PUZZLING EPIDEMIOLOGICAL SITUATIONS IN AFRICA
Those of us interested in the health/disease patterns in sub-Saharan African countries note from time to time unusual and seemingly inexplicably high, or low, disease/disorder data. Such wide differences in health/ill-health behaviours are unexpected, bearing in mind the almost invariable poverty and poor living conditions in large sections of the population. For perspective, we always compare such diversity of data with corresponding data reported from developed populations. Here are a few examples of contrasting situations.

In Harare, Zimbabwe, the annual standardized incidence rate (ASIR) of cancer of the cervix in African women has been stated to be 67.2 per 100 000, a rate apparently the highest yet reported worldwide. As a comparison, in South Africa, according to the National Cancer Registry, the ASIR in African women in 1993–95 was far lower (26.5 per 100 000). Furthermore, in the Gambia, the rate was still lower (10.5 per 100 000), a rate which is of the same order as that reported for affected women in most western countries.

In Kyadondo County, Uganda, between 1967–71 and 1995–97, the incidence of Kaposi’s sarcoma in children rose inexplicably, from 2.5 to 55.8 per 100 000, when it accounted for about half the total cases of cancer. This dramatic increase was attributed to the rising occurrence of HIV infection. In that country, the prevalence of the latter among urban pregnant women in the city of Kampala was reported to have reached 30% in 1990–92. In contrast, in South Africa, the situation is paradoxical. On the one hand, the incidence of Kaposi’s sarcoma is very low (0.6 per 100 000) while on the other hand, the overall HIV infection rate (22.4%) is among the highest yet reported. The reasons for this large difference in the incidence are far from clear. This particular cancer has a very low prevalence in developed populations.

We now turn to a totally different subject, obesity. Until a generation ago, in virtually all sub-Saharan populations, after the young had reached adulthood, there was little or no gain in weight with age, due to the poor economic circumstances. However, with rising prosperity in some segments of the population in African countries, the prevalence of obesity in women, although not in men, has risen considerably in some parts. In South Africa, the proportion of women who are obese (body mass index ≥30) has reached 35% in some rural areas, and 45% in some urban areas such as Cape Town. The latter figure is almost the highest on record. However, in many rural indigent areas in African countries, as in Nigeria, the prevalence of obesity remains low (3.2%). In South Africa, the high level mentioned in women in rural areas in South Africa cannot be readily explained, in view of women’s lower energy intake compared with that in men, and of their especially high level of everyday activity. There is evidence that the obesity experienced by African women has less adverse effects on their health compared with the situation in White women.

Another puzzling feature is that although in many big African cities the prevalence of obesity in women and of hypertension and diabetes have reached, or have exceeded, those in juxtaposed White populations, as in South Africa, coronary heart disease (CHD) remains rare. It is absent in rural areas and has a very low occurrence in major urban areas. For example, in Soweto, adjacent to Johannesburg, in 1997 it accounted for only 0.3% of deaths. Yet, interestingly, this puzzling situation in southern Africa also prevailed in the UK and in other western countries in the past. Thus, despite the relatively high prevalence of risk factors which occurred in the small, well-to-do sections in cities, CHD remained rare until the 1920s. It then rose rapidly, resulting in one-third of all deaths. In the late 1980s the mortality rate, but not the incidence, started to fall, to become half of that in some countries, such as in the USA. Furthermore, currently there are wide, largely inexplicable variations in rates prevailing in some countries, e.g. 95 and 460 per 100 000 in France and Hungary, respectively. Known risk factors still account for only half of the variation in the occurrence of the disease, as is the case with many cancers.

Every now and then, in South Africa, despite westernization of the diet and lifestyle (occurring increasingly in our large cities), there are reminders of the relatively primitive lifestyles still prevalent in parts of the African continent. As an example, in the Gambia, in 1993–97, in a study in a rural area on the fertility and reproductive health of both men and women, total fertility rates were found to be very high. They were 12.0 for men and 6.8 for women. In men, fertility began later but reached higher levels and continued into older ages, compared to women. Of married men, 40% were married polygamously. On an average, married men desired 15.2 children for themselves and 7.3 for each wife. What an enormous contrast to the current situation in some urban centres in Africa! In Soweto, an unpublished study indicates that the average African family size in the upper socio-economic bracket has decreased to about 2 children. At the extreme, in developed populations, the number appears to have fallen to an average of 0.75 children in Asturias in the north of Spain, a predominantly Catholic country.

In African countries as a whole, there is much to depress one, when facing the high morbidity/mortality situations, with little hope of amelioration of socio-economic conditions in the near future. But to the epidemiologist, there can be few situations more challenging. We should be continuously seeking to learn the reasons for the often encountered contrasting incidence and mortality rates.

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**Letter from Chennai**

**HARD TIMES**

The state of Tamil Nadu is near bankruptcy. Our two major political parties blame each other, as they have been doing for as long as I can remember. The difference this time is that the government has taken steps to do something about it. In a surprising move, it withdrew a number of populist measures. Bus fares were raised, though the government presented figures showing that Tamil Nadu fares are still cheaper than those in 7 other states. While our neighbours Andhra Pradesh and Kerala were cited, it may be important that Karnataka was not. I presume the states not mentioned have lower fares than ours. Prices of food distributed through the public distribution system were also raised. Lower rates were fixed for families below the poverty line, but even for them the price of rice rose from Rs 3.50 to Rs 5.65 per kg. Domestic electricity charges rose to 150% of the previous rate. Taxes on edible oil, cotton hosiery, computer software, urea, diesel, furnace oil, low sulphur oil and cement were also raised. The motor vehicles tax was raised for all varieties of motor vehicles, from two-wheelers to heavy transport vehicles. And, as an afterthought, a day later, the state government-owned Aavin dairy announced a rise in the price of milk and milk products.

The government also sought to pare its expenses. A government release said staff strength ‘shall be reduced by 30 per cent over five years’. A voluntary retirement package is to be introduced for employees in the government, public sector undertakings, local bodies and cooperative institutions. A complete ban on the creation of new posts was announced, and a ban on filling of vacant posts except for teachers, doctors and police constabulary. The bureaucrats were especially hard hit as their travel perks, leave travel allowance and medical reimbursements were cut by 10%. There has been a downgrading of entitlement to fly on official business and only the top officers will be allowed to fly. The rest will have to submit to the tender mercies of the Indian Railways. As travel expenses cost the government Rs 1.72 billion every year, by these measures it hopes to save Rs 0.5 billion.

Nothing was mentioned about the salaries and perquisites of legislators who, many of us feel, have too good a deal at our expense. Nor was there any mention of the free power supply given to agriculturists—about 3 million connections—leading to an annual loss of around Rs 32 billion. This important vote bank has not been tampered with.

The government began its austerity and staff reduction drive by announcing the appointment of a commission to look into government staffing and spending, and to find further ways to reduce expenditure. Perhaps a good start would be to abolish this commission.

The parlous state of its finances did have one good outcome for the government. For once, it stood firm against the blackmail attempted by the State Transport Unions. The State Transport Corporation offered its employees a bonus of 8.33%, while the unions stood out for 20%. The government declared itself unable to offer more as the State Transport was losing money. Therefore, the unions went on strike. We would normally have seen the authorities cave in, but this time the Chief Minister reminded the workers that service rules provided for disciplinary action against those who kept away from duty for more than 9 days without official sanction. When they found the government unyielding, the unions dropped the strike and returned to work without any conditions.

Of special interest to us is the information that hospitals and medical colleges are also to be involved in the fund-raising drive. A fee of Rs 5 will be levied for ‘issue of outpatient ticket to patients who avail themselves of medical facilities from superspecialty wings of government hospitals’. While access to the hospitals for visitors will remain free during visiting hours, a fee of Rs 5 will be levied for visits outside hospital hours. I have doubts of the ability of hospital authorities to collect fees from visitors. The person who must ensure the possession of an entry ticket is a member of the vast number of lower grade hospital staff who already make a large illegal income from patients and their visitors. This gives them another opportunity, and the only way the government can realize some income from this would be to contract out the entry of visitors to private parties. As it stands, the government is thinking of hiring private companies for many such services.

Meanwhile, the president of the Tamil Nadu Congress Committee submitted a petition to the High Court that visitors should not be permitted in hospitals outside visiting hours anyway, and to collect a fee from them was contrary to social justice since only the poor seek treatment in these hospitals. The Court agreed with him and restrained the government from collecting any fees from visitors, at the same time prohibiting the entry of visitors outside hospital hours.

The fee structure in government medical colleges will be revised upward ‘with a view to extending better training’. The government has also decided to increase the number of undergraduate medical seats in government colleges and allot half of these to non-resident Indians on payment. Now that the Medical Council of...