Food for Thought . . .

Child Health in the RSA

A. MOOSA

Professor Moosa is head of the Department of Paediatrics and Child Health at the University of Natal, Durban. This is taken from his inaugural lecture.

THERE ARE approximately 10 million children in South Africa today of whom 8 million are black. What then is the state of health of these children? One way of looking at this is to analyse the number of infants under 1 year of age who die out of every 1 000 that are born, ie the infantile mortality rates. It is generally accepted that this rate is a good index of the overall state of health and socio-economic development of the population to which it applies.

The official Department of Health infantile mortality rates for the different population groups are as follows:[1]

White	20,1
Black	100,2
Coloured	104,0
Asian	34,7

But this varies from area to area; for instance in Germiston for 1976 the rates were (based on notifications and not registrations):

White	9,1
Black	179,7
Coloured	444,4

On the other hand in Cape Town the infantile mortality for 'Coloured' for 1977 was 25,9/1 000.[2]

But these figures only reflect deaths up to 1 year of age. Our experience at King Edward VIII Hospital, Durban, shows that about 80 percent of deaths in our children's wards occur in those under 2 years.[3] Although most of these are in children under 1 year, about 1/5th occur in the age group 1-2 years. This is not reflected in the infantile mortality rate. A recent survey[4] of deaths in hospitals in Natal and KwaZulu during the month of March revealed 670 child deaths of which 86 percent occurred in children up to 2 years.

The most vulnerable group therefore are the young children up to 5 years. Amongst the Blacks they constitute 16 percent of total population. Yet deaths amongst this age group constitute 55 percent of total mortality for Blacks, figures which are very similar to other African countries, eg Liberia 17 percent and 57 percent respectively. Amongst the Whites this group constitutes 11 percent of the population but only contributes 7 percent to the total mortality which resembles the situation in a developed country, eg Denmark 8 percent and 2,9 percent respectively. We in the Republic of South Africa therefore are in a unique situation (not that I'm proud of it) of having a level of health and socio-economic development of one section of the population similar to that of a Third World country and of another section similar to that of a developed country. Yet, unlike some of the Third World countries, we are a rich country and it is within our means to eliminate this discrepancy.

Why then are so many of our children dying each year? We lose more than 8 000 children a year in the hospitals of Natal and KwaZulu alone and about 2 000 of these deaths occur in King Edward VIII Hospital.

The principal causes of admissions to the children's ward, King Edward VIII Hospital, Durban, are chest infection (21 percent), gastro-enteritis (13 percent), infectious illness especially measles (10 percent) and TB (7 percent), and these are the same conditions responsible for the majority of deaths occurring amongst our children. The tragedy is that these are to a large extent preventable.

Take measles for example — the annual death rate for measles in children under 5 years in the Republic of South Africa (1970-1974) for the different population groups, according to Dr M Klein, is as follows:

White	11	
Coloured	451	
Asian	54	
African	2 035	(corrected for total population)

This gives a mortality rate for measles per million population of 4 for Whites, 225 for Coloureds, 89 for Asians and 128 for Africans. Compare this with the rate in USA of 0,25 — the difference is quite striking. Yet measles, like many of the other infections, is preventable.

You may well ask why chest infections lead to death in these children, when in most of our own children it is usually a minor non-fatal illness. The answer lies in the fact that the vast majority of those who die from these infections are malnourished. Of all admissions to our children's wards, 45 percent have one or other form of severe malnutrition — marasmus or kwashiorkor-or, to put it another way, of our 6 649 admissions in 1978, 2 775 were malnourished, and one quarter of these died.

This represent only the severe end of the spectrum. Children with mild malnutrition are not as a

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rule admitted. Malnutrition depresses the immunity of the child and so not only is he more prone to infection but he is also more likely to suffer from it more severely. So we have a vicious circle set up in which malnutrition leads to recurrent infections which in turn cause more malnutrition, each infectious episode causing the child to slide more rapidly down the slope that eventually ends in death. Because of the high infantile mortality, the parents have more children as a safeguard against the future, thus further compromising the meagre family resources.

But what we see in hospital and on the death certificate is only the tip of the iceberg. A survey from Soweto in 1977 revealed that 45 percent of 10-12 year olds were undernourished,[5] in Cape Town in 1978 40 percent of school entrants were malnourished[6] and in Durban in Umlazi in 1977 60 percent of boys 3-4 years old were below expected height and 30 percent of boys 12 years of age were below expected weight[7] and amongst Indian school children in Durban 50 percent were undernourished.[8]

What effect does all this have on these children? There is now incontrovertible evidence that malnourished children do not achieve their full potential. Whether this is directly due to the malnutrition or to the poor socio-economic environment from which these children come, is not clearly established — and it probably does not matter anyway. The two factors are so intimately linked that to try and consider them separately is futile, but it does help to explain the high drop-out rate amongst black school children, and high incidence of social 'maladjustment', depending of course which social norms these children are judged against. These children literally need food for thought.

Why then is malnutrition still so prevalent in South Africa today? The answer lies in one word — POVERTY.

The survey from Soweto referred to above found that 30 percent of the households interviewed existed below the poverty datum line and, to quote a recent article in the Sunday Tribune (3/6/79), 'Estimates of numbers living below the subsistence level vary between one third and half of the working black population'.

I have painted a rather grim picture of child health in South Africa today but if you work as I do in a hospital such as King Edward VIII, Durban, then you will realise these are realities with which we are faced daily. For me these are real issues, the priority areas in terms of child health in the Republic of South Africa.

What then should be done? 'How are we going to break the vicious circle of malnutrition, infection, and multiple reproduction? We can, of course, provide aid in the form of food to the starving masses as has been done in many developing countries, but this is doomed to failure as experience throughout the world has clearly shown: malnutrition is still as prevalent as before, despite all forms of aid. In fact this form of aid may be positively detrimental, as it may suppress possibilities for social change.

We may of course stem the tide of a rising population by distributing contraceptive devices freely, but how does one convince a mother to use these when experience has taught her that the best security for the future is to have as many children as possible, knowing that half of them may not survive beyond the 5th birthday. When Dr Williams, who first described the condition of kwashiorkor, was asked to comment on family planning she said: 'If we look after the quality of a population, the quantity will look after itself'.[9] The best contraceptive is good nutrition.

We can immunise all the children to protect them against infectious diseases, but this is less effective in malnourished children, and how does one get to these children, most of whom reside in rural areas?

The one important way to break the circle is to eliminate malnutrition, ie poverty. Only then will all the other approaches discussed above have the desired effect.

The solution, therefore, is not a medical one. It is essentially, a political and socio-economic one. As Dr J de Beer pointed out, the health priorities in the Republic of South Africa are the provision of clean, constant water, constant adequate supply of food, adequate sanitation and adequate housing. In order to achieve this we need a complete re-orientation in the thinking of those who decide how our monies are to be spent. Instead of building bigger and better 'disease palaces' or what I like to describe as towering monuments to our failure, like the new Johannesburg General Hospital which cost R156 million to build and R50 million per annum to maintain, the money should be used to provide much needed basic health services in the rural areas. In so doing we will reach a much larger section of our population.

It must be remembered that 70 percent of our Black population lives in rural areas which are largely undeveloped and do not have the basic amenities for healthy existence. 80 percent of these people are mothers and children, the least vociferous and most vulnerable section of our population. To invest in their health is to invest in a healthy future. What we need is a proliferation of maternal and child health centres or primary health

care centres which must be accessible, acceptable and appropriate to the needs of the population. Israel, with a population of 3½ million, has approximately 850 of these centres throughout the country. In KwaZulu with a population of approximately 5 million we have only 100 and these are not necessarily adequately staffed. But these health care centres must be seen as part of an overall development plan for the rural areas — agricultural development, educational and technological development — which must be appropriate. I believe the University of Natal has a leading role to play in this regard. Recognising the constraints under which the University operates due to the laws of this country, and recognising that the community it serves is unfortunately not the one most in need, I nevertheless believe the University should seriously consider the establishment of a Rural Development Unit which will undertake research into and co-ordinate activities related to rural development in Natal and KwaZulu.

What rôle should the medical profession play? For one I think we as a medical profession should realise that the health care of our children and, for that matter, of all people is not the sole prerogative of the medical profession — but that other disciplines are of equal, if not greater, importance in the provision of adequate health care for our children. We must realise that 'western style medical education is an antiquated model of testified incapability in solving health problems of the type existing in developing countries'. We must move away from the so-called western pyramid of élitism (which probably stems from the 13th century when Emperor Frederich II of the Holy Roman Empire decreed that no one should practise medicine without sitting an examination before the masters of the medical school at Salerno), and see the provision of health care as a broad front of health for all by all and, especially, free for all. This reorientation process must start right at the beginning of the training of our doctors and indeed even before that. In the training of our doctors we must kill two birds with one stone — not literally speaking, of course, although this may be a way of solving the population explosion! Whilst training them in the art of diagnosis we must at the same time teach them about the importance of prevention and health education.

But it is not just the University that has a rôle to play. Each one of us has a contribution to make. We cannot simply sit on the sideline and watch our children die in their thousands each year from preventable causes. We must all get involved and do something about this. **What, you may well ask, can I do in this regard?** For a start, become aware of what the real priorities in child health in the Republic of South Africa are and, secondly, bring pressure to bear on the policy makers and planners to deal with the roots of the problems and not merely the symptoms. If we can convince our health minister that instead of spending 98 percent of the health budget on curative services and the other 2 percent on preventive and promotive aspects, the reverse should take place until such time as we have overcome the major health problems in this country. After this about half of the budget should be spent on curative and the other half on other aspects of health. We would then have achieved an important victory in our struggle to provide health care for all our people in the Republic of South Africa. If I may quote the late John F Kennedy when he opened the World Food Congress in Washington in 1963:

> So long as freedom from hunger is only half achieved, so long as two-thirds of the nations have food deficits, no citizen, no nation, can afford to be satisfied. We have the ability as members of the human race. We have the means, we have the capacity to eliminate hunger from the face of the earth in our lifetime — we need only the will.

Do we have the will?

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Points of View

'I WONDER what the Blacks, who shiver in the middle of a dark night and who are hounded early in the morning, call the department, surely not co-operation and development. Perhaps callous and destructive would be nearer the truth'. Dr Alex Boraine (PFP, Pinelands). — The Star

DR KOORNHOF said it was his duty to ensure that as far as possible Blacks living in White South Africa retained their bonds with their own national states. He was a friend of the Black man, and urged the Opposition not to destroy that friendship.

Dr Koornhof has claimed that the evictions and demolitions would be carried out compassionately with due regard to the dignity of those being evicted. 'I am sure he means what he says. I am only a little puzzled — how can you evict and demolish compassionately? How can you do something that is fundamentally inhumane inhumanely?'

— Bishop Tutu quoted in The Star