and other caretakers of pre-school children bringing them to the immunisation points, which will be at creches, schools, halls and mobile units.

While there has been no case of polio reported in Gauteng in the past 10 years, there is a real risk that polio could be imported, particularly from African states where the disease is still endemic. Nearly 1 600 polio cases were reported in Africa last year.

The campaign is necessary because routine immunisation at clinics reaches only about 75% of children. It will also cover measles as there are about 6 000 cases in the country each year.

'Kick polio out of Africa'

Sowetan 8/8/96

By Josias Charle

THE Pretoria City Council is to embark on a mass immunisation campaign in Mamelodi and Atteridgeville, targeting pre-school children.

Run by the health department of the council, the campaign will form part of the strategy to "kick polio out of Africa".

Council spokesman Mr Harry Matolong said the campaign will run from August 12 to 14.

"The recent outbreak of polio in other African countries has raised concern with health authorities who are committed to the total eradication of the disease in South Africa by the year 2000," Matolong said.

He said a measles vaccine will also be administered to children brought in for polio treatment.

"All parents are requested to ensure that children whose ages range between 11 months and five years must receive the necessary extra polio and measle vaccines," said Matolong.

(89)

Immunisation campaigns will be held at the following centres in Mamelodi: Salvation Army Church, Mamelodi West clinic, Mamelodi East TB clinic, Mamelodi Day Hospital, Makhanana Chemist, Phagameng NG Church and Stanza Bopape village.

The time will be from 8am to 4pm.

Creche-going children will be attended to at their creches.

The campaigns in Atteridgeville will be held at all the clinics between 8am and 4pm.

Council starts its drive against child killer diseases

(89) Star 14/8/96

By Anna Cox

A huge measles and polio immunisation campaign aimed at 500 000 children in greater Johannesburg has been launched.

The campaign, organised by the Greater Johannesburg Transitional Metropolitan Council, aims to eradicate polio by the year 1998.

Although no cases of polio have been recorded since 1989, immunisation levels were low enough to cause concern because there was a real risk it could be imported from neighbouring countries where it was still endemic, said Wendy Ovens, strategic executive for community services at the Eastern Metropolitan Substructure.

In Africa 1 597 cases were reported last year – nearly two-thirds of them in Angola, Ethiopia, Nigeria and Zaire.

Polio was an infectious disease which usually afflicted children under the age of five. The disease normally caused fever, followed by the sudden onset of lameness or paralysis which could be permanent.

South Africa still registers a high annual incidence of measles. Last year more than 6 000 cases were recorded and during the 1992 measles outbreak 22 000 cases were reported.

"Measles is by no means a mild childhood disease. It is still a significant cause of severe illness and can sometimes lead to death. The young and malnourished are particularly prone to complications such as pneumonia and blindness.

"Polio and measles are preventable by immunisation and all children should be routinely immunised," Ovens said.

Many people have volunteered their services to assist in managing this massive immunisation campaign, including pharmacists and doctors as well as nursery school teachers and day mothers.

Workers get shots against meningitis

(21)(96)(89)

MEDICAL CORRESPONDENT

Star 30/8/96

West Rand mines have chosen to immunise their workers against meningococcal meningitis and the Gauteng health department will be immunising high-risk ambulance drivers and health workers, the department announced yesterday.

The decision to immunise selected people was taken with the assistance of community health consultants from Wits and Pretoria universities, the South African Institute of Medical Research, the World Health Organisation and the Centres for Disease Control in Atlanta, said Gauteng's director for Aids and communicable diseases Dr Liz Floyd.

The West Rand meningococcal meningitis outbreak has claimed seven lives and infected 44 people, mostly in the mine hostels and in Bekkersdal, with a scattering of cases elsewhere.

The province had concluded from the expert advice that blanket immunisation was unnecessary and ineffective, but focused immunisation should be considered, the department said.

Immunisation was necessary in a community when the number of new cases per week exceeded a rate of five per 100 000 residents, sustained over three weeks.

In Far West Rand mines, the ratio at one stage rose above this level, said the department.

In Bekkersdal, the ratio had stayed below five per 100 000, said the department.

Help Kick Polio out of Africa

(89)

CT 6/9/96

STAFF WRITERS

IT will be determined next week whether the Western Cape becomes the first province to be declared polio-free.

The co-operation of parents is crucial.

The first round of the Kick Polio out of Africa campaign was a success, according to the Health Department, but parents need to ensure that they return with all their children under the age of five for the second and last set of free polio drops.

The first was given to about 80% of toddlers from August 12 to 16, but for the immunisation to be effective a second set a month later is essential.

This is available at all public health facilities all of next week. Even those children who are up to date with vaccinations need to be brought again, to make doubly sure they cannot contract the virus.

The World Health Organisation says there should be an 80% coverage rate before it declares an area polio-free.

No new cases have been reported in the province since 1989, but the blanket coverage is necessary to ensure there is no chance of a future outbreak. If next week's effort is not successful, the entire exercise would have to be repeated next year.

The Western Cape could be the first province to be declared polio-free as its health status is highest, and the availability of clinics and staff to administer the polio drops is greater.

A problem identified in the first round is the failure by parents to sign and return consent forms to crèches. Immunisation cards must be brought along

Parents who need more information can call Dr Lilian Dudley on 948-8151 or page her on 591-0112-3210.

Immunisation campaign exceeds expectations

A mass immunisation campaign to eradicate polio and measles in Gauteng has exceeded all expectations, with more than 750 000 children being immunised in the first stage. The province is now gearing up for a second round in the coming week.

This is a follow-up to the "Kick Polio out of Africa" continental mass campaign launched in Gauteng last month, in which 755 000 children were immunised for polio. A further 660 000 were immunised in the first major anti-measles campaign. The results far exceeded the target of 620 000 children.

The Gauteng health department says the response from the informal settlements was "particularly impressive", while it was good in most townships.

"The 1996 campaign is not over. For the polio immunisation to be effective, children must be brought back for another dose of drops next week," it said.

"I'm sure people who have missed out on the first round won't be turned away, and perhaps some arrangement will be made for them to get their second dose," said Jo-Anne Collinge of the Gauteng premier's office as she emphasised the importance of immunisation.

(89) (95) Star 7/9/96

Star 28/10/96

Malaria cases on the increase, say experts

(89)

BY JANINE SIMON
Medical Correspondent

South Africa has already recorded more cases of malaria this year than in any year since 1966.

And with the onset of the rainy season, it seems likely that the epidemic will continue throughout the region, experts have warned.

More than 22 000 people contracted malaria in the first half of 1996, compared to a total of about 9 000 cases in the whole of 1995, the Health Department said.

It warned that if adequate precautions were not taken the epidemic could recur, and said it would be circulating guidelines for prevention and treatment of malaria to pharmacists, doctors, travel agents and tour operators during the next two weeks.

SA has not been singularly affected by the epidemic. About 60% of Mozambicans are infected with the parasite, Zimbabwe recorded more than 1,2 million cases and Botswana 40 000, according to Dr Brian Sharp of the National Malaria Research Programme.

The danger has been highlighted by the recent death of broadcaster Retief Uys, who died of malaria two weeks after visiting a game farm outside Messina in the Northern Province.

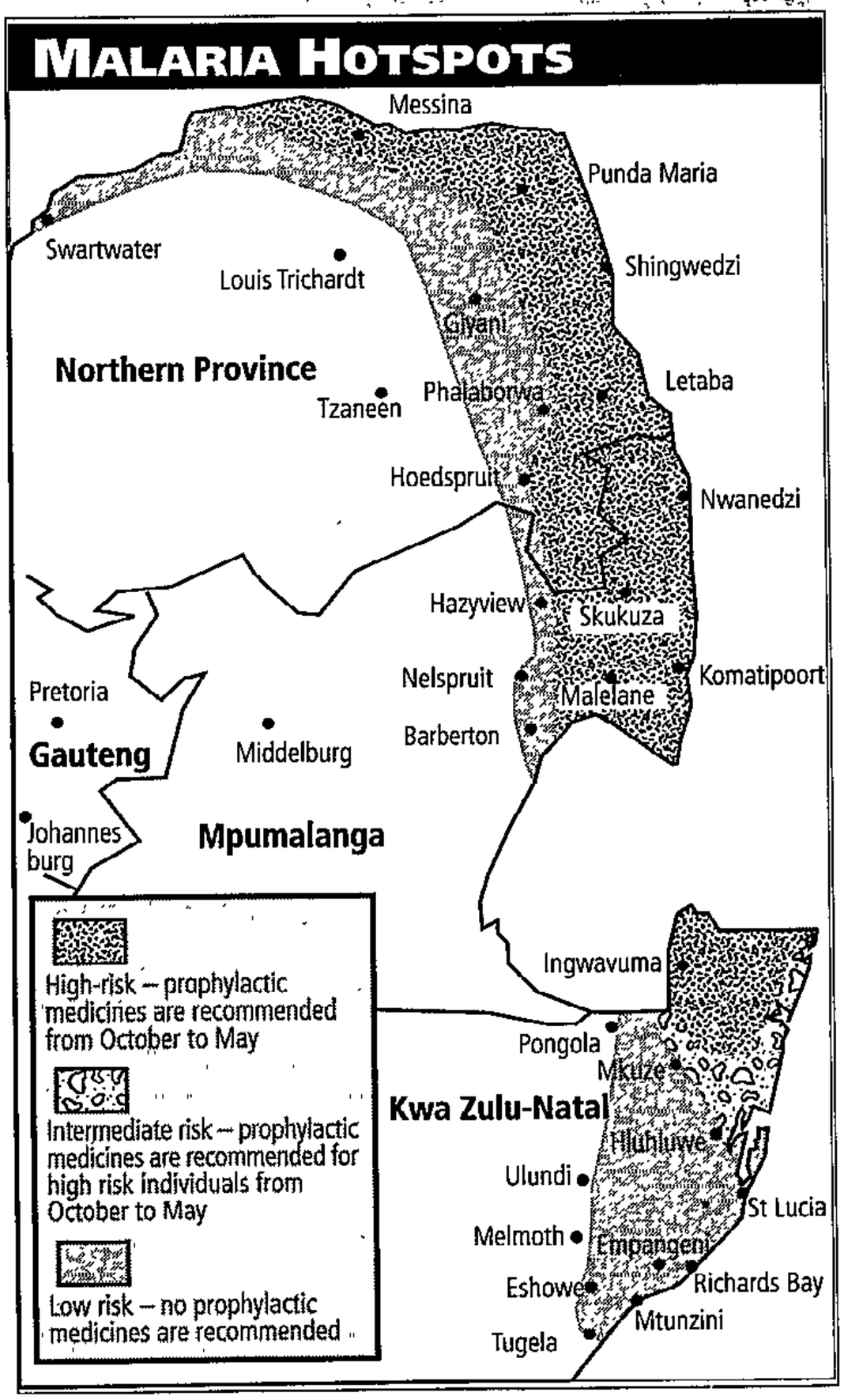
Sharp warned that if good rains fell, conditions were ripe for high rates of malaria transmission in the coming months. "The epidemic means there is a large reservoir of people carrying the parasite in their blood, and we have people migrating from areas where there is no malaria control."

Malaria risk areas for 1996-97 have been revised, based on notified malaria cases in the risk areas during the past 15 years. Risk areas are divided into high, intermediate and low areas.

In all risk areas, precautionary measures must be taken throughout the year. These include staying indoor from dawn to dusk, wearing long sleeves and long pants, using repellent on exposed skin, spraying sleeping quarters with insecticide and using mosquito coils and mats, and sleeping under mosquito-proof nets impregnated with insecticide.

Using anti-malarial drugs is recommended from October to May in high-risk areas, and for high-risk people (children under 5, pregnant women and immunosuppressed people) in the intermediate-risk areas.

It is imperative to contact a doctor if flu-like symptoms develop anything up to six months after visiting a malaria area.



Death increases Congo fever fears

(89)

JENNY VIALL
HEALTH REPORTER ARG 4/11/96

A person has died in Oudtshoorn Hospital, probably of highly infectious Congo fever, and the condition of three others believed to have the disease deteriorated rapidly last night.

At least 22 people are now suspected of being victims of the disease and a team of doctors and health department officials will fly to Oudtshoorn today to decide on which patients should be brought to Cape Town for treatment.

Meanwhile, four people in isolation at Tygerberg Hospital, who were airlifted from Oudtshoorn by the air force last night, were serious but stable, said Mark Beale, head of the infectious diseases unit.

They four were brought to the unit as a precaution to be tested for Congo fever and to be nursed in the isolation ward. Tests have not yet confirmed whether the people, workers at an abattoir in Oudtshoorn, have Congo fever. But as they were haemorrhaging it was extremely unlikely to be anything else, said Tom Sutcliffe, head of the Western Cape health department.

Congo fever was a blood-borne disease, said Dr Beale. There was no cause for panic and the population at large was not at risk of contracting the disease.

7 workers in hospital as ostrich meat tested for Congo Fever link

Oudtshoorn – Tests will show today whether the deadly Congo Fever is the mystery disease which killed one woman and laid low seven other workers over the weekend at an Eastern Cape ostrich abattoir.

Four patients were transferred to Cape Town's Tygerberg Hospital and the remaining three, who were hospitalised in Oudtshoorn, will be airlifted to Tygerberg as soon as the present overcast conditions clear, said Klein Karoo Co-op personnel manager Coenie Louw.

The condition of the Tygerberg patients was described today as stable. "At this stage we await confirmation of our suspicions, but all indications are that the disease is Congo fever," Louw said.

The entire factory was closed yesterday and the remaining members of the 400-strong staff are being regularly monitored for any signs of lowered blood counts, leading to bleeding which was one of the first indications of the disease, Louw added.

Tests are being conducted at the SA National Institute of Virology in Johannesburg where an expert suggested the initial diagnosis of Congo fever was correct.

About 1 000 ostriches are slaughtered daily at this abattoir, but Co-op spokesman Ben de Kock stressed that meat from all ostriches slaughtered from October 22 had been isolated and would probably be destroyed.

The deadly Congo fever is commonly carried by a tick. – Ecna.

(89) Star 5/11/96

PANIC SWEEPS THROUGH OUDTSHOORN

(89)

ct. 5/11/96

Congo fever confirmed at Tygerberg

PROVINCIAL HEALTH MEC Mr Ebrahim Rasool is to visit Oudtshoorn today where 20 people have been isolated with suspected Congo fever. Results of tests being done in a Johannesburg laboratory will be known today.

CONGO fever has been confirmed in three of the suspected cases from Oudtshoorn admitted to Tygerberg Hospital.

Medical superintendent Dr Lizelle Schoeman confirmed the diagnoses late last night.

As panic seized Oudtshoorn yesterday, a team of senior medical staff flew there from Cape Town to help contain the illness.

One woman has died and 20 people — all of whom worked at an abattoir slaughtering ostriches — were isolated yesterday.

Western Cape MEC for Health Mr Ebrahim Rasool said he would visit the area today.

Oudtshoorn Hospital superintendent Dr Stanley Janicki said 10 people who had symptoms similar to those of Congo fever were being treated.

Ten more people had been isolated for tests.

Abattoir worker Mrs Joyce Japhta, a mother of six, died at her Toekomsrus home yesterday. She had not been admitted to hospital.

The hospital was negotiating with the SA Air Force last night to fly five of the patients, who had been admitted bleeding, to Tygerberg Hospital. Four patients were flown to Tygerberg on Sunday.

A doctor and four nurses, one of whom is an expert on Congo fever, were left in Oudtshoorn to help and train staff at the hospital to deal with the disease. The wing in which the patients are accommodated has been isolated.

The chief superintendent of Tygerberg Hospital, Dr Abul Rahman, said: "If things get out of hand we will use the military base as a general hospital and use the

❐ Turn to Page 3

How the fever is contracted

THE chances of a human catching Congo fever from eating "infected" meat are remote — unless the meat is raw and the virus active.

● Only humans and baby mice become ill from the virus, spread by ticks. Sheep and cattle exposed to the virus are usually infected when young and develop immunity within a week. If they are infected later, meat from their carcasses could be infectious.

● In 1984 a man contracted the disease when blood from ticks on an ostrich he was skinning got on to cuts on his hand

P.T.O.

How the crisis unfolded

TWENTY abattoir workers, 10 with suspected Congo fever, were admitted to an Oudtshoorn hospital.

● Abattoir worker Mrs Joyce Japhta, 44, died at home early yesterday after displaying Congo fever symptoms.

● Specialists from Tygerberg Hospital flew to Oudtshoorn yesterday to monitor the situation.

● Blood samples were sent for tests and the diagnosis is expected this morning.

● All ostriches slaughtered since October 22 in Klein Karoo abattoirs have been isolated and an embargo has been placed on their distribution.

● Export of all fresh meat has been stopped, while fresh meat supplies have been removed from butcheries where possible.

● Klein Karoo abattoirs have been closed until further notice.

Townships panic over Congo fever

❑ From Page One

Oudtshoorn Hospital to treat patients with these symptoms."

Municipal workers took the temperatures of the 399 employees at the abattoir and referred 33 to the hospital for screening. Nursing staff worked into the night testing 440 people who arrived at the hospital thinking they had the symptoms.

"In the early stages of infection one experiences flu-like symptoms followed by diarrhoea, stomach pain and internal and external bleeding," Janicki said.

Professor Bob Swanepoel of the National Institute for Virology in Johannesburg said blood samples from the suspected cases were still being tested.

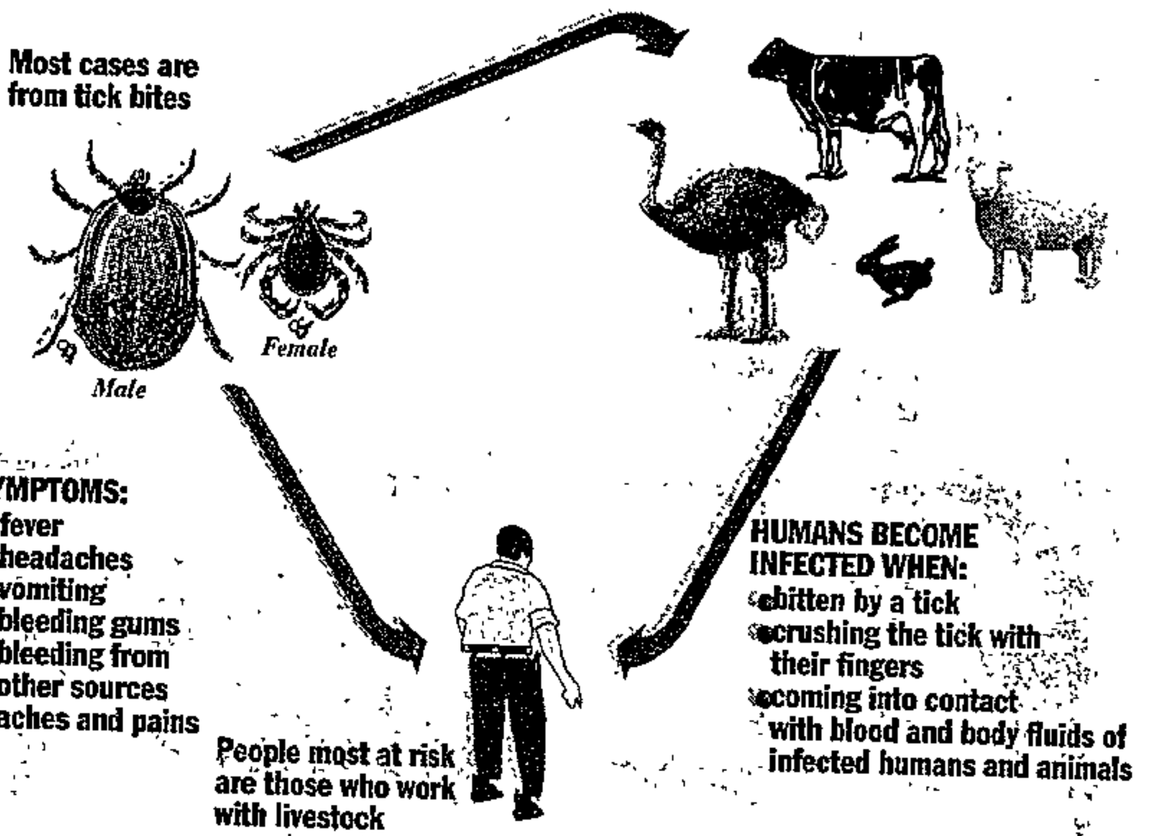
He said workers at the abattoir apparently complained after a consignment of ostriches "covered in ticks" was delivered. "Once the ostriches were killed, the ticks apparently climbed on to the workers."

A spokesman for the Klein Karoo Co-op, Mr Ben de Kock, said meat from all ostriches slaughtered since October 22 had been isolated. "The export of all fresh meat has been stopped and meat supplies removed from butcheries."

According to Dr Willem Burger of the Department of Agriculture, there are no known cases of people becoming infected with Congo fever after eating infected meat.

Experts said the incubation period was about two days if a person was bitten by an infected tick and between five and nine days through contact with infected blood. Once a patient began bleeding there was no cure. — Staff Writers

How Congo Fever is spread



AREAS WHERE CONGO FEVER IS FOUND
Throughout Africa, Mediterranean countries, China, Central Asia, India and Middle East, Former Soviet Union

NEWS

It's hazardous, it's infectious and the mortality rate is high

Why Congo fever has to be treated in isolation

ARG 5/11/96 (40) (89)

JENNY VIALL
HEALTH REPORTER

A security guard sits outside the isolation ward at Tygerberg Hospital. His job is to keep people out of the ward, where four abattoir workers are in a serious but stable condition with what is probably Congo fever.

Nursing sister Dorothy Solomons comes to the door, clad in layers of protective plastic clothing, looking like something from a futuristic movie.

Her voice is muffled through the plastic hood that will keep her safe from contracting this highly infectious disease. In another few hours it will be confirmed whether this is indeed Congo fever.

Already one person has died and 22 are suspected of having it. Eighteen people are being assessed and treated at Oudtshoorn, where the frightening disease broke out last week.

The reason for the slow confirmation of Congo fever is that blood samples have to be sent to the National Institute of Virology in Johannesburg, one of five such "Biohazard Class 4" maximum security laboratories in the Western world able to test for viruses so classified.

As the name suggests, these viruses are hazardous, highly infectious and have a high mortality rate.

Congo fever is a viral haemorrhagic fever, one of many that include lassa fever and ebola. It is transmitted through contact with blood from infected people and animals.

Ticks are the usual mode of transmission and result in more serious symptoms than transmission through contact with infected animals.

This outbreak is thought to have begun through contact with newly slaughtered ostriches, but it exists in "silent" form in animals like cattle and sheep, which show no symptoms.

Abattoir workers were not generally a high risk group, said Tygerberg Hospital virologist Anthony Keen. Congo fever followed a seasonal pattern, with ticks infecting animals at this time of the year.

Outbreaks like this were, however, uncommon, said Dr Keen. The disease began with body pains, fever and a headache. In some cases it stopped there and people felt they had flu.

In others it advanced and became more serious, causing internal bleeding, which could lead to death. Complications for those who survived were low white blood cell counts and kidney problems.

The latest outbreak was serious in that it had affected so many people. There were usually only a few cases a year in South Africa, but the outbreak already seemed to have affected more than 20 abattoir workers.

Fortunately, Congo fever had a short one-week incubation period, which meant that the full extent of the outbreak would be known soon.

At this stage it had affected only those working at the abattoir and had not spread to family members or health personnel – a good sign.

Congo fever was not to be trifled with. It was highly infectious, had a high mortality rate and the protocol for health workers treating patients suspected of having it was extensive. That was why Tygerberg Hospital's isolation ward, which stood empty for most of the year, had to be opened. Nobody was allowed into the isolation ward without protective gear.

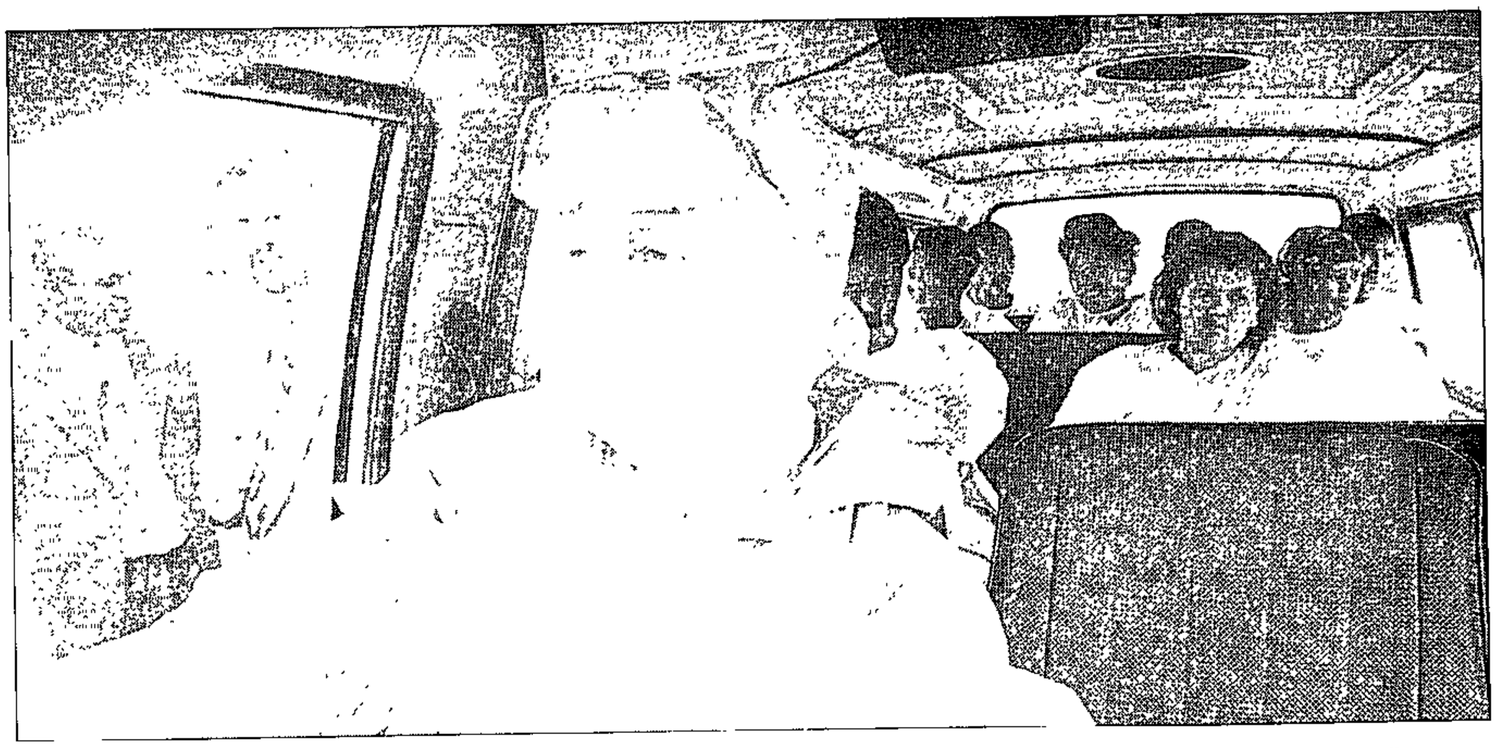
Today the four people being treated there were joined by 12 others from Oudtshoorn, airlifted by the air force.

Although the outbreak was serious, all precautions were being taken and there was no reason for panic, said health authorities. The Klein Karoo Co-operative's abattoirs had been closed. Meat had been held back and ostrich meat on sale was not contaminated.



ANDREW INGRAM

Fever victim: medics wheel a Congo fever victim into Tygerberg Hospital today



Flown in: watched by Health Minister Ebrahim Rasool, some of the less serious victims are driven to hospital by a well-protected medic

see page 6 + until 4am.

Congo fever patients fly to city in sealed ambulances

ARG 5/11/96 (90)(89)

JENNY VIALL
HEALTH REPORTER

A Hercules C130 aircraft, carrying 12 people suspected of having Congo Fever, landed at Ysterplaat Airforce base today.

The military aircraft, which flew from George airport, was cordoned off while the Metro ambulances carrying the patients on the transport aircraft, were offloaded. Patients had travelled in the sealed vehicles in the aircraft.

Minister of Health Nkosazana Zuma and Ebrahim Rasool, the Western Cape Health Minister, met the flight.

A Metro ambulance carried four stretcher patients in an advanced stage of the disease. The other eight patients were transported in a minibus.

The vehicles were sealed with duct tape to prevent contamination.

The aircraft will now be fumigated.

The ambulances were escorted by traffic police and Metro rescue vehicles to Tygerberg Hospital, where the patients were transferred to the isolation ward. Four other patients were brought in on Sunday night.

The outbreak has claimed one life – that of abattoir worker, Joyce Japhta, who died at home. So far 399 workers at Klein Karoo Co-operative abattoir have been traced and are being screened in Oudtshoorn.

The workers are thought to have been infected by contact with ostrich blood.

Meanwhile, a medical team has gone to Oudtshoorn to help with the outbreak – the biggest of its kind for many years, though authorities say there is no reason to panic.

The disease is not airborne and can be spread only by contact with blood or through tick bites.

Ostrich meat has been been held back and removed from butcheries, although there are no known cases of people contracting the disease through eating infected meat.

Pictures, background report, page 4



LEON MULLER

Watching: Nurse Dorothy Solomons with James Joubert, head of medicine at Tygerberg Hospital.

OFFICIALS, FARMERS MEET TODAY

Congo fever: ostrich meat dangers unclear

(89) CT 6/11/96

IT IS not yet known whether people can contract Congo Fever by handling infected meat — but distributors have been advised, as a precaution, not to sell ostrich meat until there is clarity. **JACKIE CAMERON** reports.

SCIENTISTS yesterday admitted that they did not know whether it was unsafe to handle raw ostrich meat — a possible source of the latest outbreak of the deadly Congo Virus which has left one person dead and 16 in hospital.

Professor Robert Swanepoel of the National Institute of Virology said it had not yet been established whether the workers at the Oudtshoorn abattoir had contracted the virus from ticks on the birds, or the slaughtered ostriches.

"We know the answer for sheep and cattle. We don't know about ostriches. We can only theorise. We have never researched them in connection with Congo Fever."

Swanepoel said abattoir workers could contract the virus from infected sheep and cattle, but the virus had never been found in a consumer of affected meat.

"Once meat is hung, there is a change in acidity during maturation. We believe, but are not certain, that this process kills off the virus."

Chickens and guinea fowl were not affected by the virus, but ostriches "are more like mammals than other birds".

He said that ostrich meat was not treated in the same manner as other meat and it was believed that freezing the meat soon after slaughter "could preserve the virus".

Swanepoel said he could not make recommendations to consumers "because I'm a small cog", but revealed that two people died of Congo fever in the Free State after coming into contact with cows which had died from a tick-transmitted disease.

"The meat was cut up fresh, and then eaten. People who ate, but didn't handle, the meat did not acquire the disease."

This emerged yesterday as distributors were asked not to sell their ostrich meat and politicians, government officials and ostrich farmers prepared for a high-powered meeting in Oudtshoorn today in connection with the crisis.

The Department of Health was not in a position yesterday to comment on the virus or give consumers advice on whether they should prepare ostrich meat bought in supermarkets, saying that Swanepoel was handling the matter for them.

Swanepoel said that there had been 126 "confirmed" cases of Congo fever in South Africa in the last 17 years, in which about 26 people died. Most incidents have not been reported in the media.

He said tests on ostriches were expected to commence today, but it could be several weeks before the results were known.

Mr Attie de Waal of the Klein Karoo co-operative said: "We have asked our customers to keep their meat as it is, frozen, until further notice. They should not touch it until there is clarity. The authorities will also make announcements.

"We want to play it absolutely safe. To our knowledge there is not yet evidence that people can get this from meat. This is a precautionary measure."



FEVER WATCH: Early yesterday 12 Congo fever patients were transferred from Oudtshoorn to Tygerberg Hospital by ambulance. Metro worker Mr Donald Nortier donned a space-age suit, including respiratory system, which shielded him from the four patients.

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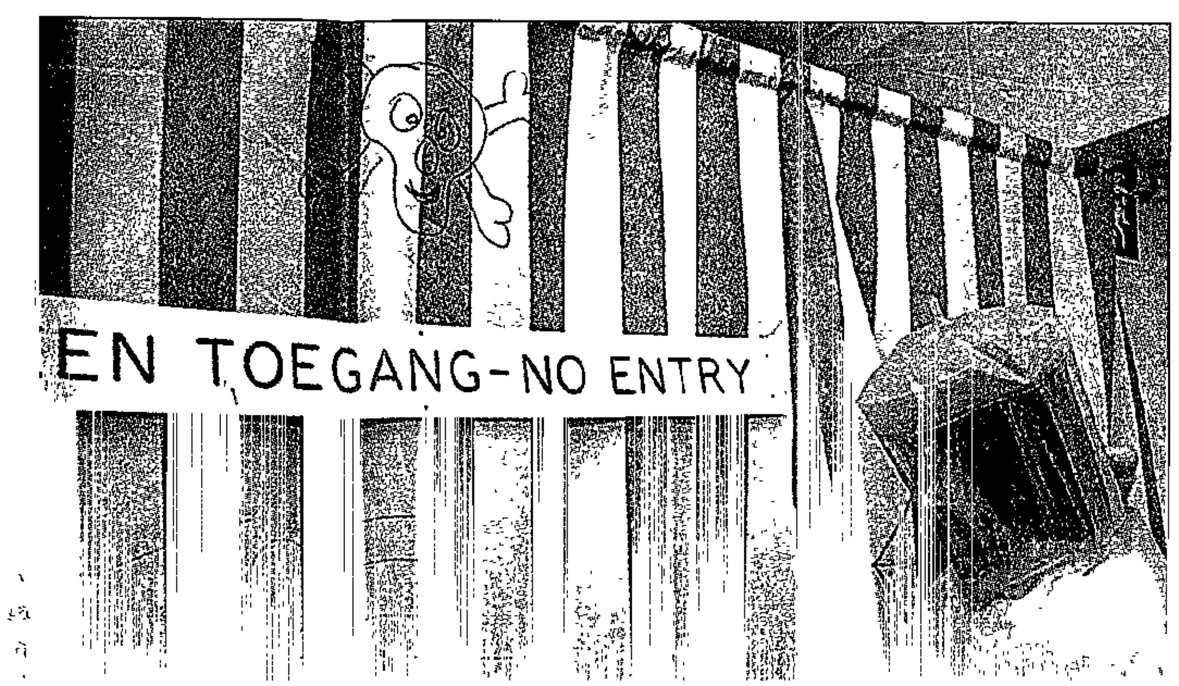

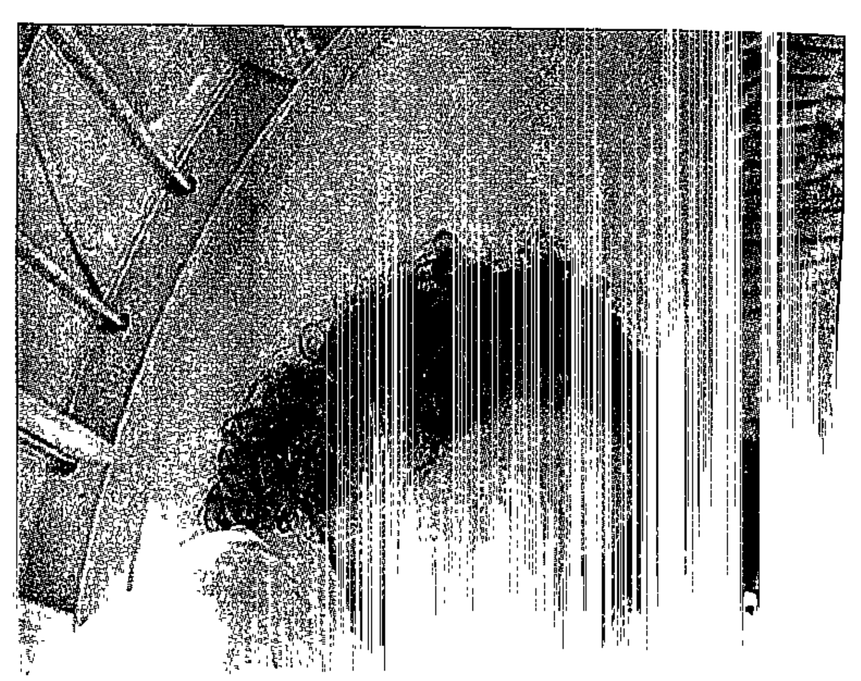

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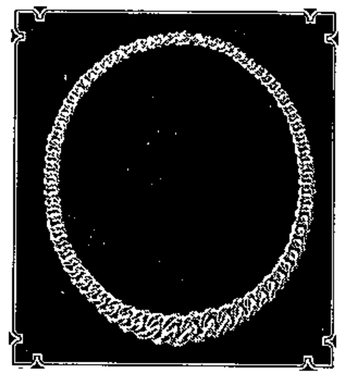

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PANIC: A policewoman visited Oudtshoorn Hospital fearing she had symptoms of Congo fever. A nurse said she had an ordinary nosebleed.

TAKING NO CHANCES: Dr Jaco Jansen donned a full body suit, a plastic hood with breathing apparatus, and three pairs of rubber gloves before entering the ward where the 12 patients were being held.

Fear and tension on a mission of mercy

CT 6/11/96 (89)

LISA TEMPLETON

SWEAT shone on the doctor's brow as he stared at his fingernails intently.

Dr Jaco Jansen was one of a team of doctors and nurses who were flown to Oudtshoorn on Monday, where the virulent Congo fever had already claimed a life and hospitalised four.

"We do not know how many people have been infected or what to expect when we get there," a doctor said before the South African Air Force Dakota took off. "We have prepared a ward at Tygerberg for 22 patients just in case."

Photographer Garth Stead and I joined the team of Tygerberg doctors and nurses for their 12-hour visit to Oudtshoorn, where they worked into the night to assess the extent of the outbreak and decide what to do with infected patients.

On the team were Tygerberg Hospital's chief superintendent, Dr Abul Rahman, senior superintendent Dr Revere Thomson; Jansen, Dr Niel du Toit, and nurses Miss Annekie Gelderbloem (former head of Tygerberg's Congo fever unit, who came out of retirement for the trip), Matron Wilma Cloete, and Senior Sister Ida Carolus.

The team arrived at Oudtshoorn Hospital to a packed waiting room of grim-faced, silent people and immediately set to work.



Jansen and Du Toit donned space-age suits with plastic covered boots, plastic aprons, three pairs of surgical gloves sealed with masking tape, and eerie plastic hoods into which air was pumped, before venturing into the wards to assess the patients.

Meanwhile nursing sisters began testing for the disease — which starts with flu-like symptoms and eventually leads to death if not treated — by taking temperatures and checking backs, chests and knees for bleeding, warning people to return if they began to feel worse.

Besides the 33 employees of the infected abattoir, another 400 people walked into the Oudtshoorn Hospital yesterday, fearing they had contracted the fever as panic spread in the townships.

Pictures by GARTH STEAD

The air of fear in the waiting room was infectious and I felt a trifle nervous knowing that only a passage away was a ward of patients who had contracted a disease which can make one bleed to death or suffer multiple organ failure.

At that stage we did not know how sick the patients were.

Among the anxious workers waiting to be tested was Mr Raymond Jafta, whose mother, Mrs Joyce Jafta — who had six children ranging in age from 12 to 26 — died early on Monday.

"It was a great shock — she was strong and healthy and her death was so sudden," he said.

He said she had first experienced dizziness last Monday and was diagnosed by the abattoir doctor as having flu. By Friday blood was pouring from her nose and on Sunday night she was in hospital, where she died early on Monday.

"I worry that abattoir workers will spread the disease to their children, particularly nursing mothers," said Jafta, expressing the fears of many of the workers.

Another woman, who had two small children, said Congo fever had caused anxiety and fear in the community as it was the first time there had been such an outbreak in the area.



TENSE: Dr Jaco Jansen was one of a team of doctors flown to Oudtshoorn on Monday — not knowing how severe the outbreak there was.

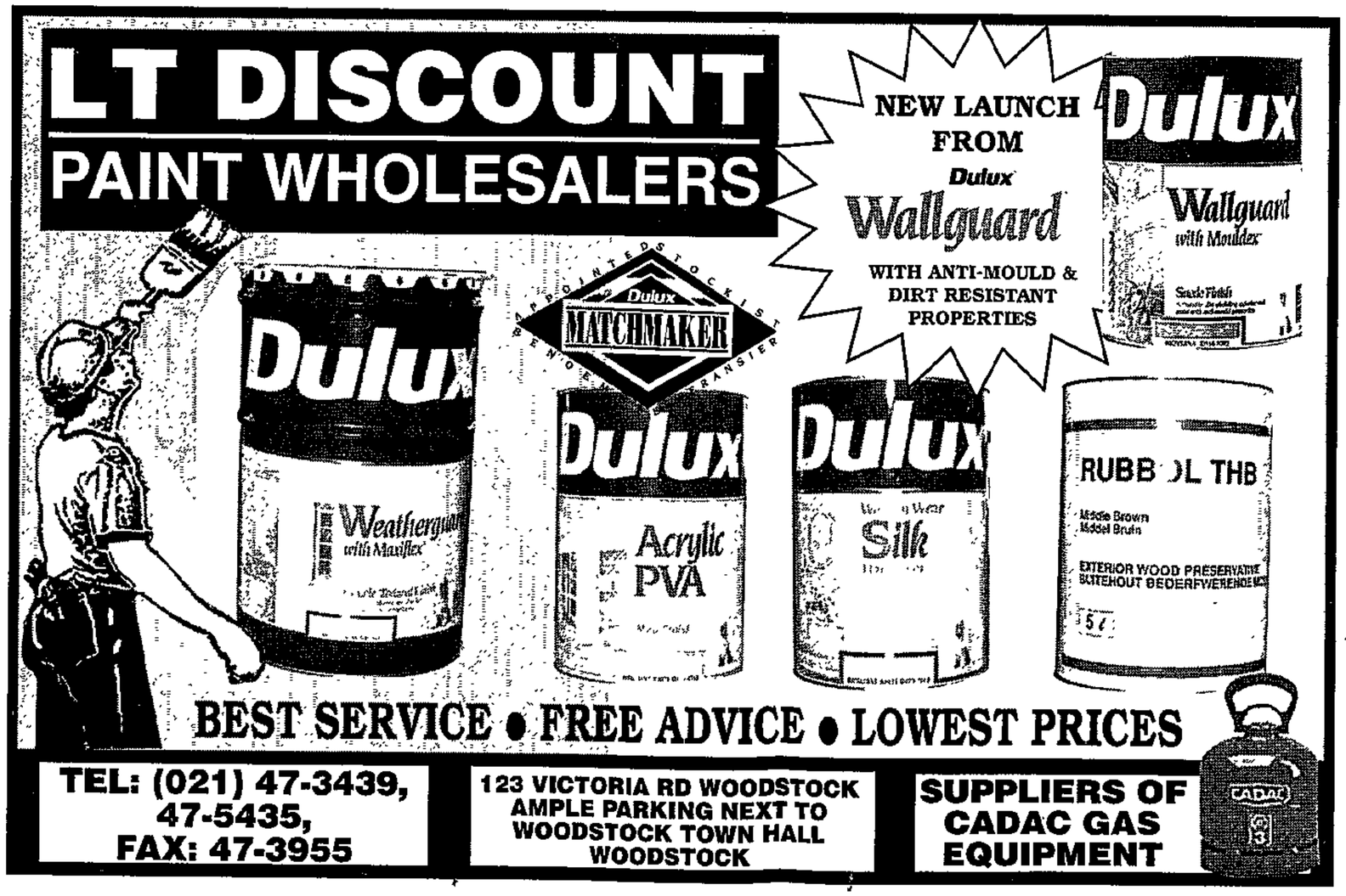
As we stood in the silent waiting room an ambulance arrived with an extended family of 10, including wide-eyed children, who had come for testing despite having nothing to do with the abattoir, because the parents feared they were infected.

It was late at night before the exhausted medical staff finally left the hospital.

When we returned early yesterday the tension had lifted and smiling hospital staff waved goodbye to patients who were dispatched in sealed ambulances for Tygerberg Hospital.

"They are more terrified than sick," said a doctor.

Late yesterday afternoon the 12 patients were in a stable condition.



Workers got disease through touching and inhaling blood

STAFF WRITER

THE 17 abattoir workers with Congo fever probably contracted the disease from inhaling and touching infected blood.

Dr Mark Beale, head of the Infectious Diseases Unit at Tygerberg Hospital, said the mildness of the cases and the four-day period in which the patients became sick, pointed to mass blood exposure rather than ticks as a cause.

"All the patients worked in the same area of the abattoir where the early part of the slaughtering process takes place — some plucked feathers, some slaughtered and others managed.

"If infected ostriches were slaughtered at the same time, there would be a lot of infected blood splattered around," said Beale.

He said blood could enter the body through small cuts, the eyes, mouth, and through inhaling vaporised blood.

"Tick bites tend to make patients more seriously ill than the mild cases we have seen, as the tick injects quite a lot of the virus into the body," he said.

Congo fever, which starts with flu-like symptoms, can result in the patient's bleeding to death, usually through vomiting or bleeding through the rectum. Alternatively, little blood clots in the brain or organs can lead to multiple organ failure and death.

The mortality rate for patients who reach the bleeding stage is 40 to 50%, but it is much lower for cases diagnosed early.

There is no cure for the virus, but patients are given supportive therapy until the body creates antibodies.

Bleeding patients can be given immunoglobulins (the blood of patients who have recovered and which therefore contains antibodies).

It takes the body seven to 10 days to develop antibodies to the virus.

There is no evidence that the virus spreads through secondary contact — from person to person — and an average of 40 people contracted the virus worldwide every year, Beale said.

He said three of the patients flown to Tygerberg on Sunday were improving, while one remained constant, and the 12 patients who arrived at the hospital yesterday did not look seriously ill.

NEWS

(89) ARLG 6/11/96

Fever fear grips the ostrich town

Minister appeals for calm

JENNY VIALL
HEALTH REPORTER

A small group of people sit in the waiting room of Oudtshoorn Hospital for their turn to be screened by health workers to see if they have Congo fever. Many are relatives of those fighting for their lives in Tygerberg Hospital.

A nurse battles to find the vein of a three-year-old girl who is having her blood tested. It's late in the day and the rush is over. Hundreds of people have been to the hospital to be examined and the staff, backed by a team from Tygerberg Hospital, are clearly exhausted.

There's no panic but there is uncertainly and fear in the town as the number of ostrich abattoir workers who have the disease increases.

To date 16 people are lying ill in Tygerberg Hospital and one woman has died from the highly infectious fever. Another is in hospital in Oudtshoorn.

At a meeting of Oudtshoorn community leaders yesterday to answer questions and allay fears, Western Cape Health Minister Ebrahim Rasool called for calm, saying people were not in danger. He stressed that the disease was not airborne. It was safe to breathe the air of Oudtshoorn, he said.

But many questions were unanswered. A clearly emotional Raymond Japhta, son of Joyce Japhta who died on Sunday, has asked for an investigation into his mother's death, saying the hospital refused to admit her on Friday even though she had a fever and was bleeding. Instead, she was given Panado, a painkiller, and sent home. That was after three visits to doctors.

At this stage it is not known how long the virus can survive in meat after an ostrich is slaughtered but it is thought to be between 12 and 30 hours. What about people who work with the bloodied ostrich hides? Who else is at risk? These were the questions that tumbled out.

The good news for the community is that the outbreak seems to be under control and today a high-level meeting has been called by the Klein Karoo Co-Op which operates the abattoir.

The origin of the tick-carrying ostriches, almost certainly to blame for the outbreak, will be traced as soon as possible.



ANDREW INGRAM

Testing time: a girl has her blood tested for Congo fever at Oudtshoorn Hospital

The co-op has closed its abattoir, which processes 700 to 800 ostriches a day and stopped all distribution of its meat, raising fears that the Oudtshoorn economy, dependent on ostriches and tourism, will suffer.

The abattoir provides work for 400 people. Co-op chairman Attie De Waal said 10 ostriches had already been sent for tests to investigate what happens when they are infected with Congo fever-carrying ticks.

Girl, 8, latest likely victim of Congo virus

JENNY VIALL
HEALTH REPORTER

An eight-year-old girl suspected of having Congo fever has been admitted to Oudtshoorn Hospital.

She is the daughter of a woman being treated for the highly infectious disease in the Tygerberg Hospital isolation unit and is a high risk case because she cleaned up her mother's blood.

The child's condition was stable, said Stanley Janicki, superintendent of Oudtshoorn Hospital.

If the child has Congo fever she will be the first secondary infection case to be admitted to the hospital.

Primary infection is through direct contact with the source, in this case infected ostriches.

But Mark Beale, the doctor in charge of the patients airlifted from Oudtshoorn to Tygerberg, said there was no cause for alarm.

The girl was at high risk because of blood contact and the outbreak would not spread to the general public, he said.

The 16 patients at Tygerberg are in a stable condition.

The defence force's SA Medical Services has provided 20 nurses and six doctors to help at Tygerberg.

More help is expected from Groote Schuur Hospital.

Bid to end transmission of Congo fever

(89) ED 6/11/96

MEASURES to prevent the transmission of Congo fever would be discussed today, Agriculture and Land Affairs Derek Hanekom said yesterday.

One worker died and 16 others were airlifted from Oudtshoorn to Cape Town's Tygerberg Hospital on Monday and yesterday after showing symptoms of the disease. It is suspected they contracted it after handling ostriches being slaughtered for meat.

Ten ostriches were sent to the Johannesburg Institute for Virology, but none tested positive. Trials conducted on cattle had confirmed the disease could not be transmitted to humans through the handling or ingestion of beef matured for 24 hours, he said. An institute spokesman agreed, and said the virus was caused by tick bites.

Nonetheless, ostriches would be quarantined before slaughter. — Sapa.



Taking no chances... 12 Congo Fever patients were transferred from Oudtshoorn to Tygerberg Hospital by ambulance yesterday morning. Ambulance attendant Donald Nortier wears a space-age suit, including respiratory system, to shield him from four contagious patients inside the vehicle.

Experts converge on Oudtshoorn as fever panic spreads

Star 6/11/96 (89)

REUTERS, SAPA AND AFP

Oudtshoorn – Forty scientists, doctors, vets, trade unionists, agricultural and municipal officials meet in Oudtshoorn today to thrash out the Congo Fever outbreak which has claimed one life and hospitalised another 18 workers at an abattoir for ostrich products.

Joyce Japhta, a mother of six, died at her Toekomsrus home near Oudtshoorn on Monday.

The suspected victims of the rare haemorrhagic fever, also known as Congo Fever, have all been flown by the air force to Cape Town's Tygerberg hospital where their condition this morning was described as "holding their own".

Blood samples are being tested by the SA Virology Institute in Johannesburg to determine if they are in fact suffering from the disease.

Klein Karoo Co-op personnel manager Coenie Louw said today the abattoir staff were not wearing protective clothing while working with ostriches as there had never been a Congo Fever scare since the facility was opened about 30 years ago.

"It would be very difficult to pull off the skin of the dead birds wearing gloves, but we will do everything possible to prevent another outbreak. If this is what they suggest, we will do anything to protect our workers," he said.

South Africa has had 123 cases of Congo Fever since 1981, mainly in the dry Karoo regions. The fatality rate has been about 25%, a SA Virology Institute spokesman said

Western Cape Health MEC Ebrahim Rasool visited Oudtshoorn yesterday where he assured people there was no cause for panic and the chances of recovery of the patients were good.

He assured people the only way the virus could be transmitted was by a bite by a specific tick or contact with bodily fluids, said Louw.

Mother of six died of fever

The outbreak of Congo Fever in the heart of the lucrative ostrich industry has forced a halt to slaughtering of the birds at the affected abattoir to the export of their meat.

"The export of all fresh meat has been stopped immediately while all fresh meat supplies have been removed from butcheries where possible," said a statement by the Klein Karoo Co-op, which dominates the world market in ostrich products.

Dr Mark Beale, head of the Infectious Diseases Unit at Tygerberg Hospital, said the mildness of the cases and the four-day time period in which the patients became sick pointed to mass blood exposure rather than ticks as a cause.

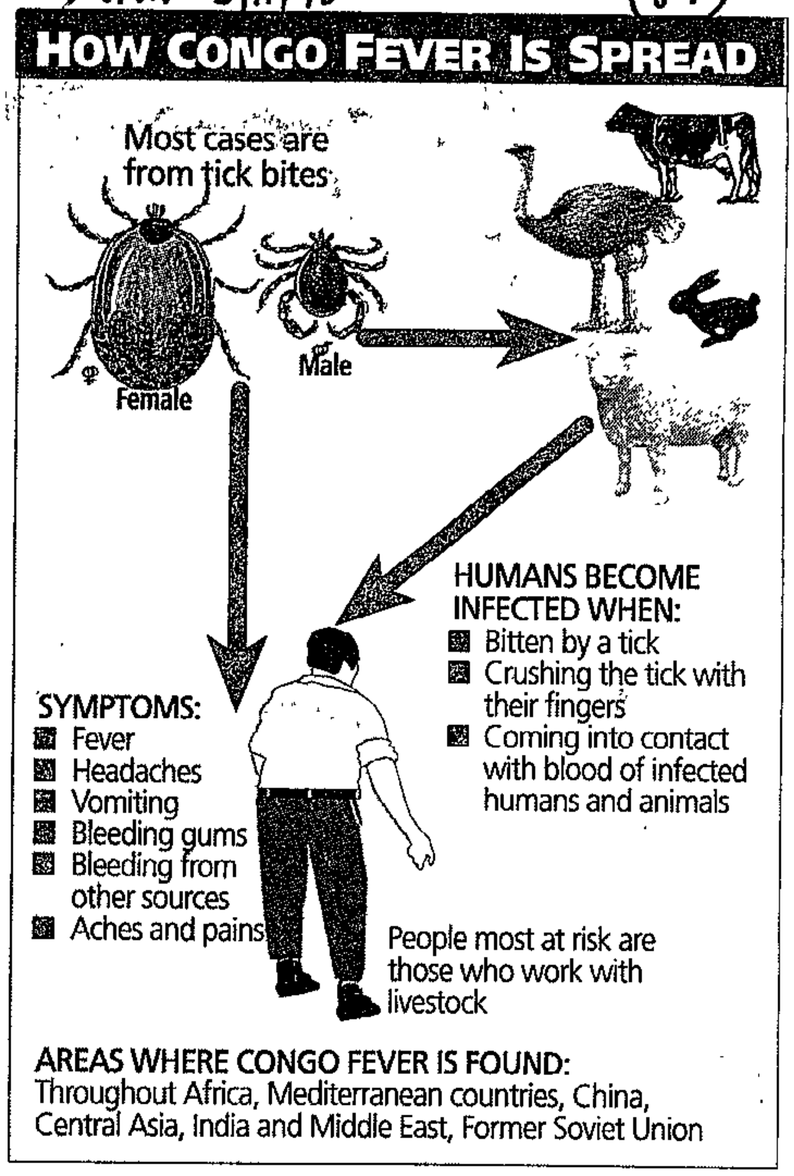
"All the patients worked in the same area of the abattoir where the early part of the slaughtering process takes place, some plucked feathers, some slaughtered and others managed. If viraemic ostriches were slaughtered at the same time there would be a lot of infected blood splattered around," he said.

"The blood could enter a body through small cuts, eyes, mouths and through inhaling vapourised blood.

"Tick bites tend to make patients more seriously ill than the mild cases we have seen, as the tick injects quite a lot of the virus into the body," he said.

There was no evidence the virus spread through secondary contact – from person to person – and an average 40 people per year contracted the virus worldwide.

Agriculture Minister Derek Hanekom said matured ostrich meat would be fit for human consumption.



MEAT HELD BACK

Ostrich abattoir closed pending test findings

CT 7/11/96 (89)

OUDTSHOORN: Veterinary and health experts meeting here following the Congo fever outbreak in the area have drawn up revised safety precautions for all abattoirs. **JACKIE CAMERON** reports.

THE Klein Karoo abattoir at which workers were infected with the deadly Congo fever virus, will remain closed — and its ostrich meat stockpile kept in storage — until scientists have completed a research project on the effects of the virus in ostriches.

This was the outcome of a meeting in Oudtshoorn yesterday at which veterinary and health experts also revised the safety precautions to be taken at all abattoirs following the outbreak.

It emerged at the meeting that between six and 20 people a year contract the disease in South Africa, mostly from contact with sheep.

Dr Dirk Verwoerd, programme manager of the ostrich unit at Onderstepoort Veterinary Institute, said: "We looked at the human and safety aspects, and how we could prevent this from being repeated. Nothing has ever been done specifically to prevent this virus.

"Klein Karoo has acted prudently by withdrawing meat. The abattoir will not be opened for 14 days at least. If no secondary cases emerge, one can say it's safe and they can start with a clean slate. Meat will be held in storage awaiting the results."

He said a directive would be sent to all abattoirs advising them to rinse safety overalls and boots in an insecticide geared to prevent Congo fever.

"Birds for slaughter must be treated in the last month for ticks. They will be inspected before slaughter. We won't allow animals with obvious ticks into the abattoir."

Professor Robert Swanepoel, of the National Institute of Virology, said he had advised that ostriches in the area should be treated with an insecticide and isolated until they are "clean and safe".

He was reluctant to comment about the ostrich meat which is being held in storage and said that tourists wanted to eat ostrich meat on the farms.

"I told them this meat was their problem. If there's a big industry at stake, they should keep their noses clean and do the best thing."

CT 7/11/96

Little Karoo farmers hope Congo scare will blow over

89 CT

LISA TEMPLETON

OSTRICH farmers fear Congo fever will harm the industry — their "bread and butter" — but hope the scare will blow over.

The farmers in the Little Karoo still don't know how the outbreak — which resulted in one death and 16 people being hospitalised — will affect business.

"We are worried because farming is our livelihood, and we have too little information to go on while the outbreak is being investigated. No-one knows yet how the disease spread," said Mr Stephen Muller, a director of Karoo Valley Farms.

"I hope in a week or two it will blow over. We will have to wait and see," he said.

Mr Jack Klass, who owns a large ostrich farm, said he was worried, but "I reckon it will be all right".

He said he and other farmers had been inconvenienced by the halt in slaughtering at Oudtshoorn's two abattoirs. Ostriches that had been intended for slaughter now had to be fed.

Meanwhile, the owners of tourist show farms, which are popular with both local and foreign tourists, say their business has not been affected by the Congo fever outbreak.

Mr Alex Hooper, owner of Highgate Ostrich Show Farm, said they were receiving the same number of visitors and there had been no cancellations.

"We took ostrich meat off our restaurant's menu on Monday and have been serving beef for three days, but people have been demanding that we serve ostrich meat," he said.

His guides had been informing visitors about the outbreak.

Mr Douggie Bester, manager of the Cango Ostrich Farm, said foreigners continued to flood on to the farm, but about 10% of the bookings had been cancelled — mostly by school groups.

"I just hope there won't be any long-term effect because of bad publicity, as there was with mad cow disease," he said.

People tended to confuse the word Cango with Congo, as in the Cango Caves, and thought there are many sick ostriches.

Bester said their restaurant had also stopped serving ostrich meat.

Panic as Congo fever hits town

(89) Sowetan 7/11/96

Abattoirs shut down after one worker dies in in Oudtshoorn

By Rafiq Rohan
Political Correspondent

PANIC HAS GRIPPED the small town of Oudtshoorn following the confirmed outbreak of Congo fever, which has already left one person dead while 14 others were airlifted to Cape Town's Tygerberg Hospital.

Yesterday Minister of Agriculture and Land Affairs Mr Derek Hanekom said that slaughtering activities at the abattoirs in Oudtshoorn had been suspended after the notification of the disease, correctly named Crimean-Congo Haemorrhagic Fever.

Hanekom said that a meeting would be held later today to discuss measures to protect abattoir workers. The disease can only spread through tick bites or through contact with contaminated blood.

The person who died was Joyce Japhtha. Workers at abattoirs have been traced and screened for possible contact with the disease.

Hanekom said the abattoirs were shut down because of a possible link between the disease and the handling of ostriches for slaughter.

Investigation

"The matter is currently under investigation by the Directorate of Veterinary Public Health, in close collaboration with officials of the Klein Karoo Cooperative, National Institute for Virology, Department of Health and provincial authorities of the Western Cape," Hanekom said.

Yesterday local MEC for health Mr Ebrahim Rasool visited the area while the South African Air Force has been drawn in to airlift possible victims to Cape Town.

There is still no clarity on the exact cause of the outbreak.

Hanekom said so far researchers were of the opinion that the most probable cause of the infection was contact with infected ticks "of the Hyaloma species" during defeathering before slaughter.

"It is not yet a certainty that contact with fresh blood and excreta from slaughtered ostriches can be ruled out as a source of infection."

He said extensive trials conducted with cattle had already confirmed that the disease cannot be transmitted to humans through the handling of beef.

Sadtu supports

14 Congo fever patients to go home

ARCT 8/11/96 (89)

HEALTH REPORTER

Fourteen of the 16 people in Tygerberg Hospital with Congo fever will be discharged and sent home to Oudtshoorn today.

The only patient in Oudtshoorn is also likely to be discharged today.

Of the 14 Tygerberg patients, one did not have Congo fever, said Mark Beale, doctor in charge of the patients.

He said it was too early to say whether the outbreak had been contained. It would take another week to see whether anyone got the virus from the abattoir workers originally infected.

The condition of the two patients remaining in the Tygerberg isolation ward was stable, Dr Beale said.

One had Congo fever and the other, while having a low platelet count, had not developed antibodies to the disease and had tested negative.

The discharged patients would be monitored closely but he did not expect complications, Dr Beale said.

None of the 400 people who had contact with the infected people, had shown any symptoms of Congo fever. They were being monitored daily.

"The eight-year-old girl suspected of contracting the virus from cleaning up her sick mother's blood, is well and does not have Congo fever," said Dr Beale.

The doctors and nurses sent to Oudtshoorn to help return to Cape Town today.

Alert Oudtshoorn doctor spotted Congo fever signs

(89) Star 9/11/96

OWN CORRESPONDENT

Cape Town – Joyce Japhta, an abattoir worker in Oudtshoorn, went to Oudtshoorn Hospital with flu-like symptoms last Friday. She had a fever and a headache and was discharged with painkillers.

On Sunday night she died, a victim of the dreaded Congo-Crimean haemorrhagic fever. But it was not her death that alerted doctors to the fact that the biggest outbreak of Congo fever ever recorded in South Africa was about to happen.

That happened before, when a private doctor in Oudtshoorn contacted Mark Beale, head of infectious diseases at Tygerberg Hospital, on Sunday morning.

He had noticed that two of his patients had similar symptoms, and they both worked at the same place, the abattoir at the Klein-Karoo Co-op.

Nursing staff had also seen patients with similar symptoms. Beale flew to Oudtshoorn on Sunday, and that night four people who were bleeding were airlifted to Ysterplaat by the air force and taken to Tygerberg Hospital, which has facilities to isolate patients and staff experienced in dealing with Congo fever.

At that stage it was not known whether it was indeed Congo fever, a highly infectious virus spread by a tick bite or infected blood. Symptoms pointed to some kind of haemorrhagic fever, but because it is so highly infectious, it can be tested for only at the National Institute of Virology in Johannesburg, one of five such maximum security laboratories in the Western world.

It took until Tuesday to confirm that the four people had Congo fever.

It is caused by a virus passed on by the bont-legged tick, either to humans through a bite, or to animals who can then infect people who come into contact with their blood or body fluids.

It is not an airborne virus, but it takes only a minuscule amount of blood or body fluid to infect a person. The virus is more deadly (mortality rate of around 60%) if the person is bitten directly by a tick. The person dies because the blood doesn't clot and he or she bleeds to death.

Less than 1% of bont-legged ticks carry the Congo fever virus, and the chances of animals becoming infected are low.

An animal bitten by the tick is infectious for two to three days until it builds up antibodies.

Although there have been previous sporadic incidents of Congo fever in SA, it usually affects only one or two people.

Meanwhile, the Klein-Karoo Co-op has arranged a meeting of health authorities, vets and scientists to determine the safety of handling ostrich meat. They say it is safe for human consumption but the co-op will withhold its meat until research has been done on it as a precaution.

Sweating out Congo fever crisis

A week of drama as biggest-ever outbreak strikes

ARG 9/11/96 (89)

JENNY VIALL
STAFF REPORTER

Last Friday Joyce Japhta, an abattoir worker in Oudtshoorn, went to Oudtshoorn Hospital with flu-like symptoms. She had a fever and a headache and was discharged with painkillers. On Sunday night she died, a victim of the dreaded Congo-Crimean haemorrhagic fever.

But it wasn't her death that alerted doctors to the fact that the biggest outbreak of Congo fever ever recorded was about to happen. That happened earlier when a private doctor in Oudtshoorn contacted Mark Beale, head of infectious diseases at Tygerberg Hospital, on Sunday morning.

He had noticed that two of his patients had similar symptoms, and they both worked at the same place, the abattoir at the Klein-Karoo Co-op. Nursing staff had also seen patients with similar symptoms.

Dr Beale flew to Oudtshoorn on Sunday, and that night four people who were bleeding were airlifted to Ysterplaat by the Air Force and taken to Tygerberg Hospital.

At that stage it was not known whether it was indeed Congo fever, a highly infectious virus spread by a tick bite or infected blood. Symptoms certainly pointed to some kind of haemorrhagic fever, but because it is so highly infectious, it can be tested for only at the National Institute of Virology in Johannesburg, one of five such maximum security laboratories in the Western world. It took until Tuesday to confirm that the four people had Congo fever.

The fever is caused by a virus which is passed on by the bont-legged tick, either to human beings through a bite or to animals, who can then infect people who come into contact with their blood or body fluids. It is not an airborne virus, but it takes only a minuscule amount of blood or body fluid to infect a person. The virus is more deadly (with a mortality rate of around 60 percent) if the person is bitten directly by a tick. The person dies because the blood doesn't clot and he or she bleeds to death.

Although there have been sporadic incidents of Congo fever in South Africa, it usually affects only one or two people. In 1984 two people died. One was a doctor treating a person who had the disease. Six others contracted the disease but survived.

By Monday it was clear this outbreak could be huge. People, all abattoir workers, were streaming to Oudtshoorn Hospital with symptoms. A team from Tygerberg Hospital flew to Oudtshoorn to help out and arrangements were made to airlift 12 people. After numerous delays, an SADF Hercules C130 carried the 12 to Ysterplaat.

In a scene akin to the movie *Outbreak*, two Metro vehicles, an ambulance and a minibus drove from the back of the Hercules, every window and door sealed with brown tape. Metro staff wore masks and protective clothing. Traffic police then escorted the convoy, sirens blaring, to Tygerberg Hospital. Four of the patients were stretcher cases. By now Dr Beale could confirm that it was indeed Congo fever.

'Everyone agrees the swift efforts of all role-players contained the outbreak'

He told a briefing session of ministers and doctors at the hospital that so far there were no secondary infections (those picking up the virus from people first infected). That was a good sign and we should pray that it stayed that way, said Dr Beale. There was a call for calm; the disease was unlikely to spread and there was no danger to those not in contact with blood of infected people.

On Tuesday afternoon provincial Health Minister Ebrahim Rasool and a delegation of health officials flew to Oudtshoorn. Community leaders reported that there was fear and uncertainty among people. Meanwhile, nurses were visiting the homes of those infected and allaying fears, while school nurses were doing their best to reassure schoolchildren.

Raymond Japhta, son of the woman who died, asked for an investigation into the way the hospital handled his mother.

At the hospital, two children – family members of an infected person – were admitted to the hospital with symptoms.

Meanwhile the Klein Karoo Co-op arranged a meeting of health authorities, veterinarians and scientists to find answers to the questions about the safety of handling ostrich meat.

They decided that ostrich meat was safe for human consumption but the Klein Karoo Co-Op would withhold its meat until after research on it.

Robert Swanepoel, a virologist with the National Institute of Virology, told the meeting in Oudtshoorn there was no documented record of people contracting Congo fever from eating meat from cows and sheep infected with the virus.

Virologists said the Congo fever virus could not survive outside a live host for more than a few hours. The chances of the outbreak repeating itself in the ostrich industry were remote, they said.

By yesterday morning the condition of the sixteen people at Tygerberg Hospital was much improved. The children in Oudtshoorn were clear of the virus and no new cases had been reported. Fourteen of the 16 people were discharged from hospital and sent home to Oudtshoorn. One did not have Congo fever. The other two are in a stable condition.

There is now cautious optimism that the crisis is ending. Everyone agrees that the swift, concerted and selfless efforts of all involved contained the outbreak.

Said Dr Beale: "Hopefully people will see from this Congo fever outbreak that there is nothing to get hysterical about. However, with the downgrading of healthcare we could easily lose the expertise we have needed for this outbreak. A lot of nursing staff have already left. Our mobilisation rate in a year's time could be far slower, and at a national rather than a local level."



Under wraps: a health worker dons protective clothing to test blood samples this week

Congo fever: Worst over

(89)
ST (CM) 10/11/96

By YVETTE VAN BREDA

DEDICATED medical staff at Oudtshoorn hospital volunteered to treat Congo fever patients — despite having no "space age" clothing to shield them from the dangerous disease.

Hospital medical superintendent, Dr Stanley Janicki, described the staff's valiant response when the Congo fever crisis broke.

"We don't have the facilities for such an emergency and the staff had none of the highly sophisticated protective plastic clothing necessary.

"Yet within two hours, four of the patients suspected to have contracted the disease were isolated," Janicki said.

Janicki said voluntary workers initially looked after the patients.

"Despite the risk they refused to stop tending patients, saying it was their job".

By yesterday morning a relieved Janicki reported that the worst was over and that the situation was under control.

How a parasite brought a Karoo dorp to its knees

By YVETTE VAN BREDA

ABOUT 300 tons of ostrich meat worth R4-million is to be destroyed following the outbreak of deadly Congo fever in the Karoo town of Oudtshoorn.

Yesterday hundreds of townsfolk attended a funeral for Joyce Japhta, 44, who died early on Monday after contracting the fever. Japhta worked at the local abattoir, where the largest outbreak of the disease in South Africa took place this week.

Sixteen other people, all abattoir workers, were airlifted to Tygerberg Hospital outside Cape Town, where 15 of them tested positive for the disease.

Fourteen of them were sent to Oudtshoorn Hospital on Friday after their condition improved.

Japhta's husband, Jan, and their six children buried her yesterday after a service at the local New Apostolic Church.

Attie de Waal, the head of the Klein Karoo farming co-operative, to which most farmers in the region belong, said the abattoir had decided to destroy all meat from ostriches slaughtered after October 22, when the abattoir reopened after closing for standard maintenance.

"We are doing this to restore the good image of the meat," he said. "To be absolutely sure that it's safe, we have decided that we will withdraw the meat stock and destroy it."

The outbreak of the disease has put a damper on the industry, which was headed for an export boom following the mad-cow disease scare in Britain.

However, neither locals nor tourists have been frightened off. Customers still ask for ostrich steaks and, although there have been inquiries about the safety of visiting the town, hotels are booked up.

Alex Hooper, chairman of the local tourism board and owner of Highgate show farm, said: "Visitors were disappointed when we told them we were not serving ostrich. The only reason we are not serving ostrich is because there is none available since slaughtering stopped."

Local councillors, people in the tourism industry, restaurateurs and farmers said the outbreak of the disease was a temporary setback.

The abattoir has been temporarily closed, but its 399 employees have been reporting to work daily to undergo medical checks. Health workers are screening families of suspected sufferers.

De Waal said production would not resume until "everything possible has been done to remove any risk of our workers contracting the disease".

Earlier this week, scientists — including virologists, experts in communicable diseases, veterinary surgeons and provincial health department officials — met farmers and others in the ostrich industry to plan against further outbreaks of the disease.

They believe the blood of a single ostrich, bitten by a tick carrying the virus, was responsible for the outbreak of the disease. The abattoir slaughters about 5 000 ostriches a week. All the infected workers except one were employed in the plucking and skinning sections, where most of the bleeding from the slaughtered animals took place.

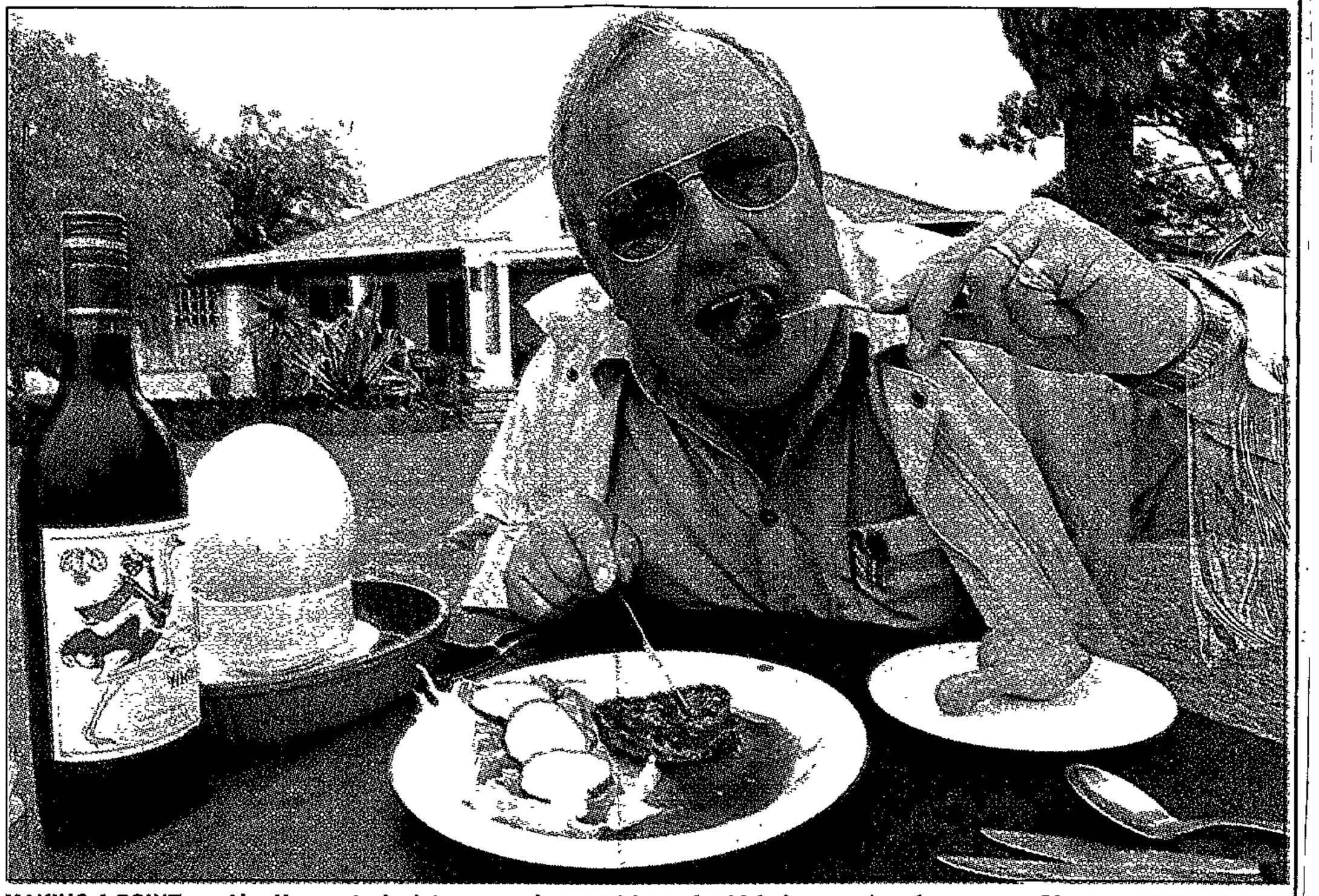
Stephen Cloete, the manager of the abattoir, said each bird was handled by hundreds of workers.

Although experts say the chances of another outbreak are remote, abattoir staff will be educated on high-risk areas and how to avoid contamination. They will also be issued with protective clothing.

The meeting recommended that birds be treated to rid them of ticks, then be quarantined for 14 to 30 days prior to slaughter.

Vicci Schoeman, the chairman of the SA Ostrich Producers Organisation, said farm workers were exposed to similar dangers as those faced by abattoir workers.

The head of the Ostrich Research Unit at Oudtshoorn, Dr Willem Burger, said cooked ostrich meat was safe for consumption.



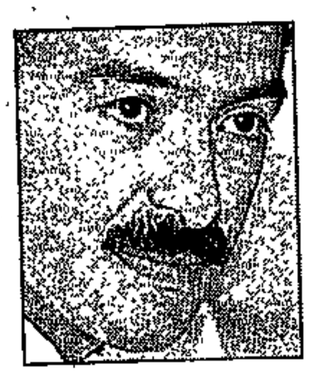
MAKING A POINT . . . Alex Hooper tucks into a succulent ostrich steak which, he says, is safe Picture: TERRY SHEAN

ST 10/11/96 (89)

MORE SPECIALISED SERVICES PLANNED

New strategy aims to assist diabetics

CT 14/11/96
(89)



A NEW APPROACH towards the treatment of diabetes is expected to improve the medical management of the disease. **ANEEZ SALIE** reports.

WORLD Diabetes Day today heralds a totally new approach to the management of the disease in the Western Cape — a "Shared Care" philosophy.

The new approach will emphasise education about diabetes within communities, in an effort to identify victims earlier.

It also aims to empower patients to participate and take charge of their own healing, through the power of knowledge.

Central to the new approach is the redevelopment of the University of Cape Town's Diabetes Centre, located at Groote Schuur Hospital.

The centre is headed by Professor Francois Bonnici, who is also president of the Pan-African Diabetes Study Group and vice-president of the International Diabetes Federation.

"We have begun to question the services our present centre provides and have examined strategies that would enable diversification and expansion," said Bonnici.

"Outreach programmes into the community healthcare clinics (day hospitals), and into groups of general practices, have proved very successful at initiating a Shared Care approach.

"The role of diabetes nurse specialists in training professional healthcare workers and patients ... is also opening a range of new possibilities for the future.

"Based on the Shared Care philosophy, we have the opportunity to develop a range of services to support those in the private and public sectors in managing their patients in the community.

"The new Diabetes Centre will ... (aim to) provide the highest-quality secondary and tertiary services ... to people with diabetes.

"The centre will have a commitment to seeking ways to improve the delivery of diabetes services, and to training diabetes health professionals in the community."

Bonnici said his unit had been regarded as one of the best in the country, yet it still operated with less facilities than a community health clinic.

"We have relied on the excellence and goodwill of our highly-trained staff, and have reached a crossroads which is opening a range of exciting possibilities for the future.

Bonnici said that underpinning the function of the centre would be the change in referral practice and "ownership" of patients.

"The patients will no longer be kept within the hospital system for long-term follow-up, but will be referred to the centre for a specific service — such as the management of an ulcer, the initiation of insulin therapy, or for complication screening.

"Our strategy will be to provide less routine follow-up, but more specialised services — targeting specific problem areas."

He pledged that the Shared Care programme would be more than just discharging patients from hospital clinics, or advising general practitioners about what to do.

"It will provide complementary services, which are integrated with the services already supplied by general practitioners or physicians in the community."

"It is unfortunately obvious that financial help will be required from the private sector," said Bonnici.

He said a UCT Diabetes Redevelopment Fund had been established in an effort to raise the money.

Diabetes: no longer a death sentence, but proper care is crucial

Quick diagnosis, treatment needed

(89)

ARG 16/11/96

ADELE BALETA
STAFF REPORTER

Diabetes, which affects millions of people, has taken centre stage this week as part of a national campaign to create awareness of the condition.

Diabetes can have grave consequences unless a quick diagnosis is made and patients have access to a team to help manage the condition holistically, say specialists working with children and adults at the University of Cape Town's Diabetes Unit at Groote Schuur Hospital.

The ancient Egyptians referred to diabetes and, although the first clinical description of the condition was by Arateaus of Cappodocia in the second century AD, there is still no known cure.

The diagnosis of Type 1 diabetes (insulin-dependent or juvenile onset diabetes) used to be a death sentence, but since the discovery of insulin 75 years ago millions of lives have been saved. The anniversary of this groundbreaking event was celebrated on Wednesday – World Diabetes Day.

There are still factors, however, which can lead to death in spite of the miracle of insulin. Specialists believe education and long-term clinical surveillance are the cornerstones of managing the condition and preventing severe complications.

Although juvenile deaths have decreased significantly, there are still occasional reports of children dying. Central to most of these cases is an incorrect diagnosis and inappropriate treatment, or failure to diagnose in time.

The symptoms in children are dramatic. There is weight loss, excessive thirst, frequent urination and fatigue and, unless the child or adolescent is given insulin as soon as possible, he or she can slip into a coma and can die in a matter of days.

'To improve programmes with children our efforts must be centered on an early diagnosis'

Insulin can only be injected and children have to learn how to administer these injections, sometimes up to four times a day, to stay alive. They also have to monitor their own blood sugar several times a day and sometimes their urine as well.

Type 2 diabetes (non-insulin dependent diabetes) or adult onset diabetes, although appearing mild, is a deadly threat. About 90 percent of people with diabetes in South Africa have this type, and due to ignorance as many as two to three million people in the country could have the condition and not know it. The condition is one of the main causes of blindness, it plays a major role in heart disease and kidney failure and 19 out of 20 amputations are as a result of diabetes.

Dr Brynne Ascott-Evans, senior specialist in the UCT Diabetes Unit at Groote Schuur Hospital, says at least 50 percent of diabetes cases in adults are picked up by chance, while in children the condition appears dramatically.

The main predisposing factor in adults is age – over 40.

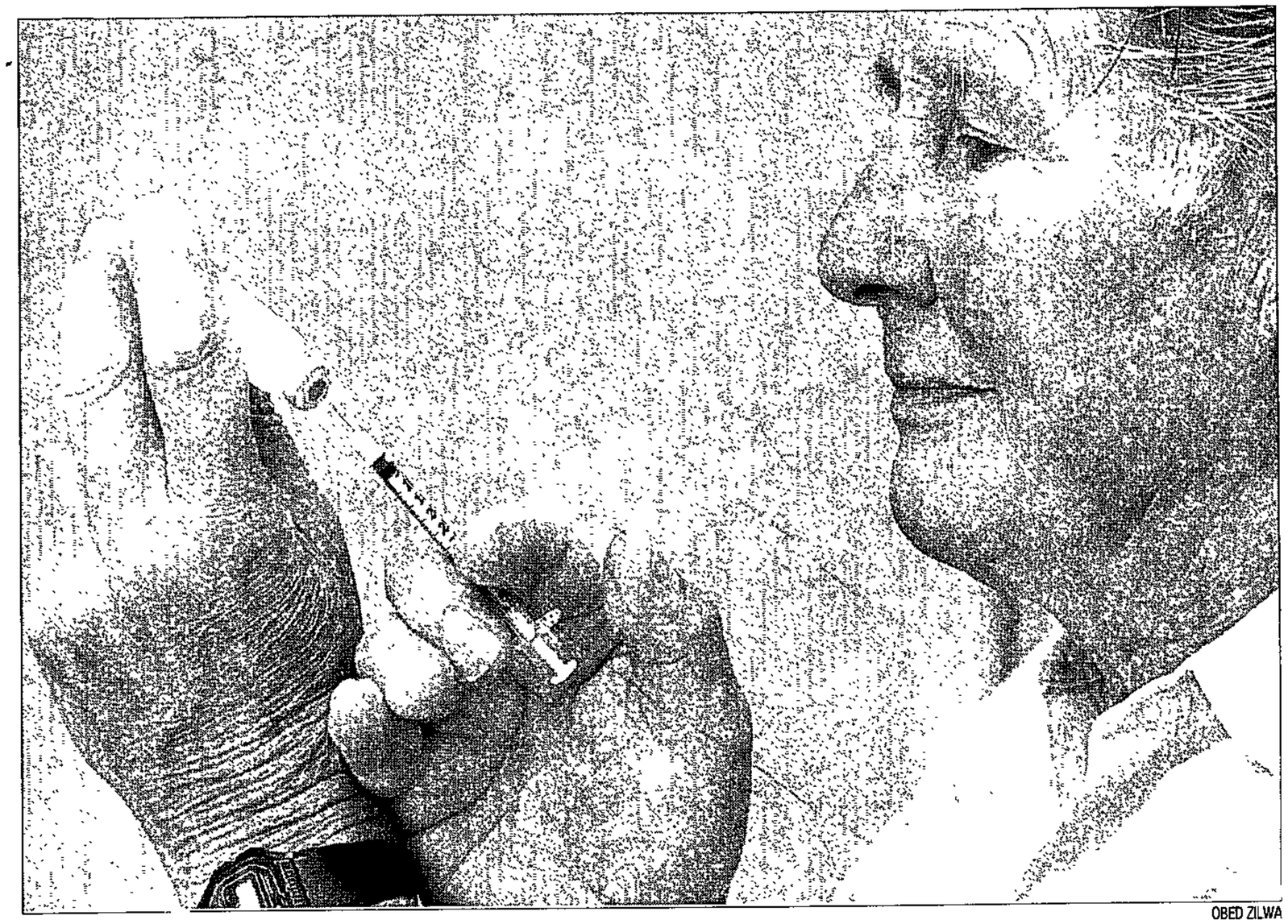
A Western lifestyle with the attendant junk food, obesity, smoking, stress and lack of exercise is the perfect scenario for the onset of adult diabetes or Type 2.

Dr Ascott-Evans says the lifestyle also puts people at risk for cardio-vascular disease, heart attacks, strokes and high blood pressure. Genes strongly predispose adults to diabetes.

He says many patients do not take their diabetes seriously and do not have an adequately controlled diet and exercise programme.

Dr Areti Philotheou, who co-ordinates clinical services for children at Red Cross Children's Hospital and runs the adolescent clinic at Groote Schuur Hospital, says there are 100 million diabetics in the world.

Most of these are adults but diabetes in children is on the increase, with as many as one or two out of every 1 000 school-going children in this country having the condition. "We see between 35 to 45 new cases a year in children who are under 12 years of age," she says.



OBED ZILWA

Still going strong: David Graham has been insulin dependent for 70 years and maintains his health and fitness by taking care with his diet

Dr Philotheou was given an award for her research trials into rapid acting insulins this year. She believes the needs of children and adolescents must be addressed by the public and health professionals.

She says children have major physiological, social and emotional differences. They cannot be seen a "little adults".

The philosophy of the unit's approach to caring for children is based on the fundamental rights of children expressed by the International Society for Paediatrics and Adolescent Diabetes.

The society says: "All young people with diabetes are entitled to competent medical management and diabetes education by a team of individuals who have expertise in and understanding of the medical and psychological needs of young people and their families.

"A child cannot fight for these rights. It is, therefore, the responsibility of society to provide all necessary support to the child and family."

Diabetes in children and adolescents is caused by the the destruction of beta cells in the pancreas as a result of an auto-immune process. This results in a deficiency of insulin, which is essential for regulating sugar levels in the blood. A lack of insulin is life threatening.

South Africa is fortunate as it is one of the few African countries which have access to insulin. In central and east Africa access to the drug is minimal and children die because of this.

"To improve programmes with children our efforts must be centred on an early diagnosis. All that was required to confirm the condition was a simple blood test and a urine test for sugar," Dr Philotheou says.

The prognosis can only improve if patients are cared for by a dedicated and committed team with experts in treating children.

She says the Red Cross and Groote Schuur diabetes units have a sound history of supporting diabetic children and their families.

The most important member of the team is the patient, who is supported by doctors, diabetes education sisters, social workers, dieticians and the family.

"Living with diabetes is not easy. Its a demanding condition that is intrusive on children's lifestyle, but with broad support including from teachers and friends children do well," Dr Philotheou says.

Medics move to contain outbreak of deadly Ebola

(89) ST 17/11/96

By CAS ST LEGER, NICOLA KOZ and CRAIG DOONAN

INTENSIVE health care is needed to save the life of South Africa's first Ebola patient, Johannesburg nursing sister Marilyn Lahana.

There is neither a drug to treat Ebola nor a vaccine to prevent it.

Lahana, who worked as a nurse at the Morningside Clinic, fell ill on November 6 and was admitted to the Sandton Clinic.

Her husband, Springbok lawn bowler Cyril Lahana, said he first knew that his wife was about to fall critically ill when she asked him: "Darling, what's wrong with me?" She had a severe headache and was unable to eat or drink. Soon afterwards, she was hospitalised.

By last Saturday, doctors suspected Lahana was suffering from viral haemorrhagic fever, of which there are many varieties, with Ebola being the most dangerous.

That day, virologists at the SA Institute of Virology, under Ebola expert Professor Bob Swanèpoel, tested Lahana's blood for antibodies to the virus. The virus was then cultured. By Thursday this week the virus had been isolated, and more tests were conducted throughout Thursday night.

On Friday morning, doctors and scientists were certain it *was* Ebola. Final confirmation came at 1pm yesterday.

By then, Lahana was very ill. Her kidneys were failing and she was put on a dialysis machine. She was given blood infusions to help fight the virus. Her husband said she was in an induced coma.

Yesterday afternoon, Lahana was transferred to an isolation ward at Johannesburg Hospital, where expert dialysis treatment and nursing of haemorrhagic fevers are available.

A flurry of emergency meetings to contain the threat of Ebola spreading followed the diagnosis.

Dr Liz Floyd, Gauteng director of communicable diseases, said this was the first case of Ebola contracted in this country. Cases of people from other countries who suffered from the disease had been treated in South Africa.

"Ebola fever is typically transmitted in a hospital setting and the confirmation of this single case presents no threat to the broader community," Floyd said.

She said the real threat of infection was to those directly involved in nursing a patient during an advanced stage of the illness, when the patient was vomiting and bleeding, and nurses were in contact with the patient's body fluids.

She said patients undergoing treatment at Sandton Clinic were not at risk.

Floyd said the exact strain of the Ebola virus had not yet been identified. Mortality varied from strain to strain.

A co-ordinating team — headed jointly by Floyd and Dr Neil Cameron, director of communicable diseases in the National Department of Health — has been set up to manage treatment and control. Swanepoel and other experts on Ebola are also on the team.

Swanepoel flew to Kikwit in Zaire last year during the Ebola epidemic there. "We're not necessarily looking at a huge outbreak, but this is the first time it has arisen in a city from a human source," he said. "We've always reckoned that in a place like this it will be hit on the head. There may have been others exposed to it but I think it will be contained.

"The present case has been diagnosed early, in conditions of high-quality care, and immediate steps have been taken to contain the spread of the virus."

Yesterday, national and provincial health officials and medical experts were locked in discussions at Sandton Clinic. Guards were posted at the entrance of the intensive care unit where Lahana was being nursed but staff from the unit appeared to be able to move freely through the hospital.

At first it was rumoured that Congo fever had been diagnosed, but authorities confirmed to the media that it was Ebola at about 4pm.

Ebola was first identified in Sudan and a nearby region of Zaire in 1976, and there have been five known outbreaks among humans. It has given rise to books, films and television docu-dramas about the villagers and nuns who died in Zaire, where the virus was spread by contaminated syringes. Transmission of the disease has also occurred through handling ill or dead chimpanzees that are infected.

An isolated case occurred in Zaire in 1977, a second outbreak in Sudan in 1979 and an epidemic in Zaire in 1995 which caused 245 deaths. Two isolated cases were identified in Cote d'Ivoire between 1994 and 1995. The most recent outbreak was in rural Gabon in October.

Monkeys are both victims and carriers of the disease. It is not known what other animals are carriers of Ebola, although a study by the virology institute suggests that bats might be carriers.

Ebola virus hits SA

Nurse fights for her life as authorities try to trace source of infection

(89)

ST 17/11/96

By NICOLA KOZ, CAS ST LEGER and CRAIG DOONAN

THE deadly Ebola virus has arrived in South Africa, infecting a nurse at a top hospital.

Gauteng health authorities said it was the first time the killer disease had been contracted in South Africa.

The victim is a 46-year-old nursing sister, Marilyn Lahana, of Parkmore, Sandton, the wife of the Springbok lawn bowler Cyril Lahana.

She is fighting for her life this weekend in an isolation ward at Johannesburg Hospital after being moved from the Sandton Clinic, where the disease was diagnosed early yesterday morning.

Medical officials are desperately trying to trace the source of the virus, but it is believed Lahana contracted the disease from a Zairian man who died undiagnosed about three weeks ago in a private clinic.

Gauteng's director of communicable diseases, Dr Liz Floyd, said Lahana was in a serious but stable condition. "It is the first time someone has been infected in South Africa, but we have had cases of people suffering from the virus coming to South Africa for treatment."

There is no drug or vaccine for the disease — but the mortality rate of 80 to 90 percent can be cut down to 25 to 30 percent with proper hospital care.

Floyd said steps had been taken to identify those who have been in close contact with Lahana — her colleagues, those who have nursed her and her family.

"They are being checked twice daily for symptoms."

She said the case presented no threat to the broader community. "The real threat is to those directly involved in nursing the patient during an advanced stage."

Ebola is one of the most virulent diseases known to man. It swept across Zaire in 1976, killing up to 90 percent of its victims. In the latest outbreak, in Gabon between early October and the middle of this month, 17 of the 24 people infected died, according to a World Health Organisation report on the Internet earlier this week.

Ebola is marked by bleeding from all the body's orifices and through the skin. Internal organs also bleed profusely. It is passed on through contact with tainted blood. Patients are nursed in strict quarantine.

Lahana, a nurse at the Morningside Clinic, fell ill a few days ago with a headache, vomiting and diarrhoea — early symptoms of the disease.

Morningside referred her to a neurologist at Sandton Clinic. Ebola was first suspected on Friday and repeat blood tests confirmed she had the virus in the early hours of yesterday morning.

The manager of Morningside Clinic, Ben Rust, said yesterday that, even before the virologist and Ebola expert Professor Bob Swanepoel confirmed the diagnosis, his staff had scoured hospital records in vain in search of a patient who could have been the source of infection.

"We cannot at this stage make a decision definitely about the patient being from outside South Africa."

Cyril Lahana said his wife's condition was "very serious but stable". "I have not seen her today as I cannot bear to see her this way," he said. Lehana has two daughters, Debbie, 19, and Candice, 22.

Professor Margaretha Isaacson of the SA Institute for Medical Research, a member of the international team which fought the first Ebola outbreak in Zaire in 1976, said there was little reason to fear an epidemic.

"There are isolated cases from time to time. There may be a couple more but I don't expect an epidemic."

Since the Ebola virus was first identified 20 years ago, there have been about 1 000 cases, 80 to 90 percent of which have led to death.

Isaacson said sophisticated health care cut down the mortality rate. "Most patients don't die of the viral infection but of complications."

She was not particularly surprised that Ebola had arrived in South Africa. She said that it was bound to arrive, "sooner or later" but had appeared earlier than she had expected.

● See Page 6



EMERGENCY . . . hospital staff in protective clothing wheel Ebola victim Marilyn Lahana out of Sandton Clinic en route to Johannesburg hospital yesterday Picture: NICKY DE BLOIS

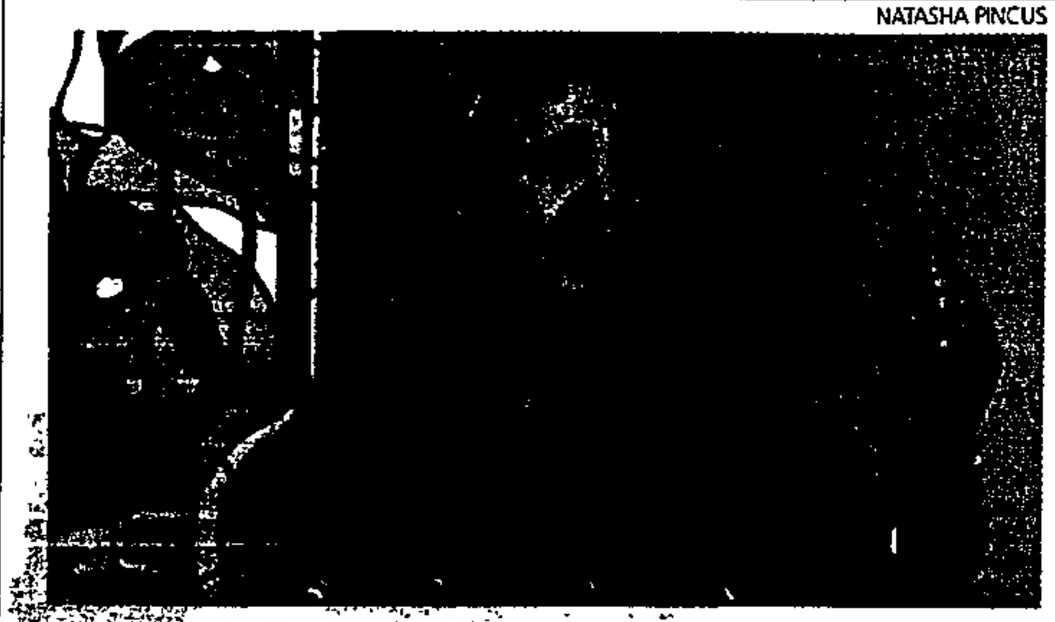
Nurse 'holding her own' in Ebola battle

Doctors stress that public need not panic as only people coming into the closest contact with an infected person can contract the disease

Star 18/11/96

(89)

NATASHA PINCUS



Under control ... Ebola expert Professor Bob Swanepoel says there is no need to panic.

HOW EBOLA CAME SOUTH

October 12	7 people reported to have died of Ebola in Gabon since October 5. Victims treated at hospital in Booué. 3 additional cases of Ebola infection reported
October 18	18 Ebola cases reported, 11 fatal, in the Booué area.
October 30	3 more people die of Ebola in Booué, bringing the total dead to 14 of 24 confirmed cases
October 27	Gabonese doctor admitted to Morningside Clinic in Sandton with "raging fever"
November 6	Marilyn Lahana shows early symptoms of Ebola
November 11	Gabonese doctor discharged from clinic
November 12	No new cases of Ebola fever detected in Gabon between October 19 and November 8: Total deaths 17 out of 24 cases
November 16	Positive confirmation that Lahana is suffering from Ebola.



GRAPHIC DAVIDA TANCHEL

BY KARIN SCHIMKE

Theatre nurse Marilyn Lahana, the first person to contract Ebola in South Africa, appears to be holding her own against the deadly virus. Lahana's condition is unchanged at "stable but critical", Johannesburg Hospital superintendent Dr Trevor Frankish confirmed to The Star this morning.

"Being the same is quite good," added Dr Liz Floyd, Gauteng's director, infectious and communicable diseases.

The departmental task team meets today to finalise the list of all who came into contact with Lahana (46) and the Gabon doctor from whom she contracted Ebola, to be monitored for the virus.

Already "close to" 200 are being screened, said health department spokesman Popo Maya.

Johannesburg doctors worked around the clock at the weekend to trace the doctor, whose name has not been released, as the person who infected Lahana.

The doctor, from Libreville, Gabon, was admitted to the Morningside Clinic with a raging fever on October 27.

He had treated Ebola patients, but did not have the tell-tale symptom of uncontrollable bleeding which is typical of Ebola. He was discharged from hospital last Monday and is recovering in a Morningside, Sandton house.

Before his discharge the doctor had been nursed by Lahana at the Morningside Clinic. Lahana is the wife of bowls Springbok Cyril Lahana. Her family has declined to speak to the press.

Medical authorities moved quickly to identify the source of the outbreak and to reassure the public that the disease was under control.

Doctors and officials from the Gauteng health department traced the doctor to a house in Morningside on Saturday and drew blood samples, confirming the man had been infected by the Ebola virus.

He is being treated on an outpatient basis at the clinic, but doctors say he is fully recovered and represents no threat of infection to anyone.

Ebola expert Professor Bob Swanepoel of the National Institute for Virology said at a press conference called in Johannesburg that people coming into contact with the man now would not become infected, except possibly sexual partners, who were at risk for the next two months.

A list had been drawn up of all the health workers and other people who had been in contact with either the Gabon doctor or Lahana in the past weeks. They are being closely monitored for symptoms of infection.

Lahana is reported to have fallen ill on November 6. She had severe headaches, lost her appetite, had diarrhoea and was vomiting. By Friday night doctors thought she might have Ebola, a suspicion confirmed in blood tests on Saturday morning.

Lahana has been sedated and is hooked up to a ventilator. She experienced kidney failure as a result of the virus and has had to undergo dialysis.

Doctors said yesterday her condition was not deteriorating, but was still serious. They could not predict whether she would survive the full onslaught of the disease, one of a group of viral haemorrhagic fevers which causes patients to bleed from all their orifices, from their skin and internally.

Congo fever, which recently broke out in Oudtshoorn in the Western Cape, is also classified as a viral haemorrhagic fever.

This Ebola outbreak has been traced to the jungle town of Booué in Gabon, Swanepoel said. Sick people from surrounding areas who were unable to get help in Booué, and were rejected by their communities, were catching trains headed for the capital, Libreville.

The doctor would have picked up the virus there, said Swanepoel, as he had been in charge of resuscitating ill patients.

Floyd emphasised that this is not a virus transmitted easily to the general public. Only people in close physical contact with an infected person's body fluids can contract the virus – not somebody in the same room as the patient.

She added that even "average health workers will not have significant exposure" and precautions were being taken at the affected institutions. Lahana was first treated at Sandton Clinic before being moved to Johannesburg Hospital.

Identifying the outbreak to a Gabon source had shown up, as false, rumours that the disease came to South Africa from Zaire.

"This (outbreak) has nothing to do with immigrants, legal or otherwise," said Swanepoel.

Dr Neil Cameron, director for communicable disease at the National Health Department, said it was important for the public to understand that no disease could be controlled through border posts and checkpoints.

Deadly virus contractible only via body fluids

BY KARIN SCHIMKE

Scientists and virologists do not know where the Ebola virus comes from and do not know of a vaccine against it or a drug to treat it.

The Ebola virus is one in a group of viral haemorrhagic fevers which cause uncontrolled bleeding through all orifices, the skin and internally. When the patient is not treated in hospital, the disease more often than not ends in death due to complications like kidney failure, heart failure, pneumonia or shock.

Patients usually start feeling the effects of the virus with common symptoms like headaches, muscle aches, fever, vomiting or diarrhoea. As their health deteriorates, bleeding abnormalities set in, so that patients often vomit blood or have bloody stools.

Ebola, much like HIV, can only be contracted through direct contact with body fluids. This was the reason the infection was mostly contracted by health workers and their immediate families, the people that would care for and clean ill patients. The body fluids would only infect another person if they enter the skin through a scratch or some other open wound.

An Ebola carrier can also spread the virus by having sex. Even if a patient survives, the virus can still be spread sexually for up to two months afterwards because it is believed it remains in genital secretions for some time after recovery.

'Spread of Ebola fever improbable'

CT 18/11/96 (89)

JOHANNESBURG: The diagnosis of Ebola fever in a Johannesburg nurse was frightening but a panel of experts said yesterday they did not foresee an uncontrolled outbreak of the disease in South Africa.

Dr Liz Floyd, Gauteng director for Aids and communicable diseases, said there were no new cases of the disease in South Africa and the public was at low risk.

Theatre nurse at Sandton's Morningside clinic, Marilyn Lahana, 46, was diagnosed with the deadly fever on Friday.

Lahana, wife of Springbok lawn bowler Cyril Lahana, was transferred to Johannesburg hospital on Saturday where she was in a critical condition in intensive care, having contracted the disease after helping in an operation on a doctor from Gabon in late October.

The doctor, whose name is being withheld, has recovered and was discharged from Morningside clinic on November 11. He is now being kept under observation at a location near the clinic.

The hospital has implemented special security to contain the disease and all health workers treating Lahana are being constantly monitored, head of Intensive Care at the hospital Dr Guy Richards said.

The condition of all patients who had been under the care of Lahana during the days before her diagnosis, were also being monitored, Floyd said.

The experts did not believe her patients were at risk because it would be unusual for a health worker's body fluids to reach those of their patients.

No other people had shown any features of the disease and all suspected cases were tested.

He said the panel thought the circle of infection in South Africa was "more or less closed, we have the means and the knowledge to contain it".

Floyd said tourists were at a very low risk because the virus could not be contracted except from direct contact with body fluids. Like HIV, the virus could not be transferred by touch but could be transferred sexually.

Cameron added that a patient recovered from the virus when the body had produced enough antibodies to annihilate the virus and then there was little change of recurrence. — Sapa

Nurse with Ebola fights for life as doctor recovers

(89)

Virus traced to Gabon

ARG 18/11/96

ARGUS CORRESPONDENT

Johannesburg — A Gabon doctor who infected 46-year-old theatre nurse Marilyn Lahana with the deadly Ebola virus is recovering in a Morningside house, while Ms Lahana fights for her life in the Johannesburg Hospital.

Doctors this weekend traced Ms Lahana's illness to a patient admitted to the Morningside Clinic with a raging fever on October 27. The man, a doctor from Libreville, Gabon, did not have the tell-tale symptom of uncontrollable bleeding typical of Ebola, and was discharged from hospital last Monday.

This has refuted rumours that the disease came to South Africa from Zaire.

Doctors and officials from the Gauteng Health Department traced the doctor to a house in Morningside on Saturday and drew blood samples confirming the man had been infected by the Ebola virus.

He is being treated as an outpatient at the clinic, but doctors say he is fully recovered and represents no threat of infection to anyone. Recognised world Ebola expert Professor Bob Swanepoel of the National Institute for Virology said people coming into contact with the man now would not become infected, except possibly any sexual partners – who were at risk for the next two months.

A list has been drawn up of all the people who were in contact with either the Gabon doctor or Ms Lahana, and they are being closely monitored for symptoms of infection.

Doctors yesterday said Ms Lahana's condition was not deteriorating, but she was still in a serious condition. They could not predict whether she would survive the disease, one of a group of viral hemorrhagic fevers that causes patients to bleed from all orifices, from their skin and internally. Congo fever, which recently broke out in Oudtshoorn in the Western Cape, is also classified as a viral hemorrhagic fever.

Ms Lahana has been sedated and is hooked up to a ventilator. She had kidney failure and has had to undergo dialysis.

This Ebola outbreak has been traced to a jungle town called Booue in Gabon, which is known for its hunting and lumber work, Professor Swanepoel said.

He said sick people unable to get help in Booue, and being rejected by their communities, were going by train to Gabon's capital city Libreville.

It was there that the doctor who was treated at Morningside would have picked up the virus.

War against crime packs the prisons

ARG 18/11/96

JOSEPH ARANES
STAFF REPORTER

South Africa's prison population has reached an all-time high as the government's anti-crime strategy puts more criminals behind bars.

Western Cape jails are almost 50 percent over capacity.

Prisons in the province were designed to accommodate 14 707 inmates, but at present house nearly 22 000 – 3 685 awaiting-trial and 18 177 convicted prisoners.

Pollsmoor Prison's maximum security section is the most overcrowded in the province – it was designed to hold 1 703, but 3 566 are now detained there.

Correctional Services Commissioner Henk Bruyn said the prison population reached an all-time high last month, with more than 123 000 criminals locked up.

This was proof that the Government's crime prevention plan was paying off. "But it is putting enormous strain on our staff, working in already understaffed and grossly overcrowded prisons."

Ebola victim critical with new infection

Star 19/11/96 (89)

Cyril Lahana recounts how his wife, now fighting for her life in ICU, complained of severe headache before her condition rapidly deteriorated

MAIN PICTURE: GARY BERNARD

By Karin Schimke and Janine Simon

The nursing sister stricken with the deadly Ebola virus, Marilyn Lahana, has developed a secondary infection and remains critically ill inside the intensive care unit at Johannesburg Hospital.

Gauteng health spokesman Popo Maja said this morning: "She's not deteriorating, but she's not improving either. She is stable because we are keeping her on a ventilator and dialysis machine," but he would not give further details about the secondary infection.



Cyril Lahana ... I wish it was me lying there instead.

▶ Reports, graphic ... Page 3

While Marilyn continued her fight for life in the Johannesburg Hospital yesterday, her husband Cyril told of the nightmare which began with his wife feeling a little ill – and ended in the horror discovery that she was in the grip of the feared Ebola virus.

Said Lahana: "We went to a party three Saturdays ago and that was the first time Marilyn showed signs of being sick. It was quite cold and a bit rainy, but she said she was feeling hot and asked for a blanket to go and sit out on the lawn. That was on November 2.

"The Sunday after that she was lying around, saying she felt guilty because she was being so lazy. It was quite unusual, because usually she's out cleaning carpets and cars and things."

By the Monday morning, Marilyn started complaining of a headache – one of the first "non-specific" symptoms of the Ebola infection.

The next day was Guy Fawkes Day and Lahana asked his 46-year-old wife, a nurse for the past 25 years, whether she was going to join him on the roof to watch the fireworks. He said she liked doing that every year, but this time she declined, saying she was "not feeling great".

"On Wednesday morning I realised for the first time that she was quite ill. She got up early because she had to be in the theatre at 7am. She got into the shower and then I heard her crying. I went to see what was wrong and she said she had a horrific headache and it even hurt to move her eyes."

He said she dressed with great difficulty, trying not to turn her head. Despite her husband's protestations, she insisted on going to work.

"She couldn't even get her key into the door, so I thought: 'Right, I'll take you to work, but I know they'll send you home again.' Twenty minutes later the hospital called and my daughter went to pick her up."

Once Marilyn was home, her husband called the family doctor who came to see her and referred her to the Sandton Clinic for observation.

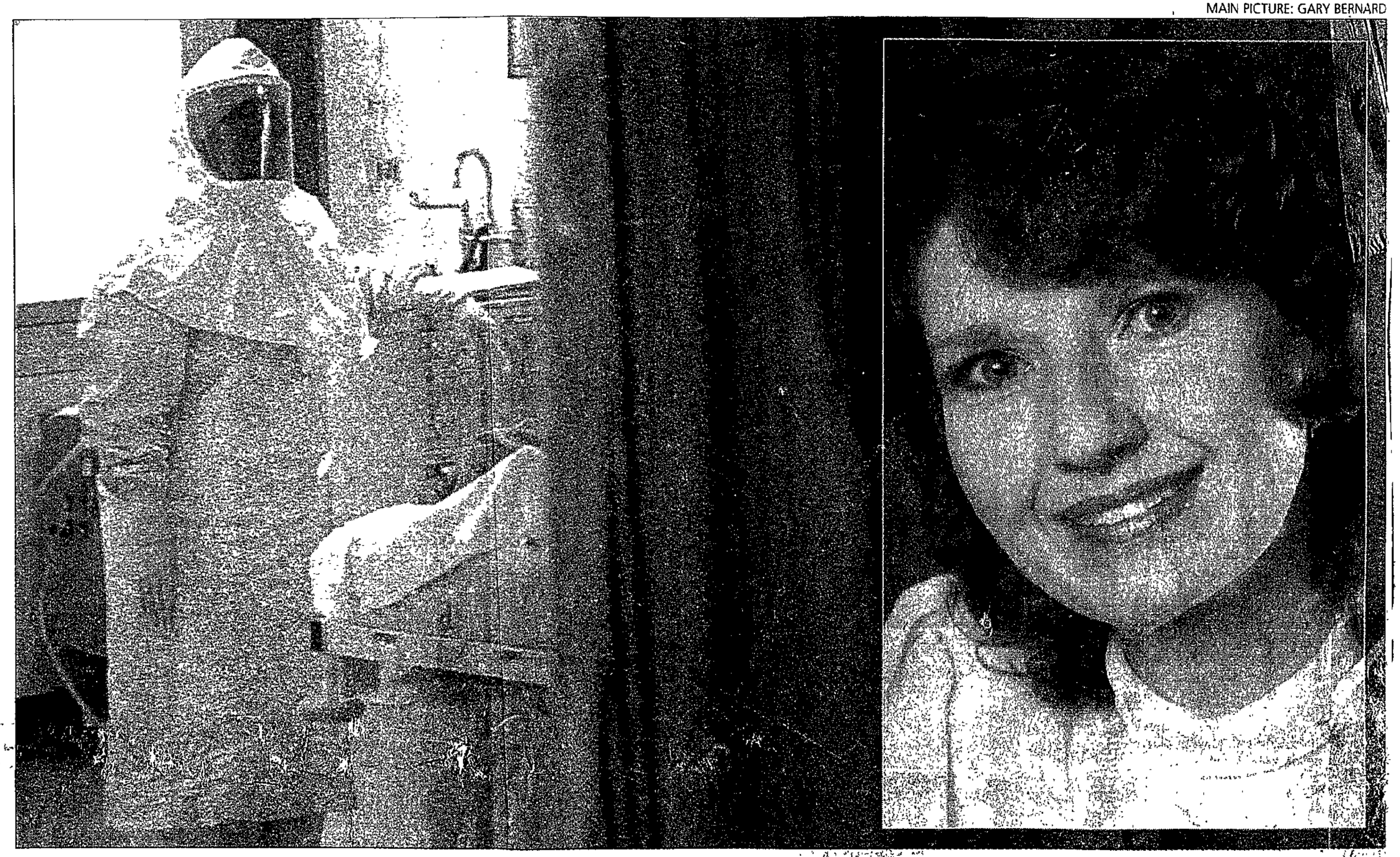
"I don't think I can praise people enough for the treatment she has been given.

"They tested her for everything and from early last week we had to wear masks and gowns whenever we went to see her."

His wife was so ill that she could hardly speak to him, so instead of visiting her for long periods he would "do quick pit-stops" to check on her progress.

"I used to walk in quickly and pinch her little toe and ask her how she was doing, but she couldn't even talk, she was feeling so awful."

The tell-tale symptom of bleeding through the skin or orifices had not started and by Friday morning doctors still had no idea what was afflicting her. They decided to do exploratory surgery.



Isolation ward ... a nurse in the isolation ward at Johannesburg Hospital treats Marilyn Lahana (inset), who is stricken with the deadly Ebola virus.

"Marilyn's stomach was very swollen so they decided to go in and see if there was a growth. That was when they saw she was bleeding internally – in the walls of her tummy. I suppose that was when they thought of testing her for Ebola."

Lahana said the first confirmation that it was Ebola came at about 3pm on Friday. The second confirmation came in the early hours of Saturday.

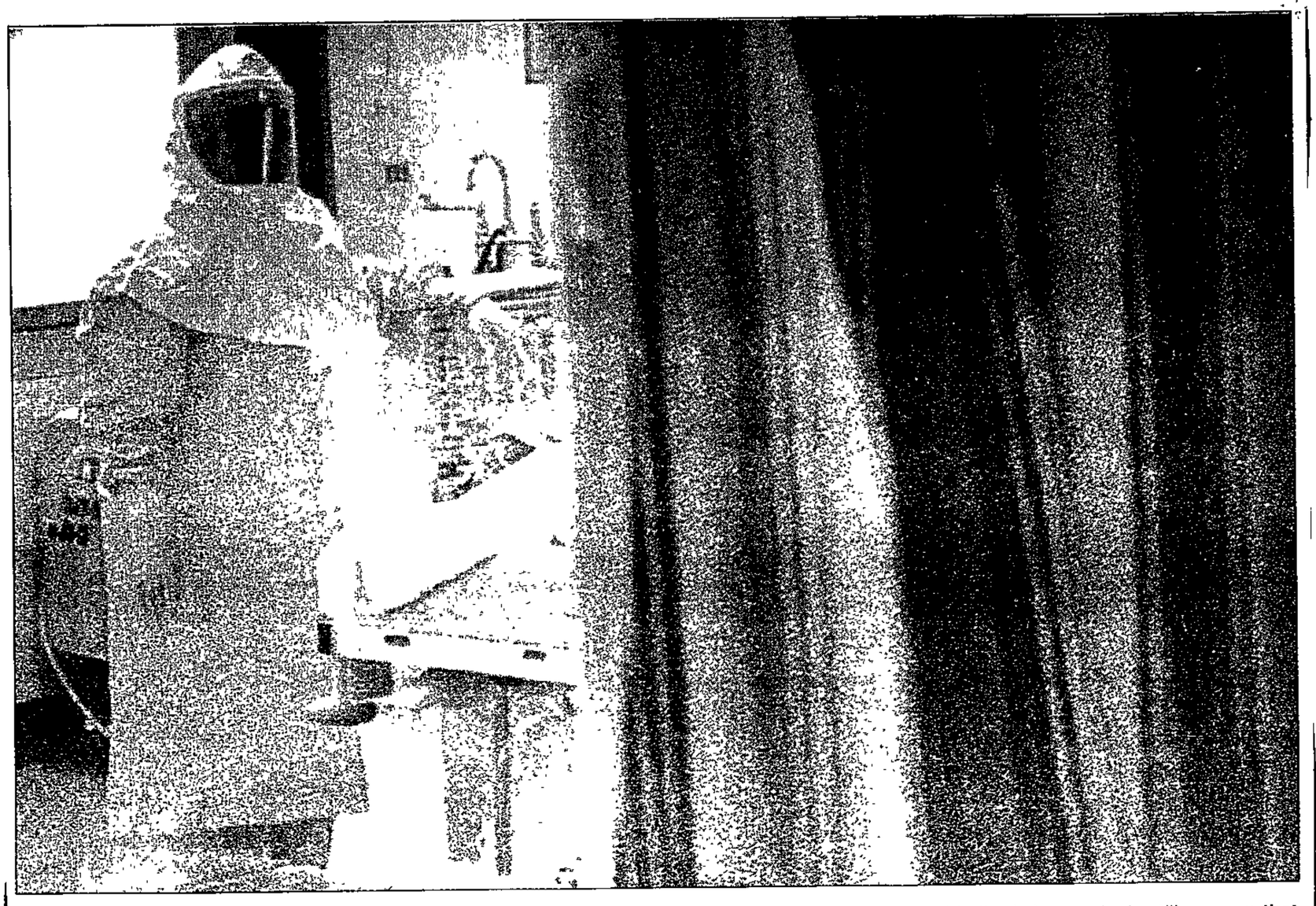
"To tell the truth, I didn't know anything about Ebola, but Candice burst into tears immediately."

Candice (19) is the Lahanas' younger daughter and, like her mother and maternal grandmother, chose a career as a nurse.

Lahana no longer visits his wife and waits in the waiting room while Candice and his other daughter, Debby (22), watch their mother through a protective glass barrier where she lies alone in Johannesburg Hospital's ICU.

"Marilyn has been heavily sedated since Friday and does not even know that she has contracted the Ebola virus.

"I have a marriage made in heaven and I know my wife is strong and she will pull through. But I wish it was me lying there instead," her husband said.



ISOLATION WARD: A nurse in the isolation ward at the Johannesburg Hospital treats a heavily-sedated Mrs Marilyn Lahana, who is still unaware that she has contracted the deadly Ebola virus. *PICTURE: THE STAR*

SA a test case on ways to contain virus

(89) CT 19/11/96

OWN CORRESPONDENT

JOHANNESBURG: South Africa is in the midst of an international experiment on how a modern city can contain a highly infectious haemorrhagic fever, according to world-renowned virologist Professor Bob Swanepoel.

So far, management of the country's first brush with a case of Ebola is regarded as excellent — national and provincial health authorities, specialist researchers and private hospitals have joined forces to isolate Morningside Medi-Clinic theatre sister Ms Marilyn Lahana, and identify and monitor contacts to prevent an epidemic.

In their favour was having both Swanepoel and the diagnostic testing facilities of the National Institute for Virology on their doorstep, said Dr Neil Cameron, the Department of Health's director of communicable diseases.

Good hospital management and the fact that the Gabon doctor, who passed on the virus to Lahana, had not yet returned home also played a role, said Mr Ben Rust, manager of the Morningside Medi-Clinic.

But the incident has pointed to the need for South African doctors and health authorities to be more keenly aware of outbreaks of disease in other parts of the continent.

Despite being a health worker from a country which had just experienced an outbreak of Ebola, the doctor from Gabon was undiagnosed because he was not bleeding.

"In future, a patient from Central Africa with a fever will raise concern," Swanepoel said yesterday.

The establishment of a health desk at the Southern Africa Development Community should help address communication problems. Doctors should also get copies of the World Health Organisation's Weekly Epidemiological Record, Swanepoel said.

Lahana, who is in a stable but critical condition, has been isolated in an intensive care unit of the Johannesburg Hospital.

Sandton Medi-Clinic's Matron Andrea Hayward said staff were still being interviewed to establish who were really contacts.

"I held her (Lahana's) hand. I'm a contact, but I'm not concerned," said Hayward.

THE BIG STORY

A forest hunt for Africa's deadly virus

Everything in sight is being examined to track down Ebola

(89)
ARG 19/11/96

FOR THE FIRST TIME, THE EBOLA VIRUS HAS INFECTED SOMEONE IN SOUTH AFRICA, SHARPLY FOCUSING ATTENTION ON THE MYSTERIOUS AND DEADLY DISEASE. TINA SUSMAN OF THE ASSOCIATED PRESS REPORTS FROM THE TAI FOREST IN IVORY COAST ON EFFORTS TO TRACK DOWN THE SOURCE OF THE ELUSIVE VIRUS

Dawn has barely broken when Jonas Tahou enters the forest, trousers stuffed into knee-high rubber boots that sink in the mud as he marches silently through the trees and tangled vines.

Somewhere in this sweltering jungle, in the deep green thicket that blocks the sun and swallows up Mr Tahou's slender form, lives a killer rarely seen, but always present, one that prowled the forest perhaps thousands of years before emerging 20 years ago to earn the name Ebola.

Two decades after the first known outbreak of the virus and 18 months after its deadly resurgence in the Zairean town of Kikwit, researchers work in this remote rain forest along the Liberian border in hopes of tracking Ebola's source before it strikes again.

Previous searches, including expeditions in central Africa, have been unable to pinpoint the source.

As Mr Tahou moves deeper into the trees, the quiet broken only by the squish of his boots and the cries of the forest, he checks dozens of traps placed on the ground to capture rodents.

If he's lucky, there will be a shrew or perhaps some mice or rats to take back to camp, euthanise and slice open to test

AIDS pandemic and by resurgent infections of tuberculosis, yellow fever and malaria that are increasingly resistant to drugs. Deaths from infectious diseases increased 56 percent from 1980 to 1992, according to the US Centres for Disease Control and Prevention.

Perhaps no disease conjures up such terrifying images as Ebola, named after the Zairean river flowing through the region where it first appeared in 1976. Ebola rapidly kills up to 80 percent of its victims, causing them to bleed to death internally.

It usually strikes in remote regions without modern medical facilities. In many cases, terror takes over – doctors are afraid to treat the ill for fear of contracting the gruesome disease, so patients remain among the general population, spreading the virus. In Kikwit, 245 people died before the outbreak was stopped. At least 13 died of Ebola in Gabon in February, and a new outbreak in October killed at least 17.

There's no guarantee the Tai project, with its shoestring $250 000 budget (R1 172 500) for two years, will succeed in finding the plant, animal or insect where the virus thrives when it's not on its deadly rampage through humans. But there are signs the hunters are on the right track.

In June, two months after the project got under way, tissue from a Red Colobus monkey found dead in the forest tested positive for Ebola. The henna-coloured apes are a major food source for chimpanzees, which in the past also have tested positive for Ebola.

That's a clue Ebola might originate in the Red Colobus, although Dr Formenty says it probably isn't that simple. With the monkeys living in large social groups with [illegible] the virus likely



ASSOCIATED PRESS

Flashback: Zairean volunteers and Red Cross workers collect the bodies of Ebola victims during the last major outbreak in May last year in Kikwit

There are no high-tech labs with filtered air pumped in, no link-up with the Pentagon to report new discoveries, no helicopters to rush deadly samples to Europe or the United States.

The traps Mr Tahou checks are plastic buckets shoved into the mud; the tiny mammals are gassed in old sour cream cups; lab liquids are stored in wine bottles. There's a jeep that works sometimes, a telephone two hours' drive away, and a steamy autopsy room lit by one bare bulb when the generator is cranked up.

This isn't *Outbreak*, the Hollywood blockbuster about an Ebola epidemic enveloping a California town.

But to the disparate group of men and women drawn together here – agile forest-dwellers like Mr Tahou, a US Army major and ex-rodeo rider, an Australian veterinarian who nurses her infant daughter between bat autopsies – it's the best chance yet to crack the riddle of one of the deadliest viruses known.

"The conditions are crude and sometimes it's difficult, but we want to get past this enigma of Ebola," said Pierre Formenty, a French doctor who heads the World Health Organisation project. "It's a struggle for the world – we're all in the same house. The diseases emerging today in Cote d'Ivoire may be the diseases emerging tomorrow in China or Colombia."

The fear of new or re-emerging diseases has been underscored by the worldwide frantic mood in Kikwit or the panic portrayed in *Outbreak*.

"My friends think I'm crazy," says Dr Anderson with a laugh, but she doesn't worry about passing Ebola to her children.

The conditions are primitive, but safety standards in the lab are strict. She and Dr Formenty wear surgical gloves, cloaks and face masks, along with plastic visors that fog up as the temperature climbs in the room. Her concentration is palpable as she inserts needles into bat wings and snips open the bellies of shrews.

'With Ebola, you don't like to see it emerge from wherever it is, but that's the only way you can study it'

A Swiss scientist contracted Ebola here in 1994, apparently during a chimpanzee autopsy performed while she wore gardening gloves. The gloves apparently allowed some of the animal's infected blood to penetrate her skin, a classic form of transmitting the virus, which is passed through bodily fluids.

She recovered, and the case prompted scientific interest in the Tai forest as an Ebola source. Ebola appears to have a cycle here, emerging late in the year after the rainy season. The Swiss woman fell ill in November 1994; one year later, a Liberian man living just across the border contracted Ebola. The Tai team hopes its project will coincide with another outbreak.

"With Ebola, you don't like to see it emerge from wherever it is, but that's the only way you can study it. By being in the Tai forest, where there's already a history of Ebola problems, we're just hoping to be here at the right time," said US Army Major Neal Woollen, a veterinarian from the Army's Medical Research Institute of Infectious Diseases who also worked on the Kikwit outbreak.

It's not only the apparent pattern that makes Tai an ideal research spot. The forest has been a focus of primate studies for more than a decade, so its monkey and chimpanzee groups are well known to other scientists who have been tracking them for years. If one dies mysteriously, the animal researchers will alert the Ebola hunters to test it.

The Ivorian Government welcomes the research, a rarity in Africa, where other governments have been loathe to admit their countries could be the source of a hideous disease.

The government of Gabon refused to acknowledge the presence of Ebola during a 1994 outbreak there and officially classified the incident as a yellow fever outbreak. When Ebola broke out again this year in Gabon, the government was similarly resistant and battled with Dr Formenty to keep casualty numbers artificially low.

Even with Ivory Coast's co-operation, there are problems. There is no laboratory in Abidjan to test for Ebola, so samples must be sent to Europe or the United States, packaged as hazardous material and transported on special flights that often are booked up a month in advance.

Science can't always wait. When medical experts suspected Ebola was loose in Kikwit, one doctor sneaked a blood sample on board a commercial flight and smuggled it out of Zaire. The blood was tested at the CDC and provided confirmation of Ebola in Kikwit.

The biggest obstacle, though, remains spotting the virus as soon as it emerges and blocking its progress to other animals or humans.

"The unfortunate side of that is if Ebola causes another problem, some more chimps or monkeys or something else in the forest are going to die," said Major Woollen. "It's kind of a two-edged thing. ... On one hand, we're hoping the virus will cause a problem from a scientific aspect. From a humane aspect, in terms of caring for the creatures of the forest, you hope it never resurfaces."

would afflict more than just one at a time. One theory is the monkeys catch the virus from bats sharing the trees in which they live, or from one of the ground rodents that scamper up these trees and leave droppings on the leaves eaten by the Red Colobus.

So the Ebola hunters have turned the closely guarded Tai forest – a protected area off-limits to all but researchers – into a rodent's worst nightmare.

It is an obstacle course of traps designed to snare everything from the tiniest shrews to the widest-winged bats. Mousetraps and buckets are sprinkled across the forest floor. Nets to snag bats and birds hang from narrow wooden planks that wobble 30 metres above the ground.

Each morning, Ivorian assistants like Mr Tahou, who has spent his life around this forest, check the day's catch. In the makeshift lab, Susanne Anderson, the Australian vet, methodically measures and weighs each animal before taking blood or tissue samples.

Dr Anderson arrived in September with her chimpanzee researcher husband, Dean, and their two children. They live, along with a fist-sized furry spider, in a simple concrete dwelling lit by candles stuffed into Chianti bottles. Evenings are spent in a thatched-roof communal gazebo that serves as a dining room and meeting spot.

The atmosphere is relaxed, far from the

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Tense time for Ebola risk group

There have been no further confirmed cases of Ebola fever, but the small group of people who are at serious risk of contracting the virus are facing a stressful week.

"Many of the doctors, nurses and other health workers who participated in caring for Sister Marilyn Lahana while she was at Sandton Clinic had no idea they were dealing with Ebola, and did not always take the meticulous protective measures which this infection demands," Dr Liz Floyd, Gauteng's director for Aids and communicable diseases, said in a statement.

"As a result, the risk of contracting Ebola is quite serious for a small group of people who cared for her during an advanced stage of the illness," she said.

Ebola's incubation period may be as long as 21 days, but the infection usually manifests five to 10 days after exposure.

Lahana, the Morningside Medi-Clinic sister who became infected after cleaning up after a procedure on an infected doctor from Gabon, is still in a serious condition in the special intensive care unit at Johannesburg Hospital.

Seven people showing symptoms associated with Ebola were referred to Rietfontein Hospital for examination, but all have been discharged and are under observation as outpatients.

The system to monitor the about 250 people considered to be at risk is well established and operating smoothly, and systems are being maintained at full alert to deal with further cases. – Medical Correspondent.

Star 20/11/96 (89)

[redacted] persons under the age of 18.

SA plans control of infectious patients

(89) BD 20/11/96

Kathryn Strachan

WHILE Ebola fever victim Marilyn Lahana was yesterday fighting a secondary infection, health authorities said they were to meet international medical rescue agencies later this week to tighten controls over bringing highly infectious patients into SA.

"We believe we can handle anything, even the Ebola virus, as long as we are aware of it and know the risks involved," health department director of communicable diseases Dr Neil Cameron said.

It was important to be open about the conditions so that local medical teams could be prepared, he said. Foreign cases were usually diagnosed simply with a doctor's physical assessment, but more stringent measures, such as laboratory tests, were needed.

Each case that came in was, as a matter of routine, treated as infectious and precautions were taken. The doctor from Gabon, who passed on the virus to anaesthetic nurse Lahana during surgery, was also treated as infectious, he said.

All medical staff were willing to help with highly infectious cases, so infected patients would not be turned away, he said. But a more detailed picture of the condition was needed to prepare the medical teams. In the Ebola fever outbreak in Zaire last year, SA medical teams were ready for a Zairean patient to arrive but she was too sick to travel.

Cameron said the main factor that had so far saved SA from an outbreak was the National Institute of Virology's rapid diagnosis. The institute is one of the five centres in the world with this diagnostic capability.

Prof Bob Swanepoel, the institute's expert, said a European country would probably not have coped as well as SA had. The fact that the local virology team had experience working with the virus in Zaire had helped it immensely, and the availability of medicine, protective clothing and disposable needles had saved it from the fate suffered by Zaire which lacked facilities.

Johannesburg Hospital chief medical Supt Dr Trevor Frankish said Lehana was still in a critical but stable condition. She was still linked to a ventilator and kidney dialysis machine in the hospital's isolation unit.

Frankish said Lahana had received a broad spectrum antibiotic to help fight the infection, and secondary infections were common in patients receiving intensive care.

The 200 people Lahana has been in contact with are still being monitored, but no further trace of the virus has been found. Four of Lahana's colleagues were kept overnight at Rietfontein Hospital on Monday for observation after calling in sick. However, they were all discharged yesterday.

Gauteng health department spokesman Popo Maja said an operational centre was established yesterday at Morningside Clinic to monitor all the contacts. A technical team, including the virology experts, health department and private clinic personnel, would be based at the centre.

Aliens act 'must be reworked'

BD 21/11/96 (84)

Stephané Bothma

PRETORIA — Apartheid's so-called last act, the Aliens Control Act of 1991, would have to be completely reworked to satisfy constitutional demands, international law expert Anton Katz said yesterday.

Katz was addressing a government-appointed task group preparing a green paper on SA's immigration policy which is to be released in May next year.

Task group chairman Idasa executive director Wilmot James said after the group's first meeting that he foresaw a major overhaul of government's immigration policy.

James said the group's brief to research the country's immigration and emigration policies came at a time when the perception existed that a mass migration from neighbouring states to SA was taking place. There was resistance to this taking place.

He said all aspects of movements across SA's borders would be considered, ranging from crime to the education of foreign students and mine workers' migration.

"Whether or not the notion of open borders within the southern African region was a viable option will also be investigated," James said.

"I will be surprised if we do not come up with a fairly major overhaul of policy."

He said new legislation could see the deportation hearings and other measures that would give illegal immigrants certain legal rights.

Katz said the existing act contradicted the constitution's administration of justice clause in many ways.

"For example, right now, home affairs can deport a person or take other action without supplying the affected person with reasons for their actions," he said.

The country had no legislation governing refugees.

The task group consists of people from universities, trade unions, business and non-governmental organisations who would look at the entire spectrum of immigration and emigration from international law to health issues, James said.

Submissions from interested parties would be invited and the policy paper would be released at the end of May next year for public opinion.

Health officials report Ebola virus checks on two more possible victims

BD 21/11/96 (89)

SA HEALTH officials said yesterday doctors were monitoring two more people with symptoms possibly indicating the Ebola virus.

Reuter reports the Gauteng health department said: "At present two contacts are under observation by Rietfontein Hospital as they have symptoms which might indicate Ebola."

Cautioning that their conditions had not been confirmed, the health department said: "They have not been admitted, and the symptoms could well be unrelated to the Ebola virus."

A nurse became the first person to contract the disease inside the country last week.

Kathryn Strachan reports there was still no change in the critical condition of Ebola victim Marilyn Lahana yesterday as health authorities continued their checks on all who had been in contact with her.

More than 200 people Lahana had been in contact with are being monitored, and two of her colleagues were kept in hospital yesterday for routine examination. Gauteng health department spokesman Popo Maja said that since the Ebola virus was discovered on Saturday, nine people had been kept under observation at Rietfontein Hospital, but all had been discharged within 24 hours.

Lahana is still on a ventilator and a dialysis machine in Johannesburg.

As National Institute of Virology expert Bob Swanepoel continued his investigations, health authorities were looking at ways of tightening the system and monitoring highly infectious patients coming into SA for treatment.

Zulu 'attacks' Sutcliffe

Farouk Chothia

DURBAN — KwaZulu-Natal Inkatha Freedom Party education MEC Vincent Zulu allegedly launched a "vitriolic racist attack" on African National Congress provincial MP Mike Sutcliffe at a function for German government officials and businessmen on Tuesday evening.

Sutcliffe said yesterday he encountered Zulu when he arrived at the function. Zulu accused him of criticising the education department because "I was a white who did not like the fact that blacks were now in charge", Sutcliffe claimed. "Zulu said on at least three occasions he would 'get me'."

Sutcliffe said he joined advocate Louis Skweyiya, former finance MEC Senzele Mhlungu and truth commission spokesman Mdu Lembede. Zulu again launched a racist attack on him, Sutcliffe said. "All three initially thought he was simply making such comments in jest."

Sutcliffe said his appeals to a "shouting" Zulu to act in a "dignified way" fell on deaf ears.

Heart disease bigger threat to blacks in South

(89) ARG 22/11/96

Boston – A study exploring high death rates among blacks has concluded that those born in the South have a greater likelihood of dying prematurely of heart disease than those born in the US North-east or Caribbean.

The study, in yesterday's New England Journal of Medicine, comes at a time when the heart disease death rate among US blacks is among the highest in the world, Richard Gillum of the Centres for Disease Control and Prevention (CDC), said.

Led by Jing Fang of the Albert Einstein College of Medicine in the Bronx, researchers compared the heart disease death rates of blacks and whites and tried to assess if there were differences related to where they were born.

Using New York City death records and US Census Data, they found that blacks born in the North-east had death rates similar to whites and those born in the Caribbean had significantly less heart disease, presumably from eating a heart-healthy diet at a young age.

But blacks born in the South were four times more likely to die from heart disease than Caribbean-born blacks, the group concluded.

"Southern-born blacks still had a rate of death from coronary heart disease more than twice that of Caribbean-born blacks," they said.

They said it had been known for years that blacks suffering from heart disease had a higher death rate than whites.

"What has not previously been noted, however, is the striking heterogeneity of mortality rates within the black population," and that blacks in the South account for much of the higher death rate among blacks in general.

If blacks born in the rest of the United States lived as long as those in New York who were born in the Caribbean, for instance, "the current interracial pattern would be reversed, and mortality from cardiovascular disease among blacks would be well below that among whites", the researchers said.

The journal also included the results of a study sponsored by the Centres for Disease Control that found that living in poor areas was hazardous to one's health. The data "paint a stark portrait of social inequalities in mortality", a group led by Arline Geronimus of the University of Michigan said. – Reuter

Rate of viral diseases bound to increase

SA Institute for Medical Research investigates many cases of suspected haemorrhagic fevers every year

(89) Star 22/11/96

By Janine Simon
Medical Correspondent

South Africa has had sporadic brushes with viral haemorrhagic fevers (VHFs) in the past and the rate is bound to increase, say the country's two top experts in tropical diseases.

The country's first contact with VHFs – probably the most frightening, but certainly not the most prevalent group of tropical diseases – was in 1975.

An Australian hitch-hiker, who had just visited Zimbabwe, died two days after going to Johannesburg Hospital. His girlfriend, and then a nurse, became ill.

The virus was identified as the Marburg virus. It had been isolated in the late 1960s, after 30 people contracted an illness from a consignment of vervet monkeys sent from Uganda to a biomedical company in Marburg, Germany, according to Professor Margaretha Isaacson.

Afterwards Isaacson, epidemiologist and emeritus professor of tropical diseases at the South African Institute for Medical Research, separated out blood plasma with Marburg virus antibodies from the nurse, who survived.

Then, in 1976, a nursing sister became ill after caring for two nuns from northern Zaire who had come to Kinshasa for treatment, and Isaacson was called to assist.

"I took half the plasma, and treated the sister. She died, and we learnt that this was a different virus: it looks identical to Marburg under the electron microscope but there's no cross-immunity, and Marburg antibodies don't work against it," Isaacson said.

The virus was named Ebola, after a river in northern Zaire where it originated, and it claimed about 300 lives in Zaire that year and another 150 in Sudan.

In Kinshasa, Isaacson, working with only surgical gloves and a mask, began forging the first barrier nursing protocols for infective patients, which are now being used by those who are caring for Marilyn Lahana.

> **"We can't keep sick people out of South Africa"**

Ebola has since flared almost a dozen times in Africa: the largest outbreaks were in Zaire and Sudan, and the most recent in Kikwit, Zaire, last year, and in Booue, Gabon, last month.

Isolated cases have also been reported in the Ivory Coast and Kenya, and even in London and Switzerland.

Over the past 15 years, says Isaacson, South African doctors have isolated Congo-fever patients quite regularly in hospitals, particularly in Kimberley, and Rietfontein, Johannesburg, but never Ebola and never again Marburg.

In the mid-80s, an outbreak of Congo fever at Tygerberg Hospital in Cape Town affected seven health-care workers, of whom one, a doctor, died. This month's Congo fever outbreak in Oudtshoorn killed one ostrich factory worker and infected 16 others.

Every year the National Institute for Virology investigates between 100 and 250 cases of suspected haemorrhagic fevers for diagnosis, of which 20 to 30 have either passed through Africa or are from Africa, says virologist Professor Bob Swanepoel.

Many of those queried do not have VHF. Heart failure, bacterial septicaemia, hepatitis A, drug-resistant malaria and tick-bite fever are often the actual cause.

These cases generally occur in specific categories of people: young tourists on a bus through Africa, wildlife researchers, expatriates living and working in Africa and, increasingly, people from other parts of Africa – like the doctor from Gabon – who come to South Africa for treatment, Swanepoel says.

"Previously, people were referred here because they were sick. Now companies are making money out of bringing people here for chronic heart or kidney problems, cancer or eye surgery." The danger lies in the possibility that cases are carrying infectious diseases.

"We can't keep sick people out of South Africa, and we have an ethical responsibility to help," says Isaacson.

"We are part of this continent, these diseases are part of our soil, it's up to us to deal with it."

Govt, medical rescue airlines to step up cross-border health controls

BD 26/11/96 (89)

Kathryn Strachan

THE SA health department is to meet medical rescue airlines and private clinics today to find ways of preventing a recurrence of tragedies such as the death on Sunday of nursing sister Marilyn Lahana from the Ebola virus.

Flying patients into SA from the rest of Africa has become a business, prompting the authorities to search for ways to improve health controls.

Health department director of communicable diseases, Dr Neil Cameron, said the first step towards tighter control was to introduce an early warning system. It would be proposed that medical airline carriers should be compelled to notify the port health official in severe cases. The port official would inform provincial health authorities and the hospital that received the patient would be obliged to inform the provincial control officer. An expert in infectious diseases would then be sent to assess the patient.

This would ensure that patients entering the country were tracked constantly. Nurses would take precautions when handling these patients until the test results were known.

Gauteng health deputy director Eric Buch said flying patients into SA from all over Africa had become a business and, in the light of this SA had to set up regulations and take steps over and above the international controls set by the World Health Organisation.

Cameron said greater care needed to be taken with patients being flown in with fever of an unknown origin. Doctors at any public or private hospital could refer these patients to Rietfontein Hospital on the West Rand where they could be isolated.

He said nurses treating Gabonese doctor Clement Mambana, who passed on the Ebola virus to Lahana during an operation, used barrier nursing procedures even though they did not know he had the Ebola virus. Nurses needed to be more aware of the risks and of the need to take universal precautions at all times with any patient, he said.

Sapa reports more cases of the deadly Ebola virus have not been ruled out by the Gauteng health department, but officials are confident that monitoring procedures will prevent the disease spreading further.

Gauteng health department director for AIDS and communicable diseases Dr Liz Floyd said yesterday further cases could develop among about 300 health workers being monitored after possible exposure to the fever while caring for Lahana.

The virus could be spread only by contact with a person exhibiting symptoms of the disease, Floyd said.

New precautions on way for cross-border disease control

(89)

Daily monitoring of contact suspects is tightly administered

Star 26/11/96

MEDICAL CORRESPONDENT AND SAPA

National Department of Health officials will today meet representatives of companies which airlift patients into South Africa for medical treatment and agencies which organise treatment for foreigners.

Gauteng's department of health said yesterday the me would focus on ways fective cross-border conti fectious diseases.

The move follows the dea Sunday of nurse Marilyn Laha from complications caused by the Ebola fever. Lahana contracted the Ebola virus from a Gabonese doctor, Clement Mambana, who was flown to South Africa for treatment of an undiagnosed fever. He was later discharged fit.

Dr Brian Gushulak, head of a World Health Organisation initiative to revise global measures on how to control infectious diseases across borders, will address the meeting.

Gushulak arrived in Johannesburg from Geneva on Sunday to discuss controls with local health experts.

The department said everyone suspected of being in contact with the virus via the Gabonese doctor or Lehana is being closely monitored. None of the 300-odd people being scanned showed signs of developing Ebola fever.

The goal now was for no one else to be exposed to the deadly Ebola virus, one of the world's st dangerous diseases.

To achieve that, the daily mon- system was tightly con- ng director of Aids icable diseases, Dr aid yesterday.

Police had been dispatched to collect a contact who had failed to report for a Saturday checkup, and those with temperatures or who were feeling unwell were admitted to Rietfontein Hospital, which specialises in tropical and infectious diseases, she said.

Carriers of the Ebola virus become infectious only once they are ill; the monitoring system meant a possible carrier was under expert medical care before another person could be infected.

Treatment units were equipped and special laboratories set aside for testing, and it was not expected that any other health workers would contract the infection, she said.

Three people had been admitted to Rietfontein for blood tests and examination. None were sufficiently ill to warrant admission, although they would be checked on an out-patient basis, she said.

An average of two to three people had been checked at the hospital daily over the past eight days, and none had showed signs of developing the fever, the department said.

However further cases could develop among the 300 health workers who had cared for Lahana, Floyd said.

"This is an anxious time for the people on the monitoring programme – we have our fingers crossed, but we are not out of the critical 21-day period yet."

Floyd said her department was determined to raise the profile of infectious diseases and develop emergency preparedness strategies to deal with epidemics.

Ebola nurse's husband thanks medical team

BY JANINE SIMON
Medical Correspondent

In the spirit of openness which has characterised the handling of the Ebola emergency, Cyril Lahana chose to face questions head-on yesterday and pay public tribute to his wife, Marilyn, and the medical team which cared for her.

Marilyn died about 8pm on Sunday after a bleed into the brain caused by damage to her blood coagulation system.

Cyril, who was unfailingly co-operative with the media throughout the week his wife lay critically ill, faced a press conference just hours after her death.

He said the 46-year-old theatre sister and mother of Debby and Candice was a devoted nurse who loved her job.

"Right from early days there was something exceptional about her," he said. "In the olden days she would work the wards and care for patients. She had such tremendous feeling for those people that she even went to visit them at home after hospital.

"She was very compassionate and loved her nursing. She would think nothing of working a 7 to 7 shift and then sew dresses for her daughters until midnight.

"If anything can come out of her death, she would be delighted if they (the medical fraternity) can learn from what happened and prevent this in the future."

Margaret van der Lith, nursing services manager at Morningside Medi Clinic, who had worked with Marilyn Lahana since 1975, said hospital staff were devastated by her death.

(89) 26/11/96

Benoni Gold Holdings Limited

(Registration number 77/02304/06)
("Benoni" or "the company")

Acquisition, change of control and offer to shareholders

1. ACQUISITION

Further to the announcement published on 13 September 1996, Nedbank Investment Bank is authorised to announce that agreement has been reached in terms of which, subject to the fulfilment of the conditions precedent set out below ("the conditions precedent"), Benoni will:

1.1 consolidate ("the consolidation") its issued capital on the basis of one consolidated share of 10 cents each ("consolidated shares") for every ten existing Benoni shares of 1 cent each ("existing shares");

1.2 change its name to Softline Limited, which will be abbreviated on the Johannesburg Stock Exchange ("the JSE") to "Sftline"; and

1.3 acquire, with effect from 1 March 1996, the entire issued share capital and all shareholders' claims on loan account of R19 827 000 against Softline Holdings (Proprietary) Limited ("Softhold") from a consortium including the directors and management of Softhold ("the consortium") for the issue of 138 530 427 consolidated shares ("the acquisition"). The purchase consideration amounts to the aggregate of the net asset value and shareholders' claims on loan account against Softhold of approximately R34 460 000, equivalent to 24,8 cents per consolidated share.

2. BENONI AFTER THE ACQUISITION

2.1 After the acquisition, Benoni will provide a broad spectrum of products and services in the information technology industry through the following focussed businesses:

2.1.1 *Softline Distribution*

A well established and one of South Africa's leading distributors of some of the world's best selling financial and business software, Internet software and range of peripherals.

2.1.2 *Ultra Technologies*

A systems integrator, designing basic structured wiring network systems, high end Internet servers as well as the planning, designing and implementation of high speed networking solutions.

2.1.3 *Masterskill Training*

A training provider to the entire business and corporate sector, using technology based training products in respect of end users, networking, information technology skills and human resources development.

2.1.4 *Softline System Technologies*

A software house focused on the research and development of leading edge business and accounting software. This organisation benefits from its number of highly skilled professional trained software engineers.

2.1.5 *Computer Parts*

A leading supplier of computer memory, specialised memory and CPU's throughout Southern Africa.

2.1.6 *On-site Technologies*

A support, services and training organisation, specialising in the implementation of turnkey business and Internet solutions. A dedicated training institute providing state-of-the-art software and Internet training.

2.1.7 *Vantage Communications*

A leading distributor of specialist networking, Internetworking as well as voice and data communications products and peripherals for the Southern African market These products address specific markets and are focused on Networking, Voice, Fax Systems, Storage devices, Imaging and Peripherals.

2.1.8 *ToolWare*

A specialist software company which markets and supports the Crystal Reporting range and Microsoft Windows based development language add-ons as well as major Visual Basic/Delphi third party development tools.

2.2 Subject to the approval and implementation of the acquisition, Benoni's:

2.2.1 board of directors will be reconstituted to consist of G B Rubenstein *(Chairman)*, I M Epstein *(Chief Executive)*, S M Cohen *(Financial Director)*, C dos Santos, M Levine, C F Turner and B M Schechter; and

2.2.2 financial year end will be changed from 31 March to the end of February. Accordingly, the current financial period will be in respect of the 11 months ending 28 February 1997.

3. CHANGE OF CONTROL AND OFFER TO SHAREHOLDERS

3.1 As a result of the acquisition, control of Benoni will change to the consortium. Pursuant to the change of control and in accordance with the requirements of the Securities Regulation Panel ("the SRP"), the consortium will, subject to the approval and implementation of the acquisition, extend an offer to Benoni shareholders to acquire their shares for a cash consideration of 2,48 cents per existing share.

3.2 The SRP has been furnished with confirmation that sufficient cash resources will be available to the consortium to implement the offer.

4. FINANCIAL EFFECTS

4.1 On Benoni

The financial effects of the consolidation and the acquisition on Benoni are set out below and are based on:

4.1.1 the forecast pro forma annualised earnings of Softhold for the 12 months ending 28 February 1997 of R6 662 000 and the forecast earnings of R10 023 000 for the year ending 28 February 1998;

Ebola is now only a flight away from anywhere in the world

LONDON: Now Ebola is just a flight away. It is a terrifying disease and for the first time it has appeared in a major city.

It was the news nobody had ever wanted to hear. The horrific and usually deadly Ebola virus has travelled from the depths of central Africa to a frontline city — Johannesburg, a city popular with tourists and with an international airport.

Public health experts are fond of warning that viruses are "only a plane-ride away". Suddenly those warnings are ringing out clearly.

Countries once complacent that Ebola would never find its way to their shores are now being told by the World Health Organisation that they must be prepared.

It will take only one infected person from an outbreak region to get on a plane for the disease to be spread around the world, the WHO says.

Ebola is one of the most nightmarish diseases ever to afflict humanity..Named after the river in Zaire near which the first major outbreak occurred in 1976, Ebola is a filovirus, a thread-like package of genetic material barely visible under an electron microscope.

Inside its shepherd's-crook-like body lies a strip of RNA, a primitive cousin of DNA, which gives the virus the instructions it needs to make just seven proteins. It is these that give Ebola its fearsome reputation: some help it reproduce, the role of others is unknown.

Their end effect is perfectly clear, however: an appalling, agonising death within 10 days of the virus entering the body. Like the Aids virus, Ebola is transmitted via blood and body fluids. Once inside, it rapidly replicates and sets about destroying organs.

Victims bleed from every pore. Their eyes fill with blood and their skin tears apart at the slightest touch. Internal organs are turned to mush, the brain becomes choked with clots. Victims often die after one final, massive seizure — spraying blood and virus over anyone and everything nearby.

There is no medical cure: only the body's own immune system can fight it. In the two recent Gabon outbreaks, around two-thirds of those who contracted the virus died. In Zaire last year, 245 people died.

"When you work with it in the laboratory, you treat it with a healthy respect," said Dr Graham Lloyd, an expert on Ebola at the Centre for Applied Microbiological Research at Porton Down, Wiltshire. "It is a Level Four virus, the highest category."

Inside the high-security laboratory, Dr Lloyd and his colleagues have been examining Ebola to see if it shows any signs of mutating into something even more terrifying: a virus as lethal as Aids but as easy to catch as influenza.

So far, the news is good: "Comparing the virus from 1976 with that in last year's outbreak in Zaire, there's about a one percent change in Ebola's genetic structure, which is very small."

Dr Lloyd's main concern is that Ebola could reach Britain and claim many victims before anyone even realises the cause. "The question is, can a young physician recognise it if it does come here, and will he know what to do?"

That concern is heightened by the fact that so far scientists have been unable to locate the origin of Ebola. Humans and chimpanzees are simply the final link in a chain that may go back to some spider or insect deep in the central African jungle.

The WHO has now sent a team to the Tai Forest on the Ivory Coast in an attempt to identify the natural cycle of the virus.

Insects, rodents and monkeys will be tested with the hope that they will find precisely where man comes into contact with Ebola.

But even if they do find the source, the problem remains that the virus, which may have been around for thousands of years, has escaped. And this, according to Dr Mike Ryan, medical officer in the WHO's emerging infectious diseases division, has enormous implications for the international transmission of diseases.

No longer can the Western world remain complacent that these horror diseases are confined to the jungle. "One of the threats is not the inherent transmissibility of a disease, but the fact that it can slip through the net and show up in major centres in the world," Dr Ryan says.

Ebola is not as easy to transmit as HIV or TB, but if it is not contained it can and does spread. It also has a 21-day incubation period, so a victim can be feeling fine only to be struck down after travelling from one country to another.

"The authorities in South Africa have to be commended for their prompt action," Dr Ryan says. "However, it is of concern that we do have a case in a major city."

This means constant vigilance from now on. The need for immediate isolation of the patient and all his contacts is of supreme importance — yet because doctors outside Africa are unlikely ever to have seen a case, by the time it is diagnosed it may be too late.

The WHO wants to create "global awareness" and the ability to respond in centres which do not normally experience Ebola. That could be anywhere, courtesy of air travel. Dr Ryan says it is important not to overreact, yet he also admits that it is a threat.

"We are living in a world of great bio-diversity," he says. "Viruses are extremely good exploiters, that is how they survive, and humans are easily exploited."

We have to "get up to speed", he warns. "We have not beaten the challenge of diseases yet, even though it's nearly the 21st century."

The world can expect to hear a lot more about viruses such as Ebola over the next few years, as the destruction of tropical rain forests exacts a terrible revenge. For as logging companies and farmers plough into these primeval habitats, they are blundering into the haunt of organisms best left undisturbed. — The Telegraph plc



GRIEVING: Mr Cyril Lahana, husband of Sister Marilyn Lahana, told journalists his wife loved her profession and would have been happy if something positive came out of her death. With him is Matron Margaret van der Lith, who was her friend. ***PICTURE: THE STAR***

MORE CASES POSSIBLE

Spread of disease contained

(784) CT 26/11/96

JOHANNESBURG: About 300 health workers are still being monitored for possible exposure to the haemorrhagic fever that killed Sister Marilyn Lahana, but doctors believe the worst is over.

MORE Ebola cases are possible, but Gauteng health department officials are sure monitoring procedures will prevent further spread of the disease.

Gauteng health department director for Aids and communicable diseases, Dr Liz Floyd, said yesterday that further cases could develop among about 300 health workers being monitored after possible exposure to the haemorrhagic fever while caring for Sister Marilyn Lahana, who died on Sunday night.

"This is an anxious time for the people on the monitoring programme — we have our fingers crossed, but we are not out of the critical 21-day incubation period yet," Floyd added.

Sister Lahana died from a brain haemorrhage caused by the Ebola virus after she contracted the disease while treating infected Gabonese medic Dr Clement Mambana . He was discharged fit on November 11 and returned to Gabon.

Floyd ruled out the possibility of further spread of the virus.

"All possible contacts are being monitored on a daily basis, and anyone showing any viral symptoms is immediately isolated at Rietfontein hospital, which has full infection control facilities."

No person regarded as a contact would be allowed to leave Johannesburg for 21 days. After this period the possibility of infection could be discounted, she said.

"We were very lucky we diagnosed the disease so soon — the reason it claimed so many lives in Zaire was that so many people were infected by the time it was diagnosed."

Floyd said the virus could be spread only by contact with a person who was exhibiting symptoms of the disease.

"A person has to be quite ill before the vomiting, diarrhoea and bleeding become an infection risk."

Professor Guy Richards, director of the Johannesburg Hospital's intensive care unit, where Lahana was treated, said no direct treatment of the disease existed at present.

"A number of anti-viral agents have been tried without success. The only treatments available at this stage are supportive," he said.

The outbreak of the virus in a sophisticated urban environment like Johannesburg allowed for better study of the disease, which had previously only been seen in rural areas in central Africa, Guy said.

"This has been an enormous learning experience for all of us. Very little was known about the control and management of the disease and this experience will help us greatly in the future," he added.

Mr Cyril Lahana, husband of Sister Lahana said at a press conference at the Johannesburg Hospital that he hoped something positive could be learnt from the tragedy.

"If something could be learnt from her dying as she did — if this could be prevented in the future — she would be very happy," he said. — Sapa

Experts say country is secure against infectious diseases

(89)

By Lara Smith

Preventive measures already in place at South Africa's borders were adequate to control the spread of infectious diseases such as the deadly Ebola virus, health authorities agreed yesterday.

Awareness of such diseases by port authorities, health practitioners and the public was the most important preventive factor, said Dr Neil Cameron, national health director of communicable diseases.

If there were this awareness, proper preventive nursing measures could be followed.

Cameron said it was important for air carriers bringing in sick passengers to inform port health authorities well in advance, especially if the patient had a fever.

This would allow medical staff to take special precautions when dealing with the patient so as to minimise the risk of their also being infected – as happened with nurse Marilyn Lahana who contracted the Ebola virus from a Gabonese doctor she was nursing in Morningside Clinic.

Health 'passport' idea for tourists

Lahana died in Johannesburg Hospital on Sunday night after a brain haemorrhage as a result of the virus.

The rule of informing port authorities of sick patients would apply not only to specialist medical air carriers such as Medical Rescue International, but also to commercial carriers on which a passenger may have become ill during the flight.

Other ways of curbing the spread of infectious diseases into the country discussed at an informal meeting yesterday was for foreigners to carry a card identifying them as visitors. This would enable local medical practitioners to be aware that they may have been in contact with an infectious disease if they get sick during their stay in this country.

In this way, correct diagnosis of symptoms would take place and if the patient did have an infectious disease, the proper precautions could be taken to prevent it from spreading.

■ The number of people currently being monitored for the Ebola virus has dropped from 300 to 280, Gauteng Health Department spokesman Jo-Anne Collinge said yesterday.

Of these, none was expected to show any signs of the disease, although a few were still in the incubation period

Star 27/11/96

WEDNESDAY
NOVEMBER 27, 1996

FEVER DIAGNOSED TOO LATE

Nurse caught Ebola mopping up blood

ET 27/11/96 (89)

THE VIRUS that killed Mrs Marilyn Lahana is extremely hardy and can survive for a long time outside the host — syringes have been found with the virus still thriving after a month in high temperatures. Staff Writer **LISA TEMPLETON** reports.

NURSING sister Marilyn Lahana contracted Ebola fever while mopping up the blood of a patient, but by the time the disease was diagnosed she was "too far gone" to assist medical staff with information.

Lahana, a 46-year-old mother of two who died on Sunday night after a severe brain haemorrhage, contracted the deadly virus while treating infected Gabonese medic Dr Clement Mambana, who was admitted to Sandton's Morningside clinic with an unidentified fever on October 27.

"She was exposed to (Mambana's) blood after he had been given a deep vein catheter — a lot of blood was spilt and she cleaned up," Professor Bob Swanepoel, a world authority on Ebola fever at the National Institute of Virology, said yesterday.

"At that stage no one knew he had Ebola fever, except maybe him."

The Ebola was only discovered after the then recovered Mambana was identified as a contact of Lahana and antibodies were found in his blood.

Swanepoel said Lahana would have been wearing standard protective equipment, but "somehow" must have been exposed to the virus through a torn glove, a small cut or by being pricked by a sharp instrument.

He said by the time the virus had been diagnosed she was too sick to assist doctors as to what happened that day.

Lahana's condition was critical for a week before her death from multiple organ dysfunction and on Friday she suffered several bleeds into the brain. On Sunday she died.

The virus is passed on through contact with body fluids and it is medical staff who generally contract the disease through mopping up blood and vomit, Swanepoel said.

"In Zaire (where 315 people contracted the disease and 245 died over four months) the care-giver in the house got the disease, got sick and passed it on to the next care-giver, so kids were not involved," Swanepoel said.

It is an extremely hardy virus which can survive for a long time outside the host — syringes have been found with the virus still thriving after a month in high temperatures, he said.

He said Ebola fever was far more lethal and more easily spread than Congo Fever, which recently infected 17 South Africans.

The disease, which generally incubates in three to 12 days, starts with malaise (headaches, fever, chills, muscle pains) and leads to diarrhoea and haemorrhaging internally and externally, from needle punctures, the nose, eyes and through bloody stool.

"Generally it damages all the organs and kills you," Swanepoel said.

The fatality rate depends on the strain of the virus and the condition of the patient, but Ebola can be cured with early diagnosis and treatment, he said.

Sapa reports that the two health workers being monitored for any infection by the virus returned to Rietfontein hospital on Tuesday "for a routine second visit", the Gauteng health department said.

The two were referred to Rietfontein, an infectious diseases facility near Johannesburg, for blood tests on Monday, after complaining of feeling unwell.

In a statement, the department said there were no new cases of the disease. The number of people being monitored for the disease had dropped to about 280, it added.

No new referrals to Rietfontein were made yesterday.

Yesterday officials of the Ministry of Health and medical experts held informal discussions with representatives of companies that airlift patients to South Africa for treatment, and with agencies that arrange treatment in SA for foreigners.

The discussions were attended by Dr Brian Gushulak of the World Health Organisation, who heads a committee reviewing international health regulations.

Dr Neil Cameron, director for communicable diseases told a media briefing the talks reinforced the regulations introduced after a Kenyan patient entered the country with Congo fever several years ago.

Captains of boats or aircraft are obliged to inform port health authorities of any international passengers apparently suffering from fever.

Parasite infections in young a neglected problem

(89) MD 20/12/96

SA is as bad as anywhere in the world when it comes to diseases of poverty. Kathryn Strachan looks at nutrition interventions that would make a difference

WITH more than 90% of children along SA's eastern coastline infected with harmful intestinal worms, which can have a damaging effect on the rest of their lives, it appears irresponsible that health authorities have not included parasite control in their much vaunted primary school nutrition programme.

The prevalence of parasitic infection among children lessens as altitude rises, and inland it falls to 40%. However, in the flood plains of northern KwaZulu-Natal the incidence of hookworm among children is touching 100%. In view of these staggering figures — and taking into account the amount of money spent on the feeding schemes and the amount that has been siphoned off through corruption — more attention should have been given to parasite infections.

Up to now, SA has had no outreach programmes at all to control bilharzia or intestinal worm infection. Excellent drugs are available, but most children are not taken to the clinic for treatment.

Dr Jane Kvalsvig, a psychologist with the Human Sciences Research Council doing research in this area, says SA is lagging behind the rest of the continent in combating this pressing problem. And many of those countries have far less resources than SA.

However, at the end of November, the first signs of a parasite-control strategy finally became evident with the launch of a pilot programme in KwaZulu-Natal and Mpumalanga. The three-year project is being funded by a R7m grant from the government of Finland.

Health department director of nutrition Nobayeni Dladla says the pilot programme will look at treatment through drugs, health education and improving sanitation and living conditions. The programme will involve testing a sample of children and where prevalence is high all children will routinely be given the treatment, whether they are infected or not.

Kvalsvig, in her pioneering work, looks at the impact infestation has on the mental and emotional development of the child, and finds a disturbing trend.

"These children have a low level of chronic infection all the time, and this has a great effect on their development," she says.

In her work on pre-school children she measures their levels of activity, their concentration and their emotional state. "After treatment, not only do they put on weight, but they are happier, more active and they have better concentration."

As worms are a disease of poverty, the children infected are already affected nutritionally, and worm infestation makes the situation worse.

Kvalsvig's work in SA focuses on KwaZulu-Natal, but she is involved also in a study in Pemba, the northern island of Zanzibar, with the World Health Organisation (WHO) and the US's John Hopkins University. The study is sharing lessons learnt between the two regions.

Kvalsvig says it is difficult at first to pinpoint exactly where the damage is. "But with a child we are talking about missed opportunities," she says. "At age five, children are starting to read and learning symbolic thinking. If they learn a pattern of failure at their school-entry years, they will come to expect failure and the infection could really be affecting their whole life.

"We need to look at intervening when children are most vulnerable, such as when they start school."

But despite the enormity of the problem, too little attention is given to it, says Kvalsvig. She started her work in 1975, and it has been a 22-year exercise in frustration. Her work has been presented to the UN children's organisation Unesco, it has been incorporated into WHO policy, it has been used in other countries, but no one has taken heed of it in SA — until last month when the health department agreed to set up the pilot projects in KwaZulu-Natal and Mpumalanga.

However, she believes that once SA implements the strategies, it will have a good chance of drastically lowering the prevalence of infection. Countries such as Seychelles have shown a good programme can bring down the level of infection.

Since the school feeding scheme was introduced, many other research organisations have been calling for a routine deworming strategy. Dladla responds that it is not logistically possible to introduce all components of the scheme at the same time. Nurses had to be trained and finances allocated. A phased approach was necessary, and first priority had to be feeding children.

By taking the time to implement a properly thought-out plan, the nutrition project will benefit by being expanded beyond its school base to include clinics and community initiatives.

In planning the deworming strategy, the first step is to map the prevalence pattern of parasites, and this Kvalsvig is doing with Prof Chris Appleton, a biologist at the University of Natal.

Using the geographical positioning system they have focused on the southern part of KwaZulu-Natal, delineating altitudinal zones and prevalence patterns.



The curbing of parasite infections should be given as much attention as feeding schemes. Picture: DAVID HARRISON

However, says Appleton, intestinal worms cannot be divorced from bilharzia, as the two are often found together, and it makes sense to tackle them at the same time.

In the area of bilharzia the same lack of sense has prevailed in government policy. For 40 years government has poured endless resources into researching bilharzia, he says, but nothing has ever been done with the results.

"We know a lot about the distribution of bilharzia, but nothing about the distribution of worms," Appleton says.

Using this distribution map as a basis, each region in the province will work out its own strategy and budgetary allocation.

In addition to the usual range of solutions — treatment, health education, improved sanitation — Appleton adds the judicious use of molluscicides to the list. Molluscicides are plants which kill the snails that carry bilharzia. They are the foremost method of attack in Egypt and the search is on in SA for plants which contain these properties. However, it is a complex solution as the toxicity of plants varies with the seasons.

Education is a cornerstone of any bilharzia-control programme, he says, and strategies in Brazil have shown that infection rates can be reduced significantly through treatment and improved sanitation. While the overall prevalence in Brazil dropped to a very low level, it was the decrease in the number of severe cases which was most encouraging.

MALARIA & ECONOMIC DEVELOPMENT

(89)
FM 31/1/97

LITTLE SUCKERS HIT SA . . .

Malaria burst through SA's defences last year and has started to surge again with the summer rains. Health authorities are spending R32m a year — more than ever before — to keep the disease at bay, yet the epidemic is the worst in 50 years, infecting nearly 30 000 people and killing 158 last year (see graph).

The impact on SA's productivity is hard to gauge but the malaria cost to sub-Saharan Africa soared to US$1,8bn in 1995, says the World Health Organisation

SA's worst-affected areas are not laden with heavy industry. Paper manufacturers Sappi and Mondi and mining conglomerates Anglo American and De Beers — which have operations in or near malaria risk areas — say productivity levels have hardly been affected. But thousands of industrial workers who live or have families in these areas have borne the brunt So has ecotourism, an important pillar of the regions' development.

"There's no doubt it's having an effect on ecotourism in those parts," says Dr Andrew Jamieson, medical director of the British Airways Travel Clinic. "We advise all tour groups with pregnant women and children under three to keep out of malaria areas. Many change their plans accordingly."

The Conservation Corp, which is heavily invested in luxury game reserves along the Kruger National Park, in northern KwaZulu-Natal and in malaria-ridden central Africa, has said it intends to expand into malaria-free areas such as the Pilanesberg.

If it were not for an intensive anti-malaria campaign, the disease would bite far deeper into SA. With the added virulence of drug-resistance, there would be a larger population at risk and a more developed economy to disrupt.

Don't compare the cost of prevention with the number of infections; compare it with the potential health risk and economic cost, says David le Sueur, senior specialist at the Medical Research Council's National Malaria Research Programme in Durban

A 1932 epidemic, for example, devastated KwaZulu-Natal's sugar industry and placed more than a million people at risk. In less than six months, more than 2% of the province's population died of the disease Outbreaks occurred as far south as Port St Johns in the Eastern Cape and well into the interior, in Pretoria and Rustenburg in the Transvaal.

Sugar planters who typically employed about 80 workers found that only three showed up The Amatikulu mill in northern Natal received only five tons of sugarcane a day instead of the expected 1 500 t. Construction of a railway line in the region came to a halt. Health workers found kraals where corpses of malaria victims had lain unattended for days because all the other residents were too sick to bury them

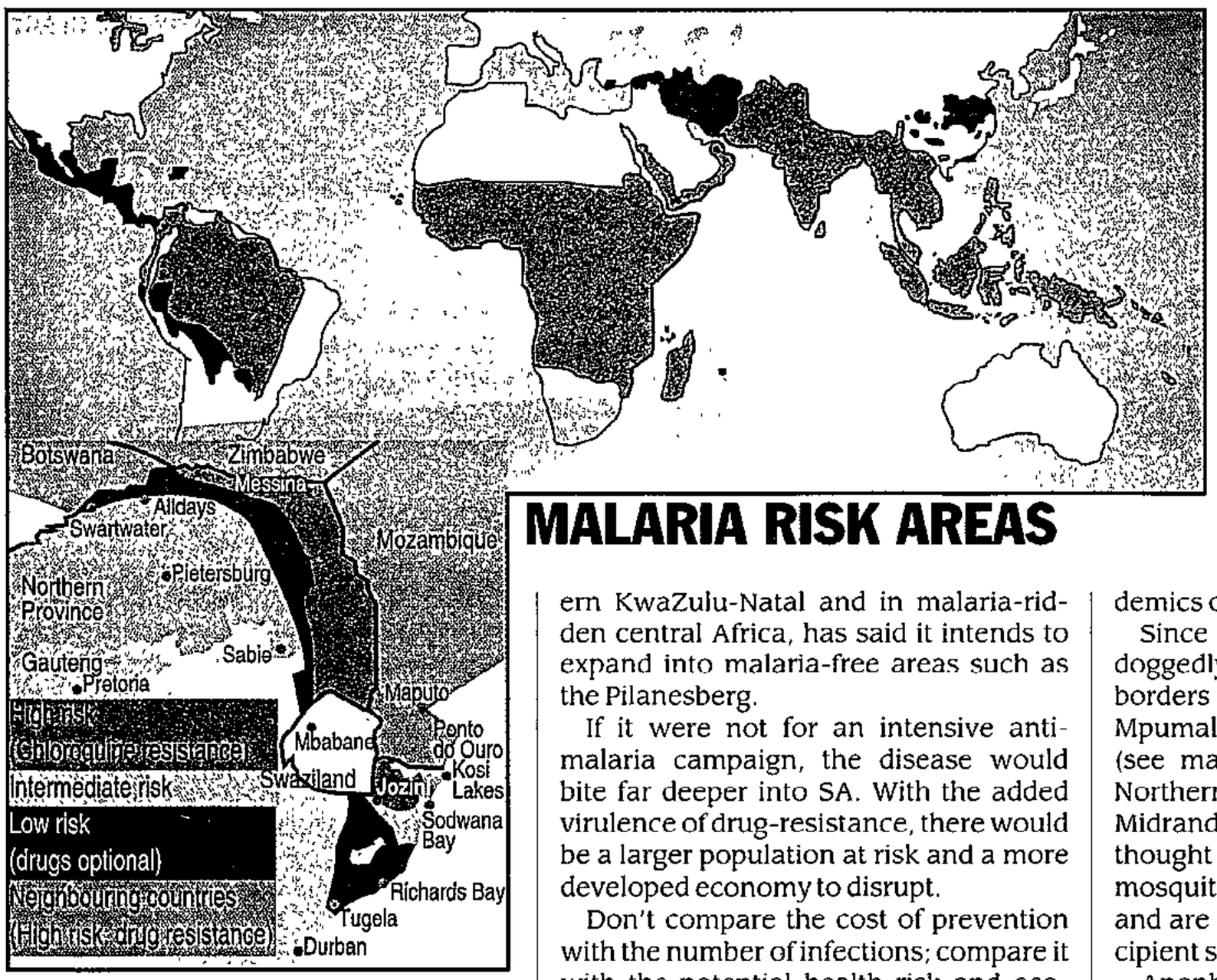
The SA Chamber of Commerce has called on government to eradicate the scourge, "which is having a serious effect on Natal and the eastern Transvaal, and seriously retarding the progress of industry, trade and agriculture in these provinces and, through them, the country."

SA's relatively cool climate has always been a natural barrier to the southward spread of the disease from its warmer, more humid neighbours. But it didn't prevent the deaths of tens of thousands in the epidemics of the Thirties.

Since then, malarial controls have doggedly driven back the disease to the borders of northern KwaZulu-Natal, Mpumalanga and the Northern Province (see map), with rare outbreaks in the Northern Cape. A few isolated cases in Midrand and Pretoria last year are thought to have been caused by infective mosquitos carried in cars or suitcases and are not regarded as signals of an incipient spread of the disease.

Anopheles mosquitos, which alone can carry malaria, occur on the Highveld in summer but cannot survive the cold winters.

Le Sueur attributes last year's dramatic rise of the disease primarily to the breaking of the drought (which helped cut malaria to 2 886 cases in 1992), the rise



MALARIA RISK AREAS

of drug-resistant parasites and the flood of immigrants and travellers — illegal or otherwise — from Mozambique, Zimbabwe and other high-risk areas of Africa, which also experienced epidemics last year

Botswana had more than 24 000 confirmed cases, 62 000 unconfirmed and 210 deaths; Zimbabwe recorded over 1,6m infections and more than 6 000 deaths. Screen tests of Mozambicans crossing into SA have shown up to 72% infected.

"If Mozambique had effective controls, we could push malaria right out of SA," Le Sueur says.

That idea takes its first step towards realisation in May when researchers and health authorities from all nations in the Southern African Development Community and Kenya meet in Maputo to try to initiate and co-ordinate steps to fight malaria throughout the subcontinent

The conference, co-ordinated by Drs Brian Sharp of the SA Medical Research Council and Avertimo Barreto of Mozambique's Ministry of Health, will be the first time southern African countries have tried to tackle the problem together.

But the 1996 epidemic in SA was caused partly by an organisational breakdown during the provinces' political reshuffling. Anti-malaria units in the three affected provinces were caught unawares, admits Northern Province malaria control officer Philip Kruger

"None of us were really geared up for it," he says "We knew it was coming but there were new people in charge or not even appointed, a serious shortage of vehicles and the organisations weren't functioning as well as they could have."

Then they ran out of anti-malarial drugs and the suppliers couldn't meet the demand as the disease hit home in the peak months from January to April. This year, says Kruger, they're prepared for another onslaught but have bought large stocks of drugs and insecticides "We won't get caught again," he says.

Such measures are expensive. The Northern Province is usually the least intensely affected of the three provinces but its malarial area is the largest, so it has the most costly anti-malarial operation, with 900 workers and a R3m budget increase this year to R20m.

Mpumalanga is worse off, with 245 workers to combat the disease.

Northern KwaZulu-Natal, the region with the highest incidence of malaria, employs 473 with a budget of R9m.

. . . AND BLEED AFRICA DRY

Africa is sick Its people suffer the world's highest per capita burden of disease — and malaria is the most prevalent of all.

At least 70% of sub-Saharan Africans fall ill with the disease every year and about 750 000 die, a World Health Organisation research group reported last week.

Sick people can't work. Or they do very little. Africa can't compete or grow economically while most of its people are ill.

In parts of Malawi and Tanzania, infection levels reach 80%. Malaria researchers in Ghana have monitored people who are infected up to 1 000 times a year — an average of nearly three malaria-infected mosquito bites a day.

The fact that most Africans have developed semi-immunity doesn't necessarily protect them from feeling ill — the parasite strains are often quite different from one infection to the next, says David le Sueur of the National Malaria Research Programme of the National Medical Council in Durban.

This is because the malaria parasite is so adaptable. When threatened, by drugs or a changed environment, it quickly seeks to protect itself by acquiring antigens from its host, thus changing its form and the way it affects its victim.

The parasites are also highly efficient in developing resistance to drugs. Scientists currently believe that the parasite is able to develop mechanisms that either break down the drug compound or literally pump it out of its body.

AFRICA can't compete when most of its people are ill

Chloroquine-resistance surfaced in Africa in the late Seventies and has now spread throughout the continent, including parts of SA (see map). In these areas mefloquine (Lariam) or a combination of chloroquine (Daramal or Nivaquine) and proguanil (Paludrine) are recommended. Lariam is an expensive drug — too costly for most Africans.

It is also controversial for its unpleasant side effects (two trials are under way in Britain on the side effects and a British report last weekend said a child had died after taking the drug).

Within five years of Lariam's release, resistance to the drug surfaced in parts of Cambodia and Thailand.. Doxycycline is now recommended for those areas. But the parasites are bound to develop resistance to that drug as well. There are already malarial strains in southeast Asia resistant to all known prophylaxis. The most promising prophylactic may be the Chinese drug artemisinin. But world health authorities are urging that its use be limited as a safeguard against emerging resistance.

Because malaria affects mostly poor or Third-World countries, drug companies aren't willing to spend money on developing new drugs. The World Health Organisation says that of the US$56bn spent on health research worldwide in 1990-1992, only $58m (one thousandth) was spent on anti-malaria research.

Vaccination is regarded as the best route to eradication. Various vaccine prototypes have been developed over the years but have achieved little success.

It is hoped that a possible new vaccine, announced by US army researchers three weeks ago, is the breakthrough which everyone has been looking for. But even if it is, researchers say it will take up to 10 years of further research and field testing before such a vaccine would be ready for general use.

Insecticide-impregnated bed nets remain the most cost-effective protection against malaria. Field trials in The Gambia showed that nets reduced mortality from all mosquito-borne diseases by 25% to 38%.

The World Health Organisation estimates it will cost about $50m to develop a vaccine but that such a vaccine would be cost-effective only in areas of high mortality. ■

Steps taken as malaria cases soar

Star 6/2/97 (89)

By Trove Lund

Emergency plans are being made by the Health Department in preparation for a malaria epidemic.

The cause of the "unremitting escalation" of malaria cases, the department said yesterday, was a result of the influx of people from African states into South Africa since 1994 and heavy, early rains.

Last year, 30 000 people were treated for malaria and 158 died. This was three times as high as the 1995 figures and the department is bracing itself for greater outbreaks this year due to heavy rains and border crossings

"The malaria problem could take years to stabilise. Figures for this year are already higher than the same time last year and we are not even in peak season yet," said spokesman Danette Lombaard.

She said the department kept records only for the three high-risk provinces – Mpumalanga, Northern Province and KwaZulu Natal.

These show that the 576 cases reported nationwide in December 1995 had increased dramatically to 1 280 for the same period in 1996. There were 2 204 cases in January last year and figures for this year show that about 2 600 cases were reported.

Northern Province had the biggest increase of cases.

Hospitals across the country have been given vast stocks of anti-malaria prophylactic drugs, and epidemic courses have been run for health department staff in the high-risk provinces.

Some hospitals in KwaZulu Natal and Mpumalanga were overwhelmed with 2 000 cases during every month of the malaria season, usually from March to May.

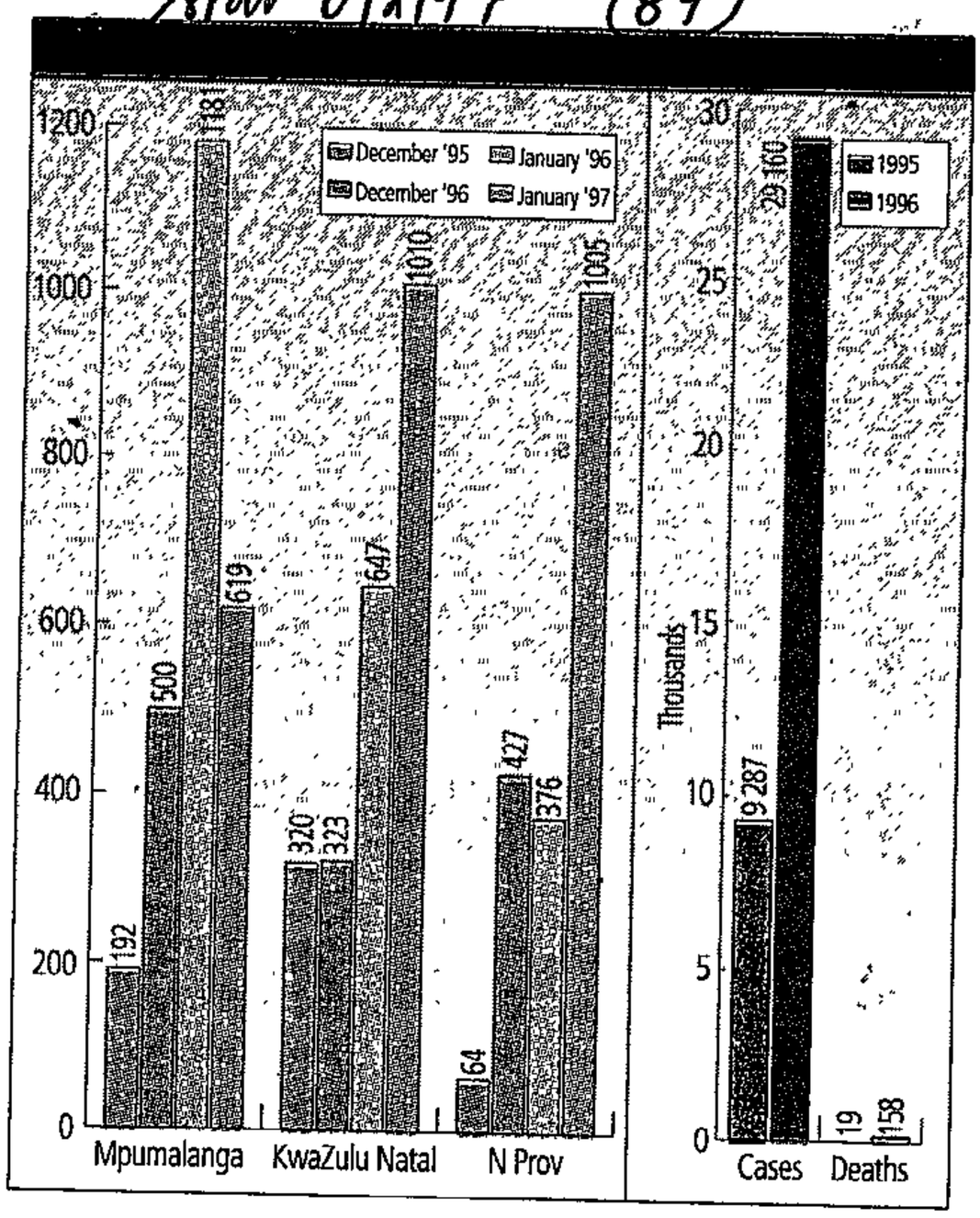
Booklets that contain guidelines for travellers as to what areas in the country are high risk, what symptoms to look for, how to take medicine and what precautionary measures to take have been issued to chemists and doctors countrywide.

Lombaard said the "snowball effect" came into play when conditions were ideal for mosquito to breed. In addition, a higher mosquito population survived each winter. Early rains ensured that the breeding of this expanded mosquito population started earlier, extending high-risk seasons every year.

Despite earlier reports that a malaria vaccine had been discovered in the United States, Lancet Laboratory haematologist and malaria expert Colin du Bruyn said he was unaware of a cure being found.

Aside from doubting that a vaccine that covered all the subtypes of the disease had been found, he said experiments with vaccines were still in their infancy.

A vaccine for Africa's vast population would be inappropriate unless it solved the high mortality rate by being an antidote to the "killer malaria" strain, which develops quickly into fatal cerebral malaria, he said.



Malaria control to cover subcontinent

Kathryn Strachan

(89) BD 19/5/97

RESEARCHERS and health authorities from across southern Africa got together last week for the first time to seek a co-ordinated plan to control malaria after last year's epidemic, the worst in 50 years.

The Maputo meeting aimed to promote long-term collaboration between countries on malaria research and control by creating links between control programmes and research efforts.

The conference highlighted the fact that because of cross-border movement and similar meteorological conditions, malaria could be combated only if all nations in the region worked together.

It was clear from the conference that fighting malaria would remain a formidable task. Scientists explained problems experienced with vaccine trials and there were reports of increasing drug resistance.

Much progress had been made in a programme established in November to map the distribution of malaria risk through the region, and new methods of predicting malaria epidemics using climate forecasting were debated.

Researchers said malaria had for too long been a neglected disease.

In SA there were almost 30 000 cases of malaria and 158 deaths last year. Zimbabwe recorded over 1,2-million infections and more than 6 000 deaths, while tests of Mozambicans crossing into SA showed 72% were infected.

ANALYSIS

Drug resistance complicates bid to stop march of malaria

Malaria continues to threaten economic growth in Africa. Health reporter **Kathryn Strachan** was in Maputo to join the search for solutions to the problem (89) BD 28/5/97

WITH last season's southern African malaria epidemic being the worst in 50 years, scientists from across the region came together for the first time earlier this month in the Mozambican capital of Maputo to find a way of halting the advance of the disease.

This was an uncertain exercise as most rays of hope — a vaccine, methods of predicting when epidemics would occur, control measures — faded as researchers gave reports on their latest findings.

The message that came across strongest was that malaria can be fought only if researchers and health authorities in all countries of the region work together.

While regional collaboration as a way forward was a point of agreement, it was the conference's only agreement.

However, through the Maputo initiative, it is expected that the economic impact of malaria will be quantified, and this will convince funders such as the World Bank of the central importance of combating malaria to any development plans.

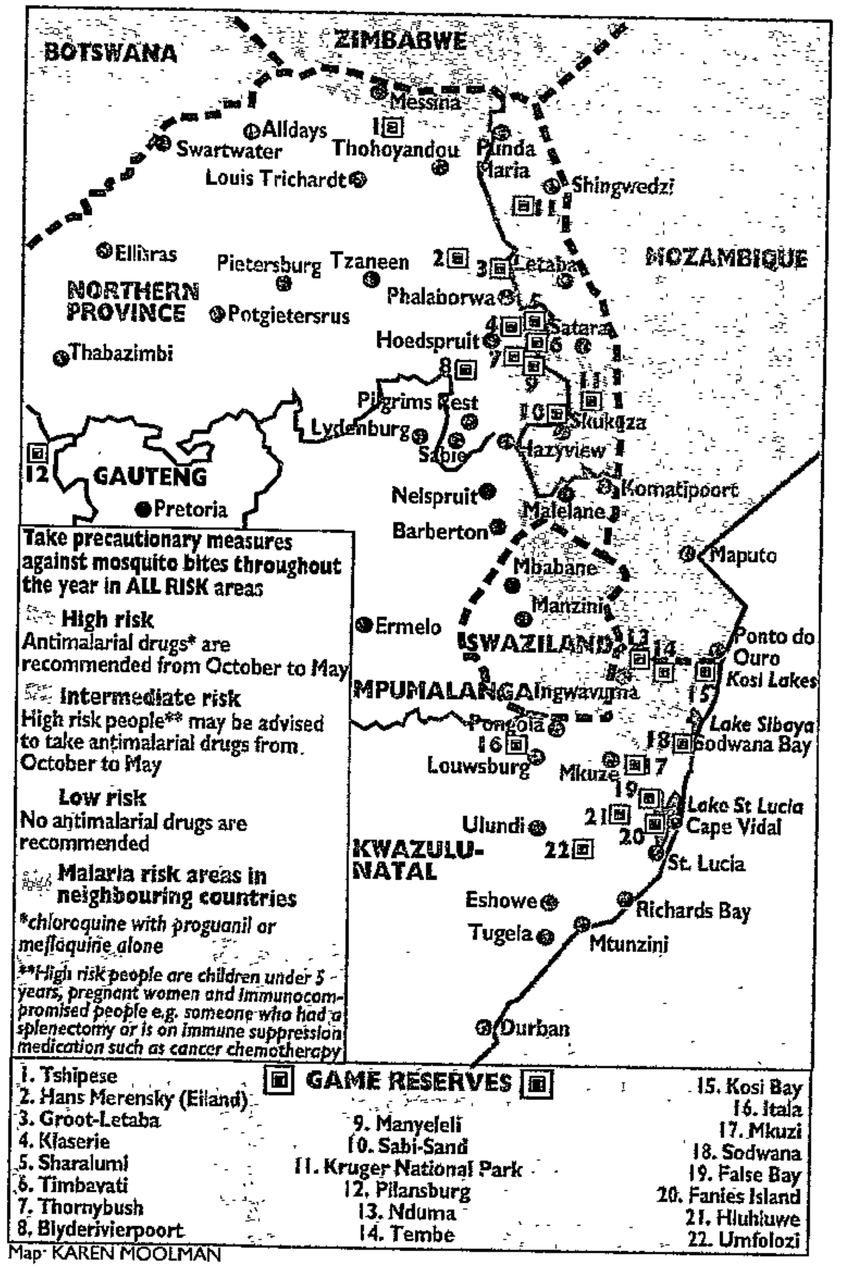
Malaria, which causes almost 3-million deaths a year in Africa, has been one of the most neglected diseases with a meagre $84m spent worldwide on combating it.

The most controversial recent claim to emerge in the malaria research world is an argument by a group of scientists that using bednets to limit the incidence of mosquito bites could possibly make the situation worse in the long term.

What these scientists argue is that this intervention would serve only to shift the age of death as immunity would take longer to develop.

Studies in two Senegalese villages have shown that in one village, where the intensity of transmission — the number of bites a year — is very high, the mortality rate peaks at two years of age and most of those that survive beyond two years develop an immunity to malaria. In a second village, the intensity of transmission is far lower, so immunity takes longer to develop and the mortality rate peaks between the ages of five and seven. In the end, the death rate remains the same; the only factor that has changed is the age of death.

"In the end it is a difficult question: would one rather lose a two-year-old child than a seven-year-old?" says epidemiologist Louis Molineaux, retired from the World Health Organisation but still considered the "godfather" of malaria research.



Map: KAREN MOOLMAN

This phenomenon is now being investigated in four central African countries, with researchers looking at whether the final death rate (including all ages) is higher or lower after intervention with nets over beds.

Other areas of research have results that are slightly more clear, and what emerges is that there is no good news, particularly regarding new drugs.

The principal factor behind the unprecedented outbreak of malaria last year was the growing resistance to traditionally used malarial drugs and prophylactics. US Centres for Disease Control malaria section director Peter Bloland painted a bleak picture for the future. "We could be facing a very difficult time in Africa. There are alternatives, but it is a question of cost," he says.

The traditionally used chloroquine costs $0,08 a dose, while the new drug mefloquine costs $3,31 and Malarone $10.

Drug resistance has increased the intensity of malarial epidemics in endemic areas. has spread the disease to areas which were formerly free of it, and has placed a massive burden on health facilities

Bloland has traced the spread of chloroquine resistance from its origins in pockets of South America and southeast Asia to all affected areas of the globe over a decade. "Right now it is going through a wave of intensive resistance," he says. The intensity of resistance also changed across Africa, with East Africa being the core of resistance, and it was important for countries to establish where they were on the spectrum of resistance levels.

Last year there were also reports of resistance to alternative drugs, and resistance to the drug fansidar was reported in East Africa.

A change in the composition of the malaria parasite species is thought to be responsible for the growing drug resistance, caused by the parasite's repeated passage through the human body. Other possible factors are the mobility of groups of people, and patients not complying with their treatment regimens. However, there is as yet no certainty on the causes of this resistance.

The response to drug resistance, said Bloland, was to develop new drugs, but this was a slow, expensive process and there were few pharmaceutical companies willing to take on the task. There were three new drugs currently in development and, in the meantime, countries had to use existing drugs more wisely by improving access to definitive diagnosis and improving patients' treatment compliance.

Bloland said that in many countries new antimalarial drugs were introduced and marketed widely before they were truly needed, increasing the likelihood of resistance developing at an early stage. He encouraged delegates to look at a regional drug policy, and collaboration on this front would have the added benefit of creating a combined pressure on pharmaceutical companies to limit the distribution of new drugs until there was a clear indication of their efficacy.

The other avenues to be investigated were preventing infections through vaccines and in the genetic manipulation of the mosquito.

Other researchers highlighted problems that had arisen in preventative approaches. There was little hope offered by the recently developed s-p vaccine which has scored only 23% effectiveness in its evaluation in six African countries. However, researchers are persevering with attempts to get it right.

"The picture is grim, there is only very modest (s-p vaccine) efficacy, and the other vaccine being tested shows no signs of efficacy," said Pedro Alonso, head of Barcelona University's epidemiology department.

However, there was a lot of development in progress and many tests were being planned, he said.

One of the main messages of the conference seemed to be: if we cannot eradicate malaria, let us at least find out where it is. Malaria is a moving target and being able to follow its shifting distribution pattern will allow health authorities to focus their efforts in the worst affected zones.

The project of mapping malaria risk in Africa now includes most of the sub-Saharan countries and hopes to produce an atlas which shows malarial risk right down to district level. In addition to collecting information on infection rates, the project will collate data on climate, rainfall patterns and population figures to give a detailed picture of areas more susceptible to malaria and exact times of the year the disease can be expected to hit.

The project, which will use the satellite-based geographical positioning system, began in November and is already well on its way with logistical centres set up in each country.

Liverpool University is involved in the project and researcher Steve Connor says recent strides in satellite technology mean captured information can be made available easily in many fields, including health. The satellites assess yearly patterns of vegetation growth and, taking into account altitude, give indications of what the potential malaria situation in an area may be.

After plotting where malaria occurs, the next step is to find a way of predicting what the effect of malaria will be in a particular season so that health authorities are not taken by surprise by epidemics.

But progress has so far been slow. The US National Oceanic and Atmospheric Administration came up with an impressive array of technology to forecast rainfall and termperature patterns and climatic changes — such as El Nino's course — but in the end its application to malaria has been limited.

Climatologists have developed also a model for predicting the year-to-year fluctuations in rainfall, and epidemiologists have taken this model and added to it data on early season malaria cases to predict the severity of seasonal epidemics.

It all sounds impressive, but the scientists concede that the model is correct in only 50% of cases.

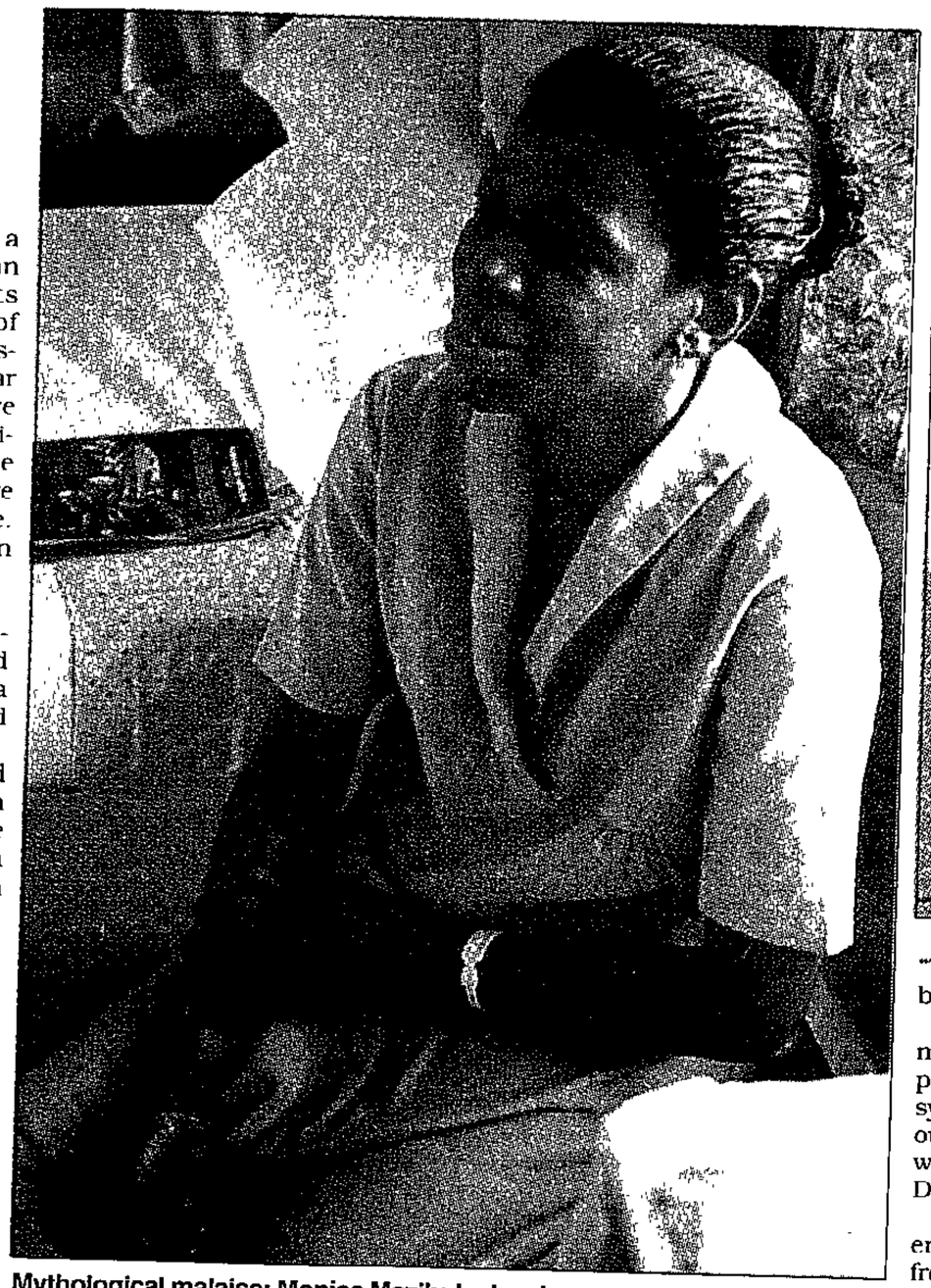
"Forgive me if I misunderstood ... but why do you not just flip a coin instead of doing all this research if you know the outcome will be wrong half of the time?" asked the no-nonsense Molineaux.

Against the tide of malaria, it does appear at times as through the entire arsenal of hi-tech science amounts to little more than flipping a coin and hoping for the best.

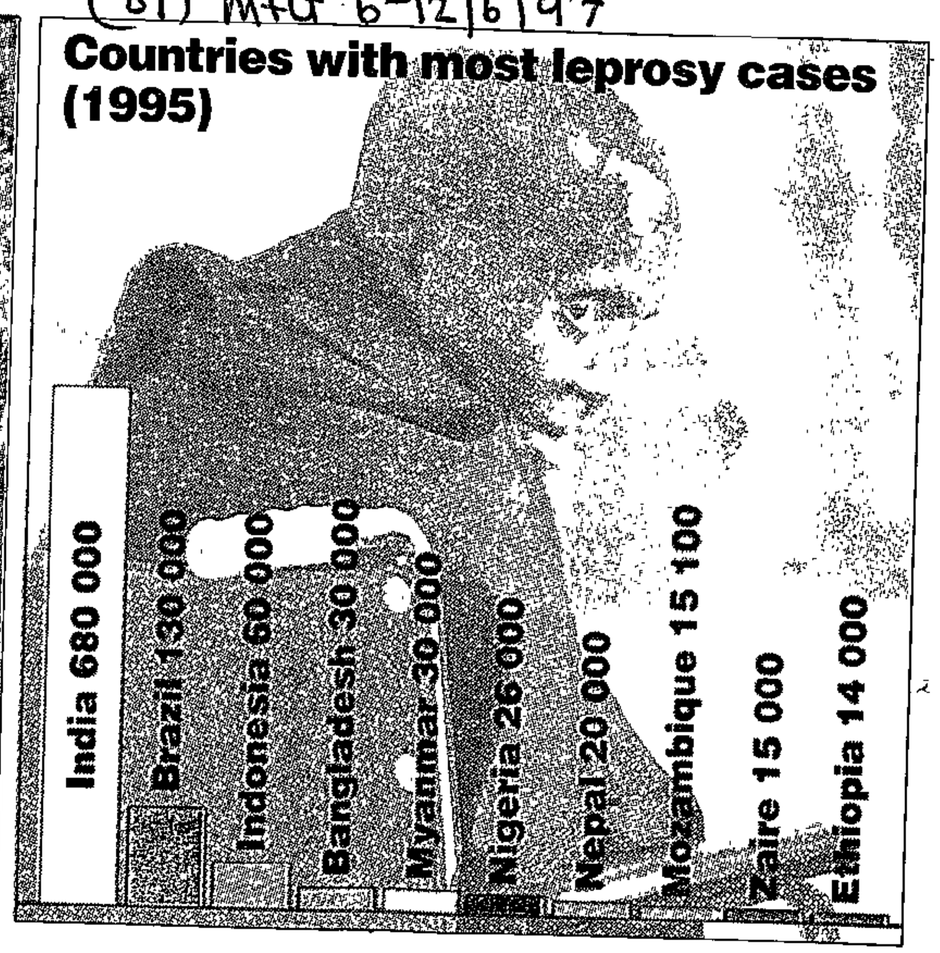
Last outpost of an ancient affliction

(89) M+G 6-12/6/97

South Africa's leprosy hospital, which dates from the Victorian era, will close next month, writes **Dawn Blalock**



Mythological malaise: Monica Mazibuko has leprosy PHOTO KENNETH MULLER



MONICA MAZIBUKO, a beautiful young woman with a shy smile, sits knitting in a patch of sunshine next to her hospital bed. Though she doesn't appear sick, decades ago she would have been a virtual prisoner in this hospital and denied any contact with the outside world. Her letters would have been passed through an autoclave. At her death, she would have been buried in a lead coffin.

Mazibuko is a leper.

The mention of leprosy evokes biblical images of disfigurement and exclusion, not the afflictions of a woman like Mazibuko, a 29-year-old waitress from Mpumalanga.

The first bacterium ever identified is by no means dead. There are an estimated two million lepers in the world. According to the World Health Organisation (WHO), leprosy is "an insidious, slowly developing disease", which still flourishes in the globe's poverty belt.

Leprosy lore is rife with myths. To answer a few: leprosy is not a skin disease, it's not very contagious, it will not make limbs fall off and, most importantly, it's curable.

In basic lay terms, leprosy is a bacillus, which is keen on the human nervous system. It spreads like a cold, but a cold that takes three to five years for the symptoms to show up. As it attacks the nerves, the sufferer gradually loses sensation. At first one would just feel a few numb patches on the arms or the face. Treated then, with a multiple-drug therapy cocktail, it's easily and cheaply curable in about six months.

Left alone, however, the patient's immune system responds to the bug and causes irreparable nerve damage. The first symptoms are skin lesions and numb patches. As sufferers completely lose sensation, their faces become flaccid, eyes don't blink and they can eventually go blind. Hands and feet curl into gnarled claws and become senseless. Since they feel no pain, they unknowingly and constantly injure themselves. Their bones fracture microscopically, and fragment over many years. Bit by bit, battered and broken fingers and toes are "re-absorbed" into the body, giving the impression that they have fallen off.

Lepers, using railway vouchers issued to them by health services, make the trek from all over the country to the West Fort Hospital leprosy clinic outside Pretoria where Mazibuko is a patient. Dr Marié Beyers, the clinic's only doctor, lives on the grounds of the Victorian-era hospital where she has worked for seven years.

She points out a wheelchair-bound old man, his nose and facial features sunken into his face, and much of his legs missing. She takes a stump that used to be his hand and runs her fingers along it.

"See that there," she says, pointing out a small protrusion where one would expect to see a pinkie finger. "That's actually his fingernail. His body has re-absorbed his fingers."

The leprosy clinic will close next month as part of the government's plan to decentralise the health-care system. The 125-year-old hospital is outdated, both physically and in its way of treating people, the Health Department says.

The "ostrich" mentality of a bygone era when lepers were locked away from the rest of society is no longer tenable, says Dr Adriaan Myburgh, a representative of the Gauteng Department of Health.

"You take all the lepers out of the community and hide them behind big walls and say we don't have a problem with leprosy."

Not everyone exposed to the disease will become lepers: it is impossible to contract leprosy without a genetically determined immune deficiency. "Most people are completely unaware of the fact that it's not very contagious," says Myburgh. Many nurses being trained to treat the disease in community clinics said their knowledge of it came from what they had read in the Bible.

Leprosy cases have been declining in South Africa, but officials expect a slight increase as immigrants from neighbouring countries plagued by war and instability such as Zaire and Mozambique bring it with them across the borders. These countries are among the 10 that have the most cases of leprosy internationally.

Though it's now scientifically possible, complete eradication of one of the world's most ancient diseases is not likely any time soon. According to a WHO report on leprosy, the disease is not a priority. Aids, other more deadly tropical diseases, poor health infrastructure, wars and social instability "make leprosy elimination seem like a luxury, an impracticable one at that".

Tune into SAfm's programme Futurewatch for more news from the world of science and technology on Mondays at 8pm on 104-107FM

Campaign stepped up against a silent killer

(89)
Star 17/7/97

South Africa is a high-risk country for hepatitis B, a chronic liver disease more easily spread than Aids

THEMBA HADEBE

By Priscilla Singh
Health Reporter

World Hepatitis Day was marked yesterday with the launch of a mass community-awareness campaign in Boksburg as the Department of Health stepped up efforts to combat the rapid spread of the disease.

Much of the department's emphasis is on hepatitis B, of which there are at least 2,8 million known carriers in South Africa.

This high prevalence makes South Africa a high-risk country, according to the World Health Organisation's classification, and routine immunisation has had to be introduced.

There are various forms of viral hepatitis from A to G, the most serious being the hepatitis B virus which attacks the liver.

Hepatitis B, also known as the "silent killer", causes chronic liver disease and increases the risk of cirrhosis (scarring of the liver), liver cancer, liver failure and death.

However, the availability of a hepatitis B vaccine prompted the Department of Health to include the vaccination in its Expanded Immunisation Programme (EPI) for newborn babies from 1995.

The vaccine provides protection for seven years and is recommended for all newborns, children, adolescents and people in high-risk groups.

Dr Rudi Eggers, the national EPI manager, said that prior to 1995 the vaccine was so expensive that a countrywide programme was not feasible.

The hepatitis B virus is blood-borne and is more easily spread than HIV.

Hepatitis B can be transmitted by transfusion, contact with infected blood via shared hypodermic needles, tattooing or body piercing, accidental exposure from needle injuries among health workers and unprotected sex.

The South African Blood Transfusion Service screens all blood donations for all forms of hepatitis.

The Sithabile Day Care Centre in Dawn Park on the East Rand, which helps sexually, physically and emotionally abused children, has been identified as one of the two community projects which will receive free vaccinations worth thousands of rands.

An additional feature of the campaign is the establishment of a Hepatitis helpline on 0800-11-40-10, which will provide information and referrals in all major languages.



Brave face ... Tumelo Lamola (10) of Dawn Park prepares himself for nurse Raylene Johnson to take a blood sample. He was one of the many children and adults who went to the Boksburg Public Library to undergo screening for hepatitis as part of World Hepatitis Day yesterday.

Alcohol syndrome study to focus on rural Cape kids

(89)

Experts examine impact of drinking in pregnancy

ARG 19/7/97

PETER MALAN

The most comprehensive study yet undertaken to determine the prevalence of foetal alcohol syndrome (FAS) in the Western Cape will start next week with the help of world experts.

Among them are Professor Kenneth Jones, one of the first medical experts to have described the syndrome in 1973.

Preliminary research shows the Western Cape – especially the wine-growing rural areas – has an extremely high incidence of the syndrome which can cause growth deficiencies, mental retardation and facial and organ abnormalities in children whose mothers misuse alcohol during pregnancy.

Incidence rates for First World countries vary between 0,5 and three in 1 000 births, while the figure for the Western Cape could be as high as 50 in 1 000.

The study, a joint project of the University of Cape Town-based Foundation for Alcohol Related Research and the Washington-based National Institute for Alcohol Abuse and Addiction, will centre on school children in the Wellington area, while children from two Cape Flats schools will also be examined.

Denis Viljoen, associate professor at the human genetics department at UCT, said the study would centre on 13 schools, examining all children of school-going age. By studying the facial features of young children dysmorphologists – experts at detecting abnormal facial features – can diagnose the syndrome.

Professor Viljoen said the American experts would train eight South African pediatricians and school doctors to diagnose the syndrome using the latest techniques.

"But this study will also for the first time give us real figures to work with. It will tell us how prevalent FAS is among this community," he said.

He said the Americans were also very keen on the South African study, because social conditions favoured a better understanding of the exact causes of the syndrome.

"We have found that most mothers in the Western Cape with FAS children don't lie about their drinking habits during pregnancy," he said. "Although they are still shy about their habit, researchers can more accurately determine how much they drank during every stage of pregnancy."

Professor Viljoen said the abuse of other drugs was not as rife, which meant researchers could more accurately assess the effects of alcohol on the foetus.

"Having identified children with FAS in the Wellington area, it will also enable us to work with these kids and provide them with the specialist care they need, whether it was the specialist care they need, physio or occupational therapy or other specialist medical care."

Two litres of wine a week, but Judith's a proud mum

ARG 19/7/97 (89)

ETER MALAN

ason's mother drank up to two tres of cheap wine a week until ıe was about seven months regnant.

"By then the heartburn was getting me, so I switched to beer. Two big ottles every Saturday.

"Some days I would not even eat, I ould only drink.

"When he was born he looked a bit ɔnormal with pointy ears," she said ɔout her son, now three years old.

"When I asked the doctor what was rong he said it was because I had en drinking while I was pregnant."

Judith Hendriks is one of hun-eds, if not thousands of mothers in ıe Western Cape rearing children ith foetal alcohol syndrome (FAS).

In spite of fact that it can be pre-ented – all you've got to do is not ink during pregnancy – the region ight have one of the highest inci-nces of the syndrome in the world.

Mrs Hendriks doesn't make any cret of her drinking habit, saying ıe hopes that being candid and open ɔout her habits will be a warning to hers not to do the same.

"I get so angry if people say my ıld looks like a bobbejaantjie (little boon). Then I say to them, just wait ıtil you get pregnant. With them inking heavily as they do, I wonder ıat their children will look like."

She looks around at the surround-g farmland and the simple brick uses of her neighbours. Most hous-have only two rooms and are dark, ummy and grimy.

"Why do the people on the farm drink so much?" I ask.

"I don't know," she says, but offers an explanation anyway. "You see, over weekends there is not much to do around here. So people drink.

"When I am sober I won't walk into somebody else's house for a visit. But when I've got a glass of wine in my hand, then I walk all over, doing huis-besoek" (house visit). By the end of the day you walk home falling."

She said of the 12 adults living on the farms, only two women did not drink.

"I did stop drinking in the past. Then I sat at home reading a Huis-genootjie. But very soon some of your friends come in for a visit and before you know you ask them to pour you a dop as well. Why should they have all the fun, you think to yourself."

She said before she fell pregnant she knew nothing about Foetal Alcohol Syndrome. "If I had known, I would not have drank as much."

Her eyes wander off in the direction of the road leading to her house.

"Jason should be coming home any minute now."

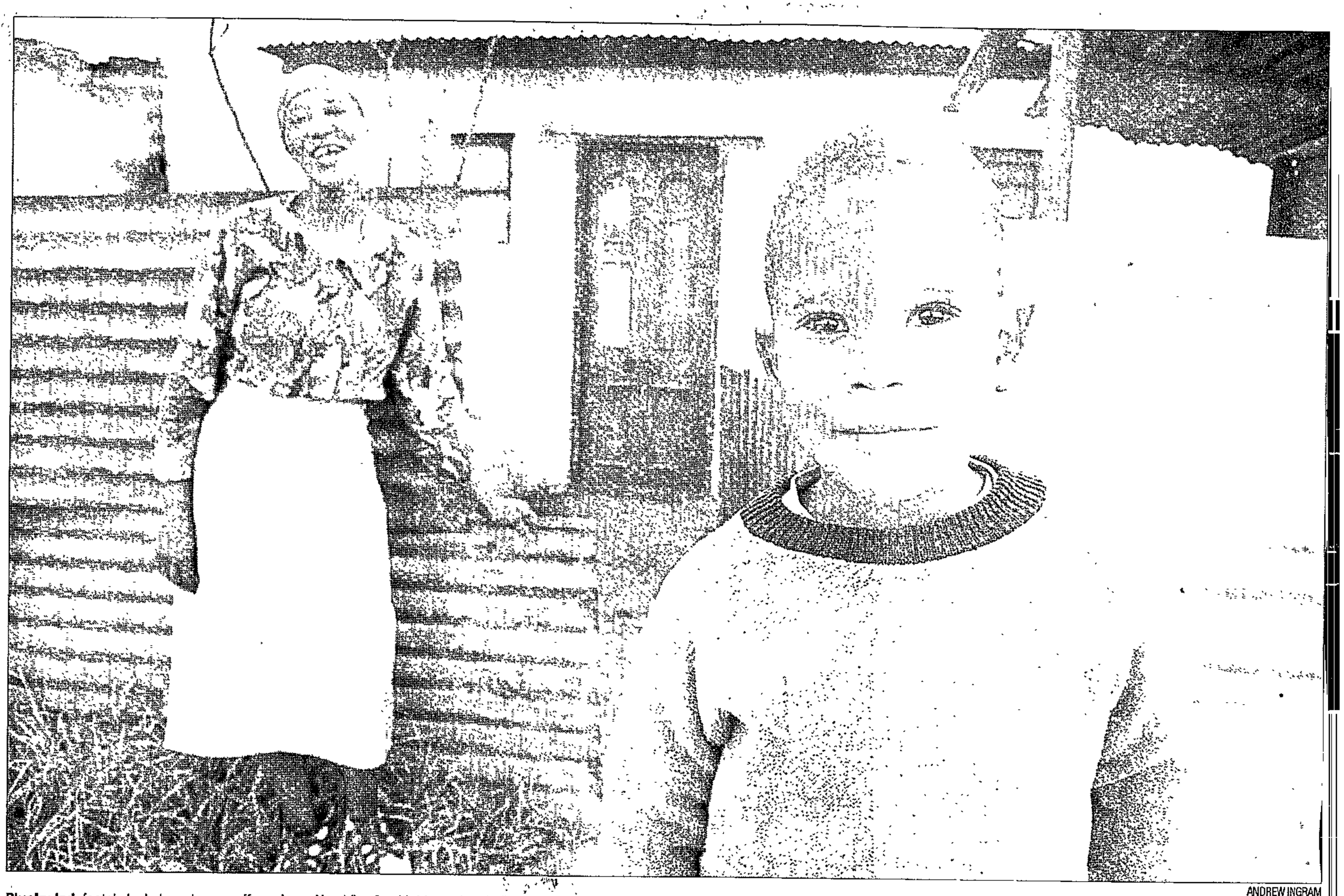
Then her eyes light up as she sees him, having just returned from the pre-school he attends.

"He's so clever. When he learnt a song at school in the morning he would come and sing it to me."

She gives him a welcome home hug and he proudly introduces himself.

"When he was small he looked a bit strange. You know, around his ears and mouth.

"But now he looks fine. Maybe I will have another child – I will just see how it goes while he grows up."



ANDREW INGRAM

Plucky lad: foetal alcohol syndrome sufferer Jason Hendriks, 3, with his mother Judith in front of their house on a farm near Philippi

the formal non-agricultural sectors.

In 1996 a total of 105 300 jobs were lost and during the first quarter of 1997, 41 946 jobs were lost.

Total Non-Agricultural Formal Business Sector

People employed

1994 Dec 5 343 820

1995 Dec 5 338 970

1996 Dec 5 233 670

1997 Mar 5 191 724

Jobs created/lost

Dec 1994 – Dec 1995: – 4 850

Dec 1995 – Dec 1996: – 105 300

Dec 1996 – Mar 1997: – 41 946

(b) Specific Industries

In this table we show the number of people employed for December 1994, 1995, 1996 and March 1997. The table also shows the differences between the number of people employed in December of a particular year and the number employed in December of the previous year.

Note: A plus sign (+) indicates the number of jobs created

A minus sign (-) indicates the number of jobs lost.

Mining

Number of people employed

1994 Dec 600 619

1995 Dec 582 766

1996 Dec 558 578

1997 Mar 556 779

Jobs created/lost Dec 1994 - Dec 1995: –17 853

Dec 1995 - Dec 1996: –24 188

Dec 1996 - Mar 1997: –1 799

Manufacturing

Number of people employed

1994 Dec 1 491 756

1995 Dec 1 477 819

1996 Dec 1 430 426

1997 Mar 1 416 344

Jobs created/lost Dec 1994 - Dec 1995 : –13 937

Dec 1995 - Dec 1996: –47 393

Dec 1996 - Mar 1997: –14 082

Electricity

Number of people employed

1994 Dec 40 515

1995 Dec 40 711

1996 Dec 39 857

1997 Mar 39 879

Jobs created/lost Dec 1994 - Dec 1995 +196

Dec 1995 - Dec 1996: –854

Dec 1996 - Mar 1997: +22

Construction

Number of people employed

1994 Dec 355 469

1995 Dec 337 276

1996 Dec 312 051

1997 Mar 314 814

Jobs created/lost Dec 1994 - Dec 1995: –18 193

Dec 1995 - Dec 1996: –25 225

Dec 1996 - Mar 1997: +2 763

Wholesale, Retail, Hotel and Motor Trade

Number of people employed

1994 Dec 760 328

1995 Dec 787 245

1996 Dec 775 577

1997 Mar 756 957

Jobs created/lost Dec 1994 - Dec 1995:+26 917

Dec 1995 - Dec 1996: -11 668

Dec 1996 - Mar 1997: -18 620

Transport, Storage and Communication

Number of people employed

1994 Dec 284 865

1995 Dec 280 235

1996 Dec 280 031

1997 Mar 278 763

Figures for the March 1997 quarter are preliminary.

Jobs created/lost Dec 1994 - Dec 1995: –4630

Dec 1995 - Dec 1996: –204

Dec 1996 - Mar 1997: –1 268

Banking, Building Societies and Insurance Companies

Number of people employed

1994 Dec 197 742

1995 Dec 208 352

1996 Dec 213 174

1997 Mar 212 378

Jobs created/lost Dec 1994 - Dec 1995: +10 610

Dec 1995 - Dec 1996: +4 822

Dec 1996 - Mar 1997: –796

Public Sector Community, Social and Personal Services

Government sector, parastatals, agricultural marketing boards, universities and technikons and laundries and dry-cleaning services

Number of people employed

1994 Dec 1 612 526

1995 Dec 1 624 566

1996 Dec 1 623 976

1997 Mar 1 615 810

Jobs created/lost Dec 1994 - Dec 1995:+12 040

Dec 1995 - Dec 1996: –590

Dec 1996 - Mar 1997: –8 166

(2) The above constitutes my statement on the matter.

* 13. Mr P I BIKITSHA – Home Affairs. [Written Question No 939] [Removed.]

*14. Mr B C BESTER – Home Affairs. [Written Question No 942] [Removed.]

*15. Mr F J VAN DEVENTER - Home Affairs. [Written Question No 943] [Removed.]

*16. Mr W L FOURIE – Home Affairs. [Written Question No 944] [Removed.]

Members of medical aid schemes/access to private health care services

*17. Past Z K MANGALISO asked the Minister of Health: [Written Question No 946]

What percentage of the South African population (a) belonged to a medical aid scheme and (b) had access to private health care services on a regular basis in 1996? N1648E

The MINISTER OF HEALTH:

(a) Approximately 15 - 18% belong to registered medical schemes. This figure is based on the latest census figures published by the Central Statistical Services and information regarding those belonging to medical schemes that we can account for as at December 1995.

(b) The above percentage does not include persons who fund their own health care expenses and those who make use of alternative insurance policies. An estimate of almost 23% of South Africans have some form of access to private health care services.

Cases of malaria in SA

*18. Mrs P W CUPIDO asked the Minister of Health: [Written Question No 947]

(a) How many cases of malaria were reported in South Africa in 1996 as compared to 1995 and (b) which areas had been declared as high risk malaria areas in South Africa as at the latest specified date for which information is available? N1649E

The MINISTER OF HEALTH:

(a) In 1996, 10 455 cases of malaria were reported in South Africa as 5 992 cases in 1995.

(b) The following areas have been declared as high risk malaria areas as on 1 August 1997:

KwaZulu/Natal

1. Hlabisa
2. Ingwavuma
3. Ubombo

Mpumalanga

1. Albertsnek
2. Block C
3. Figtree
4. Klipspruit
5. Mbangwane
6. Mbuzini
7. Naas
8. Nelspruit town
9. Steenbok

Northern Province

High risk areas are North Eastern of the northern region and the eastern side of the Lowveld.

The specific districts are:

1. Dnazini,
2. Giyani,
3. Letaba,
4. Luiekani,
5. Malamulele,
6. Mapulaneng,
7. Messina,
8. Mhala,
9. Mutale,
10. Namakgale,
13. Phalaborwa,
12. Thohoyandou,
13. Tshitale,
14. Vuwani.

Source: Provincial Departments of Health, August 1997

Private/public hospitals: number of hospital beds

*19. Dr S J GOUS asked the Minister of Health: [Written Question No 948]

What was the total number of hospital beds in (a) private and (b) public hospitals in each of the provinces in (i) 1995 and (ii) 1996? N1650E

The MINISTER OF HEALTH:

Province	Total number of beds in:			
	(a) Private Hospitals		(b) Public Hospitals	
	(i) 1995	(ii) 1996	(i) 1995	(ii) 1996
1. 1 Military Hospital	0	0	386	386
2. 2 Military Hospital	0	0	236	236
3 3 Military Hospital	0	0	180	153
4. Western Cape	*4 857	*4 857	14 762	14 402
5 Free State	2 152	2 216	7 267	7 183
6 KwaZulu-Natal	3 107	3 107	24 884	25 033
7. North West	*722	*722	7 905	7 905
8 Eastern Cape	1 199	1 199	17 416	17 416
9 Northern	196	196	10 299	10 430
10. Mpumalanga	1 353	1 353	4 427	4 427
11. Gauteng	14 594	14 594	19 967	19 733
12 Northern Cape	*449	*449	2 206	1 741
Total	28 629	28 693	109 935	109 045

* Information from the National Department of Health and not the Province

Source: Provincial Health Departments, 1997

Dentists/phamacists/specialists/general practitioners in practice

*20. Dr W A ODENDAAL asked the Minister of Health: [Written Question No 964]

What percentage of (a) dentists, (b) pharmacists, (c) specialists and (d) general practitioners practised (i) in the private sector, (ii) full-time in the government sector, (iii) in the private sector, but rendering services in the government sector, and (iv) in the government sector, but also part-time in private practice, in (aa) 1995 and (bb) 1996? N1666E

The MINISTER OF HEALTH:

	(aa)				(bb)			
	(i)	(ii)	(iii)	(iv)*	(i)	(ii)	(iii)	(iv)*
(a)	75.3%	17.0%	2.9%	3.0%	75.4%	17.3%	2.9%	3.7%
(b)	73.3%	15.0%	0.75%	2.6%	75.3%	13.3%	0.75%	3.3%
(c)	45.7%	38.0%	34.5%	2.5%	49.8%	37.8%	32.1%	2.0%
(d)	42.7%	27.0%	15.7%	7.3%	45.7%	25.0%	13.8%	6.2%

*Only those for whom authority has been granted (Limited Private Practice or Remunerative work outside employment in the Public Service in accordance with PSSC. Chapter Moonlighting cannot be determined in percentage.

Sources: Representative Association of Medical Schemes (RAMS), Personnel and Salary System (PERSAL), Department of Health (DOH), South African Medical Services (SAMS), Provincial Health Departments, Interim Medical and Dental Council of SA, Interim Pharmacy Council of SA.

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QUESTIONS

†Indicates translated version.

For written reply:

Public health institutions: shortages of staff/equipment

435. Mr M J ELLIS asked the Minister of Health:

(1) Whether any public health institutions are currently experiencing shortages of (a) staff and/or (b) equipment; if so,what are the relevant details in each case;

(2) whether any steps have been or are being taken to make up these shortages; if not, why not; if so, (a) what steps in each case and (b) when is it anticipated that these shortages will be made up? N715E

The MINISTER OF HEALTH:

The hon member is advised to table this question in the Provincial Legislatures for a reliable answer.

Deaths from breast cancer/prostate cancer

476. Mr K M ANDREW asked the Minister of Health:

(a) How many (i) women die from breast cancer and (ii) men die from prostate cancer in South Africa each year and (b) what amount is spent by the Government each year on research into (i) breast and (ii) prostate cancer? N814E

The MINISTER OF HEALTH:

The most recent statistics available (published August 1997) with regard to the abovementioned cancer types are for 1992.

(a) (i) 1 252 women died from breast cancer in 1992.

(ii) 983 men died from prostate cancer in 1992.

Source: Cancer in South Africa, 1992 (Published in 1997 by the National Cancer Registry).

(b) The Government partially funded the National Cancer Registry to the amount of approximately R260 000 (1996/97), and R266 000 (1997/98) for surveillance of all cancer types. An additional R100 000 was allocated to the Cancer Registry in July 1997 to overcome the backlog in data entry and enable the Registry to have more current data available by early 1998.

The amount spent by the Government specifically on prostate and breast cancers is not available.

Most wanted criminals: court appearances/bail

950. Mr A J LEON asked the Minister for Safety and Security:

(1) (a) How many of the 10 000 most wanted criminals identified during the "Sword and Shield" campaign had appeared in court as at the latest specified date for which information is available and (b) how many of these persons have (i) been granted bail, (ii) failed to appear in court on the appointed date following their release on bail and (iii) been convicted;

(2) whether his Department has communicated with the Department of Correctional Services in regard to special security measures for these persons; if not, why not; if so, what are the relevant details? N1652E

The MINISTER FOR SAFETY AND SECURITY:

(1) (a) Unfortunately this information is not readily available. To obtain this specified information, faxes will have to be sent to all police stations countrywide, thereby placing an extra burden on limited manpower and financial resources. Members will in such a case have to be withdrawn from other essential duties and specially allocated to the time consuming and labour intensive process of perusing case dockets and registers.

(b) (i), (ii) and (iii) See (1) (a) above.

(2) Yes. On 1996-06-19 a directive was sent to all Provincial Commissioners whereby all Area Commissioners and Station Commissioners were instructed, as a matter of urgency, to take the necessary steps to liaise with the Department of Correctional Services in their respective areas of responsibility.

Zakhe Project offers new hope to SA's three million diabetes victims

Star 8/8/97 (89)

By Priscilla Singh
Health Reporter

The treatment and monitoring of diabetes has received a major breakthrough with the donation of blood sugar testing strips and other equipment worth R400 000 from a German-based manufacturer.

Boehringer Mannheim (BMZA) has adapted a World Health Organisation programme to suit South African conditions. Called the Zakhe Project which means "self-development", it contributes to the management of the disease in the country.

Diabetes is growing at a frightening rate according to the South African Diabetes Association (Sada) and it is estimated there are more than one million diagnosed diabetics, and alarmingly, a further one to two million undiagnosed.

Incidence among whites is estimated to be about 4%, among blacks 8-10% and rising, and Indians from 18-23%.

The Zakhe Project is run all over the country, but the donation will be distributed to eight clinics in KwaZulu Natal. Zakhe is run jointly with the Independent Development Trust, BMZA and Sada.

Diabetes is different from other chronic ailments, in that the sufferer plays a role in the management of his condition.

Sada spokesman Sue Leuner said that if well-informed and motivated, a diabetic could learn to balance his diet, medication and exercise and could live a full, healthy life.

If uncontrolled, diabetes can lead to severe health complications such as blindness, amputations, heart attacks, strokes and kidney failure.

The Zakhe Project was developed for type 2 diabetics who constitute 90% of sufferers in the country. Type 2 diabetics do not depend on insulin and many can control their sugar levels with diet and exercise.

Zakhe is taught using 24 large flip charts in four two-hour sessions, over a four-week period to small groups of people.

BMZA nurse educators, Karen Denton and Nana Masike have been teaching instructors at clinics countrywide. "Managing diabetes is a balancing between food intake, which puts sugar into blood, exercise and medication which reduce sugar levels. Diabetics need to have an understanding of this process," said Leuner.

Parliament should stay in Cape Town, says DP

BD 25/8/97

Linda Ensor

CAPE TOWN — A national referendum should be held if MPs, voting with a free vote, decided that Parliament should be relocated to Gauteng, the provincial congress of the Democratic Party decided on the weekend.

The party noted the undesirability of all national institutions being sited in the one province that accounted for about half of gross domestic product, and resolved that Parliament should remain in Cape Town.

In his speech, re-elected provincial leader Hennie Bester attacked the increasing lawlessness of People Against Gangsterism and Drugs (Pagad), which he said posed a serious threat to public order in the Western Cape.

The organisation had been responsible for 71 attacks on homes of alleged drug dealers. Of the 60 people arrested, only three had been convicted while 30 cases had been withdrawn — a seriously bad record, Bester said.

He called for a High Court judge to head a multidisciplinary team to focus on prosecutions relating to Pagad and gang-related crime. He said the creation of a metropolitan police force would give fresh impetus to dealing with the gangs on the Cape Flats.

Union federation Cosatu was criticised for inhibiting job creation and transformation of the public service Affirmative action in the Western Cape was attacked for excluding coloureds.

DP leader Tony Leon highlighted the danger of single party dominance. "Democracy has not been consolidated here; intolerance is endemic over wide areas of the country; and a democratic culture has yet to take root.

"There are signs that two of the larger opposition political parties are beginning to break up ... South Africans who value democratic government must be concerned at the decay of opposition parties," he said.

Malaria campaign to use new drug

Business Day Reporter

A NEW malaria treatment available in SA will be the focus of a massive free malaria treatment programme that gets under way in East Africa next month as part of a global awareness campaign to stop the spread of malaria over the next 10 years.

One million treatments of Malarone, which has proved 98,5% effective in treating malaria, will be handed out to malaria patients who have failed to respond to conventional treatments, a spokesman for drug manufacturer GlaxoWellcome said.

The Malarone donation programme is being co-ordinated by the US-based task force for child survival and development in conjunction with the World Health Organisation. Similar projects are expected to be set up in Vietnam and Brazil over the next year.

To prevent resistance to the product developing too rapidly, it was being administered only as a last resort when other drugs had failed and was therefore not available as a prophylactic.

BD 25/8/97

More black people getting diabetes

Sowetan 10/11/97 (89)

Association urges early diagnosis so that disease can be managed

By Mokgadi Pela

THE MYTH that diabetes afflicts only white people has been shattered by the growing number of black South Africans being diagnosed with this disease, dubbed the silent killer.

According to statistics, an estimated four percent of whites in South Africa are diabetic. Diabetes afflicts between five and eight percent of blacks; between eight and 10 percent of coloureds; and 13 to 18 percent of Indians.

These figures _ confirm an announcement two years ago by the International Diabetes Foundation (IDF) that the world is facing "an explosion of diabetes".

According to the IDF, the number of people with diabetes is expected to double in the next 15 years. In Africa it is expected to triple.

Experts say diabetes affects between three and five percent of people living in the Western world. In South Africa there are more than three million diabetics.

Dr Dinky Levitt of the endocrine unit at Cape Town's Groote Schuur Hospital said: "There are many reasons for the increase in diabetes, chief of which are urbanisation with its attendant change in lifestyles, different eating habits, increased obesity, less physical activity and increased stress."

Professor Harry Seftel of the University of the Witwatersrand's medical school was more blunt: "Diabetes is a direct result of a Western 'death-style.' "

Many will agree with Levitt and Seftel that westernisation has caused more black people to adopt lifestyles foreign to them. This has had adverse consequences.

It is a lesson which cannot be ignored, considering the huge numbers of black people already suffering from diabetes.

Medical researchers agree diabetes is a fatal disease, but that with proper information, support and management it can be either avoided or managed.

If undiagnosed, diabetes (or sugar sickness as it is known in the townships), causes irreparable damage.

It has been ranked as the third most frequent cause of death after heart ailments and cancer.

Experts say if undiagnosed, diabetes leads to kidney failure, heart failure and blindness.

Limbs may even have to be amputated because of irreparable damage.

Among the known symptoms of diabetes are frequent urination, excessive thirst, excessive hunger, weight loss or weight gain, fatigue and weakness, blurred vision, tingling and numbness in the hands and feet, skin infections, the slow healing of cuts and itching.

South Africans hope to learn more about this ailment during International Diabetes Awareness Week from November 9 to 15.

The South African Diabetes Association (Sada) believes through effective education and public awareness campaigns diabetics can look forward to a healthy life.

Only 10 percent of diagnosed diabetics are likely to be dependent on insulin daily.

Most can control their condition through correct eating, exercise and various medications.

Sada has called on people to be tested for diabetes as early detection can help in managing the disease.

What is diabetes?

DIABETES is a disorder in which the body is unable to control the amount of sugar in the blood because the mechanism which converts sugar to energy no longer functions properly.

How does it develop?

- Because the blood sugar is not converted to energy, the amount of sugar in the blood builds up and spills into the urine;
- In an attempt to compensate for the lack of energy, the liver produces much more sugar than normal.

Types of diabetes:

- Insulin-dependent diabetes – also known as Type 1 diabetes or juvenile diabetes;
- Non-insulin dependent diabetes – also known as maturity onset diabetes or Type 11 diabetes.

Causes of diabetes:

- Diseases of the pancreas;
- Accidents or illnesses;
- Some drugs can increase blood sugar levels and may reveal pre-existing diabetes;
- The oral contraceptive pill does not normally cause diabetes, but it may raise the blood sugar slightly in those who already have the condition;
- Heredity.

Onset of symptoms and their severity:

- Thirst and a dry mouth;
- Passing large amounts of urine;
- Weight loss;
- Tiredness;
- Itching of the genitals; and
- Blurred vision.

Treatment:

- Insulin and diet – for insulin-dependent diabetes;
- Diet only or diet and tablets – for non-insulin dependent diabetes.

Toll-free numbers for information: 0800-117-575 or 0800-121-555.

Katlehong diabetic tells all

By Mokgadi Pela

AFTER being diagnosed as a diabetic, Katlehong pensioner Salaminah Moshime spoke of the dramatic adjustments to her lifestyle and eating habits she had to make to survive.

Moshime (65) is among three million South Africans who suffer from diabetes.

Her encouraging story comes against the background of the toll the disease has exacted on its victims.

"I have had to watch what I eat since my doctor told me I suffer from sugar disease. This came after I experienced a slow healing of a cut I sustained on my foot earlier this year

"After undergoing a few tests at Natalspruit Hospital, I was informed that I have diabetes," Moshime, of 504 Motsamai Section in Katlehong on the East Rand, told *Sowetan*.

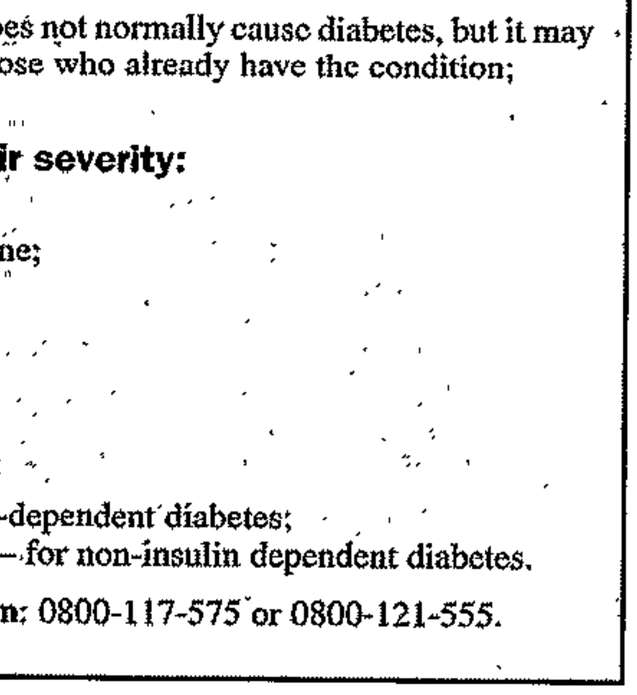
Moshime, who is the mother of three sons, Botshe, Nchime and Lebohang, now goes for a regular medical check-up. "This is the only way I can ensure that I'm still in tip-top condition," she said.

Moshime said diabetics should follow their doctors' advice so that their "days on earth can multiply"

"I'm convinced that if we do the right thing, we'll reap the fruits of our efforts and avoid the tragic consequences," she said.

To those who are not diabetic, or who are unaware that they might be, Moshime said: "Go for a check-up now. Tomorrow may be too late."

She reiterated the long-held belief of the South African Diabetes Association: "If recognised early enough, diabetes can be managed. Diabetics can lead normal, healthy lives."



Katlehong pensioner Salaminah Moshime says diabetics can lead normal and healthy lives.

Diabetes: the silent disease that threatens millions who don't even

ENNY VIALL
EALTH REPORTER

n South Africa there are more than million diabetics. But many don't now they have it, and without diagosis and treatment can go blind or evelop heart and kidney problems.

One focus of National Diabetes Week is to make people aware of the symptoms of diabetes, because a person with the illness can live a normal life if it is recognised early enough and managed appropriately.

Late diagnosis can result in failing eyesight leading to blindness, poor circulation leading to amputations, kidney disease and heart disease.

There are many reasons why the incidence of diabetes is increasing, says Dinky Levitt of the endocrine unit at Groote Schuur. "Around the world urbanisation has meant changing lifestyles, different eating patterns, increased obesity, less physical activity and increased stress."

The South African Diabetes Association, a national organisation providing support and information on diabetes, says it can be controlled by leading a healthy lifestyle.

There is no "diabetic diet" as such; diabetics should follow the healthy eating guidelines which apply to everyone. These are: eat at least three meals a day at regular times; choose low-fat foods, use little fat in cooking; eat plenty of starchy foods, especially those high in fibre, such as wholewheat bread and cereals, rice, pasta, potatoes, maize meal, samp, beans peas and lentils; eat at least five servings of fruit and vegetables each day; exercise regularly and lead a more active life. Being overweight is a risk factor in diabetes.

If you have the following symptoms it is advisable to go for a blood sugar test:

- Constant thirst.
- Frequent need to urinate.
- Always feeling tired.
- Recent weight loss (without trying).
- Always feeling hungry.
- Slow-healing wounds, cuts and bruises.

There will be a workshop for diabetics and their families at Red Cross Hospital this Saturday from 8.30am to 12 noon. Cost is R20. Contact 461 1166 (9am to 1pm) for more information on diabetes.

know that they have it

CAPE ARGUS, WEDNESDAY, NOVEMBER 12, 1997

89

Call for insulin to be made accessible to all diabetics in SA

Star 14/11/97 (89)

By Janine Simon

Insulin, the life-saving drug for diabetics, is not freely available at clinics, nor easily available at subsidised rates for private patients whose medical aids have run out.

Speaking to highlight World Diabetes Day today, Earl Bell, who co-chairs the International Diabetes Federation's insulin task force, said all diabetics should have access to the drug at cost price.

There is a chronic lack of access to insulin, despite the fact that it is deemed an essential drug by the World Health Organisation and should be universally available, he said.

Bell, the first lay South African to sit on the management board of the IDF, said insulin is included on South Africa's Essential Drugs List, but most diabetics still obtain their drugs from secondary hospitals rather than clinics.

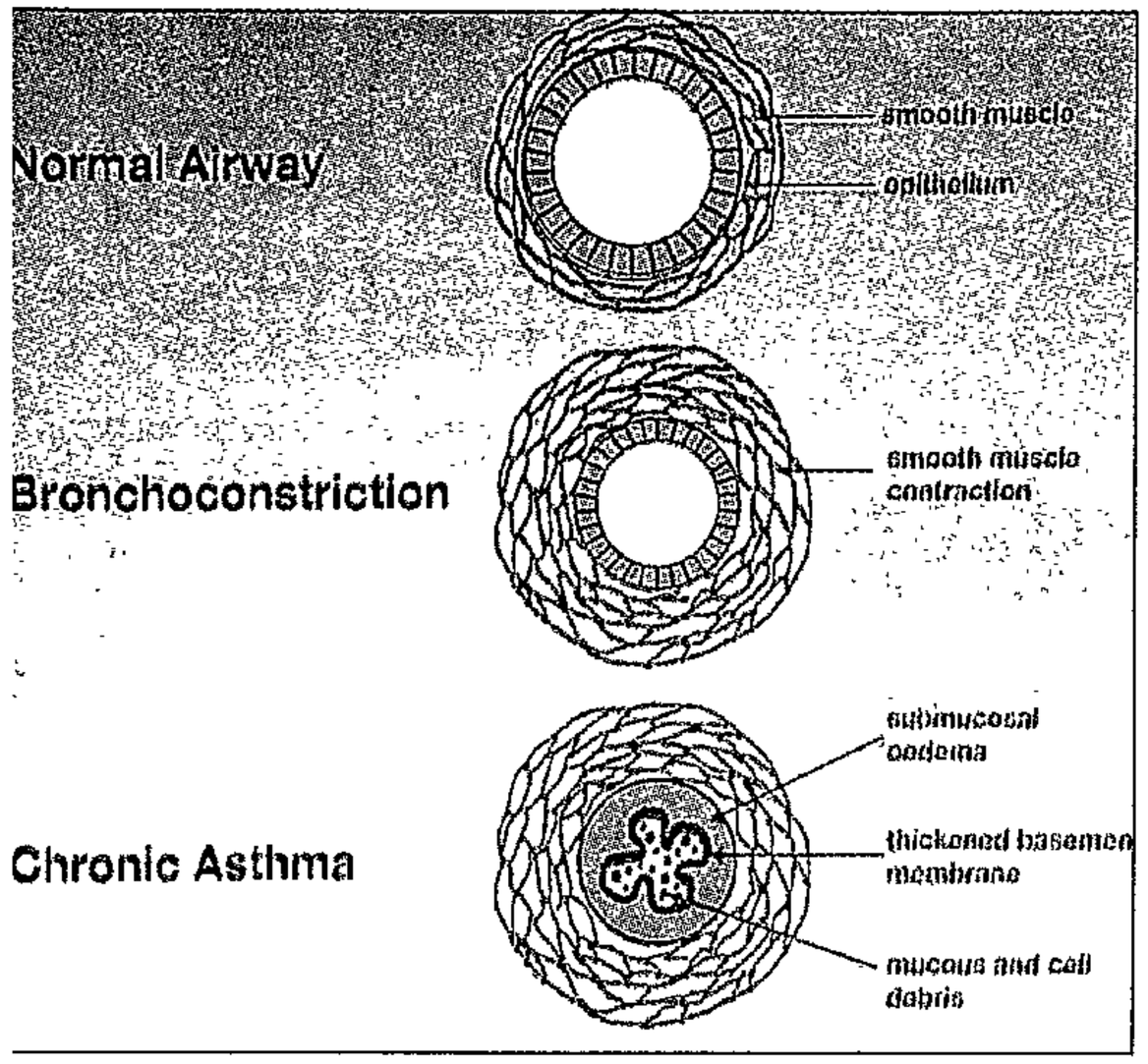
In South Africa, up to 4% of whites, 8% of blacks, 10% of coloureds and 18% of Indians are diabetic.

According to the IDF, diabetes is now ranked as the third most frequent cause of death after cardiovascular disease and cancer in urbanised communities. The number of sufferers is expected to double worldwide in the next 15 years, and to triple in Africa.

■ Contact the Diabetes Association of South Africa at (011) 788-4595.

200 die from asthma each year in W Cape – are you breathing easily?

(89) ARG 20/11/97



Asthma has become one of the most common chronic diseases in South Africa – affecting about 10% of the population, especially young children.

"If left untreated, asthma can be fatal. Between 1% and 7% of asthmatics can die from their asthma," said Dr Gillian Ainslie of the National Asthma Education Programme.

The death rate from asthma in South Africa is about eight per 100 000 – that is about 200 asthma deaths a year in the Western Cape.

"The increase in prevalence may be related to our westernised urban lifestyle. One theory is that asthma is caused by indoor pollution – dust and mites in the home, especially in carpets, bedding and upholstery, as well as a lack of fresh air. When people exercise less, they spend more time indoors."

Dr Ainslie explained that asthma narrows the lung's airways (bronchi), making breathing difficult – and sometimes even impossible.

"The disease waxes and wanes. A lot of things can trigger an asthma attack, such as when someone has a cold or is exposed to cigarette smoke. Symptoms are coughing, shortness of breath, wheezing (from a "tight" chest). This usually happens more severely early in the morning or in the evening. A person prone to allergies or coming from an allergic family is more likely to get it."

She said that education was one of the most effective ways of improving asthma control – and to assist both sufferers and medical professionals, the National Asthma Education Programme had been launched nationally.

"Asthma is a significant health problem. It is not curable, but in the vast majority of patients, if treated timeously, it can be well controlled even when severe. We need to increase public awareness of the symptoms so that patients know more about the detection, treatment and control of asthma.

"Treatment is with 'pumps' or 'puffers', syrups or pills. We prefer pumps because they are fast, effective, get directly to the problem and have fewer side effects. There are other inhaler devices for the young or elderly who cannot use pumps," said Dr Ainslie.

Because asthma is similar in both children and adults, most of the information disseminated by the NAEP pertains to all asthmatics.

NAEP was established in Gauteng in 1994 by Dr Mike Greenblatt, Dr Robin Green and several medical experts in the fields of lung diseases and allergies, with the aim of educating both patients and health workers to improve the quality of care and quality of life of all asthmatics.

In April this year, the focus shifted to disseminating this information regionally.

"Due to generous sponsorships from pharmaceutical companies, we have been able to set up education programmes around the country aimed at both health professionals and the general public," said Dr Ainslie. "There are two main initiatives – those developed and run by NAEP which are funded by drug companies, and those run by the individual companies, which have the approval, guidance and backing of NAEP."

Already more than 13 pamphlets, written by leading asthma experts, are now available. They cover a variety of topics from inhaler devices and lung function tests to advice on asthma, sport and exercise, and indoor and outdoor pollution. In addition, a school programme has been set up, and information stands in shopping malls and at sports events have been successful. Community awareness programmes include a puppet show produced by a community youth group for schoolchildren.

Public meetings are being organised where a panel of medical experts will be on hand to answer queries. Dates and venues will be advertised in the local press. In Cape Town, the first meeting took place on Thursday October 2 in the Parow municipal hall, and another is planned to take place at the Wynberg Boys' High School hall at 7pm on Thursday, November 27.

"Although lectures and workshops are being held at practices, clinics and community health centres for health professionals, a primary goal of NAEP is to get patients and the public more involved in running the organisation themselves, and having medical experts in an advisory role only," said Dr Ainslie.

Further information, including the asthma education leaflets, diary cards and action plan cards (with guided self-management plans) can be obtained from NAEP in Cape Town at Box 88, Observatory 7935, fax (021) 448 2348 or e-mail gainslie@uct-gsh1.uct.ac.za. No telephone numbers are available as present but NAEP hopes to have a hot line in the near future.

The Star ... Monday November 24 1997

Rural areas on alert for cholera outbreak

Star 24/11/97 (89)

KwaZulu Natal, Mpumalanga and Northern Province seen as high-risk areas, after scores of deaths in Mozambique

By Priscilla Singh and Anso Thom

Unless precautionary measures are taken, South Africa's rural areas could experience a cholera outbreak similar to that in neighbouring Mozambique, where at least 120 people have died, the Department of Health has warned.

Cholera has infected at least 2 700 people in various parts of Mozambique and its capital Maputo.

The department said it was leaving nothing to chance, but that no special measures were being implemented at ports of entry into SA as it was impossible to detect the disease or prevent cholera-infected people from entering the country.

Dr Neil Cameron, national director of communicable disease control, said that with conditions as they were in northern KwaZulu Natal, Mpumalanga and Northern Province, "we can expect cholera in the country".

The department has sent a cholera alert to the three provinces and a request to report any cases immediately.

Cameron said the oral vaccine provided only about 50-60% protection and did not stop the spread of the organism.

According to the department's guideline document, vaccination was not recommended because vaccines currently available do not help in controlling cholera.

In Mpumalanga, communicable disease control consultant Dr Dave Durrheim said: "In the most high-risk area, east of Nelspruit, the environmental health team have embarked on a media campaign to inform local communities on how to make water as safe as possible by providing basic-hygiene messages and warning them of the threat of cholera," he said.

The British Airways Travel Clinic in SA has run out of the vaccine for the disease because of the unusually high number of requests for the vaccine from tourists and locals since cholera broke out in Mozambique two months ago. Unconfirmed reports also said there was a shortage of intravenous fluids in Maputo.

Travel clinic spokesman Dr Andrew Jamieson joined the department in telling people to be careful of what they eat and drink and how it is prepared.

Gauteng plans to halt cholera

Sowetan 11/12/97 (89)

By Mokgadi Pela

THE Gauteng department of health is planning to reach before December 15 all communities at risk of cholera so as to contain the disease.

The department hopes to achieve this through education about clean water as a means to prevent the transmission of the disease.

The department estimates that about five percent of the population of Gauteng is at risk of cholera.

So far, only one case of imported cholera has been notified in the province.

As a means of combating the disease, the department has focused on promoting the use of safe water in "at risk" communities in each of the province's 25 health districts. This it does by educating such communities to use piped water and to purify river water with bleach.

Communities identified as being at risk include rural areas and plot settlements such as Bronkhorstspruit, Magaliesburg, Nigel, Heidelberg and the Vaal, small recently established informal settlements that do not have piped water and small groups of people living along rivers outside informal settlements.

According to the department, a small number of people may be infected by contaminated food, but this mode of transmission would not cause a serious outbreak.

To prevent cholera due to food contamination, it is important to:

- Eat thoroughly cooked food that is hot when served; and
- Use clean water in preparing food.

Meanwhile, the department is also promoting communication with people who may be travelling to and from Mozambique over the holiday period.

Already pamphlets are available from the department's directorates of health promotion and communication and environmental health dealing with:

- How to make river water safe for drinking or cooking; and
- What to do to cure the acute diarrhoea associated with cholera infection.