

Section of Pædiatrics

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The Health of the Coloured Child in Great Britain

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Medical Problems of Coloured Immigrant Children in Britain

Coloured immigrant children differ from the native population in two fundamental respects: first, in genetic constitution and second, in cultural background, family patterning and socio-economic situation. It is their misfortune that the major genetic difference is visible and the dark skin has important social consequences as well as possible medical significance. Other more subtle ethnic genetical differences show as disease processes unknown or exceedingly rare in the indigenous population. The cultural and social factors which influence the child also have medical implications which cannot be ignored. It is therefore somewhat surprising that the medical problems brought about by the large scale immigration of Commonwealth citizens have received little attention. This is partly due to a laudable wish to avoid enquiries which might appear discriminatory and partly to an erroneous and complacent belief that the existing health, welfare and social services are sufficiently effective and flexible to cope with any problems without special methods.

Considerable concern has indeed been shown regarding the import and possible spread by immigrants of diseases not found in Britain or which have been largely controlled or eliminated. Health services are rightly troubled by the problems of tuberculosis, dysentery, venereal disease and parasitism; hospital doctors have had their interest awakened by hæmoglobinopathies,

hepatomegaly of varying cause and curious eosinophilias. Pædiatricians have a fair share of these problems but also have a special duty to safeguard the health and development of the new generation of coloured infants who are growing up in unusual circumstances.

The pædiatric department at St Mary's Hospital includes two small children's hospitals as well as the parent hospital, and this group serves residents in Paddington, North Kensington and neighbouring boroughs. The predominant immigrant group is West Indian. This is relatively stable because both work and housing are available in the area. There are a number of more transient coloured families from Africa, India, Pakistan and the Eastern Mediterranean, many of whom are students and tend to return to their land of origin or move out of the district. A large Irish immigrant community exists side by side with the coloured population so we have available a native English community and both white and coloured immigrant groups.

From a hospital setting it is not easy to study the prevalence of illness in a community and our attempts to do so have been limited in scope and scale. The first attempt was in 1960 when Dr WG Henderson, Dr P Lanzkowsky and I surveyed the hæmatological status of 300 children under the age of 5 years who attended Paddington Green Children's Hospital during a three-week period. Most had trivial illnesses or had come for out-patient advice. We estimated hæmoglobin concentration and mean corpuscular hæmoglobin concentration, and examined stained blood films. A sickle-cell screening test was done on the blood of all coloured children. Any children suffering

Table 1
Mean hæmoglobin concentration (g%) and standard deviations

Ethnic group	No.	Under 5 months	5 months-1 year	1-2 years	2-3 years	3-4 years	4-5 years
English	120	11.7±0.9	11.0±1.5	10.8±1.5	11.8±1.1	12.2±0.8	11.5±1.1
Irish	64	11.3±1.3	11.5±1.3	10.1±2.2	11.5±1.5	11.9±1.2	12.5±1.4
West Indian (Negro)	73	10.8±1.0	10.0±1.2	9.1±1.5	10.1±3.1	10.9±3.0	11.1±1.4
Other	35	11.1±1.7	10.8±1.4	10.4±1.4	11.8±1.1	11.3±0.8	11.9±1.1

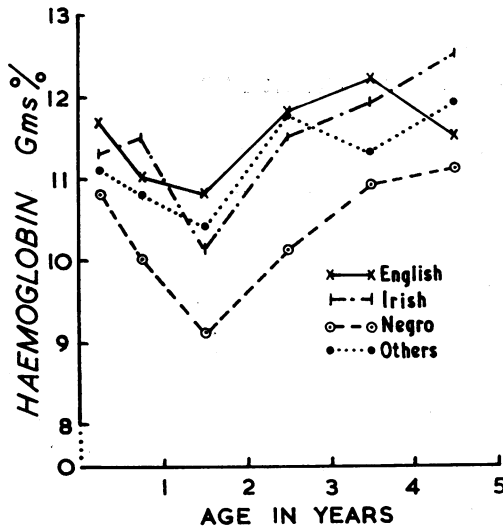


Fig 1 Mean haemoglobin concentrations of 292 children attending hospital during the first five years of life

from anaemia not due to iron deficiency were excluded from the series.

The results show that in the population tested iron deficiency anaemia is common, especially in coloured toddlers (Table 1).

The difference between the 1-2-year-old coloured West Indians and all other groups is highly significant and this is also found when the MCHCs were compared. The excess of iron-deficiency anaemia in the West Indians could not be accounted for by differences in birth weight, duration of exclusive milk feeding or past illness. Similar findings have been reported by Davis *et al.* (1960) in South London who, reporting only on two groups of children, white and coloured, suggested that genetic factors might be responsible for the difference. Our data (Fig 1) show that during the second year the Irish immigrant children form an intermediate group which argues against a simple genetic difference between the English and West Indian toddlers. It is debatable whether iron-deficiency anaemia is a serious pathological condition. Our impression is that anaemic toddlers are greatly improved by treatment especially in regard to appetite and reduction in irritability. An important association with iron-deficiency anaemia is the symptom of pica. These toddlers living in dilapidated houses with ill-kept walls and furniture are prone to lead ingestion and intoxication. In the summer of 1960 we admitted 6 cases of lead poisoning, one fatal and all in immigrants. Apart from this hazard it is hard to accept haemoglobin levels of 9-11 g/100 ml as 'normal' for pre-school children and yet doctors in infant welfare clinics can rarely obtain even the simplest haematological investigations.

Clinical diagnosis of anaemia is unreliable and even when proved it is still necessary to make an exact diagnosis before prescribing treatment, especially in the case of coloured children. Sick-cell anaemia may be present without hepatosplenomegaly or skeletal changes and in this country is compatible with normal health during childhood apart from the anaemia. It is, however, important to make the diagnosis, not only to avoid the prescription of iron but to anticipate crises during infections and anaesthesia.

In order to obtain further clues as to the distribution of illness in the coloured community Dr Bert Gampel in our Unit undertook a survey of all new casualty attendances during a six-month period in 1963. Our two children's hospitals have an 'open-door' policy and it is a neighbourhood tradition for worried parents to bring their ailing children for advice and treatment. Some 3,250 cases were seen during the study period and Dr Gampel has permitted me to quote from his analysis of the data. About half the cases (55.6%) were English, 20% were Irish and 13.5% West Indian, the remainder being of various other ethnic groups. Some interesting differences were apparent when the main diagnostic categories were scrutinized (Table 2).

Table 2
Percentage attendances by diagnosis of 3,250 children

	English	Irish	West Indian	Other
Upper respiratory disease	18.3	25.0	37.8	29.7
Lower respiratory disease	5.1	6.6	10.1	7.7
Injuries (not fractures)	31.4	22.8	5.6	15.1
All other conditions	45.2	45.6	46.5	47.5

The differences between the West Indians and all other groups in regard to respiratory disease and minor injuries are significant. They may indicate that there is less minor trauma among the coloured children or may merely reflect differences in acceptance of illness or injury, and variations in the use made of medical care facilities. It is clear, however, that the West Indians suffer from much the same disorders as the native population and the possible excess of respiratory disease is probably determined by social conditions rather than ethnic factors. Brief analysis of in-patient material leads to similar conclusions. Of 100 consecutive admissions of coloured children to one medical ward in 1963, the diagnosis was respiratory disease in 55. However, ethnic factors were important in 3 cases of rickets, 2 sickle-cell disease, 1 typhoid fever and 1 hepatomegaly due to veno-occlusive disease of the liver.

Rickets is probably widespread among coloured immigrant children, and may be missed unless kept in mind. One of the most interesting

by-products of the British Paediatric Association's surveys of hypercalcaemia, rickets and scurvy has been the revelation of the extent of the problem of rickets in immigrant children. Experience in our Unit agrees with the reports of paediatricians concerning the main factors responsible for the prevalence of rickets among coloured immigrants. The most important is nutritional as it is found that rachitic infants have either been weaned early on to liquid cow's milk, or have been exclusively breast fed for most of the first year of life. The second factor is non-utilization of welfare services and welfare foods: the early weaned babies often have mothers in whole-time employment and are taken care of by 'baby-minders'; the breast-fed babies are in families which find it difficult to adapt to new conditions. The result is a diet through the first year deficient in dietary or medicinal vitamin D. The third factor is more problematic. It has been suggested that persons with coloured skins do not get as much vitamin D from sunlight as light-skinned individuals (Dancaster & Jackson 1960). This may be a factor but we also have the impression that the coloured children tend to be less exposed than the native children to the scanty available sunlight of British industrial cities.

The clinical diagnosis of severe rickets is easy but mild cases are missed both by infant welfare clinics and general practitioners. Confirmation of the clinical diagnosis is best obtained by radiology of the bones and estimation of the serum alkaline phosphatase concentration (Corner 1944). Active rickets is often present without abnormalities of the serum calcium and phosphate levels. As with hæmatological investigations it seems that the simple radiographic and blood chemistry tests for rickets should be widely available.

Care and concern for the welfare of their children is characteristic of the immigrant families. However, the percentage of working mothers is high and many babies are 'fostered' or cared for by 'relatives' and 'friends'. This imposes heavy burdens on the health visitors whose task is already made difficult by the mobility of families from street to street. Many infants escape all forms of health supervision and thus do not come to medical notice until they are ill. Violence against children is rare and our experience of 'battered babies' does not suggest any predominance among the coloured immigrants. It is worth remembering that the inexperienced may misinterpret Mongolian blue spots as bruises, that hæmophilia and other bleeding diseases can cause hæmatomata and hæmarthroses, and only the sophisticated know that deliberate scratching of the face is a 'folk-cure' for enuresis. These are pitfalls that we have met in the accurate diagnosis of alleged assaults on coloured children.

From this brief review it is apparent that we have to consider much more than the inborn differences between the coloured immigrants and the white population. These we can do little about but the handicaps imposed upon coloured children by their environment can be modified. I would like to emphasize that the medical services have specific tasks in ensuring that no coloured children are deprived of medical care through ignorance, that their basic needs are met by continuous health education and that those who work with coloured immigrants should be trained to understand their problems and to communicate with them.

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REFERENCES

- Corner B D (1944) *Arch. Dis. Childh.* 19, 68
 Dancaster C P & Jackson W P U (1960) *S. Afr. med. J.* 35, 890
 Davis L R, Marten R H & Sarkany I (1960) *Brit. med. J.* ii, 1426

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Social Aspects

The coloured child in Great Britain presents a challenge, not only to the medical profession but to administrators, teachers, social workers of all kinds and, indeed, the general public. It is a challenge which must be taken up, for it involves the important question of how successfully this country can fulfil its role as the head of a multi-racial Commonwealth and absorb these new citizens who come from totally different backgrounds overseas.

Where health is concerned, the importance of environment is self-evident and in the case of the coloured child it is clear that certain quite recognizable environmental or social factors are in operation. These factors fall into the two groupings which have been classified as socio-economic factors and psycho-cultural factors. Together they make up what might be termed the immigrant situation. Whether a child was born overseas and brought here or whether he was born here of immigrant parents he moves within this situation and it will inevitably affect his health and well-being.