SUB-SAHARAN AFRICA’S ENDLESS HEALTH PROBLEMS

In developing populations, such as those in Southern Africa, particularly those living in urban areas, the ongoing westernization of lifestyle—dietary and non-dietary—brings many pleasures, which few are willing to forego. Unfortunately, one of the undesirable results is the decreasing consumption of plant foods, associated with a lowering of the intake of certain vitamins. In this respect, one remedial approach is for the State to introduce the fortification of a staple food with a vitamin/mineral salt, or to facilitate the distribution of a nutritional concentrate. In Sub-Saharan Africa, there is considerable concern over the low level of intake of vitamin A, particularly in the African population. In this connection, more than a decade ago, the world collectively pledged to combat the scourge of vitamin A deficiency. In 1990, at the World Summit for Children, and in 1992, at the International Conference on Nutrition, high priority was given to elimination of the deficiency by the year 2000. Although considerable progress has been made, deficiency of vitamin A remains a major health problem in much of the world.

In 1992, according to the World Health Organization (WHO), the deficiency was a public health problem in more than 60 countries, putting at risk the lives of 250 million children, of whom at least 5 million develop xerophthalmia, and 0.5 million become blind every year. In South Africa, it has been estimated that a third of children under 6 years of age are marginally deficient in vitamin A (serum retinol level <20 mg/dl), thereby making the deficiency an important public health problem. Studies have shown that vitamin A supplementation could reduce the all-cause mortality rate by about a quarter among children between the ages of 6 months and 5 years. In South Africa, there are high hopes for the implementation of such a plan. It should be possible, for currently 4.1% of the country’s gross domestic product (GDP) and 15.1% of the overall budget is devoted to the maintenance of health.

Again, in South Africa, although in a different health field, there is ongoing concern over the numerous difficulties being faced in hospitals, both rural and urban. A major problem is that, with the usual overcrowding of patients, there is little time for the staff to give much needed guidance to patients regarding prevention of avoidable diseases. Needless to say, this prevails, in varying measure, in all African countries. Thus, in Kenya, according to a recent government report, their public health facilities are in very poor condition. ‘Hospital services are falling apart and people are dying because of the severe shortage of resources and staff. Most hospitals did not have a doctor available for 24-hour periods, which placed a serious burden on nursing staff. Less than half of all delivery facilities had only one doctor or clinical officer available at night. More than a quarter of the institutions were managed by a single nurse. Most doctors are seeking jobs in other countries, or in the private sector, where salaries are higher.’

A report published in the Lancet entitled ‘Ghana: Defining the African challenge’, provides comprehensive information. The annual health spending in Ghana (%GDP) is relatively low (18%), births attended by skilled staff is 44%; infant mortality rate is 63 per 1000 live-births; fertility rate is 4.6 children; school enrolment is 42%; and the adult literacy rate is 29.7%. There are 6 physicians and 11,941 malaria cases per 100,000 population; and 37% of dwellings have inadequate sanitation. According to the author, ‘the picture I saw was one of a country clear about what it wants to do, but divided about how it should achieve its goals. If Ghana is to be a model for Africa, it is more a model of problems to be faced than solutions discovered.’

Alas, there remains the ongoing problem of HIV/AIDS in Africans in all sub-Saharan countries. The adverse situation in South Africa has been cited repeatedly in the medical press. At present, about 24.5% of pregnant women are infected; in women under 20 years of age the prevalence is lower (16.1%). In neighbouring Botswana, 35%—40% of secondary school teachers are now infected. In Uganda, most HIV-positive mothers insist on breastfeeding, rather than using the free infant formula, despite knowing the risks. There are practical problems too, ‘in Europe, to wake up at night and mix infant formula is not a problem, because they have electricity, fridges, etc.; ’ ‘but in Uganda, when you are talking about a woman who does not even have paraffin to boil water, it becomes difficult.’ In Tanzania, ‘in a rural population with HIV, prevalence is close to 7% among adults aged 15–44 years; during the mid-1990s, HIV/AIDS was having a substantial impact on adult mortality.’ A common response to the death of a head of a household in this community is household dissolution, which has implications for the measurement of the demographic and socioeconomic impact of AIDS. In Kenya, HIV transmission by blood transfusion is of major concern. A recent study revealed ‘a high proportion of blood transfusions transmitted HIV in this high prevalence area of Africa, primarily because of erroneous laboratory practices’. Since then, ‘the Kenya Ministry of Health has introduced a number of practical and inexpensive interventions to improve national blood safety’.

With regard to the use of condoms for the prevention of HIV/AIDS, ‘in South Africa the number distributed free by the government to the public rose rapidly from 6 million in 1994 to about 198 million in 1999; when these are coupled with commercial brands and condoms sold through social marketing programmes, the total number of condoms distributed approached 210 million. The distribution of over 200 million condoms should have met the need (17 condoms per man per year x 12 million men=204 million condoms required). Yet during 1999, as in previous years, shortages were common at all levels of the distribution chain, as the demand for condoms throughout the country greatly outstripped supply.’

As to the current level of the infection, at the large King Edward VIII Hospital in Durban, from 1995 to 1997 the HIV-positive rate rose from 19% to 34%. From 1997 to 1998, HIV-positive patients admitted to medical wards alone jumped from 39% to 53%. Last year, 86.2% of all HIV-positive patients admitted were women in their 20s. The figure of HIV-positive patients in medical wards now stands at a conservative 55% to 65%. And so the huge problems of health maintenance and disease treatment in Sub-Saharan African countries go on, with little respite in sight.

While there is much to depress, there are numerous epidemiological reports of considerable interest. For example, a study just published, concerns the cardiovascular disease risk factors and diet in African Fulani pastoralists in northern Nigeria. Despite a diet high in saturated fat (total fat supplied a high 48% of total energy), Fulani adults have a lipid profile indicative of a low risk of cardiovascular disease, with a low mean cholesterol level (3.5 mmol/L). The mean body mass index of the groups of men and women studied was uniformly low. The population was addi-
tionally characterized by a low mean energy intake (6988 kJ), being non-smokers, lean and very active physically. In these respects, some will recollect an African study of 1925, on the Masai in Kenya—a pastoral population with a high intake of fat, which supplied 40%-45% energy. However, as noted subsequently, they have a low occurrence of atherosclerotic lesions, attributed in large measure to their low energy intake and their high level of activity. In South Africa, two generations ago, in urban Africans in Johannesburg, the low extent of atherosclerosis lesions in the aorta of elderly Africans resembled those of young White adults and they had a relatively low mean serum cholesterol level (4.5 mmol/L). At that time, coronary heart disease (CHD) still had a low occurrence, which continued to be so until quite recently. This relative rarity of CHD in town-dwellers is puzzling. However, the disease was very uncommon in African Americans as late as the 1970s. Also, in London during the same period, Caribbean Africans had a tenth of the heart attack rate compared to the White population. Currently, in the USA, such has been the increase that the mortality rate of African American women from CHD exceeds that of White American women.

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Letter from Chennai

PROHIBITION IS BANNED…

Gandhiji believed in prohibiting the intake of alcoholic beverages. In the early years of Independence, when he was still of some relevance to the country, the framers of our constitution incorporated a directive: ‘… the state shall endeavour to bring about prohibition of the use except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health…’

Tamil Nadu has an ambiguous relationship with this principle. Prohibition is a powerful magnet for votes. Almost in a block, most parties find some excuse to permit its intake of alcohol is by permitting the sale but not the consumption of liquor in public. There are wine shops everywhere, and you could buy whatever you desired, but you had to take it home to drink it. Since this would often cause domestic strife, most wine shops would have a little room where favoured customers could take their legally bought ambrosia and illegally drink it. All it took was a small sop to the guardians of the law, who imposed their own unofficial licence fees and looked the other way. The finance minister decided he might as well take this levy and make the state richer, and so he licensed the bars at a price, Rs 300 000 a year in the seal of approval of his government, to keep them from drinking the wrong stuff. There were three problems with this idea. First, it had women up in arms, as it would presumably induce still more men to drink. Second, it deprived the state of a considerable part of its income. And third, it provided a useful weapon for politicians from the opposition to attack the government.

Mr Panneerselvam inevitably yielded place to Dr Jayalalithaa. We were reminded of the parlous state of Tamil Nadu’s finances, and the Budget presented in March banished the very thought of cheap liquor. The government’s favoured brand of intoxicant was back to its old price. Besides, the government added another alcohol-based source of revenue. One of the ways in which the state governments of both parties have pretended to discourage the intake of alcohol is by permitting the sale but not the consumption of liquor in public. There are wine shops everywhere, and you could buy whatever you desired, but you had to take it home to drink it. Since this would often cause domestic strife, most wine shops would have a little room where favoured customers could take their legally bought ambrosia and illegally drink it. All it took was a small sop to the guardians of the law, who imposed their own unofficial licence fees and looked the other way. The finance minister decided he might as well take this levy and make the state richer, and so he licensed the bars at a price, Rs 300 000 a year in...

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