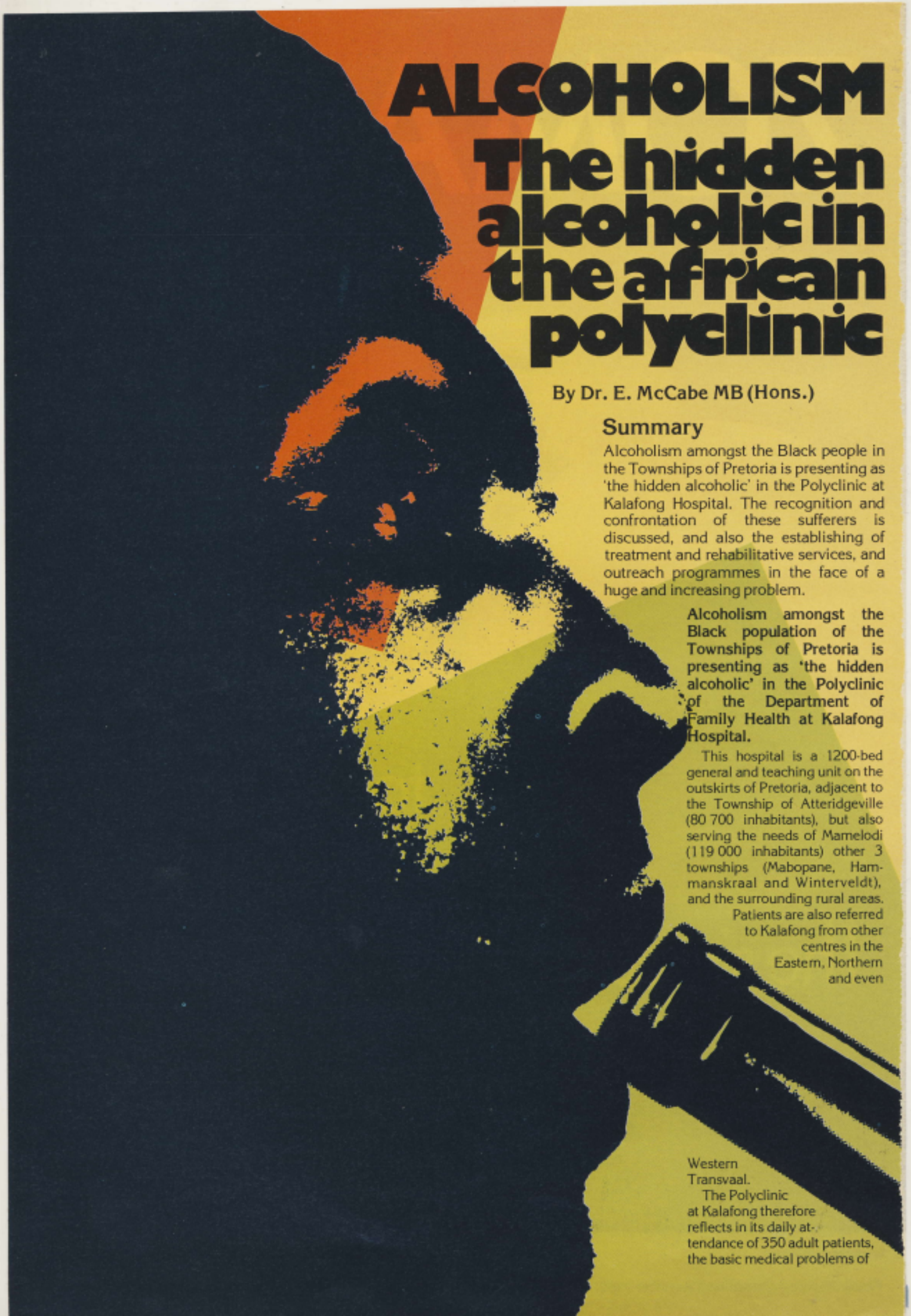

ALCOHOLISM
The hidden alcoholic in the african polyclinic

By Dr. E. McCabe MB (Hons.)

Summary

Alcoholism amongst the Black people in the Townships of Pretoria is presenting as 'the hidden alcoholic' in the Polyclinic at Kalafong Hospital. The recognition and confrontation of these sufferers is discussed, and also the establishing of treatment and rehabilitative services, and outreach programmes in the face of a huge and increasing problem.

Alcoholism amongst the Black population of the Townships of Pretoria is presenting as 'the hidden alcoholic' in the Polyclinic of the Department of Family Health at Kalafong Hospital.

This hospital is a 1200-bed general and teaching unit on the outskirts of Pretoria, adjacent to the Township of Atteridgeville (80 700 inhabitants), but also serving the needs of Mamelodi (119 000 inhabitants) other 3 townships (Mabopane, Hammanskraal and Winterveldt), and the surrounding rural areas. Patients are also referred to Kalafong from other centres in the Eastern, Northern and even Western Transvaal.

The Polyclinic at Kalafong therefore reflects in its daily attendance of 350 adult patients, the basic medical problems of

the African people in this area. We found that many patients, presenting with a variety of symptoms, were in fact patients with an alcoholic problem.

We do not refer to the weekend load of drunks and stab-wounds attending Casualty, but to the decent solid middle class and middle-income Africans (mainly male) with jobs and homes and families, who now, nearly 20 years after liquor has been freely available to them, are presenting with the "white-man's" alcoholic problem.

METHODOLOGY

We began to keep a register of these alcoholic patients, and over a period of time during which 1250 patients were seen in one of our general clinic rooms, we assessed 92 to be alcoholic, i.e. 7%. These patients did not come complaining of a drink problem — in fact only one man out of the 1250 patients surveyed, gave as his presenting symptom "I drink too much."

The others came with all kinds, and all sorts of complaints but most of them (75%) presented with one or other or all of these symptoms:

1. **Abdominal pain** with or without vomiting — the pains being mostly in the upper abdomen.
2. **Chest complaints** pains, coughs, "bronchitis."
3. **Trauma** various forms (from falls, car accidents, muggings etc). — bruises, broken ribs etc.
4. **General body pains** (Flu)

On examination 76,5% were found to have one or more of the following:

1. Enlarged tender liver.
2. "The Shakes" - tremor, sweating, nausea, anxiety — (in fact all degrees of the alcohol withdrawal syndrome to the severe frank Delirium Tremens were seen.)
3. Blood-shot Eyes — and puffy face.
4. Peripheral Neuritis — of legs and feet (all degrees of severity).
5. Malnutrition — but only 5 with Pellagra.

OTHER FINDINGS

Average age — 40+ (which included a few young men — this reducing the average.)

Sex incidence — 6 men to 1 woman.

% still in work — 81% — many in the same job for the last 20-25 years. (Those 'out of work' were mostly recently dismissed or pensioned off.)'

All these facts and figures corresponded with the world-wide statistics for chronic alcoholism.

There was however *one very significant difference.* We found that when these patients were confronted with their diagnosis — *70% admitted to the disruption of their lives by excessive drinking at once, and asked for help.* They admitted that the Alcoholic problem was affecting:

Health	in 100%
Family/Home	in 74%
Work	in 49%
All 3 of them	in 46%

The denial rate therefore in the African was found to be only 30% compared with 99,9% or more in other racial groups.

We began, therefore, to look into the background scene, in order to try to understand *why.* We did this with the help and cooperation of our nursing staff, and an African colleague who practises in the Townships.

1. The great majority of the township dwellers are decent respectable folk living in their little homes, and bringing up their families.

a) 50% of these people are westernised and 'sophisticated.'

b) 50% are less so — and live in the old traditional ways.

2. In the African home, the man is traditionally the boss, and cannot be questioned or criticised, whatever he does. The wife, therefore, faced with an alcoholic husband, accepts all that comes with unbelievable stoicism, knowing (certainly in group (b)) that should she complain, she will just be sent back to the country and another 'wife' will replace her. These women will not look for help in the alcoholic dilemma, nor will their drinkers be found in the Polyclinic except in extremis, in the late stages of the illness.

In the more sophisticated group (a), the wives are educated and liberated and although they still have the same basic traditional attitudes, they see "the writing on the wall" and seek help from outside agencies, and object to the destruction of their marriages and homes. It is the menfolk of this group whom we are finding in the Polyclinic, they appear to have a degree of insight which other racial groups are devoid of, they recognise that they stand to lose ALL, and whatever complaint they may produce as a pretext, they have come to terms with themselves and are desperately *looking for help.* So when we recognise them and confront them they do not deny their problem.

3. The shebeen scene today - where most of the drinking is done - is very different from pre-1962 days. There are upwards of 4 000 shebeens in Atteridgeville alone (as found in a recent H.S.R.C. survey), and these are Social Meeting places (like the village pub in England). Some are very select and superior, and others quite simple, but all sell clean wholesome bottle store liquor, and all are illegal. Anybody can open a shebeeen merely by stocking up their home with liquor, but shebeens also offer a relaxed and happy and congenial atmosphere with food, disco music, television and dancing. They therefore fill the great need for social life and activity in the townships. Most of the drinking is done in the shebeens, but many people find it more convenient to buy there, and drink at home.

Before 1962 there were many shebeen deaths from the foul liquer served there, and much violence. **But Alcoholism**

as we are seeing it today was not found

4. The Migrant Labourers - about 1 in 10 of the population of Atteridgeville - live in huge hostels. The official Beer Halls - which sell only African Beer - are strategically situated near the hostels, and are used almost solely by the hostel-dwellers. Compared with the happy relaxing conviviality of the shebeen, these are cheerless and uninteresting places with no real fellowship, and always a tendency to rowdiness and brawling. It is however interesting to note that Beer Hall liquor does not produce the picture of Alcoholism as do the stronger brews.

5. Finally we found there were **no rehabilitative services** for alcoholics in Atteridgeville - only a defunct Bantu Society for Alcoholism.

ACTION

Knowing these facts, and being faced daily with the **extraordinary** situation of alcoholics **asking for help** in our Polyclinic, and nothing more than the essential medical care at hospital level to offer them, the Department of Family Health took up the matter at once. A meeting of all interested parties was convened at Kalafong Hospital, as a result of which the "Bantu Society for Alcoholism" was recuscitated and is now reformed under an African chairman, and is coordinating itself with the South African National Council for Alcoholism (Northern Tvl. Branch) with a view to extensive outreach to the Townships.

Also members of the fellowships of Alcoholics Anonymous and Al-Anon in Pretoria were only too glad to come to Kalafong and help start groups with the African people, and these are slowly growing. There are many problems and difficulties involved - communication across the cultural line, social distinctions amongst the Africans themselves, the fact that although 'sophisticates' in our eyes, "one foot is still well in the old world" (as one African Al-Anon member put it) and in addition it is just not done for an African wife to go out alone at night - so only the wives of those attending the AA meeting can manage to attend Al-Anon. However a beginning has been made, and already there are three African A.A. members and two Al-Anon members who are ready to carry the message of recovery and hope to their own people in their own language in the Townships.

"Drinking is many peoples' pleasure, but Alcoholism is everyone's problem". What we are seeing at Kalafong is but the tip of the iceberg - each alcoholic adversely affects at least 16 others, so the magnitude of the problem is enormous. It is our duty to appreciate this, and to look for, and recognise the "hidden alcoholics" in our clinics, to confront them and treat them, and to hand them on to the "rehabilitation team" with the maximum co-operation.

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Dr PR Makhambeni, Atteridgeville.

Alcoholics Anonymous and Al-Anon, Pretoria.

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During her MB.ChB. (Honours) graduation year, 1944, at Aberdeen University in Scotland, Dr McCabe received the Murray Gold Medal for the most Distinguished Graduate 1939-1944, the Mathews Duncan Gold Medal in Obstets/Gyne, the Prax, Accessit — Anderson Gold Medal in Medicine, and the McGibbon Prize in Surgery.

Dr McCabe emigrated to South Africa (East London) in 1951, leaving the post of Assistant Country Medical Officer in South West Herts, England. She was initially casualty officer at East London's Frere Hospital, subsequently holding medical officer posts at the Oranje Hospital, Bloemfontein, Groote Schuur Hospital, and back at Frere Hospital (1974-1976).

Widowed with two sons, Dr McCabe was working in the adult outpatients' department at H.F. Verwoerd Hospital and Kalafong Hospital before assuming her present position.