Letter from Johannesburg

IS AFRICA NEAR TO COLLAPSE?

In 1993, JAMA carried an article entitled 'Africa on the precipice—an ominous but not yet hopeless future.' Another warning came from the President of the Royal Society of Tropical Medicine in the United Kingdom: 'If it is not controlled there will be widespread starvation and the strife that goes with crowding and hunger. The hygienic state of tropical nations will break down completely, so that there will be totally inadequate sanitary services, a shortage of water and all the diseases that go with a primitive society . . . We are facing a potential disaster of a magnitude such as we have never contemplated before . . . The people of the tropics should be educated at once to know the danger of their situation . . . a way to get over the disaster of having large families.' In a further analysis on the subject, published in the BMJ, it was concluded that (i) two-thirds of the people living in sub-Saharan Africa are desperately poor; (ii) standards of health and education continue to deteriorate; (iii) more money is spent on debt servicing than on health and education; (iv) within Africa, corruption, wars and lack of commitment to health have contributed towards the appalling health indices; and (v) the role of the industrialized countries in destabilizing Africa needs to be openly debated. It averred, inter alia, that more than half the Africans do not have access to safe drinking water and 70% are without proper sanitation facilities; and that the infant mortality rate (IMR) is 55% higher than that in the rest of the world's low income developing countries, and average life expectancy, at 51 years, is 11 years less.

Africa is an enormous continent. While the affairs of many countries appear almost beyond remedy, in the case of some others, such as South Africa, which are better placed, the outlook is relatively favourable. Some countries such as Sierra Leone are in great need of help; the IMR is extremely high (366 per 1000 live-births), six times higher than that in South Africa. In Sierra Leone, life expectancy has been stated to be only 39 years, compared with 60 years in South Africa. In Zaire, life expectancy at birth is 41.4 years in men; 43.5 years in women, which compares with 58.3 years (56.5 years in men; 60.5 years in women) in people known to be seronegative. However, it is necessary to keep these figures in perspective. In Africa, since the early 1980s, there have been 2 million deaths from AIDS, 6 million from tuberculosis and 16.8 million from malaria.

The situation is not without some heartening aspects. For example, in the Gambia, trachoma is the leading cause of blindness. Since 1959, there has been a dramatic fall in the occurrence of the disease, paralleled by improvements in sanitation, water supply, education, and access to health care in the villages. Of particular importance is the fact that the decline in trachoma occurred without any trachoma-specific intervention. The prevalence of active inflammatory trachoma among children aged 0–9 years fell from 65.7 cases per 100 children in 1959 to 2.4 cases per 100 children in 1996. The prevalence also fell equally dramatically among children and adolescents of 10–19 years, from 52.5 to 1.4 per 100 and among those of 20 years and older from 36.7 to 0 cases per 100. In quite another connection, in Zimbabwe—despite hardships, half of a series of elderly said that they were happy, and satisfied with their lives. The factors named as relating to current happiness were living in rural areas, receiving material support from one's children, and being satisfied with one's financial circumstances.

The latest South African Health Review, 1997, has just been published by the Health Systems Trust. While progress has been made in some fields, in others, much remains to be undertaken. One inquiry concerned the facilities at clinics, which may be of interest to many. Information was collected from 160 clinics (71 rural, 39 peri-urban and 50 urban), spread in randomly selected districts throughout the country. There was an average of 553 patients seen per nurse per month at these clinics, with relatively more patients at the urban than the rural clinics. In all provinces the clinics were visited regularly by a nurse supervisor, but urban clinics had more frequent visits from doctors than the rural ones. Almost all the urban clinics had telephones (90%), electricity and regular water supply (98%), but in rural areas less than 50% had working telephones, 80% had electricity and 55% had water (22% were without taps), and only 41% had an ambulance at their door within an hour of an emergency call. Almost all the clinics had baby weighing scales in good working order, and all except for 3 had refrigerators, although 22% of the rural clinics reported them to be not working. One-half of the clinics offered immunization services on a daily basis and three-quarters offered family planning services, but a third of the rural clinics did not provide syphilis testing for pregnant women, compared with 17% in urban and 7% in peri-urban areas. Only 16% of the 113 clinics offering tuberculosis services were able to receive sputum results within 48 hours (the average was 10 days). Drug supply ranged from 97% availability for vaccines to 65% for anti-diabetic drugs.
Oxygen supply is also a cause for concern, with its availability (61% overall) in as few as 10% of clinics in the Eastern Cape, but up to 100% in Gauteng.

In Africa, how can further progress be made, in view of the all-pervading limitations of money? The major health need is to considerably augment primary health care. The need for medical auxiliaries is undoubted.10 In parts of China where barefoot doctors have been replaced, the sickness and death rates of children have increased. Since there will never ever be enough doctors and dentists, use will have to be made of the services of health, dental, agricultural, and other technical helpers. Educationally, there should be colourful health posters with a clear message in schools and clinics, on billboards, in post offices, and other public buildings, regarding nutrition, family planning, breast-feeding, immunization, tuberculosis, the avoidance of HIV, and so forth. Yet posters are few and far between. Health visitors could prompt mothers to take their young children to clinics when sick, and give advice to village authorities on water supply, litter, and refuse disposal. Various auxiliaries could undertake straightforward dental treatment, give training in agriculture, advise on gardens at school and at home, and similar tasks. Women, with a measure of training, as repeatedly urged by the World Health Organization, could greatly facilitate most of the above. While extra money will certainly be required for services, many of the interventional measures described need not be prohibitively expensive. Perhaps of greatest importance is health education in its widest sense. Cecily Williams, of kwashiorkor fame, insisted that if African mothers could make the best use of what was actually at hand, there would be far less of gastroenteritis, protein-energy malnutrition, and the like. This touches the hugely important subject of knowledge acquired v knowledge applied. As Minerva, of BMJ fame, recently underlined—if only individuals/communities would themselves practice what they know to be health-giving, what an enormous difference this would make to health experience and outlook! This applies to all populations and more so to Africa.

REFERENCES
14 Derbyshire SWG. AIDS is less of a health threat than other diseases in Africa. BMJ 1995;311:633.

A. R. P. WALKER

Attention Subscribers

The subscriptions for The National Medical Journal of India are being serviced from the following address:

The Subscription Department
The National Medical Journal of India
All India Institute of Medical Sciences
Ansari Nagar, New Delhi 110029

The subscription rates of the journal are as follows:

<table>
<thead>
<tr>
<th></th>
<th>One year</th>
<th>Two years</th>
<th>Three years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indian</td>
<td>Rs 500</td>
<td>Rs 900</td>
<td>Rs 1300</td>
</tr>
<tr>
<td>Overseas</td>
<td>$80</td>
<td>$140</td>
<td>$200</td>
</tr>
</tbody>
</table>

Personal subscriptions paid from personal funds are available at 50% discounted rates.

Please send all renewals and new subscriptions along with the payment to the above address. Cheques/Demand Draft should be made payable to The National Medical Journal of India. Please add Rs 20 for outstation cheques.

If you wish to receive the Journal by registered post, please add Rs 60 per annum to the total payment and make the request at the time of subscribing.