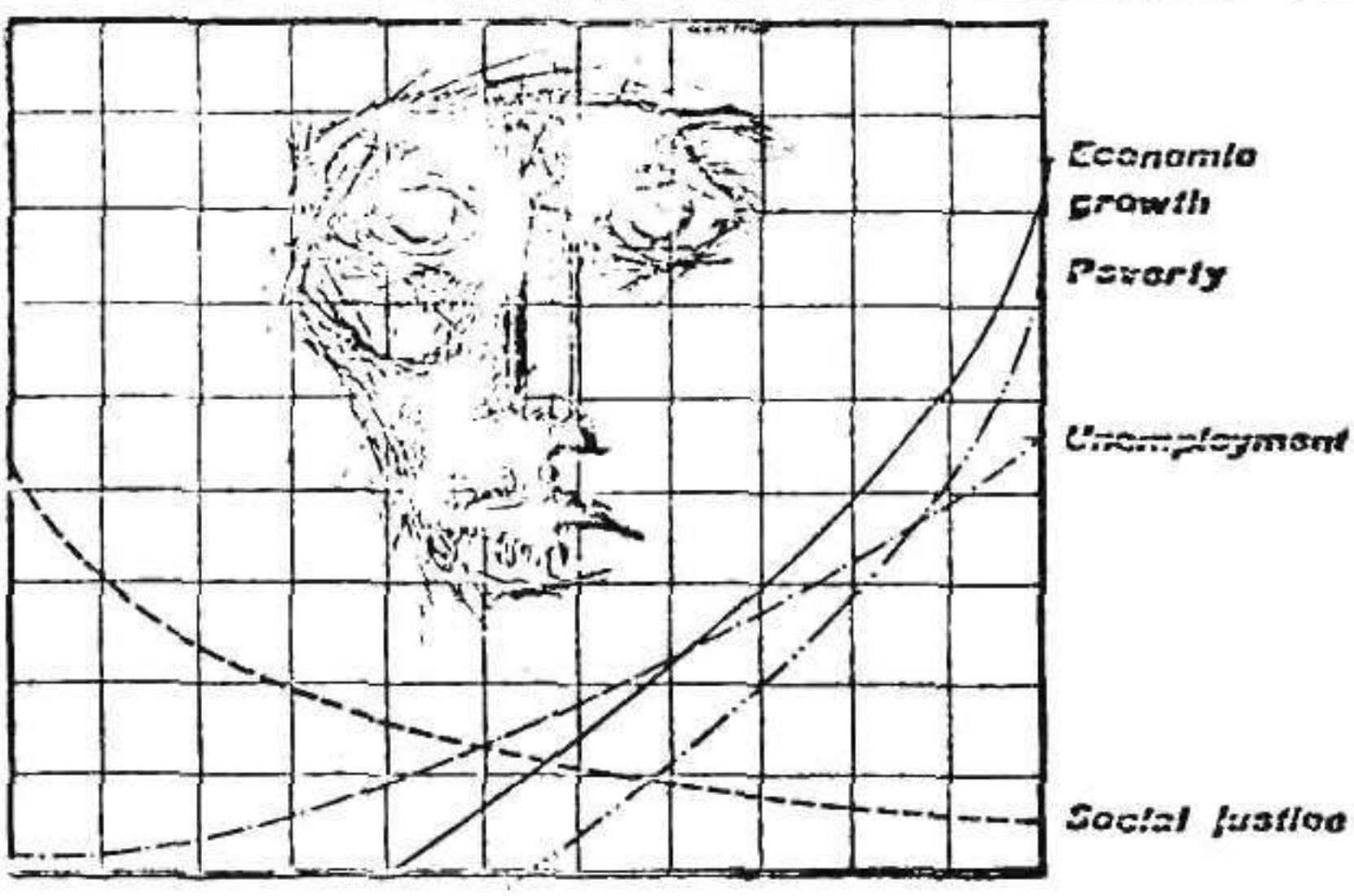
BEYOND COMMUNITY MEDICINE:

THE EXPLOITATION OF DISEASE

AND THE DISEASE OF EXPLOITATION.



BEYOND COMMUNITY MEDICINE: THE EXPLOITATION OF DISEASE AND THE DISEASE OF EXPLOITATION

In the past decade or so, concern about the prevalence of ill health in the face of apparently significant advances in medical treatment has le to a reassessment of health care priorities and the nature of health care delivery. The result has been an assault on the old order. It is, say the critics, incapable of providing adequate health care to all the people of the world. A new set of health care principles has been created.

These principles, with slight variations, are expounded by progressive bodies such as the World Health Organisation, the Christian Medical Commission, and, lately, have even taken root in South Africa. Put together under such names as "Community Medicine", "Primary Health Care" and "Preventive Health Care", these principles have come to be the accepted wisdom of that part of the medical world which is concerned to do something about the poor, and often detericrating health of the masses who live (or often only exist) upon this planet.

In this paper I hope to give some words of caution. It seems that this new dogma is in danger of entrenching the very things that is claims to be combating; that it is a potentiall powerful weapon for change that may become, albeit unintentionally, a prop to the existing order. In order to demonstrate this, I have given this paper the following structure:

PART 1 outlines the criticisms which have been levelled against the old medical order by the proponents of Community Medicine, and looks at the alternatives that they present.

Part 2 looks at the conservative tendencies contained within the new school.

Part 3 tries to look for a way to make the critique of the old order true to its own premises. I try to look for a real role for health care in an unjust social order.

Although I believe that the argument presented here has general relevance, I have tried to situate the paper in the South African context. This is because of the nature of this publication, but also because I believe that all theoretical debate only has meaning if grounded in a social reality.

PART 1 - THE ASSAULT ON THE CITADEL.

Health care throughout the Western World has been shaped by two dominant and connected factors. The first is that health care, like almost everything *else, has been turned into a commodity to be* bought and sold. This means that the nature of health care is largely determined by the effective market: by those who can afford to pay. The second factor is that medicine, along with almost all other branches of science, has taken an extremely mechanisitic direction. It puts the emphasis on the purely physical processes of the individual body. Thus,as long as the physiology of the organism is understood, it is possible to analyse any malfunction and to take the body apart and to put it back together again, or to intervene in some other, purely technical way, in order *to correct what has gone wrong.*

These two elements are linked. If health care is something which an individual buys, then it is logical that those who sell the care will concentrate on the body of the buyer, rather than on the relationship between people and the physical and social environment in which they live.

It is the consequences of these two factors that give rise to much that the community medicine

school criticises (although the critics themselves often do not realise the roots of these aspects of modern medicine that they so vehemently reject).

Arising out of these factors comes a tendency towards ever more complex and expensive types of medical technology which are, it is claimed, necessary to deal with the degenerative diseases of opulence. The cardiac unit, with its own South African pinnacle, the heart transplant, is perhaps the most extravagant example. (Whether these forms of treatment are in fact successful, or whether they rather constitute a form of modern witchcraft to ease the troubled mind of the patient is itself a subject of some debate). This technology requires ever more specialised training, and this, in turn, raises the cost of providing health care.

Thus this increasingly technical approach to medicine re-inforces another consequence of the commodity nature of health care: its accessibility to the masses. Our society is stratified along lines of race and class. It follows logically that access to health care, as a commodity to be bought, will be similarly stratified. But if the technical nature of health care has this direct effect on its accessibility, it also has an indirect effect. The very expense of modern equipment requires it to be centralised to an ever greater extent, in one or two national and provincial hospitals, thus rendering it not only economically, but also geographically inaccessible to the majority of people. These factors are not really separable. The cost of long distance travel, extended separation *from family and crops, or absence from* place of work are prohibitive to those living on the very margins of survival. So, say the critics, conventional western medical practice is rendered inaccessible to those who need it the most: the poor. (It is as well to anticipate the thrust of my argument by pointing out that it is at least as much the division of the

society into rich and poor, as it is the nature of the technology that renders access so difficult).

The "engineering", mechanical nature of medical practice ensures that, even discounting its inaccessibility, it would still be ineffective. This is because trying to treat the major contributors to morbidity and mortality on an individual level is like trying to hold back a tidal wave with a mechanical teaspoon: it does not matter how sophisticated the device, there are inexorable forces that are going to swamp it.

The major diseases to be dealt with are various forms of diarrhoea, pneumonia, T.B., measles, worms, malaria, etc. and, of course, the greatest killer of them all, in that it is often a fatal complicating factor in all the others, protein energy malnutrition. The problem is that these diseases, or at least their prevalence, is direct-ly related to the social and physical environment. So, although drug and other treatment may be extremely effective in individual cases, two problems arise. The first is that not enough people have access to this treatment. The second is that even where there is access, the success of the treatment is, in time, negated when the victim returns to the environment which is itself pathogenic.

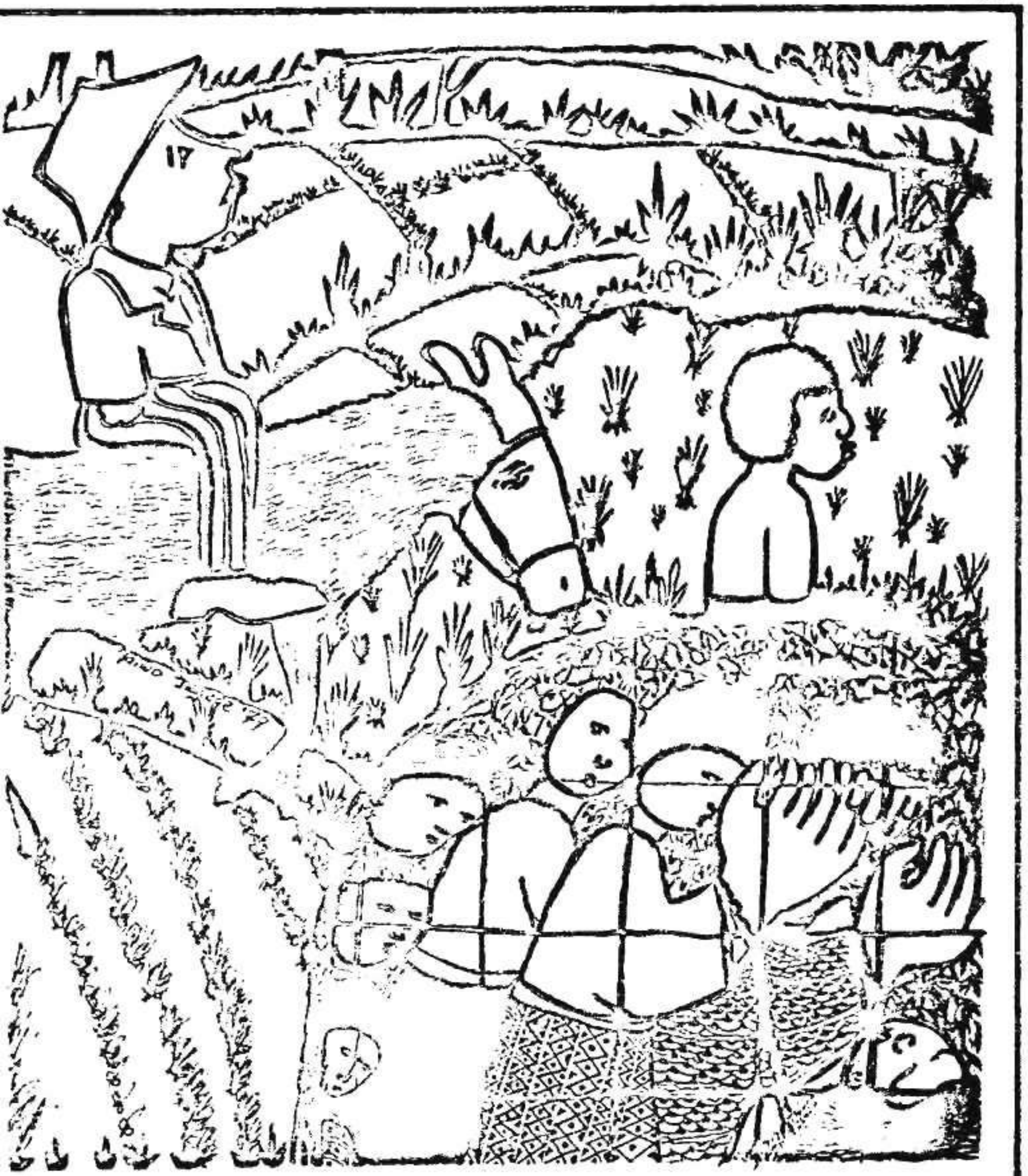
It has been documented on numerous occassions (1) how in Europe, deaths related to these diseases had dropped to almost their present levels before the introduction of antibiotics and immunisation on a mass scale. The conclusions are inescapable. The effects of these diseases are reduced or negated when the standard of living rises, when sanitation is improved, and when nutritional status rises. Thus, social, economic and environmental factors are far more important determinants of health than is the discovery of a new drug.

The commodity nature of health care ensures that current medical practice is not only inaccessible

and ineffective but also, in terms of the effective utilisation of resources, wasteful. The fact that health care has to be purchased ensures that it is a profitable undertaking. So, in order to protect their exploitation of disease, doctors have established, with offical backing, a monopoly over the provision of health care. This monopoly is dressed up in the guise of "maintaining professional standards", "protecting the public", and so on. The effect of this monopoly is that when doctors do reject the careers for which their background and training prepare them, and try to practice amongst those who have the least access, the rural poor, they find that a good 80% of their time is spent on treating cases that could be adequately dealt with by people with considerably less training than themselves. Thus is the scarcity of resources made even greater, and much money is spent on imparting substantial skills to people who then spend much of their time as glorified dispensers of first aid.

Furthermore, argue the critics of conventional medicine, western medicine is developed in the "advanced" first and second worlds, and is often foisted, with very little explanation, onto a population with customs and social practices very different to the society in which the system of medicine was developed. This is exacerbated by the fact that medical practice is undertaken by doctors who, almost by definition, have difficulty in communicating with the people that they are serving by reason of cultural, class, and often language differences. Furthermore these doctors, being arrogantly sure of their scientific superiority, tend to ignore indigenous forms of healing and care, or to regard it as superstitious claptrap, thus not making use of a significant local resource.

Thus argue the critics, conventional, hospital-based, curative medicine is too expensive for the available resources, ineffective, inaccessible,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and often both technically and socially inappropriate. In response to this curative approach to individual health, there has been formulated an alternative: a community approach to prevention, with cure as a secondary necessity only when prevention fails. What follows is an attempt to outline briefly (and non-exhaustively) the major principles of this formula.

THE FIRST PRINCIPLE is that if social, economic and environmental factors are decisive in deciding the overall health of a community, then it is on the level of these factors that decisive health interventions will occur. More specifically, basic health needs are: adequate sanitation including a clean and accessible water supply; adequate housing; and a reasonable level of nutrition and hygiene. Thus, all attempts to improve the health of impoverished communities must combine medical care with a general programme of community development to provide these facilities.

According to this principle, the following are integral to health programmes: attempts to improve the agriculture of the target population, or at least to promote vegetable gardening as a nutritional supplement; nutrition education in order to teach people how to improve their food intake on very small amounts of money; other types of health education to encourage hygenic practices and the building and usage of latrines; and a wide variety of "appropriate technology" hardware to ensure that basic water requirements. cooking facilities and the other necessities of life are met.

THE SECOND PRINCIPLE is that every effort must be made to involve the community in both the decision making and the implementing of programmes aimed at improving health. This principle has a number of different roots that I think should be spelt out. First, such things as vegetable gardening schemes and improved sanitation are only going to work if the community thinks that they

are a good idea, works hard to create them and continues working to maintain them. Secondly, people will only participate willingly and effectively if they feel that they have a stake in the programme, and involving them in the beginning is a good way of ensuring that this happens. Thirdly, "outsiders" often have misconceptions about the most pressing needs of a community. It is only by means of involving the communities that these problems can be overcome.

A THIRD PRINCIPLE grows out of the belief that conventional medicine takes no account of established patterns of life and the existing cultural beliefs and paractices within communities. So the principle is espoused that primary health care should not disrupt established community relationships, and should have the approval of all elements of the community. This is a tactical question as well as an ethical prinicple, for if powerful elements within a community are opposed to particular programmes, then the chances of these programmes getting off the ground are reduced.

A FOURTH PRINCIPLE is that extensive use should be made of people called cariously "village health workers", "barefoot doctors", or "medical auxiliaries". It is felt that doctors are overtrained for much of the work that they do, and that at any rate it would be prohibitively expensive to train sufficient doctors to provide health care to all. Furthermore, these auxiliaries, coming from the communities that they are to serve, understand local customs and would not carry a foreign aura around with them.

THE FIFTH AND FINAL PRINCIPLE that I want to mention is that there is a need for a re-allocation of priorities in health care and a decentralisation of resources. It is necessary to direct most efforts at prevention rather than cure; there must be a change of emphasis away from complex high technology to simple means for

combating the most prevalent diseases, and away from bigger and "better" hospi-als to the creation of a network of clinics and health posts within easy reach of every person. Health care must cease to be a profitable enterprise and become a service.

There can be no doubt that this school of thought, in its critique, and in some of the suggestions that it makes for reforming health services is a progressive one. Contained within these ideas is part of the solution to the problems of health and disease. In the next section I try to show how this school of thought, by not taking its own principles to their logical conclusion is in danger of betraying them. The criticisms are severe, but I have no intention of calling into questions the goodwill or integrity of any practitioner or theoretician of community health programmes.

PART 2 - THE UNFINISHED REVOLUTION:

My argument in this section has the following elements:-

1. The proponents of community medicine have not sufficiently analysed the social reality in which they are trying to intervene. As a result, when seeking the social and economic causes of disease they tend to focus on the wrong things.

2. This means that their actions, and those towards which they guide others, tend to come to grips with the wrong things.

3. The overall consequence is that they create a false reality and course of action, while at the same time directing both attention and effort away from the crucial aspects of society that need to be changed, while at the same time claiming that they are combating disease at its very roots. Thus, like those they criticise, they become guilty of treating

symptoms not causes.

It is commonly accepted by the proponents of community medicine that the overiding factor in the major diseases contributing to South Africa's mortality and morbidity statistics is poverty. There is an undeniable correlation between poverty and malnutrition, poverty and lack of hygiene and education, sanitation, housing and so on. Therefore, goes the reasoning, we must teach the poor how to grow vegetables, how to feed their children. We must teach them basic hygiene. In addition, we must engage in community development programmes so that people will do these things for themselves. We must teach people to overcome the apathy and lack of initiative that comes with poverty and ignorance. We must develop simple health technologies so that they can look after themselves, and be looked after more cheaply and easily. We must engage in "relevant research" to discover who is most "at risk", most liable to fall prey to the various diseases that the indigent are prey to. Thus we can help people to help themselves to counteract the effects of their poverty.

These responses are understandable. They come from people who, on a day to day basis, have to deal with the effects of poverty on those amongst whom they work. Furthermore they often meet with some success in this type of work, and this can only reinforce the feeling that they are on the right track, that if only enough people thought and acted as they do, health problems of the poor would soon be dealt with

I believe that these responses are based on an inadequate understanding of poverty. They derive from a world view that sees poverty as a stable state from which people can be helped, if only the right tools, techniques and push buttons can be found. Poverty is seen as the problem of the poor. Something from which they must be taught to escape.

This view, the rest of this section will argue, is erroneous and extremely patronising. By and large the poor are pretty resourceful people, who manage to survive under conditions to which most of us would succumb. In contrast I will argue that poverty is not simply a condition from which people can lift themselves, but rather a situation imposed on people by a historical process, and to which they are bound by forces which have been unleashed during that process. I will argue that the poverty of the broad mass of people does not merely co-exist with the wealth of the elite, but that the two are inextricably linked; that the wealth of the rich is in fact built on the exploitation of the poor; that to talk about overcoming the effects of poverty without seeing it as necessary to change the social structure that gives rise to it is to admit the permanence of the structure, and thus of the diseases of poverty.

I have said that analysis only has meaning if it takes place in the context of a concrete reality. I want briefly to outline this process of exploitation, and the political domination that accompanies it, as it has developed in South Africa. Although it is not possible to undertake a detailed historical analysis here, I feel that it is important to gain at least some insight into the processes which have created mass poverty and malnutrition and the associated diseases in South Africa.

When the European settlement of South Africa began, the settlers did not find that the local population were agriculturally incompetent, that they were unable to look after and feed their children, nor that they suffered from mass malnutrition.

If this is the case, then the poverty and, in some cases, near endemic malnutrition, currently found in South Africa cannot be put down to an original state of underdevelopment. Rather it must be sought in the progressive underdevelopment

which has resulted from the interaction of an indigenous economy in which the surplus produced was redistributed to the community, and an intruding, colonial cash economy, backed in the final instance by the guns of the settlers. It must be sought in the driving of people off their land, ending in the bottling up of the black population on 13% of the land by the Land Acts of 1913 and 1036. It must be sought in the compelling of large portions of the male population into the cities to work on the mines and later in the factories. This was achieved by the imposition of taxes such as hut, dog, or poll taxes: the only way to earn the white man's money was in the white man's mines. Resistance was sharply crushed. (In 1922 General Smuts dealt with a refusal by the Bondelswarts to pay a tax on their dogs. He ordered that the village be bomed from the air, and then sent in a column of men armed with machine guns. More than 100 people died in the attack). Increasingly the reserves and their indigenous economy degenerate, unable to cope with the strains and limitations imposed on them. Too little land resulted in overgrazing, overstocking and overloading.

South African History of the 20th Century is taught as the history of the white political parties, their changing alliances and policies. These are only the surface facts. The underlying realities are the growth of a black labour force, driven to the mines and industry as their traditional livelihoodcrumbled. This labour force is controlled by a migrant labour system that breaks up homes and families and gives the rural male no choice as to his place of work. The real South African history is the growth of political control and the repression of attempts by blacks to break out of the cycle of exploitation in which they found themselves. This has involved the suppression of black trade unions and political movements. Finally it is the history of the consolidation of the reserves into "homelands" where are dumped the growing number of

unemployed, and where the highest morbidity and mortality rates are to be found.

There is of course another side to the story. Out of this same process has emerged the powerful South African economy, and with it a white middle and upper class with one of the highest standards of living in the world. Here are found the degenerative diseases of superabundance. White prosperity has of course not merely happened at the same time as the exploitation of the black *population. It is a consequence of it.*

It is against this background that the proponents of community medicine must judge whether they have faced up to, let alone begun to answer the most important questions in which they should be involved: if poverty is the most important cause of disease, then what are the most important causes of poverty? If actions in the health sector are aimed at eradicating disease, then how effective are these actions in eradicating the causes of poverty?

And these are the crucial questions. If community medicine, in its theory and practice, is dealing only with the effects of poverty, and is leaving the basic structure of exploitation untouched, while at the same time claiming to deal with the very roots of disease, then it is doing a very conservative thing. For not only is it accepting that the causes of poverty cannot be done away with, thus giving the current social structure the status of a law of nature, it is also giving the system credibility by claiming, against all the available evidence, that the effects of poverty can be overcome within the very system that has created that poverty.

There is a second, closely allied misconception which is propagated by the conventional truths of "community medicine". This is the belief in "community". It is widely held that there are a series of "poor communities" which need to undergo a process of community development.

This assumes that there is a common interest amongst all members of the community. If however one examines these communities in the light of historical processes of underdevelopment, then a different picture emerges. There are the ordinary people and there are chiefs; there are those with land, and there are the landless; there are the unemployed, the traders and the transport riders. There are those who have been given some kind of a stake in the system of "homeland government". The communities are in fact divided by class, status, sex, and a variety of other criteria. We find that the structures of domination and exploitation are reproduced right throughout South African Society, and into these very "communities". In fact the concept of community is a myth of the unperceptive outside eye.

This raises serious questions about the principles of "community participation" and "community involvement in planning". These "democratic processes of decision making" are often simply a way of smoothing the way for the richer, the better educated and the more powerful to hi-jack any particular project for their own ends.

This is not the only way in which programmes can have the effect of increasing economic discrepancies.

One of the common attitudes found among people working in rural areas, is that if people are starving it is important to increase food production. As a result, extension officers are brought in, co-operatives are established to help people acquire implements, seeds are provided, and often a range of "wonder" crops such as soya beans are promoted for their high yields and nutritional value. These programmes, because they rest on false assumptions, are likely to fail. It is not that there is not enough food in South Africa to feed everybody. Farmers allow tons of food to rot weekly because

they cannot get a high enough price for it. It is rather that the poorest people cannot afford to buy it. Secondly, the poorest people are precisely those without money or land. That is why they are starving. This means that all the "wonder crops" in the world will not help them. Thus only those a few runds up the economic ladder can benefit.

A devastating example of how these programmes can make things worse comes from India and the Green Revolution of a few years back. Here it was commonly believed that improved grain varieties were going to solve the malnutrition problem. What in fact happened was that only the comparatively well off could afford to buy the new grain and the fertilizer and equipment necessary to use it. They benefited so much that they pushed the marginal farmer off the land, and the overall incidence of poverty, landlessness and starvation has in fact increased. (3)

This kind of result is reproduced wherever "community development" programmes proliferate (4). The fact of the matter is that people learn very quickly from such experiences, and are unwilling to participate in such programmes a second time. This leads to the rural poor having gained a reputation for being "anti-development", "apathetic" or even "lazy". They understand well enough that they are kept poor by certain forces, and that until these are tackled at their roots, there is little point in trying to combat the mere symptoms that they give rise to.

There is another aspect of the emphasis on community and preventive medicine which is in danger of bolstering existing inequalities. There is a danger that it can provide an excuse for "making communities responsible for their own health" when the resources within that community are patently inadequate - not because of the communities inherent inadequacy, but because of its history of deprivation. Thus it becomes a respectable

reason for the authorities to wash their hands of responsibility for a situation which they, and the exploiting classes which they represent, have created.

In this light the enthusiasm with which some people have regarded the new South African Health Act as being a progressive step because it allows for the implementation of many of the basic principles of community medicine should be treated with some caution. This is the case particularly in view of the discrepancies in the allocation of health resources. For example, the new Johannesburg Hospital has cost something in the region of 100 million rands to build, and will cost about a third of that per year to maintain.

There are other bizarre consequences of the refusal to recognise that lack of resources is socially determined rather than a law of nature. one of these is the emphasis placed on "family planning" and nutrition education amongst the poor. The assumption here is that if people are hungry, there are simply too many of them for the available food supply. The other side of the "grow more with the wonder bean" coin, is the "lets have smaller families with less mouths to feed" syndrome.

On the surface all these things seem reasonable enough. But no-one tells the rich to have fewer children lest they starve. No-one insists that the mothers of Houghton or Constantia feed their children so many grammes of protein carefully balanced against so many milligrammes of minerals, vitamins and trace elements.

It is not even as if these evangelists for birth control say to the poor: "we know that you are exploited and oppressed. We will fight with you to achieve freedom, but in the meanwhile here is a survival recipe for your children". Or, "we know that you cannot farm because you are landless while the majority of the land is in the hands of


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the white farmers. We will fight with you for a redistribution of land and power. In the meantime, here are ways of growing vegetables to keep yourself alive."

Rather, these techniques are put forward as solutions in themselves to the problems of the exploited. The only inference is that exploitation is part of the natural order, and people are going to have to learn, literally, to live with it.

Similar flawed reasoning lies behind the continuing search for an Appropriate Health Technology. If one asks the question "appropriate to what?", the only reasonable answer is "appropriate to survival in conditions of extreme exploitation and poverty." This research ignores the fact that the technical possibilities already far outstrip the social and political ability to use them. If this is the case, the continued search merely reinforces the myth that a social and political problem will have a solution, if only we can find the right bit of technological magic. A word about other types of research is opposite at this point. In order to make preventive outreach programmes more effective, it has become fashionable to conduct extensive research programmes into, for example, what it is that makes certain children in a rural slum suffer from malnutrition while others do not. Typically these programmes come up with the answer that it is not so much economic status, as the fact that the child comes from a broken home, or his mother has deserted him or some other fact of social dislocation that is responsible. This is fine. No one knows who is most at risk, and can maximise one's efforts to minimise the effect of malnutrition amongst that particular target group, during the continuing phase of oppression. Unfortunately much more is read into these surveys. Suddenly broken homes become the cause of malnutrition - which can then presumably be prevented by a timely bit of marriage guidance or social work. Yet the children of Hollywood divorcees do not

starve, nor do the offspring of Johannesburg's jet-set broken homes. The most that can be deduced from this research is that where everyone is living below the breadline, survival tends to depend on the stability of the home environment, rather than exactly how far below the breadline one is.

One could go on in this vein indefinitely. I hope that I have given sufficient illustrative examples to make my case. In brief, I have *argued that the theory and practice of community* medicine often tends to obscure the roots of disease which are to be found in exploitation and political oppression; that this is done by providing inadequate explanations, by portraying survival strategies as ideals, thus accepting the permanence of the social order which makes survival difficult; by creating the myth of community where none exists, and so creating in the name of democracy, avenues for the rich and the powerful to pursue their own interests; by giving government an excuse to evade its responsibilities in providing health care to all; in short, in obscuring the truth that health care can only provide care, whereas health can only be provided by a political solution to the inequities inherent in our society.

PART 3: THE ROAD AHEAD.

The first step is to undertake a careful evaluation of all the principles of community medicine, and particularly their application in specific programmes.

The critical understanding of the role of health care must begin with putting the interaction of *the social structure as a whole, and the* "communities" with which the system of care is concerned, into the correct perspective. Many of the false attitudes that I have described stem from a tendency to generalise an approach to the world out of immediate experiences in a small part

of the world. Thus it may be true that a family has more children than it can feed. A village may be able to overcome a number of its health problems by acquiting a cheap water supply. This is very different from saying that the answer to the world's malnutrition problems is better family planning, or that the right technology would do away with water-related diseases.

Rather, one must undertake a thorough analysis of the dynamics and structures of a society as a whole, including a careful understanding of its history. Then one must examine how this or that "community" reflects these dynamics and structure, and how our actions will affect them. Will they reinforce domination and exploitation or help to challenge them?

There is nothing wrong with assisting people to survive when they are down and out. It only becomes reprehensible when it distracts from the more important work - eradicating the evils of malnutrition and other diseases of poverty at their roots.

I have said that health care can only provide care, that it is essentially in the realm of politics that the health of the nation will be determined. It is only when we stop trying to "help the poor", and join with them in the struggle for political and economic freedom that we can be truly said to be striking at the heart of ill health.

I am not suggesting that those concerned with health care should lay down their scalpels and take up arms or that nothing can be done in the field of health until a just political and economic order have been created. That would be both negative and impractical. It is simply that we must take care not to reinforce the existing imbalance of power in order to achieve short term goals.

On the other hand care should be taken not to fall into a paralysis of disillusionment and hope-

lessness. I cannot spell out in detail what people should do. I can only outline some general guidelines.

1. The link between exploitation and ill health must be fully spelt out, not only in academic journals and pleas to politicians, but in the day to day work with the victims themselves.

2. Health personnel must move beyond the superficial conception of "community". They must take sides and put their skills at the disposal of those acting with the poorest and the most powerless, in order to increase their ability to resist the threat to their existence which the present order poses.

3. In embryo form, in local projects, the practices of a just health system must be put into effect. These must be used to highlight the inadequacies of the present system, and to create expectations for the future.

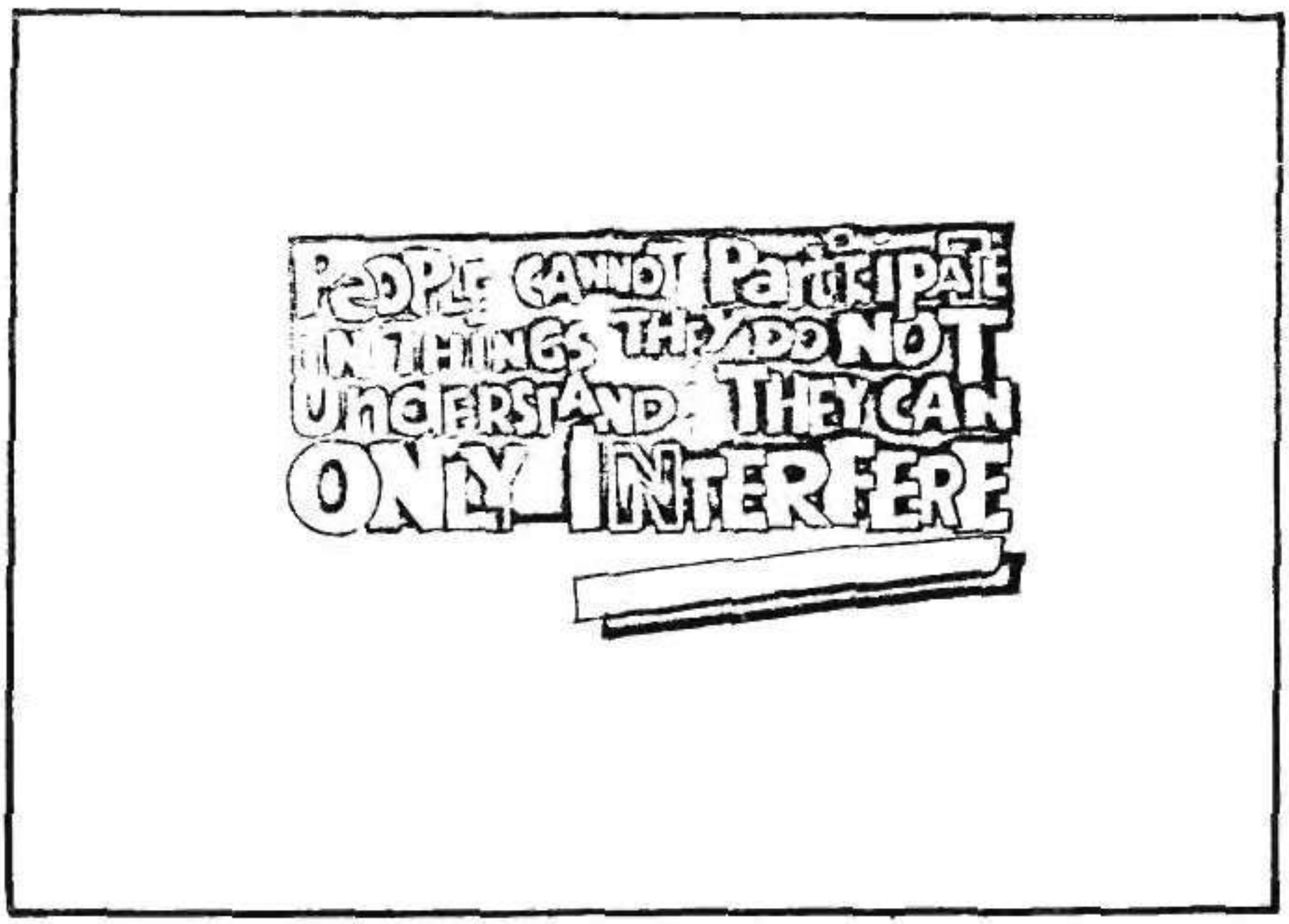
4. A concerted effort must be made to build up a reservoir of politically conscious and dedicated people who will form the core of a new and just health system at some point in the future, when a just and non-exploitative society has been built.

Western medicine, despite the good intentions of some of its practitioners, has become a huge industry. Its practices, its structures, its professional organisation and the society in which it exists have made sure of this. It has more to do with the exploitation of disease than the provision of health care.

What I have tried to show in this paper, is that understanding this, and the attempt to look for alternatives within the present system is only half the task. If medical practitioners, and others, wish to see the creation of a truly

healthy society, then they must examine carefully what role they can play in ridding society ofthe disease of exploitation.

PTO for NOTES on this article.



NOTES:

1. See for example. Mckeown T. A Historical Appraisal of the Medical Task, in Mclachlan, Gordon and Mckeown (eds) Medical History and Medical Care.

2. This kind of unfounded optimism can be found even in those programmes which have gone furthest in understanding the types of criticisms that are levelled in this paper. So for example Berhorst C. The Chimaltenago Development Project in Health by The People. World Health Organisation 1975.

3. For a good introduction to the relationship between hunger and social injustice see: Powers J. and Holenstein A.M. World of hunger Temple Smith 1976.

4. For a detailed and devastating account from the Transkei see: Claassens A. An Assessment of Self Help Projects in a District of the Transkei. A paper presented to a conference on The Economics of Health Care in Southern Africa. Cape Town September 1978.

A Comprehensive bibliography would be overpowering. What follows is simply a guide to some of the reading available.

For the seminal works on the community medicine approach see: King M. Medical Care in Developing Countries OUP 1966 Bryant J. Health in the Developing World Cornell University Press, 1969.

L.G. Wells. Health Healing and Society Ravan Press 1974 is an instructive booklet applying the principles of community medicine to South Africa.

A concise statement on appropriate technology for health and the use of medical auxiliary is to be found in:

Gish O. (ed) Health Manpower and the Medical Auxiliary Intermediate Technology Publications 1971.

An interesting publication in which most of the issues raised here arise from time to time is CONTACT a bulletin published by the Christian Medical Commission in Geneva.

The most comprehensive critiequ of the structure, organisation and function of western medicine can be found in:

Navarrro J Medicine Under Capitalism

A somewhat eccentric, sometimes devastating, sometimes conservative attack on the entire medical world is to be found in Illich I. Medical Nemesis. This should be read in conjunction with Navarro's critique of Illich.

For descriptions of alternative health care services and projects the logical starting place is

Newell K. (ed) Health by the People World Health Organisation 1975.

The commonest case study is China. Short introductions are

Health Care in China Christian Medical Commission 1974.

Chabot HT. The Chinese System of Health Care published in Tropical and Geographical Medicine 28 1976.

A fascinating personal account is Horn J. Away with all Pests. Hamlyn 1969.

Apart from the above other articles which I have found interesting are:

Powles J. The Medicine of Industrial Man Published in the Ecologist of October 1972 and

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Readings on South African History are difficul because they are often locked away in academic journals. As a general reference see:

Wilson M. and Thomson L. (ed) The Oxford History of South Africa. Published by Oxford University Press in 2 volumes.

An interesting paper on the interaction betwee the colonial and the indigenous economies is

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