



Cancer Association of South Africa (CANSA)

Fact Sheet and Position Statement on Exposure to Radiofrequency Electromagnetic Fields

Introduction

On 31 May 2011, The International Agency for Research on Cancer (IARC) as part of The World Health Organization (WHO) classified radiofrequency electromagnetic fields as possibly carcinogenic to humans (Group 2B), based on an increased risk for glioma, a malignant type of brain cancer, associated with wireless phone use.



[Picture Credit: Electromagnetic Fields]

Over the last few years, there has been mounting concern about the possibility of adverse health effects resulting from exposure to radiofrequency electromagnetic fields, such as those emitted by wireless communication devices. The number of mobile phone subscriptions is estimated at 5 billion globally (IARC).

Cell Phones in Use in South Africa

In 2011 the GSM African Mobile Observatory reported that there were 50 586 757 cell phones in use in South Africa. This places South Africa in 28th position in the world. (African Mobile Observatory; Wikipedia).

The number of cell phones in South Africa surpasses the number of people living here. On the average, every one of South Africans (babies included) has 1,5 (or so) cell phones. Those are the averages; in real life, some have several handsets, some none, though the latter group is diminishing daily.

Cell phone use in South Africa has increased enormously during one decade, from 17% of adults in 2000 to 76% in 2010, says the 2012 Global Entrepreneurship Monitor. South Africa has one of the largest telecommunications markets on the continent. The main cellular providers are Vodacom, MTN, Telkom Mobile, Cell C, and virtual network operator Virgin Mobile.

Besides calling and talking to people, South Africans use their cell phones to send text messages, access social media sites, chat with a group of friends on one of instant messaging services, and browse the internet.

A World Wide Worx Mobile Consumer in South Africa survey noted that cell phone usage in South Africa underwent a dramatic shift between 2012 and 2013, with spend on voice dropping from 73% of mobile budget to 65% and spend on data increasing from 12% to 16%.

Due to high cost of personal computers and poor coverage with fixed communication lines, cell phones have been touted, in South Africa and elsewhere in the developing world, as a basic necessity. They are seen as the tool to bridge the digital divide between the rich and the poor and become an enabler of economic development.

Mobile phones are the dominant communication technology among low-income users and informal businesses; in 2012, about three quarters of low-income South Africans, in rural and in urban areas, possessed a cell phone.
(South Africa Web).

According to the World Health Organization (2014):

A large number of studies have been performed over the last two decades to assess whether mobile phones pose a potential health risk. To date, no adverse health effects have been established as being caused by mobile phone use.

- Tissue heating is the principal mechanism of interaction between radiofrequency energy and the human body. At the frequencies used by mobile phones, most of the energy is absorbed by the skin and other superficial tissues, resulting in negligible temperature rise in the brain or any other organs of the body.
- To date, research does not suggest any consistent evidence of adverse health effects from exposure to radiofrequency field at levels below those that cause tissue heating.
- Research has not been able to provide support for a causal relationship between exposure to electromagnetic fields and self-reported symptoms, or “electromagnetic hypersensitivity”.
- Results of animal studies consistently show no increased cancer risk for long-term exposure to radiofrequency fields.
- The International Agency for Cancer Research (IARC) has classified radiofrequency electromagnetic fields as possibly carcinogenic to human (Group 2B).
- The increasing use of mobile phones and the lack of data for mobile phone use over time periods longer than 15 years warrant further research of mobile phone use and brain cancer risk.

CANSA's Position

CANSA subscribes to cell phone radiation being classified as a Group 2B carcinogen until such time when consensus at IARC (International Agency for Research on Cancer) is reached to change the classification.

- Furthermore, in uncertain situations, CANSA advocates the Precautionary Principle which simply means being safe rather than sorry until scientific clarity is achieved. The precautionary principle states that if an action or policy has a suspected risk of causing harm to the public or to the environment, in the absence of scientific consensus that the action or policy is not harmful, the burden of proof that it is *not* harmful falls on those taking an action (Wikipedia).
- CANSA stands for minimal use of cell phones as described below.
- CANSA acknowledges the existence of several very recent scientific studies that indicate that frequent exposure to cell phone radiation over periods longer than 10 years correlate with an increased risk for certain brain cancers like gliomas and meningiomas as well as multifocal breast cancer in young women with prolonged contact between their breasts and their cell phones.

Consequently, CANSA proposes that exposure to cell phone radiation be kept to a minimum by:

- Limiting the number and duration of calls
- Texting rather than making calls
- Switching the sides of the head when a call is long – one should, however, avoid long conversations
- Making use of hands-free kits or speaker phone mode to keep the phone a distance from the head
- Instructing children and teenagers to limit calls to emergencies only as they are more vulnerable to electro-magnetic radiation because of the thickness of their skulls and their brains are still developing
- Not sleeping with one's cell phone close to one's bed or under one's pillow
- Women not to keep their cell phones in their brassiere
- Men not to carry their cell phones in the pockets of their pants (close to their testicles)

CANSA Further believes that:

Additional data should be gathered on exposures to cordless phones, other wireless transmitting devices (WTDs), mobile phone base stations and Wi-Fi routers to evaluate their impact on public health.

CANSA, therefore, advises that the 'as low as reasonably achievable' (ALARA) principle be adopted for uses of this technology until sufficient evidence shows that exposure from these devices is safe.

IARC Classifications

Group 1

The agent is carcinogenic to humans.

This category is used when there is sufficient evidence of carcinogenicity in humans. Exceptionally, an agent may be placed in this category when evidence of carcinogenicity in humans is less than sufficient but there is sufficient evidence of carcinogenicity in experimental animals and strong evidence in exposed humans that the agent acts through a relevant mechanism of carcinogenicity.

Group 2

This category includes agents for which, at one extreme, the degree of evidence of carcinogenicity in humans is almost sufficient, as well as those for which, at the other extreme, there are no human data but for which there is evidence of carcinogenicity in experimental animals. Agents are assigned to either Group 2A (probably carcinogenic to humans) or Group 2B (possibly carcinogenic to humans) on the basis of epidemiological and experimental evidence of carcinogenicity and mechanistic and other relevant data. The terms probably carcinogenic and possibly carcinogenic have no quantitative significance and are used simply as descriptors of different levels of evidence of human carcinogenicity, with probably carcinogenic signifying a higher level of evidence than possibly carcinogenic.

Group 2A

The agent is probably carcinogenic to humans.

This category is used when there is limited evidence of carcinogenicity in humans and sufficient evidence of carcinogenicity in experimental animals. In some cases, an agent may be classified in this category when there is inadequate evidence of carcinogenicity in humans and sufficient evidence of carcinogenicity in experimental animals and strong evidence that the carcinogenesis is mediated by a mechanism that also operates in humans. Exceptionally, an agent may be classified in this category solely on the basis of limited evidence of carcinogenicity in humans. An agent may be assigned to this category if it clearly belongs, based on mechanistic considerations, to a class of agents for which one or more members have been classified in Group 1 or Group 2A.

Group 2B

The agent is possibly carcinogenic to humans.

This category is used for agents for which there is limited evidence of carcinogenicity in humans and less than sufficient evidence of carcinogenicity in experimental animals. It may also be used when there is inadequate evidence of carcinogenicity in humans but there is sufficient evidence of carcinogenicity in experimental animals. In some instances, an agent for which there is inadequate evidence of carcinogenicity in humans and less than sufficient evidence of carcinogenicity in experimental animals together with supporting evidence from mechanistic and other relevant data may be placed in this group. An agent may be classified in this category solely on the basis of strong evidence from mechanistic and other relevant data.

Group 3

The agent is not classifiable as to its carcinogenicity to humans.

This category is used most commonly for agents for which the evidence of carcinogenicity is inadequate in humans and inadequate or limited in experimental animals. Exceptionally, agents for which the evidence of carcinogenicity is inadequate in humans but sufficient in

experimental animals may be placed in this category when there is strong evidence that the mechanism of carcinogenicity in experimental animals does not operate in humans. Agents that do not fall into any other group are also placed in this category. An evaluation in Group 3 is not a determination of non-carcinogenicity or overall safety. It often means that further research is needed, especially when exposures are widespread or the cancer data are consistent with differing interpretations.

Group 4

The agent is probably not carcinogenic to humans.

This category is used for agents for which there is evidence suggesting lack of carcinogenicity in humans and in experimental animals. In some instances, agents for which there is inadequate evidence of carcinogenicity in humans but evidence suggesting lack of carcinogenicity in experimental animals, consistently and strongly supported by a broad range of mechanistic and other relevant data, may be classified in this group. (IARC Monographs).

Electromagnetic Fields (EMF) and Public Health

Mobile telephony is commonplace around the world. This wireless technology relies upon an extensive network of fixed antennas, or base stations, relaying information with radiofrequency (RF) signals. Over 1.4 million base stations exist worldwide and the number is increasing significantly with the introduction of fourth generation technology. As the number of base stations and local wireless networks increases, so does the RF exposure of the population.

- According to the World Health Organization (2006), there has been concern about possible health consequences from exposure to the RF fields produced by wireless technologies.
- The common concern about base station and local wireless network antennas relates to the possible long-term health effects that whole-body exposure to the RF signals may have. To date, the only health effect from RF fields identified in scientific reviews has been related an increase in body temperature ($> 1^{\circ}\text{C}$) from exposure at very high field intensity found only in certain industrial facilities.
- The levels of RF exposure from base stations and wireless networks are so low that the temperature increases are insignificant and do not affect human health.
- The strength of RF fields is greatest at its source, and diminishes quickly with distance. Recent surveys have indicated that RF exposure from base stations and wireless technologies in publicly accessible areas (including schools and hospitals) are normally thousands of times below international standards.
- Media or anecdotal reports of cancer clusters around mobile phone base stations have heightened public concern. It should be noted that geographically, cancers are unevenly distributed among any population. Given the widespread presence of base stations in the environment, it is expected that possible cancer clusters will occur near base stations merely by chance.
- From all evidence accumulated so far, no adverse short- or long-term health effects have been shown to occur from the RF signals produced by base stations. Since

wireless networks produce generally lower RF signals than base stations, no adverse health effects are expected from exposure to them.

- Considering the very low exposure levels and research results collected to date, there is no convincing scientific evidence that the weak RF signals from base stations and wireless networks cause adverse health effects.

(World Health Organization, 2006).

Electromagnetic Hypersensitivity

For some time a number of individuals have reported a variety of health problems that they relate to exposure to Electromagnetic Field (EMF) exposure. While some individuals report mild symptoms and react by avoiding the fields as best they can, others are so severely affected that they cease work and change their entire lifestyle. This reputed sensitivity to EMF has been generally termed “electromagnetic hypersensitivity” or EHS.

EHS is characterised by a variety of non-specific symptoms, which afflicted individuals attribute to exposure to EMF. The symptoms most commonly experienced include dermatological symptoms (redness, tingling, and burning sensations) as well as neurasthenic and vegetative symptoms (fatigue, tiredness, concentration difficulties, dizziness, nausea, heart palpitation, and digestive disturbances). The collection of symptoms is not part of any recognised syndrome.

The symptoms of EHS are certainly real and can vary widely in their severity. Whatever its cause, EHS can be a disabling problem for the affected individual. EHS has no clear diagnostic criteria and there is no scientific basis to link EHS symptoms to EMF exposure. Further, EHS is not a medical diagnosis, nor is it clear that it represents a single medical problem.

For EHS individuals with long lasting symptoms and severe handicaps, therapy should be directed principally at reducing symptoms and functional handicaps. This should be done in close co-operation with a qualified medical specialist (to address the medical and psychological aspects of the symptoms) and a hygienist (to identify and, if necessary, control factors in the environment that are known to have adverse health effects of relevance to the patient).

World Health Organization, 2005).

For further reading, please access the following World Health Organization (WHO) publications:

- Backgrounder. 2006. Electromagnetic fields and public health: Base stations and wireless technologies. Backgrounder, May 2006.
- Backgrounder. 2007. Electromagnetic fields and public health: Exposure to extremely low frequency fields. Backgrounder, June 2007.
- Backgrounder. 2006. Electromagnetic fields and public health: Static electric and magnetic fields. Backgrounder, March 2006.
- Backgrounder. 2005. Electromagnetic fields and public health: Electromagnetic hypersensitivity. Backgrounder, December, 2005.

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Sources and References

African Mobile Observatory 2011

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Electromagnetic Fields

<http://www.cnet.com/news/who-cell-phones-may-cause-cancer/>

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http://www.iarc.fr/en/media-centre/pr/2011/pdfs/pr208_E.pdf

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<http://www.southafricaweb.co.za/article/south-africans-and-their-cell-phones>

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https://en.wikipedia.org/wiki/Precautionary_principle

https://en.wikipedia.org/wiki/List_of_countries_by_number_of_mobile_phones_in_use

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