THE AFRICAN CHILD

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George Bernard Shaw in his wisdom said that the worst sin towards our fellow creatures is not to hate them, but to be indifferent to them. In my reflections of the past 14 years on the life of the African child as seen at King Edward VIII Hospital, there is much to narrate, and I wonder whether we have not been indifferent to the requirements of this section of our community. The African population was not hospital conscious 14 years ago, and our estimation of the medical problems was consequently very inadequate. During the past 8 years, and particularly in the last 3 or 4 years, the demand for hospitalization has been very intense. Let us review the general improvements in medical science during this period.

Many discoveries of great importance in diagnosis and therapy have been made, e.g. the introduction of penicillin and a large group of antibiotics, many of which have reduced the hazards of a long illness and actually saved life. Another revolution in our daily lives has been the advent of poliomyelitis vaccine, which has received universal acclaim and has been equitably distributed throughout our multiracial society. The repair of congenital heart lesions, almost a forbidden territory to surgeons some years ago, has become an essential part of the thoracic surgeon's duties today. The geophysical year has brought us into contact with the moon, and meaning-

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less space and sound no longer baffle modern scientists. Since the last war the welfare state of Britain has focused its greatest attention on the child and, during its most difficult moments, allocation of food for children was of paramount importance. This aspect of preventive work has been of great value to the citizens of Britain.

Kwashiorkor

With regard to the problem of child care as it affects this country, malnutrition has been studied seriously for the past 14 years or so. During this time kwashiorkor, or protein deficiency, has reached astronomical figures, and its rise has been particularly great during the past 4 years.

What are the factors that cause this devastation of the African child? While ignorance concerning feeding undoubtedly plays a certain part, social and economic circumstances are also responsible for the end results which manifest themselves in the disease known as kwashiorkor. Kwashiorkor exists on the whole of the African continent, and the original name, derived from Nigeria, means the 'deposed child' because, when a mother becomes pregnant again and removes her infant from the breast, this 'deposed child' then suffers from protein deficiency, since the proteins necessary for the child's health are to be found in milk. Deficiency of these proteins causes oedema of the face, body and limbs; enlargement of the liver; hair changes giving a gingery or grey appearance; and denudation of the skin of the body, particularly in the lower abdomen and buttocks. Eye symptoms, ranging from destruction of the eye to blindness; anaemia; and a host of other symptoms are also present. In practically all these cases the monotonous diet has consisted of mealie-meal porridge and water, samp, bread, and occasionally beans, with no other nutriment, and very little in the way of fresh food.

The disease presents from 6 months to 2, 3 or 4 years of age, and there is a general deterioration of every organ of the body, resulting in an abnormal being, one who has to be nurtured back to life at considerable expense. The most important age group affected is the preschool one, when supply of milk is absolutely essential. This milk can be prescribed as skimmed-milk powder, and the cost of providing this food for an infant would not amount to more than 5 cents a day, whereas the estimated cost for a child with a full-blown kwashiorkor, who requires blood transfusions and hospitalization, amounts to R90 a month. A random group of statistics from King Edward VIII Hospital for 1955 - 1956 is given in Table I.

TABLE I. COMPARISON OF STATISTICS RELATING TO KWASHIORKOR AND ALL OTHER FORMS OF MALNUTRITION, KING EDWARD VIII HOSPITAL, 1955 - 1956

		Admissions	*Deaths*
Kwashiorkor	1955	731	392
	1956	834	429
Total		1,565	821
All other forms of malnutrition	1955	283	189
	1956	175	90
Total		458	279

To deal with this very vexed question, the basic requirements of the African must be closely studied and, as Prof. O. P. E. Horwood of the University of Natal has stated, the African's salary must amount to at least R30 a month for a meagre existence. Statistics show that many are living under the R18 - R22 level and are unable to obtain the necessary food to keep kwashiorkor at bay. Many of the children affected with kwashiorkor are prone to develop other infectious diseases, such as dysentery, typhoid and tuberculosis. Therefore it is in the best interests of all children that this group is kept in a good nutritional state, so that these diseases may not be spread throughout the community. We should be cognizant of the fact that health is interdependent — one half of the community depends on the good health of the other half for its survival. In the *South African Medical Journal* of 21 October 1950[1] I reviewed the position of malnutrition at that time and stated that 'the problem is too large for other than governmental control, particularly in urban areas where conditions of living among the Bantu have deteriorated owing to congestion and increased cost of living. All our researches will prove fruitless unless the problem is tackled vigorously and energetically. The preservation of good health must prove less expensive than treatment of the disease. Prevention is better than treatment'.

Since 1950 the problem has increased considerably. What active steps have we taken to educate and improve the lot of the African, and are we not perhaps allowing the position to overreach itself? Before this happens let us adjust our thinking and invoke the aid of the 3 tiers of Government, Municipal, and Provincial authorities to help surmount the problem.

May King Edward VIII Hospital in its Jubilee year rejoice in the results achieved by milk as a therapeutic agent at all the oupatient clinics under its control.

My thoughts end with these apt words: 'In each one of us stands this instinct pointing with its upraised finger the path we have to walk in. We may call it love of freedom, or justice, but neither quite defines it, it is something more; it is the deep conviction buried somewhere in our nature not to be eradicated that man is a great and important thing, that the right of himself and his existence is the incontestable property of all men; and above all the conviction that not only we have a right and are bound to preserve it for ourselves, but that where we come in contact with others we are bound to implant it in them'.

REFERENCE

1. Klenerman, P. (1950): S. Afr. Med. J., 24, 891.