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THE CHANGES WHAT ARE TAKING PLACE IN THE HEALTH AND DIET OF NATIVES (AFRICAN) IN URBAN AREAS AND THEIR EFFECTS"

Read before the World Education Fellowship

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This is an interesting but difficult subject because one has no source of reliable official statistical records. African health so called in South Africa is treated as something apart from European health. Mortality rates statistics refer to Europeans only. Registration of births and deaths in the Union is compulsory for all races in the urban areas and for all others in rural areas except the Africans. Even these figures for urban areas are fluctuating and unreliable because a large number of African male labourers have their families permanently resident in rural areas. They visit their families or are visited by their wives at intervals.

Another factor which adds to the difficulty is that preventive and prophylactic welfare services such as antenatal clinics, child welfare service school medical and dental inspection which would be a source of valuable information are conspicuously lacking just beginning in certain urban areas under Mission stations or certain Municipal authorities.

Besides it will be surprising to many to know that the last Union census in which the African population was included was in 1921. The European census has since been taken twice in years 1926 and 1931. In view of these facts one is justified in concluding that so are as Non-Europeans are concerned any attempt at computing accurate vital statistics would not only be incomplete but also useless and meaningless. The only valuable and reliable information in regard to Native Health is that pertaining to African Mine labourers in the Gold and Coal Mines in the Union.

The subject of our discussion presumes the existence of reliable figures for information on African health in rural areas
on the one hand

hand and the urban areas on the other as would permit of a comparative study. Such information or figures we have proved to be non-existent.

Under these circumstences our discussion will consist chiefly of personal experiences, observations and impressions with few or no figures at all. We shall have served a great purpose, if in this paper we arouse an interest in the subject and suggest problems for investigation either to prove or disprove beyond question any impressions we may leave.

We shall now refer to the diet of the African. Formally the people's diet was simpler, coarser, harder and better balanced. It consisted chiefly of Mealies and Amabele (Kaffir Corn") grains. The mealies was eaten as whole grain. The green ears were roasted or boiled (Ibaqu). Even when dry they are roasted and eaten as (Amaqashu) or the shelled-off grain is boiled and eathen (Inkobe) or parched and eathen as (Ugcado). All this tends to exercise the teeth. The amabels (kaffir corn) also are boiled and eaten as (inkobe) or may be mixed with sour-milk (Umvubo). Mealies is also likewise mided with our milk. Of course in those days milk was abundant and often supplemented most of all these dishes. Herds and flocks were large and pasture was plentiful.

During the green mealie season the people chew a lot of sweet-cane. Besides certain fibrous roots and wild fruit and berries were always available and people ate them.

Meat was also eathen chiefly venison and also slaughtered animal. The meat was roasted on open fire or boiled. It was often cooked under done. This process left the piece of meat juicy and slightly bloody inside. In this way the proteins were not completel destroyed by the roasting or cooking process. The principal thing to note here is that most of the food used by the people tended to leave very little deposit upon the teeth. The teeth were almost invariably rinsed with water after meal. Ash or wood cinders are used as dentifrice or tooth paste the index finger as tooth-brush

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This made a smooth non-irritating tooth brush on the gums.

In urban areas the diet tends to be soft and less balanced than the African's diet was formerly. It is true that mealies or amabele meal used as mealie or amabele porridge are still basal diet. Wheat bread is also largely used. Unlike the African diet of former days instead of milk which is scarce and too expensive for the people, tea and sugar are used as supplements. Often porridge or wheat bread are taken without either milk, tea or sugar. Notwithstanding it may be said the African townsfolk use more sugar than formerly. Among these people milk and meat are used only occassionally on account of the scarcity of money.

The diet of the African urban dwellers is usually unbalanced and poor in the right kind of proteins. It may have more far reaching effects on the health of the people than are believed as the following analysis will show.

Investigators on nutrition such as Mendal and Osborne have proved by annual experimentation that there are certain groups of proteins which could not promote growth no matter in what quantities thy are added to base diet. Of these proteins the following two Zein and Gliadin, are of special interest for our discussion. Zein (or protein of maize or corn) and gliaden (or protein of wheat or rye) are respectively found in the mealie porridge and the wheat bread. Wheat bread lacks the important amino acid lysine which has been established to be essential for growth. As a supporting proof to this statement we know this amino acid is present in a high percentage in all proteins that are naturally used as food for the young, such vitellin, or ovalbumin and casein and lactalbumin in milk. It was found that a basal diet with gliadin as the chief protein without lysine being added, the growth of the animals fed on such diet was stunted. But, as soon as lysine was added to gliadin diet normal growth was resumed. Zein(the protein of maize or mealies) besides being dificient in glycocoll which is non-essential lacks lysine (growth promoting amino acid) and tryptophane (body

weight) maintain animo acid. Animals that werefed on a basal diet with zein as chief protein showed a curve of growth which falls below the maintenance level. This indicated that the animal was starving and would soon succumb. On the other hand we have pointed above that casein in milk and ovalbumn in the egg, containing a high percentage of these building ~~xxxxx~~ stones - lysine and tryptophane. If these proteins or their amino acids are added to a basal diet of either zein or gliaden, growth at once follows. Thus eggs, milk and meat would be good balancing factors in the diet. But many of the African urban area residents who have high rents and high transportation charges to pay public authorities cannot afford these foods of food elements regularly and in quantities large enough to balance their diet.

I believe we all agree that this diet in the light of the facts just mentioned must be having a gradual deleterious effect predisposing the race to disease and infection. It may be mentioned in passing that the diet of the African in rural areas is fast becoming unbalanced because of inceasing poverty due to repeated droughts, scarcity of milk as result of diminishing herds and flocks from crowded reserves and lack of pastures. I should have mentioned that the African child's food consisted chiefly of mother's milk. Breast feeding after six months as supplemented with milk chiefly sour milk. Since African mothers were almost invariably fit and free to nurse their babies, artificial feedings was never a problem to reckon with. The death rate among infants was at a minimum.

We must now consider health conditions among urban Africans. However, before going on with our discussion on this phase of our subject we would like to point out that according to the Annual Report of the Department of Public Health year ended 30th June 1927 White South Africa is considered one of the healthiest countries in the world as the following figures show:-

> "Infantile mortality rate, i.e, Death of European infants under one year per 1000 births 1925: 68.39; 1926, 64.82."
> Death rate: European per 1000 of population, crude 9.39 standardized (i.e., corrected for age and sex distribution so as to correspond with the international

"Standard population in these respects 10.15"
"Survival rate or Rate of Natural Increase, i.e. excess of European population per annum. The Union stands first on the International list with a rate of 17.12... U.S.A. 5th., England and Wales 6th 6.6.

This is most pleasant reading for the white population giving a false sense of security but most misleading when the health conditions of thew hole population, irrespective of colour are taken into consideration. One wonders whether South Africa would appear in the International list if her vital statistics were taken for the whole population as it is done for the countries with which South Africa appears on the list. About African health one thing is clear. That is, among the Africans in the Urban Areas the death rate is unnecessarily high and the infant mortality rate shamefully and disgracefully high. By reason of this last fact the survival rate or rate of natural increase among the Africans must be extremely low.

Generally speaking the African shows decreased resistance to disease and infection. There is a poor general physical condition among the people. The physique tends to be poor and puny. This is due to many factors such as poor deficient diet plus more strenuous living which is gradually sapping the stamina of the people. Even in rural districts this loss of stamina and physique has been so evident that some of the N.R.C. Centres reject an increasing number of men, because of their poor physical conditio For example, the centre at Engcobo, Transkei
There are less strenuous open air endurance exercises or tests. However, these tests were in vogue when men had leisure and were well-fed. In certain urban areas there is poor accomodation in certain industrial compounds (not necessarily mine compounds) and Municipality Locations. The majority of the working people are not hygienically clad, and are underfed. Their clothings are often scant or insufficent for the seasonal changes in weather. Many of these people cannot afford new clothes or even enough cover at home for themsleves and children from the generally low wages they receive and the high rent and transportation fee they must pay from their distant location homes. Their low economic

conditions force them to live in crowded areas and under conditions not conducive to good health.

Classification of Diseases in order of Prevalence

In our experience supported by that of others, the order of prevalence of diseases when we include the chief causes of infantile mortality the order according to systems is as follows:-

1. Gastric Disease 2. Respiratory Disease 3. Circulatory Renal and Cardiac 4. Gynaecological 5. Genito-urinary and Venereal Diseases.

Gastric Diseases and infantile mortality are chiefly Gastro-Enteritus which is the chief cause of infantile mortality. The incidence of Gastro-enteritus declines with the increase in the age of the patient. In some of the Municipal locations the infantile mortality rate is anywhere between 200 to 700 per 1000 births. Compare that with 64.82 per 1000 reported for the whites. What then in the true position for the Union of South Africa in infantile mortality? This fact of high infantile mortality is supported by a health report signed by Dr. L.Fourie Assistant M.O.H. of the Union, which was summarised in the Rand Daily Mail of June 8, 1934 as follows:-

> "Gross overcrowding, unsatisfactory sanitary and health conditions and infantile mortality rate of 600 per 1000 are mentioned in a report by the Union Department of Public Health following a departmental investigation into the State of Benoni Location"

It is well to mention in passing that Benoni is the town that received the Empire shielf on or about 1928 for having the healthiest white children when it had an infantile mortality alleged to be between 700 - 800 per 1000. Some of the factors in infantile mortality are largely preventable. They are, for instance, the low economic status of the people, the inability of some of the mothers to nurse their babies regularly or inabilit to nurse them at all. This is due to the fact that many mothers have to walk long distances to do odd jobs in order to supplement their husbands low wages. The babies, under these circumstances are left under the care of children barely older than they for feeding and general care. There is often poor nursing or ignorance of child care under modern conditions. Some people are often ignorant of the proper quantities of the food and methodsof preparing children's food. Many people cannot afford to

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buy the approved baby feeds for their children on account of lack of money. The often resort to home preparations which upset the child's digestion with often regrettable results. There is also a great delay in calling medical assistance because of financial difficulties.

RESPIRATORY DISEASES:

The Respiratory diseases are second only to Gastric diseases in order of prevalence for all ages. They are more prevalent among children and adults than Gastric Diseases. We find that factors such as exposure, lack of minimum comforts for bodily and home needs reduce the resistence and predispose the people to disease. Lobar Pneumonia is quite common among the adults and Bronchitis and Bronch-pneumonia among the children. Bronchial Asthema is frequently to be seen especially during winter months.

It is important to state before we leave the diseases of the respiratory system that Tuberculosis is increasingly becoming more common. Its spread is bound up with the general factors of poverty and ignorance of the consequences. Poor ventilation and spitting habit. To illustrate something of the prevalence of this condition I shall take figures from the analysis of In-Patient cases of the Victoria Hospital, Lovedale C.P. for the years 1933. This, of course is a semi-rural area. Of 880 cases admitted into that hospital for the year 156 cases had Tuberculosis of different type. This was nearly 20% of the In-patients. Tuberculosis is essentially a disease of poverty. I must here caution my audience. The figures just mentioned do not mean as some may conclude that the incidence of Tuberculosis in the Union is 20% of the African population. They can only be taken to show that his disease needs to be closely watched and all possible efforts used to stop its spread.

DISEASES OF THE TEETH: (Dental Caries).

Formerly among the African one saw commonly cases of Teeth that showed attrition or wearing down from use on the part of the old people. Most of them did not know what a toothache was. However, some of their teeth wore down or narrowed elongated and loosened only to

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to be pulled off by the owner with a piece of string. The gums were usually sound.

Nowadays we see more signs of decayed teeth and bad gums among children and young adult. The work done in South African on Dental caries among Africans by different investigators as reported by Dr. J.C.Middleton Shaw implies the conclusion that dental caries among the Africans is about as common in the African as in the European. The only difference is one of degree being less in the individual African. So far as the cause of dental caries in the African noneof these investigators have been able to suggest. The writer of this paper if of the opinion that so far as the Africans are concerned the factor of diet and less of environment may bring us nearer the solution of our problem. While the balancing of the diet may play its part, but, one would think that sugar and cheap sweets will be an important element in the diet.

The best apprach to this problem would be to study the teeth of groups of Africans not so much according as to whether they are urban dwellers or rural but more in reference to the food they have adopted. Have the groups under study adopted European food and in particuler the elements such as sugar and sweets that the writer suspects as either cause or predisposing factors. Or, are these signs of malnutrition, improper food, bad hygiene or signs rickets or other disease?

OBSTETRICAL AND GYNAECOLOGICAL PROBLEMS: To-day one hears of and sees many difficult confinements. Yet, those of us who had been brought up in rural areas know of families after family and large families at that where children were born without resort to a midwife or Doctor. Within the last twenty or thirty years I have known of and seen many babies born away from home when the mother had gone to fetch firewood or water or had been hoeing the fields. Many women I have seen do their work and do not stop until barely an hour before the baby is born. This is not a mere impression on the speaker's part. It is supported by numerous accounts of similar experiences from old women. I have heard them say to me individually, "My child, we do not know what is the matter with our children. We do not know

these things, we are not used to any such difficulties. "For instance", one may say "I have had ten, eightor seven children and I was alone with all of them except the first two or three"

It is also true that the African woman was taught to look upon labour pains as a natural course of events. Consequently they stood them stoically and used them most effectively. Not only that, immediately after the birth of the baby many women tidy their own bed, wash the baby and som on. This,one still sees even in the City on the part of older women or those who have recentely come from rural areas. Of course it must be admitted that these African women of previous generation carried loads that gave them a graceful carriage and a general muscular development. What then are the causes of this increasing difficulty in labour among the African women in urban areas? Are there any pathological conditions during the growth of the woman that brings about pelvic deformities which complicate labour. Are there unobserved signs of rickets among the women during development? Have the habits of dress and sitting posture anything to do with this problem? For instance the African woman formerly sat on the floor, carried heavy loads and more loose clothing. It it the nature of the work that the women do under modern conditions? Does this work leave the essential muscles and mechanical powers in labour weak and undeveloped? Is the increasing fear of labour pains and constant desire to be assisted by physicians or midwife a contributory inhibitory factor? Besides these problems of labour and confinement one sees and gets more histories of abortions and miscarriages among urban Africans than one hears of among rural African women. Any of the usual causes known to bring on abortion or a miscarriage may be a factor but one is led to believe that the specific factor is playing an increasing part in these conditions. Impressed with the large number of cases with signs of pelvic inflammations and their sequelae. Along with these one get histories of or two births and thereafter sterility. Other cases which are more serious are those of childless marriages with history of a typical vaginal discharge often soon after marriage followed by

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symptoms of pelvic inflammation. On Examination one find may find land marks of a specific infection.

To illustrate the importance of the specific infection factor on abortions and miscarriages, Dr.Hope Trant of the Bridgman Hospital, Johannesburg reports as follows:-

> "There were 35 abortions up to 3½ months pregnant in 1932.... In 28 cases out of the 35 the blood was tested for Wassermann reaction. It was positive in 67% including doubtful cases".
> There were 41 miscarriages 3½ - 7 months pregnant during 1932."
> The Wasserman reaction was taken in 34 out of 41 patients and was positive in 52.2% including doubtful cases.

THE SIZE OF THE FAMILY SMALLER.

Among Africans in urban areas the size of the family is becoming smaller. It is due to several important factors. Among the young intelligent married couples there is a desire to make provision for their children under modern conditions. They feel that with their low economic status they can only have a limited number of children. The marriage age is increasing as a result of longer preparation for carrers on the part of both boys and girls. The African girls to-day are in increasing numbers attending schools training for carrers such as Teachers, Nurses, Midwives and so on. Many work for years before marriage. The young men on the other hand feels that he must either work and accumulate before marriage or train for occupation that will offer a reasonably comfortable income before he ask for the hand of the girl who has an independent earning capacity. Besides these economical factors , we have patholigical factors which decrease the families either by causing frequent abortions and miscarriages or sterility complete or partial. These pathological conditions are the pelvic inflammations and specific injections. Besides, the infantile mortality due to reasons stated previously tend to decrease the family. Finally we have the social element playing its part. The marriage among the urban African is becoming more unstable. The people from European example are increasingly getting fond of settling their differnces in the divorce court.Many men and women tend not to marry. Others marry, separate and live apart even though not divorced. Under these circumstances the number of children must of necessity be small.

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MENSTRUATION: The onset of menstruation is earlier about 13 years as against 15 or 16 years formerly. This may be due to increasing knowledge of children in immoral ways. Small children boys and girls from lack of school facilities and lack of means on the part of their parents to send them to school do not get discipline that well regulated family life and school attendance would give. These little ones then for no fault of theirs find themselves victims of evil influences. Their education during the absence of the adult members of the family at work is from the street.

LONGEVITY: There is an impression though difficulty to prove that the people do not live as long.

CIRCULATORY DISEASES: One sees quite a number of genito-urinary cases such as acute nephritis, pyilo-nephritis and acute cystitis during the cold winter months. B.Coli is the commonest organism. We, however, do not agree with Dr. Hope Trant of the Bridgman Memorial Hospital when she says "The South African native is almost invariably constipated" Our experience with thousands of patients of various types lead us to to call this statement rather loose and not well considered. In some of these cases there are sometimes a history of an acute urethritis. Of Cardiac conditions which are not as common as the venal conditions the chief lesions is the nutral negurgitation with commonly a history of acute Pheumatic Fever.

VENEREAL DISEASES: The problem of Venereal Disease of syphilis in particular is one that causes all thinking people great concern. The correct percentage of Africans showing a positive Wassermann is not definitely known. The incidence varies locality, race or tirbe. In urban areas the incidence is much higher than in rural areas. In the Annual report of the Department of Public Health year ended June 1928 we find this statement. "In Non-Europeans the proportion varies more widely. Amongst the coloured population of the Cape Peninsula and the vicinity, it is very high. In the report of the South African Institute of Medical Research for the year ended December 1927 a table is given showing the results of blood examinations of 1200 apparently healthy native

labourers belonging to eight different tribes before commencing work on the gold mines - made at ther equest of this Department. Positive Wassermann test varied from 2 per cent in Xosa to 29.5 in Basutos, East Coast Natives showing 7 per cent; Pondos 8.5 per cent and Bechuanas 22 per cent of positives"

Dr. Hope Trant of the Bridgman Hospital gives report of Wassermann Tests at the Bridgman Hospital for Non-European women. We summarise her figures including the doubtful cases with negatives as follows:-

40.75 per cent positive and 62.5% negative. She then quotes Dr. S.E.Smith, late of Jane Furse Memorial Hospital with the following conclusions 43.9 percent positive and 56.1 per cent negative. Dr. Trant then concludes, "So that the difference between the urban and rural native as regard syphilitic infection is slight." This conclusion is too sweeping and incorrect. The figures refer only to a particular type of patient and does not refer to the general population. For instance, a family may have three or four children before infection takes place and taking an average of such families the percentage will be quite different. Besides even among urban and rural areas the incidence varies according to lacality and class of people.

In the report of the Victoria Hospital, Lovedale for the year ending December 1933 we find that in a total of 880 in-patients of all types and sexes there were only 64 cases of syphilis. The wide variety of patients, age and sex here offers a more satisfactory percentage for the population of that particular area.

The chief factors that enter into the increase of syphilis among the African race are personal indifference and ignorance of the victim as to the implications of the disease. Many of the people have no conception of the mode of its transmission. There is often lack of a proper and convenient treatment centre that ensures privacy. When treatment centre is miles away from Town such as Rietfontein Hospital for the Treatment of African (native) cases there is loss of time, loss of work, and a stigma associated. Many patients find themselves unable to pay for long expensive private treatment. The increase of marriage age exposes more people to infection. Besides there are many male

labourers living away from their wives and more women living out of wedlock. All these conditions tend to play a part in the spread of the disease. The nervous diseases do not answer any of our questions. We only know that most of the Africans who go to Insane Asylum are chiefly cases of Dementia Praecox, Manic depressive Insanity and epileptics. Hysteria is rather race. Here we have not enough experience to say whether the nervous disease are increasing or no.

In conclusion we wish to state with all the emphasis in our power that the African is subject to the same diseases as his European neighbour. Fortunately he responds to the same treatment as Europeans and his condition can be improved if his case were to receive the same care and attention as the European's. In our experience and observation we are quite convinced that the apparent changes of increase in the incidence of certain disease conditions, such as Gastro-enteritis in infants, Tuberculosis and venereal diseases are not vital or peculiar to the African but are secondary and environmental. They are fortunately enough controllable conditions. Their prevalence indicate the existence of certain social evils and apathy on the part of those who have assumed control over the African. The low economic status of the African, the overcroweded conditions under which he lives either in rural or urban areas, the ignorance of the first principles of hygience and public health due to lack of education, which would enable them to appreciate health propaganda all play a large part in maintaining this undesirable state of affairs.

In practice the Africans are excluded in the operation of certain preventive health and welfare services such as Ante- or pre- Natal clinics, child welfare, school medical and dental inspections as if their health were something different.

Mortality rates among the Africans in urban areas are a disgrace to our sunny South Africa or would be to any country classed as civilised. It is a false sense of security and a misleading record to report statistic of only a minority population while we leave in

our vital statistics the most deplorable conditions in the health of the majority, though backward part of the population. They are here. Let us face up to the question, get the facts on the situation and tackle problem boldly and honestly.

Obviously we shallneed a change of attitude towards the health of the whole community. We shall have to treat publichealth as such irrespective of colour or race. It is clear from what we have said that raising the economic status of the Africans will be a great factor in improving the health of the people. It will give them more home comforts better food and make it easier for them to get medical assistance in time. Education would also help the people to appreciate health propaganda throughlectures, the press, and other health literature. Besides health welfare service such as ante-natal and child welfare clinincs, medical schools and dental inspections as well as establishment of convenient treatment centres for venereal diseases would give not only valuable informaton on the the State of health of the people, but would also have an educative value to the community as well as offer an opportunity for the dissemination of health knowledge.

Finally the best possible training for African men and women as medical doctors, trained Nurses, Nurse-midwives, and health visitors is a crying necessity. The real progress in health matters among the Africans will come from within when there are enough Africans with the highest medical training to lead their people.

A helathy African community is the best insurance for a healthy European community since disease knows no colour line.

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