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IT HAS OFT been stated that progress in Africa is hindered by three big problems: ignorance, poverty and disease. Unfortunately they are so closely interrelated that they present a formidable obstacle to anyone seeking to solve them. But one thing is certain: sickness in Africa presents an opportunity and a challenge to all who would heed the precept of charity. To approach it one must think not only in terms of sickness in general, but also of the problems peculiar to sickness in the African. And when I refer to the African, I refer particularly to the Luos, Bakuria and Basambiti who live in the vicinity of Kowak Mission.

First of all, the African is born into a relatively hostile environment where less than half of the babies reach their first birthdays. He is raised in the shadow of ignorance and schooled in the pagan practices of magic and witchcraft. He is fed a monotonously starchy diet of cereals supplemented by a few greens and a bit of meat. He has no knowledge of hygiene and is surrounded by poor sanitation. Even the use of the simple outhouse is ignored. Outside of the rainy season he is perennially short of water, and the surface water he must use is usually contaminated. He must work under a fierce tropical sun to wrest a precarious living from a poor, impoverished soil. And, finally, he lives in a climate better suited to the growth of insects, parasites and bacteria than to his own nature.

And so we find that sickness is more common in the African than robust health. And, contrary to our opinions, he is not stricken with the myriad of tropical diseases exclusively but suffers the more common ailments like colds, headaches, pneumonia, and such, just like the average American. One can only guess at the millions suffering from malaria, bilharzia, typhus fever, intestinal parasitic infestations, relapsing fever and the nutritional deficiencies. In addition there are other diseases which thrive in a tropical environment, diseases such as tuberculosis (sometimes referred to as No. 1 killer of Africa), leprosy, syphilis, yaws, yellow fever, filariasis, kala-azar, African sleeping sickness, typhoid fever, and amebic dysentery.

In general the African has a much lower resistance to disease than the white man. That is why such diseases as tuberculosis tend to run a rapid, fatal course. Still he has some natural advantages. His dark skin protects him from the ravages of the tropical sun. His placid, good-natured temperament conserves his expenditure of limited energy. His simple life precludes many of the hazards of

modern civilization. For instance, as a result of his simple, restricted diet digestive disorders such as peptic ulcers are a rarity; obesity is seldom observed; gall bladder disease is all but unknown; diabetes is most uncommon; and but few cases of high blood pressure are noted. Appendicitis, so common in the United States, is seldom seen in the African. While it is known that tumors do occur in the African it is rare to see them in dispensary work. Perhaps this scourge of modern times belongs only to civilization also.

As regards infectious diseases the African has his troubles too. Chicken pox, measles, mumps and whooping cough are very common, the latter often terminating in pneumonia and death in infants. On the other hand diphtheria and scarlet fever are relatively rare diseases while small pox epidemics are sporadic. Rheumatic fever occurs in African children also but it seems to be less commonplace and runs a milder course. But it is still a killer. I recall one of our early African patients, a twelve year old girl with a rheumatic mitral stenosis which precipitated decompensation with pronounced dyspnea. Under rest and Digitalis she improved rapidly and was sent back to her village with a supply of Digitalis and instructions to return for a periodic check-up. With the return of good health both medicine and advice were forgotten. Months later she returned, in extremis, and died shortly after receiving the Last Sacraments.

Injuries of violence are relatively rare, although we occasionally see snake bites or injuries from wild animals such as a rhino goring. In the past year we did not see one fracture in our Kowak Dispensary, although one of the school boys did dislocate his elbow playing soccer. Lacerations, however, are common, most of them following careless use of the panga, the large, wicked-looking African knife of many uses. Often to get at such wounds one must clean off cattle dung or muddy herb mixtures. Infections are common and healing is quite slow. Burns likewise are common, particularly among small children, as all food is cooked over open fires. Amputations present their own problems as demonstrated recently when an elderly African presented us with an amputated thumb to be replaced. It took a half an hour's gentle persuasion on the part of Maryknoll's Sister Mary Agnes Jude, R.N., to convince this trusting soul that his confidence was flattering but unwarranted.

Through ignorance and long-established pagan practice the sick African often consults a herb doctor or a witch doctor before reporting to a modern dispensary. Often he arrives far advanced in his illness, and many die enroute or shortly after arrival. But for those who arrive in good time there still remains the problem of diagnosis. First, there is the language barrier. Even after this has been hurdled we find that the African speaks in broad general terms. ("My stomach is eating me." "A cough has grabbed me.")

Finally, the African patient is passive and inclined to be disinterested in his illness, and he is totally unable to associate his symptoms. As an example, he'll complain of sore glands in his armpit, but will omit any reference to the tell-tale tache noir of tick fever around his waistline—unless you specifically ask him. Worst of all, he'll probably have one or more chronic diseases which confuse the picture of his present illness. In this connection a good laboratory is absolutely essential, yet they are few and far between in East Africa, even in the larger cities, for they require sizable investments for establishment, and highly trained personnel for operation.

The African is a fatalist. One is often amazed at his lack of a will to live. So often we see an African die of what seems to be insufficient cause — he is just resigned to death. He is not as stoical as many assume and while he often exhibits a high degree of pain tolerance, he has no more love for the needle or the knife than the white man. But he is always a trusting, docile and submissive patient, even if not entirely cooperative. Unhappily, in a sense, he has a fanatic faith in a "sandan," a hypodermic injection. One day I drove out into the veldt to see a woman suffering from hemorrhage and shock following a miscarriage. After examining her I advised that she return to the Kowak Dispensary with us in our lorry. She agreed. To minimize the danger and discomfort of travel I administered a "sandan." That was it!—She was cured!—and she refused to leave the village. God watches over His own—she lived!

After the question of diagnosis, we come to the problem of treatment. The African is an impatient patient — after all he's used to magic. So he expects quick results, and this complicates the treatment of all illnesses. In chronic illnesses such as syphilis or leprosy it further complicates the problem as they require long periods of treatment. So we can expect many of our treatments to be abandoned. By his own logic the African reasons that if a little medicine is good, more is better. So we sometimes find him taking several days' supply of medicine at one time. Recently an elderly African woman tried this procedure with some native herbs. She died, while the non-plussed herb doctor drank his medicine publicly to prove it was not poison. Perhaps. worst of all, is the discouraging thought that after an African is cured of his illness he will soon become reinfected or fall victim to some other malady equally as bad.

Contrary to popular opinion the African has his mental problems too. Accurate diagnosis of these afflictions is most difficult while institutional care is woefully inadequate. A United Nations survey indicates that the incidence of mental disease in the African is less than half of that in more civilized countries. So today the mental patient is tolerated in his village, sometimes manacled if he proves to be obstreperous. Recently one patient ran amok near the mission, armed with a panga. He was promptly speared to death by the villagers.

It is apparent that medical care in Africa must be approached from a public health viewpoint. In this connection, Sister James Elizabeth, R.N. has recently opened a maternity unit at Kowak. In addition to providing the usual amenities, she will train young African girls in the basic principles of village mid-wifery. Also, a leprosy clinic has been initiated under Maryknoll's Sister Catharine Maureen, R.N. With limited facilities plus a high incidence of leprosy in this locality there is already a long waiting list. But for these efforts much remains undone. For example, no effort at all is made to cope with the problems of defective vision or impaired hearing. Dental care is unknown, and no one would dare to start doing tonsillectomies—the work would be endless. Practically every African baby presents a pot-belly with an umbilical hernia. But no one thinks of repairing these hernias — the Africans regard them as a thing of beauty and a joy forever!

In spite of all the problems in caring for the sick African the work has its compensations. Andre Paré, the great French surgeon, once observed that we merely tend the sick, that God heals them. In this we concur, but it is soul-satisfying work to be an active partner in the Divine Plan. And deep within the heart of every humanitarian worker in Africa lies the hope and conviction that among our African people will one day arise those dedicated workers to pursue the work and ideals which we are striving to establish. Such is the history of progress—and the missions!

Author's Note: For those seeking an introductory book on the subject of disease in Africa, the author recommends, *The Sick African* by Doctor Michael Gelfand, published by Stewart Printing Company, Ltd., of Capetown, South Africa, and to which the author acknowledges a debt for both inspiration and information.

THE WHITE MASS is scheduled for October 18 to honor St. Luke, Patron of Catholic Physicians. Plan to assist at Mass with your Guild for this special observance.