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Editorial

Health Hazards in the Urbanization of the African

Among the indigenous inhabitants in Africa, changes are taking place at varying speed—from primitiveness to sophistication, and from savagery to commerce. In the process the trend has been, as so often observed in past history, to leave the land to settle in centers of population. The migration has been promoted in part by the mechanization of farming, but more particularly by the increasing labor needs of industry and commerce, by the ease of travel, and by the greater opportunities and other attractions of town life. Of the whole Continent, this movement by far has been most marked in South Africa, and of the South African cities, Johannesburg. In 1911, 12.6 per cent of South African Bantu were urbanized; by 1960, the figure had reached 28 per cent. In Johannesburg, in 1936, the Bantu and white moieties of the population were 260,000 and 246,000; by 1960, the figures had increased to 594,000 and 375,700.

In the movement described, it may well be asked—what advantages to the Bantu have been gained in relation to their health picture? The same may be asked with equal justification regarding the disadvantages, for the past abounds in examples that have shown that "civilization" has not been an unmixed blessing to underdeveloped populations.

On the credit side there are better provisions for medical treatment and hospitalization, infant and antenatal services, and preventive inoculations (smallpox, diphtheria, poliomyelitis) in urban centers. With few exceptions, these facilities are free to the whole of the local Bantu population. In regard to housing, there have been great changes—about 36,000 dwellings having been built in the last eight years in Johannesburg. Associated with this building activity is the concomitant provision of potable water and of sewage and refuse disposal. Seasonal shortages of food, so often a feature of rural life, are no longer to be feared. Free education is available, and the literacy rate among the present generation of urban Bantu children is 90 to 95 per cent. Wages are higher, and employment is much more regular. Capable workers can progress from unskilled to skilled occupations. Relatively short hours of work, a five day week for a large proportion of workers, allow time for entertainment (cinema or "bioscope") and recreation.

However, many results of the urbanization of the African are disquieting, to say the least. Under *kraal* conditions, delinquency, especially among the young, presents little problem, being dealt with by robust, if rough and ready, tribal justice. In town life crime is more prevalent, both petty and serious, and there are more traumatic injuries and deaths. One sequel of relaxing discipline is that whereas in rural areas the incidence of positive serologic test results for syphilis may be 1 per cent or

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under, the figure in towns may reach 15 to 20 per cent. Understandably, the instability of family life is greater, with adverse ramifications especially in the well-being of the young. With many workers, much time, money and energy are spent in transport to and from places of employment. Easy facilities for credit encourage spending beyond means, unfortunately with frequent sequestration of the hire purchase articles. In regard to nutrition—with which this article is primarily concerned—breast feeding, almost invariably successful among Bantu mothers, by pressure of plausible advertising, is giving place to the adoption of processed foods. These, almost invariably, are prepared in too dilute a manner, predisposing to, if not causing, kwashiorkor, a disease by no means uncommon in urban centers. The intake of vitamin D is low, so that the overclothing of babies (who in *kraal* life are seminaked), with consequent insufficient exposure to available radiation, causes rickets (sometimes severe) to be common. The considerable replacement of coarsely ground or lightly milled maize by white bread and the decreasing consumption of fermented porridge (*magou*) have resulted in a reduced intake of the B complex vitamins. This change, together with increased consumption of illegal alcoholic concoctions supplied by the *shabeens*, has contributed to an increase in alcoholic pellagra and, to a lesser extent, beriberi. Wild spinach and greenery (*m'fino, morogo*) are far less abundant in urban areas so that there is a decrease in the intake of certain mineral salts and vitamins. The familiar iron "kaffir pot" is being superceded by enamel and aluminium vessels thereby lessening the intake of iron; we have found the hemoglobin levels of Bantu women servants in white households to be significantly lower than those in poorer Bantu women living in the country. Despite improvements in hygienic conditions, our studies indicate that about half of the Johannesburg urban Bantu children are infested with parasites; yet in parts of somewhat sparsely populated local *highveld*, helminthiasis is as low as 5 per cent, providing correspondingly lower nutritional handicap.

While the leading causes of death in adults, for example, respiratory tract infection (particularly pulmonary tuberculosis), are such as prevail in any underdeveloped population, it must be pointed out that the health pattern is altering in relation to "diseases of civilization." Dental caries, generally so uncommon in rural areas, is becoming a matter for concern in urban centers. From surveys on the incidence of diabetes, it is now fairly certain that this disease is also increasing. There are signs that coronary heart disease, although still uncommon, is occurring more frequently among urban dwellers, and evidence suggests that cancer of the lung is diagnosed more often now than previously, presumably being related to the known increase in smoking. These and similar changes in incidence are far from being explicable on the basis of increased life expectancy. Against the increase and development of such diseases we are virtually helpless.

What can be done to deal with the unsatisfactory aspects which are remediable? The immediate reaction (as it would be when considering the poorer section of any population) is—if their socioeconomic level be raised, to what extent can we look forward to improvements? If increased spending power means better housing and hygiene, more nourishing food, and so forth, then we can confidently expect benefits to health and nutritional state. If, however, much of the increase in money goes into expensive clothing, cigarettes, gramophone records, transistor radios, public amusement, "fah-fee" (a betting game), and, insofar as food is concerned, on more white bread, sugar, soft drinks and European liquor, then the results of increased spending power will be disappointing. What has just been written, unfortunately, is already taking place, and we fear that it will continue to be the pattern for the future. Therefore, until we are able to educate these people in the economics and practical aspects of health and nutrition, and until we can help them to become more self-reliant and provident, the efforts of State and community (as outlined earlier) to alleviate the position will partially fail to achieve their object. Nor may the present situation largely

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be overcome simply by teaching these people to read and write, since the great majority of urban Bantu already are literate. In many parts of the world where kwashiorkor is rife, it has been amply demonstrated that ignorance is more blameworthy than poverty. It would also seem that many of the unsatisfactory aspects of urban Bantu health, nutrition and general well-being, are partly due to ignorance, and not wholly attributable to insufficient means, although the latter certainly is a critical factor in a proportion of the population. In relation to nutrition in particular, we must not assume that these people will continue to have an inferior bill of health until such time as they are able to afford and eat precisely the same kinds and amounts of food as the white population. As Cathcart was wont to stress, it is possible to be well and to keep well on very simple diets as long as they contain the dietary essentials—these need not be as expensive as is usually thought to be the case. But how are the Bantu to be given to understand and practice this knowledge? While there is no desire to minimize the constructive efforts being made by teachers, hospitals and clinics, state and municipal health departments, and welfare bodies, there is alas much ground for despondency over the poor response to their endeavors.

The crucial difficulty lies in endeavoring to inculcate into these people, within their resources, the capacity to choose more wisely in their pattern of living, and to be governed less by snobbish thinking, by the acquisition of status symbols and by personal pleasure—certainly features which strongly influence the life of "civilized" people but which are perhaps more dominant in backward populations in the process of their becoming westernized. Sufficient has been written to show that neither more schooling nor higher wages will provide the immediate answers to this problem of seeking to improve and maintain the well-being of the urbanized African. The problem is far from being parochial, for it will be encountered to a varying degree in all emergent African states within the present century.

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