Can aspirin cure poverty?

Typhoid outbreak hits black Jo'burg township

96 SA children will die today of malnutrition

People do not think of health and illness as a political problem. This is because it seems to be a technical matter, for experts to deal with. When someone gets sick, he or she goes to a clinic to be cured. This is called **curative medicine.**

But there is a different way of looking at health care. It is stupid to build hospitals and train doctors, which cost enormous amounts of money, and not do anything about starvation, contaminated water or lack of shelter for people. Many illnesses could be prevented if these things were attended to, and there would be less need for medicines and doctors. This is called **preventative medicine.** The most common illnesses in Alexandra are malnutrition, skin infections, TB, parasites (worms in the stomach and intestines) gastro-enteritis, VD and so on. All of these have **social** causes. For example, people who do not have enough to eat, or do not get enough sleep, become weak, and then they are more likely to get some disease.

Slum deseases

We know that malnutrition is a result of low wages; and we know that many workers spend long hours travelling to work and back, which cuts down on their sleep. As for skin infections, they are partly caused by inadequate diet, partly by the dust and dirt in Alexandra. TB is well known to be a slum disease. It is nurtured by bad housing, poor ventilation, malnutrition, bad hygiene and overcrowding. Many other diseases besides develop in these ways – they are diseases of poverty.

Overcrowding makes the problem worse because illness can spread fast in conditions like in Alexandra where 60 000 people occupy 1 square mile, and where in some cases as many as 50 people live in a single yard.

Curative

A scientific attitude to illness is obviously necessary, and trained doctors, nurses and researchers are needed. But it is important that we realise that basically health is a social matter, that looking after health is a social, that is political, duty. While it is true that sick individuals are helped very often by medicine and by specialist treatment, medicine itself cannot remove the **causes** of many illnesses, so long as the conditions which give rise to them exist.

In South Africa preventative medicine is far more urgently needed than curative medicine; and yet it is the state's policy to develop high technology equipment, hospitals, highly trained doctors etc, rather than **eliminate** the social causes of disease. What can their reason be for this policy?

Who benefits?

One answer is that curative medicine is very profitable. Most doctors see their training as a way to make money. Also the manufacturers of medicines and the pharmacists who sell them, make very high profits. In fact these profits are also often shared with doctors in the form of bribes to induce them to use and prescribe particular brands of medicine. This has recently been revealed in an investigation by a large Sunday newspaper. We must also not forget that company profits also means money in the governments hands, as they get tax.

It is a consequence of capitalist policies, that we see on the one hand terrible social conditions in the Alexandra ghetto, and on the other a clinic (which of course is a relief to people suffering from illness: it is a blessing in their lives.) The Alexandra Clinic is rather famous. Not only does it serve the 60 000 inhabitants of Alexandra, but people come from far away to be treated there. It is understaffed, and the staff members are underpaid, in comparison to white hospital

staff. Its annual income is small. It relies on donations from Big Business, from Wits Rag Charity and so forth.

There is of course little the clinic can do to improve conditions in the township. It is itself set up as part of the **curative** medicine that, as we have explained, is favoured by the system in this country. As it receives support from drug companies and capitalist business, it is quite unlikely to challenge the system in any meaningful way. People will go on getting 'filth diseases' in Alexandra, and then getting treatment at the clinic.

There is no way in which the clinic or its staff could enter the social (political) struggle, and work with trade unions or community organisations, to alter the inequality that lies at the base of South African society.

What does the clinic hide?

In other words, the clinic is inevitably part of the problem. It repeats or continues the system of curative medicine in a situation which desperately needs the other approach. In a sense, therefore, the Alexandra Clinic conceals the most urgent problem of illness. It is useful to the state in that it disguises the social problem and makes it seem that donations of cash or drugs are a benefit, when they are actually a curse.

Preventative

Preventative medicine is a form of medical care that attempts to find out the social causes of illness, and tries then to get rid of these causes. It attempts to **prevent** illness, by removing its causes. Health is a political matter; and to health problems there must be political solutions. What this would mean in practice is that workers themselves should control such medical centres as the Clinic, and take part in defining health care, and the way to overcome illness. This would be possible only when workers control the factories and their profits; it is not a possibility in the present South African form of society.

It's unhealthy, say doctors

By LIZ McGREGOR
Medical Reporter

IN A "gross maldistribution", 80% of South African doctors care for 20% of the people.

This figure was given in a report in the latest issue of the South African Medical and Dental Council on a conference on "Health Realities in Africa" held recently at Medunsa.

The "gross maldistribution" of health manpower could partly be attributed to students training in a city with sophisticated medical facilities — and were then "ill-prepared to cope with the adverse circumstances and frustration prevalent in rural areas".

One solution was to take training to the areas of need — some medical schools now require students to do some training in rural areas.

Although South Africa was highly sophisticated in certain fields, such as cardiac and renal transplants, coronary bypass surgery and nuclear medicine, most of the health problems of developing countries — such as gastro-enteritis, tuberculosis, rheumatic heart fever and malnutrition — were still found in the Republic, said the article.

It was clear poor water sources, poor sanitation, nutrition and communication routes were at the roots of health problems in developing countries, it said.

"The importance of the World Health Organisation's goal of providing water to all by 1990 was frequently stressed; a piped water supply to every family and a good sewage system would greatly improve the health status of a population as a whole," it said.

There was also a strong feeling among delegates that the people should become involved in their own health care, it said.

"This approach has been applied with success in remote African villages where village health workers and health committees have been recruited from the local population and given relevant training," said the report.

Health in Alex

Every large size settlement of people needs arrangements for their health and hygiene. The first duties of a local authority are to secure a supply of fresh, clean water, and to plan the regular removal of waste, eg excrement, rubbish, rotten food and so on.

Alexandra has lots of underground water, and for many years the water supply came from wells, some of which were polluted because they were near to pit latrines. Piped water was not laid on until 1941. As for waste there have from time to time been slight improvements in the system of bucket removal; but it is a primitive and dirty method, and it is still in operation.

Early days

In the early days of Alexandra cleanliness was not adequate and by 1935 the township was becoming overcrowded, making the problem worse. In 1936 a Provincial Health Inspector, Dr Fourie, scared everyone with his report on health conditions:

'Both the water supply and the sanitary conditions in the township, as well as the night-soil depositing site, favour the presence of enteric fever. Unfortunately the community is not an isolated one. Most of the inhabitants are employed in Johannesburg and there is reason to believe that a considerable number of them come into close contact with the population of Johannesburg in their homes as cooks, nursemaids and so forth.

There are other intestinal diseases, such as infantile dysentery, and the available records of Alexandra Township show quite a high incidence of mortality due to those diseases among infants and young children. As I said before, it would not matter very much if Alexandra Township were an isolated community, but it has a very close contact with the population of Johannesburg.'

What disturbed Dr Fourie is that disease does not seem to be colour conscious. It ignores the boundaries drawn up by white legislators, and might spread from Alexandra to the residents of white suburbs in Johannesburg. These residents took fright from his report and feared infection from servants quarters (ie Alexandra). Pretty soon things were being done to improve the township's condition.

Improvements

By 1939 the Alexandra Medical Officer of Health, Dr AB Xuma, reported:

Since Mr Justice Feetham's Commission in 1936, the Health Committee has acquired new grounds for a cemetery and for a depositing site, the need of which was largely the cause of the enquiry into the conditions in Alexandra township.'

And he goes on to point to the remarkable decrease in cases of Enteric Fever, 'a filth disease', from 176 cases in 1936 to 34 cases in 1938. Caution on the part of the citizens of Johannesburg was having an effect.

What about the medical side of health in Alexandra? The first organised effort at clinical treatement was introduced by missionaries. The situation was outlined in 1935:

'The present Health Committee has in the past given financial support to the medical work of the American Board of Missions, and is making an annual grant to the Committee which has taken over the Alexandra Health Centre from the Mission. The staff of the Centre consists of an honorary physician, a European sister in charge and two trained Native nurses. The doctors leave instructions for the nursing of their patients at the clinic, and a nurse is sent to carry them out.'

By the year 1940 it has grown somewhat larger:

'The clinic was established in a small way and has now grown to the dimensions of a double storyed concrete building. It is situated in 2nd Avenue just off the Pretoria Road. The full-time staff consists of a doctor, one European sister and five native nurses. The clinic contains a casualty dressing room, dispensary and two consulting rooms.'

WITS sees a chance

In this year the Centre began to interest Wits Medical School. A valuable insight into the Wits Clinic is given in a report by the first students to have used Alexandra for their medical training:

It does not appear to be generally known by medical students that our University has appointed Dr Prestwich as a Medical Officer to provide medical service, with the assistance of students, to the poor people of Alexandra Township. As we are the first group of medical students to have availed ourselves of the priviledge of working in the Township for a fortnight, we felt that a description of our experiences might be of some value to the student body.

The report that the students then give shows an interesting mixture of attitudes. On the one hand they are really learning things about society.

'For the first time in his training the student comes face to face with real poverty and its devastating effects on the health of the population...'

But on the other hand, their reaction to this seems almost completely exploitative, as they go on to say:

'Therefore the stay in Alexandra was regarded as invaluable for bringing students in contact with the practical aspects of general medicine and of revealing how potent is the environment in the production of disease.'

The students are amazed by the sheer amount of disease in the township: or should one rather say, they were delighted by it?

The incidence of TB, enteritis in children, marasmus in infants, and utter ignorance of infant feeding all seemed incredibly high. There were cases which really should have been sent to hospital, but which demanded treatment at the clinic or at home. Such procedures as the administration of intra-peritonial salines to wasted infants had to be performed. In addition there was ample scope for giving N.A.B. injections and doing an occasional tooth extraction or lumbar puncture.

This is what they term '.. *gaining valuable clinical experience.*' It is so useful indeed, that they go on to say, *'The establishment of a hospital at Alexandra should be the ultimate aim of all medical students.'*

Practise makes perfect

You can't blame medical students for their interest in disease. They are naturally excited by the battle-field, casualty ward or urban slum, for in such places one contacts the most interesting medical problems in all their variety and intensity.

What we are speaking of is not the individual medical student or doctor, however, but the social process that gives certain selected people (students of Wits University, for example) possession of technical skills in doctoring, while it gives to others (residents of Alex, for example) possession of illnesses.

Capitalism behind poverty

This is a class arrangement. Wits is a capitalist university; Alexandra a working class ghetto. White education is supported on the back of black worker exploitation. White doctors are the product of their class advantage.

Most of the doctors in South Africa when they have qualified, work among white patients in towns and cities: very few are willing to go to rural areas, where poor black people live. This is partly because it is more comfortable for whites in towns, but also because white patients can afford the very high fees doctors like to receive. Most doctors don't even see

these facts. They come to believe that they are doctors because they are clever- er than other people; in other words they think that their priviledge comes from their own brains and hard work, whereas in fact it comes from the advan- tage of their class position.

It must also be said, that when doctors work in places like Baragwanath Hospi- tal or at the Alexandra Clinic, it is often another form of exploitation. It is re- garded as part of their training; after which they go into private practice, and neglect the real problems of health work, which are mostly to be found in rural areas, or urban location.

What the doctor did not know

In his 1940 report, Dr Xuma remarks,

"One finds it difficult to understand the tendencies of public authorities who spend hundreds of thousands of pounds on subsidising housing schemes and free clinics for the poor, but do not seem to be making any attempt at removing the root cause of these peoples' misery, namely poverty."

He would have understood better if he had realised that poverty is actually a **product** of the capitalist system. It is not an accident. The 'public authorities' have simply no reason to abolish poverty, since it is a necessary part of the system that they have created.

Wits medical students, and Alexandra patients are on two sides of the class division in South African capitalism. Doctors will only be motivated to serve the people when they come from the working class, and are subject to the social values of that class. That is a more important thing to understand, than the mere technicalities of curing this or that disease.

Nomads of Apartheid

By the early 1950's my mother started working as a domestic servant in Pre- toria. She lived with her aunt, brother and sister in Eersterus. She was the only member of the family who was working – her brother and sister were still at school and her aunt was unem- ployed – she sold liquor and vegetables. As a domestic worker my mother earned six pounds per month, and this money was not enough to pay rent, transport, schoolfunds and books, so selling of liquor and vegetables helped them to maintain the family. Later in the mid fifties they were evicted and my mother came to Johannesburg while her brother, sister and aunt went to Pelindaba.

She went to J.H.B

In Johannesburg she found employment at an old age home, but left the job for domestic work which was paying better. Her new employers provided accommo- dation. She lost this job and the accom- modation when her employers went to live overseas. She went to Alex and lived with a relative in 7th Avenue. Shortly afterwards, she found a job at a certain factory in Johannesburg, and here she worked for a long time earning R24,00 per month. Late in 1957 she and her future husband found a room in 4th Avenue, by this time their first child was born and she had to leave the job.

Shortly afterwards, her husband lost his job, so she had to return to work as soon as possible. She found a new job with the same employers as before, but this time doing domestic work.

Slave wage

From the R24 which she was earning she had to pay rent, buy food, pay trans- port, buy clothing for the baby and pay a nanny to look after it for about R1,00 per month, buy milk, napkins and so on. Early in the sixties her wage was increas- ed to R30,00 per month. By this time they had two children: a boy and a girl born in 1960. Now she had to support a family of four from the R30,00.

They had to live on cheap food, like Mala, mogodu, maotwana and mealie- meal.

When her husband was banned later in 1963 their last born child was in Roode- poort Hospital where he spent two years. All this cost a lot for a woman who was underpaid. When her son was discharged from the hospital she had to get someone to look after him, and my brother was about to go to school. The R30 was not sufficient so she joined a mogodisana for buying and sharing groceries. This helped her a lot because she could save more than if she was going to the shop