INVALIDISM IN AN URBAN BANTU COMMUNITY

W. G. HEARN, M.B., B.CH. (RAND), *City Health Department, Johannesburg*

The apparently high incidence of chronic sick patients attending an urban Bantu polyclinic, and the social problems arising from invalidism led to an investigation into this matter. The problem of invalidism in the South African Bantu is aggravated by many unusual factors. These include deeply rooted tribal customs, ignorance of some groups and illiteracy of others, the persistence of migratory tendencies and inter-tribal differences. Even geographical factors such as long distances and lack of rural communications influence the problem.

This study dealt with protracted invalidism among the approximately half million Bantu living in the south-western areas of Johannesburg. The material was obtained at 1 of 7 polyclinics in the area and in the district served by the clinic. The district contains an average socio-economic and ethnic representation of an urban Bantu community. The Bantu races differ to a wide degree historically and culturally, not only from the Whites but also among themselves, and these differences still exist in urbanized communities. Investigating the problem has required not only intensive medical investigation, but also a sympathetic approach based on an understanding of Bantu customs, in order to win their confidence.

Protracted Invalidism

Hereby was understood a state of incapacitation resulting from an illness or disability which is causing, or will cause unless controlled or treated, a person to be an encumbrance upon his family or the community. For the purpose of this paper invalidism was further considered to be either *partial* or *complete*.

Extent of the Problem

As far as could be ascertained no assessment has previously been made of the problem in the Bantu area of Johannesburg. In fact, no proof could be found of any similar investigation in a comparable community. A pilot survey showed that the problem warranted further investigation. 2,000 houses, representing the dwellings of 2,027 families, were selected at random. A White health visitor in charge of a team of 2 Bantu health visitors and a senior Bantu clinic nurse visited each home. The Bantu nurses were instructed to detect every suspected case of invalidism. In consultation with the health visitor in charge, they completed questionnaires. All cases detected were medically examined and the *degree* and *cause* of invalidism was assessed by the medical officer.

TABLE I. INCIDENCE OF INVALIDISM

Families interviewed	2,027
Invalids questioned	547
Completely incapacitated invalids	162
Partially incapacitated invalids	385

TABLE II. AGE INCIDENCE OF INVALIDS

Age group	*Completely incapacitated*	*Partially incapacitated*	*Total*
0–19	67	60	127
20–39	15	64	79
40–59	21	111	132
60 upward	59	150	209
Total	162	385	547

One in 4 families harboured an invalid and 1 in 12 had the encumbrance of a complete invalid. The prevalent belief of medical and social workers in these areas that the problem is primarily geriatric was not substantiated.

Facilities for Alleviation

An investigation was conducted into the facilities available for the alleviation of adverse circumstances under which the invalids lived.

Medical supervision. A full and comprehensive service is provided by a large base hospital (Baragwanath Hospital). Strategically placed throughout the Bantu areas are 7 polyclinics linked by radio communication with the base hospital and an ambulance depot controlling a fleet of radio-equipped mobiles. The clinics offer a complete medical and nursing service including casualty, outpatient, midwifery and domiciliary facilities and an active health-visitor service which includes an immunization and a child-welfare department. Liaison with the hospital is healthy, and extensive use is made of its specialist services. Health education is receiving considerable attention.

Social assistance is provided by central government statute and by the local authority. The central government, by means of various pensions acts, provides pensions for old age, invalidity, blindness, pneumoconiosis, leprosy, military disability, and also provide for unemployment insurance. In addition, numerous voluntary organizations and local authorities receive grants and other financial assistance from the central government. The local authority administers social assistance through its Department of Non-European Affairs. A team of welfare workers assists in the administration and distribution of pensions and other benefits, many of which are made available by voluntary welfare organizations. Voluntary assistance is provided by over 50 active welfare organizations, some of which are large branches of country-wide institutions working in cooperation with the authorities, while others are smaller, limited by finances, but influential by virtue of enthusiastic and prominent workers.

Habilitation and rehabilitation. Various organizations operate sheltered employment schemes which could form the nucleus of an organized and coordinated habilitation and rehabilitation scheme.

Extent to which Service is Used

Medical services. In spite of the fact that treatment for invalids is free,[1] less than half of the invalids obtained regular treatment. Of 547 invalids questioned, only 241 were receiving regular treatment. Of 162 completely incapacitated invalids only 48 received regular medical supervision, while 40, representing 25%, had never seen a doctor. Many of the remainder had at some time been treated, but exact figures were impossible to determine. Irregular attendance is very often the result of the migratory habits of the Bantu.

Social assistance. Of 547 invalids the vast majority were eligible for some type of social assistance, whether statutory or voluntary, yet only 211 had obtained aid. Pulmonary tuberculotics received their assistance automatically upon notification, owing to effective welfare organization in this field in Johannesburg. They totalled 126. Thus, of the other 405 invalids, only 85 (*approximately 25%*) received assistance.

METHODS OF MEETING THE PROBLEM

It is suggested that the problem should be approached on the following broad principles:

1. The focusing of attention on the problem both among the population and the authorities controlling medical and social services.

2. Establishment of an Information and Referral Service. Interesting and specialized work has been done in this field in the USA[2] and Great Britain.[3]

3. Promotion and development of a coordinated Home Care Programme. The local health department is strategically placed to institute such a programme. The programme established by the Newton Health Department[4] could possibly be adapted as a basis for a similar scheme in the Bantu areas. The liaison which exists between medical and social services, the fact that medical care is accepted as the concern of an organized service, the presence of a large and well-trained domiciliary nursing service and an enthusiastic health-visitor service could ideally be adapted to such a programme. The addition of a domiciliary physiotherapy service would be of great value, and a very good case could be made out for a mobile unit which would bring immense benefit to arthritic, neurological and orthopaedic cases.[5]

COMMENTS AND DISCUSSION

The field investigation showed the unsatisfactory conditions affecting many urban Bantu invalids. A great number were suspicious of the investigation, and many more were unable to understand that assistance was obtainable. Pride and distrust also influenced many of the families questioned. There was less reticence in accepting medical aid than social assistance. The local health department has for many years provided essential services, expanding them as needs have arisen. It is felt that a new need has arisen. By making use of the existing services and application of such principles as health education, morale building in invalids and relatives, adequate therapy and diet, avoidance of bed-fastness, stimulation of mental activity, home care supervision and equipment for the disabled,[6] considerable alleviation of these adverse conditions could be obtained.

SUMMARY

Invalidism in the Bantu community of Johannesburg was investigated. It was found that 1 family in 4 was encumbered by an invalid, less than one-half of whom received regular medical treatment, and less than one-quarter received social assistance, although both are available. The medical, social and rehabilitation services were investigated and the use made of these services was assessed. Methods of meeting the problem are suggested. It is advocated that local authorities with urban Bantu populations of the type described in this study could ideally promote a community programme for the care of long-term patients.

My thanks are due to Dr. J. W. Scott Millar, Medical Officer of Health, Johannesburg, for permission to publish this paper; and to Dr. I. W. F. Spencer, Assistant Medical Officer of Health, Johannesburg, for many helpful suggestions.

REFERENCES

1. Hospital Services Department, Transvaal (1960): Hospital Circular No. 28.
2. American Medical Association, Committee on Ageing (1959): J. Amer. Med. Assoc., **170**, 1079.
3. Godber, G. E. (1956): Practitioner, **177**, 5.
4. Phillips, H. T., Palmer, L. and Weinberg, R. (1962): Publ. Hlth Rep., **77**, 815.
5. Baker, D. M. (1958): Practitioner, **180**, 316.
6. Rudd, T. N. (1962): Med. Offr, **2814**, 395.