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Social and Cultural Perspectives

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Awareness of the connection between health and lifestyle has increased greatly over the past two decades. In developed countries, this awareness has arisen in the light of findings from medical research since about 1960. Examples of lifestyle factors that have been studied extensively include diet, alcohol consumption, cigarette smoking, physical activity, sexuality and reproductive behaviour. Collectively, these personal behaviours are now thought to be related to about three-quarters of the premature illness and death that occurs in contemporary Western populations.

The idea that health is related to lifestyle is not new. The Greeks and Romans recognised that health and disease reflected the conditions of living. Hygeia, the Greek goddess of health, represented the view that ‘health is the natural order of things and a positive attribute to which men are entitled if they govern their lives wisely.’ The Greeks considered that medicine’s function was to discover the natural laws by which human beings ensured ‘a healthy mind and a healthy body’.

There is a strong social dimension to health – the health of the individual is very much dependent on both the physical and social environment.

In the Third World rural communities, a high prevalence of infectious disease, particularly bowel and respiratory infection, reflects poor sanitation, overcrowding and inadequate nutrition. The urban communities of Europe in the nineteenth and early twentieth centuries and Asian cities now beginning to industrialise also suffer from a high prevalence of infectious disease, again
'Health is the natural order of things and a positive attribute to which people are entitled if they govern their lives wisely.' Greek view of health

associated with poor sanitation, overcrowding and inadequate nutrition.

Modern metropolitan communities in the West, which have proceeded a long way on the path of industrialisation and now have reasonably good sanitation and better housing, have developed a sedentary lifestyle with access to plenty of high-energy foods, alcohol and cigarettes. These communities have a quite different pattern of health problems – characterised by coronary heart disease, stroke, certain forms of cancer, and other chronic (especially respiratory and digestive) conditions related to cigarette smoking and alcohol consumption. These differences are demonstrated clearly in figure 2.1, which shows the changing profile of mortality in Australia and New Zealand during this century.

It is this latter pattern of health problems that is the concern of this book. These diseases are non-infectious in contrast to the infectious diseases, which were the major problem until about 1940 in Western countries, and are still the main concern of Third World countries today. These late twentieth-century diseases are related to personal behaviour which in turn is conditioned by social and cultural factors. In the case of the once dominant infectious diseases, the personal factor is overwhelmed by the importance of the physical environment.

HEALTH: DEFINITIONS AND COMMUNITY ATTITUDES

The World Health Organization has defined health as ‘a state of physical, mental and social wellbeing and not merely the absence of disease or infirmity’. This refers to a general and positive state of health – an ideal which is attractive and important to everyone, but which is difficult to study in contrast to the more clearly defined specific disease states. Indeed, the WHO definition has been
The fall in deaths due to infection and rise in deaths due to coronary heart disease is shown.

Source: data from the Australian Bureau of Statistics and New Zealand National Health Statistics Centre

criticised because it has not been readily translated into useful and measurable goals.

It is of interest to know just what Australians’ current attitudes to health are. A survey was carried out in 1985 by the Better Health Commission (appointed by the Minister of Health in early 1985). 1 1266 persons aged fourteen years and over (a random sample from all of Australia) were asked (in a formal interview at home) what ‘health’ meant to them as individuals.

Their responses were fairly evenly distributed over the four listed available answers: health was described as ‘being free from
illness’ by 26 per cent, as ‘feeling well and being able to cope’ by 25 per cent, as ‘being physically fit and active’ by 31 per cent, and as ‘being able to do the things one tries to do’ by 18 per cent. Men and people from rural areas were much more likely to choose the latter two, action-oriented, answers. Women’s answers in particular, emphasised the importance of ‘being able to cope’ (31 per cent versus 18 per cent of men), especially in the child-rearing age range, 18-39 years (34 per cent).

Respondents were then asked how much control they had over their own health. Only 10 per cent considered that they had ‘little’ or ‘almost no’ control, 24 per cent said they had ‘some’ control, and a majority (70 per cent of women and 61 per cent of men) said they had either a ‘lot of’ control or ‘almost complete’ control. While neither age nor income bore any clear-cut relationship to the response, the subject’s amount of formal education did. Twenty per cent of people reporting little or almost no control had no secondary education, 10 per cent had 1–3 years, 8 per cent 4–6 years of secondary education, and 5 per cent had tertiary education. The corresponding proportions reporting a ‘lot of control’ or ‘almost complete control’ were 60, 62, 65 and 77 per cent.

When asked to select which six changes would most improve their future health, 18 per cent said ‘better diet’, 26 per cent said ‘more exercise’, 17 per cent said ‘stop or reduce smoking’, 3 per cent said ‘reduce alcohol consumption’, 12 per cent said ‘cope better with stress’, and 23 per cent said that no change was needed. Men and women gave similar answers; slightly more men referred to smoking and alcohol, while slightly more women referred to diet and exercise.

Respondents were then asked why they had not made the specified change. Approximately one-quarter said they were too lazy and another quarter said they had no time; 17 per cent said it was too hard, 12 per cent said they were unsure how to go about it, 10 per cent were not convinced it was worthwhile, and 9 per cent said they lacked the facilities, money, or social support.

When asked to pick out the lifestyle or behaviour pattern responsible for the most health problems in Australia, 25 per cent nominated alcohol abuse, 23 per cent the abuse of legal or illegal drugs, and 23 per cent poor diet. Insufficient exercise was nominated by 14 per cent, while 13 per cent considered smoking was the main health problem.
Finally, respondents were asked to state their main source of information about health and lifestyle. The orthodox health professionals (doctors and nurses) are the most frequently cited sources; women also report obtaining much information from magazines. Reliance upon the print media is positively correlated with educational attainment, whereas reliance upon doctors and nurses is strongly inversely related to education.

When asked to identify the behaviour pattern responsible for most health problems in Australia, 25% of respondents nominated alcohol abuse, 23% the abuse of legal or illegal drugs, 23% poor diet, 14% insufficient exercise, 13% smoking.

This information is of great interest. Most important is the awareness of a majority that they had considerable control over their own health. In other words they accepted some degree of personal responsibility for their health. This is a prime focus for the preventive approach that is advocated in this book, entailing the sharing of responsibility between individual and community.

PIONEERING STUDIES

The importance of behavioural factors to health has been indicated by investigations that have been carried out by Lester Breslow and his colleagues in the Human Population Laboratory in California. In one study which extended over fifteen years, mortality was examined in relation to a ‘health practice’ score derived from seven basic health-related behaviours or habits:

- Never smoke cigarettes
- Regular physical activity
- Moderate or no use of alcohol
- 7-8 hours sleep regularly
- Maintaining proper weight
- Eating breakfast
- Not eating between meals
An initial survey of health habits was carried out in 6928 adults in 1965. The first follow-up was carried out in 1970, a second in 1974. The health practice scores (1–7) determined in 1974 revealed little change as compared to 1965: those with a low score in 1965 usually maintained their low score in 1974. (The average score was 4.9 for both the 1965 and 1974 survey.)

A man aged 45 who observed six or seven of the seven health practices had a life expectancy of about 11 years more than one who observed three or less.

The results of the 1974 follow-up indicated clearly that as the health practice score increased so did the age-adjusted mortality rate fall. Men following seven health practices had a mortality rate only 28 per cent of that of men following zero to three health practices. Women following seven health practices had a mortality rate only 43 per cent of that of women with a score of 0–3. This inverse trend of mortality in relation to health practice was shown clearly for cancer, cardiovascular diseases and all other causes in men. In women the trend was evident for total cardiovascular disease, but not for cancer or all other causes. This meant that a man aged forty-five observing six or seven of these health practices had a life expectancy of about eleven years more than that of a forty-five year old man with a health practice score of 3 or less.

Another aspect of lifestyle examined by the Human Population Laboratory in California was the social network – a measure of social connections in the form of marriage, contacts with close friends and relatives, and membership of community groups. The age-adjusted mortality in the most isolated men was 2.3 times higher than in men with strong social connections; among women the difference was 2.8 times. These differences could not be explained by the presence of pre-existing disease or other risk factors. The differences in mortality were apparent with coronary heart disease, stroke and cancer.

The importance of social support in relation to health has also
been shown in a cross-cultural perspective in studies of Japanese migrants to California and Hawaii. A series of 3809 Japanese-Americans in California were classified according to the degree to which they retained a traditional Japanese culture. The most traditional group of Japanese-Americans had a coronary heart disease prevalence rate similar to that observed in Japan. By contrast, the group that had undergone most change towards Western culture had a three- to five-fold excess in prevalence of coronary heart disease. This difference in rate between the groups of Japanese-Americans could only partially be accounted for by difference in diet or smoking or other known risk factors.

It was suggested that the features of traditional Japanese cultural-community ties, group cohesion and social stability were important in protecting the Japanese from coronary heart disease. The contrast between this pattern and the strongly individualistic American emphasis on geographic mobility and ambition may be significant in relation to coronary heart disease.

These several studies indicate the relevance of personal behaviour and social factors to health status. People with high risk health practices and weak social networks do not live so long. These associations were found to be independent of age, sex, socioeconomic status, and initial physical health.

**HEALTH AND LIFESTYLE ACROSS CULTURES**

It is instructive to consider health and lifestyle from the perspective of human cultural evolution. By reference to various historical stages, we can see that lifestyle is part of the dynamic relationship between humans and their environment, including other humans, the plants, and the animals, and the physical environment on which all living beings depend. ‘Ecosystem’ refers to the dynamic equilibrium between all these various components. Changes in any component can affect the other components – an obvious example is the effect of Western communities on the physical environment as they have proceeded to clear vast forests in order to plant crops for agriculture. Massive soil erosion then follows because of loss of the permanent holding structure for the soil. This in turn affects the future of agriculture, and can threaten the food supply.

The three major ecosystems in human history have been: the
The hunter/gatherer ecosystem; the peasant agricultural ecosystem; the affluent industrial ecosystem.

The hunter/gatherer ecosystem

The hunter/gatherer ecosystem has existed for 30,000–50,000 years. Typically, the men do the hunting while the women collect the plant foods. There are a number of these hunter/gatherer groups still surviving today – they include the Australian Aborigines and the Kung Bushmen of Africa (north-west Botswana). The supply of meat is intermittent so that the diet is essentially vegetarian (for this reason, some anthropologists prefer the term gatherer/hunter). Meat, when available, is lean game meat, which has about one-fifth the saturated fat content of meat from domesticated animals.

Survival in the desert was dependent on careful restriction of numbers so that mobility was preserved – only the fittest could survive. The desirability of few (and small) babies is obvious and infanticide was practised. Contraception was achieved by a reduced frequency of menstrual cycles due to the combination of marginal nutrition, physically strenuous lifestyle, and prolonged non-nutritive suckling, which would go on for four or five years. Cause of death was likely to be by starvation, injury or infection or a combination of these. The small size of the nomad communities (up to thirty) precluded significant childhood epidemics, which awaited the arrival of the white man. However, boils, eye and intestinal infections are frequent. The danger of starvation is always present for the hunter/gatherer.

Data on the diet of the Australian Aborigines are available from Arnhem Land in 1960 and from Central Australia in 1971. The diet mainly consists of various edible seeds – supplemented by snake, lizards and mice which were described as reasonably plentiful. On the coast, fish were also available. The desert-dwelling Aborigines when first seen by the nineteenth-century explorers impressed them with their fitness – they looked like well-trained athletes, which indeed they were. Mature height was within the normal European range but the Aborigines had a lighter, lean body frame quite different to the modern urban Australian. More recent studies of blood mineral and vitamin levels revealed a normal range and haemoglobin was normal indicating there was no anaemia due
Studies of Aborigines in South Australia reveal that cardiovascular diseases and obesity develop as a Western lifestyle is increasingly adopted.

to iron deficiency. Blood pressure has been found to be low as late as 1975 and the blood cholesterol was also low (relative to Caucasian Australians). There was no evidence of cardiovascular disease at post-mortem.

It is of great importance that recent studies of Aborigines in South Australia reveal the development of vascular diseases (coronary heart disease, hypertension, diabetes mellitus) and obesity in association with increasing adoption of the Western lifestyle. The rates for these disorders were lower in the less urbanised reserves (Ernabella and Yalata), compared to the more urbanised (Point Pearce, Koonibba) indicating the relevance of lifestyle including particularly diet and physical activity.4

The peasant agricultural ecosystem

The growing of crops and domestication of animals appeared first in the Mesopotamian region between 9000 and 8000 BC. Agriculture provided the base for the great ancient civilisations of China, Egypt, classical Greece, and the Mayans. The highland village of Papua New Guinea provides a good example of the early peasant agricultural ecosystem. The village groups vary in size from 20 to 200, mostly living on the hills and mountains surrounded by their gardens on land cleared from the jungle by fire. Their food is almost entirely root vegetables – taro, sweet potato and yam. Pig once every one to two years would be a great luxury.

The supply of food in this ecosystem is much more reliable than in the hunter/gatherer ecosystem. However, reliance on a single crop presents an ever-present danger of starvation due to crop failure, and can lead to specific deficiency diseases, which the diverse diet of the hunter/gatherer would avoid.

Such deficiency diseases are more likely to occur in children because of their low social status and the extra nutrients required
for growth. Examples are iron deficiency causing anaemia, and iodine deficiency causing endemic goitre and endemic cretinism (brain damage); both conditions are very common in Papua New Guinea, and are also common throughout Asia (China, India, Indonesia). Vitamin A deficiency causing blindness due to softening of the cornea of the eye (keratomalacia) and Vitamin B (thiamine) deficiency due to removal of the husk of the rice by milling also occur.

Another problem is deficiency of protein in children, because it may not be possible for them to eat enough of the root vegetable to ensure an adequate intake due either to lack of availability or indigestibility. The sweet potato which was introduced about 350 years ago grows at higher altitudes than the taro or yam so that settled communities extended from altitudes of 2100 metres up to 2700 metres. But the protein content is low in the sweet potato and it is very susceptible to frosts.

Studies of the diet taken by the people of Murapin in the Western Highlands in the 1970s revealed that sweet potato supplied over 90 per cent of the food, carbohydrate provided 94.6 per cent of the energy with fat only 2.4 per cent and protein 3 per cent. (In Australia, as we shall see later, the figures would be approximately 48 per cent (carbohydrate), 40 per cent (fat), 12 per cent (protein).) The protein intake was 34g per day for males and 27g per day for females (compared with Australian and European figures of 150–200g per day).

Growth in height was not completed until the age of 18 years in females and 24 years in the case of males (compared with 15 years and 17 years in Australian school children). This difference reflects the difference in protein intake.5

Cardiovascular disease is virtually unknown in the Highland communities but has begun to appear in the indigenous community living in Port Moresby where European foods are readily available and a sedentary lifestyle is much more prevalent.

The affluent industrial ecosystem

The industrial revolution dating from the eighteenth century in Europe, which moved with an accelerated pace through the nineteenth century, has led to an unprecedented degree of affluence in the Western world in the latter half of the twentieth
century. One effect of industrialisation has been the development of large cities with populations in millions (Sydney and Melbourne now have populations of three million each, while much bigger cities exist elsewhere – Tokyo, Sao Paulo, New York, London). All the indications are that these cities will increase further in size.

A big city is itself an ecosystem with a metabolism requiring air, food, water from its environment and excreting waste products into its environment. Appropriate provision has to be made for these functions to provide the basis for a healthy lifestyle for its inhabitants.6

Lifestyle in large cities is very different from that of the rural world in preceding centuries. There is only limited space available for living, including recreation, while there is a much greater number of casual human contacts than ever before, which allows the transmission of respiratory infection on a scale never before known. Big city life promotes a sedentary way of life which is reinforced by television and mass spectator sport, public transport and the private motor car. There is increasing pressure of time, with tension as appointments and deadlines have to be kept by white-collar populations of administrators, clerks and professionals of all sorts; other pressures and tensions occur in the mechanised factory production line. Such tensions are associated with the smoking of cigarettes, the drinking of alcohol and the taking of various drugs and ‘tonics’ prescribed and unprescribed, including vitamin and mineral supplements.

Family life is characterised by small nuclear families composed of parents and children, in contrast to the large extended families of most parts of the rural world. One in three marriages in Australia ends in divorce; one in eight children is being raised by a single parent. Children are exposed to long hours of television, as an alternative to longer contact with parents. The mother is likely to be working outside the home with pressure on time for conversation, food preparation and general care of the family, in contrast to the former rural lifestyle. Fathers generally have not compensated by assuming greater involvement with family life. Reproduction is controlled efficiently with modern methods of contraception. The ageing grandparents are likely to be living some distance from the nuclear family and therefore not nearly so readily available for support, advice and recreation. There has also been a loss of
religious belief which provided support and authority for control of behaviour in previous generations. These aspects of contemporary Western life, entailing diminution of social support networks and of a sense of personal purpose and control, are discussed further in chapter 10.

There has been a big change in diet with much greater availability of processed foods of high-energy content – sugar and fat – in contrast to the higher complex carbohydrate content in previous centuries from staple cereals of wheat, with a much higher fibre content. This changed food supply has resulted from a more efficient agriculture, and food industry, with the production of dairy products, meat and processed food, on a scale never before known. The development of larger-scale food multi-nationals incorporating agriculture with the marketing and distribution of food has accelerated this process. The relation of this changed diet to health forms a major topic for discussion in this book. There is now a large body of evidence pointing to the relevance of diet to the twentieth-century epidemic diseases of cardiovascular disease, diabetes mellitus, hypertension, and certain forms of cancer.

THE DEVELOPMENT OF LIFESTYLE

The development of lifestyle is a social phenomenon, beginning in childhood in the setting of family, friends and cultural background. The parents are a very important influence – especially the mother in many societies. The infant learns first from the parents in many different cultural settings. There are great differences between cultures – demand feeding with absence of toilet training is characteristic of the Hindu culture; in Germany a strict control is enforced; in Japan children are seldom punished and mothers are renowned for their patience; distant relationships are characteristic of the Kibbutz in Israel and the crèches of the People's Republic of China, associated with a full working life for both parents.

There is today in developed countries a greater variation in parental relations than previously. Marriage followed by divorce is more common and many other types of relationships occur and are often transient compared to traditional marriage. This means that children do not have the same parental figures for as long as they
did in previous generations. Many school teachers are well aware of the association of ‘problem children’ with troubled family backgrounds.

In these circumstances the role of media, especially television, becomes more significant than otherwise. Children are commonly spending 20-30 hours a week with television (either direct broadcast or video recorder) and its impact is likely to be greater in the absence of stronger and more caring parental figures. The American College of Pediatrics has expressed concern about the ‘gimme syndrome’ which has been developed partly as a result of television advertisements. Many of these advertisements are concerned with foods and so aim to influence the lifestyle of children. Television has been described as the ‘third parent’.

During childhood, extending from the age of five to twelve years, children usually learn to manage their environment and impulses, which is an essential prelude to adolescence. They learn to concentrate and achieve at work and play and to socialise. At school they are no longer the centre of attention, as in the limited family, but are in a group situation requiring conformity and imposing some competition. They discover themselves through contact with others outside the family circle. So the child’s orientation and lifestyle moves from that of the family to that of the outside world. The influence of television on this process has not yet been adequately studied.

In adolescence, the peer group becomes a very important influence on lifestyle. There is a very strong feeling of seeking identity and achieving it through the peer group. Adolescence entails a striving for emotional independence from the parents, a search for stable, intimate relationships, often culminating in marriage, career choice, and the attainment of some philosophy of life or religious belief. In the past these major landmarks have often been achieved by the age of twenty years in developed countries, and together constitute what Erik Erikson has called ‘identity’. Many adolescents do not in fact achieve this personal identity for many reasons – including an inadequate home background and a greater range of choices available today than ever before. In this setting, the use of drugs including alcohol and cigarettes may be seen to offer an opportunity for quick achievement of self-identity –
certainly often a way of flaunting independence from parents.

The high level of alcohol and cigarette consumption by adolescents has become a matter of great concern in many developed countries and will be discussed further in chapters 6 and 7. The probability is that such patterns will persist into adult life. Obviously the advertising industry believes this, and so has paid special attention to the trainee consumers of this age period.

In Australia, one brand of cigarette associated with promotion by one particular television personality, Paul Hogan, had become very popular among adolescents. It is of interest that a public health activist group – Action on Smoking and Health (ASH) – was successful in securing a court injunction leading to the banning of television appearances by Paul Hogan because of contravention of the voluntary code controlling advertisements directed to adolescents. There is also a voluntary code covering advertisements of alcoholic beverages. As this code has evolved, advertisements directed to adolescents that were passed as acceptable ten years ago are no longer considered acceptable. However, the sponsorship of sports heroes and major sporting events by alcohol and tobacco companies, although specifically condemned by the Senate Select Committee of Social Welfare in its 1977 report on Drug Taking in Australia, has become an influential, albeit indirect, form of advertising.

Television offers new possibilities for education and the enrichment of life. It could also be a major resource for promoting a healthy lifestyle. Its control should not be left to the market place.

There is a quiet evolution proceeding in these matters which recognises the hazards to adolescent lifestyle from the media. The same applies to adults but they are less susceptible than are adolescents. Health education programs, aimed at promoting a healthy lifestyle among adolescents, have not been very successful so far, but we shall be considering some new initiatives in chapter 11.

The impact of television on the behaviour of younger age groups
requires much more investigation. Initial studies in the USA, investigating the relationship of television to violence, attempted to minimise the impact. More recent investigations have taken a different view. Experiments are now proceeding in the USA with a 7–9 pm ‘family hour’ from which violence and sex have been largely banished.

The availability of television offers new possibilities for education and the enrichment of human life. It is also a major resource for promoting a healthy lifestyle. Its control should not be left solely to the market place, although as indicated later, the market place is sensitive to a better-educated consumer.

The overall impression that emerges from this brief review of the development of lifestyle is its plasticity and flexibility. There is plenty of evidence indicating that lifestyle can be modified in the interests of better health. This clearly involves both individual and social aspects which will be considered in subsequent chapters.

CHANGES IN HEALTH OVER THE LAST CENTURY

Data available from Australia and other industrialised countries show how health has improved over the past century. One basic indication is by the measurement of life expectancy. The change of life expectancy at birth for both sexes over the period 1930–83 in Australia is shown in figure 2.2.

Three phases can be distinguished. In the first phase there was a long period of increase of life expectancy; this occurred progressively from the 1880s to 1950. The increase is similar for both men and women, and antedated most of the modern advances in medical treatment. This better health status is attributed mainly to improvements in the food supply, housing and control of sanitation. The advent of antibiotics during the 1940s made a late, and small, contribution.

In the second phase, dating from 1950 until 1970, there is a relative plateau indicating little increase. This is particularly true of men, so that the difference between men and women has become greater than it was before. This relative plateau has been due to the epidemics of coronary heart disease (which accounts for 30 per cent of deaths), followed by cancer (20 per cent) and stroke (13 per cent), bronchitis, emphysema and asthma (4.1 per cent) and motor
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   (ii) B.S. Hetzel & H. J. Frith (eds), The Nutrition of Aborigines in Relation to the Ecosystem of Central Australia, CSIRO, Melbourne, 1978. This book reviews the evidence about the lifestyle and diet of Aborigines before and since the coming of the white man.
7 Life expectancy data. Australian data are published annually in the report of the Director-General of Health, Canberra. A published compilation Perspectives on Health by the South Australian Health Commission (1985) provides a useful collection of available data and charts on all aspects of mortality and morbidity with primary reference to South Australia.
8 National Heart Foundation, Risk Factor Prevalence Survey, no.1 (1980), Canberra, 1982. More recent data are provided by the 1983 survey (no. 2).
11 A.J. McMichael, ‘Social class (as estimated by occupational prestige)

### 3 Diet: Fatted Calves or Loaves and Fishes

4 US Senate Select Committee on Nutrition and Human Needs, *Dietary Goals for the United States*, US GPO Washington DC, 1977. This is the famous 'McGovern Committee' which first popularised the idea of dietary goals in the Western world. The committee was initially concerned with the food supply of underprivileged groups in the USA but soon became aware of the major problem of overnutrition.
7 G.A. Bray, 'Obesity, definition, diagrams and disadvantages', *Medical Journal of Australia*, vol. 142, 1985, Supplement, 1 April, 1985. This is an excellent review – in the same supplement there are other good review articles on the other aspects of obesity.
8(i) W.A. Langsford, 'A food and nutrition policy', *Food Nutrition Notes and Reviews*, vol. 36, 1979, pp. 100–3; this is the first formal statement of the dietary guidelines by the Commonwealth Department of Health. (ii) A useful series of articles on the development of dietary guidelines and their implications for food industry and agriculture are published in *Food...*
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