

Editor's comment

The prevention imperative



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As this issue of *CME* goes to press another 800 people in Masiphumelele, an informal settlement near Noordhoek, Cape Town (close to where I live), are homeless as a result of a fire. Inevitably, several people, including children, were injured. Such is the situation in the Western Cape every winter – burn season. We used to dread it as surgical interns at Red Cross Children's Hospital.

Burns are an important cause of injury, disability and death across the developing world. The most recent figures from the World Health Organization (WHO) are for 2002. In Africa, there are 39.2 burn deaths per 1 000 and 5.8 per 100 000. These deaths account for 12.2% of global mortality caused by burns. South East Asia has the highest rates: 184 per 1 000, 11.6 per 100 000, and 57.2% of global mortality. Two out of three of these deaths in South East Asia are among women. Fire-related burns were responsible for 322 000 deaths globally in 2002.

In addition:

- Burns rank fourth as a cause of unintentional child injury death in the USA.
- Burns are a leading cause of adult deaths in the slums of Karachi, Pakistan.

- Burns cause an estimated 1 700 deaths annually in Nepal (7 deaths per 100 000 population).
- House fires are the leading cause of unintentional injury deaths among aboriginal communities in Greenland and North America.
- In Australia a patient with a burn of 80% of total body area can be expected to survive with a good functional outcome. In Nepal, no patients who have burns to more than 40% of their body surface survive.

House fires are responsible for the most lethal events, and that is what hits the news in South Africa as fires rage through closely packed, poorly constructed shacks in informal settlements. But, even here, it is scalds and other mild-to-moderate burns that are the most common.

A very high percentage of those admitted to burn units worldwide are children under 12 years of age. A study in Saudi Arabia showed that about 71% of admissions were of children under 12. The elderly are another group who figure disproportionately in the literature.

Burns occur mainly in the home and in the workplace – among women and children they usually occur at home. Women cook

over open fires; they and children are injured by hot oil and other hot liquids as well as the cooking fires themselves. Poor outcomes are more common in those living in rural areas. In rural South Africa, for example, the average interval from the time of the burn to arrival at hospital is 42 hours.

While there is little information about the socio-economic costs associated with burns in low- to middle-income countries, there is no doubt that these are significant. The impact is broad, from loss of work and income to disability and disfigurement.

Prevention is the imperative. Informal settlements need more space between houses. People should not have to rely on wobbly paraffin stoves or wood fires for cooking. There needs to be enough space for children to be kept away from pots of hot liquids. The same safety regulations that pertain to formal housing need to be applied to informal housing.

As with so many health outcomes, where you are in the world or where you are in the country makes a huge difference to the risk of burn injury and the outcome of that injury. Prevention needs to happen at a community level and this means poverty alleviation – isn't it always?

Once again we are looking for doctors' drawings, paintings, or photographs for the cover of *CME* in 2009. Please contact the editor if you have anything available.

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