

**POVERTY, HEALTH AND DISEASE IN THE ERA OF HIGH APARTHEID:**

**SOUTH AFRICA, 1948-1976**

**by**

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**November 2006**

## DECLARATION

I declare that “**Poverty, Health and Disease in the Era of High Apartheid: South Africa, 1948-1976**”, is my own unaided work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references. I further declare that the thesis has never been submitted before for examination for any degree in any other university.

Stephens Ntsoakae Phatlane

\_\_\_\_\_  
November 2006

## DEDICATION

I dedicate this thesis to my late parents, **Thalitha** and **Ditsepu** and to all *bo*:

*Mmamogale 'a mašiatheko 'a rumo  
Rena re bowa hupeng, rena re bowa lehupa molapo  
Lehupa le a banyabanya nke ke theko tša bašimane  
Rena re bowa mmotobošupja 'a Bokone bofologa hlolo  
A bo mmamokala 'noka Sebilwane  
Noka tšešo di a lla Mphanama  
Di a lla Mphanama ' Mabula  
Mo pudi ya nsthse ya gola maphaphalešitla*

*Rena re magotlo maso magotlo maripa leselo  
A bo mosadi 'a go tseba go tswala  
A šitwa ke go fepa Mologadi  
A bo koto la tshela legora  
Le lengwe la šala le hlabana ntwā  
Le hlabanela kokoto 'a setsiba sebotse sa makgwadipa  
Setsiba sa bo lahla Puleng 'a Manala  
Le go koloba se sekeng se koloba 'a Manala*

*Re maPhatlane 'a Mmamogale 'a mašiatheko 'a rumo  
Batho ba seapara kobo tšhweu le magoši a sa e apare  
A bo nakana ' mmitša moeletši  
Naka e lletše maPhatlane 'a Mmamogale 'a Mogošadi  
Ka hudu e lletše le bo Kolotane 'a Mathiba*

*Re batho ba bo Tomane ge a tomatomela Legadimana  
A ke gona ge a tomela ba Magakala ' Mafefe  
Ge a bona Kgošikgolo Mampuru a tshetše  
Ke ra yena Mampuru 'a bo Sekwati  
Sekwati sekwatakwatiša motho botlakala  
Sekwati ba bagolo le ba banyane ba mo tseba  
Ge a rotoga ba tloga ba nyabanyaba  
Ba re ke mang wola ' marumo 'a tšhabahla?  
Nkego maleme dithlathlara di fologa lekgwareng*

*Ba re ke maPhatlane 'a mmamogale  
A mašiatheko 'a rumo  
Ke batho ba bo ngwana llela nakana mokhura  
O sehle o mo nee.*

*Ke tšhaba baditi.*

## **ABSTRACT**

A higher infant mortality rate and shorter life expectancy, coupled with a high prevalence of a variety of diseases commonly associated with malnutrition, are usually a reflection of the social conditions of poverty in a society. By arguing that apartheid formed the basis of inequality and therefore the main underlying cause of an unacceptable burden of the diseases of poverty among black South Africans, this thesis, *Poverty, Health and Disease in the Era of High Apartheid: South Africa, 1948-1976*, locates these health problems within their social, economic and political context. It further argues that if health and disease are measures of the effectiveness with which human beings, using the available biological and cultural resources, adapt to their environment, then this relationship underpins the convergence of medical and cultural interests. Under the impact of modern technology and society's dependence upon it, profound cultural changes have taken place and issues of health and the etiology of disease are among the areas most affected by these changes. This thesis explains why, in a pluralistic medical setting, where only modern (scientific) medicine was recognised as legitimate medicine by the apartheid government, for the majority of black South Africans the advent of modern medicine was viewed not so much as displacing indigenous (African) medicine but as increasing the medical options available to them. It is therefore contended here that for most black South Africans, indigenous medicine has played a critical role; it has mitigated the impact of apartheid medicine. Since differences that people perceive in these two medical systems are crucial to the medical choices that they make at the onset of illness, this thesis argues that knowing and understanding the reasons for making such choices would not only have practical value for health authorities in their efforts to improve local, regional and national health service delivery, but would also contribute to a general understanding of human therapy-seeking behaviour in this age of the HIV/AIDS pandemic.

## **LIST OF KEY TERMS**

Apartheid, Poverty, Modern medicine, Indigenous medicine, Inequality, Health, Infectious diseases, Bantustans, Blacks, Whites.

## **ACKNOWLEDGEMENTS**

To borrow the words of Stanley Greenberg, “writing is an indulgence that makes extraordinary demands on other people and institutions, asking that they disrupt their routines to worry about your work”.<sup>1</sup> Researching and writing a doctoral thesis is a solitary exercise in many ways but many people have shared this lonely task with me. Though it is every writer’s nightmare that in thanking people for their contribution to his scholarly work he is sure to leave someone out, I shall not forego to name those who have shared their academic expertise with me.

First and foremost, I owe an immense debt of gratitude to Professor J.P Brits of the University of South Africa and Professor Alan Jeeves of Queen’s University, Kingston, Canada, for supervising this study. Both have been constant and invaluable critics, managing to find time to read drafts of my thesis in great detail. They have given me the benefit of their incisive, constructive criticism; their invariably helpful suggestions have guided and motivated me. Despite the distance involved, Alan Jeeves was always there to breathe life into the sometimes arid and often cryptic documentation of events and to criticise the draft as it developed. Then too, it is said that the editor is a work’s most attentive reader, so I extend a special word of appreciation and gratitude to my colleague, Dr Bridget Theron, for her meticulous attention to detail in editing this thesis.

Although I cannot hope to do justice to all those who willingly offered me enthusiasm and advice, I should particularly like to single out those whose help was available on a more or less continuous basis. In this regard, the study has benefited immensely from the advice and comments of colleagues in the Department of History at the University of South Africa. During the research process, I was privileged to be associated with Professor Greg Cuthbertson, whose interest in my work has enriched this study immeasurably. I also owe a debt of gratitude to Dr Mucha Musemwa for reading parts of the draft and giving me valuable feedback. My thanks too to Professor Russel Viljoen for not only providing me additional sources relevant to my study, but for giving me encouragement and moral support when it became difficult to juggle my teaching duties with the demands of compiling this thesis.

In addition to these particular colleagues, I wish to record my indebtedness to the scholars

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1 S.B. Greenberg, *Legitimizing the Illegitimate: State, Markets and Resistance in South Africa* (Berkeley, University of California Press, 1987), p. xx.

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Above all, I would like to thank the Almighty for protecting and guiding me. *Ga se ka bohlahe bjaka, ke ka mogau wa gago. Bophelo ke wena fela Senatla, empa batho ga ba tsebe, ba lahlegetšwe ke tsela, ba kgelošitšwe ke sebe.*

**Stephens Ntsoakae Phatlane**

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## **NOMENCLATURE**

Owing to the arbitrary racial classification of South African society as expressed in the Population Registration Act, a number of terms have become politically loaded. Yet it is next to impossible to attempt an analysis of state policy in South Africa without recourse to these

terms. In his preface to *The Political Mythology of Apartheid*, the historian Leonard Thompson claims that anyone writing about South Africa has to cope with “a terminological minefield,” because of the controversial nature of this country’s racial nomenclature.<sup>2</sup> This is certainly true. To analyse the impact of apartheid on medicine during the period 1948-1976 the use of racial categories cannot be avoided. Although use of the terms *Black* and *White* to denote an African and a person of European descent respectively is commonplace throughout southern Africa and other societies on the continent and indeed worldwide, these are politically nuanced terms. Therefore in this study, whenever it is necessary to distinguish between the specific South African population categories, I use the labels *African*, *Coloured*, *Indian* and *White*. I consistently use these terms when I refer to them separately because they were the official, legal categories as defined by the Population Registration Act. Their use here, however, does not imply legitimacy of the apartheid terminology nor the writer’s endorsement of such labels.

When I use the category *Black* without further qualification, (except when I specifically say *black* South Africans) I refer to people of Afro-Asian descent (Africans, Coloureds and Asians collectively). This is not used simply as an alternative for Africans, but to portray a common unity that is forged out of the experience of discrimination and oppression in South African society. Although it carries the risk of denying the diversity of cultures and ethnicities that form South Africa’s Black population, a capital B is used to indicate that the term refers to the social and political identity associated with being Black, rather than the colour of people’s skin. According to De Wet Nel, Minister of Bantu Administration and Development in 1959:

to refer to all Blacks in Africa as “Africans” was unscientific, misplaced and created a perverse spirit of intolerance by one national group against the rest ... The word ‘African’ used in this sense carried with it an insinuation that Africa belongs only to the Black inhabitants of the country.<sup>3</sup>

Notwithstanding the foregoing argument, the category *Africans* is used in this thesis to refer specifically to black South Africans. Similarly, *Afrikaners*, refers to the settler white community that came into being from the end of the seventeenth century. *South Africa* refers to the territory of the modern Republic of South Africa, including the former ‘homelands’ or

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2 L.M. Thompson, *The Political Mythology of Apartheid* (New Haven, Yale University Press, 1985), p .ii. The same sentiments on apartheid terminology are shared by Merle Lipton in her *Capitalism and Apartheid: South Africa, 1910-1986* (Wildwood House, David Philip, 1986), pp. vii-viii.

3 De Wet Nel, *The Argus*, 20 March 1959.

'bantustans' that were created from the early 1960s within its borders as part of the apartheid programme and were disbanded in the early 1990s.

However controversial the use of the terms, Coloureds, Indians, Blacks and Whites etc may be, they cannot be avoided in historical reconstructions because they are understood here only as social constructs embedded in the apartheid system and not as natural subdivisions of humankind in South Africa or anywhere else in the world. The biases inherent in the terms are in fact a significant and telling component of the phenomenon "apartheid" that is a central concern of this study. The assumptions and stereotypes that need to be challenged are already present, and if our language reflects them, then it may be useful to recognise the biases that are inherent in the language that we use. Thus, what might begin as a justification of racist terminology can emerge as an effective way of challenging and reforming racist assumptions and biases, both conceptually and linguistically. Therefore, they have been used throughout this study only as part of what is to be understood, and in no way signifying what Leonard Thompson calls, in the same source, a "justification of the contorted apartheid lexicon".

Also very confusing can be the unexplained use of concepts such as segregation, apartheid, separate development and multinational development. Similarly, concepts like Native reserves, Bantu homelands, bantustans, self-governing states, independent national states, etc. should be used within their particular historical contexts. For example, in the 1960s the tendency of the National Party was to drop the word apartheid from the vocabulary of politics because it was associated with practices which the world viewed as discriminatory. In its place, "separate development" was preferred; something new and different; something which avoided injustice but gave "alike to all only separately".<sup>4</sup>

Throughout the thesis, for the sake of convenience, the male gender is used. This could equally well have been expressed in the female gender, as there is no gender discrimination in ill health and death, which Sop Ntuli regards as the two most democratic phenomena imaginable. Similarly, the title Doctor (Dr) has also been a hotly contested concept in South African medical literature. But nowhere else is the controversy more apparent than in the *South African Medical Journal* editorial:

... in South Africa, all sorts of practitioners with only the slightest training or

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4 C.M. Tatz, *Shadows and Substance in South Africa: A Study in Land and Franchise Policies Affecting Africans 1910-1960* (Pietermaritzburg, University of Natal Press, 1962), p. 208.

connection with the profession of medicine are calling themselves “doctor” without specifying what kind of practitioners they are ... in South Africa chiropractors and homeopaths and other non-medically qualified practitioners have also taken to so calling themselves.<sup>5</sup>

For the sake of clarity and to avoid confusion, I have used the word “Doctor” throughout the study to refer only to university-trained practitioners of modern medicine and I have used the word Ngaka,<sup>6</sup> to refer to practitioners of indigenous African medicine, sometimes without distinction as herbalists, diviners and sangomas. I concur with Griffiths and Cheetham that

Even the English words like diviner, healer, medicine-man, and many others do not seem to adequately cover the practice of a *ngaka* – a person who has been made special by the ancestors so as to carry on the respectable practice of being a custodian of culture ...<sup>7</sup>

I also deliberately use the word Ngaka as opposed to the colonial nomenclature “Witchdoctor”, not only because the latter name is regarded as derogatory by the people to whom it refers, but also because there is no evidence that every practitioner of indigenous medicine is automatically engaged in or is furthering the objectives of witchcraft. For many people, this pejorative term has come to stand for savagery, superstition, irrationality and malevolence. As Sodi explains,

Like other debates raised against indigenous healing, the view that practitioners of indigenous medicine are associated with witchcraft appears to be more of a reflection of unfavourable Western attitudes that are disguised as scientific grounds for the invalidation of indigenous healing.<sup>8</sup>

Though in reality the Afrikaners also emerged as an indigenous ethnic group as early as the eighteenth century, I use the word “indigenous medicine” to refer to medicine as practised by black South Africans from time immemorial until the present day. I prefer this designation to “traditional medicine,” because the latter gives rise to a host of other questions, the answers to which are difficult and complex. Besides indicating the endogenous character of this branch of medicine, for Marion Wallace, “indigenous medicine” also suggests medical practices with an origin in Africa, if not purely African, while “traditional medicine” sets up tradition as if it were some abstract, unchanging corpus of practices and knowledge, which

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5 Editorial, *South African Medical Journal*, (1985), p. 685.

6 Though the word, “ngaka” is a Sotho rendition of “doctor”, I have made the distinction in this study between a modern doctor and a practitioner of indigenous medicine.

7 J.A. Griffiths and R.W.S. Cheetham, “Priests Before Healers – An appraisal of the iSangoma or iSanusi in Nguni Society,” *South African Medical Journal*, vol. 62 (1982), pp. 959-60.

8 T. Sodi, “Towards Recognition of Indigenous Healing: Prospects and Constraints,” *Chasa: Journal of Comprehensive Health*, vol. 7, no. 1 (1996), p. 8.

we today know to be evolving in a dialectical relationship of adaptation and competition with what is called “modern” or Western medicine.<sup>9</sup> Similarly, to refer to biomedicine as “Western medicine” is very problematic in a number of respects. As Leslie Swartz noted:

The categories “Western” and “non-Western” are our creations and reflect neither the diversity of beliefs (often mutually contradictory) that people hold, nor the commonalities that exist across apparently very different groups of people.<sup>10</sup>

In one respect it is possible that people in Western traditions may well hold stereotypic non-Western beliefs, and vice versa. Again, the distinction itself is potentially problematic ideologically, in that the terms may reflect biased and loaded assumptions. I have therefore decided that if indeed the labels, “Western” and “non-Western” are such a problem, then why use them? Instead, for the purpose of this study, I find “modern medicine” or simply “biomedicine” more appropriate and relevant.

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9 M. Wallace, “‘Making Tradition’: Healing, History and Ethnic Identity Among Otjiherero-speakers in Namibia, 1850-1950”, *Journal of Southern African Studies*, vol. 29, no. 2 (2003), p. 355. For an in depth exposition of this aspect, see H. Deacon, “The Cape Doctor and the Broader Medical Market, 1800-1850” in H. Deacon, H. Phillips and E. Van Heyningen (eds), *The Cape Doctor in the Nineteenth Century: A Social History* (Amsterdam, Rodopi, 2004), p.49.

10 L. Swartz, *Culture and Mental Health: A Southern African View* (Cape Town, Oxford University Press, 1998), p. 92.

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### **ABBREVIATIONS AND ACRONYMS**

AHPC	Allied Health Professions Council
AIDS	Acquired Immunodeficiency Syndrome
ANC	African National Congress
ARI	Acute Respiratory Infection
BAD	Bantu Affairs Department
BCG	Bacillus Calmette Guerin (anti-tuberculosis vaccine)
BCM	Black Consciousness Movement
BIG	Basic Income Grant
BMR	Bureau of Market Research
CAD	Cape Archival Depot
CBW	Chemical and Biological Warfare
CDC	Centre for Disease Control
CHD	Coronary Heart Disease
CRHO	Chief Regional Health Officer

CMC	Christian Medical Commission
CSIR	Council for Scientific and Industrial Research
DDT	Dichloro-Diphenyl Trichloro-Ethane
FOSA	Friends of the Sick Association
GDP	Gross Domestic Product
GNP	Gross National Product
GST	General Sales Tax
HEL	Household Effective Level
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
HSL	Household Subsistence Level
ICD	International Classification of Disease
IES	Income and Expenditure Survey
INH	Isoniazid
MASA	Medical Association of South Africa
MEDUNSA	Medical University of Southern Africa
MOH	Medical Officer of Health
NAD	Native Affairs Department/National Archival Depot
NEC	Native Economic Commission
NGO	Non-governmental Organisation
NHSC	National Health Services Commission
NP	National Party
NNRI	National Nutrition Research Institute
NRC	Natives Representative Council
ORT	Oral Rehydration Therapy
PAC	Pan Africanist Congress
PEM	Protein Energy Malnutrition
PCM	Protein Calorie Malnutrition
PDL	Poverty Datum Line
PHC	Primary Health Care
RDA	Recommended Daily Allowance
RDP	Reconstruction and Development Programme
RHOSA	Regional Health Organisation of Southern Africa
RSA	Republic of South Africa

SABCTV	South Africa, Bophuthatswana, Ciskei, Transkei, Venda.
SABRA	South African Bureau of Racial Affairs
SACC	South African Council of Churches
SAIRR	South African Institute of Race Relations
SACTU	South African Congress of Trade Unions
SAJM	South African Medical Journal
SANTA	South African National Tuberculosis Association
SASO	South African Students' Organisation
SOWETO	South-western Townships
STD	Sexually Transmitted Disease
TB	Tuberculosis
TBA	Traditional Birth Attendant
TBRI	Tuberculosis Research Institute
TAM	Traditional African Medicine
TM	Traditional Medicine
TRC	Truth and Reconciliation Commission
UNICEF	United Nations Children Emergency Fund
UNISA	University of South Africa
USA	United States of America
UNO	United Nations Organisation
WHO	World Health Organisation

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## CHAPTER 1

### INTRODUCTORY ORIENTATION

Those who do research belong to a community of scholars, each of whom has journeyed into the unknown to bring back a fact, a truth, a point of light. What they have recorded of their journey and their findings will make it easier for you to explore the unknown: to help you to discover a fact, to bring back a point of light.<sup>1</sup>

#### 1.1 Setting the scene

Futuristic literature of the 1970s has diagnosed human society in our age and pronounced it sick, to the point of suggesting that humans were an endangered species.<sup>2</sup> However, it was probably after the publication of Alvin Toffler's *Future Shock* (1970) that the possibility of a very bleak future entered the consciousness of people all over the world.<sup>3</sup> John Platt's observation was even more blunt: "We may have even less than a 50-50 chance of living until 1980".<sup>4</sup> Based on such apocalyptic warnings of impending doom, which implicitly suggest the extermination of the human race, it was not surprising that in 1975 the committee that planned the World Future Society's second general assembly, after spending weeks trying to choose a theme for the meeting finally decided on "The Next 25 Years: Crisis and Opportunity."<sup>5</sup> Though most of these works were written during the Cold War against the background of a disturbing rate of nuclear proliferation and possible war before the blood-stained twentieth century was out, it was perhaps Kenneth Watt's warning that came closest to the mark:

The world is in the grips of a critical disease, characterized by excessive, undirected, and destructive growth. The world's planners are failing to take adequate steps to deal with the disease because of a basic human tendency to ignore potential enormous disasters as 'unthinkable' since they have never

- 
- 1 P. Leedy, *Practical Research Planning and Design* (London, Macmillan Publishing, 1989), p. 66.
  - 2 See Roberto Vacca, *The Coming Dark Age* (New York, Doubleday, 1973) and G.R. Taylor, *How to Avoid the Future* (London, Secker & Warburg, 1975).
  - 3 A. Toffler, *Future Shock* (New York, Random House, 1970).
  - 4 J. Platt, *Perceptions and Change: Projections for Survival* (Michigan, University of Michigan Press, 1970), p. 163.
  - 5 E. Cornish, *The Study of the Future: An Introduction to the Art and Science of Understanding Tomorrow's World* (Washington DC, World Future Society, 1977), p. 38.

happened before.<sup>6</sup>

Although historians are not in the business of speculating about the future it is easy to suggest, with the wisdom of hindsight, that in the light of the apparent failure of mass prevention programmes, unless some effective vaccine intervenes in the short term to arrest the HIV/AIDS pandemic<sup>7</sup>, the scourge has the potential to bring about the outcome that these writers warn us about. Admittedly, significant medical advances were among the cornerstones of human development in the previous century. These included the total eradication of smallpox and advances in the ability to manage tuberculosis, typhoid, leprosy, syphilis and more recently, some forms of cancer.<sup>8</sup> Though some of these diseases are still great killers of the poor in many parts of the world, despite the availability of cheap and effective drugs to treat them, it can be argued that through population-based interventions such as the development of adequate water and waste disposal systems, the introduction of mass immunisation and major improvements in levels of nutrition, communities have generally managed to control and in some cases, prevent major lethal, infectious diseases. For its part, South Africa also made international headlines in the 1960s with Dr Chris Barnard's pioneering heart surgery, previously unheard of in the history of medicine, at the Groote Schuur Hospital; South Africa has since enjoyed international recognition and public acclaim in the terrain of organ transplants.<sup>9</sup> For example, in 1971 the fourth heart and lung transplant in the world was also performed at the Groote Schuur Hospital, while at the same time the first pancreas transplant in the southern hemisphere was carried out at Tygerberg Hospital by Professor D.F. du Toit of the Faculty of Medicine at the University of Stellenbosch.<sup>10</sup>

Despite these remarkable “high-tech” medical achievements, albeit available only to the lucky few (mostly white) who could afford medical insurance, basic health care remained out of reach of a great number of ordinary South Africans (mostly black). What this outcome then

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6 K.E.F. Watt, *The Titanic Effect: Planning for the Unthinkable* (New York, E.P. Dutton, 1974), p. 72.

7 *Time* magazine has referred to HIV/AIDS as “humanity’s deadliest cataclysm”, See *Time*, 17 July 2000, p. 31.

8 See J.N. Hays, *The Burdens of Disease: Epidemics and Human Response in Western History* (New Brunswick, Rutgers University Press, 1998), p. 240. Although cancer can be overcome, it must be emphasised that this can only occur if the disease is detected early and appropriate steps are followed. Available evidence also suggests that most forms of tuberculosis (a particularly resistant form has recently made news headlines) can only be defeated once the full course of treatment is taken. If this is interrupted by relocations from areas with adequate health facilities to those where there are none, as will be shown in this thesis, the outcome can be jeopardised.

9 Elise Keyter, “Laudable Medical Achievements,” *South African Panorama*, vol. 33, no. 7 (July 1988), p. 16.

10 *Ibid.* It is remarkable that South Africa also enjoyed international recognition in the area of nuclear medicine.

suggests is that medical technology is by itself inadequate, if not inappropriate for addressing the health problems of mainly rural communities. This limitation was best recognised by John Bryant, who rightly observed that, “more than half of the world’s people do not have access to health care, while for many of those who do, the care they receive does not answer the problems they have”.<sup>11</sup> Internationally, an effort was made in the late 1970s to address this particular limitation in medicine by resurrecting the principles enunciated as early as the 1930s and 1940s by scholars like John Ryle and the social medicine movement. It was in 1978 at Alma Ata that the member states of the World Health Organisation (WHO) pledged their commitment to the attainment, through the primary health care strategy, of “health for all by the year 2000.”<sup>12</sup> It is refreshing to note that this social medicine approach had South African roots going back as far as the National Health Services Commission and the pioneering clinic at Pholela in the 1940s, the details of which are central to chapter two of this study.<sup>13</sup> Notwithstanding such progressive approaches to health care however, hardly three years after this relative Alma Ata optimism, there were already warnings of a new, deadly, “sexually transmitted disease,” perhaps comparable in magnitude to the worst and most tragic pandemics in human history.<sup>14</sup> Thus, by the time of the Alma Ata target date of “health for all”, the epidemic had already claimed three million lives globally, while a further 36.1 million people had already been infected.<sup>15</sup> By any standards, HIV/AIDS statistics involving South Africa are cause for alarm. With one in nine South Africans infected in 2000, the country had the largest number of people living with HIV/AIDS in the world.<sup>16</sup> What was even more alarming was the estimation then that the daily infection rate in the country

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11 J. Bryant, *Health and the Developing World* (London, Cornell University Press, 1978), p. ix.

12 Alma Ata, *Report of the International Conference on Primary Health Care in USSR* (Geneva, WHO, 1978).

13 For a full account of these initiatives, see among others A. Jeeves, “Health, Surveillance and Community: South Africa’s Experiment with Medical Reform in the 1940s and 1950s”, *South African Historical Journal*, 43 (2000), 244-266; Shula Marks, “South Africa’s Early Experiment in Social Medicine, its Pioneers and Politics”, *American Journal of Public Health*, 87 (1997), 452-59 and D. Harrison, “The National Health Services Commission, 1942-44, its Origins and Outcome”, *South African Medical Journal*, 83 (1993), 679-84.

14 C.L. Gesheker, “Rethinking AIDS in Africa”, Paper presented at the 37<sup>th</sup> Annual Meeting of the African Studies Association, Toronto, 3-6 November 1994, p.1. For a detailed exposition of epidemics in human history, see, Hays, *The Burdens of Disease: Epidemics and Human Response in Western History*.

15 UNAIDS, *AIDS Epidemic Update* (Geneva, UNAIDS, 2000), p. 143.

16 S. Horwitz, “Migrancy and HIV/AIDS: A Historical Perspective”, *South African Historical Journal*, 45 (November 2001), 103-123, p. 103. It is noteworthy that there was an initial period of denial in South Africa with the media focusing on such neighbours as Botswana, Zimbabwe and Uganda. But when the true statistics about the prevalence and infection rates were revealed, with Kwazulu-Natal leading the list, it was a shock that South Africa was in fact under siege by the epidemic from which it was thought to be protected to some degree by both the wealth and anti-homosexual and prostitution legislation.

accounted for 10 per cent of the world's total.<sup>17</sup> But it is Nicoli Nattrass' most recent revelation that more than one in five adult South Africans are HIV-positive,<sup>18</sup> that makes the epidemic one of the most serious demographic threats to the new democratic order. With five million people infected in 2006 and 500 000 more being infected annually,<sup>19</sup> it is understandable why Patrick Furlong and Karen Ball regard post-apartheid South Africa as home to more HIV-positive people than any other country in the world.<sup>20</sup>

The fact that internationally, poverty is recognised as a major driver of the epidemic, explains why individuals and countries who have access to the fewest resources carry the greatest burden of ill health and mortality from HIV/AIDS. Eminent historians such as John Iliffe,<sup>21</sup> attribute the uniqueness of the African AIDS epidemic to "time". He argues that Africa suffers the worst epidemic primarily because it experienced the epidemic first, and that unlike in other parts of the world, in Africa the epidemic established itself in the general heterosexual population a little earlier and perhaps even before anyone knew the disease existed. It is however interesting to note that "poverty" as a major factor fuelling the epidemic, is still hard to ignore in Iliffe's list of critical factors in the spread of AIDS in Africa.<sup>22</sup> In the light of this assertion, it is hardly surprising that Africa, which at the turn of the century accounted for 34 of the world's 49 poorest nations, has become the epicentre of the AIDS pandemic.<sup>23</sup> What is in fact surprising is that South Africa, arguably one of the richest countries by sub-Saharan standards, had one of the highest per capita HIV prevalence and infection rates in the world at the time.<sup>24</sup> It is against the backdrop of these contradictions that the assertion is made in this study that any medical history of post-World War II South Africa will remain incomplete if it disregards tracing the historical roots of the major health problems experienced by black South Africans. Only then will it be possible to apply what can be learnt from previous experience of disease control to the management of the contemporary epidemic of HIV/AIDS.

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17 *Business Day*, 12 October 1999.

18 N. Nattrass, *The Moral Economy of AIDS in South Africa* (Cambridge, University of Cambridge Press, 2004), p. 13.

19 *Pretoria News*, 27 October 2006.

20 See Patrick Furlong and Karen Ball, "The More Things Change: AIDS and the State in South Africa, 1987-2003", in A.S. Patterson (ed.), *The African State and the AIDS Crisis* (Aldershot, Ashgate, 2005), pp. 127-153.

21 J. Iliffe, *The African AIDS Epidemic: A History* (Athens, Ohio University Press, 2006), pp. 1, 158.

22 *Ibid.*, p. 63.

23 *Pretoria News*, 13 November 2001.

24 C. Van Aardt, "The Demographic and Economic Impact of AIDS in South Africa", Inaugural lecture, Bureau of Market Research: UNISA, 14 March 2002, p. 1.

Considering that South Africa during the period covered in this thesis could justifiably be regarded as being in the forefront of medical technology, if not a pace-setter in social medicine and other medical innovations, the foregoing HIV/AIDS statistics suggest that something fundamental went wrong with the country's approach to issues of health and disease. In Elizabeth van Heyningen's view, the entire story of HIV/AIDS in the country would have been very different had the vision for a new medical approach (suggested in the South African Health Services Commission alluded to above), been consistently implemented at the end of the Second World War.<sup>25</sup> Social research has revealed that HIV/AIDS is spread readily and more rapidly in poverty-stricken and vulnerable populations. Alan Whiteside and Clem Sunter for example, like most of their contemporaries, have blamed apartheid for the grinding poverty, overcrowding, inequality, social dislocation and conflict in South Africa, all of which are conducive to the spread of HIV/AIDS.<sup>26</sup> Nicoli Nattrass on the other hand, after examining the link between unemployment, poverty and disease, also concludes that the history of apartheid-engendered inequality lies at the root of the HIV/AIDS problem in South Africa.<sup>27</sup> In the light of all these revelations it would not be out of place to suggest, from an historical point of view, that it was the combined effects of poverty and the peripheral position in national politics of black South Africans during apartheid, that inevitably gave HIV/AIDS in this country the necessary foothold that it required. It was perhaps the recent appearance of a deadly multi-drug resistant (MDR) and extensively drug-resistant (XDR) strains of tuberculosis,<sup>28</sup> strains that actually thwart the first line of antibiotics conventionally used to treat tuberculosis, that served as a wake up call for mankind to accept that it is not *uhuru* yet with regard to modern medicine's assumed ability to overcome disease. I have also pointed out elsewhere that the prevalence of malnutrition and a variety of diseases of poverty, emanating mainly from the collapse of rural food production, resulted in a population whose health was consistently compromised, thus making it increasingly vulnerable to the spread of epidemics.<sup>29</sup>

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25 E. Van Heyningen, "Recent Research on the Social History of Medicine in Africa", *South African Historical Journal*, 45 (2000), p. 183. See also footnote 13 above.

26 A. Whiteside and C. Sunter, *AIDS and the Challenge for South Africa* (Cape Town, Tafelberg and Human & Rousseau, 2000).

27 Nattrass, *The Moral Economy of AIDS in South Africa*, p. 15.

28 See *Pretoria News*, 27 October 2006.

29 S.N. Phatlane, "Poverty and HIV/AIDS in Apartheid South Africa", *Social Identities: Journal for the Study of Race, Nation and Culture*, vol. 9, no. 1 (2003), 73-91. See also Hays, *The Burdens of Disease*.

In countries such as Cuba the state perceived health as a right of all citizens and therefore structured society in such a way that it allowed for maximum participation in health care through mass mobilisation campaigns and neighbourhood committees.<sup>30</sup> In sharp contrast, in apartheid South Africa the state tragically left health care to market forces, denying political rights to the majority of the population. This went counter to the letter and spirit of health as understood by an eminent scholar of social medicine, John Ryle, that “there is one prime quality that no man of whatever nation, race or creed should grudge another, and that is the equality of health opportunity”.<sup>31</sup>

As could be expected, the resulting health policies in South Africa from 1948 onwards reflected the political system itself, with health services being used as an instrument of apartheid to uphold the social, economic and political institutions structured along legally defined racial categories. Not surprisingly another related factor central to the apartheid programme was the fragmentation of the country’s health services through the creation of an additional ten ethnic-based departments of health. Consequent to this fragmentation, in my view, the country lacked the necessary infrastructural readiness to respond adequately and timeously to the scourge of HIV/AIDS. In view of the foregoing, this thesis, which seeks to trace the historical roots of the health problems of black South Africans by examining the role of apartheid in the creation of poverty and the relationship between poverty, health and disease in the period 1948-1976, argues that black South Africans should nevertheless not be viewed as mere hapless, helpless victims of circumstances, but as people who also demonstrated a resilience and the will to survive against overwhelming apartheid odds. They did this through recourse to their own tried and tested indigenous therapies and practices that had sustained them for centuries, albeit in a country that always had the lowest regard for indigenous cultures and their healing alternatives.<sup>32</sup>

## 1.2 The central concerns of the study

This thesis is anchored on three closely related questions. Firstly, what was the basis of the disparities in health status between black and white South Africans in the period 1948–1976?

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30 G. Walt, *Health Policy: An Introduction to Process and Power* (Johannesburg, Wits University Press, 1994), p. 11.

31 Friends of the Sick Association, acc. 63, *A Story of Faith: 33<sup>rd</sup> Annual Report*, 7 June 1975.

32 Largely because of the racism intrinsic in European conceptions of Africans and their cultures, it would have been extreme optimism for Africans to expect White governments in South Africa to have high regard for indigenous medicine to the point of acknowledging its utility, whatever that may mean.

Secondly, how did black South Africans adapt to, cope with, and at times struggle against their health problems during this period when health resources, both human and material, were allocated according to political and ideological considerations rather than in accordance with health criteria? Thirdly, and perhaps most importantly, what accounted for the persistence of indigenous medicine in spite of the country's well publicised achievements in modern medicine?

In responding to these questions, this study concludes as follows: First, that apartheid, as the basis of inequality and therefore of widespread poverty, lies at the root of the health problems of black South Africans during the period under review and beyond.<sup>33</sup> Second, amidst all the poverty, hardship, and inadequacies of the modern medical system during this period, black South Africans were not merely helpless victims; they responded creatively to safeguard their health. And third, although a health care system involves a complex of scientific and cultural processes, for much of the apartheid period it was only the scientific component which dominated the state's perception of health care – to the exclusion of the cultural component. However, despite the rapid social change brought about by greater access to formal education and competing religions, and despite its internal structural weaknesses as a system, indigenous medicine has survived.<sup>34</sup> It has been relied upon by the majority of black South Africans for the treatment and management of many illnesses and the provision of midwifery services; it also serves as an element of social regulation. "Indigenous medical practitioner" is of course a very general term that encompasses a broad variety of roles such as religious-medical specialists, herbalists, traditional birth attendants or midwives and a combination of these skills. Though Martin West conveniently classifies them into the categories of faith healer, prophet and isangoma or diviner,<sup>35</sup> it appears that the best classification is that provided by Harriet Ngubane. She acknowledges the role of the faith healer in health care,

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33 There is persuasive evidence that despite the rhetoric, even the post-apartheid governments have failed to adequately address the issue of poverty in African communities. In fact, the evidence suggests that poverty has actually become worse since 1994. For an elaboration of this point, see Furlong and Ball, "The More Things Change: AIDS and the State in South Africa, 1987-2003"; Patterson (ed.), *The African State and the AIDS Crisis*, pp.137-8; J. Seekings and N. Nattrass, *Class, Race and Inequality in South Africa* (New Haven, Yale University Press, 2005).

34 See for example I. Sindiga et al (eds), *Traditional Medicine in Africa* (Nairobi, East African Educational Publishers, 1995); D. Dunlop, "Alternatives to Modern Health Delivery Systems in Africa: Public Policy Issues of Traditional Health Systems", *Social Science and Medicine*, vol. 9 (1975); R.H. Elling, "Relations Between Traditional and Modern Medical Systems", *Social Science and Medicine*, vol. 15 (1986); P. Singer (ed.), *Traditional Healing: New Science or New Colonialism? Essays in Critique of Medical Anthropology* (New York, Conch Magazine Ltd, 1977).

35 M.E. West, *Bishops and Prophets in a Black City: African Independent Churches in Soweto* (Cape Town, David Philip, 1975).

and goes on to explain the distinction between the isangoma (usually, but not exclusively, female) who uses indigenous medicines and techniques in a clairvoyant manner, and the inyanga (usually, but not exclusively, male) who uses African medicines in a non-clairvoyant manner.<sup>36</sup> On the whole, indigenous medical practitioners are the main custodians of African culture and therefore indigenous medicine represents the authoritative delivery of that culture's cumulative experience with the healing arts. As Charles Good puts it, "It relies on the resources of the past; yet to remain vital to contemporary society it must remain open to the future and in dialogue with the total culture".<sup>37</sup> Although indigenous and modern medicines proceed from fundamentally different – and frequently contradictory principles – about the causes of disease and how it should be treated, there are nevertheless points of convergence between the two that can be developed to ensure complementarity. For example, by seeing themselves in a battle against afflictions that interfered with well-being, practitioners in both systems generally share a commitment to help their patients. Thus, by merely acknowledging that herbalists possess knowledge of natural biochemical preparations, some of which have undoubted therapeutic benefit, proponents and practitioners of modern medicine can slowly begin to accept that they too have something important to learn from indigenous science. Again, perhaps unlike the modern medical practitioners, indigenous healers appear to be working within a holistic approach and for this reason their ministrations represent a major therapeutic resource in the country.<sup>38</sup> Since African customs and traditions view disease largely as a man-made phenomenon, brought on either through the agency of ancestral spirits or malevolent witches, indigenous medicine is usually the therapeutic intervention of choice at the onset of disease, rather than modern medicine. Cheetham and Griffiths, both psychiatrists working among the Zulu people in KwaZulu Natal, have also found during their clinical practice at King Edward VIII Hospital in Durban, that while Zulu patients submitted themselves for the removal of the symptoms of their health problems, they invariably returned to the isangoma for removal of the cause; by implication this was to "complete the treatment".<sup>39</sup> Hence today, no less than in the period covered in this study, black South Africans still face a bewildering choice of medical treatments that are an

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36 H. Ngubane, "Clinical Practice and the Organization of Indigenous Healers in South Africa", in S. Feierman and J.M. Janzen (eds), *The Social Basis of Health and Healing in Africa* (Berkeley, University of California Press, 1992), p. 366.

37 C.M. Good, *Ethnomedical Systems in Africa: Patterns of Traditional Medicine in Rural and Urban Kenya* (New York, The Guildford Press, 1987), p. 2.

38 I.M. Mkhwanazi, *An Investigation of the Therapeutic Methods of Zulu Diviners* (MA dissertation, Unisa, 1986), p. 4.

39 R.W.S. Cheetham and J.A. Griffiths, "Patients Before Healers: An Appraisal of the Isangoma in Society", *South African Medical Journal*, vol .58 (1980), pp. 959-60.

alternative to modern medicine. This explains why, in spite of the achievements of high-tech medicine referred to above, the majority of Africans continue to be committed to indigenous healing practices.

Historically, it stands to reason that in South Africa, as in the rest of the African continent, different conceptualisations of medical systems have always coexisted side by side. Even a superficial examination of anthropological literature clearly reveals that some highly elaborate theories of health and disease existed alongside the widespread belief in supernatural powers.<sup>40</sup> This has resulted in the development in this country of two medical traditions alongside each other which still persist even beyond apartheid. Several reasons have been advanced why Africans utilise modern medicine while simultaneously having recourse to indigenous medicine without any feelings of contradiction. In the first place, the majority of Africans perceive disease as a cultural experience and thus interpret illness from a cultural perspective.<sup>41</sup> The belief in the social causes of certain illnesses is critical in the choice of therapeutic intervention. But compounding this, particularly in the period under review, depending on a person's geographic location in the country (urban or rural), the choice of therapeutic intervention was often influenced by issues of the accessibility and cost of medical services available. Another closely related matter in urgent need of academic attention, but briefly echoed in chapter three of this study, is the relationship between apartheid-created poverty and the health (or lack thereof) of black women. Admittedly there is general consensus that women live longer than men, but contrary to this conventional wisdom, in apartheid South Africa, black women suffered higher levels of illness and poor health to the extent that they were even outlived by white males. Quite often, the exploration of women's poverty has tended to focus primarily on the reasons for their vulnerability to poverty and deprivation. I have pointed out elsewhere in this enquiry that while the study of poverty has been ongoing for years, traditional definitions and forms of measurement have largely been gender-blind because they have focused on women's poverty as experienced by households rather than individuals. Though space does not allow for an in-depth exploration of this point, it is important to recognise that studies thus far have tended to obscure the poverty and deprivation of black women that is experienced within affluent households.<sup>42</sup>

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40 D.W. Hammond-Tooke, *Rituals and Medicines: Indigenous Healing in South Africa* (Johannesburg, AD. Donker, 1989); D. Landy, *Culture, Disease and Healing: Studies in Medical Anthropology* (New York, Macmillan, 1977); J. Janzen, *Ngoma: Discourse of Healing in Central and Southern Africa* (Berkeley, University of California Press, 1992).

41 Interview with Nganka Conrad Tsiane, 4/11/ 2004.

42 S. Payne, *Women, Health and Poverty: An Introduction* (New York, Harvester Wheatsheaf, 1991), p. 1.

There can be no doubt that the central focus of the National Party (NP) government's interpretation of "life" in apartheid South Africa was the struggle for the survival of the white man.<sup>43</sup> This study therefore concludes that government policy was guided by the notion that the rapid urbanisation of black South Africans threatened the precarious position of the white group in the urban environment and their specific interests as a minority in a country numerically dominated by Blacks.<sup>44</sup> Apartheid thus became a survival strategy, and was projected as the practical solution to possible racial conflict in a multi-ethnic society. Afrikaners, urban workers and marginal farmers who relied on apartheid's defences against black competition all feared the consequences of effective political rights to blacks; apartheid offered them the necessary security against this eventuality.<sup>45</sup> It is therefore suggested in this study that what actually guided the Nationalist government's policy formulation throughout the period under review, were the twin issues of ensuring "white security" and maintaining "white supremacy" at whatever cost. The fear of being swamped by blacks was clearly expressed in various ways, such as in a pamphlet issued by the Head Office of the NP prior to the general election in May 1948, in which the party stated unequivocally, that the choice before the electorate was one of two divergent courses:

Either that of integration, which in the long run would amount to national suicide on the part of the whites or that of apartheid, which professed to preserve the identity and safeguard the future of every race, with complete scope for ... [each "homeland"] ... to develop within its own sphere, while maintaining its distinctive national character in such a way that there would be no encroachment on the rights of others and without a sense of being frustrated by the existence and development of others.<sup>46</sup>

In the late 1950s and early 1960s, the same fear was expressed by the alarmist NP politicians in their public pronouncements on race relations, but was often coupled with their vision of bantustans as a possible new instrument of social control:

The choice for the White man in South Africa is either *to survive* and preserve what is ours and simultaneously as guardians of the Bantu within the borders of our country, to extend the same opportunities for advancement to the Bantu

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43 H. Giliomee, *The Afrikaners: A Biography of a People* (Cape Town, Tafelberg, 2003), p. 327.

44 See Margaret Ballinger, *All Union Politics are Native Affairs*, South African Affairs Pamphlets, no. 4 (1944); Ballinger, *From Union to Apartheid: A Trek to Isolation* (Cape Town, Juta, 1969); Helen Suzman, *In no Uncertain Terms: Memoirs* (Johannesburg, Jonathan Ball, 1993).

45 Although a number of reasons may be advanced for the rationale behind apartheid, no one can deny the fact that critical among those reasons was the issue of the disparity in numbers of black and white South Africans and the risks involved, in one way or another, of allowing the majority to take part in the political decision-making process.

46 Quoted by W.J. Filander, *The Nationalisation of Coloured Education in the Transvaal* (M Ed dissertation, UNISA, 1977), pp.42-43.

in his own areas or otherwise *go under and be destroyed as a result of being swamped or absorbed and assimilated by the non-white population*<sup>47</sup> (my emphasis).

Again, albeit in a completely different context, the same fear was also expressed by politicians like Thomas Boydell who declared that “If Bantustan fails, the future of the white is black. Why? Because the country will swing from White control to Black baasskap”.<sup>48</sup>

For some sections of white society, security meant economic security, security in their jobs and the removal of any threat that they would be ousted by African labour that worked for lower rates of pay. For others, however, security meant safeguarding their racial identity and their culture. Still others felt that security translated into physical security in the face of the numerical superiority of the black population; this fear had been exacerbated by the generally hostile post-war world attitude to racial discrimination of any kind. Hence, in whatever way it was expressed, from 1948 onwards security was the yardstick used by the white electorate to measure, to judge and weigh the worth of the policies put before it by the political parties who were vying for votes. This explains why providing white security and ensuring that white supremacy prevailed was the overriding preoccupation of the NP government; most other considerations were secondary to this primary objective. Consequently, the outlines of health policy from 1948 were laid down in accordance with the objectives of apartheid. They had to allow for the reproduction of the labour force while at the same time protecting white health from the perceived danger of infection from the black population.<sup>49</sup> In this way, the ideology of apartheid formed the basis of inequality in the provision of health care along race, class and gender lines.

This study contends that as a country of many contradictions, South Africa’s health care during the period 1948-1976 opens the best window to examine and expose apartheid’s inherent inequalities. It is argued that although the government had the necessary economic prerequisites to provide adequate health care for all its people, both black and white, the health status of the majority of the black population did not reflect that wealth. Instead, a

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47 *The Cape Argus*, 6 November 1959.

48 *The Natal Mercury*, 2 June 1960.

49 Most White-produced historical literature on sexually transmitted diseases (STDs) in Africa makes the direct inference that Africans were by nature promiscuous and predisposed to immorality. The white population had to be protected from these basic tendencies. See P.W. Setel, “Comparative Histories of Sexually Transmitted Diseases and HIV/AIDS in Africa: An Introduction”, in P.W. Setel et al (eds), *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa* (London, Greenwood Press, 1999), p. 7.

major criticism of the state-sponsored health care service was not merely its failure to direct health resources towards the major causes of mortality and morbidity in the population as a whole, but also its bias towards the health needs of the politically privileged white minority. Closely related to this point is the contention that the bias in favour of urban areas in the provision of health care resources should be seen as a result of NP attempts to keep the black working class sufficiently healthy to perform the kind of work required of them by the white economy, and to control the various epidemic diseases rife among the black population; this would hopefully prevent any spill-over of health hazards into the white population.

There is a degree of consensus in the literature that in the apartheid era white South Africans enjoyed one of the highest standards of health care found anywhere in the world.<sup>50</sup> In comparison those of their black counterparts mirrored health care in the newly-independent, much poorer African states further north with their characteristically high infant mortality rates and significantly shorter life expectancy<sup>51</sup> Black South Africans under apartheid were constantly at risk of contracting and eventually dying from “diseases of poverty” such as tuberculosis, pneumonia, typhoid and gastroenteritis, while the greatest killers among the white group were diseases associated with affluence, such as coronary artery disease.<sup>52</sup> Based on the evidence, then, this study argues that contrary to official rhetoric, the greatest problem in South African medicine during the period 1948-1976 was not the lack of resources; it was the unequal distribution and misdirection of these available resources. This being so, black South Africans relied on their own indigenous forms of healing in an attempt to safeguard their health despite debilitating poverty, hardship, and the inadequacies of the apartheid medical system.

### **1.3 The significance of the study**

Admittedly, scholars have already drawn attention to the paradoxical situation in South Africa during apartheid, a time when the health of the majority of its people did not reflect the wealth of the country. There is also a vast array of advocacy literature on alternative systems of healing such as homeopathy, osteopathy, acupuncture and so forth.<sup>53</sup> But there are very few

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50 E. Buch, “The Struggle for Health”, *Critical Health*, 21 (1987), p. 4.

51 H.C.J. van Rensburg and A. Mans, *Profile of Disease and Health Care in South Africa* (Pretoria, Academica, 1987).

52 Buch, “The Struggle for Health”, *Critical Health*, p. 5.

53 See for example A. Sharma, *Complementary Medicine Today: Practitioners and Patients* (New York, Routledge, 1992); E. Anderson and P. Anderson, “General Practitioners and Alternative Medicine”,

historical works that address the matter of how black South Africans struggled against, and coped with ill-health, to the extent that they even experienced population growth and a marked increase in life expectancy.<sup>54</sup> For the Afrikaner historian, Hermann Giliomee, the fact that the NP “presided over a dynamic economic growth that saw the size of the economy increase four and a half times,”<sup>55</sup> is sufficient to justify his conclusion that significant progress was made in the apartheid era.<sup>56</sup> In the light of the health status of the black population, one is tempted to offer a counter argument to Giliomee’s claim.<sup>57</sup> For instance, an issue of particular concern is Giliomee’s deafening silence on the unequal distribution of that wealth among the country’s various population groups. Nor does he offer sufficient explanation for the persistent disparities in the infant mortality rates between black and white population groups despite the progress he identifies. Furthermore, Giliomee does not give sufficient explanation to why African unemployment increased after 1970 rather than decreasing as a result of the economic boom.<sup>58</sup> Above all, he offers no adequate explanation for the exploitative wage structure that effectively prevented large segments of the black population from being in a position to adequately house, clothe and feed themselves during the period when, by Giliomee’s own admission, the country’s gross domestic product (GDP) was among the top 30 in the world.<sup>59</sup>

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*Journal of the Royal College of General Practitioners*, vol. 37, no. 52-5 (1987); H. Baer, “The Organisational Rejuvenation of Osteopathy: A Reflection of the Decline of Professional Dominance in Medicine”, *Social Science and Medicine*, vol. 15A (1981); V. Christie and E. Sandberg, “A Dialogue Between Practitioners of Alternative (traditional) and Modern (school) Medicine in Norway”, Paper presented at the Eleventh International Conference on Social Science and Medicine (1989); S. Fulder, *The Handbook of Complementary Medicine* (Sevenoaks, Coronet, 1988).

54 Giliomee, *The Afrikaners*, p. 666.

55 One must however take note of Brits’ warning against a simplistic categorisation of Giliomee. See J.P. Brits, “An Afrikaner History for All Times? Hermann Giliomee’s *The Afrikaner: A Biography of a People*”, in *Kleio: A Journal of Historical Studies from Africa*, 36 (2004), 47-78, p. 48.

56 Professor Brits has also referred to this point of criticism in *Ibid.*, p. 75.

57 In an article entitled “Did the Apartheid Economy Fail?” Terence Moll of the African Studies Centre at the University of Cambridge is not inclined to concur with Giliomee’s conclusion. Instead, by proposing four growth criteria to evaluate whether the economy did indeed grow as rapidly as is suggested, Moll concludes that it did not surge forward after 1948 to the same extent as other developing economies. He argues that its comparative output and productivity growth record was poor, and its share of developing world country manufactured exports fell steadily from 1955. For an in-depth development of this argument, see, T. Moll, “Did the Apartheid Economy Fail?,” *Journal of Southern African Studies*, vol. 17, no. 2 (1991), p. 271.

58 The pioneering work that measures the level of unemployment among all South Africans was carried out by Charles Simkins, *Structural Unemployment Revisited*, Saldru Fact Sheet, no. 1, 1982. Simkins found that not only was the level of unemployment extremely high, but also that it had risen dramatically since the beginning of the 1960s. According to the *Johannesburg Star*, 7 May 1977, between May 1976 and May 1977 South Africa’s factories slashed their labour force by more than 136 000 workers. This resulted in the following picture of a drop in jobs by racial categories: Whites 9.3%, Blacks 7.9%, Indians 13.5% and Coloureds 8.7%. Although the percentage for Africans was lower, it nevertheless brought the figure for African unemployment to over two million.

59 Giliomee, *The Afrikaners*, p. 666.

However, one may ask, were it not for the NP's preoccupation with an apartheid agenda, how could one explain the widening economic gap between black and white South Africans despite the overall gains in the economy from the mid 1960s until the early 1970s? Although the growth of the black population and the increase in its life expectancy is often presented as evidence of an impressive performance by the NP, it is argued in this study that these advances occurred not because of, but in spite of apartheid. Afrikaner pre-occupation with such concerns as the "black peril" in the segregation period apparently continued to dominate much of official NP thinking and therefore influenced policy formulation in the period after 1948. Government's attempts to deal with such concerns lies in the argument developed in chapter three of this study, which seeks to demonstrate that the government's obsession with the defence of the apartheid state precluded the equitable distribution of the country's wealth. The effects of this policy on the health of the majority of South Africans, were both enormous and tragic.

On another level it is worth noting how the high incidence of infant mortality and disease, particularly in sub-Saharan Africa, have frequently been used by apologists of apartheid to justify the high levels of morbidity and mortality among black South Africans. Closely analysed, this is shown to be a mere strategy, one devised to deflect public attention, both domestic and foreign, from the role of apartheid in the creation of poverty among the black population by comparing South Africa to other African countries in varying degrees of development. Such arguments do not explain why the health status of the white population was comparable to that of citizens in the developed countries, while that of the black population, part of the same economic reality, remained remarkably similar to the health status of impoverished developing countries, particularly those of sub-Saharan Africa, as illustrated by John Bryant,<sup>60</sup> Maurice King,<sup>61</sup> and Wilbert Gesler.<sup>62</sup> In contrast, this thesis argues that in all fairness the health standards of black South Africans during the period 1948-1976 should not be compared with those of the rest of sub-Saharan Africa; they should instead be weighed against the general health possibilities of all South Africans, given the country's economic wealth at the time. It is perhaps Sampie Terreblanche who best encapsulates the contradictions in South African health care when he remarks that "few

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60 J. Bryant, *Health and the Developing World* (London, Cornell University Press, 1978).

61 M. King, *Medical Care in Developing Countries* (London, Oxford University Press, 1966).

62 W.M. Gesler, *Health Care in Developing Countries* (Washington, DC, Association of American Geographers, 1984).

countries in the world are as renowned as South Africa for the sharp contrast between extravagant wealth and luxury on the one hand, and extreme poverty and destitution on the other”.<sup>63</sup> With this in mind, any investigation of the health implications of inequality and poverty would do well to focus on South Africa during the period of high apartheid, 1948-1976.

This study is significant because it reveals that many people’s understanding of current health issues in South Africa comes primarily from studies undertaken by members of the medical profession and on behalf of biomedicine. As such, what is currently known about disease, health and the lack of it, as well as therapy-related behaviour of individuals and communities is almost always defined in terms of an orthodox Western medical science outlook. Despite social and behavioural scientists’ growing interest in Africa’s flourishing systems of traditionally-based health care, broad-based accounts of such systems are rare in South Africa. Reliable and applicable research-based information on indigenous medical systems is acutely unavailable to those influential opinion-makers and well-intentioned public health officials responsible for formulating realistic policies and programmes for the improvement of health service delivery. In fact, the role of indigenous medicine is typically highlighted as a matter of public concern only when some healer, acting within the domain of his professional competence and obligation, gets involved in ritual homicide.<sup>64</sup> Be that as it may, it is my view that the increasing claim that more than 80 per cent of indigenous people in South Africa utilise the services of indigenous healers to varying degrees, is in itself sufficient reason to warrant an historical investigation of the issue. Indeed, a growing interest has been shown in recent years towards understanding the health concerns of under-served societies, and this in turn has stimulated interest in the relevance and practical utility of indigenous healing. Any thorough-going critique of health services planning and provision of health care requires the imaginative consideration of modes of healing based upon alternative conceptualisations to the dominant mode. Steven Feierman for example, has described “plural healing systems” where a variety of modes of health knowledge, practice and practitioners exist side by side in a society.<sup>65</sup> Where there is such plurality, members of society have choices to accept, to

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63 S. Terreblanche, *A History of Inequality in South Africa, 1652-2002* (Pietermaritzburg, University of Natal Press, 2002), p. 29.

64 H. Ngubane, “The Predicament of the Sinister Healer: Some Observations on ‘Ritual Murder’ and the Professional Role of the Inyanga”, in M. Last and G.L. Chavunduka (eds), *The Professionalisation of African Medicine* (Manchester, Manchester University Press, 1986), p. 194.

65 S. Feierman, “Change in African Therapeutic Systems”, *Social Science and Medicine*, vol. 13 (1979), 277-284.

believe and to decide which healers to seek help from. In apartheid-South Africa however, the study of indigenous healing has for a long time remained the exclusive preserve of anthropologists with their in-depth interviews, and of sociologists with their tendency to elicit information by questionnaires, but less so by historians, in spite of Lord Acton's advice that, "If the Past has been an obstacle and a burden, knowledge of the Past is the safest emancipation".<sup>66</sup> As an historian therefore, by drawing attention to the impact of apartheid-created poverty and inequality in medical provision from 1948 to 1976, through the use inter alia, of anthropological and sociological literature, this study will hopefully shed some light on two neglected aspects of the country's medical history. These are, first, the way the disease patterns of black South Africans can be related to specific pieces of apartheid legislation and practices. Second, it examines the adaptive strategies and coping mechanisms used by those who were on the receiving end of the particular policy; how, in other words, did they react when they were faced with institutionalised racial discrimination as regards health provisioning and the allocation of other resources that had a significant bearing on health?

In the midst of the struggle against the contemporary epidemic of HIV/AIDS, the significance of the present study also lies in its value in furthering the understanding of diseases not simply as sudden events discontinuous with the past, but in the realisation that years of ill-health have often preceded the full-blown disease.<sup>67</sup> Internationally, evidence about the extent of poverty and its impact on health has helped to persuade governments that anti-poverty legislation was critical to maintain the efficiency of a nation and the safeguarding of its population stock. Bearing in mind the post-apartheid government's declared goal of "a better life for all", this study will add to our understanding that because disease is best dealt with when the social conditions of poverty are addressed, the battle against HIV/AIDS can only be won when the social environment of the epidemic is taken into account. It cannot be overemphasised that the virus nests in the destroyed and broken habitats of victims of the migrant labour system and hostel life, where it finds the ideal conditions for spreading. The primary contribution of this study, then, lies in its effort to shed light on the interconnections between political deprivation, poverty and disease; it argues that poverty should not only be understood as lack of money, but should rather be seen as the breakdown and dissolution of contexts that sustain human life, families and cultural traditions. In more practical terms, the study likens the apartheid-created poverty with a bomb that has hit South Africa in the period

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66 Lord Acton, "Inaugural Lecture, Cambridge, June 1895", cited in Terreblance, *A History of Inequality in South Africa, 1652-2002*, p.3.

67 M. Wilson, *Health is for People* (London, Longman & Todd Ltd, 1975), p. 46.

1948-1976; the resulting bombsite, which now stretches out over the horizon, is the feeding-ground for the current epidemic virus. Of course, critics on the political right might argue that what now exists in South Africa is unavoidable inequality, a social patterning of difference that largely reflects the natural innate differences between individuals; something that no amount of social legislation can correct. In stark contrast, this study contends that the contemporary problems of rich and poor are correctable because they stem from apartheid contradictions whereby massive wealth was accumulated by the few, while mass poverty was suffered by the majority – this because of deliberate state action and non-action. The argument posited is that apartheid formed the basis of a racial, class and gender-based stratification that reinforced and reproduced the economic and social inequalities that continue to be experienced even beyond apartheid.<sup>68</sup> And it is precisely for this reason that this study argues for the continued use of racial categories in the allocation of wealth in order to correct past inequities. The significance of this project also lies in its potential to inform policy formulation in the national Department of Health by providing research-based findings relating to the historical role of indigenous medicine. Thus the study is a contribution to the process of transformation in the health sector by helping policy makers understand a range of issues in South African medical history including the plurality of the medical market. This is done not only by identifying indigenous medicine's strengths and its potential role in the ongoing battle against the HIV/AIDS pandemic, but also by pointing to its numerous weaknesses.

#### **1.4 Interest in the topic**

This thesis was born out of a desire to expand on the research project I undertook during the course of my MA studies for a dissertation entitled *The Kwandebele Independence Issue: A Critical Appraisal of the Crises Around Independence in Kwandebele, 1982-1989*. It was while I was immersed in this research, making enquiries about the political and economic viability of “independence” of South Africa’s youngest bantustan, that I was confronted by the ambient social and economic conditions in that minuscule homeland. Ahead of Kwandebele, by 1986, four bantustans had already acquired the status of Pretoria-style “independence”, namely, the Transkei (1976), Bophuthatswana (1977), Venda (1979) and the Ciskei (1981). Together with the rest of the so-called “white South Africa,” these areas

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68 For an in-depth exploration of this theme see Seekings and Natrass, *Class, Race and Inequality in South Africa*, p. 300.

formed what Dan O'Meara labelled the "SABCTV club".<sup>69</sup> What emerged from my research on Kwandebele was a picture of a "homeland" characterised by a shocking lack of readiness in terms of physical resources and prospects for self-sustained economic growth. I was more particularly struck by the fact that at the very time it hoped to gain independence from Pretoria the bantustan had only seven clinics, about five medical practitioners and hardly a hospital to its credit.<sup>70</sup> Apart from this meagre excuse for state medical services, health care was provided by a variety of indigenous healers.

Recognising that these conditions were by no means peculiar to the Kwandebele bantustan, and that they might well be mirrored in other bantustans and the rest of black South Africa, I decided that an in-depth academic enquiry might be elucidating. Part of my intention was to understand why at a national level a black person's life expectancy was as low as 44 years, while that of a white person was as high as 71.<sup>71</sup> I also wanted to discover why in both urban and rural areas African mothers died in childbirth four times as often as did white mothers, and black babies died in infancy almost three times as often as white babies; these findings appeared to contradict the fact that significant advances had been made in the field of medical technology.<sup>72</sup> Clearly this was the same system at work; the system that encouraged the maintenance of separate blood banks for black and white South Africans and also segregated black and white hospital patients in terms of race. I decided that the best way to come to grips with the issues involved was to probe the interconnections between poverty, health and disease in the years from 1948 to 1976, the period in which apartheid approached police-state proportions and health care services for black South Africans reached an all-time low.

All these considerations provided the motivation for this enquiry, but added to this there was clearly a need for a critical examination of the historical contribution of indigenous medicine in South African health care. I decided that this two-pronged approach would fill the significant gaps left by previous research into the health needs of the underprivileged African population. Admittedly, the initial intention was merely to examine the influence of politics on the provision of health care in South Africa and the role of health services in the

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69 O'Meara, *Forty Lost Years: The Apartheid State and the Politics of the National Party, 1948-1994* (Randburg, Ravan, 1966), p. 275. SABC is the acronym for the South African Broadcasting Corporation, the state-controlled television service.

70 Interview with former Philadelphia Hospital Matron, Mabindisa, at Dennilton, 1/12/2004.

71 Department of Statistics, *South African Statistics 1968*, p. 18. See also SAIRR, *Race Relations Survey 1959-1960*, p. 241.

72 Department of Statistics, Report no. 07-03-04: Bantu Deaths in Selected Magisterial Districts 1968-1971 (Pretoria, Government Printer, 1975).

maintenance of the apartheid programme. But after engaging with the literature on the topic it became evident that my original view of the real health problems of black South Africans under apartheid were superficial and I began to revise most of my theoretical assumptions. A wider view of the issues was necessary.

Based on the reasoning above I concluded that in the period under review the NP government was well aware that any national effort to improve the health status of the majority of the black population could not be separated from simultaneous efforts to remove the social, economic and political constraints that had been imposed artificially on the black majority. It is further contended that a commitment to the removal of race barriers in general and the racial categorisation of patients in particular was a prerequisite for South Africa to realise the WHO's goal of "health for all by the year 2000".<sup>73</sup> A limited number of general works have since appeared on the provision of health care in South Africa, and there is also extensive material on specific aspects of apartheid and medicine in the form of journal articles. However, no serious academic study such as this one has been undertaken to probe the impact of apartheid, its links with poverty and disease and the simultaneous recourse by black South Africans to indigenous medicine as a coping mechanism.

### **1.5 The scope of the study**

A number of considerations have informed my choice of the period 1948-1976. In the opinion of Leonard Thompson, this was a time when Afrikaner nationalism triumphed and took control of the state apparatuses. On the one hand the NP set about transforming the ambiguity of the United Party's racial policy with a plethora of legislation and other instruments of social control to ensure white domination; the stage was set for Afrikaner nationalism to defend white social status and the economic interests of its constituency.<sup>74</sup> While on the other hand, African nationalism was gathering momentum; it was equally determined to challenge this racial domination, attain power and transform South Africa into a non-racial society.<sup>75</sup>

It is for this reason that the general characterisation of the 1950s as the "decade of defiance"

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73 L. Baldwin-Ragaven et al, *An Ambulance of the Wrong Colour: Health Professionals, Human Rights and Ethics in South Africa* (Cape Town, University of Cape Town Press, 1999).

74 L. Thompson, *A History of South Africa* (New Haven, Yale University Press, 1990), pp. 187-88.

75 See I. Liebenberg et al (eds), *The Long March: The Story of the Struggle for Liberation in South Africa* (Pretoria, HAUM, 1994).

is so entrenched in popular political consciousness. This period featured not only the defiance campaign but also the treason trial, national strikes and widespread boycotts. However, it was the vicious repression of Sharpeville and Langa that represented the most serious crisis of legitimacy for the Verwoerdian administration. These events attained a special status within the political culture of the opponents of apartheid, making the 1960s an important decade in the history of the country. It was a period in which the leadership of the liberation movements opted for open defiance, fought heroically against the armoury of the apartheid regime, and lost.<sup>76</sup> This led to further entrenchment of apartheid through the ethnic balkanisation of the country – with tragic consequences for the health of the people on the receiving end of the policy. The 1970s was also an eventful decade in the political history of this country, particularly as far as resistance is concerned. The decade opened with the 1973 labour strikes in Durban and climaxed with the 1976 youth uprisings in Soweto.<sup>77</sup> These events crystallised the contradictions and conflicts which had developed in South Africa since the banning of the liberation movements in 1960 and the Rivonia treason trial in 1964. Thus, by 1976 years of tireless effort by the South African government to contain the struggle north of the Zambezi had failed. The Portuguese colonies and Rhodesia, the crutches that had shored up white rule, had also collapsed.<sup>78</sup> The importance of the period 1948-1976 lies in the fact that it represents the era of high apartheid; it saw the elaboration of influx control, vicious forced removals, a stepping up of migratory labour and the fragmentation of South Africa into bantustans. It was policies such as these and the contradictions they produced that led to the unravelling of the apartheid system in the 20 years after 1976. Black insurrection, war on the border, economic stagnation, demographic pressures and the international anti-apartheid movement all played their part.<sup>79</sup> Therefore, as a watershed in the history of the struggle against apartheid, 1976 is a convenient and appropriate cut-off date for an examination of the impact of apartheid on medicine.<sup>80</sup>

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76 Terreblanche, *A History of Inequality in South Africa 1652-2002*.

77 J. Hyslop, *The Classroom Struggle: Policy and Resistance in South Africa 1940-1990* (Pietermaritzburg, University of Natal Press, 1999); B. Hirson, *Year of Fire, Year of Ash – The Soweto Revolt: Roots of a Revolution* (London, Zed Press, 1979).

78 B.M. Magubane, *The Political Economy of Race and Class in South Africa* (New York, Monthly Review Press, 1990), p .x.

79 For an exploration of these contradictions, see Terreblanche, *A History of Inequality in South Africa 1652-2002*; W. Beinart and S. Dubow (eds), *Segregation and Apartheid in Twentieth Century South Africa* (London, Routledge, 1995); P. Waldmeir, *Anatomy of a Miracle: The End of Apartheid and the Birth of a New South Africa* (London, Viking, 1997); T Lodge, *Black Politics in South Africa Since 1945* (Johannesburg, Ravan Press, 1983).

80 Ending an analysis of the impact of apartheid on medicine in 1976 should not be seen as a suggestion that the health status of Black South Africans improved after that date, as many health officials would have had the world believe. On the contrary, evidence reveals that the situation grew even more grim after that date. Note that the Transkei, the first bantustan to accept Pretoria-style independence did so in

I also end this study in 1976 precisely because, like 1948, the year represents a critical turning point in the history of apartheid. Indeed this year may be said to have in many ways marked the beginning of the end for apartheid as South Africa's official policy. As Thompson so aptly remarks: "Whereas in the 1960s the government had successfully imposed its own version of law and order by arresting apartheid dissidents and banning their organisations, similar tactics in 1976 failed to have the same effect".<sup>81</sup>

Instead, after 1976 African resistance and labour strikes became even more frequent and formidable, thus forcing both government and capital to re-examine the wisdom of some of apartheid's less fundamental principles. Afrikanerdom's confidence in and commitment to apartheid were eroded by the events of that year. In response to these challenges the regime creatively devised alternative strategies to deal with the thorny issue of granting limited black political rights without relinquishing white domination. This process, undertaken amidst the liberation of neighbouring Mozambique in 1975, entailed the granting of pseudo-independence to the bantustans within South Africa's borders. I therefore argue in this thesis that during this period of government preoccupation with such an expensive political programme, the health of the people in general and of the African majority in particular, became secondary to issues involving the security of a beleaguered regime.

This study makes no pretence of providing a detailed history of medicine in South Africa since the mid-twentieth century, nor does it give more than limited insight into the role of politics as an important determinant of health care. It does not deal with aspects of apartheid as a central policy issue; on the contrary it focuses on apartheid's adverse impact upon medicine by probing the health problems of the country's African citizens and their coping strategies. However, since an examination of health conditions of the various population groups indicates that health was one of the variables that stratified South African society, my analysis focuses primarily on the health problems of Africans, as opposed to those of Blacks in general, for the latter designation includes Indians and Coloureds.<sup>82</sup> This choice should in no way be construed to mean that the health status of Indians and Coloureds were any better under apartheid. The intention in using this particular approach is merely to emphasise that

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October 1976, exactly four months after the Soweto student uprising.

81 Thompson, *A History of South Africa*, p. 228.

82 See the different meanings of these concepts in the short section entitled *Nomenclature* in the front of this thesis.

the political dominance and status of the white population (as architects and beneficiaries of the health policy) gave them the advantage of low death rates almost on par with those found in developed countries. In contrast it was particularly the African group, those with the most disadvantaged socio-economic status, that had health statistics comparable with poverty-stricken developing countries. Since modern medicine was itself divided into public and private sectors, there is evidence that white middle class South Africans who belonged to medical-aid schemes and received their medical services mainly outside the public health system, had health standards that were even higher than those in certain Western countries such as the United Kingdom. It should be noted that although Asians and Coloureds were also in many ways as disadvantaged as the Africans,<sup>83</sup> my decision to study African health status seeks to demonstrate that there were nuances of inequality under apartheid. This is the approach favoured by Amartya Sen in his examination of entitlement; he argues that though a small peasant and a landless labourer may both be poor, their fortunes are not tied together. In understanding the proneness to starvation of either, we need to view them not as members of a huge army labelled “the poor, but as members of particular classes, governed by different entitlement relations”.<sup>84</sup> Similarly, an examination of the health status of both Coloureds and Asians in the period 1948 to 1976 would no doubt reveal that these were on an intermediate between the two extremes – between the African and the White poles – with the Asians nearer to the Whites, and the health status of the Coloureds closer to that of the Africans.<sup>85</sup> One explanation for this is that neither the Asians nor the Coloureds have been exposed to the devastating effects of migrant labour; nor have restrictions on their movement in and out of cities been subject to pass laws and influx control to the same degree as was the case for Africans.<sup>86</sup> Perhaps an even more critical difference is that neither group had ever known what it was like to be condemned to eke out a life in an impoverished bantustan.<sup>87</sup> With these differences in mind, whenever Asians and Coloureds are included in the statistical analysis

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83 The situation of Coloureds and Asians under white majority rule was described as poor, almost as bad as that of Africans, by Lord Selborne, the British high commissioner for South Africa and governor of the Transvaal Colony and Orange River Colony from 1905-1910. Cited by Magubane, *The Political Economy of Race and Class in South Africa*, pp. 10-11.

84A.K. Sen, *Poverty and Famines: An Essay on Entitlement and Deprivation* (Oxford, Clarendon Press, (1986), p. 156.

85 D. Mechanic, “Apartheid Medicine”, *Society*, March/April 1973, 36-44, pp. 36, 42.

86 See Belinda Bozzoli, *Women of Phokeng: Consciousness, Life Strategy, and Migrancy in South South Africa, 1900-1983* (Portsmouth, Heinemann, 1991); S. Greenberg, *Legitimizing the Illegitimate* (New Haven, Yale University Press, 1987); S. Marks and S. Trapido (eds), *The Politics of Race, Class and Nationalism in Twentieth Century South Africa* (New York, Longman, 1987).

87 Although Asians and Coloureds were permitted to remain in segregated townships in the so-called white areas, like their African counterparts, they were denied political rights. Little wonder that they rejected the 1983 constitutional changes that were intended to incorporate them into the white-controlled legislative system.

provided in this study, it is solely for purposes of emphasis in the absence of reliable data on Africans. The inclusion of Asians and Coloureds thus serves to emphasise that if their situation was bad, then that of Africans, in spite of the unavailability of statistical records, was in all probability even more dismal. Race is probably only a significant factor to the extent that apartheid has ensured that there was always a close correlation between race and class.<sup>88</sup> The study does not encompass those medical services provided by private practitioners, the medical services provided by the mining industry and the defence force or the large number of government-subsidised voluntary associations. Instead it focuses on the inadequacy of apartheid medicine and how this indirectly created space for marginalised indigenous medicine to reassert itself and in the process retain the confidence of the majority of its African clients in terms of its effectiveness in preventing and curing disease. From an historian's point of view, this socio-medical and political subject matter is sufficiently complex and topical to merit academic attention. In exploring these fields it is hoped that the effects of apartheid on the health of black South Africans and the role of indigenous medicine in mitigating these effects, will be understood in their proper historical context. This study of *Poverty, Health and Disease in the Era of High Apartheid: South Africa, 1948 – 1976* is my own personal contribution to that understanding.

## **1.6 A review of the literature**

A number of medical and historical works have been critical to the formulation of my central thesis in this study. For practical reasons, however, any researcher on the subject of apartheid and medicine in South Africa has to traverse at least four historiographical traditions, namely, the history of apartheid, the social history of medicine, the political economy of health and the history of indigenous medicine in South Africa. These four literatures have informed my attempt to bring the strands of medicine, culture and politics together to examine the effects of repressive apartheid on the health of the majority of the country's African population and to investigate their coping mechanism.

In the 1970s, a growing literature on the political economy of health drew attention to the relationship between political and economic power, disease patterns and health care systems

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88     Seekings and Natrass, *Class, Race and Inequality in South Africa*. See also The Centre for the Study of Health Policy, "A Note on Terminology", *A National Health Service for South Africa: Part 1: The Case for Change* (Johannesburg, University of the Witwatersrand, 1988), p. ii.

in developed capitalist societies.<sup>89</sup> In doing so, the literature emphasised the extent to which the health system formed part of the totality of social and productive relations, and that problems in medicine emerged from and reflected broader structural contradictions in the society at large. This, in the words of Shula Marks and Neil Andersson involved, “the conflicting demands for profit and safety, the maldistribution of health workers and the inequality of access to health care for different groups in society, the rising costs and diminishing returns of high technology medicine, the differential mortality and morbidity rates geographically and between social classes, and the ideological role of much health care”.<sup>90</sup>

The increasing prestige of the medical profession in the early twentieth century led to the expansion of medical authority and the redefinition of many forms of deviant behaviour in medical terms. However, as soon as the specific disease concept failed to deal with the problem of mental disorders and the chronically ill, medicine was subjected to increasing criticism. Among the notable critics of contemporary medicine and medical practice is Ivan Illich, whose analysis of various aspects of society led him to the somewhat simplistic, flawed conclusion in my view, that health care systems actually cause illness through doctor-induced medicine (iustrogenesis).<sup>91</sup> For Illich therefore, health care systems become self-perpetuating bureaucracies, causing more illness than they cure, creating a dependency by ensuring that people will rely on them. For him therefore, the solution lies in destroying the health care system, de-doctoring society and giving people the autonomy to care for themselves.<sup>92</sup> What Illich failed to realise was that medicine or health systems do not by themselves create illness and the kind of dependency he is worried about. Instead the criticism should be that health care systems based solely on the curative model often do not fulfil their stated aims. Applied to South Africa, Illich’s scepticism would be welcomed by the apartheid planners in that it could be used to justify the inadequate provision of medical services in the black population, under the guise that the National Party government wished to give black people the autonomy to care for themselves. If this sort of well-intentioned

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<sup>89</sup>Bryant, *Health and the Developing World*; M. King, *Medical Care in Developing Countries*; P. Conrad and E.B. Gallagher (eds), *Health and Health Care in Developing Countries* (Philadelphia, Temple University Press, 1993).

<sup>90</sup> Marks and Andersson, “Issues in the Political Economy of Health in Southern Africa”, *Journal of Southern African Studies*, Vol.13, No.2 (1987), p.178.

<sup>91</sup> I. Illich, *Limits to Medicine, Medical Nemesis: The Expropriation of Health* (London, Marion Boyers, 1976), p. 83. See also, I. Illich, “The Epidemics of Modern Medicine”, in B. Davey et al (eds), *Health and Disease: A Reader* (Buckingham, Open University Press, 1995), 237-242.

<sup>92</sup> Illich, *Limits to Medicine: The Expropriation of Health*, p. 83.

criticism of modern medicine were applied to South Africa, it would carry the risk of justifying apartheid medicine and health authorities would call for fewer doctors and a lower level of technology in the society by trading on the dangers identified by Illich. Similarly, historical epidemiology has shown that medical interventions on their own have had little impact on the overall decline in infectious disease mortality. For example, John and Sonja Mckinlay have found that new medical measures have had almost no detectable effect on disease-specific mortality rates, because such measures were introduced some decades after a significant decline in death rates had already set in.<sup>93</sup> Thomas McKeown and his colleagues have also come to a similar conclusion in their study of the mortality trends in England and Wales, where they attributed the observed decline in mortality not to modern medicine, but to community factors and other public health measures, particularly better nutrition and improved hygiene.<sup>94</sup>

The historical maldistribution of resources on a geographic basis has also been highlighted by a number of economic researchers. Here attention may be drawn to the critical role played by capitalism in determining the nature of health and health care. For example, Lesley Doyal and Imogen Pennell emphasise that the pursuit of profit under capitalism transformed medical care into capitalist enterprises rather than practices generally aimed at eradicating ill health.<sup>95</sup> Vincent Navarro also argues in the same vein that health services are often underdeveloped due to the control that various capitalist sectors exercise over the distribution of medical resources.<sup>96</sup> Navarro has further argued that doctors act as servants of the capitalist state by ensuring that health and illness are conceptualised in individualistic terms. For this reason, they emphasise diet, lifestyle and exercise rather than the part played by industrial processes and capitalist production. They regulate sickness and thereby contribute towards the productivity of capitalism by treating sick workers and returning them rapidly to the workforce. Hence the contention in this enquiry, which concurs fully with Karen Jochelson's view, is that the health services provided for Africans by the NP government were premised

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93 J.B. McKinlay and S.M. McKinlay, "The Questionable Contribution of Medical Measures to the Decline of Mortality in the United States in the Twentieth Century", *Milbank Memorial Fund Quarterly*, 55 (1977), p. 425.

94 T. McKeown et al, "An Interpretation of the Decline of Mortality in England and Wales During the Twentieth Century", *Population Studies*, vol. 29 (1979), p .415. See also T. McKeown, *The Role of Medicine: Dream, Mirage or Nemesis?* (Oxford, Basil Blackwell, 1986); T. McKeown, "The Medical Contribution", in B. Davey, *Health and Disease: A Reader* (Buckingham, Open University Press, 1995); T. McKeown, *The Modern Rise of Population* (London, Edward Arnold, 1977).

95 L.Doyal and I. Pennell, *The Political Economy of Health* (London, Pluto Press, 1983).

96 V. Navarro, *Medicine Under Capitalism* (New York, Prodist, 1979).

on the misguided assumption that Africans were primarily migrants whose health was only important insofar as it determined their fitness to labour and their suitability for contact with the white population.<sup>97</sup> Michael Savage has argued from a similar standpoint stressing that the unequal distribution of medical resources was generated by political inequalities which characterised the policy of apartheid.<sup>98</sup> In similar vein, Max Price has analysed the economic organisation of health services in South Africa in the apartheid period with the view to identifying the various structural obstacles to the provision of equitable health care for all; he concludes that the consequences of apartheid for health policy were so profound that racial differences as well as the allocation of health care clearly reflected the inequalities of power and wealth produced by the political economy of apartheid.<sup>99</sup> Price has also examined the expansion of private health care schemes to urbanised Africans and he argues that increasing private sector participation in health was particularly attractive to the state because through private health care the government was able to bypass a considerable financial burden in the reproduction of the workforce to capital. However, since medical aid schemes were enjoyed by a small minority of Africans who were employed,<sup>100</sup> this only served to increase the existing inequalities of health care among the population. What most of the foregoing literature emphasises is that if we continue to treat health issues as an individual matter, then the social implications will never be fully understood. Without fear of vindicating Illich, there is no doubt that if curing rested purely with the doctors, then in the case of apartheid South Africa the social restructuring that was necessary for building a healthy society would be obscured.

Dominated as it was by a political economy approach, the history of medicine only emerged late in South African historical writing. In her review of the extent of historical writing on medicine in this country, Elizabeth van Heyningen argues that the failure of historians to enter the field of medical history over the years can to a large extent be ascribed to lack of comparative research that might have provided a useful context for the local situation.<sup>101</sup>

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97 For an exploration of this view, see, Karen Jochelson, "Sexually Transmitted Diseases in Nineteenth and Twentieth-Century South Africa", in P.W. Setel et al (eds), *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa* (London, Greenwood Press, 1999), p. 230.

98 M. Savage, "The Political Economy of South Africa", in G. Wescott and F. Wilson, (eds), *Economics of Health in South Africa: Perspectives on the Health System* (Cape Town, Ravan Press, 1979), p. 42.

99 M. Price, "Health Care Beyond Apartheid: Economic Issues in the Reorganisation of South Africa's Health Services" *Critical Health Dissertation* (1986), p. 1.

100 See the Snyman Commission Report.

101 E. van Heyningen, "Epidemics and Disease: Historical Writing on Health in South Africa", *South African Historical Journal*, no. 23 (1990), p. 123.

Medical history has been compiled for the most part by people who are medically trained, and judging by its jargon, it has been written primarily for colleagues in the medical field.<sup>102</sup> In this way, medical scholarship remained essentially in-house. As Roy Porter and Andrew Wear put it, “by doctors, about doctors, for doctors”.<sup>103</sup> No wonder, as might be expected, that such writers<sup>104</sup> sang the praises of modern medicine and its achievements while giving very little, if any attention to its failures, either perceived or real; nor did they acknowledge other equally significant determinants of health, such as socio-economic factors.<sup>105</sup> Similarly, the history of nursing as pioneered by Charlotte Searle, is a recent development, connected in some ways to the impact of feminist thought on history writing and the major shift towards social history in South African historiography.<sup>106</sup> According to Siphamandla Zondi the nursing history that emerged, like the medical history referred to above, was written by practising nurses and was aimed at protecting professional interests rather than providing critical insight into its development.<sup>107</sup> For example, although Grace Mashaba departs from Searle’s exaltation of white hegemony in the nursing profession, she does not challenge this undercurrent that is so pervasive in Searle’s writing. In fact Mashaba tends to give unqualified credit to Searle and the rest of the white hegemony in nursing for the present state of the profession. In this history, the racial inequality in nursing is clearly accepted as a natural outcome of unequal experience of civilisation between the races. What Grace Mashaba does differently is to allow black nurses to creep into her nursing story rather more forcefully than simply as a faceless, insignificant mass. Clearly lamenting the insignificant position of Africans in most of these early narratives, Alexander Butchart argues:

such histories of medicine that explain medicine’s development in Africa as achievement or as a functional response to overwhelming need do not lend any special focus to the African. Certainly, Africans are present in these histories,

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- 102 M. Foucault, *The Birth of the Clinic: An Archeology of Medical Perception* (London, Routledge, 1976), p. 54.
- 103 R. Porter and A. Wear (eds), *Problems and Method in the History of Medicine* (London, Croom Helm, 1987), p. 1. See also C.E. Rosenberg, “The Medical Profession, Medical Practice and the History of Medicine”, in E. Clarke (ed.), *Modern Methods in the History of Medicine* (London, Routledge, 1971), pp. 24-25.
- 104 E.H. Burrows, *A History of Medicine in South Africa up to the End of the Nineteenth Century* (Cape Town, Balkema, 1958); H. Menko, *Contributions of the Netherlands to the Development of South African Medicine, 1652-1902* (Cape Town, H.A.U.M, 1954); P.W. Laidler and M. Gelfand, *South Africa: Its Medical History, 1652-1898* (Cape Town, Struik, 1971); A.F. Hattersley, *A Hospital Century – Grey’s Hospital, Pietermaritzburg 1855-1955* (Cape Town, Balkema, 1955).
- 105 Porter and Wear, *Problems and Method in the History of Medicine*, p. 1. See also Van Heyningen, “Epidemics and Disease”, p. 123.
- 106 C. Searle, *The History of the Development of Nursing in South Africa 1652-1960: A Socio-Historical Survey* (Pretoria, The South African Nursing Council, 1980); G.T. Mashaba, *Rising to the Challenge of Change: A History of Black Nursing in South Africa* (Kenwyn, Juta, 1995).
- 107 S. Zondi, “Genderising Nursing History in South Africa”, Seminar paper presented at the University of Pretoria, 13 February 2002, p. 3.

but their role is a peripheral one, subordinate to the heroic deeds of white doctors.<sup>108</sup>

But this is hardly surprising if regard is taken of the popular saying: “until the lions have their own historians, the history of the hunt will always glorify the hunter”.<sup>109</sup> Either because they are intimidated by the technical knowledge apparently required, or repelled by the crudeness of a historiography that was still enmeshed in celebrating “great men”, economic and social historians have tended to keep clear of medical history.

The foregoing notwithstanding, some groundbreaking studies focusing on an earlier period in South African medical history have since appeared and broadened the scope. For example, Howard Phillips’s study of the 1918 Spanish influenza epidemic,<sup>110</sup> and Maynard Swanson’s seminal article, have gone a long way towards charting a way forward for the “social history of medicine” in South Africa.<sup>111</sup> Then too, Roy Macleod and Milton Lewis,<sup>112</sup> Russel Viljoen,<sup>113</sup> all have researched specific aspects of medicine and disease in South Africa as it unfolded from its colonial roots. A number of other historical studies, also based on specific diseases, have since laid a solid foundation on which future studies can be built and the necessary comparative analysis made. This literature further affirms the role of socio-economic factors in the production of disease; Elaine Katz writes on silicosis,<sup>114</sup> Marks and Andersson on typhus,<sup>115</sup> Randall Packard on tuberculosis,<sup>116</sup> Alan Jeeves on syphilis,<sup>117</sup> and so

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- 108 A. Butchart, *The Anatomy of Power: European Constructions of the African Body* (Pretoria, Unisa Press, 1998), p. 5.
- 109 Personal communication with Sop Ntuli, Tweefontein “K” Mpumalanga Province, 7/11/2004. In this, I fully concur with Sop because indeed, until the hunted produce their own historians, so long will their victories be obliterated for the human record by those who abrogate to themselves the right to define themselves as victorious hunters.
- 110 H. Phillips, “‘Black October’: The Impact of the Spanish Influenza Epidemic of 1918 on South Africa,” *Archives Yearbook for South African History*, 1990, vol. 1 (Pretoria, Government Printer, 1990).
- 111 M.W. Swanson, “The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909m’, *Journal of African History*, vol. 18, no.3 (1977), 387-410.
- 112 R. Macleod and M.J. Lewis, (eds), *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London and New York, 1988).
- 113 R. Viljoen, “‘The smallpox War’ on the Kimberley Diamond Fields in the mid-1880s”, *Kleio*, 35 (2003), 5-18.
- 114 E.N. Katz, *The White Death: Silicosis on the Witwatersrand Gold Mines 1886-1910* (Johannesburg, 1994).
- 115 S. Marks and N. Andersson, “Typhus and Social Control: South Africa, 1917-50m” in R. MacLeod and M. Lewis, (eds), *Disease, Medicine, and Empire: Perspective on Western Medicine and the Experience of European Expansion* (London and New York, Routledge, 1988).
- 116 R.M. Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Pietermaritzburg, University of Natal Press, 1989).
- 117 A. Jeeves, “Public Health in the Era of South Africa’s Syphilis Epidemic of the 1930s and 1940s”, *South African Historical Journal*, no.45 (2001), 79-102.

forth. A more recent addition to this growing literature is Bettzieche's essay on polio.<sup>118</sup> More recently, the history of social medicine was given a boost by the appearance of *The Cape Doctor in the Nineteenth Century: A Social History*, edited by Harriet Deacon, Howard Phillips and Elizabeth Van Heyningen.<sup>119</sup> Though the focus of the book is the nineteenth century Cape medicine, its argument is refreshingly relevant to my own study because besides exposing the discriminatory practices of the Cape medical profession based along race, class and gender lines, it also recognises the historical coexistence of modern and indigenous medical systems. The Malthusian paradigm that "a population can grow freely to fill the economic space, as water fills a pool, but the maximum level of the pool is fixed by the point of overflow",<sup>120</sup> is very much a matter of contention. An attempt to understand the historical connections between nutrition, poverty and disease was the subject of a 1982 conference at Bellagio, Italy, and the conference papers were captured in a publication edited by Robert Rotberg and Theodore Rabb.<sup>121</sup> Following closely on this conference, another conference on the professionalisation of African healers was held in Gaborone in 1984, the proceedings of which are contained in a publication by Murray Last and Gordon Chavunduka.<sup>122</sup> African healers were first professionalised in Ghana on Kwame Nkrumah's initiative in 1969. Since then, professional associations have been formed in other parts of the African continent. Gordon Chavunduka for instance has described how in Zimbabwe at independence, at the prompting of the then Minister of Health, who recognised the active part "spirit mediums" had played in the independence struggle, he organised a Zimbabwe National Traditional Healers' Association (ZINATHA).<sup>123</sup> In this way, 22 000 of the country's 35 000 traditional healers then registered and gained the recognition they were contemptuously denied under white rule. It was however in the context of a growing international resentment against modern medicine that AIDS arrived, "as a novel and frightening stranger as cholera had been a century and a half ago, posing in stark form the

118 W. Bettzieche, "Polio, People and Apartheid: South African Poliomyelitis Epidemics of the 1940s and 1950s with special reference to the Cape Peninsula" (BA Honours dissertation, University of Cape Town, 1998).

119 H. Deacon, H. Phillips and E. Van Heyningen (eds), *The Cape Doctor in the Nineteenth Century: A Social History* (Amsterdam, Rodopi, 2004).

120 T.R. Malthus, *An Essay on Population* (London, Dutton, 1927), See also, T.R. Malthus, *An Essay on the Principles of Population, Text, Sources and Background Criticism* (New York, W.W. Thorton, 1976).

121 R.I. Rotberg and T.K. Rabb (eds), *Hunger and History: The Impact of Changing Food Production and Consumption Patterns on Society* (Cambridge, Cambridge University Press, 1985), p. 285.

122 M. Last and G.L. Chavunduka, *The Professionalisation of African Medicine* (Manchester, Manchester University Press, 1986).

123 G.L. Chavunduka, "Development of African Traditional Medicine: The Case of Zimbabwe", Centre of African Studies, *African Medicine in the Modern World*, Seminar Proceedings, No.27 (University of Edinburgh, 10-11 December 1986), p.59.

questions about the cultural and biological meanings of disease”.<sup>124</sup> Indeed, arriving in the age of modern antibiotics, a time when the age of transmissible, lethal infections was deemed long past, the epidemic fractured society’s false sense of confidence in modern medicine. Charles Rosenberg’s conclusion is a telling one. He claims that the AIDS pandemic illustrates both man’s dependence on medicine and the way in which disease reflects and lays bare every aspect of the culture in which it occurs.<sup>125</sup>

It was against this background that I began my preliminary reading of the published literature for this enquiry. Diana Wylie makes an observation – with which I fully concur – that in studying the era of apartheid both the Liberal and Marxist historians concentrated their efforts on writing histories of South Africa with the main objective of stripping the apartheid government of its “legitimacy” by putting more weight on African resistance to the apartheid system.<sup>126</sup> While it has been the emergence of apartheid itself that has preoccupied most scholars,<sup>127</sup> others were more interested in examining the conditions and strategies that were critical for its eventual demise.<sup>128</sup> For example, it was not until historians such as Saul Dubow<sup>129</sup> questioned certain aspects of the crude “cheap labour” thesis, that scholars have devoted a vast amount of energy trying to discredit the regime whose wealth, it was argued, was based on the exploitation of cheap African labour.<sup>130</sup> Though the specific impact of

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124 E. Fee and D.M. Fox, “Introduction: AIDS, Public Policy, and Historical Inquiry”, in E. Fee and D.M. Fox, (eds.), in *AIDS: The Burdens of History* (Berkeley, University of California Press, 1988), p. 5. See also Rosenberg, footnote number 62, p. 27.

125 C.E. Rosenberg, “Disease and Social Order in America: Perceptions and Expectations”, in Fee and Fox, *AIDS: The Burdens of History*, pp. 12-32.

126 D. Wylie, *Starving on a Full Stomach: Hunger and the Triumph of Cultural Racism in Modern South Africa* (London, University Press of Virginia, 2001), p. 6.

127 T.D. Moodie, *The Rise of Afrikanerdom: Power, Apartheid and the Afrikaner Civil Religion* (Berkeley, University of California Press, 1975); G.M. Carter, *The Politics of Inequality: South Africa Since 1948* (New York, Octagon, 1977); S. Dubow, *Racial Segregation and the Origins of Apartheid in South Africa, 1919-1936* (Oxford, Macmillan, 1989); J.P. Brits, *Op Die Vooraand van Apartheid: Die Rassevraagstuk en die Blanke Politiek in Suid-Afrika, 1939-1948* (Pretoria, Unisa, 1994).

128 Liebenberg et al (eds), *The Long March*; G.M. Gerhardt, *Black Power in South Africa: The Evolution of an Ideology* (Los Angeles, University of California Press, 1978); H. Adam and K. Moodley, *South Africa Without Apartheid: Dismantling Racial Domination* (Cape Town, Maskew Miller Longman, 1986); T. Lodge, *Black Politics in South Africa Since 1945* (Johannesburg, Ravan Press, 1990); J. Seekings, “Civic Organisations in South African Townships” in G. Moss and I. Obery (eds), *South African Review*, no.6 (Johannesburg, Ravan Press, 1992); O’Meara, *Forty Lost Years: The Apartheid State and the Politics of the National Party*.

129 Dubow, *Racial Segregation and the Origins of Apartheid*, pp. 63-65.

130 Martin Legassick, “Gold, Agriculture and Secondary Industry in South Africa, 1885-1970: From Periphery to Sub-metropole as a Forced Labour System” in Robert Palmer and Neil Parsons (eds), *The Roots of Rural Poverty in Central and Southern Africa* (London, Heinemann, 1977). See also, Marian Lucey, *Working for Boroko: The Origins of a Coercive Labour System in South Africa* (Johannesburg, Ravan Press, 1981).

apartheid on health in South Africa has received some attention in recent years, most writers on the subject tended to focus narrowly on racial inequalities in the provision of health care to the country's various racial groups, while saying next to nothing about how Africans responded to their situation by embracing their alternative healing systems outside the formal health care system. In fact part of the literature reviewed here reveals that apologists of South Africa's racial ideology have frequently questioned the validity of any analysis that singles out apartheid as the principal source of poverty and deny that in turn, it constituted the root cause of the health problems of black South Africans. According to Shula Marks and Neil Andersson, such writers suggest instead that African poverty and its associated health problems were the unavoidable consequences of the processes of industrialisation and urbanisation in a multi-ethnic society.<sup>131</sup> Moreover, the majority of these writers appear to claim that even if there were indeed differences in health status between the white minority and the black majority these were rapidly diminishing due to the liberating work of Western medicine. In this way, they, like the government-sponsored publications at the time, conveniently emphasise the differences between the health status of black South Africans and that of blacks elsewhere on the continent. "With all its aspects considered", so runs an article in an official publication, "South Africa has probably the finest health services on the African continent, services which certainly are better than or compare favourably with those in many other countries throughout the world".<sup>132</sup> Similarly, in his foreword to an edition of the *South African Panorama*, the Minister of National Health and Population Development, Dr W.A. van Niekerk remarked, "We are particularly grateful that through the hard work and dedication of our health care personnel, we have been able to make substantial inroads into what are in fact, third world health problems".<sup>133</sup> An attempt is made in this study to expose this strategy as a sheer public relations exercise by arguing that such a comparison was irrelevant in the light of South Africa's economic capacity at the time relative to most of continental Africa. Such arguments were intended to deflect both domestic and foreign attention away from the plight of black South Africans and to lump these together with the overarching problems of sub-Saharan Africa. It is contended here that the only relevant comparison should be a domestic one, one that takes account of the economic resources of South Africa and then compare how the country's white and black population groups

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131 Marks and Andersson, "Industrialisation, Rural Health, and the 1944 National Health Services Commission in South Africa", in Feierman and Janzen, *The Social Basis of Health and Healing in Africa*, pp. 131-161. See also, WHO, *Apartheid and Health* (Geneva, WHO, 1983), p. 167.

132 Department of Information, *Report from South Africa* (London, South Africa House, 1972), p. 20.

133 W.A. Van Niekerk, "Foreword", *South African Panorama*, Vol.33, No.7 (1988), p.2.

benefited, or did not benefit. It should also examine the impact of other social policies in maintaining or closing these differences.

Admittedly, industrialisation and urbanisation can be sources of stress in a society and may have adverse effects on health and psycho-social well-being. Not surprisingly, the contemporary epidemic of HIV/AIDS has come to be regarded by some scholars as a “disease born of modernisation”.<sup>134</sup> Contrary to this view, I am inclined to concur with Nicoli Nattrass, who argues that “the history of South Africa’s AIDS policy is a sorry tale of missed opportunities, inadequate analysis, bureaucratic failure and political mismanagement”.<sup>135</sup> Also clearly concurring with Nattrass, Louis Grundlingh adds that the AIDS problem in South Africa was exacerbated because the apartheid government initially understood it incorrectly as a homosexual disease and had little comprehension of its vast implications for South Africa’s future.<sup>136</sup> Furthering this debate, the most interesting analysis of the epidemic in the context of the country’s epidemic history was that provided by Howard Phillips.<sup>137</sup> Indeed, Phillips has offered the kind of comparative analysis that has been lacking in historical literature on health and disease lamented above.

At the political level, it was the externalisation of the struggle in the 1960s by the banned liberation movements that brought the phenomenon of apartheid to the attention of the international community. In the early 1980s the strategy paid some dividends when an International Conference on Apartheid was held at Brazzaville, People’s Republic of the Congo, under the auspices of the World Health Organisation(WHO). The primary purpose of the conference was to examine the harmful effects of apartheid on the policy’s victims.<sup>138</sup> Flowing from presentations at this conference was a publication specifically drawing attention to apartheid as one of the most important historical forces in the moulding of both

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134 R. Gronemeyer, *Living and Dying with AIDS in Africa: New Perspectives on a Modern Disease* (Frankfurt, Brandes & Apsel, 2005).

135 Nattrass, *The Moral Economy of AIDS in South Africa*, p. 41.

136 L. Grundlingh, “A Critical Historical Analysis of Government Responses to HIV/AIDS in South Africa as Reported in the Media, 1983-94”, Paper presented at the International AIDS in Context Conference, University of the Witwatersrand, Johannesburg (2001), p. 28.

137 H. Phillips, “HIV/AIDS in the Context of South Africa’s Epidemic History: Preliminary Historical Thoughts”, *South African Historical Journal*, No.45 (2000). See also, H. Phillips, “HIV/AIDS in the Context of South Africa’s Epidemic History”, K.D.Kauffman and D.L. Lindauer (eds), *AIDS and South Africa: The Social Expression of a Pandemic* (Palgrave, Macmillan, 2004), 31-47.

138 Referring to black South Africans as “victims” of apartheid should not create the impression that they were mere hapless victims of the policy. Central to this thesis is the argument that through their struggles against oppression and the repressive policies of the NP government, particularly in the period since Sharpeville, black South Africans were to a great extent, agents of change which ultimately saw the adoption of such far reaching legislation as the National Health Act of 1977.

the country's health care system and the health of the people.<sup>139</sup> Although not the first of its kind, the publication was one of numerous attempts by the WHO to increase international awareness of the health implications of apartheid in South Africa. Placing equivalent emphasis upon the state manipulation of health care resources in the service of African oppression, the contributors argue that, "apartheid has shown itself to be a veritable racist ideology ... which guides all health action in South Africa".<sup>140</sup>

Apart from this publication, there are many other books and journal articles that touch on the subject of apartheid and its links with medicine;<sup>141</sup> there are at least a few which deal directly with the issue of apartheid, health and disease, and these have proved particularly useful to my study. Cedric de Beer's monograph, *The South African Disease: Apartheid Health and Health Services*, deals fairly comprehensively with the sort of issues that constitute the central focus of this thesis.<sup>142</sup> Indeed, De Beer argues that it was mainly in the sphere of ethnic separation that the most obvious inter-penetration of ideology and health services took place. He grows even more aggressive when he concurs with Sheena Duncan that health services in apartheid South Africa reflected the interests and policies of the ruling class and a government which had evolved a "virtually genocidal approach to health and health care."<sup>143</sup> A critical point echoed in my thesis is that one of the cornerstones of the apartheid policy during the period 1948-1976 was to conjure up ten ethnic "national states" whose health services were so underfunded and bankrupt that they could hardly be regarded as adequate justification for the existence of such institutions. The very existence of these fragmented health services was in the final analysis more functional to the apartheid state than the people it purported to serve, because it helped to consolidate ethnic, rather than South African loyalties. The National Party government used the separate ethnic-based health services to break down the reality of a single, united South African nation. In the final analysis, it soon

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139 WHO, *Apartheid and Health*.

140 Ibid, p. 6.

141 D. Mechanic, "Apartheid Medicine"; H.C.J. van Rensburg and S.R. Benatar, "The Legacy of Apartheid in Health and Health Care", in W.C. Cockerham et al (eds), *Readings in Medical Sociology* (New Jersey, Prentice Hall, 1998), 520-539; S. Marks et al, "Health, Apartheid and the Frontline States" *Social Science and Medicine*, vol .27, no. 7 (1988); M. Price, "Health Care as an Instrument of Apartheid Policy in South Africa", *Health Policy and Planning*, vol .1, no. 2 (1986), 158-170; I.K. Zola, "Medicine as an Institution of Social Control", *The Sociological Review*, vol. 20 (1972); A.B. Zwi, "The Political Abuse of Medicine and the Challenge of Opposing it", *Social Science and Medicine*, vol. 25, no. 6 (1987).

142 C. De Beer, *The South African Disease: Apartheid Health and Health Services* (Johannesburg, SARS, 1984).

143 Sheena Duncan was president of an anti-apartheid women's organisation called the Black Sash, quoted by De Beer, *The South African Disease*, p.21.

became evident that by creating a network of self-governing and pseudo-independent bantustans, the apartheid government relied on the fact of their existence to abandon its responsibility for the health care needs of the people living there. According to Cedric de Beer, by taking over the rhetoric of “self help”, “self reliance” and “community medicine” at the close of the 1970s, the state also sought justification for denying its responsibility of providing adequate health care. Instead, it was argued that since it was desirable for people to help themselves it would be patronising if the state did it for them, as this would eventually promote dependence on the “mother” state, a dependence which could hardly be sustained.<sup>144</sup>

In a more recent publication co-authored by Baldwin-Ragaven, De Gruchy and London, *An Ambulance of the Wrong Colour: Health Professionals, Human Rights and Ethics in South Africa*, there is a vivid depiction of the irony of apartheid in medicine and an insightful examination of the ethical problems that afflicted the health sector under apartheid. The authors also provide a useful discussion on the complicity of the medical profession in the political abuse of medicine.<sup>145</sup> The book’s title itself reveals some of the absurdities of apartheid medicine referred to in chapter three of this thesis. Based largely on submissions to the Truth and Reconciliation Commission (TRC), the book argues that rather than allowing health to be the driving force of its policy, the Department of Public Health concentrated its efforts and resources on only one part of the population, in line with the political objectives of the state. It allowed itself to become part of the oppressive apparatus of officialdom by not taking a stand or intervening when medical ethics were being violated, even by their own employees. In effect it was the death in detention of the Black Consciousness leader Steve Bantu Biko on 12 September 1977, in one of the most notorious events of apartheid medicine, that marked the turning point in the long history of the medical profession’s collusion with human rights abuses. The authors draw attention to the way silence, apathy and acceptance of the status quo were just as abusive of human rights as overt participation in violations. Anthony Zwi has also commented on the various ways in which the practice of medicine under apartheid was used to promote the political aims of the ruling National Party.<sup>146</sup> He tends to agree with Michael Savage<sup>147</sup> that allowing health policies to be

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144 De Beer, *The South African Disease*, p. 75.

145 Baldwin-Ragaven *et al* (eds), *An Ambulance of the Wrong Colour*. In an article entitled, “The Political Abuse of Medicine and the Challenge of Opposing it”, *Social Science and Medicine*, vol. 25, no. 6 (1987), 649-657, Anthony Zwi echoes some of the issues addressed by Baldwin-Ragaven and his co-authors. See also E Meyer-Lie, “The Political Abuse of Medicine”, *Social Science and Medicine*, vol. 25, no. 6 (1987), 645-648.

146 A. Zwi, “The Political Abuse of Medicine”, p. 649.

147 Savage, *The Political Economy of Health in South Africa*.

influenced by undemocratic political considerations could hardly be done without contradicting accepted medical ethics.<sup>148</sup> Nor could strict observance of such ethics be done within the apartheid programme, because in reality, apartheid and good medical practice are incompatible and mutually exclusive.

There were also some excellent sociological and anthropological studies that I used for reference,<sup>149</sup> but although I found them inspiring and useful in both analysis and interpretation, such studies do not have a historical analysis of the connections between apartheid, poverty, health and disease as their point of departure. Many of them hardly acknowledge the historical contribution of faith and indigenous healers as alternative providers of health care in South Africa. As pointed out above, Charlotte Searle, in one of the best-known publications on nursing history, also fails to give recognition to the contribution of indigenous healers in curing disease and alleviating suffering among the indigenous communities from the pre-colonial to the apartheid period. All that she offers on this is to make brief reference, in a negative light, to Nongqawuse and the Xhosa cattle killing tragedy.<sup>150</sup> The work by Shula Marks is a notable exception. In her classic study of the nursing profession not only does she draw attention to the role of class and gender in nursing; she also acknowledges the contribution made by indigenous healers to health care long before the onset of the colonial period and the advent of modern medicine.<sup>151</sup> She argues persuasively that relations of domination and subordination are not simply the result of class and racially defined divisions, but that they also result from inequalities in power between men and women, and between black and white.<sup>152</sup> Central to the ideology of nursing as “women’s work”, she argues, is the concept of femininity which embodies the idea that there is a cluster of characteristic, distinctive behaviours and outlooks that are peculiar to women. This perhaps explains why the vast majority of nurses are black and female while the majority of doctors are white and male. Closely analysed, this notion of nursing as women’s work is also embedded in the history of nursing itself. For example, even the alleged founder

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148 Zwi, “The Political Abuse of Medicine”, p. 649.

149 Francis Wilson and Mamphela Ramphele, *Uprooting Poverty: The South African Challenge* in C. Cockerham, et al (eds), *Readings in Medical Sociology* and H.C.J. van Rensburg, et al *Health Care in South Africa: Structure and Dynamics* (Pretoria, Academica, 1992).

150 Searle, *The History of the Development of Nursing in South Africa*, p. 4. For information on the cattle killing catastrophe see J.B. Peires, *The Dead Will Arise: Nongqawuse and the Great Xhosa Cattle Killing Movement of 1856-7* (Johannesburg, Jonathan Ball, 2003). See also a more recent article on the Nongqawuse syndrome by Achille Mbembe, in *City Press*, 4 June 2006, p. 29.

151 S. Marks, *Divided Sisterhood: Race, and Gender in the South African Nursing Profession* (New York, St. Martin’s Press, 1994), p. 78.

152 *Ibid*, p. 3.

of the nursing profession, Florence Nightingale, defined a good nurse rather vaguely as “a good woman”.<sup>153</sup> This also explains why the often patriarchal nature of knowledge production in the social sciences in general and more sharply in disciplines like history and anthropology, have always stifled investigation into women’s spaces in the collective past.<sup>154</sup> Unlike the majority of the works reviewed here, my study contends that women’s experiences should be central to analyses of material deprivation and the inevitable impact on health and disease. Just as feminist scholarship is broadening its perspective on gender, traditional scholarship on race, ethnic relations and class analysis should also incorporate a gender focus. This approach will lead to a better understanding of race, class and gender as inseparable determinants of inequalities in society. Amartya Sen<sup>155</sup> and Esther Chow<sup>156</sup> recognise that together these form interlocking patterns that serve as bases for developing multiple systems of domination that affect access to power and privilege.

It is in this feminisation of the nursing profession that we may well find the explanation why historically the majority of sangomas have been women while the diviners and herbalists have generally been men. However, class, rather than gender, was the most pervasive form of stratification in industrialised societies, with the class system being based primarily on economic differences between groups. Those who had unequal access to and control over material resources suffered as far as health standards were concerned. The difference with regard to apartheid South Africa is that stratification was almost always racially and gender-based, until the dying stages of apartheid when class began to displace race as a determining factor.

For the purposes of my study, L.G. Wells’ brief work, *Health, Healing and Society*, has particular merit in that it is an account of the health situation in apartheid South Africa by a medical practitioner who had first-hand experience of the difficulty of observing the ethical demands of the profession within the framework of apartheid.<sup>157</sup> According to Wells, the

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153 L. J. Jones, *The Social Context of Health and Health Work* (London, Macmillan, 1994), p. 262. Searle, *A History of the Development of Nursing in South Africa*, p. 4, shares the same view of nursing as a woman’s occupation.

154 Zondi, “Genderising Nursing History in South Africa”, p .3.

155 A.K. Sen, “Agency and Well-Being: The Development Agenda”, in N. Heyzer (ed.), *A Commitment to the World’s Women: Perspectives on Development for Beijing and Beyond* (New York, UNIFEM, 1995), pp. 103-112.

156 E.N. Chow, “Introduction in Transforming Knowledge: Race, Class, and Gender”, in E.N. Chow et al (eds), *Race, Class, and Gender: Common Bonds, Different Voices* (London, SAGE Publications, 1996), p. xix.

157 L.G. Wells, *Health, Healing and Society* (Johannesburg, Ravan Press, 1974).

problem of inequitable provision of medical services was by no means peculiar to apartheid South Africa. He claims that it arises whenever a small, powerful elite takes the decisions about the division of resources between themselves and the majority. What was peculiar to the South African situation was the remarkable lack of sympathy that had built up between the privileged minority and the under-privileged majority. The important point that Wells makes here is that what actually exacerbated the South African problem was the fact that the white NP elites did not even have to woo the under-privileged majority in order to maintain their political power and dominance. Although Wells' analysis was useful in that it informed my analytical framework for this study, the value of his work is limited because it does not deal in any depth with the important issues it raises.

According to Michel Foucault, for a long time biomedicine dominated our thinking about health and disease.<sup>158</sup> He goes on to argue that biomedicine's scientific approach and conceptualisation of the body as a machine have constituted a distinctive way of "seeing and knowing", which has been highly influential in our thinking about health. This is so in spite of Northrop's warning:

One must seriously ask oneself whether superstition and myth, in the derogatory or non-scientific connotations of these words, are not due to our judging a given people from our perceptual standpoint, rather than theirs. ... When the trouble was taken to find their concepts, then it became evident that everything made sense and that their behaviour and cultural norms followed as naturally and consistently from their particular categories of natural experience as ours do from our own. I believe it is just as much an error to suppose that there was no people anywhere who insisted on empirically, and hence scientifically, verified basic concepts before Galileo, prevalent as the latter belief is, it is nonetheless rubbish.<sup>159</sup>

In Foucault's view, "the truth claims" of biomedicine have been successfully projected at the expense of older ways of thinking about health and disease.<sup>160</sup> Small wonder that it was only recently that indigenous medicine received attention within the context of the World Health Organisation's primary health care strategy.<sup>161</sup> However, on the basis of available evidence, despite the increasing scholarly interest in indigenous healing throughout the continent,<sup>162</sup> in

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158 Foucault, *The Birth of the Clinic: An Archeology of Medical Perception*.

159 F.S.C. Northrop, quoted by Peter Morley and Roy Wallies (eds), *Culture and Curing: Anthropological Perspectives on Traditional Medical Beliefs and Practices* (London, Peter Owen, 1978), p. 1.

160 Foucault, *The Birth of the Clinic*.

161 W. Bichmann, "Primary Health Care and Traditional Medicine – Considering the Background of Changing Health Care Concepts in Africa", *Social Science and Medicine*, vol. 13B (1979), pp. 179-82.

162 Singer (ed.), *Traditional Healing: New Science or New Colonialism?*; S. Feierman, "History of Pluralistic Medical Systems: Change in African Therapeutic Systems", *Social Science and Medicine*,

South Africa, the history of indigenous medicine has been a relatively neglected subject.<sup>163</sup> Although William Rivers was by no means the first anthropologist to report on the medical beliefs and practices of non-literate peoples, he was nevertheless a pioneer in attempting systematically to relate indigenous medicine to other aspects of culture and social organisation. Rivers argues that, “native medical practices are not a medley of disconnected and meaningless customs ... [but rather] ... are inspired by definite ideas concerning the causation of disease”.<sup>164</sup> For practical reasons, the existence of a large volume of literature on a country’s indigenous medicine (or lack of it), depends largely upon the extent to which the government of that particular country has recognised, suppressed, marginalised, ignored or outlawed the practice of the craft. Little wonder then that the literature on indigenous medicine in South Africa is limited to sociological and anthropological works, while there is very little by writers from the medical profession,<sup>165</sup> and even less by historians. With very few exceptions, and until very recently when a number of journal articles began to appear,<sup>166</sup> researchers have been strongly wedded to the notion of high technology medicine. They have hardly been inclined to acknowledge that mainly due to the inaccessibility of modern medicine and its failure to deal with certain “culture-bound” illnesses among African communities, indigenous medicine has filled this void by providing a stable, culturally meaningful and psychological support base to well over 80 per cent of the African

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vol. 13B (1979), pp. 277-84; T. Asuni, “The Dilemma of Traditional Healing with Special Reference to Nigeria”, *Social Science and Medicine*, vol. 13B (1979), pp. 33-39; L. Swantz, *The Role of the Medicine Man Among the Zaramo of Dar es Salaam* (PhD, University of Dar es Salaam, 1972); G.L. Chavunduka, *Interaction of Folk and Scientific Beliefs in Shona Medical Practices* (PhD, University of London, 1972); H. Fabrega and P.K. Manning, “Illness Episodes, Illness Severity and Treatment Options in a Pluralistic Setting”, *Social Science and Medicine*, vol. 13B (1979), pp. 41-51; M. Wallace, “‘Making Tradition’: Healing, History and Ethnic Identity Among Otjiherero-Speakers in Namibia, c. 1850-1950”, *Journal of Southern African Studies*, vol. 29, no. 2 (2003).

- 163 M. Freeman, “Negotiating the Future of Traditional Healers in South Africa - Differences and Difficulties”, *Critical Health*, no. 40 (1992), 64-69; M. Freeman and P. Motsei, “Planning Health Care in South Africa – is There a Role for Traditional Healers?”, *Social Science and Medicine*, vol. 27 (1992); T. Sodi, “Towards Recognition of Indigenous Healing: Prospects and Constraints”, *Chasa: Journal of Comprehensive Health*, vol. 7, no. 1, 1996).
- 164 W.H. Rivers, *Medicine, Magic and Religion: The Fitzpatrick Lectures Delivered Before the Royal College of Physicians of London in 1915 and 1916* (London, Routledge, 2001), p. 51.
- 165 M.V. Gumede, *Traditional Healers: A Medical Practitioner’s Perspective* (Cape Town, Skotaville Publishers, 1990).
- 166 J. De Jong, *Traditional Medicine in Sub-Saharan Africa: Its Importance and Potential Policy Options: Working Papers* (World Bank, 1991); I. Wolfers (ed.), *The Role of Traditional Medicine in Primary Health Care – Papers Presented at a Workshop at the Third International Conference on Traditional Asian Medicine in Bombay, India in January 1990* (Amsterdam, VU University Press, 1990); S.D. Edwards, “Traditional and Modern Medicine in South Africa: A Research Study”, *Social Science and Medicine*, vol. 22, no. 11 (1986); Sodi, “Towards Recognition of Indigenous Healing: Prospects and Constraints”, *Chasa: Journal of Comprehensive Health*; E.M. Mankazana, “A Case for the Traditional Healer in South Africa”, *South African Medical Journal*, vol. 56 (1979), pp.1003-1007; M. Jacobs, “The Role of Traditional Medicine in a Changing South Africa”, *Critical Health*, no. 43 (1993).

population.<sup>167</sup> Similarly, the anthropological study of health and disease has increasingly veered towards disease-orientated studies emphasising only the more unusual disease episodes, where supernatural explanations are invoked; everyday ailments are underplayed.<sup>168</sup> Then too the emphasis on the disease episodes that are peculiarly African tends to exaggerate racial differences between blacks and whites.<sup>169</sup> This emphasis on differences had significant implications for health care in that it provided sufficient ammunition to cultural racists who pointed to the perceived cultural differences between people in their justification of apartheid medicine. In such cases, areas of shared understanding of disease and its causation are often minimal and indigenous beliefs are conveniently regarded as a stumbling block to the reduction of disease and improvements in levels of health.

One of the central questions about African healing practices is whether and to what extent they can be compared to science-based medicine. Peter Morley and Roy Wallis, have succinctly described the relationship between modern and indigenous medicine and concluded that there has always been a tendency to view indigenous medical systems and beliefs from the vantage point of contemporary Western medical science, arguing on these grounds that they were primitive and irrelevant to the health of human populations.<sup>170</sup> Although there are serious, scholarly accounts that demonstrate the inseparability of indigenous medicine and moral culture, they have been written principally by European anthropologists. They do, nevertheless, provide a useful base from which one can draw conclusions about the worth of indigenous medicine. A good example is Evans-Pritchard's classic study of the people of southwest Sudan,<sup>171</sup> *Witchcraft, Oracles and Magic Among the*

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167 In spite of its well publicised achievements, it is important to acknowledge the effects of the longstanding suspicion with which biomedicine was seen by some Africans. No doubt this has in many ways influenced their therapy-seeking behaviour over the years, within a plural medical system. But as I have pointed out earlier, for the majority of Africans, growing confidence in the efficacy of biomedicine did not automatically translate into loss of confidence in indigenous medicine or indigenous therapies. All it did was merely to add to the existing medical options.

168 H. Holland, *African Magic: Traditional Ideas that Health a Continent* (Viking, Penguin, 2001); P. Mabetoa, *Psychotherapeutic Implications of Ancestral Veneration and Spirit Possession in Africa: The Case of South Africa* (Berlin, Schreiber, 1992).

169 M.V. Buhrmann, "Lifestyle and Disease – Thwasa and Bewitchment", *South African Medical Journal*, vol. 61 (1982), pp. 877-9. This may be contrasted with H.C. Seftel's study on medical differences between black and white South Africans, "The Rarity of Coronary Heart Disease in South African Blacks", *South African Medical Journal*, vol. 54, no. 99 (1978).

170 Morley and Wallis, *Culture and Curing: Anthropological Perspectives on Traditional Medical Beliefs and Practices*, p.56.

171 E.E. Evans-Pritchard, *Witchcraft, Oracles and Magic Among the Azande* (Oxford, Clarendon Press, 1937). See also E.E. Evans-Pritchard, *The Azande: History and Political Institutions* (Oxford, Clarendon Press, 1971); E.E. Evans Pritchard, *The Institutions of Primitive Society: A Series of Broadcast Talks* (Oxford, Blackwell, 1954) and E.E. Evans-Pritchard, *Man and Woman Among the Azande* (London, Faber and Faber, 1974).

*Azande*, in which he assesses the worth of their therapeutic magic as a system of natural observation and prediction. He then analysed Azande practices and abstracted chains of causal reasoning which he found to be flawed when they were evaluated against accepted standards of “science” and logic. In similar vein, in an article entitled “Divination versus Diagnosis”, Robin Horton argued that unlike Western science, which is amenable to change because it is “open”, African folk-reasoning about disease leaves no room for disproof. He describes traditional African reasoning as “closed” in that it systematically blocks out alternatives to accepted causal explanations.<sup>172</sup> Although his original assessment of African medicine was more sympathetic, Roy Porter, has as recently as 1997 also continued this trend of measuring the worth of indigenous medicine by scientific standards, but he admits that “recent pharmacological investigations have demonstrated the efficacy of many traditional cures”.<sup>173</sup> Social scientists have long warned against this tendency of interpreting the actions or beliefs of other peoples by using one’s own standards. Steven Feierman challenges this approach, arguing that this contrast between the so-called “closed” intellectual system of traditional African thought and the “open” one of Western science, when applied to medicine, is misleading and irrelevant.<sup>174</sup> In his consideration of indigenous healing, David Landy also cautions: “Although welcoming these important analyses of the social structural role of the healer, it is an error to downplay the actual medical aspects of the role”.<sup>175</sup> Corinne Wood, too, is persuasive in her argument that in their use of scientifically verifiable ingredients, indigenous curers have made noteworthy contributions to the worldwide medical pharmacopoeia. She claims that many important drugs in wide use were originally derived from the medical kits of “bush healers” and indigenous herbalists.<sup>176</sup>

Against this background, it is clear why the way people select and make use of different forms of medical treatment in settings where there are competing systems, has always attracted the worldwide interest of social scientists. However, in South Africa indications are that despite the fact that this has stimulated intellectual debate and commentary in recent

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172 R. Horton, “African Traditional Thought and Western Science”, *Africa*, no. 37 (1967), pp. 50-71. See also R. Horton, “African Conversion”, *Africa*, no. 41 (1971), p. 85.

173 R. Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to Present* (New York, W.W. Norton, 1997), p. 37.

174 S. Feierman, “History of Pluralistic Medical Systems: Change in African Therapeutic Systems”, *Social Science and Medicine*, vol. 13B (1979), p. 277. See also S. Feierman, “Struggles for Control: The Social Roots of Health and Healing in Modern Africa”, *African Studies Review*, vol. 28, no. 2-3 (1985), 73-145.

175 Landy, *Culture, Disease and Healing: Studies in Medical Anthropology*, p. 418.

176 C.S. Wood, *Human Sickness and Health: A Biocultural View* (California, Mayfield Publishing Company, 1979), p. 307.

years, academic studies have generally remained impressionistic and anecdotal.<sup>177</sup> Lack of a common set of definitions and methods of procedure has hampered empirical studies of the determinants of differential use of facilities. However, writing about traditional and modern medicine in coastal Peru and Chile, Simmons maintains that the theories associated with modern medicine, such as the “germ theory of disease” have had no impact on the basic theories of the traditional medical belief system. He goes on to explain that although the technologies of biomedicine, such as major surgical interventions and the administering of injections for which there exist no counterparts in the indigenous system, are more readily accepted, they are seen as mere additions to the traditional resources rather than a decided substitute for indigenous therapies.<sup>178</sup> Then too, Charles Erasmus emphasises people’s preparedness to discard their old customs for new ones if they can readily perceive the benefit of doing so; when cognitive situations are not conducive to such perceptions, it is often not surprising that people simply continue their traditional ways of doing things or merely add new practices while still retaining the old ones.<sup>179</sup> From a somewhat different perspective, Milton Roemer, has accused anthropologists of exaggerating the grip of tradition and for underestimating the receptivity of people to change in their medical behaviour if they experience new measures that help them.<sup>180</sup> Perhaps the truth of the matter, which Roemer might be unaware of, is that in situations of poverty such as obtained in South Africa during the period under review, while demonstrated therapeutic advantages of modern medicine had gained widespread and growing adherence among the relatively wealthy minority white population, the personal experiences of the relatively poor majority black population prevented them from perceiving these advantages. Under the oppression of apartheid traditional medicine may well have dominated their perceptions of available curative measures and influenced their health seeking behaviour at the onset of illness. The specific illness, with all its implied meanings within a given culture, is seen as the primary determinant of the appropriate therapeutic resource. For those illnesses where the perceived etiology is in the area of ritual uncleanness, about which biomedical practitioners can do very little, practitioners of indigenous medicine are consulted. Despite this, surprisingly the

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177 H. Fabrega and M. Zucker, “Components of Illness and Type of Medical Practitioner: A Comparative Study”, *Social Science and Medicine*, vol. 13A (1979), pp. 13-23.

178 O.G. Simmons, “Popular and Modern Medicine in Mestizo Communities of Coastal Peru and Chile”, *Journal of American Folklore*, vol. 68, no. 57 (1965).

179 C.J. Erasmus, “Changing Folk Beliefs and the Relativity of Empirical Knowledge”, *Southwestern Journal of Anthropology*, vol. 8 (1952), 411-428. See also, C.J. Erasmus, *Man Takes Control* (Minneapolis, University of Minnesota Press, 1961).

180 M.I. Roemer, “Health Service Organisation as a Task in Applied Social Science”, *Canadian Journal of Public Health*, vol. 45 (1954), 133-145.

health dimension of the African medical domain has received scant attention from professional historians. Although Harriet Ngubane's ethnography of health<sup>181</sup> is an exception, she too tends to focus on utopian beliefs about an ideal state of health and in so doing gives little attention to the practical day-to-day issues of nutrition, lack of housing, lack of clean water, inadequate sanitation and generalised poverty which characterised much of South Africa's rural black population in the period under review.

It was the combination of the various forms of deprivation under apartheid that provided the rationale for many Africans in the medically under-resourced areas to uphold their dependence on both modern and indigenous medical systems. For some, the modern medical services were preferred for minor and epidemic complaints, obstetric difficulties and accidents. But as pointed out above, vague, nonspecific and chronic complaints, the origins of which were hard to explain, have always been taken to the indigenous healer.<sup>182</sup> Elsewhere, Anthony Colson has reported on the differential use of multiple medical resources. He first reviewed the types of explanations given in the medical sociology literature about the critical factors influencing choice of treatment and concluded that the modern practitioner is preferred for the relief of the symptoms, while the indigenous practitioner would be consulted to help deal with the perceived etiology, such as a disturbance in relationships with other persons or with supernatural beings.<sup>183</sup> Morgan has focused his interest on the categorisation of people who used modern and indigenous medicine respectively and his general impression was that the modern system was used only in cases of emergency, when all indigenous sources had failed.<sup>184</sup> For the majority of the others for whom the indigenous healer was the only health resource available, the question of what kind of therapy to turn to at the onset of illness was irrelevant. However, this reality has not always been acknowledged by the professional medical establishment and the health authorities in the public service, who viewed indigenous medicine negatively and saw it as a potential threat to the much-acclaimed modern medical achievements of the twentieth century.

Notwithstanding the foregoing, in a book entitled, *Traditional Healers: A Medical Doctor's*

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181 H. Ngubane, *Body and Mind in Zulu Medicine* (New York, Academic Press, 1977). See also, H. Ngubane, "Some Aspects of Treatment Among the Zulu", J.B. Loudon (ed), *Social Anthropology and Medicine*, A.S.A. Monograph 13 (London, Academic Press, 1976), pp.319-57.

182 Interview with Ngaka Conrad Tsiane, 4/11/2004.

183 A.C. Colson, "The Differential Use of Medical Resources in Developing Countries", *Journal of Health and Social Behaviour*, vol. 12 (1971), p. 226.

184 R.W. Morgan, "Migration as a Factor in the Adaptation of Medical Care", *Social Science*, no. 7 (1973), p. 865.

*Perspective*, M.V. Gumede, a qualified medical practitioner and a trained indigenous healer, whose views on the subject cannot be dismissed as inconsequential, maintains that the existing tension between modern medical practitioners and indigenous healers should first be resolved before the issue of collaboration between the two systems can be considered.<sup>185</sup> S.D. Edwards is inclined to agree. His studies on the functioning of both medical systems have led him to the conclusion that “notwithstanding the fact that indigenous and modern practitioners proceeded from different theoretical orientations, they were in significant agreement as to diagnosis and treatment of patients when faced with the same limited choice of options”.<sup>186</sup> Noting that patients perceived both modern and indigenous practitioners as equally helpful, Edwards urged the promotion of indigenous medicine.

Among the few academic works focusing on the role of indigenous healers in the prevention of disease in South Africa was that undertaken by Shai-Mahoko.<sup>187</sup> She explored the experiences of indigenous healers in providing health care to a specific African community within their cultural context. Shai-Mahoko concluded that there was dual utilisation of both formal and indigenous health service systems by black South Africans in the North-west Province. And most importantly she found that there was significant involvement of indigenous healers as primary health care workers, especially in the field of paediatric preventive care.<sup>188</sup> In a similar examination of the role of indigenous healers in the promotion of health within the context of primary health care, E.T. Makoia found that although there was no formal relationship between traditional healers and nurse practitioners, traditional healers played a significant role in the promotion of health. The study also recommends increased collaboration between the two medical systems in the interest of the communities they served.<sup>189</sup> Julia Bereda on the other hand, focussing on the same theme, argued against the conventional view of indigenous medicine as being a closed system.<sup>190</sup> Instead, she concurs with Sataugard,<sup>191</sup> that indigenous healers represent a relatively open system, and are free to adapt to peoples’ perceptions and needs within a much more holistic framework. Bereda is

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185 Gumede, *Traditional Healers: A Medical Doctor’s Perspective*.

186 Edwards, “Traditional and Modern Medicine in South Africa: A Research Study”, pp.1274-75.

187 S.N. Shai-Mahoko, *The Role of Indigenous Healers in Disease Prevention and Health Promotion Among Black South Africans: A Case Study of the North West Province* (PhD thesis, UNISA, 1997).

188 *Ibid.*, p. iii.

189 E.T. Makoia, *Collaboration Between Traditional Healers and Nurse Practitioners in Primary Health Care in Maseru Health Service Area, Lesotho* (PhD thesis, UNISA, 2000).

190 J.E. Bereda, *Traditional Healing as a Health Care Delivery System in a Transcultural Society* (M.A. dissertation, UNISA, 2002), p. 27.

191 F. Staugard, *Traditional Medicine in Botswana* (Gaborone, Ipelegeng Publishers, 1985), p. 68.

particularly outspoken when she declares that it would be a demonstration of extreme irrationality for the Ministry of Health to ignore the lessons of history by excluding indigenous healers from the health care delivery system as a pre-condition for the attainment of the noble goal of “health for all”.<sup>192</sup> More recently, Mavis Mulaudzi drew attention to the role of indigenous knowledge systems in general and of indigenous healers in particular in the management of sexually transmitted diseases among Venda women.<sup>193</sup>

By using a range of sources, some of which were either ignored or unavailable to the authors whose work has been reviewed above, the present study seeks to demonstrate that although the poor health status of black South Africans was not a function of apartheid ( in the sense that it was not intentional on the part of apartheid planners to keep Africans in poor health) it was largely the result of the policy’s impoverishing impact on the population. It cannot be denied that the health of the African people was hardly a priority of the apartheid government. I therefore argue that during the period 1948-1976, when the health status of the black majority was very poor, indigenous medicine played a critical role in mitigating the effects of apartheid-created poverty and thus contributed immensely to both the promotion of health and the prevention of disease. Because of the highly topical nature of the subject, any suggestion of integrating the two diametrically opposed medical paradigms within the South African political, economic and legal framework will be highly contentious, particularly in the light of the country’s divergent communities varying in culture, modernisation and level of education. This study aims to make a significant contribution to this debate.

### **1.7 How this research was conducted**

I have tried to situate this thesis in the context of a wider literature in order to develop a theoretical framework which embroiders the historical analysis that follows. The principal *modus operandi* has been archival and library research of primary political and medical documents. The bulk of the empirical information used was drawn from archival sources, particularly from the large body of correspondence in the Department of Health files located in the National Archives of South Africa (NASA). I also spent quality time in the Jan Hofmeyr Reference Library of the South African Institute of Race Relations (Johannesburg); the Archives of the South African Institute of Race Relations; the William Cullen Library of

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192 Bereda, *Traditional Healing as a Health Care Delivery System*, p. 27.

193 F.M. Mulaudzi, *Women and Sexually Transmitted Diseases: An Exploration of Indigenous Knowledge and Health Practices Among the Vhavenda* (PhD thesis, Unisa, 2003).

the University of the Witwatersrand and the UNISA Library Archives. Other primary sources consulted were various newspapers dealing with specific aspects of the topic. I also spent time in the library of Johannesburg's oldest surviving daily newspaper, *The Star*, perusing files of reports about aspects of indigenous medicine, indigenous beliefs and value systems.

Although I am mindful of the fact that there are still some scholars (albeit a small minority) who are not entirely convinced of the credibility of unwritten source material for historical reconstruction, I have no doubt that such sources, particularly oral evidence, is extremely valuable, used either with or in the absence of written documents. This in my view, is precisely what is implied when it is said that "contemporary historians have an advantage in gaining access to the recent memory of participants". Because traditional African belief systems and practices are not written but instead they are inscribed in people's minds and hearts, in their proverbs and sacred ceremonies, holding interviews with practitioners of indigenous medicine as custodians of African cultures could hardly be avoided. Indeed, it has often been said that in contrast to the spoken word, which is committed to memory by several people in the community, Africans shunned the written word because they believed that written history had the potential to be corrupted by the writer.<sup>194</sup> And this is probably what is meant by the saying that "in Africa when an old man dies, a whole library disappears". Based on this understanding, my ethnographic research included unstructured interviews with a number of indigenous healers, but most notably Ngaka Conrad Tsiane and Ngaka Hlathikhulu Ngobeni, their sangoma trainees as well as their patients. My decision to select only these two indigenous healers was informed primarily by their popularity and the fact that they have a large number of apprentice sangomas under their guidance, which offered me the opportunity to discuss aspects of indigenous healing with a much wider audience than would otherwise have been possible. Of course one should acknowledge that opinions expressed by an unrepresentative number of indigenous healers in 2004/2005 may not necessarily reflect the views of the majority of indigenous healers some four decades ago, primarily because of changed socio-economic and political circumstances since 1994. Therefore the acceptance and use of oral evidence in this regard, like the use of oral evidence in general historical reconstructions, should always be made with the utmost caution. Notwithstanding its shortcomings however, oral evidence nevertheless does fill a significant gap in the literature by providing information that could otherwise not have been available through recourse to the written record alone, particularly in an area as under-researched as the contribution of

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194 Gumedé, *Traditional Healers: A Medical Practitioner's Perspective*, p. 128.

indigenous medicine to health and healing in apartheid South Africa. For practical reasons therefore, the findings in this area cannot be said to be representative of all “black communities”, which in turn precludes the kind of generalisation one would have had, had the sampling net been cast much wider. The research undertaken for this part of the thesis was mainly conducted in the former bantustan of Kwandebele, now in the Mpumalanga Province, with the assumption that the situation there was a reflection of what transpired in other black areas around the country. I also interviewed groups of indigenous healers in Kwazulu-Natal and Limpopo Province, mainly for comparative purposes. Apart from these discussions, the most revealing sources of data were the interviews conducted with selected members of the medical profession who are affiliated to a variety of sectional groups within the biomedical profession. These interviews provided important insight into the perceptions and viewpoints of the principal figures in the health care situation and I have endeavoured to corroborate this information with documented evidence. On many occasions, however, the study also benefited from conversations that were not, at the time, regarded by the people I was talking to, or even by myself, as data for an academic enquiry. I have therefore, except for a few individuals, not ascribed particular comments or quotes to those people, although their views helped to shape my own. This was particularly true of indigenous medical beliefs and practices in different cultures.

The Black Community Programmes Limited was a voluntary organisation established in the early 1970s with the objective of conscientising black South Africans about their identity. The idea was to enable them to analyse their own needs and problems and to mobilise their resources, including pride in their own healing systems, to meet these needs. In October 1973, the programme produced its first issue of the *Black Review*, a quarterly publication reflecting black thinking on matters of topical interest on a variety of subjects. The publication encouraged black people to begin to use other black people, whose views could not find space in the daily newspapers, as points of reference. This development was of critical importance in that it helped to reinforce the belief that Africans could survive despite an oppressive system, by taking pride in their own indigenous knowledge, including medicine. I have consulted this literature, a full collection of which is available in the Documentation Centre of the UNISA Library Archives.

Perhaps the most distressing part of my fieldwork, particularly in some parts of one of the most under-resourced ex-bantustans, Kwandebele, was to come face to face with the long

term effects of forced resettlement in the form of acute unemployment, grinding poverty and malnutrition. Questions about family members who had died due to the dismal living conditions experienced after resettlement in the “bantustan” in the mid 1970s, were extremely sensitive issues which at times provoked emotional responses. Although I assured the respondents that they were under no obligation to answer such questions, most were anxious to oblige.

I was deeply humbled by the remarkable resilience of the majority of the people who had been at the receiving end of the NP policies but refused to give in; they continued to resist and struggle against apartheid, and ultimately prevented Kwandebele from becoming South Africa’s last bantustan to gain Pretoria-style independence. Indeed, not only did each interview add a new piece to the puzzle of what really transpired, but pertinent to my study, they also revealed the contradictions in the arguments for and against indigenous medicine. Though most of the people I interviewed chose to accept the offer of anonymity, others categorically requested that their identity and their comments on this topical issue be acknowledged. Because of the historian’s ethical obligation to his research subjects, I have kept my word both in the footnotes and in the list of sources appearing at the end of this thesis.

In spite of the obvious limitations of statistics, a systematic analysis of relevant statistical data was also undertaken, most notably, from reports published by Statistics South Africa. However, official South African statistics such as those reviewed in chapter four on particular diseases, comprise for the most part notification data analysis of deaths provided by the Medical Officers of Health (MOH) of specific areas, at particular times. These data were further supplemented by annual reports from the Department of Health and annual surveys from the South African Institute of Race Relations, covering the period of high apartheid from 1948 to 1976.

Another most fruitful source of published material lay in the rich supply of figures and articles of many kinds in the *South African Medical Journal* and in the journal of *Social Science and Medicine*, published regularly from the 1950s to 1976 and beyond. In addition to these, other reports and specialist publications of many kinds were also perused for relevant material. Copies of departmental minutes, press statements, professional and academic commentaries and numerous official circulars dealing either with pieces of apartheid

legislation or with observance of apartheid in public health institutions, as well as a number of dissertations and theses, all came my way, and in no small measure they all amplified the picture.

Despite strong arguments to the contrary,<sup>195</sup> there is no need for an historian to apologise for analysing any material data of the apartheid era in terms of the racial categories into which South African society was economically and politically stratified. Neither should any historian be compelled to justify this approach, because whether or not one recognises such racial categories, they remain part of the historical reality of South African politics; therefore no analysis of the population data of the period 1948-1976 can do justice to the issues involved if it ignores these categories. Again, it is my view that race-based statistics should be retained because marked differences within each social class are still apparent for different racial groups even in the post-apartheid period. The use of race in instances such as this need not on its own be viewed as discriminatory or as legitimising apartheid terminology, if its purpose is to target resources to those racial groups most in need of them. I also feel that the removal of these race terms from the health statistics in the absence of adequate social and economic variables with equivalent power to differentiate between the historically disadvantaged and the beneficiaries of the system, could impair the ability of service providers to target resources in a manner that will effectively address the apartheid legacy of access inequalities. In the final analysis, the insights gleaned from all the interviews and from documentary source material, both primary and secondary, have impressed upon me to reconsider a range of issues about which I was initially very ignorant. Subsequently, the material has compelled me to modify some of my initial contentions and to revise most of my theoretical assumptions. By using this array of approaches and methodologies, it is hoped that the study provides a holistic and comprehensive analysis of the indigenous medical system as a complementary alternative to modern medicine in this age of the AIDS pandemic.

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195 Baldwin-Ragaven et al, in the most useful work, *An Ambulance of the Wrong Colour*, p. 134, maintain that if we accept the compelling evidence that genetically distinct human sub-species do not exist and that “race” is not a valid category in human biology, it can be argued that the use of racial labels and categories in health research is “ill-conceived, misleading and divisive”. They claim that using nationality to differentiate between groups, tends to reinforce the view that geographically isolated and genetically distinct human races exist. And using the racial categories legitimises the process of discrimination and generates a “racially” structured view of society that encourages further discrimination. My counter argument in this study is that this would be a narrow view of the subject, resulting from an uncritical application of apartheid terminology. Since history is a record of what happened, it cannot realistically shy away from such historical concepts.

## 1.8 Limitations of the study

As could be expected, however, the study is not without its limitations. There is no doubt that vital statistics, i.e. data on births, deaths and population size are the basis of any national health information system and are crucial for any public health planning. These are used mainly to determine and monitor profiles on cause of death and to generate hypotheses on the relationship between exposure of particular race groups to certain risk conditions and ill health. Yet, in apartheid South Africa, particularly during the period under review, very little attempt was made to collect valid and reliable data for the black population. In fact, for political reasons, it was state policy not to collect these essential statistics at all. In point of fact, the exclusion of blacks from the statistical record was part of an effort to remove black health problems from public view long before the advent of apartheid. As early as the 1930s, the Department of Public Health, clearly recognising the declining health status of rural and black communities, admitted that the extent of the problem could not be fully measured without vital statistics for the black population.<sup>196</sup> As a consequence to this recognition, an interdepartmental committee led by the Departmental Secretary, Sir Edward Thornton, argued very strongly for the extension of vital statistics to all people in the Union, including the black population, but their arguments were rejected by the politicians.<sup>197</sup> What this refusal meant was of course very serious because of the practical problems of mounting effective public health policies or doing serious epidemiology in the absence of reliable statistics and morbidity data. In the period covered in this thesis (1948-1976) very little had changed. For example, in his analysis of the leading causes of death for Asians, coloureds, blacks and whites, Wyndham, noted that neither mortality rates nor the age distribution of the black population could be calculated directly from the official reports of the Department of Statistics. He was however able to show that the all-cause age-standardised mortality rate for Africans aged 15 to 64 in 1970 was almost twice that of whites.<sup>198</sup> In spite of inadequacies in the data, very little reliance can be placed upon the mortality statistics of black South Africans in the period under review because a large number of cases still went unrecorded. After the homelands were established, which promptly added more darkness to a night already devoid of stars, African vital statistics became even more fragmented and less

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196 GES 1079 34/33F CPH, Minutes of the 18<sup>th</sup> Meeting, 9-10 February 1938.

197 GES 1902 11/32E Report of the Interdepartmental Committee on Vital Statistics of the Non-European Population, 1937.

198 C.H. Wyndham, "The Loss from Premature Deaths of Economically Active Manpower in the Various Populations of the Republic of South Africa", *South African Medical Journal*, vol. 86, no. 7 (1981), p. 418.

reliable. Similarly, in his monumental history of tuberculosis control in South Africa, Randall Packard has drawn attention to the government's commitment to eliminate the problem of tuberculosis among black South Africans through the application of exclusionary policies that physically removed those blacks from centres of white settlement and thus expunged any record of their sickness from official health statistics.<sup>199</sup> The absence of basic statistical data relating particularly to African births and deaths for the entire country, or a data base that would allow reasonably confident inferences about mortality during the period 1948-1976, was a serious limiting factor. Compounding this problem was the fact that for reasons alluded to above, the activities of indigenous healers were largely unrecorded. The issue here is that those individuals, and there were many,<sup>200</sup> who relied exclusively on indigenous medicine were not covered in statistical records in terms of births and deaths, even when these services became available. Much as there is no documented record of babies who were successfully delivered by traditional birth attendants (TBA), there is also no record of those who died while on indigenous medication. Similarly, reliable data on the numbers and varying practices of practitioners of indigenous medicine is not available. Even information obtained from surveys is bound to have the limitation of understating the social significance of indigenous medicine because respondents are often reluctant to reveal to researchers from the modern sector (mainly because of the latter's well known attitudes to indigenous cultures) the extent of their reliance on indigenous healing. The limitations of using health surveys in the study of indigenous medicine stem mainly from the fact that such surveys often fail to capture rare and seasonal events because they adopt short recall periods in order to increase reliability of responses. Another limitation is that which was identified by David Hammond-Tooke,<sup>201</sup> that unlike the pooled knowledge of biomedical science, the knowledge of the indigenous healer is often secret. In the absence of the written record, there is thus no public accumulation of medical lore or built-in checks on its effectiveness. Herbalists, especially those who have attained prestige through their specialism, such as Ngaka Tsiane and Hlathikhulu who provided the evidence here tend to guard very jealously the secrets of their success. Yet despite the data limitations, there is no question that among black South Africans, a substantial proportion of people (both ill and well)<sup>202</sup> used the services of indigenous healers

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199 Packard, *White Plague, Black Labor*, p.21.

200 In her paper entitled, "'We Would Rather Die at Home': Health Care in Windhoek, 1915-1945", Marion Wallace sums up the attitude of many indigenous societies who preferred to die at home *in the hands of indigenous healers* rather than entering a hospital with no guarantee of surviving anaesthesia and surgery (emphasis mine).

201 Hammond-Tooke, *Rituals and Medicines: Indigenous Healing in South Africa*, p.147.

202 The issue of annual fortification of homesteads and family members against "witches" suggests that not only sick people sought the services of indigenous healers but even healthy individuals who regarded

to varying degrees. The other significant limitation is the lack of systematic protection of ownership of orally transmitted information, which is a vital form of intellectual property in indigenous medicine.

Identifying and tracking demographic trends in South Africa is a unique challenge, given the country's long history of apartheid and the limited availability of demographic information about Africans lamented above. Despite the fact that the modern census in South Africa began as early as 1911 after the formation of Union, the census does not cover the entire period under investigation, and one fact remains consistent throughout the period of enumeration in the region: administrators have racialised every population enumeration in South Africa by sub-classifying the population according to race. This means that the population statistics produced from their enumerations inevitably reflected the racialised agendas of the various administrations.<sup>203</sup> In other words, the available statistics must almost always be understood in terms of South Africa's policies that legitimised racial classification; anyone who wishes to be informed of the effect of social policies on health and health care in South Africa, has no option but to look at racially stratified statistics. The limitation with this racial categorisation of statistics is that it is extremely difficult to identify the effects of class differences on health within and across racial divisions.<sup>204</sup> The foregoing notwithstanding, the importance of census data for empirically based research and social planning cannot be overemphasised. No systematic empirically based literature on demographic processes, socio-economic factors and life opportunities exists for the period between 1970 and 1976 because the last nationwide South African Population Census conducted in the period under review was in 1970.<sup>205</sup> This then suggests that from 1970 to 1976 information on demographic processes such as fertility, mortality and migration was based largely on fragmentary data collected from random localised censuses and surveys during that period.

Basic indicators such as infant mortality, that are used for assessing the impact of health services of a society anywhere in the world, have thus been immensely difficult to calculate

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themselves vulnerable to attacks by other people using "African science".

203 Although racial classification in population enumeration might be a tradition of convenience, in apartheid South Africa this tradition was used to justify racial stratification, and the classification impacted upon the life chances and quality of life for different races.

204 The Centre for the Study of Health Policy, "A Note on Terminology", *A National Health Service for South Africa*, p. ii.

205 P.J. Lehohla, Foreword in T. Zuberi et al (eds), *The Demography of South Africa* (London, M.E. Sharpe, 2005), p. xix.

for the whole country in the period 1948-1976.<sup>206</sup> Initially, the Union government only published vital statistics for whites, but in 1937 official vital statistics for Coloureds became available and a year later they were published for Asians. During this period, no official vital statistics at all were produced for Africans. Unfortunately, this limitation was functional to government in the apartheid years to the extent that government literature clearly shows that whenever mention was made of the fact that apartheid-induced malnutrition might have taken a heavy toll on young black lives, this was often brushed aside with offhand excuses such as “figures for blacks are unavailable”. Because reliable calculation of the infant mortality rate depends entirely upon the maintenance of both birth and death registers, a service which was deliberately made unavailable to the black population in the early apartheid years,<sup>207</sup> or perhaps not considered necessary for them, the use of this indicator in this study could only be made with a fair amount of caution. If anything, the picture became even more bleak as the census reports from the mid 1970s conveniently began to exclude those blacks in the so-called “independent” bantustans from all official records. Randall Packard, sums the situation up very appropriately when he writes of the “Great Disappearing Act.”<sup>208</sup> Apartheid apologists employ a strategy of claiming that the health situation in the country improved when the reality was that the very worst segments of the black population had been excluded from official statistical records by a convenient legislative device.

It therefore remains unclear whether eminent scholars such as Hermann Giliomee do indeed include (or continue to exclude) the “citizens” of the “independent” bantustans in their evaluation of the performance of the National Party government during apartheid.<sup>209</sup> Be that as it may, the lack of sufficient scholarly literature on the subject of apartheid and medicine suggests a clear limitation that impacts upon this study, namely the lack of the necessary basis for comparison. This explains why the comparative analysis provided in this study had to be largely confined to internal comparisons between the health of black South Africans, particularly those in the bantustans, versus that of white South Africans in the rest of the

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206 See Marks and Andersson, p. 669, for details on the Browne Commission.

207 Available evidence suggests that even during this period, registration of births and deaths in the reserves was purely ‘voluntary’ and as a result, very few black births and deaths were registered. See, UG 52-37, *Annual Report of the Department of Public Health Year ended 30 June 1937* (Pretoria, Government Printer, 1943), p. 20.

208 Packard, *White Plague, Black Labor*, p. 249.

209 The peculiar logic of apartheid allowed government officials to regard bantustan residents as non-South Africans. For example in the “white” areas of Natal, many black patients came in from the bantustans. And this led a Dr Clarke, who was in charge of hospital services in Natal to complain: “Natal’s biggest health problem is that every one of our hospitals is burgeoning with foreign blacks”. See De Beer, *The South African Disease*, p. 60.

country.

### **1.9 The organisation of the study**

The seven chapters in this thesis begin with a scene-setting introduction. This first chapter discusses the central concerns of the thesis, the motivation for the study, method of research, review of the relevant literature and the exposition of the study. To understand the meaning of some key concepts and the development of health care under apartheid it is necessary to look briefly at their historical roots. To this end, a historical review of pre-apartheid medicine is dealt with in chapter two.

Although poverty has been identified as a factor in the burden of disease in developing countries and numerous studies have proposed a causal relationship between malnutrition and disease susceptibility, the link between apartheid-created poverty and the ill health of black South Africans has not been adequately explored. Compelling evidence from Western societies has suggested that social factors have had a greater impact than medical factors with regard to the reduction of infectious diseases,<sup>210</sup> and chapter three pays particular attention to the important role of apartheid in the social production of disease among black South Africans. It is well established that high infant mortality rates and the high incidence of infectious fevers, as well as the variety of diseases commonly associated with malnutrition are closely associated with social conditions of poverty. Therefore the contention in chapter three, which is divided into two parts, is that poverty and disease are so closely bound together that any successful strategy to deal with disease must be accompanied by an equal government commitment to alleviate poverty. This chapter describes how a cycle of causation, characterised by unequal distribution of resources, resulted in widespread poverty of the people on the receiving end of apartheid, and that this in turn contributed to the burden of disease among those communities. The contention held throughout this thesis, that South Africa was markedly different from other developing countries in that it had the requisite economic capacity to provide quality health care to all its population, but lacked the political will to do so, is also captured in this chapter. Also featured prominently is the view that at the time South Africa was arguably one of the wealthiest countries in sub-Saharan Africa but its wealth was not reflected in the infant mortality and life expectancy figures of all population groups. Instead, apartheid created conditions whereby some state departments such as

defence, particularly from the mid 1970s, were more privileged than others in terms allocations from the national budget. Also discussed is the view that the government was more concerned with the reduction of the African birth rate while they actively encouraged the growth of the white population; this was a reflection of their increasing concern with white security in the face of numerical superiority of the subordinate races. The chapter concludes that low quality health care inevitably leads to low productivity which is a recipe for poverty, but explains that faced by this process of material deprivation, Africans demonstrated a will to survive by other means.

Chapter four draws special attention to the specific ways in which poverty causes disease. It does this by reviewing the history of some of the diseases of poverty in South Africa and how these have resulted from government preoccupation with an apartheid agenda rather than the health of the people. It concludes that such diseases of poverty were largely the inevitable outcome of the illiberal policies of the government towards the black population, the effects of which were, to some extent, mitigated by black South Africans' recourse to indigenous medicine and faith healing as a means of coping with their health problems.

The impact of apartheid on medical education and practice is discussed in chapter five. The issue of medical practitioners deploying themselves in urban areas where the people with medical insurance lived, people who were able to afford their services, has been well established. It would probably take more than a changed medical education to entice these medical practitioners to practice holistic medicine among the poor segments of society, particularly in the rural areas of the country. But the general maldistribution of health personnel as part and parcel of apartheid can also not be denied. Since the tenets of Western medical practice are taught as if no other beliefs and practices have any place in a country with such a multiplicity of cultures, a graduate of the country's medical schools is often the type of medical practitioner who erroneously assumes that health care is exclusively dependent on the expertise of medical doctors.

Since illness is ubiquitous, all societies have naturally developed ways of coping with it in all its ramifications.<sup>211</sup> With this in mind it is contended in chapter six that the denial of political rights to Africans under apartheid was coupled with a systematic denigration of some aspects

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211 H. Fabrega and M. Zucker, "Components of Illness and Types of Medical Practitioner: A Comparative Study," *Social Science and Medicine*, vol. 13A (1979), p. 13.

of indigenous African cultures and value systems. In examining this aspect of the apartheid period, the chapter draws attention to the contribution of indigenous medicine in mitigating the effects of apartheid, with particular focus on the Kwandebele bantustan. The contention here is mainly on how the bantustan residents of Kwandebele in particular adapted to their situation and coped with their health problems in the face of state neglect. In short, the chapter deals with the social dimensions of health and disease-coping strategies in a situation of extreme underdevelopment where the essential resources pertaining to health, such as food, income, shelter, clean water and sanitation were grossly inadequate, largely as a result of the historical and political processes beyond their control. In the final analysis, the chapter argues that the adverse environmental conditions in the wider South Africa were compounded by the policy of herding people into impoverished bantustans on the pretext that black people were less functional in the country's economy. Regardless of how illness is defined and treatment actions rationalised, it is contended in this chapter that the way the system of medicine works also reflects the cultural beliefs and values of particular communities. There can be no doubt that extreme poverty limits a person's choice of therapy at the onset of illness. In such situations, issues of availability, accessibility, affordability and cultural appropriateness are critical in determining the individual's choice of therapy. Finally, the conclusions that I have reached in this thesis, based on the interpretation of the data and on the analytical framework developed in chapter one, forms the central focus of chapter seven.

## CHAPTER 2

### AN HISTORICAL REVIEW OF PRE-APARTHEID MEDICINE

People make their own history but not in a circumstance of their own choice; they act in an arena shaped by the past. Accordingly, to understand the present conjuncture in South Africa it is essential to have a sense of its history, to reflect on constraints and the possibilities created by that history.<sup>1</sup>

#### 2.1. Introduction

Although the period since 1948 is generally considered to be the era of apartheid in the socio-political context, the available medical literature reveals that skin colour segregation and its manifestation in health care cannot be attributed solely to the coming to power of the National Party. Instead, the so-called “apartheid medicine”, characterised as it was by the white domination of the official South African health care system, has a long history, the origins of which are traceable back to the colonial era.<sup>2</sup> Similarly, although Afrikaners had tended to accept white superiority and racial discrimination as a natural part of life since their early contact with the indigenous communities, they were nevertheless not the sole architects of a coordinated strategy of segregation and apartheid as it became known in the twentieth century. Admittedly, there was no explicit reference to race in the Cape Colony but from the middle of the eighteenth century, people of colour were required to carry documents from their employers as a mechanism of preventing desertion.<sup>3</sup> Apart from the segregationist Glen Grey Act passed in the Cape at the close of the nineteenth century, Theophilus Shepstone, Natal’s Secretary for Native Affairs, had also instituted segregation of indigenous communities, laying down that chiefs (answerable to the colonial government) would rule their people according to tribal law.

Thus, for decades before the NP take-over of the reins of power, racial segregation in the country had generally manifested itself in a number of forms. Among these were pass laws, which since the nineteenth century had controlled the movement of black South Africans in

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1 C. Bundy, “Challenging the Past: South Africa in Historical Perspective” in Genlili (ed.), *Sudafrica: Processi di Mutamento Politico & Costituzionale* (1993), p. 39, quoted by S.Terreblanche, *A History of Inequality in South Africa, 1652-2002* (Pietermaritzburg, University of Natal Press, 2002), p. 1.

2 Burrows, *A History of Medicine in South Africa Up to the End of the Nineteenth Century*; Dubow, *Racial Segregation and the Origins of Apartheid*.

3 J.P. Brits, “Afrikaners and the Genesis of Apartheid”, Inaugural Lecture, Department of History, Unisa, 1996, p. 4.

the cities, “native reserves”, differentiated ownership of property and numerous other measures that sought to achieve and maintain white minority domination over the black majority. And contrary to expectations, this white domination and segregation did not end with the British victory over the Boer republics at the turn of the century. In the field of medicine in particular, the pre-1948 apartheid existed not only in the form of racially separate health authorities and health institutions, but also in the form of unequal state provision for and access to health care, differential availability and quality of health facilities as well as a disproportionate distribution of health manpower.<sup>4</sup> Over and above this, pre-1948 apartheid also existed in the form of state marginalisation of practitioners of indigenous medicine and their therapies. Shula Marks and Neil Andersson have surveyed a range of health problems and policies from the time of the mineral revolution to the period just prior to the NP take-over of power.<sup>5</sup> They argue that during this period, changes in the economy and in the structure of racial privilege (notably the privileges that improved the health conditions of the “poor whites”) immediately decreased the government’s sense of urgency concerning health reform, given that such reform could only benefit races other than white. Thus, even in the period before apartheid, white political and economic power determined in very significant ways the distribution of poverty and disease.

In the light of the foregoing it is understandable why the colour differentiated mortality and morbidity pattern of the South African society in the period before 1948 was such a recurring phenomenon and one which with very few exceptions had always come down the hardest on the African sector of the population.<sup>6</sup> It is for this reason that to understand the impact of inequality in medicine under apartheid it is imperative to look, albeit very briefly, at the historical roots of such inequality. This derives from the fact that virtually all the key apartheid measures such as the pass laws, influx control, labour migrancy, native reserves and so forth, had their origins in the pre-apartheid period. What the post-1948 governments brought to the whole story was their much more ruthless, systematic and comprehensive efforts to define and enforce these policies. Hence the argument in this chapter is that it was the pre-apartheid governments that provided the foundation upon which the Afrikaner

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<sup>4</sup>Van Rensburg et al, *Health Care in South Africa: Structure and Dynamics*, p. 64.

<sup>5</sup> Marks and Andersson, “Industrialisation, Rural Health, and the 1944 National Health Services Commission in South Africa”, Feierman and Janzen (eds), *The Social Basis of Health and Healing in South Africa*, pp. 131-161.

<sup>6</sup> Most of the epidemics in South African medical history have taken their toll on the African population rather than the white group. This is true of the smallpox epidemic, the influenza epidemic, syphilis, etc.

nationalists were later to build what Roy du Prè calls the “apartheid monolith”.<sup>7</sup>

## 2.2 On defining key concepts in the study

### 2.2.1 The meaning of medicine

To understand the concept “medicine” in this study it is necessary to distinguish between “modern medicine” and “indigenous medicine”. Medical anthropologists and sociologists sometimes use the term “biomedicine” when referring to drug-based high-tech medicine as opposed to other types that are known collectively as complimentary or alternative medicine. Homeopaths, on the other hand, call modern medicine “allopathic” to stress the difference in principle between the two systems. For Nancie Gonzalez, medicine may be defined as “any substance applied to or introduced into the body, which is believed by some specialist and/or the sick person to change the existing state of the body in the direction of better health”.<sup>8</sup> The Collins English Dictionary has a general definition of medicine as, “the science of preventing, diagnosing, alleviating or curing disease, or any drug or remedy for use in treating, preventing or alleviating the symptoms of disease”.<sup>9</sup>

However, this strictly Western view of medicine can be criticised for its narrow physical and biological orientation and its failure to recognise the social, political and economic dimensions of health and disease as discussed in the present study. Since the nineteenth century, modern medicine has been carried out by practitioners who focus on prevention and were centrally concerned with the environmental, social and economic dimensions of disease causation. Public health, with its emphasis on sanitation, clean water, municipal health control etc, clearly represents that focus. But once antibiotics and other advanced treatment techniques became widely available it would seem that many biomedical practitioners deem it no longer necessary to worry about the role of poverty and other conditions in the spread of disease. For many doctors therefore, the treatment of disease has become the most important priority. It is precisely this curative orientation of modern medicine that helps to explain why

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7 R.H.Du Pre, *Separate but Unequal: The Coloured People of South Africa - A Political History* (Johannesburg, Jonathan Ball, 1994). See also, R.H. Du Pre, *Strangers in their Own Country: A Political History of the “Coloured” People of South Africa 1652-1992* (East London, Southern African Association, 1992).

8 N.S. Gonzalez, “Health Behaviour in Cross-Cultural Perspective: A Guatemalan Example”, *Human Organisation*, vol. 25 (1966), pp. 122-125.

9 *Collins English Dictionary*, Complete and Unabridged, Sixth Edition (London, Harper Collins Publishers, 2003), p. 1013.

tuberculosis, now the hand-maiden of HIV, continues to be such a major killer of black South Africans, even in the period beyond apartheid.

It is clear that the biomedical definition given above excludes the existence of other non-Western notions of medicine and therefore contributes to the denial of a place for indigenous medicine in the prevention of disease and the promotion of health. However, the World Health Organisation (WHO) has clearly recognised the historical contribution of indigenous medicine as evidenced in its definition:

the sum total of practices, measures, ingredients and procedures of all kinds, material or otherwise, which from time immemorial had enabled the African to guard against disease, to alleviate his suffering and cure himself.<sup>10</sup>

Ataudo, on the other hand, has defined indigenous medicine as, “the medicine of the people, by the people and for the people, which has been practised and handed down from generation to generation. It is the ‘first contact medicine’”<sup>11</sup> Although it is virtually impossible to ascertain with a reasonable degree of accuracy the exact number and types of indigenous practitioners at any given time and locality, they are easily categorised according to their fields of expertise. A traditional healer has been defined more generally as someone:

who is recognised by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background as well as the prevailing knowledge, attitudes and beliefs regarding physical, mental and social well-being and causation of disease and disability in the community.<sup>12</sup>

Chonco, who regards an inyanga as a physician–seer states:

These physician–seers are the masters of the healing art, combining their wide empirical knowledge of medicines with their astute insight into the psychological make-up of the community of which their patients are part. They are the basic custodians of the doctrine or theory of African medicines, and their commitment to it shows a very high degree of coherence, stability, depth, conventionality, and explicitness.<sup>13</sup>

An anthropologist Hammond-Tooke, on the other hand, regards herbalists as ordinary people

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- 10 *The Promotion and Development of Traditional Medicine*, WHO Technical Report, no. 622 (Geneva, WHO, 1978), p. 10.
  - 11 E.S. Ataudo, “Traditional Medicine and Biopsychosocial Fulfilment in African Health”, *Social Science and Medicine*, vol .21, no. 12 (1985), p. 1345.
  - 12 Van Rensburg et al, *Health Care in South Africa: Structure and Dynamics*, p. 328.
  - 13 M. Conco, “The African Traditional Healers”, Z.A. Ademugan et al (eds), *African Therapeutic Systems* (Los Angeles, Crossroads Press, 1979), p. 63.

who, although they have acquired an extensive knowledge of marginal techniques, nevertheless do not typically possess occult powers.<sup>14</sup> For the purpose of this enquiry, however, herbalists may be defined as those health care-givers who diagnose and prescribe medication for ordinary ailments and alleviate misfortune and disaster by providing protection against sorcery, thereby promoting health and preventing disease. In contrast, Vontress defines “indigenous healing” rather more authoritatively as “that technique which is used by indigenous healers, either singly or interactively to eliminate, ameliorate or prevent physical, psychological and spiritual problems of patients with the use of special divine powers”.<sup>15</sup>

### 2.2.2 The meaning of health

In order to understand indigenous medicine in its proper context, it is important to define what we mean by the term health. Although highly valued and pursued throughout the history of humankind the concept of health has also proved difficult to define and describe with any degree of precision. The Collins Concise English Dictionary defines it as “the state of being bodily and mentally vigorous and free of disease”.<sup>16</sup> Clearly this definition excludes concepts of health in terms of relationships between individuals or of spiritual health. According to David Atkinson, the Bible views health as a holistic concept which includes individual, social, physical and mental temporal and spiritual life.<sup>17</sup> “There does not exist any precise definition of health applicable to everyone”, declared Aumont, the French doctor who wrote an article on the subject for Diderot’s *Encyclope’die*, “each has his own state of wellbeing”.<sup>18</sup> Daniel Callahan has also observed that like most general concepts such as “peace”, “justice” and “freedom”, that of “health” poses enormous difficulties of definition.<sup>19</sup> Michael Dolman reviewed the changes that have occurred in the generally accepted meaning of the term over the years and concluded that it has travelled a full circle; it has gone from a very general term

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14 Hammond-Tooke, *Rituals and Medicines: Indigenous Healing in South Africa*.

15 C.E. Vontress, “Traditional Healing in Africa: Implications for Cross-Cultural Counselling”, *Journal of Counselling and Development*, vol. 70, no. 1 (1991), p. 241.

16 *Collins English Dictionary: Complete and Unabridged*, p.510.

17 D. Atkinson, “Towards A Theology of Health”, *Health: The Strength to be Human*, IVP/CMF, UK (1993).

18 A. Aumont, “Sante”, in D. Diderot (ed.), *Encyclope’die ou Dictionnaire Resonne des Scienies des Arts et des Metiers* (Paris, 1751-65), p. xiv. This passage and others have been translated from French by G.B. Risse, See F. Kafker, *The Encyclopedists as Individuals: A Biographical Dictionary of the Authors of the Encyclope’die* (Oxford, Oxford University Press, 1988), p. 629.

19 D. Callahan, “Health and Society: Some Ethical Imperatives”, in J.H. Knowles (ed.), *Doing Better and Feeling Worse* (New York, W.W. Norton & Co., 1977), p. 25.

to a narrow one then back to a broad interpretation.<sup>20</sup> But Yedidia suggests that health can be operationally defined as:

the absence or control of those diseases whose existence has been recognised by established medical authorities and whose treatment regimes emanates from acceptable medical doctrine.<sup>21</sup>

Yedidia's definition may be criticised for its exclusion of any notion of health based on non-Western understanding of disease causation. This clearly biomedical perspective does not allow for the socio-economic and political as well as environmental determinants which often influence one's perceived ability to attain or maintain health. There are two main approaches to health that have been used to determine its definition. For example, Agere classified the first approach as "contagionism", within which health is defined as "the absence of disease".<sup>22</sup> Baillies has also identified this approach and agrees with Agere that the definition is inadequate because it seeks to confine health to a biological condition, without due regard for the social, economic and political factors within which the health care delivery system operates.<sup>23</sup> It is the second approach which Agere terms "anticontagionism" that tends to place sufficient emphasis on socio-economic and political factors as being critical to health maintenance.<sup>24</sup> Closely analysed, this is the approach also adopted by the WHO, that defines health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".<sup>25</sup> This definition is often quoted as a modern illustration of the social model of health, offering an alternative to the medical model. However, while emphasising positive in contrast to negative aspects of health, this definition conveys a curiously passive, steady, state idea of well-being instead of one grounded in more active fulfilment.<sup>26</sup> It is in line with this definition that the preamble to the WHO constitution declares that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being and that governments have a responsibility for the health of their peoples which can be fulfilled by mobilising all resources, human and material,

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20 M.T. Dolman, "The Concept of Health: An Historic and Analytic Examination", *Journal of School Health*, vol. 48, no. 8 (1973), p. 491.

21 M.J. Yedidia, *Delivering Primary Health Care: Nurse Practitioners at Work* (Boston, Auburn House, 1981), p. 34.

22 S.T. Agere, "Progress and Problems in the Health Care Delivery System", in I. Mandasa (ed.), *Zimbabwe: The Political Economy in Transition, 1980-1986* (Senegal, Codesria Books, 1986), p. 355.

23 C. Baillies, "The Meaning of Health in Africa", *Review of African Political Economy*, vol. 36 (1986), pp. 62-76.

24 Agere, "Progress and Problems in Health Care Delivery System", p. 355.

25 R. Coker, *Alternative Medicine: Helpful or Harmful?* (Crowborough, Monarch, 1995), p. 26.

26 P. Townsend et al., *Health and Deprivation: Inequality and the North* (London, Croom Helm, 1988), p. 9.

and, one might add, modern and indigenous, scientific and unscientific.

Inherent in the WHO definition is the view which is echoed throughout this thesis, that health care is a basic human right that a just society, through its government is obligated to ensure to the fullest extent possible for all its citizens. Admittedly, the language of rights is both philosophically and politically complex. Within the context of health, the word “rights” generally refers to moral rights, which is part of moral philosophy.<sup>27</sup> There is little doubt that even if there was general agreement on what the concept “healthiness” meant, it would still be something that society could not guarantee. It is highly probable that even in societies where there was no institutionalised racial discrimination as was the case in South Africa during the apartheid period, to assert a blanket “right to health” would be no less than a mere sloganistic exercise. It would be making unattainable demands on society in the name of moral rights. Perfect health is probably incompatible with the process of living. Hans Selye reflects the same sentiment with his assertion that “stress” is endemic to life and that to realise a full life, an individual must experience stress.<sup>28</sup> Therefore, the idea of a right to health may instead be rephrased as a principle: that in a just society, everyone irrespective of race or geographical location should enjoy equal access to the resources that are critical for health.

Whatever definition is accepted, this study asserts that the health services of the country should ensure that all people have equal access to basic health care, and that this should be provided in an environment compatible with health. However, contrary to Yedidia’s notion of health above, there is also an urgent need to define health in non-Western contexts. For example, the concept “health” which in Sesotho is *bophelo*, goes beyond just being healthy. In this African context, “health” and “life” are understood as one concept, *bophelo* and the two are only distinguishable depending upon the context in which they are used. For example, to say *ke phetse hantle* (I am healthy) is the same as *ha ke na matsapa fa bophelong ba me* (my life is trouble-free). Similarly, linguistically, “disease” and “death” are but one concept in Sesotho. Thus to say, *o na le lefu la mafathla* (he suffers from tuberculosis) is the same as *lefu la hae le bakilwe ke mafathla* (he died of tuberculosis).<sup>29</sup> This then suggests that in

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27 R. Hingison et al, *In Sickness and in Health: Social Dimensions of Medical Care* (Toronto, C.V. Mosby Company, 1989), pp. 95-96.

28 H. Selye, *The Stress of Life* (New York, McGraw Hill, 1956), p. 29.

29 For an exploration of this debate, see D. Hall and G. Malahlela, *Health and Family Planning Services in Lesotho: The People’s Perspective* (Maseru, Morija Printing Works, 1989), p. 1.

Sesotho, as in other African contexts, the quest for good health, which is *bophelo jo botle*, is a quest for good life, which is also *bophelo jo botle*. Another good illustration of this is afforded by the Xhosa word for health *impilo* (fulness of life) which is also a much more comprehensive term than a simple translation leads one to expect.<sup>30</sup> Jansen takes it even further stating that this well-being, as understood in the African context, belongs not only a healthy body but also “a flourishing family and fat cows”.<sup>31</sup> This being so, to deny good health to any person, whether by accident or by design, is tantamount to denying that person life itself. This includes physical well-being and much more. By implication, then, a government that denies the majority of its citizens better education, clean water, decent shelter, adequate nutrition, acceptable incomes, proper sanitation etc, is in effect denying those people *bophelo jo botle* (a better life). It was probably with reference to this understanding of health that Neumann remarked, albeit in a completely different context and circumstances:

The state argues that its responsibility is to protect people’s property rights. For most people the only property which they possess is their health. Therefore the state has a responsibility to protect people’s health.<sup>32</sup>

Thus, if the concept of health in the African context is different from that in the Western context, it would be inappropriate to impose the Western notion of health upon African societies with scant regard for their own health beliefs. Throughout this thesis, I use the concept of health in the more holistic African context, where the meaning goes beyond just being healthy in the narrow, Western sense. Similarly, the phenomenon of healing should be understood holistically as something much more than just the curing of disease.

## **2.3 Medicine before Union**

### **2.3.1 The historical coexistence of competing medical systems**

South Africa’s medical history may be divided into a number of distinct periods, namely, the precolonial period; the nineteenth century with two distinct eras (before and after the rise of the “germ theory”) and the twentieth century characterised by significant medical advances, including antibiotics. An historical review of these periods reveals that the notion of a single medical profession with a monopoly over medical practice dates back from the latter part of

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30 Van Rensburg and Mans, *A Profile of Disease and Health Care in South Africa*, p. 185.

31 G. Jansen, *The Doctor-Patient Relationship in an African Tribal Society* (Assen, Van Gorcum, 1973), p. 38.

32 S. Neumann, *Die Öffentliches Gesundheitspflege Und das Eigenthum* (Berlin, 1847), quoted by H.E. Sigerist, *Medicine and Human Welfare* (Oxford, Oxford University Press, 1941), p. 93.

the nineteenth century. Harriet Deacon,<sup>33</sup> and Elizabeth Van Heyningen,<sup>34</sup> address this issue of professionalisation and both agree that until the 19<sup>th</sup> century there was very little formal control over medical practice at the Cape, but in 1807 regulations were promulgated which provided for the licensing of regular practitioners and the prohibition of unlicensed practice. In the opinion of Elizabeth van Heyningen, until 1880, the medical doctors at the Cape, as ‘agents of the empire’ were more functional to colonialism.<sup>35</sup> This suggests therefore that, like in most of the developed world, the contemporary health care system with its biomedical focus, its hierarchy of trained professionals and complex primary, secondary and tertiary facilities for cure, came fully into being only in the twentieth century. It was at the close of the nineteenth century that the “germ theory” of disease began to be accepted, but it was another 30 years before professional health workers in the West saw it as the orthodox way of thinking about disease. This suggests that the contemporary way of thinking about disease and organising health care are relatively new. Nevertheless well-being has always been a human concern in societies, and because humans, like other life forms are susceptible to illness, the care of the sick, prevention of disease and promotion of health have been man’s fundamental preoccupation since time immemorial. The fact that long before the advent of modern medicine societies were concerned with issues of health and curing disease, suggests that non-Western forms of healing have always existed among Africans. There are many different behaviours and beliefs in each culture and at first glance these may not appear related to issues of health. Indigenous healers, as custodians of African culture have helped to enforce numerous non-medical aspects of that culture to maintain the health of their communities.<sup>36</sup> On the surface the primary task of the indigenous healer may be to minister to the ills of his society, but it would be deceptively simplistic to restrict a description of the role of indigenous healers in general to such narrow confines. Indeed, the healer is often found to be a consistent and primary force that builds and maintains what may be called the “psychic unity” of the culture. As Wood puts it, an “indigenous healer is viewed by his society as the seer who provides explanations in historical contexts that give life a sense of continuity and depth”.<sup>37</sup>

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33 H. Deacon, “Medical Gentlemen and the Process of Professionalisation Before 1860”, Deacon et al, *The Cape Doctor in the Nineteenth Century*, p.87.

34 E. Van Heyningen, “‘Regularly Licenced and Properly Educated Practitioners’: Professionalisation 1880-1910”, Deacon et al, *The Cape Doctor in the Nineteenth Century*, p.195.

35 E. Van Heyningen, “Agents of Empire: The Medical Profession in the Cape Colony, 1880-1910”, *Medical History*, xxx (1989), 450-71.

36 Ngubane, “Some aspects of Treatment Among the Zulu”, Loudon, *Social Anthropology and Medicine*, pp.318-320.

37 Wood, *Human Sickness and Health: A Biocultural View*, p. 294.

It is difficult to fathom what the health conditions of black South Africans might have been before colonialism because of the lack of documented evidence on indigenous healing. We do know that it dominated health care for most of the period and oral evidence suggests that Africans as a group, like all pre-industrial populations, bore the brunt of periodic famine; their infant mortality and maternal death rates were much higher than those of the settler populations.<sup>38</sup> However, the fact that modern medicine was introduced into the country at the beginning of the colonial period suggests that it was designed to meet the health needs of the colonisers and their families,<sup>39</sup> and that Africans had their own pre-existing means of coping with health problems. This study therefore contends that indigenous African medicine played a critical role, not only in the promotion of health, but also in the prevention and cure of disease, which partly explains the reason for the persistence of indigenous medicine as a complementary alternative health resource for most Africans in this age of HIV/AIDS.

In South Africa, as in the rest of the developing world, there are a number of competing health care sectors operating simultaneously.<sup>40</sup> Besides a well-developed popular sector based on self-help and self-medication, there is the much more powerful professional sector consisting of the modern biomedical practitioners and providers of a wide range of complementary therapies. Alongside these there has always existed a thriving indigenous medicine sector dominated by African indigenous healers and herbalists.<sup>41</sup> However, these sectors are not hermetically sealed as there is a substantial movement of patients seeking health advice and alleviation of disease between and across these sectors, without any feeling of contradiction. A change in medical philosophy in favour of the doctrine of specific aetiology, with its origins in the industrial revolution, also had far reaching consequences for the South African situation. To begin with, it resulted in the holistic principles of healing being summarily discarded in favour of the cure of specific diseases. And one might argue that it is precisely this lack of a holistic approach of modern medicine which is one of its major shortcomings. This weakness is clearly reflected in the persistence of indigenous and other complementary medical therapies, even where modern medical facilities are readily

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38 Searle, *The History of the Development of Nursing in South Africa*, pp. 39-42.

39 Burrows, *A History of Medicine in South Africa*, pp. 87-88.

40 D.D.O. Oyebola, "Professional Associations, Ethics and Discipline Among Yoruba Traditional Healers of Nigeria", *Social Science and Medicine*, vol. 15B (1981), p. 87.

41 R.A.H., Bhikha, *African Renaissance in Health Education: Developing an Integrative Programme of Unani-Tibb Training for Health Care Professionals in Southern Africa* (PhD thesis, University of the Western Cape, 2004), p. 6.

available and more than adequate. According to the health belief model as formulated by Rosenstock,<sup>42</sup> and described in detail by Becker,<sup>43</sup> it is primarily the person's present beliefs and expectations that influence what he/she will do at the onset of disease. The two constructs, "beliefs" and "attitudes", are central to the understanding and prediction of health-related behaviour. This in turn helps us understand why in spite of advances in biomedical technology the majority of Africans insist on indigenous medicine for the explanation of disease and removal of its cause.

Alfred Bryant also confirmed the coexistence of different medical systems in Africa. Bryant is a missionary-ethnologist whose studies of African herbalists reveal that in the early twentieth century indigenous African practitioners were familiar with over 700 medicinal plants.<sup>44</sup> Similar to apothecaries and osteopaths in Europe, who were marginalised and suppressed throughout the nineteenth century, African indigenous healers and their therapies were the subject of intemperate attack during the colonial era from missionaries, and in the apartheid period in South Africa, by members of the modern medical profession. Not only did they ignore the important healing functions that indigenous healers performed in the society before the advent of modern medicine but also strove to discredit and dismember them.<sup>45</sup> Closely analysed however, the clash between these two diametrically opposed medical systems was strictly speaking not one of science versus superstition as it has so often been portrayed; instead it centred on the socio-political function of health care in society in general.

Just as the health problems of black South Africans in the pre-colonial and the colonial periods are difficult to reconstruct because the history of indigenous healing has not been adequately documented, the same can also be said of the disease patterns of the settler population before the second half of the nineteenth century. Despite the existence of few medical institutions in the British colonies of the Cape and Natal, medical care was still not readily available even to this population, who for the most part also depended on herbalists, home remedies and patent medicines.<sup>46</sup> The point is that if the situation among the settler

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42 I.M. Rosenstock, "Why People Use Health Services" *Milbank Memorial Fund Quarterly*, no. 44 (1966), pp. 94-127.

43 M.H. Becker, "The Health Belief Model and Sick Role Behaviour", *Health Education Monograph*, no. 2 (1976), pp. 409-419. See also M.H. Becker, "Understanding Patient Compliance: The Contributions of Attitudes and Other Psychosocial Factors", in S.J. Cohen (ed.), *New Directions in Patient Compliance* (Lexington, Mass, 1979), pp. 1-31.

44 A.T. Bryant, *Zulu Medicine and Medicine-Men* (Cape Town, Struik, 1970), pp. 84-115.

45 Interview with Ngaka Tsiane, 8/11/2004.

46 Burrows, *A History of Medicine in South Africa up to the End of the Nineteenth Century*.

community in the Cape Colony and Natal was bad, then it must have been even more dismal in the rural trekker republics of the Orange Free State and the Transvaal, particularly among black communities. In more general terms, it appears that the absence of any high concentrations of populations before the discovery of minerals, meant that there was not much pressure for a public health system.<sup>47</sup>

### 2.3.2 The advent of the mineral revolution

Shula Marks and Neil Andersson have drawn attention to the fact that the health pattern of the South Africa of the apartheid era was in fact deeply rooted in the social changes which began with the discovery of minerals in the last third of the nineteenth century.<sup>48</sup> As might have been expected, these mineral discoveries affected the health of the country's population as dramatically as they transformed every other aspect of material life.<sup>49</sup> This was the time when the country still comprised a cluster of independent African polities, two Afrikaner republics (the Transvaal and the Orange Free State) and two British colonies (The Cape and Natal). However, the discovery of diamonds in the 1860s and gold in the 1880s, in Kimberley and the Witwatersrand respectively transformed this earlier picture and brought major demographic, economic and social changes in their wake. People streamed to the gold fields; there were blacks from the overpopulated reserves and whites from unviable farming areas. Soon conditions of overcrowding, social evils such as prostitution and its attendant health implications arose on the mines. This was particularly so in the sprawling 'locations' where poverty-stricken Africans lived on the outskirts of the towns. And within a few decades, due primarily to its potential economic benefits, the entire sub-continent had come under colonial control.<sup>50</sup>

A careful examination of the post-1948 government approach to the plight of the African work force, reveals that it was in this "mineral revolution" that many constituents of South Africa's later apartheid policies were first formulated. For example, in the aftermath of the discoveries, the capitalists' demand for cheap and expendable African labour became virtually

47 WHO, *Apartheid and Health*, p. 88.

48 Marks and Andersson, "Issues in the Political Economy of Health in Southern Africa", *Journal of Southern African Studies*, Vol.13, no.2 (1987), pp.177-186. See also, Marks and Andersson, "Industrialisation, Rural Health and the 1948 National Health Services Commission in South Africa", in Feierman and Janzen, *The Social Basis of Health and Healing in Africa*, p.132.

49 Van Heyningen, "Regularly Licensed and Properly Educated Practitioners", p.195.

50 S. Marks and R. Rathbone (eds), *Industrialisation and Social Change in South Africa: Class Formation, Culture and Consciousness 1870-1930* (New York, Longman, 1982). See also C. Van Onselen, *Studies in the Social and Economic History of the Witwatersrand, 1886-1914: New Babylon* (Johannesburg, Ravan Press, 1982).

insatiable. In the towns, the reserves and on the mines there were generally appalling working and living conditions, often exacerbated by inadequate nutrition. All this lay at the root of what may be termed the “diseases of poverty,” afflicting predominantly the African sector of the country’s labouring class. It was in this social milieu that the prevalence of tuberculosis arose, a disease that has been described as the first penalty that capitalistic society had to pay for the ruthless exploitation of labour,<sup>51</sup> in the same way that sexually transmitted infections (STIs) were part of the price paid by the migrant workers on the mines.<sup>52</sup>

A growing body of literature on the social consequences of the mineral revolution reveals that it was the migration to Kimberley and the Rand of British miners who were already suffering from silicosis that, according to Burke and Richardson, made “miners’ phthisis” a dramatic killer at the time.<sup>53</sup> In the opinion of these authors, it is evident that even though miners’ phthisis was a problem for both black and white workers, the discriminatory policies of the pre-apartheid governments ensured the availability of adequate compensation for white miners – due to direct state intervention on their behalf – but very little concern was shown for the plight of black miners who showed the same symptoms. It is also interesting to note that rather than provide compensation for black miners, white miners were instead replaced by black workers, so that the major burden of tuberculosis phthisis was passed on to the black work-force.<sup>54</sup> The ruthlessness with which black labour was procured, and the scant regard shown for health matters, is an indication of the fact that the mining industry was colluding with successive white governments in accepting legislation that ensured the availability of cheap labour. A complex historiographical debate has since developed and it has been revealed that these pre-apartheid whites-only governments that maintained their hegemony in the country also preferred a racially stratified social order based on economic exploitation and segregation of the races. Hence the view held throughout this study that the practice of racial stratification based on economic exploitation did not only begin with the coming to power of the National Party in 1948. It is however true to say that the NP carried out their racial policies more systematically and rather more ruthlessly than its predecessors. Of course,

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51 WHO, *Apartheid and Health*, p. 89.

52 See, S. Horwitz, “Migrancy and HIV/AIDS: A Historical Perspective”, *South African Historical Journal*, no. 45 (2001), p. 103.

53 In a series of acts known as the Prior Law, the discriminatory Union government laid down the basis for a comprehensive system of compensation for white victims of phthisis and it was this gesture that accounted for the virtual elimination of the disease among white miners. See G. Burke and P. Richardson, “The Profits of Death: A Comparative Study of Miners’ Phthisis in Cornwall and the Transvaal, 1876-1918” *Journal of Southern African Studies*, vol. 4, no. 2 (1978), p. 166.

54 WHO, *Apartheid and Health*, p. 89.

public health professionals within the department of health had repeatedly challenged the idea that segregation and the pass laws could safeguard the health of the white population. They argued, albeit to no avail, that such an objective could only be achieved if the health status of Africans was also addressed. The perception, quite common among whites, that the African labourer was nothing less than a walking reservoir of disease, was no doubt responsible for all the efforts to keep a hygienic distance between African and White population groups before and throughout the apartheid period. Quite clearly however, it was only the politicians and the white public who thought in terms of such simplistic and unworkable solutions as compulsory medical examination of all African male workers in towns and so on.

## **2.4 South African medicine in the context of segregation**

### **2.4.1 The Public Health Act of 1919**

Available evidence suggests that the health policy in South Africa has also evolved through a number of distinct periods. Before Union, policy was largely coincidental and control was practically non-existent. For most of the period, British influence was manifested in the construction of military hospitals and in a series of health-related legislative acts and ordinances, the major aim being to regulate health and to contain the spread of epidemics. Yet despite these efforts, neither uniformity nor synchronisation was achieved.<sup>55</sup> In 1910, in the aftermath of the South African War, (Anglo-Boer War) of 1899-1902, the Cape Colony, Natal, the Transvaal and the Orange Free State, formed the Union of South Africa. Unlike the other provinces, according to Van Heyningen, only the Cape entered this Union with the most sophisticated health care system in the country, the advantages of which were soon lost due to the general backwardness of the other colonies.<sup>56</sup> Quite obviously, the members of the National Convention did not think it necessary to plan for a Ministry of Public Health, and the South Africa Act of 1909 made only incidental reference to health. At the same time, health matters were tragically left in the hands of local, provincial and municipal authorities. And such health control not designated to the provinces was centrally assigned to the Department of the Interior. Thus, instead of increased coordination of health services, which had been identified as the possible solution to the problem of providing health care to the whole population of the Union, the delivery of public health in South Africa in the period from 1910 onwards was also compromised by the acute administrative fragmentation of such services. A number of writers and commissions of enquiry have pointed to this limitation as the most

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55 H.C. van Rensburg and D. Harrison, "History of Health Policy", *South African Health Review 1995* (Durban, Health Systems Trust, 1995), p. 53.

56 Van Heyningen, Regularly Licensed and Properly Educated Practitioners, p.217.

revealing feature of health services since Union. Unification thus meant very little in the way of consolidation of health services. Perhaps even more revealing was the fact that the health laws and ordinances of the erstwhile colonies and republics still remained on the statute books. Even the appointment in 1915 of a Union-wide Tuberculosis Commission only served to confirm the view that successive whites-only governments, prior to and since Union were only propelled into action on public health matters when the health of the white population was endangered.<sup>57</sup> The more African locations came to be seen as a menace to the health of the white population in the form of the spread of both tuberculosis and venereal diseases, the more the health authorities thought in terms of exclusionary policies.

The second phase in South Africa's twentieth-century medical history began with the proclamation of the Public Health Act of 1919. In fact, it was the 1918 influenza epidemic that exposed the inadequacy of the Union health legislation.<sup>58</sup> Taking a massive toll of over 300 000,<sup>59</sup> the crisis of the epidemic led to a complete reorientation and reorganisation of health services, hastening the adoption of the far-reaching Public Health Act No.36 of 1919 and the establishment, for the very first time, of a Department of Public Health under the Department of the Interior, with Sir Thomas Watt as the first Minister of Public Health and Dr Mitchell as the first Secretary.<sup>60</sup> Though it took a crisis to place the health Bill on the Statute Books, this measure represented a serious attempt to coordinate health care more effectively at national level than was previously the case.<sup>61</sup> During his 12 years of office under successive Ministers, Dr Mitchell established the Department of Public Health as a major department of the Public Service, so much so that when he retired in 1932, and succeeded as Secretary by Sir Edward Thornton, a leading Cape newspaper wrote in its issue:

Dr Mitchell may be regarded as the founder of our Department of Public Health, and the father of the Public Health Act. Although it is a hastily timbered piece of legislation, it has served a useful purpose and the amending

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57 UG document 34-14, *Report of the Tuberculosis Commission* (Pretoria, Government Printer, 1915), pp. 124-26.

58 For a detailed account of this event, see, Phillips, '*Black October*': *The Impact of the Spanish Influenza Epidemic of 1918 on South Africa*, G. Kolata, *Flu: The story of the Great Influenza Pandemic of 1918 and the search for the Virus that Caused It*; and a much more recently published book, H. Phillips and D. Killingray (eds), *The Spanish Influenza Pandemic of 1918-19: New Perspectives* (London & New York, Routledge, 2003).

59 Van Heyningen, "Epidemics and Disease: Historical Writing on Health in South Africa", p. 132. For a detailed exposition of the influenza epidemic, see also Howard Phillips, "Black October: The Impact of the Spanish Influenza Epidemic of 1918 on South Africa", *Archives Year Book for South African History*, vol. 1 (Pretoria, Government Printer, 1990).

60 J. Gilliland, "Health Legislation – A Historical Review", *South African Medical Journal*, Vol.55, No.1 (1979), p.480.

61 Van Rensburg and Mans, *Profile of Disease and Health Care in South Africa*, p. 200.

Acts of 1927 and 1928 have materially improved it. The Housing Act came in 1920; the Medical, Dental and Pharmacy Act became law in 1928. This was followed by the Food, Drugs and Disinfectants Act in 1929. It is no exaggeration to say that to Dr Mitchell is due much of the credit for shaping these Acts and for successfully passing them through a legislature that was never keenly interested and sometimes decidedly antagonistic. His courtesy, his tact and his insistence upon essentials did much to facilitate the passage of these Bills through Parliament, and his Ministerial chiefs owed him a debt of gratitude for the manner in which he simplified their task.<sup>62</sup>

Closely examined, it is clear that the inclusion of town planning clauses in the Health Act may be seen as a devious attempt by the Union government to entrench urban privileges for whites while at the same time marginalising urban Africans.<sup>63</sup> Though the act was not overtly racist and discriminatory, it did nevertheless reflect a new welfarist approach to white health. For instance, prior to this act, both Africans and whites had been treated for STDs in the same hospitals or suffered similar neglect, whereas after the Public Health Act, this was considered demeaning for the white population and there were calls for segregated facilities, which subsequently led to very different treatment for Africans. By 1922 clinics for whites had been established in Johannesburg, East London, Pretoria, Pietermaritzburg, Barberton, Stellenbosch and several other centres.<sup>64</sup> Although intended to regulate white residential conditions, it is clear that the Public Health Act, the subsequent Housing Act of 1920 and the Native Urban Areas Act (Act No.15 of 1923)<sup>65</sup> all provided municipalities with additional legislative means of regulating African urbanisation and thus enforcing segregation.<sup>66</sup> With the benefit of hindsight, all these laws were crucial in shaping the government's approach to African health as well as underpinning its policy on African influx into urban areas.

Admittedly the act was instrumental in defining for the first time a national jurisdiction on health matters. For example, as a sub-department of the Department of Interior, the new Department of Public Health operated the district surgeoncy.<sup>67</sup> Considerable expansion of hospital facilities for whites and the establishment of medical services with free treatment for

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62 *The Cape Times*, 9/4/1932.

63 S. Parnell, "Creating Racial Privileges: The Origins of South African Public Health and Town Planning Legislation", *Journal of Southern African Studies*, vol. 19, no. 3 (1993), 470-488, p. 470.

64 Jochelson, "Sexually Transmitted Disease in Nineteenth and Twentieth-Century South Africa", p. 227.

65 The role of this act in terms of giving legislative expression to the principles of Stallardism was examined by S.Parnell, "Creating Racial Privileges: The Origins of South African Public Health and Town Planning Legislation" *Journal of Southern African Studies*, Vol.19, No.3 (1993).

66 *Ibid.*, p. 473.

67 A. Jeeves, "Public Health in the Era of South Africa's Syphilis Epidemic of the 1930s and 1940s", *South African Historical Journal*, 45 (2001), 79-102, p. 79.

the indigent were among the outcomes. Control over these hospitals and other allied services remained the competence of the provinces and municipalities. Needless to say there were critics of government policies who claimed that this kind of welfare provision for the white voter was made financially possible through the exploitation of the blacks. Despite its obvious shortcomings, the 1919 health legislation and its amendments, were important because they served as a valid basis for all health action in South Africa until the National Health Act of 1946 which created a separate Department of Health with Henry Gluckman as the first Minister of Health. From 1946 onwards this independent department had an expanded mandate to define and co-ordinate national health policy, resulting in the creation of the National Health Council to advise the minister in that regard. However, contrary to the Gluckman Commission's recommendations and recommendations of several earlier commissions, most public hospitals remained under the jurisdiction of the provinces. Divided authority, poor planning, uneven service delivery and weak standards were some of the ongoing consequences of undermining the commission's basic recommendations. This situation marked the state of affairs until the adoption of the National Health Act in 1977, and beyond.

#### **2.4.2 Rejection of the Loram Committee Proposals**

The belief that government concern for the health of black South Africans in the segregation era was driven more by the economic interests of the white population than by the genuine desire to provide better health care for all sectors of society, was widespread from the late 1920s and early 1930s. Scholars have frequently cited the appalling health conditions among African communities in the reserves and its repercussions for the labour supply in the mines and factories as well as the risk of infection for the white population as primary reasons for state action in this period. Though there was wide recognition of the need within the profession to train black doctors to "serve their own people", there was great resentment when black doctors competed with whites.<sup>68</sup> In 1925 the question of admitting blacks to the University of the Witwatersrand (Wits) medical school presented itself when a coloured applicant, J. du Randt, applied for admission. Attempts to refuse him permission to enrol were thwarted when it was found that the university's statutes made no provision for the exclusion of any applicant on the grounds of colour. The University Council and Senate were unhappy to realise that legally they had no option but to admit black applicants to medical school. In

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68 B.K. Murray, "The 'Liberal' University: Questions of Discrimination at Wits 1922-39", Wits History Workshop on Town and Countryside in the Transvaal: Capitalist Penetration and Popular Response, 5-9 February, 1981, p. 6.

an attempt to find ways of excluding future black applicants, Council appointed a committee in 1927 to make representations at government level in this regard, and the government's appointment of the Loram Committee afforded the university the opportunity to present its case. On 24 October 1927 the Council approved the resolution including, among others, the provision that if the government decided on a policy of training black people in medicine, then no separate medical school should be instituted for the purpose but that facilities should be offered by the existing medical schools; Wits declared itself prepared to undertake such a training, albeit in separate classes from white students.<sup>69</sup>

The upshot of the incident was that the Department of Native Affairs initiated an inquiry into the training of Africans in medicine and public health.<sup>70</sup> Under the chairmanship of Native Affairs Commission member, Dr C.T. Loram (a former chief inspector of Native Education for Natal), a committee was appointed to inquire into the possibility and feasibility of establishing a training institution for "natives" in medicine and public health. Committee members included Dr W.A. Murray, representing the newly established Department of Public Health, Dr J.C. Pretorius (Orange Free State), Dr Darley Hartley (Cape) and Professor Raymond Dart (Transvaal).<sup>71</sup> Prior to this, an effort to train African medical personnel and the expansion of modern medical education to Africans had never been a government priority, but the authorities were aware that the French authorities in West Africa had already successfully established a Native Medical School at Dakar with impressive results.<sup>72</sup>

After drawing attention to the grossly inadequate supply of doctors for the black population, to the "excessively high" rate of infantile and maternal mortality among blacks as well as to the rise in the general death rate in the more impoverished areas, the committee concluded: "such a condition of things is a double menace to South Africa. Firstly there is the immediate danger of the spread of infectious and contagious diseases from areas where they may be said to be practically endemic. Secondly, there is the economic danger of the deterioration and eventual failure of the labour supply..."<sup>73</sup> After noting the worsening health conditions of the African population in the rural reserves, the Loram Committee urged the need to organise the Union medical services to take account of the situation. Its proposals included a state-

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69 Ibid., p. 10.

70 TES 7159 56/76, letter from Secretary of Public Health to Secretary for Finance, 3 February 1928.

71 NA 46/315, correspondence: Secretary for Native Affairs to Secretary for Finance, 19 March 1926.

72 TES 7159 56/76 Letter from Secretary of Health to Secretary for Finance, 3 February 1928.

73 UG 35-28, Report of the Committee Appointed to Inquire into the Training of Natives in Medicine and Public Health (Loram Committee Report).

subsidised training programme for African doctors and the establishment of rural health units to be staffed by African Health Assistants and nurses.<sup>74</sup> It was felt that unlike in the rural areas, the health needs of urban Africans were partially met by the mine hospitals which not only serviced the mine labourers, but also the growing urban African population who were employed elsewhere.<sup>75</sup> For the Union government, the prevalent socio-economic conditions in the rural areas were clearly a “double menace” to the country in that there was the immediate risk of the spread of infectious diseases to the white population from areas where they were endemic; in addition, there was the possibility of the deterioration and eventual failure of the labour supply that would have grave economic implications.<sup>76</sup> It is interesting to note that because the committee considered the cost of establishing a new medical school for this purpose to be beyond the resources of the Union at the time, it invited the University of Cape Town (UCT) to provide the necessary clinical training for African students – an invitation that the UCT rejected for political and ideological reasons. As pointed out above, even the University of the Witwatersrand which accepted the invitation and undertook to provide the training, also agreed only on the *proviso* that such training would take place in racially segregated classes.<sup>77</sup> This was contrary to the opinion of some officials like Sir Edward Thornton, the Union’s senior assistant health officer and later honorary professor of Public Health at Wits, that blacks should be trained not as medical practitioners but as auxiliary medical officers, as the French were already doing in Dakar. It was felt that such a scheme would minimise costs, retain the authority of white medical officers (the district surgeons) in black areas and would also ensure that blacks would not be in a position to compete with white doctors in urban areas.<sup>78</sup> Later Edward Thornton is said to have strongly protested against the prospect of “opening the profession to a specially subsidised invasion by Natives”.<sup>79</sup>

The proposal to restrict African doctors to employment in the government’s Native Medical Service, was clearly compatible with the regime’s ideology of racial segregation. The Loram

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74 UG 35-28, Loram Committee Report. See also, S. Marks, “The Historical Origins of National Health Services”; Towards National Health Service-Proceedings of the 1987 NAMDA Annual Conference, p. 5.

75 K.A. Shapiro, “Doctors or Medical Aides: Debate Over the Training of Black Medical Personnel for the Rural Black Population in South Africa in the 1920s and 1930s,” *Journal of Southern African Studies*, vol. 13, no. 1 (1986), p. 235.

76 UG 35-28, Loram Committee Report, para. 11.

77 Ibid., para 55.

78 Murray, “The ‘Liberal’ University”, p. 7.

79 E. Thorton, “Conference Paper”, *Journal of the Medical Association of South Africa*, 13 September 1930.

Committee, however, insisted on a full training for black medical practitioners, arguing that the problems of health and disease were the same among blacks as among whites, thus requiring the same skilled treatment. As might have been expected, the Union government's refusal to establish a "Government Native Medical Service" in which African doctors could work, impeded the implementation of the committee's other central recommendations.<sup>80</sup> Following the Loram report on the need for a separate black medical school, the Gluckman Commission also recommended that one such school be established in Durban and that an Institute of Hygiene be set up to train doctors, nurses, and health assistants in the principles of social medicine. However, the power and authority of the medical profession and its hostility towards the training of black doctors prevailed and these initiatives were killed. For example, in a memorandum sent to the government in 1931 on "Medical Services for Rural areas", the federal Council of the Medical association of South Africa submitted that "the Government would be better advised to train a corps of black male and female 'Nursing Aids' for the 'Native areas' rather than devote limited resources to training black medical practitioners".<sup>81</sup> But it was clearly in view of the committee's recommendation that a training centre, the Institute of Family and Community Health was set up in Durban under Sidney Kark. It was also from these initiatives that funding from the Rockefeller foundation led to the establishment in the early 1950s of a segregated institution, the Durban Medical School, with George Gale as the first Dean.

### **2.4.3 The health of the "poor whites" and government action**

The emergence of an unemployed class of unskilled whites in the urban areas and particularly the cities of the Witwatersrand at the turn of the century, inevitably produced a social crisis. The resolution of the "poor white" issue lay at the heart of the explanation for the intensification of racial segregation in South Africa. Although it was the deterioration of the health of their black workers which often caused concern in capitalist circles, it stands to reason that the white population had also been exposed to the impact of industrialisation and proletarianisation. Throughout the first half of the twentieth century the stream of African workers making their way to the towns was paralleled by the newly proletarianised Afrikaners, who were pushed off the land by the capitalisation of agriculture.<sup>82</sup> Hence, the

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80 Shapiro, "Doctors or Medical Aides", p. 245.

81 *Journal of the Medical Association of South Africa*, 24 October 1931, cited by Murray, "The 'Liberal' University", p. 11.

82 Marks, "Historical Origins of National Health Services", p. 7.

1920s and 1930s witnessed an accelerated movement of black as well as white rural dispossessed people into the towns. And it was for this reason that the crisis in black health in the 1930s was paralleled by an equal crisis in white health during the same period. Though it was the African population that bore the main brunt of these developments, within the white community there was also a great unevenness in the distribution of health problems and availability of medical attention. Reports by public health officers and school medical inspectors during this period reveal a very high rate of morbidity among rural Afrikaners, particularly in the malarial bushveld regions of the Transvaal.<sup>83</sup> In the towns too, tuberculosis was common among newly proletarianised Afrikaners, although never on the same scale as among Africans. The Carnegie Commission appointed to investigate the “poor white problem” in the early 1930s, besides reporting on a high degree of malnutrition among this group, also revealed that their health status was generally deplorable, and like their black counterparts, they suffered under a great deal of preventable ill health.<sup>84</sup> According to the Gluckman Report, this group of Afrikaners had, “... ceased to share in the standards of living of the dominant race, and have sunk to the lowest depths of poverty and sometimes depravity”.<sup>85</sup>

However, recognising that malnutrition was merely one part of the wider issue of the so-called “poor white problem” and that it was imperative to tackle this wider problem by improving the political and social circumstances of this community in order to deal with malnutrition, the state made a direct intervention into the deteriorating health status of this white group. J.C. Smuts (prime minister of a United Party government from 1939 to 1948) was concerned that the poor whites, the majority of whom were Afrikaners, would be “swamped” by the growing masses of urbanised black workers, and he ensured that the economic spin-offs of the war would benefit the white workers. This explains why, when the National Party took over the reins of government in 1948, poor whitism had virtually ceased to be a problem for the state.

Closely analysed however, even although the state was very slow to address the health needs of this group, a great deal of good health was ultimately purchased for the poor whites, not by

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83 I.A. Frack, *A South African Doctor Looks Backwards – and Forward* (South Africa, Central News Agency, 1943), pp. 77-78.

84 W.A. Murray, “Health Factors in the Poor White Problem”, *Carnegie Report on the Poor White Problem*, vol. 4 (Stellenbosch, Pro-Ecclesia Printers, 1932).

85 UG 30-44, *Report of the National Health Services Commission 1942-1944* (Gluckman Commission) (Pretoria, Government Printer, 1944).

buying more drugs or providing more health facilities, but instead by merely instituting a direct and co-ordinated response to poverty as the underlying cause of their affliction. This involved a deliberate programme of community development in which the health services played only a limited role. The emergence of job reservation and the so-called “civilised labour policy”,<sup>86</sup> are well documented state responses to the weak market position of skilled and unskilled whites respectively. At the same time, government-subsidised housing helped many white families to improve their immediate environment, while expanded technical education provided new opportunities for the youth.<sup>87</sup> Although there is evidence that generally, the level of poverty and access to medical care for whites before apartheid was cause for concern, it cannot be denied that by the late 1940s and throughout the apartheid period, the majority of whites no longer showed a pattern of disease as closely related to poverty as that of the majority of the African population. The explanation for this is crystal clear: state interventions that were available to the poor whites were not provided for the Africans who, like the whites, had also been on the receiving end of the process of industrialisation and the effects of the Great Depression. Writers such as Parnell even went as far as arguing that the urban reform initiatives of the segregation period were largely an attempt to contain the urban poor white problem that seemed to threaten the social order on which South African capitalism was being built.<sup>88</sup> Indeed, the poor white problem was a major force in inspiring future Afrikaner leaders to explore institutionalised methods of separating the two racial groups in an effort to protect the white minority.

#### **2.4.4 The health problems of Africans and government in-action**

Explanations for the rise of urban segregation have tended to concentrate on the creation of separate, yet unequal, administrative structures that controlled black residence. Such accounts create the impression that segregated and better- standard “white” residential areas just developed without any state intervention. Yet in reality, state manipulation of planning regulations to protect white working class residential conditions in the industrial centres, was a mechanism by which the living standards of poor whites were protected. But for the Africans, without the privilege of such interventions as enjoyed by their white counterparts

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86 The policy replaced non-white workers in the state service with poor whites who were then paid inflated wages. Similarly, protective tariffs encouraged local industry and job reservation ensured poor whites a place in those industries.

87 B. Unterhalter, “Inequalities in Health and Disease: The Case of Mortality Rates for the City of Johannesburg, South Africa, 1910-1979”, *International Journal of Health Services*, vol. 12, no. 4 (1982), p.632.

88 Parnell, “Creating Racial Privilege: The Origins of South African Public Health and Town Planning Legislation”, p. 473.

and with their living and working conditions changing for the worse, their health status became even more dismal.

The contemporary debates on the social issues involved in the HIV/AIDS epidemic have a long history. In his study of the state of public health in the 1930s and 1940s in South Africa, Alan Jeeves found that in addition to the scourge of tuberculosis,<sup>89</sup> and other venereal diseases, this was the period of the country's rampant syphilis epidemic. Even as conditions improved in the mine compounds, largely because of the improvement of mining conditions and the work of the mine medical services,<sup>90</sup> doctors in the rural areas were beginning to note the spread of tuberculosis and venereal disease among hitherto healthy populations on an alarming scale.<sup>91</sup> In the 1930s and 1940s syphilis became by far the most common communicable disease among black people. According to Elizabeth Fee non-venereal syphilis, which is spread by the microorganism *Treponema pallidum* is a common childhood disease in some Asian and African countries that are characterised by poor socio-economic conditions and antiquated sanitary arrangements.<sup>92</sup> At about the same time, the Bantu Nutrition Survey found that the incidence of congenital syphilis among schoolchildren in rural areas was 23%, as high as in urban areas.

Before the availability of penicillin in the 1940s, there was no willingness at all shown at either cabinet or parliament level to confront the socio-economic conditions that were crucially involved in promoting the outbreak and spread of venereal diseases and other infections in the black rural communities. Instead, there was complete state inaction and whenever action was taken there was a tendency to seek solutions to these public health problems in curative medicine rather than preventive measures. And in the early 1960s government action to deal with the health problems of "poor blacks" was limited to policies of exclusion through bantustanisation and influx control. In this way, the poor health standards of black South Africans could conveniently be blamed on the incompetence of bantustan authorities rather than on Pretoria.

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89 Jeeves, "Public Health in the Era of South Africa's Syphilis Epidemic of the 1930s and 1940s". It was estimated that 75% of the Transkeian population was infected by tuberculosis while in most rural parts of South Africa the disease had become endemic. See UG 28-'48, *Report of the Native Laws Commission, 1946-1948* (Pretoria, Government Printer, 1948 (The Fagan Report), pp. 36-39.

90 According to the evidence of the Gold Producers' Committee to the Fagan Commission, the Chamber of Mines was already providing its workers with the finest hospital and medical services. See The Fagan Report, p. 35.

91 P.H. Cluver, *Public Health in South Africa* (Pretoria, 1948), p. 183.

92 Fee, "Sin versus Science: Venereal Disease in Twentieth-Century Baltimore", in Fee and Fox, *AIDS: The Burdens of History*, p. 123.

## 2.5 The 1940s and the work of the National Health Services Commission

In most of the developed world, debates about twentieth-century medicine have been characterised by an increased preoccupation with the delivery of health services. This meant that much more regard was being attached to the medical profession, whose status and power was intrinsically associated with its increased ability to cure the sick. This was in part the result of the rise of the “germ theory” and the increased marginalisation of other community-based, “non-Western” forms of health care.<sup>93</sup> Underlying this has been the fundamental assumption that personal health care delivered by a doctor in a highly technical hospital setting is a worthy endeavour that should be made available to everyone.<sup>94</sup> This belief in the progressive power of modern medicine to cure was even shared by policy makers who (with tragic results) provided the medical profession with both the privilege and authority to determine the content of medical services.

In South Africa the connection between industrial development and underdevelopment in the countryside as well as the links between ill-health and socio-economic change, were not entirely lost on the state in the 1940s. In fact, during the tenure of Dr Eustace Cluver (1940-1942) and Dr Peter Allan (1942-1946) as secretaries for Health, informed public opinion repeatedly pressed for the reorientation of the country’s health services on a more realistic basis. Thus fuelled by a growing public dissatisfaction with the general lack of a comprehensive approach to the country’s health needs, a search for such an approach led to the appointment in 1942 of the National Health Services Commission, under the chairmanship of Dr Henry Gluckman,<sup>95</sup> who later became Minister of Health (from 1945 to 1948) in the Smuts administration. The setting up of the commission was mainly in direct response to numerous calls on the United Party-led government to provide *inter alia*, a central health authority in the place of a highly fragmented one, a national insurance scheme and free hospital facilities. To understand the origins of such calls, it is important to remember the historical context within which they were made. On the one hand, South Africa was fighting in the war against Nazism and thus, with calls for “a national health service” in some parts of the world, it was not surprising that there were individuals in the country who began to

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93 J.R. Kriel and D.J. Beuster, “Health and Health Care Systems”, *South African Medical Journal*, vol. 5 (1977), p. 167.

94 TES 7159 56/76, Correspondence from Secretary of Public Health to Secretary for Finance, 15/5/44.

95 UG 30-44, Report: Gluckman Commission.

question the basis of their own society. On the other hand, the rising tide of black working class militancy in this period also had implications for health. The commission's work is particularly valuable because in its report it not only summarises the state of pre-apartheid medicine in South Africa, but also provides a detailed assessment of the nation's health. It goes on to highlight the unacceptable level of disease throughout the country and is particularly telling when it comes to the shocking health standards among African rural communities.

It will be remembered that by this time the government had already proposed the creation of a native health unit and medical service for the reserves and made funds available for three clinics to be established on a trial basis, using white doctors working closely with black nurses and health assistants. Pholela in rural Natal was the first such Native Health Unit, focussing its efforts on developing a combined preventive-curative family and community health service.<sup>96</sup> Similar health units near Umtata in the eastern Cape and at Bushbuckridge in the Transvaal were also established and the project ultimately culminated in about 40 such clinics serving largely impoverished communities, both black and white. According to available evidence, when Sidney Kark went to Pholela, to set up the first clinic he was confronted by a community that had virtually no access to modern medicine. It is interesting to note that because they had no experience of wellness, the people actually thought that their unwell condition was normal. Among other things, Kark found that not only was infant mortality unacceptably high, but life expectancy was also very low. And because of high rates of malnutrition, the people's immune systems were compromised, which rendered them more vulnerable to opportunistic infections such as tuberculosis and other diseases of poverty.<sup>97</sup> According to the Gluckman Commission, existing measures were inadequate to provide by any mere process of expansion, a national health service of the range and quality demanded

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96 GES 2900 PH42, Report of the Medical Officer in Charge of the Institute of Family and Community Health for the Year Ending 30<sup>th</sup> March 1950.

97 GES 2704 1/62 B, Sidney Kark to Secretary for Health, 20/10/50. For a detailed account of this experiment in 'social medicine,' see, S. Kark and E. Kark, *Promoting Community Health: From Pholela to Jerusalem* (Johannesburg, Wits University Press, 1999); Marks and Andersson, "Industrialisation, Rural Health", in Feierman and Janzen, (eds.), *The Social Basis of Health and Healing*; S. Marks "South Africa's Early Experiment in Social Medicine, Its Pioneers and Politics," *American Journal of Public Health*, vol. 87 (1997); H.T. Phillips, "The 1945 Gluckman Report and the Establishment of South Africa's Health Centres," *American Journal of Public Health*, vol. 83 (1993); Jeeves, "Health, Surveillance and Community"; M. Susser, "A South African Odyssey in Community Health: A Memoire of the Impact of the Teachings of Sidney Kark", *American Journal of Public Health*, vol. 83 (1993); D. Yach and S. Tollman, "Public Health Initiatives in South Africa in the 1940s and 1950s: Lessons for a Post-Apartheid Era", *American Journal of Public Health*, vol. 83 (1993); S.M. Tollman, "Community Oriented Primary Care: Origins, Evolution, Applications", *Social Science and Medicine*, vol. 32 (1991).

by its terms of reference.<sup>98</sup>

Not surprisingly, among other points of criticism, the commission lamented the total lack of coordination in health care, the problems of private practice in relation to the health needs of the majority, as well as the need for preventive, as opposed to curative medicine.<sup>99</sup> Among other points of criticism, the commission found that the general health services were “disjointed and haphazard, provincial and parochial”.<sup>100</sup> Primarily because health care in this country had developed in such haphazard fashion and generally in response to specific health crises, a largely fragmented, unplanned, uncoordinated and often chaotic health care dispensation came into existence.<sup>101</sup> It also pointed out that the absence of reliable and complete health statistics made rational and effective planning of health services very difficult.<sup>102</sup> The commission also blamed the appalling health realities of the majority of the population on the social and economic conditions and concluded:

Unless there were vast improvements in the nutrition, housing and health education of the people, the mere provision of more ‘doctoring’ would not lead to any real improvement in the health of the people.<sup>103</sup>

To address these problems, the commission recommended a number of measures, among them the establishment of a national health service and the creation of a network of local health centres that would deal with ill health by setting up teams of medical workers in which the doctor would comprise only one small part.<sup>104</sup> In the view of the commission, the concept of health centres was a practical expression of two of the most important and universally accepted conclusions of modern medical thinkers. The first was that the days of individual isolationism in medical practice had passed and that medical practitioners and their auxiliaries could make their most effective contribution to the needs of the people through team practice. The second was that the primary aim of medical practice should be the promotion and

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98      GES 2900 PH 42, Report of the Medical Officer in Charge of the Institute of Family and Community Health for the Year Ending 30<sup>th</sup> March 1950.

99      UG 30-44, Report: Gluckman Commission, pp. 97-102.

100     *Ibid.*, p.84.

101     Van Rensburg, “The History of Health Care in South Africa”, p.75. Of the various authorities responsible for control and provision of health care at the time there was: the Department of Public Health, local authorities, provincial authorities, the mines, missionary societies and charitable institutions, private hospitals and private practitioners.

102     UG 30-44., Report: Gluckman Commission, pp. 84-85.

103     *Ibid.*, pp. 97-102.

104     GES 2900 PH42, Report of the Medical Officer in Charge for the Year Ending 30<sup>th</sup> March 1950. See also, UG 30-44, Report: Gluckman Commission, p. 100. See also Wells, *Health, Healing and Society*, p. 30.

preservation of health.<sup>105</sup> The commission further recommended the centralisation of the public medical system under a single authority to be funded through a national health tax. Available evidence reveals that although applauded by many people (including highly-placed officials at the political level) as very revolutionary, the proposals were sadly not carried out for a number of reasons. Firstly, Smuts was not prepared to remove hospital services from the jurisdiction of the provinces.<sup>106</sup> Then too, members of the medical profession were hostile to the commission's report which they viewed as an attempt to turn doctors into public servants. As Jeeves puts it, "The Health Services Commission envisioned a medical service that was not only administered and funded differently from what they knew, but that also gave participating doctors significantly less freedom than they were used to".<sup>107</sup>

The hostility of the medical profession towards the idea of teams of health workers may partly be explained by the fact that the medical establishment of any country is usually conservative and resistant to change. But what was more peculiar about the South African case was that although the country was a multiracial society with a white minority and a black majority, the medical profession was dominated by members of one race, and apparently preferred to cater only for the health needs of the white population. However, it was the entrenchment of a separate "Bantu Health Service," recommended by the Tomlinson Report, which signalled the end of any attempt by the Department of Health to create a unitary health service. Closely considered however, it must be admitted that the major recommendations of the Gluckman Commission were dropped even before a change in government in 1948; and with it, so too did the spirit of reform which characterised the 1940s.

## **2.6 "1948" and all that!**

### **2.6.1 The meaning of apartheid**

A system? An ideology? A coherent blueprint? No, rather a pragmatic, tortuous process of consolidating a nationalist movement's leadership of establishing the Afrikaner's right to self-determination, not primarily against a coloured force, but by preventing the return of the United Party.<sup>108</sup>

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105 GES 2900 PH42, Report of the Medical Officer in Charge of the Institute of Family and Community Health for the Year Ending 30<sup>th</sup> March 1950.

106 GES 2851 PC1, Minutes of the First Meeting of the National Health Council Bloemfontein, 11 August 1947.

107 Jeeves, *Public Health and Rural Poverty in South Africa: "Social Medicine" in the 1940s and 1950s*, p.10

108 R. Schrine (ed), *Leadership in the Apartheid State: From Malan to De Klerk* (Cape Town, Oxford University Press, 1994), p. 139.

Perhaps what makes apartheid difficult to define is that it meant different things to different people at different times. For example, as an electoral slogan adopted by the National Party in 1948 to distinguish their own clear-cut “native policy” from that of the United Party, the concept simply implied the keeping apart of the major racial groups in the country, as far as could be possible and convenient. In this context, the literal meaning of the concept would in Cornevin’s words be, “apartness” or “setting apart” or “the state of being apart”.<sup>109</sup>

Primarily because he too had an irrational obsession with race mixing and also believed in the superiority of the white race, it is not surprising to note that an Afrikaner sociologist, Geoffrey Cronjé, regarded apartheid as a means of safeguarding whites.<sup>110</sup> It was indeed him and a number of Stellenbosch academics who as early as the 1940s began to toy with the concept and publish views that created the broad guidelines along which apartheid would be established.<sup>111</sup> It was no doubt their early pronouncements on apartheid that formed the basis of the Sauer Commission’s report which clarified the policy for the next four decades of National Party misrule. For Eiselen, apartheid went beyond the survival of the white race and reduced opportunities for blacks to escape the inequalities created by segregation.<sup>112</sup> Also writing in the 1950s, Rhodie and Venter, argued that apartheid was in fact the crystallisation of a collective approach to life as well as a national consciousness whose roots and basic principles derived deep into the past.<sup>113</sup> For Hermann Giliomee, apartheid was a modernised form of paternalism and trusteeship, and comprised elements of liberal ideology not used by segregationists.<sup>114</sup> Though there are clear indications that the origin of the term dates back to the early twentieth century, it was only in January 1944 that the National Party leader, Dr D.F. Malan, used it for the first time in the South African parliament.<sup>115</sup>

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109 M. Cornevin, *Apartheid, Power and Historical Falsification* (Paris, Unesco, 1980). See also J.D.L. Kruger, *Bantustans: A Study in Practical Apartheid* (Queenstown, The Daily Representative, 1951), p. 1 and R.W. Patterson, “South Africa and Apartheid”, in *Facts on File* (New York, 1971), p. 1.

110 Based at the University of Pretoria, Geoffrey Cronjé was an influential Afrikaner Christian-nationalist theoretician, whose early writings on the subject formed part of the apartheid manifesto in the 1940s. Cronjé was the author of a number of works, including *Regverdige Rasse-Apartheid* (Cape Town, Citadel Press, 1947) and *Voogdyskap en Apartheid* (Pretoria, JL Van Schaik, 1948).

111 P.J. Schoeman, “Territoriale Segregasie: Enigste Doeltreffende Naturelle Beleid vir Suid Afrika” *Wapenskou*, Junie 1941; F.J. Language and B.I.C. Van Eeden, “Die Oplossing van die Naturellevraagstuk in Suid Afrika: Wenke Ooreenkomstig die Afrikanerstandpunt van Apartheid” *Wapenskou*, April 1943 and W.W.M. Eiselen, “The Meaning of Apartheid” *Race Relations*, vol. xv, no. 3 (1948).

112 Brits, “Afrikaners and the Genesis of Apartheid”, p. 19.

113 N.J. Rhodie and H.J. Venter, *Apartheid: A Socio-Historical Exposition of the Origin and Development of the Apartheid Idea* (Cape Town, HAUM, 1959).

114 H. Giliomee, “The Making of the Apartheid Plan, 1929-1948”, *Journal of Southern African Studies*, vol. 29, no. 2 (2003), p. 372.

115 Ibid.

Perhaps the most authoritative analysis of the historical origins of the apartheid idea is the classic work by Deborah Posel.<sup>116</sup> There seems to be a general consensus among the writers mentioned above that the concept of apartheid grew out of the old Boer tradition of “no equality in church or state”, the bulwark of white supremacy in the country. And it was therefore not implemented as a blueprint by the NP when it came to power. Instead it was merely adapted from time to time to suit prevailing circumstances. There is however neither the space nor the need here to be concerned with a detailed historical account of the genesis of the concept of apartheid and its various interpretations at different periods; nor is it necessary to illustrate its inherent difference from its antecedent, segregation. Such an analysis and detailed description has been ably done by J.P. Brits.<sup>117</sup>

### **2.6.2 New policy or the affirmation of existing practices?**

It is easy, and perhaps even tempting to blame apartheid for all the health problems of black South Africans in the period since 1948. Yet from the evidence presented so far and what has been revealed in both the general and the medical literature, it is self-evident that racial discrimination in South Africa was the accepted practice for decades before the National Party came to power. The roots of segregation were clearly visible from as early as seventeenth century Cape society; it was only after 1948 that segregation assumed a fixed form as government policy.<sup>118</sup> Apartheid did not entail a complete rejection of segregation, but rather it sought to remould it in terms of an ideology deeply- rooted in Afrikaner Christian nationalism, of which ethnic identification provided a pillar. It should be remembered that despite their previous quarrels, the Afrikaners and the British did not allow their antagonisms to disrupt the existing racial order. Even after the bitter South African War at the turn of the century, when the terms of unification were being decided, the British agreed (on a temporary basis at least, which as was expected by both white parties, became a longer-term reality) to the principle of exclusive white power. Indeed, General Smuts’s remarks in London as early as 1917 are a clear indication of how long the discriminatory policies of apartheid had been in operation in South Africa and that they had very little to do with the coming to power of the

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116 D. Posel, *The Making of Apartheid 1948-1961: Conflict and Compromise* (Oxford, Clarendon Press, 1991). See also D. Posel, “The Meaning of Apartheid Before 1948: Conflicting Interests and Forces Within the Afrikaner Nationalist Alliance”, *Journal of Southern African Studies*, vol. 14, no, 1 (1987).

117 J.P. Brits, *Op Die Vooraand van Apartheid: Die Rassevraagstuk en die Blanke Politiek in Suid Afrika, 1939-1948* (Pretoria, Unisa Press, 1994); Brits, “Afrikaners and the Genesis of Apartheid”, and J.P. Brits, “The Voice of the People? Memorandum Presented in 1947 to the Sauer Commission by ‘Knowledgeable’ Afrikaners”, *Kleio*, 32 (2000), 61-83.

118 Brits, “Afrikaners and the Genesis of Apartheid”, p.1.

Afrikaner nationalists in 1948. Smuts declared:

A policy is developing in South Africa today which may have profound effects on the future development of the continent ... We have got into the habit of giving to the Natives their own separate institutions, which are parallel to ours ... through this parallelism we shall solve a problem which otherwise would have been insoluble ... each day we are more and more convinced that it is useless to try to govern White and Black under the same system ... their political institutions should be different, but always on the basis of self-government ... In our system of the ownership of land, in the form of our administration, our policy consists of separating the races ... and so in the final analysis you will have in South Africa *vast regions cultivated by Blacks and governed by Blacks ... and in the remainder of the country, you will have Whites governing themselves*<sup>119</sup> (my emphasis).

What Smuts failed to mention was that effectively, Blacks would govern themselves in only 13 per cent of the land while whites would do so in the remaining 87 per cent. A defining characteristic of the policy was the separation of the races based on racial inequality, with the white minority always being the dominant group. It is in statements such as these that the roots of the homeland system of the apartheid period can be traced. The fact that Smuts made these remarks in the immediate post -World War I period suggests that apartheid was not an exclusive Afrikaner idea, but on the contrary, it was an affirmation of existing practices.

According to Brits, both “segregation and apartheid came into being as coordinated systems within the changing social, economic and political circumstances of a modern, industrialised South Africa.”<sup>120</sup> An examination of official thinking behind the formulation of these policies reveals that the same “survival mentality of the frontier whites” as well as the fears of the “black peril,”<sup>121</sup> were critical and deterministic, and that all future racial relations in South Africa were influenced by this particular thinking. However, Riëtte Lubbe has argued convincingly, that the so-called “black peril” was only a propaganda employed by the pro-Pact government newspaper, *Die Burger*, long before the apartheid idea was conceived, to scare the white voter and therefore maximise support for Hertzog’s party.<sup>122</sup> In the final analysis however, it cannot be denied that although built on the firm foundation laid by segregation, apartheid tended to reaffirm its uniqueness rather than its continuity with its antecedent.

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119 P. Giniewski, *Bantustans: Trek Towards the Future* (Cape Town, Human & Rousseau, 1961), p. 90.

120 Brits, “Afrikaners and the Genesis of Apartheid,” p. 2

121 Brits, *Op die Vooraand van Apartheid*, p. 113.

122 H.J. Lubbe, “The Myth of ‘Black Peril’: *Die Burger* and the 1929 Election” *South African Historical Journal*, no. 37 (1997), p. 107.

### 2.6.3 Apartheid and the rejection of the health centre concept

It was Rudolph Virchow's observation that "both political powerlessness and economic insecurity, lead through a complex web of interactions, to a preponderance of illness and early death",<sup>123</sup> that set the tone for the social medicine movement in Germany and elsewhere in the world. Based on this understanding, Virchow's policy recommendations embrace a series of profound economic, political and social changes including increased employment, better wages and community participation in the political decision-making processes.<sup>124</sup> Therefore, in their design of a comprehensive health system in the 1940s, a small group of progressive South African doctors, aided by an equally small group of key individuals in the Department of Public Health, all clearly shared Virchow's analysis of the root causes of ill health in society. In the forefront of the initiative were doctors like B.A Dormer and F.J. Wiles (Durban); Eustace H. Cluver (secretary of Health from 1940 - 1942); Harry S. Gear (deputy chief Health Officer, and later, assistant director general of WHO); George Gale (secretary of Health and chief Medical Officer, 1946-1952 and later Dean of Durban Medical School, 1952-1955) and Henry Gluckman (chairman of the National Health Services Commission and later Minister of Health). Also active in this health reform move were Sidney and Emily Kark, whose pioneering community health centre in Pholela was funded by the Department of Health as a means of establishing, albeit on a segregationist framework, an alternative to the expensive provincially-run hospitals to cope with the increasing burden of ill health among black rural South Africans. Sadly, the basic recommendations of the NHSC flowing from these reformist initiatives had already been dropped by the time the National Party entered office in 1948.<sup>125</sup>

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123 R. Virchow, cited in S. Tesh, "Political Ideology and Public Health in the 19<sup>th</sup> Century", *International Journal of Health Service*, vol. 12 (1982), 321-342.

124 Rosen, "The Evolution of Social Medicine".

125 For an in-depth exposition of social medicine in South Africa during this period, see Jeeves, "Health Surveillance and Community: South Africa's Experiment with Medical Reform in the 1940s and 1950s"; S. Marks, "South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics", *American Journal of Public Health*, vol. 87 (1997), 452-59; Marks and Andersson, "Industrialisation, Rural Health and the 1944 National Health Services Commission in South Africa", in Feierman and Janzen (eds), *The Social Basis of Health and Healing in Africa*; D. Harrison, "The National Health Services Commission, 1942-44 - Its Origins and Outcomes", *South African Medical Journal*, vol. 83 (1993), 679-84; H.T. Phillips, "The 1945 Gluckman Report and the Establishment of South Africa's Health Centres", *American Journal of Public Health*, vol. 83 (1993); M. Susser, "A South African Odyssey in Community Health: A Memoire of the Impact of the Teachings of Sidney Kark", *American Journal of Public Health*, vol. 83 (1993); D. Yach and S.M. Tollman, "Public Health Initiatives in South Africa in the 1940s and 1950s: Lessons for a Post-Apartheid Era", *American Journal of Public Health*, vol. 83 (1993); Kark and Kark, Promoting Community Health; S.M. Tollman, "Community Oriented Primary Care: Origins, Evolution, Applications", *Social Science and Medicine*, vol. 32 (1991).

Whereas within the Smuts administration there had been at least one powerful section of the people who were committed to some kind of stabilisation of the workforce as well as an improvement in their working and living conditions, with the political victory of the Nationalists in 1948 most of the changes espoused by the Gluckman Commission immediately fell into disfavour. Although a limited application of the proposal to establish a programme to train health assistants was undertaken by Sidney Kark in 1948, the philosophy of the Ministry of Health changed when the new government took over. Close analysis shows that Professor John Ryle has a lot to answer for in the collapse of the project. He had earlier visited the Institute of Community and Family Health and expressed his concern about the comparative inexperience of some of the medical officers who held teaching posts and the use of “non-European” health assistants without university training for the investigation of the social aspects of medical cases. His advice was that both the teaching and research aspects of their work should be placed under university control.<sup>126</sup> This was indeed, a damning critique by an arrogant and condescending academic who took no account of South African conditions and showed no sympathy with the political realities obtaining there. As can be expected, his criticism of the scheme was hijacked by people who had always been hostile to the whole idea of health centres for other reasons and the concept was promptly killed. Although the government had accepted the Gluckman Report in its entirety when it was first issued, it soon became evident that this acceptance had been largely due to the personal influence of individuals like Karl Bremer.<sup>127</sup> Although Bremer was a NP man, available evidence suggests that he was less of a party politician than a gifted social crusader who was genuinely interested in the health and welfare of all South Africans.<sup>128</sup> But by the early 1950s even Karl Bremer, who had succeeded A.J. Stals as Minister of Health, had undergone a drastic change in his views on these issues. He was even less sympathetic to the Institute of Family and Community Health and the associated health centres than his predecessor Stals had been. Stals had shown concern that the commission’s emphasis on “social medicine” was unsatisfactory in the light of the need for curative medicine in the immediate post-war period.<sup>129</sup> Not surprisingly therefore, most of the progressive aspects of the report were dropped and so too was the concept of the health centres. Similarly, the government felt that

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126 GES 2900 PH 42, Secretary for Health (Gale) to Minister of Health, 7 November 1951.

127 Dr Karl Bremer Collection, *Die Brandwag* 31 July 1953.

128 *The Rand Daily Mail*, 20 July 1953.

129 Union of South Africa, *House of Assembly Debates*, vol. 68, May 1949, cols 4924. See also *The Friend*, 12 February 1951.

the commission's emphasis on multi-cultural teams was antithetical to the apartheid doctrine.<sup>130</sup> Thus "the bitter anti-communism of the Nationalists", argues Shula Marks, "which was strengthened by the Cold War, further heightened the hostility to notions of social medicine with its connotations of *socialized medicine*".<sup>131</sup>

The importance of 1948 in South African medicine lies in the fact that the few health centres that had been established found themselves having to operate within a very different administrative, financial and ideological framework from the one envisaged by the Gluckman Commission; the health centres were hindered from functioning as efficiently as the commission had initially anticipated. It thus came as no surprise that in 1952 the minister of health, Karl Bremer himself, announced in the National Assembly that the health centre programme as outlined by the commission and instituted by the Smuts administration was being dropped.<sup>132</sup> The conventional explanation, according to Alan Jeeves, is that "it was killed by the National Party government after 1948 for political and ideological reasons".<sup>133</sup> Both Jeeves and Shula Marks challenge this conventional wisdom that apartheid alone killed social medicine; they argue persuasively that long before 1948 Sidney Kark, George Gale and others had already come under attack by the government, the medical profession and by the National Health Council. Alan Jeeves is of the opinion that John Ryle's damning criticism of the system was even more decisive than the onslaught of apartheid itself. Of course, as pointed out earlier, speculation has no place in historical analysis and interpretation, but the indications are that, had the NP not come to power in 1948 the opposition to social medicine might have been managed and the project saved. In the event, the advent of apartheid practically guaranteed that the critics of social medicine would win. One of the tragedies ascribed to 1948 is that people of stature such as Edward Thornton, Peter Allan, Eustace Cluver, Harry Gear, George Gale, Sidney and Emily Kark, David Landau and a number of other internationally respected champions of social medicine, were lost to the country and their progressive vision vanished with them. In their place, according to Alan Jeeves, came functionaries and ideologues with the sort of attitude and policies that came to characterise the department's new approach to public health.<sup>134</sup> In view of this, it may be concluded that it was the NP's attitude to the people-orientated, preventive and community-based health

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130 Jeeves, *Public Health and Rural Poverty in South Africa*, p. 10.

131 Marks, "South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics", p. 455.

132 Union of South Africa, *House of Assembly Debates*, vol. 79, June 1952, cols 7000-1.

133 Jeeves, *Public Health and Rural Poverty in South Africa*, p. 9.

134 Jeeves, "Health Surveillance and Community: South Africa's Experiment with Medical Reforms in the 1940s and 1950s".

service system that set the tone for the post-1948 medicine that constitutes the subject of this enquiry.

## **2.7 Conclusion**

By way of conclusion, in the light of the foregoing background it is fair to suggest that responsibility for the health problems of black South Africans should be shared, albeit unequally, between the pre-1948 governments and the National Party government after that date. This chapter has referred to some of the earliest applications of race-based interventions into the living and working environment of the black and white population groups. It has pointed out that such interventions were mainly geared towards preventing infectious diseases in the black communities from spilling over into the white group. However, the direct state intervention to save the poor whites from being completely swamped by the urbanised black workers and the institution of a deliberate programme to deal with malnutrition as a health issue in this particular community, is an example of what a government was able to achieve given the necessary political will. This chapter also sought to draw attention to the fact that not all the health problems of black South Africans should be attributed to the coming to power of the National Party. There was very little in the way of coordination of health services during the colonial period and for the most part, health care was rendered on an *ad hoc* basis. It is also important to note that during this period successive governments did not prioritise the health of the black population; they were far more preoccupied with the interests of capital and the white minority group. In the changed post-war environment the NP government's goal was to guarantee the health and welfare of the white minority. Quite clearly, the health consequences of the migrant labour system, with tuberculosis and venereal diseases as major problems, only received official attention when they threatened the health of the white population. During its term of office the United Party did very little to address these problems and the National Party policies made the situation even worse. The Smuts government's policy changes in response to the Smit Report were very temporary, while the Fagan Report came rather too late for the UP to effect any meaningful response. Thus when the NP came to power, they inherited a racially-based health service system from the Smuts administration, which they rapidly developed into hardline race separation in all spheres. The major difference between the two periods is that in the pre-1948 era the country did not yet have the necessary economic prerequisites to provide better health care to all sections of the

population to the same extent as it did after 1948. Close analysis indicates that the exclusion of the black population from the benefits of economic growth and participation in the decision making process, became more goal-directed and systematic after that watershed year in South African history.

In the same vein, all infectious diseases ever since were far more prevalent among blacks than whites, thus reflecting the effects of poverty, poor housing and overcrowding. Similarly, the distribution of venereal diseases in general was virtually identical with the distribution of tuberculosis, which in turn mirrored the distribution of political power and income among the various population groups. It is instructive to note that whereas the problem of venereal disease among blacks during this time was clearly an effect of economic and social conditions, most whites saw venereal disease as a question of sexual immorality. And since blacks were popularly perceived as highly sexual, uninhibited and promiscuous, they were viewed by most whites as the victims of their own uncontrolled sexual instincts and impulses. And it is partly the intention of this study to dispel this myth and to argue that the most blameworthy culprit in this was the social conditions of apartheid-created poverty, the details of which will be the central concern of the next chapter.

## CHAPTER 3

### APARTHEID AND THE CREATION OF POVERTY

When you are so poor that you cannot refuse eighteen-pence from a man who is too poor to pay you any more, it is useless to tell him that what he and his sick child needs is not medicine but more leisure, better food and a better drained and ventilated house. It is kinder to give him a bottle of something almost as cheap as water and tell him to come again with another eighteen-pence if it does not cure him ...<sup>1</sup>

#### 3.1 Introduction

Contemporary debates about poverty and its relationship with disease are not new. There is a wealth of historical evidence suggesting that even Victorian social reformers such as Edwin Chadwick, the campaigner for public health legislation<sup>2</sup> and Charles Booth, who documented the extent of poverty in London in the 1890s,<sup>3</sup> although they did not agree on the nature of the link, they nevertheless admitted that poverty and health status were indeed interconnected. In the last quarter of the twentieth century research into the health inequalities gathered pace and once again the issue of poverty became linked to debates about health and disease. In the current age of the global pandemic, HIV/AIDS, this debate has become even more robust as attempts are increasingly made to understand the link between poverty and AIDS. No doubt the history of nineteenth century sanitary reforms in Europe also provided inspiration for those who were working to improve the health of their populations in many developing countries. The most significant analysis of the relationship between nutrition, mortality and population growth was carried out by Thomas McKeown.<sup>4</sup> Without undermining the

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- 1 D. Sanders and R. Carver, *The Struggle for Health: Medicine and the Politics of Underdevelopment* (Hong Kong, Macmillan, 1985), p. 114.
  - 2 Great Britain Poor Law Commissioners, *Report on the Sanitary Condition of the Labouring Population of Great Britain* (Edinburgh, Edinburgh University Press, 1965).
  - 3 C. Booth, "Charles Booth's London: A Portrait of the Poor at the Turn of the Century". Drawn from *Life and Labour of the People in London* (London, Hutchinson, 1969). See also T.S. Simey, *Charles Booth: Social Scientist* (London, Oxford University Press, 1960).
  - 4 T. McKeown, "Food, Infection and Population" in R.I. Rotberg and T.K. Rabb (eds), *Hunger and History: The Impact of Changing Food Production and Consumption Patterns on Society* (Cambridge, Cambridge University Press, 1985), p. 29.

relevance and/or importance of Massimo Livi-Bacci's query<sup>5</sup> and Simon Szreter's critique<sup>6</sup> of Thomas McKeown's celebrated theory that a disease declines due mainly to improved nutrition rather than improved medical care,<sup>7</sup> there can be no doubt that an examination of the public health experiences of nineteenth century England and Wales also points to socio-economic development as a major determinant of health. David Sanders and Richard Carver also share McKeown's view that the disease profile of industrialisation in these countries was substantially altered in relation to massive improvements in both living and working conditions rather than in consequence to advances in medical science.<sup>8</sup> However, Amartya Sen has no sympathy with this food-centred view which, he argues, tells us very little about starvation because it does not tell us much about why some groups had to starve while others were able to feed themselves. He nevertheless concedes that since income does give one entitlement to food, starvation may be caused not by food shortage but by the shortage of income and purchasing power.<sup>9</sup> It is interesting to note that McKeown strangely suggests that it is historians rather than medical personnel who find it difficult to accept the argument that fortuitous variation in the character of infectious diseases is not an adequate explanation for the major changes in mankind's experiences of those diseases, and that medical intervention such as immunisation and therapy had very little to do with it.<sup>10</sup> Similarly, the social historian of medicine Richard Shryock, in highlighting the critical role of social factors in health also argued that the development of public health in the West began primarily in response to the social and health problems of industrialisation. This partly explains why in the main, the movements for sanitary reform were led by individuals whose primary concern was economic and social change.<sup>11</sup>

As alluded to in chapter two, the significance of this social approach to health is attributed to

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5 M. Livi-Bacci, "The Nutrition-Mortality Link in Past Times: A Comment", in Rotberg and Rabb (eds), *Hunger and History*, p. 95.

6 S. Szreter, "The Importance of Social Intervention in Britain's Mortality Decline 1850-1914: A Re-Interpretation of the Role of Medicine", in B. Davey et al (eds), *Health and Disease: A Reader* (Buckingham, Open University Press, 1995), p. 191.

7 McKeown, *The Role of Medicine: Dream, Mirage or Nemesis?*

8 Sanders and Carver, *The Struggle for Health*, p. 36.

9 Sen, *Poverty and Famines: An Essay on Entitlement and Deprivation*, p. 154. See also A.K. Sen, *From Income Inequality to Economic Inequality* (London and New Haven, Yale University Press, 2004), pp. 59-82.

10 McKeown, "Food, Infection, and Population", pp. 30, 33.

11 R.H. Shryock, *The Development of Modern Medicine: An Interpretation of the Social and Scientific Factors Involved* (Madison, University of Wisconsin Press, 1979), p. 221. See also R.H. Shryock, *Medicine and Society in America, 1660-1860* (New York, New York University Press, 1960).

Rudolph Virchow as illustrated in the works of George Rosen and René Dubos.<sup>12</sup> Indeed, Virchow's policy recommendations not only emphasise the need for scientific investigation of the impact of social and economic conditions on health and disease but he also stressed that society has the obligation to assure the health of its members. With this understanding, he advocated social intervention to promote health and to combat disease. Thus, while acknowledging that poverty was responsible for much ill health in a society, he also maintained that doctors had a duty to support social reforms in general and to improve health in particular.<sup>13</sup> In terms of this approach, the treatment of sick individuals is only a small part of medicine, while the major concern is the control of disease. René Dubos on the other hand, traced the origins and adoption of different ideas about health and also concluded that until the landmark discoveries of Louis Pasteur and Robert Koch, which admittedly changed medical opinion about disease causation, disease was generally understood as resulting from a lack of harmony between the sick person and his environment.<sup>14</sup> This is the kind of holistic approach to issues of health and disease that is generally thought to be the strength of indigenous medicine.<sup>15</sup>

For the purpose of this chapter however, one may say that although not all disease in apartheid South Africa was caused by social factors, there can be little doubt that the disease patterns and their distribution in the period under review reflected major cleavages in society. Even a cursory examination of health records during this period clearly reveals that neither health services in general nor disease patterns in particular can be divorced from the social matrix in which they were embedded. Therefore this chapter is divided into two parts, the first of which draws attention to the fact that as some developing countries began to recognise that socio-economic factors such as adequate housing, clean water, basic sanitation, better nutrition and basic education are critical in improving the health of their populations, in South Africa industrial expansion tragically coincided with the NP government's preoccupation with an illiberal agenda in terms of which the various racial groups would have unequal life chances. These in turn became the basis of poverty for the majority of black

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12 G. Rosen, "The Evolution of Social Medicine", in H.E. Freeman et al (ed), *Handbook of Medical Sociology* (Englewood Cliffs, Prentice Hall, 1965); R. Dubos, *Man Adapting* (New Haven, Yale University Press, 1965).

13 L.J. Rather (ed), *Disease, Life and Man: Selected Essays of Rudolf Virchow* (Stanford, Stanford University Press, 1958).

14 R. Dubos, *Mirage of Health: Utopias, Progress and Biological Change* (New York, Harper & Row, 1959).

15 Interview with Bertha Johanna Nkondo

South Africans.<sup>16</sup> Part two draws attention to the fact that even though the South African economy experienced phenomenal growth in the 1960s and 70s, the wealth was primarily used to fund programmes that had more to do with the maintenance of minority white domination and very little to do with the health of the people.

According to Abebe Zegeye and Julia Maxted, colonialism and apartheid have left the majority of South Africans living in a highly unequal society in which poverty and social dislocation have had profound and traumatic effects on the social fabric.<sup>17</sup> Of course, poverty among the lower strata of the White population, both urban and rural, was a fairly well known social phenomenon in the Cape from at least the eighteenth century. By the beginning of the twentieth century, partially as a result of the socio-economic transformations brought about by the discovery of gold in the Transvaal, poverty among the White population became a specific social problem.<sup>18</sup> However, from the Great Depression of the 1930s, the White rulers of South Africa were confronted with the reality that large numbers of Afrikaners who had been uprooted from the land by war, drought, pestilence, population growth and the capitalisation of agriculture, were pouring into the cities; here they were ill-equipped for modern industrial society and lived in dire poverty.<sup>19</sup> Faced with this problem, but unwilling to acknowledge the wider ramifications of poverty in general, the government set up the Carnegie Commission to investigate the “poor white” problem in South Africa. In 1932 the commission emerged with a number of reports that spelled out the dimensions of poverty amongst White South Africans while also drawing attention to the process of impoverishment.<sup>20</sup> As could be expected, the commission’s concern with whites logically meant that its findings would be used to promote strategies for improving the position of poor whites to the exclusion of poor blacks. Tragically, these findings were eventually incorporated into the thinking of the National Party leadership in their drive for power as well as in the implementation of some of the party’s policies. An attempt is made in this chapter to

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16 Among other absurdities of this period, besides the population register, was that each person in South Africa had to carry a form of identity or “pass book” on which the person was classified as either “European”, “Bantu”, “Asian”, or “Coloured”. How the person was classified determined where he or she would live, what education he would receive, what work he would do, how much money he would earn, whom he could marry, where his wife and children would live, whether he had any political rights and where he could exercise them, which ambulance would pick him up when ill, to which hospital he would be taken and where he would be buried when he died.

17 A. Zegeye and J. Maxted, *Our Dream Deferred: The Poor in South Africa* (Pretoria, Unisa Press, 2002), p. 1.

18 L. Lange, *White, Poor and Angry: White Working Class Families in Johannesburg* (Aldershot, Ashgate, 2003), p. 133.

19 J. Iliffe, *The African Poor* (New York, Cambridge University Press, 1987), p. 117.

20 Terreblanche, *A History of Inequality in South Africa*, p. 53.

explain the callous indifference of many whites towards the poverty of black South Africans during the period under review without taking into account their strongly-felt racial prejudices. I shall defend the view taken in this thesis that it was primarily because of these racial prejudices that the white people supported illiberal policies that directly created more poverty for black South Africans. This is done with the view to demonstrating, in the chapter that follows, how such poverty impacted upon their health status. As evidence that the “poor black problem” posed no threat to White supremacy, it may be suggested that the one important reason for parliamentary scepticism towards the welfare state proposals of the Gluckman Commission just before the Nationalist take-over, was that the poor white problem was already beginning to recede.

## **3.2 Part I: Apartheid and the construction of a segregated society**

### **3.2.1 The meaning of poverty**

To understand the role played by apartheid in the creation of poverty, it is important to understand first what the concept means, because there is a difference between poverty and inequality.<sup>21</sup> As Amartya Sen put it, “poverty and inequality relate closely to each other, but they are distinct concepts and neither subsumes the other”.<sup>22</sup> Like most sociological concepts, as a symptom of deprivation, poverty has no single definition that can be useful for every situation. Though the World Bank’s definition, “the inability to attain a minimal standard of living measured in terms of basic consumption needs or income required to satisfy them,”<sup>23</sup> is widely used, there is no question that each definition depends upon how well it serves the position one wishes to advance. For instance, according to Dasgupta, the constituents of “a basic minimal standard of living” may include access to primary health care, clean water, adequate sanitation, income, food, clothing, shelter and basic education.<sup>24</sup> Thus, the ability to identify well-being requires an understanding of destitution, while to understand destitution, it is important to know what the person is being deprived of. Amartya Sen argues that “poverty is of course, a matter of deprivation”.<sup>25</sup> Similarly, there is a difference between “absolute” poverty and “relative” poverty. Absolute poverty refers to the material conditions

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21 P. Townsend, *The International Analysis of Poverty* (New York, Harvester Wheatsheaf, 1993), p. 119.

22 Sen, *Poverty and Famines: An Essay on Entitlement and Deprivation*, p. 23.

23 World Bank, *World Development Report* (Oxford, Oxford University Press, 1990), p. 26.

24 P. Dasgupta, *An Inquiry into Well-Being and Destitution* (New York, Oxford University Press, 1993), p. 4.

25 Sen, *Poverty and Famines: An Essay on Entitlement and Deprivation*, p. 22.

of people who earn or possess less than a specified amount of money, food and shelter. It is usually said to exist when people have too few resources to maintain a specified standard of living.<sup>26</sup> In contrast, Peter Townsend defines relative poverty as a condition when poor individuals lack the resources to obtain the types of diet necessary for the health and living standards that are customary in the society to which they belong.<sup>27</sup> However, Townsend's abandonment of the idea of "absolute" need in his definition of the concept has come under heavy criticism by Amartya Sen. He argues: "At the risk of oversimplification, I would like to say that poverty is an absolute notion in the space of capabilities, but very often it will take a relative form in the space of commodities or characteristics".<sup>28</sup> Returning to the same theme Sen maintains that relative deprivation is essentially incomplete as an approach to poverty, and supplements (but does not supplant) the earlier approach of absolute dispossession.<sup>29</sup>

In this thesis I lean towards material definitions because besides being easy to conceptualise for quantitative analysis, they also enable one to make comparative descriptions of socio-economic conditions in different contexts. This also contrasts with the victim-blaming assumptions so often prevalent among white South Africans, that the poverty of black South Africans stems from their own wrong eating habits and their feckless ways. This view ignores the reality that chronic poverty can produce some distinctive behaviour. I have also argued elsewhere, that the questionable behaviour of poor people may be a desperate response to their material conditions or a struggle against them. I make this assumption on the basis that it is often the case that as the material conditions improve, the aberrant behaviour recedes.<sup>30</sup>

If the definition of poverty is based on various calculations of human subsistence requirements, and assuming that no money is spent on anything other than food, then the majority of black South Africans under apartheid were indeed poor. Largely unemployed, relegated to impoverished and largely underresourced bantustans, harassed at every turn by the strict enforcement of influx control measures, excluded from better paid jobs by the job

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26 B. Rogers, *White Wealth and Black Poverty: American Investments in Southern Africa* (Westport, Greenwood Press, 1976).

27 P. Townsend, *Poverty in the United Kingdom: A Survey of Household Resources and Standards of Living* (London, Pelican Press, 1976), p. 3. See also Townsend, *The International Analysis of Poverty*, p. 3

28 A.K. Sen, "Poor Relatively Speaking", *Oxford Economic Papers*, 35 (1983), pp. 153-69. Cited in Townsend, *The International Analysis of Poverty*, p. 124.

29 Sen, *Poverty and Famines*, p. 22.

30 S.N. Phatlane, "Poverty and HIV/AIDS in Apartheid South Africa" *Social Identities: Journal for the Study of Race, Nation and Culture*, vol. 9, no. 1 (2003), p. 86.

colour bar and their menfolk subjected to an unnatural existence in single- sex hostels, it can hardly be denied that black South Africans lived under conditions of poverty. It is in this context that the concept of poverty has been used in this study.

### 3.2.2. Race classification as the basis of inequality and poverty

An understanding of inequality between black and white South Africans depends on one's knowledge of the population itself. Peter Townsend has not only attempted to determine the link between ill health and deprivation but has also analysed the relationship between health and prosperity, though in a completely different context.<sup>31</sup> In the case of South Africa, segregation on the basis of skin colour was not strictly an invention of the National Party in 1948.<sup>32</sup> Nor did inequality end with the death of apartheid.<sup>33</sup> Instead, what the apartheid ideologues did after that date was merely to promote legislation, both new and amendatory, to give effect to existing practices. However, a critical step unique to apartheid was the racial classification of society into White, Asian, Coloured and African. It was the Population Registration Act and the Group Areas Act (both passed in 1950) that formed the legislative basis of such a classification.<sup>34</sup> In a cynical effort to create a white majority the NP government also promoted the concept of black nations based on ethnicity, leading to the ridiculous situation of one white nation and a number of black nations, as the table below illustrates:

**Table 3.1. South African population in 1960**

<b>Total Population</b>	<b>15, 841, 128</b>
Xhosa	3 432 000
White	3 067 638
Zulu	2 959 000
Coloured	1 488 267
Northern Sotho	1 122 000
Southern Sotho	1 089 000
Tswana	863 000

31 Townsend, *Health and Deprivation: Inequality and the North*, p. 74.

32 See Terreblanche, *A History of Inequality in South Africa*.

33 Seekings and Nattrass, *Class, Race and Inequality in South Africa*, pp. 188, 216.

34 The use of the label "African" is still a hotly contested issue in South African historical writing. Note that the terms used to refer to a Black South African have changed with time from: Bantu, Native, non-White, non-European, Black and more recently, African.

Asian	477 414
Tsonga	366 000
Swazi	301 000 <sup>35</sup>

According to a different set of statistics, the relative size of the South African population based on race during the period under review was as follows.

**Table 3.2 South African population in 1960**

Year	Whites	Africans	Coloureds	Asians	Total
1950 <sup>36</sup>	2 641 689	8 556 390	1 103 016	366 664	12 667 759
1960 <sup>37</sup>	3 088	10 927 922	1 509 258	477 125	16 002 797
1970 <sup>38</sup>	3 751 328	15 057 952	2 018 453	620 436	21 448 169

Although the population statistics provided by Barber and Barrett for 1960 differ slightly from those found in the country's statistical records given in Table 3.2 above, I have referred to both sets of figures because as a strategy, the NP's classification formula which masked the numerical inferiority of the white population may appear real to the uninformed. It is important to mention that even though there were no fundamental differences between segregation and apartheid, the issue of race classification and the elaborate effort to define and enforce it was something essentially new after 1948. So confusing and contradictory was the classification that at the margins it was extremely difficult to distinguish between White and Coloured and Coloured and African in a population that over the centuries had experienced so much miscegenation and racial mixing. An elaborate and virtually unworkable

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35 J. Barber and J. Barratt, *South Africa's Foreign Policy: A Search for Status and Security 1945-1988* (Cambridge, Cambridge University Press, 1990), p. 93.

36 Department of Statistics, *Annual Report for the Year-Ended 31 December 1953*.

37 Department of Statistics, *Population Census 16<sup>th</sup> September 1960: Geographical Distribution of the Population*, vol. 1 (Pretoria, Government Printer, RP 62/1963).

38 Department of Statistics, *Report No. 02-05-01: Population Census 6<sup>th</sup> May 1970, Republic of South Africa, Population of Cities, Towns and Rural Areas* (Pretoria, Government Printer, 1970).

bureaucratic process was required to define people according to the Population Registration Act (PRA) and the many amendments and increasingly absurd definitions of the racial groups are evidence of the impossibility of doing this with the necessary rigour and consistency that the apartheid planners required. Criteria included descent, appearance (skin colour) and community acceptance. However, insurmountable problems arose when the criteria failed to match. Often appearance did not line up with descent and/or community acceptance. According to Katherine Manzo, whereas White and Coloured were defined by skin colour, “native” was defined by country of origin and Asian by continent of origin. “Anyone of these criteria”, argues Katherine Manzo, “country, colour, continent, could have been applied consistently to differentiate the population, but consistency was not conducive to the requirements of white domination”.<sup>39</sup> Country of origin as the defining hallmark of race would have split the required common identity among whites. Similarly, continent of origin would have made the classification of Coloureds impossible, while colour alone would have created a single black majority. “The politics of social diversity”, concludes Manzo, “as a way to maintain domination, thus made inconsistency an imperative, not an oversight”.<sup>40</sup> Critics of government policies have charged that if the Afrikaners were indeed such a distinct nation, different from the English, Germans, French and so forth, why then were they lumped together as “White” by the very people who insisted on Afrikaner essentialism? Quite clearly, identity for whites and difference for blacks was part of the survival strategy that was crucial to the maintenance of white supremacy. An earlier survey of available data on the life expectancy, mortality, morbidity, and physical efficiency of the Cape Coloured people and the reliability of the evidence upon which alleged differences between them and the white people, has found no evidence that differences in the genotype play any role in determining the observed differences in mortality and morbidity.<sup>41</sup> The sorry history of this legislation is a clear demonstration of the truism that “race” has no validity as a tool of social analysis except, of course, to a racist.<sup>42</sup> The difference in the black and white groups is more often than not in the nature of the diseases that kill them.<sup>43</sup>

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39 K A. Manzo, *Domination, Resistance, and Social Change in South Africa: The local Effects of Global Power* (London, Praeger, 1992), p. 173.

40 Ibid.

41 GES 2717 P32E-P35, Report on the Work of the Social Medicine Research Unit at the University of Cape Town Up to 31 December 1949.

42 For the contradictions involved in this legislation, see SAIRR, *Laws Affecting Race Relations in South Africa, 1948-76*; and SAIRR, *Race Relations Survey, 1970*, p. 29.

43 This report found that among Whites the three principal causes of death were old age, cardiac diseases and arterial diseases; cancer and tuberculosis stood only fourth. Among Blacks on the other hand, tuberculosis stood first with a figure nearly seven times that encountered in the White group, while bronchitis, pneumonia, enteritis and diarrhoea stood second. For an overview of this finding, see, GES

Racial classification, then, was a social process used to direct social stratification, which in the case of South Africa had a direct bearing on the social position of different members of the population. As a rule, if the state advances a policy of racial stratification then the use of race facilitates the administration of racially marginalised populations. Similarly, if the state advances a policy against racial stratification, then the use of race facilitates the state's fight against racial stratification. Finally, if the state advances a policy against racial distinctions, the use of racialised data becomes part of a process to end the everyday practice of racism that necessitates race.<sup>44</sup> However, race classification was very crucial to the survival of the white race because it determined the person's life chances and his or her ability to access education, health services, employment and much more. Hence the contention is made in this study that race classification formed the basis of poverty in South Africa.

### **3.2.3 Verwoerd's rejection of the Tomlinson Report**

Mindful of the fact that the earlier segregationist ideas of J.B.M. Hertzog and D.F. Malan were being over-run by economic developments, in the early 1950s the two prominent officials in the Native Affairs Department (NAD), H.F. Verwoerd and W.W.M. Eiselen, the minister and the departmental secretary respectively, urged the reorientation of South Africa's economic development. To this end, a commission headed by Professor F.R. Tomlinson was appointed. His brief was to inquire into and report on a scheme for the rehabilitation of the "Bantu" areas with a social structure based on socio-economic planning in keeping with "Bantu" culture.<sup>45</sup> Based on the 1951 census of 2.65 million Whites, 1.1 million Coloureds, 370 000 Asians and 8.56 million Blacks, the commission favoured a set of extrapolations giving an estimate of 6.15 million Whites, 3.9 million Coloureds, 1.38 million Asians and 21.4 million Blacks in the year 2000. Prompted by white fear of the potential threat of the numerical superiority of the black population, the Tomlinson Commission recommended a policy of separate development to be realised in part through the full-scale economic development of the "Bantu" areas, without which, the commission warned, the whites would be swamped by the 21.4 million blacks at the turn of the century.<sup>46</sup>

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2819 P32E-P35, Report on the Work of the Social Medicine Research Unit at the University of Cape Town Up to 31 December 1949.

44 A.K. Khalfani, et al., "Population Statistics" in T. Zuberi et al (eds), *The Demography of South Africa* (London, M.E. Sharpe, 2005), pp. 8-9.

45 CAD-K20, *Report of the Commission for the Socio-Economic Development of the Bantu Areas Within the Union of South Africa* (Tomlinson Report), vol .3, File no. p/6/12.

46 Ibid.

When this recommendation is analysed it becomes clear that Tomlinson was expected to negate the cardinal findings of the Fagan Commission. The Fagan Report, to the consternation of the NP, had concluded that the ideal of total segregation as envisaged by the Stallard Commission before it, were utterly unattainable.<sup>47</sup> Fagan's commission had maintained that the movement of people of all groups from country to town should be seen as having a background of economic necessity.<sup>48</sup> It found that the economic integration of the Blacks was inevitable and unstoppable if work and welfare were to be created and maintained.<sup>49</sup>

The Tomlinson Commission made a number of far reaching proposals regarding the reserves. Firstly, with scant regard for the grandiose pipe-dreams of Verwoerd and De Wet Nel, it found that the ideal of politically separate and economically independent homelands could only be achieved if there was substantial state backing.<sup>50</sup> Faced with the possibility of this undue expense the government's approach to homeland development was to create a Bantu Development Corporation (BDC) and give it a pittance of R500 000 with which to create these "utopias".<sup>51</sup> Among other recommendations of the commission was that R208 million would have to be spent on a ten year programme for developing secondary and tertiary industries in order to provide the basis for increasing the carrying capacity of the reserves.<sup>52</sup> Health services in the reserves would have to be brought under a single health authority and be allocated R10 million, while training facilities for black health workers had to be provided.<sup>53</sup> There is reason to believe that despite his expensive recommendations for development, even Tomlinson was not optimistic about achieving complete economic independence for the homelands. For instance, only a small number of Africans would use agriculture as a means of making a living in terms of his scheme; most would live in villages and then travel to "white areas" to find work as migrants. The Tomlinson report thus couched the apartheid ideology in relatively scientific terms, for it rejected more strongly than any

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47 S.B. Greenberg, *Legitimizing the Illegitimate: State, Markets and Resistance in South Africa* (Berkeley, University of California Press, 1987), p. 39.

48 UG, 28-1948, *Report of the Native Laws Commission, 1946-1948 (The Fagan Commission)*, (Pretoria, Government Printer, 1948).

49 Greenberg, *Legitimizing the Illegitimate*, p. 150.

50 CAD-K20, The Tomlinson Report. See also Giliomee, *The Afrikaners: Biography of a People*, p. 516.

51 CAD-K20, The Tomlinson Report. See also, *The Mercury*, 14 December 1959.

52 CAD-K20, The Tomlinson Report.

53 Ibid., p. 150.

previous document, the homogeneity of the African population.<sup>54</sup> For all practical purposes, it appears that Professor Tomlinson took very seriously, the government's rhetoric about "unlimited opportunity for the bantu in their own areas."

It is however interesting to note that, like the major proposals of the Gluckman Commission before it, the basic proposals of the Tomlinson Commission were not favourably received, largely because of the government's emerging political priorities for the reserves. Verwoerd's government was extremely reluctant to make any sacrifices that would hurt its electoral support and criticised the report because it purported to deal pragmatically with the demand for black labour. I therefore argue here that by pursuing the homelands policy on the one hand while rejecting the commission's key proposals on the other, the government was laying a firm foundation for rural poverty. Yet this was not surprising in the light of such public pronouncements as made by Nico Diederichs, Minister of Economic Affairs at the time:

Economic considerations should never stand in the way of keeping South Africa white. Economic considerations should never stand in the way of preventing the Native areas from being Black.<sup>55</sup>

Thus, even though Verwoerd welcomed the commission's justification of apartheid, he rejected out of hand the notion of committing his administration to a meaningful development programme in the reserves. For example, in his announcement of the government's position he was critical of the recommendation that R60 million be budgeted for the development of industries in the reserves with the help of white entrepreneurs. Besides the issue of affordability, Verwoerd rejected this proposal on the grounds that it was contrary to the basic tenets of apartheid.<sup>56</sup> Tomlinson had merely set out the minimum levels of government investment and development that would be necessary to slow the accelerating rate of permanent urbanisation of the black population. Instead of the proposed R10 million for health services, only R6 million was allowed.<sup>57</sup> It is clear that by suggesting that parallel industrial and commercial development in the reserves should take place with substantial financial backing by the state and by advocating a sustained political and economic development of the reserves, the commission broke the mould of the segregationist thought on which Verwoerd had based his vision of separate development. Instead he proposed to rely

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54 Giliomee, *The Afrikaners: Biography of a People*, p. 517.

55 *The Argus*, 8 October 1959.

56 CAD-K20, Memorandum: Government Decisions on the Recommendations of the Commission for Socio-Economic Development of the Bantu Areas within the Union of South Africa, F-1956, Decision no.10.

57 CAD-K20, The Tomlinson Report, File no.61/1955.

on pass laws and influx control to prevent and/or reverse black urbanisation. Indeed, it was this decision that actually deepened one of the central contradictions of apartheid. Closely analysed, It appears that in formulating his vision for apartheid society, Verwoerd ripped all the economic substance out of the development plans of the Tomlinson Commission, but he cleverly used its political proposals and ideological arguments to justify his own aims. When debating the report in parliament, Verwoerd employed the commission's demographic projections to demonstrate that whites in "white areas" would be "swamped" by the year 2000 if most of the expected black increase of 11 million lived in the "white areas". Hence his solution was to play the demographic card to stop black urbanisation and to accommodate the projected influx of black people by shunting them into the bantustans.<sup>58</sup> However, black communities refused to remain helpless and hapless victims of this repressive strategy and as poverty in the reserves grew ever worse, the pressure for black people to escape and move permanently to the cities intensified. In the event, the number of black South Africans outside the bantustans increased over the years rather than decreased. And to the extent that influx control succeeded in preventing their drifting into the cities, it only made African poverty worse.

### **3.3 Importing labour and exporting poverty**

#### **3.3.1 Ethnic "balkanisation" and poverty**

It is Randall Packard's monumental study of tuberculosis in South Africa that has exposed the apartheid government's attempts to import African labour into both industries and mines while simultaneously exporting poverty and disease to the countryside.<sup>59</sup> Indeed, by condemning the majority of the country's population to 13 per cent of the land in terms of the 1913 Land Act and its subsequent amendments, the pre-apartheid governments had virtually laid the basis for an environment of poverty which the NP policies merely exacerbated.<sup>60</sup> By restricting African rights to land ownership to the "native reserves" and thus denying them the security of tenure that comes with landownership throughout the so-called white areas, the legislation undoubtedly formed the basis of African impoverishment, particularly so because it undermined the subsistence farming of the African people in the reserves. Thus, the Nationalists made a bad situation worse when in the 1950s they began to embark on the

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58 Giliomee, *Afrikaners: Biography of a People*, pp. 517-18.

59 Packard, *White Plague, Black Labor*, p.211.

60 Lacey, *Working for Boroko: The Origins of a Coercive Labour System in South Africa*, p.29.

policy of ethnic balkanisation based on these reserve areas. As Paul Giniewski puts it:

When two men are seated on a horse, one of them must seat behind the other. It is normal for the one who is guiding the horse to sit in front. Whites and the Bantu of South Africa are in the uncomfortable position of horsemen on the same mount. The White man who is holding the reins, and who has the spurs, does not want to get off, but he is beginning to understand that it would be wise to give the Bantu another horse - a black one, perhaps - and that the Bantu could then ride at his own sweet will.<sup>61</sup>

But to achieve this result, the NP government had to follow a different blueprint for reform than that offered by the Fagan Commission,<sup>62</sup> which maintained that the development of a permanent urbanised African workforce was critical for the economic development of the country. Although one of the widely held myths was that the homelands were agricultural areas where the population could support itself, I have pointed out above that in spite of the Tomlinson scheme, only a small number of Africans could live by farming in those areas, as the report itself so clearly acknowledges:

the reserves were so overcrowded that more than 300 000 families would have to abandon “Bantu” agriculture in order to give those who remain the opportunity of making a living out of the land without resorting to periodic spells of work elsewhere.<sup>63</sup>

Little wonder that liberal critics in the 1950s and 1960s argued that apartheid was having the opposite effect; not only was it ensuring the poverty and deprivation of millions of black people but it was also making the white population even more insecure and threatened. AS such, the ethnic balkanisation of the country soon became central to the government’s efforts to control the entry of Africans into the general economy except as units of labour. By serving as virtual “dumping grounds” for the unemployed, the sick, the infirm, the women and children, the reserves-cum bantustans contributed to the underdevelopment and ultimate collapse of rural agriculture. This process was pushed to the extreme from the mid 1970s with the granting of nominal “independence” to four of these impoverished constructions. For the purposes of this study, an important effect of such demographic shifts was that by pushing the particularly susceptible subsections of the population to the bantustans, some of the worst cases of disease in “White South Africa” were removed from the country’s statistical records. As one observer noted: “Logically, one could continue this trend and eliminate TB altogether

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61 Giniewski, *Bantustans: A Trek Towards the Future*, p .87.

62 UG, 28-48, Fagan Commission Report.

63 UG. 61/1955, Summary of the Report of the Commission for the Socio-Economic Development of the Bantu Areas Within the Union of South Africa, p. 145.

from South Africa with a few flourishes of a statistical pen”.<sup>64</sup> And it may further be argued that by developing welfare services in these areas the government merely disguised the extent to which the very existence of the bantustans was the cause of poverty and disease. No wonder a newspaper editorial, commenting on Transkeian “independence” argued that the problem of malnutrition in the area had been redefined from a problem of the South African state to one of the Transkeian government. And “this is being done in the guise of giving freedom to blacks. Could anything be more cynical?”<sup>65</sup>

### 3.3.2 The job colour bar and poverty

The use of job opportunities and income as a starting point for an exploration of the relationship between poverty and health status appears to be the most appropriate way of tackling the issue. Studies of the association between occupational status and mortality no doubt lead to that conclusion. Perhaps to reiterate the point made earlier, racial discrimination since 1948 was not necessarily an invention of the National Party, but had existed in legislative form long before that date. What the National Party did after 1948 was merely to tighten up and enforce more rigorously the existing discriminatory practices of their predecessors. For example, in economic life the practice of prohibiting blacks from performing certain types of skilled work had been maintained in terms of the Mines and Works Act of 1911 which the government merely strengthened in 1956 by means of the Industrial Conciliation Act and its subsequent amendments.<sup>66</sup> This law clearly sought to provide safeguards against interracial competition between black and white South Africans. Even in the face of “poor whiteness” in the pre-apartheid period, the white working class called not only for the elimination of inroads that Africans had already made into formerly “whites-only” occupations during the war years, but the reversal of the practice. Thus, after 1948, convinced that the colour bar was essential for the maintenance of white supremacy, the government simply incorporated it into the evolving social system of racial domination that characterised apartheid.<sup>67</sup>

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64 Coovadia, “BCG in South Africa”, quoted in Packard, *White Plague, Black Labor*, p. 298.

65 *The Rand Daily Mail*, 30 December 1977.

66 For an overview of these and other laws, see, Muriel Horrell, *Laws Affecting Race Relations in South Africa, 1948-1976* (Johannesburg, SAIRR, 1978).

67 J. Crush, A. Jeeves and D. Yudelman, *South Africa's Labour Empire: A History of Black Migrancy to the Gold Mines* (Cape Town, David Philip, 1991), p. 83.

It is interesting to note that as Deputy Minister of Labour, Marais Viljoen is on record as trying to justify the colour bar by declaring: “job reservation had brought industrial peace ... it was an essential measure used with great discretion for the protection of all races”.<sup>68</sup> In an effort to carry this job colour bar to its logical conclusion, the Deputy Minister of Bantu Administration (BAD), P.G.J. Koornhof issued Government Notice R531 of 3 April 1970, entrenching the existing prohibitions placed upon Africans to undertake certain types of work.<sup>69</sup> In consequence to this declaration, many Africans were informed that their services would have to be terminated. However, because of the acute shortage of skilled whites to fill those jobs, employers resorted to simply re-naming the jobs held by Africans without altering the duties they performed. The effect of this labour legislation was illustrated rather more graphically by Roy du Pré:

At the University of Cape Town (UCT), a number of non-whites were enrolled in the faculty of engineering. The student could receive all his theoretical training at the university, but no firm was prepared to apprentice him to give him the practical experience in the final years of the course. In spite of this, the students still completed the course and graduated, but found all doors of employment closed to them.<sup>70</sup>

Du Pré’s statement above is also echoed in Merle Lipton’s remark that, “if blacks are excluded from engineering faculties, they will not become engineers even in the absence of a formal job colour bar”.<sup>71</sup> Similarly, as I will attempt to show in chapter five, if blacks were denied high school mathematics, then effectively they would be excluded from the medical profession, even without actual government decree to that effect.

### **3.3.3 Population relocations and poverty**

One of the most harrowing aspects of apartheid was the forced removal of millions of black South Africans from their established homes to the rural bantustans. The real reasons behind these removals are best captured by Cosmas Desmond

It is not the result of a sadistic aberration, it is not the expression of a pathological negrophobia, above all, it is not a mistake. It is being done because it has to be done if apartheid is to survive. The foundations of apartheid are not shaken by people sitting together on park benches, or eating together in multiracial restaurants, or playing together in “international”

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68 *The Argus*, 22 September 1961.

69 SAIRR, *Race Relations Survey 1970*, p. 88.

70 Du Pré, *Separate but Unequal*, p. 111. See also *The Argus*, 5 September 1970.

71 Lipton, *Capitalism and Apartheid: South Africa 1910-1986*, p. 38.

sports. But they would be shaken by the absence from the “white area” of those blacks whose labour is needed there and by the presence in those areas of blacks who are “superfluous”. The resettlement policy is the cornerstone of the whole edifice of apartheid.<sup>72</sup>

Apart from such chilling stories told by Desmond, and the well documented works of Gerhard Maré,<sup>73</sup> Margaret Nash,<sup>74</sup> and in the mid-1980s, Laurine Platzky and Cherryl Walker,<sup>75</sup> very little historical attention has been focused on the impoverishing effects of uprooting African communities from their homes. While some removals took the form of physical relocation of whole townships into the ethnic homelands in accordance with the apartheid scheme, others involved the expulsion of individual families from farming areas or from white-designated towns in an effort to fulfil the apartheid planners’ schemes for racially segregated living areas in the cities and rural villages of South Africa as well as the clearing of what the authorities called “black spots”.<sup>76</sup> It has been reliably estimated that in the intervening years since its promulgation in 1950, the Group Areas Act has led to the forced removal of well over three quarters of a million people.<sup>77</sup> In reality, these enforced removals were a manifestation or a dimension of poverty as well as a cause of further impoverishment. The bitter experiences of these involuntary demographic shifts is well illustrated here:

Prior to the move from Ga-Tlthose to Bendell, the people were involved in subsistence farming and cattle grazing. The economically active men lived within walking distance of the mines at Sishen and found regular employment there. After the move they were much further from the mines and those who did have work found it impossible to return to their families more often than once a year.<sup>78</sup>

In this way the state’s resettlement policies and devastating effects of separating men from their families, were added to the effects of labour migrancy. An analysis of the social consequences of force removals was undertaken by Scudder, who argues that relocation, whether voluntary or compulsory, is a stressful experience and that the stress of relocation limits the range of coping

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72 C. Desmond, *The Discarded People: An Account of African Resettlement in South Africa* (Harmondsworth, Penguin, 1970), p. xviii.

73 G. Maré, *African Population Relocation in South Africa* (Johannesburg, SAIRR, 1980).

74 M. Nash, *Black Uprooting from White South Africa* (Johannesburg, SACC, 1980).

75 L. Platzky and C. Walker, *The Surplus People: Forced Removals in South Africa* (Johannesburg, Ravan Press, 1985).

76 BAD, Paragraph 4 (a) of Circular No.2/10/3, 14 April 1965. In terms of this circular, “Black spots” were pockets of black families living in an otherwise white-designated rural area.

77 The Surplus People Project Report, *Forced Removals in South Africa*, vol.1 (Cape Town and Pietermaritzburg, 1983), pp. 1, 5. See also Platzky and Walker, *The Surplus People: Forced Removals in South Africa*, p. 10.

78 Wilson and Ramphele, *Uprooting Poverty: The South African Challenge*, p. 88.

responses of those involved.<sup>79</sup> This is more so because in terms of health care, the effects of relocations were more deceptive than real. For example, in his analysis of the social and economic development of urban and rural areas of South Africa from 1950 up to the end of the 1970s, Randall Packard found that contrary to official rhetoric, the rise in African TB notifications between 1953 and 1963 was less the product of better case finding, as of the increase in rates of infection.<sup>80</sup> For practical reasons, the conditions of poverty, overcrowding and malnutrition resulting from population resettlements continued to provide a catalyst for tuberculosis. Similarly, the decline in the rate of TB infection in the wider South Africa was also found to have had a direct relationship with the removals. For all practical purposes, the most susceptible segments of the population had been exported from urban areas where record-keeping and medical surveillance were efficient, to the rural homelands and thus beyond the statistical boundaries of the country.<sup>81</sup> Thus from the masses of evidence collected by the Surplus People Project, the Carnegie Commission and the earlier works such as that by Cosmas Desmond referred to above, there can be little doubt of the extent to which the practice of compelling millions of people to move from one place to another increased the burden of their poverty. In the relocation camps around the country unemployment also emerged as a major problem. The Surplus People Project found that the average unemployment rate in 12 relocation areas was 17 per cent for men and 36 per cent for women, while in Glenmore the figures went up to a staggering 56 per cent.<sup>82</sup> To make matters even worse the bulk of available evidence also suggests that most families affected by removals had to sell their livestock to white farmers at a tenth of its value because they were often “dumped” in settlements where it was practically impossible to keep cattle.<sup>83</sup> Commenting on the lack of employment opportunities in the resettlement areas, apparently without the slightest regard for the impoverishing effects of their policies, the minister of Bantu Administration and Development, M.C. Botha, pointed out that resettlement areas were not supposed to be areas of employment, but areas from which workers could become

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79 T. Scudder, “A Sociological Framework for the Analysis of New Land Settlements” in M.M. Cernea (ed), *Putting People First: Sociological Variables in Rural Development* (Oxford, Oxford University Press, 1985), pp. 121-53.

80 Packard, *White Plague, Black Labor*, p. 293.

81 The fact that the primary targets were the unemployed, women and children and old people (high risk groups) suggests that the NP resettlement policies had the effect of exporting into the rural bantustans not only the marginalised subsections of society but also the most vulnerable to disease. Hence it was no coincidence that the period of most intense resettlement was also the period during which the most dramatic drop occurred in TB notifications countrywide.

82 The Surplus People Project Report, *Forced Removals in South Africa* (Cape Town, 1983), p. 18.

83 BAD, Official Circular N2/10/3, 14 April 1965. See also, Wilson and Ramphela, *Uprooting Poverty: The South African Challenge*, pp. 219-220.

migrants.<sup>84</sup> Repeating the same statement, the Chief Commissioner for the department, D.J.F. Hidge also announced “We will provide the necessary infrastructure of water and toilets in the camp. Where the people work is not my business ... the provision of jobs has nothing to do with me”.<sup>85</sup> That such social dislocation would be a source of ill health for the people involved was a foregone conclusion. I have argued in chapter two that as early as the 1940s South African health professionals and state health officials had already recognised the social production of disease and the close connection between ill health and social change.<sup>86</sup> Yet in the post 1948 period, this truism was utterly denied and ignored for political and ideological considerations.

### 3.3.4 Labour migrancy and poverty

The issue of labour migrancy and its implications for people’s health has received close scholarly attention for decades.<sup>87</sup> Indeed, the migrant labour system, introduced by the mining industry and buttressed by the pass laws, had been a central feature of the South African political economy since the beginning of the country’s industrial revolution.<sup>88</sup> However, even though labour migrancy itself pre-dated the coming to power of the National Party in 1948, compelling evidence suggests that the system was intensified after that date in keeping with the policy of apartheid. Admittedly migrant workers are also used in other parts of the world, but there was no other country where the system trapped such a large proportion of the labour force in a dehumanising manner as in this country’s barrack-like hostels. What made the South African system unique was the fact that unlike in other countries where the worker migrated with his family, in South Africa the migrant worker was forced to leave his family behind in the impoverished conditions of the rural bantustans.<sup>89</sup> I concur fully with Mamphela Ramphele that, besides being an important legacy of a policy of systematic racial

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84 Maré, *African Population Relocation in South Africa*, p. 3.

85 *Sunday Tribune*, 8 October 1978.

86 Marks and Andersson, “Industrialization, Rural Health, and the 1944 National Health Services Commission in South Africa” in Feierman and Janzen (eds), *The Social Basis of Health and Healing in Africa*, pp.131-132.

87 C. Murray, “Migrant Labour and changing family Structure in the Rural Periphery of Southern Africa”, *Journal of Southern African Studies*, vol. 6, no. 2 (1980); J. May, *Migrant Labour in Transkei: Cause and Consequences at the Village Level* (Durban, University of Natal, 1985); F. Wilson, *Migrant Labour* (Johannesburg, SACC and SPROC-CAS, 1972); E.C. Gordon, “An Analysis of the Impact of Labour Migration on the Lives of Women in Lesotho”, *The Journal of Development*, vol. 17, no. 3, 59-76; J. Crush et al, “Undermining Labour Migrancy in the South African Gold Mining Industry” (South African Migration Project, Cape Town, Idasa, 1999).

88 W.G. James, *Our Precious Metal: African Labour in South Africa’s Gold Industry, 1970-1990* (Cape Town, David Philip, 1992), p. 5.

89 R.P. Mazibuko, *The Effects of Migrant Labour on the Family System* (MEd dissertation, Unisa, 2000), p. 8.

discrimination and economic exploitation of black South Africans, hostels were also a logical outcome of the process of conquest.<sup>90</sup> The system obviously had profound consequences on the health of the population in general. As Colin Murray puts it, “A system in which large numbers of men spend long periods at work leaving their women and children at home generates economic insecurity, marital disharmony, marital and emotional misery and problems relating to sexual morality and legitimacy”.<sup>91</sup> Also expanding this theme, Lamb argues that the husband’s absence may be harmful not necessarily because a sex-role model is absent, but because many other aspects of his role- economic, social, emotional all go unfulfilled or are inappropriately filled.<sup>92</sup>

From a tuberculosis point of view, the overcrowding that was often the order of hostel life no doubt provided fertile breeding ground for the spread of infections. Today, this social structuring and its consequences in sexually transmitted infection patterns continue to determine the nature of the HIV/AIDS epidemic among black South Africans.<sup>93</sup> A German sociologist, Reimer Gronemeyer who spent four years interviewing African AIDS victims and their families also concluded that the destruction of traditional African living environments, the dissolution of contexts that sustain human life, families and cultural traditions, have been the decisive requirements for the rapid spread of the AIDS virus.<sup>94</sup> Harry Seftel, an outspoken professor of medicine at the University of the Witwatersrand, told an International Cardiology Conference in 1975, that South Africa’s migrant labour system was the major contributory cause of heart disease among Witwatersrand Africans.<sup>95</sup> As if to concur with Seftel, Margaret McLaren told the same conference that the rate of rheumatic heart disease among Soweto school children was found to be the highest in the world until then.<sup>96</sup> Francis Wilson on the other hand argues that beriberi, heart failure due to deficiency of vitamin thiamine, was largely a disease of male migrant workers who lived in hostel-type quarters

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90 M. Ramphele, *A Bed Called Home: Life in the Migrant Labour Hostels of Cape Town* (Cape Town, David Philip, 1993), p. 15.

91 Murray, “Migrant Labour and Changing Family Structure in the Rural Periphery of Southern Africa”, p.150.

92 M.E. Lamb (ed), *The Father’s Role: Cross Cultural Perspectives* (Hillsdale, L. Erlbaun Associates, 1987), p. 15.

93 Phatlane, “Poverty and HIV/AIDS in Apartheid South Africa”, p. 82.

94 Gronemeyer, *Living and Dying with AIDS in Africa: New Perspectives on a Modern Disease*, p. 13. See also C. Wren, “AIDS Rising Fast Among Black South Africans”, *New York Times*, 7 September 1990, cited by C.W. Hunt, “The Social Epidemiology of AIDS in Africa: Migrant Labour and Sexually Transmitted Disease”, in Conrad and Gallagher, *Health and Health Care in Developing Countries*, p. 30.

95 *The Rand Daily Mail*, 5 May 1975.

96 Ibid.

and drank heavily.<sup>97</sup> Some of the contradictions of the system were further revealed by Colin Murray, whose assessment of its effects on the rural periphery also led him to the conclusion that:

Virtually every adult male in the Bantustans is faced with the contradiction that his absence is a condition of his family's survival. But his absence also undermines the conjugal stability from which his family derives its identity.<sup>98</sup>

That this system directly contributed to rural poverty is not in doubt. Unstable family relationships resulting from the system were marked by unsatisfactory remittance and loss of sense of responsibility for the family at home. "Hostels as living spaces", concludes Mamphela Ramphele in her examination of the effects of the migrant system on family life, "are a type of environment which not only represent an assault on human dignity, but have created a legacy that South Africans have yet to come to terms with".<sup>99</sup> Apart from its systematic depression of African wages, the migrant labour system was a powerful force in the disruption of the whole social fabric of Africans in South Africa. The system destroyed the family unit by physically removing the father, as the primary wage-earner, in the struggle for subsistence. Hence the whole system not only promoted illegitimacy and a debasement of the role of women but also led in many ways to the intensification of poverty and social deprivation.

### **3.3.5 Influx controls and poverty**

It has been shown that influx control was applied in South Africa before 1948. However, while the policy of the Smuts government was to prescribe areas as subject to influx control at their request, National Party policy after 1948 required that all urban areas be so prescribed.<sup>100</sup> It will be remembered that as far back as the 1920s, the goal of keeping Africans out of the cities except as units of labour was clearly spelt out by a government commission that declared "The native should be allowed to enter urban areas which are essentially the white man's creation, when he is willing to enter and to minister to the needs of the white man and to depart therefrom when he ceases so to minister."<sup>101</sup>

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97 Wilson, *Migrant Labour*, p. 186.

98 Murray, "Migrant Labour and Changing Family Structure in the Rural Periphery of Southern Africa", p. 150.

99 Ramphele, *A Bed Called Home*, p. 88. See also M. Ramphele, *The Politics of Space: Life in the Migrant Labour Hostels of the Western Cape* (Cape Town, David Philip, 1991).

100 C. Simkins, *Four Essays on the Past, Present and Possible Future of the Distribution of the Black Population of South Africa* (Cape Town, Southern African Labour and Development Research Unit, University of Cape Town, 1983), p. 119.

101 UG 1/22, *Transvaal Province Report of the Local Government Commission (Stallard Commission)*

Included in the array of strategies and tactics adopted by the apartheid state after 1948 to enforce this position was the tightening up of the pass laws and the limitation on African housing construction. However, I have pointed out earlier that with the collapse of the rural economies, the social and economic situation in the bantustans became so severe as to encourage large numbers of black South Africans to drift to the urban areas in spite of the influx control laws. This influx control strategy intended to serve two racial objectives. The first was to regulate and police the process of African urbanisation. From a political point of view, influx control led to a reduction of pressure for reform. For example, by keeping the unemployed and homeless out of the cities, the system had the effect of hiding behind some mountain in the rural areas, the misery which most of the rich and powerful in the society could not see.<sup>102</sup> The second was to confine as many African communities as was practicable to the rural bantustans.<sup>103</sup> For Stanley Greenberg, however, the entire system of influx control was internally contradictory. He maintains that the system was creating pressures it could not contain and rising economic and political costs it could not meet.<sup>104</sup> Consequently, as the contradictions deepened between the labour demands of the growing industries and the imperatives of separate development, a rapidly increasing number of African people were arrested for offences related to influx control, thus plunging the women and children left behind in the rural areas even more into poverty and destitution. Belinda Bozzoli offers a graphic description of how some black women who were trapped in these conditions had to make significant coping adaptations to survive in an otherwise uncertain environment.<sup>105</sup>

It has been estimated that over the seventy years from 1916 when the first statistics were recorded until 1986, when the pass laws were abolished, the total number of black South Africans prosecuted in the country under these laws was well over 17 million. In the words of Wilson and Ramphele, "One person was arrested on average once every two minutes, day and night, for the entire period from the year before the Russian Revolution until the time of President Reagan's second term of office".<sup>106</sup>

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(Pretoria, T.P.I., Government Printer, 1922), para. 267.

102 Wilson, *Migrant Labour*, p.186.

103 S. Bekker and R. Humphries, "State Control Over African Labour", in W.G. James (eds), *The State of Apartheid* (USA, Lynne Rienner Publishers, 1987).

104 Greenberg, *Legitimizing the Illegitimate*, p. xviii. See also H. Gilomee and L. Schlemmer (eds), *Up Against the Fences: Poverty, Passes and Privilege in South Africa* (Cape Town, David Philip, 1985).

105 Bozzoli, *Women of Phokeng*.

106 Wilson and Ramphele, *Uprooting Poverty in South Africa*, pp. 208-9.

It was clearly in view of the foregoing that South Africa's representative at the International Commission of Jurists, Joel Carlson lamented:

The pass laws are the greatest single cause of disruption of race relations in our society, creating more hatred and fear, sowing more suspicion and causing more insecurity, than any other single cause of injustice in South Africa. The pass laws are a cancerous growth, causing the depersonalisation of human beings and degrading not only the persons suffering under them, but also those enforcing them.<sup>107</sup>

The constant fear of police raids coupled with the indignity of arrest comprise one of the faces of poverty that is distinctly South African.<sup>108</sup> However, whereas until the 1960s both influx and labour controls were generally designed to coerce blacks into the white dominated economy, by the 1970s, this had begun to change. According to Stanley Greenberg, the pattern of race domination was in many ways functional to capitalist growth,<sup>109</sup> and a huge inflow of investment capital ensured high levels of technological development. Thus, concludes Margaret Nash, rising unemployment and general frustration among urban youth resulting from these developments, contributed to the 1976 Soweto outbursts.<sup>110</sup>

### **3.3.6 Apartheid's feminisation of poverty**

Against the background of women's vulnerability and economic dependence, it is logical to conclude that black women's experiences of poverty are critical to any examination of the impact of apartheid-created poverty on health in this country. While the health consequences of poverty were serious for both men and women under apartheid, there is no question that the experience of black women differed from that of black men in substantial respects because of women's position both in the labour market and in the home. It should be borne in mind that the mainstream Anglo American ideal that husbands and wives should share equally in the decision making process is not shared by all cultures, and even less so by Africans. As Gordon has observed, while the migrant's wife was expected to fulfill the dual role of father and mother in the home, she often lacked the power and status inherent in the

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107 SAIRR, *Race Relations Survey 1970*, pp.171-2.

108 Ibid., p. 209.

109 Greenberg, *Legitimizing the Illegitimate*, p. xiii.

110 M. Nash, *Black Uprooting from White South Africa: The Fourth and Final Stage of Apartheid* (Braamfontein, South African Council of Churches, 1980), p. 2.

father's role.<sup>111</sup> Although she was left to shoulder the burden of responsibility for family affairs such as fields and livestock, the woman had very little decision-making power with regard to these issues. It is contended here therefore, that it is this positioning of women and the work they are often called upon to do that structures women's patterns of health. For rural black women, health experience is the sum of their caring work, paid and unpaid, and the conditions under which they carry out this work. For the majority of them, the cumulative effect of living in poverty and deprivation causes an accumulation of frightening health hazards which often arise not only from the impact of poverty and the gender specific experience of that poverty, but also from the nature of the demands made upon these women in the midst of this deprivation. It is perhaps Muriel Mabindiza's words that capture the black woman's position under apartheid more accurately:

If a man oppresses you because you are illiterate he gives you chance because you can go to school and be educated so he won't oppress you. If he oppresses you because you are poor, he still gives you chance to work hard and become rich so he won't oppress you. But if a man oppresses you because you are black and woman, then he gives you no chance.<sup>112</sup>

Although significant research has been done on the relationship between socio-economic status and health much of it has been gender blind. This gender blindness often hinders attempts to understand the causal mechanisms that created and maintained the social patterning in health during apartheid. Similarly, traditional poverty research also tends to treat poverty as only a class issue and not a race and gender issue. This also obscures not only the association between poverty and race, but also the association between poverty and being a black woman. Therefore, by examining poverty as a gender issue during the period under review, some light may be shed on the socio-economic gradients in health, particularly among the rural black population.

Lists of the causes of poverty often cite lack of access to the labour market and the responsibility of caring for dependants as major explanations for women's poverty.<sup>113</sup> There is no question that the entire system of influx control and the pass laws were geared to restrict black women to the rural bantustans so that the system of labour migrancy could remain

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111 Gordon, "An Analysis of the Impact of Labour Migrancy on the Lives of Women in Lesotho", *The Journal of Development*, p. 60. See also G. Galanti, *Caring for Patients from Different Cultures* (Philadelphia, University of Pennsylvania Press, 2004), p. 99.

112 Interview with Muriel Thembeke Mabindiza, 1/12/2004.

113 R. Barbara, *The Domestication of Women: Discrimination in Developing Countries* (London, Tavistock, 1980).

intact.<sup>114</sup> Government commissions have also pointed out that had women been allowed into the cities, the state would have had to acknowledge the need for family housing, schools and hospitals to accommodate family needs. No wonder then, that as early as 1964 an administrative decision was taken to condemn thousands of black women to a life of poverty and starvation when an embargo was placed on women without section 10 rights,<sup>115</sup> preventing them from entering any urban area to work or to stay. This restriction of women to the bantustans was also functional to industry because it became a convenient rationalisation for low wages paid to their migrant husbands. At other levels, the apartheid government had in terms of the Departmental Circular No.25 of 12 December 1967, ordered that widows, unmarried mothers, divorced or deserted women could not be registered tenants of municipal houses.<sup>116</sup> Similarly, the names of unmarried mothers who had reached the age of 16 years were automatically removed from the permits of their parents for occupation of the family home. The result was the development of a generation of young, rootless and bitter people.<sup>117</sup> The primary effect of this blatantly gender-biased, discriminatory legislation was to exclude black women residents of bantustans from any legal, productive activity in the industrial centres of South Africa. This, in the words of Papi Lekotoko, when looking at the criteria for exclusion, amounted to removing one's cover umbrella just when it began to rain.<sup>118</sup>

Considering the appalling bantustan conditions, exacerbated by an increasing concentration of land in few hands, there is no question that black women struggled to eke out an existence off the land. For many others, there was total dependence on the erratically remitted earnings of their migrant husbands, who were earning wages barely sufficient for their own needs; anxiety and a sense of insecurity were the main causes of stress among women.<sup>119</sup> This explains why black women under apartheid were more likely to seek help for stress-related problems for which indigenous healers are a more appropriate human resource.<sup>120</sup> Bearing in mind that social research has revealed that repeated and prolonged stress can increase susceptibility to health problems,<sup>121</sup> it is no coincidence that a large part of women's higher

114 See Belinda Bozzoli's *Women of Phokeng* and Mamphela Ramphele's, *A Bed Called Home*.

115 In terms of Section 10 (1) of the Bantu Urban Areas Consolidation Act, black people had to get permission to be in the urban areas, without which they would be endorsed out, and deported to the rural bantustans to which they fitted ethnically according to the apartheid divisions. See, SAIRR, *Race Relations Survey 1970*, p. 89.

116 SAIRR, *Race Relations Survey 1970*, p. 169.

117 Ibid.

118 Interview with Papi Lekotoko, 12/6/2002.

119 Ramphele, *A Bed Called Home*, p.15.

120 Interview with Ngaka Hlathikhulu Ngobeni, 14/8/2005

121 V.P. Makosky, "Sources of Stress: Events or Conditions?" in D. Belle (ed), *Lives in Stress: Women and*

levels of morbidity and health service consultation has been in relation to mental breakdowns and stress-related health problems, themselves the consequence of poverty and deprivation.<sup>122</sup> Although apartheid planners assumed that women in the bantustans were economically supported by their male breadwinners, this assumption is not supported by historical evidence. On the contrary, the literature reveals that it was precisely due to unmet economic dependency needs that some courageous women eventually migrated to the cities to look for work in the male-dominated labour sectors.<sup>123</sup> The rest were condemned to perform the vast majority of domestic chores such as having to trudge up and down stony hills to fetch water and wood. This is the kind of unpaid labour that is usually counted as non-productive in development surveys.<sup>124</sup> Again, the relationship between poor housing and women's health is highly suggestive of the value of this indicator in the assessment of women's poverty. As a result of the government's resettlement and bantustan policies, millions of black South Africans lived in substandard mud houses that leaked in the rainy season. This, when research has linked damp housing with increased levels of morbidity, in particular with such diseases as asthma, respiratory disease, chest problems, depression, diarrhoea and vomiting.<sup>125</sup> The shanties and shacks found in most bantustans to which many black women and children were virtually condemned by apartheid, were not conducive to good health. Overcrowded and unsanitary homes are the root causes of social disease throughout the world.<sup>126</sup> Against this background, it is therefore no coincidence that the majority of mutual aid societies, including the burial societies so popular with Africans today, are largely managed by women and have far more women on their books than men. The fact of the matter is that these, too, are strategies to help Africans cope with the financial aspects of poverty and the crises of unemployment and death.<sup>127</sup>

Despite the challenges they face, Amartya Sen,<sup>128</sup> has drawn attention to the "agency role" of women, and points out that women in general should no longer be seen as the passive

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*Depression* (Beverly Hills, Sage, 1982), pp. 35-53.

122 Interview with Doctor Magampa, 4/2/2000.

123 B. Bozzoli, *Women of Phokeng*.

124 Rogers, *Domestication of Women: Discrimination in Developing Countries*, pp. 44, 62.

125 S.J. Hyndman, "Housing Damp and Health Among British Bengalis in East London" *Social Science and Medicine*, vol. 30 (1990), pp. 131-41.

126 The concept, "social diseases" has not been accurately defined, but has been used here to indicate those diseases which are particularly prevalent in sections of a population at the lower end of the socio-economic scale (Blacks). These are diseases in which the most important aetiological factors are deficiency of the health promotive factors such as food, warmth, cleanliness and so forth.

127 WHO, *Apartheid and Health*, p. 168.

128 Sen, "Agency and Well-Being: The Development Agenda", pp. 103-112.

recipients of welfare-enhancing help but rather as active agents of change. Sen argues that while there is every reason not to downplay the concern about women's well-being, there is also an urgent necessity to take an agent-oriented approach to the women's agenda. This is the approach adopted by this study, not only in terms of women's problems but in terms of the health problems of all black South Africans. According to Amartya Sen, the significant argument for focusing on agency is the role that such agency can play in removing the inequities that depress well-being.

### **3.4 Part II: Apartheid and the misdirection of resources**

#### **3.4.1 The "golden years of apartheid": 1960-1972**

The three decades from the end of World War II up to the economic recession of the mid-1970s, the period corresponding to the one examined in this study, was a period of unparalleled economic growth in South Africa.<sup>129</sup> Although some scholars maintain that central to this dynamic expansion was the rapid industrialisation of the country,<sup>130</sup> historians such as John Omer-Cooper argue that it was the introduction of apartheid which in many ways accounted for this phenomenal growth rate, because the policy ensured that the accumulated wealth was not passed on to the black majority to any significant extent.<sup>131</sup> This economic growth was, however not without interruptions. Apart from the recession of the late 1950s, unrest loomed early in the 1960s. On 21 March 1960, the poverty, political powerlessness and general frustration of the African population eventually provoked resistance to apartheid on a scale not anticipated by the government. At Sharpeville a demonstration launched against the pass laws and strong-arm attempts by the state to restore order, resulted in chaos and bloodshed unprecedented in the history of the struggle against apartheid thus far.<sup>132</sup> The event marked a major turning point in the international attitude towards South Africa, resulting in a considerable net outflow of capital from the country until government restrictions on currency movement stemmed the loss. Nevertheless investor confidence in the country's stability was, albeit temporarily, compromised<sup>133</sup> and by June 1961 a total of R248 million had left the country, while the gold and foreign exchange

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129 J. Nattrass, *The South African Economy: Its Growth and Change* (Cape Town, Oxford University Press, 1981); M. Lipton, *Capitalism and Apartheid: South Africa, 1910-1986* (Aldershot, Wildwood Home, 1986).

130 Lipton, *Capitalism and Apartheid: South Africa, 1910-1986*.

131 J.D. Omer-Cooper, *History of Southern Africa* (Claremont, David Philip, 1987), p. 210.

132 Lipton, *Capitalism and Apartheid: South Africa, 1910-1986*, pp. 29-30.

133 D.M. Sher, "The First Five Years", in B.J. Liebenberg and S.B. Spies (eds), *South Africa in the 20<sup>th</sup> Century* (Pretoria, J.L. Van Schaik, 1993), p. 415.

reserves had fallen from R315 million to R142 million in the six month period between January and June 1961.<sup>134</sup>

As could be expected, in reaction to the situation the NP government adopted draconian measures, including the tightening of security measures and banning of the liberation movements including the ANC, PAC and the SACP.<sup>135</sup> With these oppressive tactics in place, anti-apartheid protests in the post-Sharpeville period were easily crushed, making the 1960s an era of diminished black resistance as compared to the previous 20 years. In addition to the existing labour controls which provided agriculture, commerce and industry with the necessary black labour, these stringent measures helped to revive investor confidence in South Africa. The highest point of the period was Verwoerd's achievement of the Nationalists' long cherished republican dream, albeit outside the Commonwealth. Subsequently, foreign capital poured back into the country to the extent that by the time of Verwoerd's death in 1966, the level of prosperity was in Davenport's words, "so marked that increased imports were already beginning to create inflationary conditions".<sup>136</sup> The banning of the liberation movements and the incarceration of a number of prominent black leaders, including Nelson Mandela, meant that the period up to the 1970s was marked by relative passivity among the black population. Indeed, according to Dan O' Meara, "not until the emergence of the Black Consciousness Movement (BCM) in 1969 did an overt black political voice again challenge apartheid".<sup>137</sup>

It is interesting to note that this remarkable economic growth occurred at the time when the world economy in general was on the decline. So well did the South African economy recover from the recession of the early 1960s that the country experienced the greatest economic boom in its history. The Gross Domestic Product increased to the extent that the period 1964-1972 has with some justification been dubbed the "golden age of apartheid".<sup>138</sup> Against this background, it would hardly be an overstatement to conclude that from an economic point of view, South Africa, at least relative to the rest of sub-Saharan Africa, had

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134 T.R.H. Davenport, *South Africa: A Modern History* (Houndmills, Macmillan, 1991), p. 360.

135 D. O'Meara, *Forty Lost Years: The Apartheid State and the Politics of the National Party, 1948-1994* (Randburg, Ravan Press, 1996); Davenport, *South Africa: A Modern History*; Omer-Cooper, *History of Southern Africa*, p. 210.

136 Davenport, *South Africa: A Modern History*, p. 360.

137 O'Meara, *Forty Lost Years*, p. 173.

138 Nattrass, *The South African Economy: Its Growth and Change*, See also O'Meara, *Forty Lost Years*, p. 173. Lipton, *Capitalism and Apartheid: South Africa, 1910-1986*.

the necessary financial prerequisites to provide improved health care for all its people but was precluded from doing so by apartheid imperatives. Under circumstances such as these the state's excuse that the lack of adequate health services among the black communities was unacceptable. The authorities claimed that South Africa was a developing country with developmental problems not dissimilar to those faced by other emerging countries. This study rejects this explanation and maintains the view that South Africa's health problems had more to do with apartheid's misdirection of resources than with alleged economic incapacity.

### **3.4.2 The health of the people vs the defence of apartheid**

In arguing that the apartheid regime encouraged this misdirection of resources, I cannot ignore the truism that no state, however humane, can take care of the health needs of its citizens in a climate of insecurity and conflict. This explains why South Africa's resources were so heavily skewed in favour of defence expenditure especially from the mid 1970s and early 1980s. Elsewhere, I have briefly sketched South Africa's unenviable position in world politics during the period coinciding with the country's economic boom. Internal unrest, regional conflicts and international hostility were bound to make heavy demands on the country's purse in terms of military spending. This in turn would automatically preclude the prioritisation of health care to marginalised groups. Thus like any other country under similar circumstances, it was logical rather than irrational, that South Africa used its economic leverage to restrain its detractors from pursuing anti-apartheid tactics. Having said this, it is another matter entirely when the country's defence expenditure leads to the almost total neglect of other important sectors such as health and education. In fact, there is persuasive evidence that after Sharpeville defence expenditure increased so spectacularly that the country was spending one-sixth of total government expenditure on arms. As Francis Wilson puts it, "with one month's expenditure, resources could be made available equivalent of R10 000 per family of six, thus making possible housing and services for 10 000 people".<sup>139</sup>

It is interesting to note that while in 1969 defence spending was between R40 and R44 million, by 1973 it had risen to R472 million,<sup>140</sup> and in 1976 it had reached a staggering R1, 257 million.<sup>141</sup> Indeed, according to the official Estimates of Expenditure from Revenue Accounts for 1973/74 alone, the defence allocation was almost 14% of the total sum voted for

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139 Wilson, *Choice and Understanding: The Economist in Society*, p. 4.

140 SAIRR, *Race Relations Survey, 1973*, p. 53.

141 A. Seegers, "Apartheid's Military: Its Origins and Development", in W.G. James, *The State of Apartheid* (Colorado, Lynne Rienner Publishers, 1987), p. 155.

all departments of state.<sup>142</sup> In a conference paper prepared for the second Carnegie enquiry into poverty and development in southern Africa, Ina Brand, provides a useful record of health expenditure, which compares most unfavourably with the defence spending for the same period.<sup>143</sup> These figures raise some important questions about apartheid. As the president of the World Bank has remarked, “It always comes down to a question of priorities. A new generation of fighters for the airforce or a new generation of infants who will live beyond their fifth birthday”.<sup>144</sup> This is not dissimilar to the sentiments expressed by Dr Rodney Hewitson in 1969 about Dr Phillip Blaiberg’s highly publicised acquisition of a new heart at Groote Schuur Hospital. Hewitson observed: “Two hundred sick and underfed infants could have been kept alive for a year with the money spent on Dr Blaiberg’s operations ...”<sup>145</sup> Admittedly, the link between resources for military purposes and health care priorities is less clear, because funds from reduced military spending may of course not necessarily translate into improved health services; yet the irony of the situation was that increased military spending did not buy South Africa the security it craved.

### 3.4.3 A strong economy and the promotion of African family planning

The relation between poverty and population growth is also not easy to identify because the connections are complex and the historical evidence, as far as cause and effect are concerned, is ambiguous. By and large, explanations of poverty among black South Africans have tended to blame the problem on the black people themselves by claiming that poverty was the result of their own uncontrolled reproduction. In his essay on the subject, Thomas Malthus argues that if unchecked, a population tends to outstrip its food supply. Therefore, “if there is no moral restraint to curb population growth, famine, misery, pestilence and war will do the job”.<sup>146</sup> According to this theory, the poor have only themselves to blame because poverty is the natural punishment for over-breeding by the lower classes of society.<sup>147</sup> And according to this perspective, if population size is not kept in balance with resources through variation in the stream of births, the only alternative is variation in the stream of deaths.<sup>148</sup> In 1974, this

142 SAIRR, *Race Relations Survey, 1973*, p. 53.

143 I. Brand, “Public Expenditure in the Republic of South Africa on Health, Welfare and Education During 1960-1, 1970-1 and 1980-1”, at Second Carnegie Inquiry into Poverty and Development in Southern Africa, Conference Paper No.128, 13-19 April (1984).

144 Quoted by R.L. Sivard, *World Military & Social Expenditure, 1978* (Virginia, Leesburg, 1978), p. 15.

145 Laurence, *Race, Propaganda and South Africa*, p. 120.

146 T.R. Malthus, “Poverty is Nature’s Punishment for Overpopulation” in H. Ginsberg (ed), *Poverty, Economics and Society* (Lanham, University Press of America, 1981), p. 30.

147 Ibid.

148 S.C. Watkins and E. Van de Walle, “Nutrition, Mortality, Population Size: Malthus’ Court of Last Resort”, in Rotberg and Rabb (eds), *Hunger and History*, p.16.

Malthusian theory that high fertility rates obstruct economic growth was cynically highjacked by those for whom population numbers were critical for the maintenance of minority dominance over the majority. As Johan Reid had earlier remarked, “I believe our children will find it difficult to forgive us when they find themselves sharing the country with 70 million others, in 50 years time, when we know how to prevent it”.<sup>149</sup>

Population control became a heavily funded aspect of South African health service, but the same health service did next to nothing to address the underlying apartheid-created poverty that was the primary cause of much of the ill health afflicting black South Africans.<sup>150</sup> The fact that poverty might be caused by socio-economic factors beyond the individual’s control was scarcely considered. The official explanations of poverty obviously rested on the mistaken assumption that if black population growth could be slowed down, then the problem of poverty would be removed. Yet, it is contended in this study that in the context of apartheid and its social and material deprivations, the size of African families, initially functional to the white economy, was only a symptom rather than a cause of poverty. For instance, in the absence of social security, in a situation where nearly all the children born might well die before reaching the age of five (as will be illustrated in the next chapter), it was logical rather than irrational, for black couples to have many children. One of the pressing considerations for such families was insurance against old age in a country where only able-bodied men were recruited for wage labour while women and children were herded into the rural areas. Couples who only had daughters were likely to face financial ruin simply from that fact alone. Little wonder that Indian brides are greeted with the traditional wish, “may you be mother of eight sons”.<sup>151</sup> As a means of coping with their situation, an extra child in an African family was seen as a distinct advantage. As Stearns Ford put it:

Promises of security, approval and prestige support the desire for children, threats of insecurity, punishment and ridicule blocking incipient wishes to escape the pain and cares of childbirth and parenthood ... If people are to reproduce, social life must offer enough rewards for bearing children to more than outweigh the punishments involved in reproduction.<sup>152</sup>

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149 GES 2827 PA2, Letter to Senator Dr J.H. Looock, 20 May 1969.

150 Marks and Andersson, “Apartheid and Health in the 1980s”, p. 668. See also Susanne Klausen, *Race, Maternity, and the Politics of Birth Control in South Africa, 1910-39* (Houndmills, Palgrave Macmillan, 2004); and S. Klausen, “Women’s Resistance to Eugenic Birth Control in Johannesburg, 1930-1939”, *South African Historical Journal*, vol. 50 (2004), 152-169; D. Beckett, “Population: The Perverse Politics of Procreation”, *Frontline*, February 1982.

151 Harrison, *Inside the Third World: The Anatomy of Poverty*, p. 220.

152 C.S. Ford, *A Comparative Study of Human Reproduction*, Yale University Publications in Anthropology, no. 32 (New Haven, Yale University Press, 1964), p. 86.

An examination of South African society and African views of childbirth as well as the Nationalists' attempts to limit or even prevent pregnancy, adds substance to Ford's thesis and in the process offers some answers to the questions surrounding human reproduction in general. By tightening up influx control, the general marginalisation of women in the labour market and the contrasting need for male labour, apartheid technically ensured that having many sons also had an economic rationale. Given the high infant and child mortality rates (discussed in the next chapter), it stands to reason that as a coping strategy, children had to be born in sufficient numbers to ensure a family's subsistence. As Denis Beckett puts it, "children are the traditional pension scheme of the poverty-stricken families, and often the only assured labour force as well".<sup>153</sup> The Chinese proverb is even more revealing, "one son is no son, two sons are an undependable son, and only three sons can be counted as the real son".<sup>154</sup> Admittedly, for the next two years or so, one more child in the family may be another child to feed and clothe, but thereafter, he is a tender of cattle, a carrier of water and firewood, an extra pair of hands who in time becomes an earner of income in the family.<sup>155</sup> In fact according to Richard Stryker, "the poorest countries in Africa are by no means those with the highest rates of population growth; the contrary is closer to the truth".<sup>156</sup>

It has been forcefully argued elsewhere, that in a society where resources were concentrated in the hands of a minority, it was logical to expect the same minority to benefit from a decrease in population growth. This would be so because when too many impoverished people have to subsist off too little, strain is put on the system from which the minority benefit. Hence the logical way of easing the strain would be to slow down the population growth of the majority.<sup>157</sup> According to Denis Beckett, this was a matter of the chicken and the egg – it is difficult to determine which came first: "The family planners argue that the only way the rural millions will ever become significantly better off is by reducing the size of their families. The rural millions reply that once they're better off, then they'll reduce the size of their families".<sup>158</sup>

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153 D. Beckett, "Population: The Perverse Politics of Procreation", *Frontline*, February 1982, p. 12.

154 Harrison, *Inside the Third World: The Anatomy of Poverty*, p. 220.

155 Beckett, "Populations", *Frontline*, p. 12.

156 R. E. Stryker, "Poverty, Inequality, and Development Choices in Contemporary Africa", P.M. Martin and P. O'Meara (eds), *Africa*, 3rd ed (Bloomington and Indianapolis, Indiana University Press, 1995), p.330.

157 B. Brown, "Facing the 'Black Peril': The Politics of Population Control in South Africa", *Journal of Southern African Studies*, vol. 13, no. 3 (1987), 256-273, p. 256. See also N.J. Van Rensburg, *Population Explosion in Southern Africa* (Pretoria, Van Schaik, 1972), p. 156.

158 Beckett, "Populations", *Frontline*, p. 12.

Challenging the effectiveness of efforts to restrict human fertility, Thomas McKeown argues that “there is no convincing evidence that the growth of any population has been limited substantially by restraints on the frequency of intercourse”.<sup>159</sup> Therefore, even though population growth and poverty reinforce each other in many significant ways, the question whether poverty causes population growth or whether population growth is a necessary condition for poverty, may be answered by considering the impact of the by-products of poverty itself. As noted by Charles Simkins these include low wages, unemployment and underemployment – all the bitter fruits of apartheid.<sup>160</sup> Population growth was not, strictly speaking, responsible for the high rate of unemployment in the rural homelands; it was not responsible for the migrant labour system, and it was assuredly not responsible for the job colour bar and population relocations underlying much of the poverty dealt with in this chapter. The responsibility lay squarely with apartheid and society’s unequal access to public resources, education and productive assets.<sup>161</sup> Against this background, it may be argued that until the NP government was prepared to accept and acknowledge that apartheid was the major underlying cause of African poverty, and that hunger, malnutrition and their associated infections were a reflection of the failure of their political and economic systems, all well intentioned population control programmes would be futile.

#### **3.4.4 A strong economy and the promotion of white immigration**

Ironically, while the government concerned itself with the effects of black population growth, it actively fostered the growth of the white population. Although Verwoerd had argued for tight controls over immigration and accused the United Party’s immigration policies as leading to the “swamping” of Afrikanerdom, changed realities in the late 1960s led to new policy directions in terms of immigration. The potential impact of immigrants on political election outcomes in the country became secondary to boosting the white minority population.<sup>162</sup> Some may argue that the promotion of white immigration had more to do with the fact that the economy soon required more skilled workers than were available in the

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159 McKeown, “Food, Infection, and Population”, p. 35.

160 C.E.W. Simkins, *Employment, Unemployment and Growth in South Africa, 1960-1979* (University of Cape Town, Southern Africa Labour and Development Research Unit, 1979) and C.E.W. Simkins, *The Demographic Demand for Labour and Institutional Context of African Unemployment in South Africa 1960-1980* (Cape Town, Southern Africa Labour and Development Research Unit, 1981).

161 M. Godfrey, *Global Unemployment: The New Challenge to Economic Theory* (Brighton, Wheatsheaf, 1986), p. 154.

162 For an exploration of similar tactics in the period before apartheid, see Brits, *Op Die Vooraand Van Apartheid: Die Rassevraagstuk en Die Blanke Politiek in Suid Afrika, 1939-1948*.

country. Nor can it be denied that the primary reason for this was to bolster their own ranks and erode the ranks of opposition political parties as well as to avoid training blacks for the required skills.<sup>163</sup> Hence, from the 1960s the Nationalists carried out an aggressive programme of overseas recruitment and eased this by subsidising the passages of immigrants. “Our motto” declared Verwoerd emphatically, “is to maintain white supremacy for all time to come, over our own people and our own country, by force if necessary”.<sup>164</sup> Consequently, the government raised the level of direct financial assistance for this programme to such an extent that in the 1972/73 financial year it had assisted 21 898 white immigrants at a cost of R3 million.<sup>165</sup> This was the same government that explained that it was unable to improve health services to its black population because these health problems were part of a development process not dissimilar to those experienced in other developing countries of Africa at the time.

### 3.5 Conclusion

In conclusion one may say that apartheid South Africa was generally unhealthy, not because it was an inherently disease-ridden country, but primarily because the majority of the population lived under conditions that were incompatible with health. I have attempted to explain black poverty in terms of the adverse socio-economic and political conditions under which the black population lived. I do so by arguing that since they did not enjoy political rights, Africans were denied opportunities for self-development; they did not effectively control their structural and institutional conditions, they were systematically exploited as unfree labour, they were herded into impoverished bantustans, and their social structures were disrupted by migratory labour. In this way, poverty among black South Africans was indeed apartheid-created. As Steven Feierman remarks:

Death is not distributed in a random way. It comes sooner to poor people than to the rich, sooner to people in the country than in the city, and sooner to the children of absent migrant workers than to children of women who live with their husbands. These inequalities are a consequence of decisions by power holders on the distribution of social costs – who is to suffer the disease ... which children are to be malnourished, which workers are to lose their health at work ...<sup>166</sup>

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163 Brown, “Facing the ‘Black Peril’”, pp. 256-7.

164 Barber and Barnett, *South Africa's Foreign Policy*, p. 92.

165 SAIRR, *Race Relations Survey, 1974*, p. 53.

166 S. Feierman, “Struggles for Control: The Social Roots of Health and Healing in Modern Africa”, <http://www.jstor.org>, p. 74, accessed on 12 October 2006.

Of course recent literature on poverty and inequality in South Africa illustrates in no uncertain terms that both poverty and inequality have actually become worse since the demise of apartheid and the advent of the democratic order in the country. Jeremy Seekings and Nicoli Nattrass make a convincing case that since 1994, with the shift in the basis of inequality from race to class, income distribution in South Africa has become more unequal than it had ever been under apartheid.<sup>167</sup> This explains the growth of the black middle class, which though it dates back from the 1970s and 1980s, has nevertheless become an important characteristic of society since the transition to a new democratic dispensation. Sampie Terreblanche, also argues that while South Africa's transition to democracy was a significant development, there has been no parallel socio-economic transformation to address the historic inequities of the segregation and apartheid periods.<sup>168</sup> The central argument in this chapter has been that in so far as poverty contributes to the genesis of illness, its causative impacts do not only involve those factors influencing the biological occurrence of disease but also those that are critical to the procurement of health services. What is being highlighted here is the fact that significant differences in the standard of health between black and white South Africans during the period under review, were, contrary to official rhetoric, not a consequence of genetic differences, nor were they in any sense biologically inevitable. Instead, they were the direct reflection of poverty, itself a product of the systematic enforcement of a plethora of apartheid laws and practices whose overriding objective was to carry out the separate development ideal, to keep the economy strong and white as well as to maintain white supremacy in the face of growing black resistance and mounting international hostility. Although these laws and practices were clearly not specifically calculated to keep black people in a state of perpetual poverty, it is difficult to see how they could be successfully enforced without achieving that result.

Scholars have also debated and offered numerous explanations for the failure of African wages to keep up with the cost of living in spite of the wage increases in the wake of the economic boom. Among the explanations is the impact of population relocations from the urban centres to the rural periphery. It was found that besides reducing their chances of informal employment, African relocations have contributed in many ways to increased transportation costs to and from work, which could only be afforded by spending much less

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167 Seekings and Nattrass, *Class, Race, and Inequality in South Africa*.

168 Terreblanche, *A History of Inequality in South Africa, 1652-2002*.

on health and food.<sup>169</sup> The racial distribution of diseases of poverty discussed in the next chapter, will not only reveal the social character of those diseases but also reflect on the effect of an uneven distribution of the income channeled to health care. Viewed from this perspective, it is clear that under apartheid health status was neither a reflection nor a good barometer of the level of the country's economic development. In fact, in the light of the present analysis, it is self-evident that although economically much stronger than most of its neighbours, South Africa used its strength to nurture programmes that had more to do with the maintenance of white minority rule than with the quality of health of all its people. In this way, health status could hardly be a spin-off from economic development.

It was also argued here that the major brunt of the apartheid deprivation fell unevenly on women and that there was an economic rationale for this gender bias. A crude comparison of male and female earnings during this period indicates that on average women earned little more than half of what men earned. Furthermore, the lucky women who gained employment were confined to poorly paid jobs because effectively, under apartheid, black women were seen as no less than hewers of wood and drawers of water in the rural areas and were out of bounds if in the cities. This also explains why the stress and frustrations of black women led to an increasing number of shebeens (shebeen queens) and excessive drinking, which I argue, was a symptom, rather than a cause of poverty.<sup>170</sup> In his study of the Cape Coloured people and their patterns of health and disease, John Brock found that even the so-called "Bantu cirrhosis" was, contrary to conventional wisdom, due to nutritional deficiency and not in any significant degree the result of alcohol.<sup>171</sup> Thus, even when both men and women suffered poverty, there were specifically gendered differences in their situations. It is for this reason that any analysis of the impact of apartheid-created poverty in South Africa cannot ignore the role of gender. In terms of the analysis developed in this chapter, the tragedy was that many of the strategies that black women could adopt to break the spiral of poverty, involved breaking the law in one way or the other. More often than not Pretoria's policies achieved directly the opposite of what had been intended. For example, every time it shoved another black family off to a resettlement area, it strengthened the conviction that the future was too

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169 SAIRR, *Race Relations Survey, 1962*, p. 72. See also, Packard, *White Plague, Black Labor*, p. 268; De Beer, *The South African Disease*, p. 34.

170 Alcoholism is at one and the same time a result and a cause of black people's poor socio-economic status. Its effects cannot clearly be differentiated from the effects of other unsatisfactory social and economic ills as well as environmental factors with which it is often inextricably associated.

171 J.F. Brock, "The Cape Coloured People: Their Pattern of Health and Disease", *South African Medical Journal*, vol. 23, nos. 40-53 (1949), p. 1007.

uncertain to be faced without the security of innumerable children. As Denis Beckett so aptly puts it:

Every time it [the government] demands a pass or a permit or a licence it creates a new imperative to go ahead and acquire practically the only thing that a black man still can acquire without the benefit of pass, permit or licence – a child. Every time it consigns another black community to poverty and degradation in some godforsaken homeland it puts a shot in the arm of the more-children mentality which is hard at work hammering nails into the coffin of all of us.<sup>172</sup>

In this way Pretoria's misguided racial policies were indirectly begetting the very thing they genuinely sought to destroy. For all practical purposes, African couples would have fewer children only when the level of infant and child mortality rates to be described in the next chapter, dropped significantly and parents were more confident that their children would survive infancy and its associated health risks. Viewed from this perspective, one may reiterate that during apartheid health status was neither a reflection of, nor a good barometer for the level of the country's economic development and capacity. South Africa was economically stronger than most of its neighbours but it used this strength to fund expensive racist programmes that had little to do with the health of the people but everything to do with the defence of apartheid and the maintenance of white domination. I have pointed out that South Africa's approach to the health problems confronting black communities under apartheid should be situated in the larger framework of a state's concerns and priorities about security and like Robert Ostergard and Crystal Barcelo,<sup>173</sup> I have argued that if the state faces multiple security threats it is difficult to prioritise these threats. The NP government chose to deal first with its political insecurity rather than the poverty which threatened the health of the people. My argument is that it is essentially *how* the country spends its resources and not *how much*, that determines health status in a society. Hence my argument above that since the distribution of resources was politically determined, it is understandable why the health status of African communities under apartheid could hardly be a spin-off from economic development. In conclusion, it may be argued that through a combination of the effects of labour migrancy and influx control laws, the appallingly high incidence of venereal diseases among blacks in many parts of the rural periphery was part of the price which had to be paid for the importation of labour to the cities while at the same time exporting poverty and

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172 Beckett, "Population: The Perverse Politics of Procreation", *Frontline*, p. 4.

173 R.L. Ostergard, Jr. And C. Barcelo, "Personalist Regimes and the Insecurity Dilemma: Prioritizing AIDS as a National Security Threat in Uganda"; A.S. Patterson (ed), *The African State and the AIDS Crisis* (Aldershot, Ashgate, 2005), p. 155.

disease to the rural bantustans.

## CHAPTER 4

### MEDICINE AND THE ADVERSE EFFECTS OF POVERTY

Illness is the night-side of life ... Everyone who is born holds dual citizenship in the kingdom of the well and in the kingdom of the sick. Although we all prefer to maintain ourselves in the kingdom of the well, most of us sooner or later spend some time in the kingdom of the sick. Yet even as we inhabit the kingdom of the well, we are haunted by the fantasies, myths and misconceptions about those who, either for a short time or a long time sporadically or continuously, cope with living in the kingdom of the sick.<sup>1</sup>

#### 4.1 Introduction

“Poverty,” declared the World Health Organisation’s Annual Report for 1995, “is the world’s deadliest disease, the world’s most ruthless killer and the greatest cause of suffering on earth.”<sup>2</sup> Generations of social scientists, health policy workers, economists, historians and demographers have pondered on the relationship between poverty and health. What stands out prominently from their studies is that poverty not only determines the sort of illnesses people have but also dictates the pattern of health care available to counteract them.<sup>3</sup> While illness thrives in an environment of poverty, poverty perpetuates illness. Similarly, while chronic disease-proneness causes poverty, poverty provides the ideal breeding ground for disease in a recurrent life cycle of reinfection. There are specific ways in which poverty puts the health of its victims most at risk. According to John Bryant, access to basic medical facilities, both preventive and curative has been characteristic of poor communities the world over, which explains why vast numbers of poor people die of preventable and curable diseases while those who survive often do so with physical and intellectual impairment for lack of even the simplest measures of modern medicine.<sup>4</sup> Edwin Chadwick on the other hand, has argued that since disease always accompanies want, health can be restored to the poor by providing them with what they want to keep themselves healthy, including pure water, good food and pleasant

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1 Susan Sontag, “Illness as Metaphor”, in B. Davey et al (eds), *Health and Disease: A Reader* (Buckingham, Open University Press, 1995), p. 33.

2 WHO, *The World Health Report 1995: Bridging the Gaps* (Geneva, WHO, 1995), pp. v, 1.

3 See Conrad and Gallagher (eds), *Health and Health Care in Developing Countries*.

4 Bryant, *Health and the Developing World*, p. ix.

surroundings.<sup>5</sup> Perhaps to reiterate, for four decades and beyond,<sup>6</sup> as a result of government policy black South Africans were systematically denied these basic necessities. Instead, as will become clear in this chapter, rather than attack the problem at its roots by removing inequality in terms of distribution of resources between races, which would have been both politically and economically unacceptable at the time, the National Party government attempted to ameliorate the problem with food subsidy programmes that did little more than keep the chronically malnourished from starving.<sup>7</sup> The problem was exacerbated by the fact that the poor are often ignorant of the most elementary steps to be taken in order to reduce their vulnerability to infectious disease.<sup>8</sup> As a matter of fact, the distribution of “diseases of poverty” along racial lines in apartheid South Africa is a classic illustration of the differences in both the living and working conditions of the races as well as the differences in their access to basic health and other resources.

The major killers of black people during the period under review was not “apartheid”(though many have died in the process of opposing it), but the conditions of life emanating from its implementation. As pointed out in the previous chapter, it was the conditions of life flowing from the migrant labour system, enforced resettlement, the job colour bar, influx controls, “bantustanisation” and so forth, that accounted for the poverty that the majority of the black people experienced under apartheid. The people had to contend with what may generally be referred to as “diseases of poverty”, most of which are largely preventable and easily treatable. The primary focus of this chapter therefore, is to draw attention to the adverse health effects of poverty by using such traditional measures as the infant mortality rates, child mortality rates and life expectancies of both black and white population groups to determine the extent to which apartheid was incompatible with health during the period 1948-1976. By arguing that

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5 Dubos, “Mirage of Health”, in Davey, *Health and Disease: A Reader*, p. 9.

6 Admittedly, the post-apartheid governments have also failed to adequately address the issue of poverty. Furlong and Ball have attributed this failure to the government’s shift from the RDP to GEAR, when in reality, the issue of poverty could clearly not be addressed without RDP-type policies and the active state intervention in income distribution from rich to poor. See Furlong and Ball, “The More Things Change: AIDS and the State in South Africa, 1987-2003” in Patterson, *The African State and the AIDS Crisis*, p. 137. Critics on the political right might argue that what now exists in post-apartheid South Africa is unavoidable inequality, a social patterning of difference that largely reflects the natural innate differences between individuals, something that no amount of social legislation can overcome. But scholars such as Sampie Terreblanche strongly maintain that, it is not unreasonable to expect some visible progress towards greater social justice for the poor after a decade of democratic rule. See Terreblanche, *A History of Inequality in South Africa 1652-2002*, p. 29.

7 See Wylie, *Starving on a Full Stomach: Hunger and the Triumph of Cultural Racism in Modern South Africa*.

8 Packard, *White Plague, Black Labor*, p. 266.

the differential incidence of diseases of poverty and high mortality among the black population was socially structured and that it was the policies of apartheid that determined this, the chapter will refute the myth that South Africa's disease patterns at the time were the inevitable outcome of processes of industrialisation and urbanisation not dissimilar to those that were being experienced in the industrialised West under similar circumstances.<sup>9</sup> Quite evidently, the people supporting this myth are at a loss to explain why infectious diseases that had practically been eradicated in many parts of the developed world, were still prevalent in South Africa under apartheid and why these were so selective as to be serious among black people and yet conspicuously absent among whites.

Unless they consult indigenous healers, poor people suffer not only because the environment around them is sick, but also because poverty interferes with their ability to utilise the strengths of modern biomedicine. Unlike indigenous medicine, which may be paid for in kind, the cost of modern medicine is usually prohibitive for people without medical insurance. Preventive vaccines for various diseases, for example, when available to the poor, are all directly dependent on resources. Even if their cost per head is minuscule, aggregate costs for a bantustan of several million people may be out of reach for the particular bantustan's fragile finances.<sup>10</sup> In a situation such as this, poverty may mean the re-use of syringes that today are known to fuel the spread AIDS and hepatitis B. Poverty may also mean that antibiotics may be too costly for whole populations even though the cost of a single dose might be small. As will be explained in this study, in the remote rural villages of Kwandebele, antibiotic treatment of such widespread diseases of poverty as tuberculosis was often frustrated by the lack of a basic health care infrastructure to cope with the treatment's prolonged character. Another related issue was the cost imposed by apartheid's balkanisation of the country's health resources, which created multiple health departments in the bantustans to add to the existing confusion. This led to a divided responsibility and often to the mis-allocation of resources already evident in a system that divided authority between provincial and national government. It is contended in this chapter that although it is difficult to quantify statistically, black South Africans instead relied on indigenous medicine, particularly when it came to

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9 Marks and Andersson, "Industrialisation, Rural Health, and the 1944 National Health Services Commission in South Africa", in Feierman and Janzen, *The Social Basis of Health and Healing in South Africa*, pp. 131-161.

10 See Anthony Zwi, "Piecing Together Health in the Homelands", *Second Carnegie Inquiry into Poverty and Development in Southern Africa*, Conference Paper no. 187, 13-19 April 1984, p. 1-28; Anthony Zwi, *Fragmenting Health in the Homelands, a Homeland Tragedy: Function and Farce*, DSG/SARS Information Publication 6, (Johannesburg, Sached, 1982)

diseases for which indigenous medicine is known to be effective.

## 4.2 Infectious diseases and other conditions associated with poverty

### 4.2.1 Defining disease/illness

The analytical distinction between disease and illness is one that has received the attention of several authors.<sup>11</sup> In general, the concept “disease” has been used to describe the pathological processes and entities of the biomedical model. Each disease in biomedicine is an abstract biological condition independent of social behaviour. In this way, different views of the meaning of the concept have resulted in different treatments. From the late nineteenth century to the mid-twentieth century, each disease was seen as an objective biological phenomenon and those who combatted it, it was assumed, were university-trained scientific doctors; they were practitioners of modern medicine. According to Cecil Helman, to such a Western-trained doctor, the aim of therapy is primarily the identification and treatment of the named diseases using the scientific paradigm and definitions of modern biomedicine, which is the culturally-specific system of the West for explaining and treating ill-health.<sup>12</sup> In contrast however, many social scientists and historians have come to conceive disease as a cultural construct, rooted in mental habits and social reactions rather than in objective biological conditions of pathology. Thus, like other concepts such as medicine, health and poverty that are dealt with elsewhere in this study, “disease” too, as both a pathological reality and a social construction, is not easy to define with any measure of accuracy. According to Ivan Wolffers, while it may be regarded as a biological condition as defined by a professional practitioner, illness may also be seen as the complaint as experienced by a patient.<sup>13</sup> In Hays’ view however, our use of the concept “disease” betrays considerable uncertainty about its meaning. “For many people” argues Hays, “disease has an objective reality, apart from human perceptions and social constructs”.<sup>14</sup> For Henry Sigerist, on the other hand, disease is a “material process”, a “biological process” which

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11 L. Eisenberg, “Disease and Illness: Distinctions Between Professional and Popular Ideas of Sickness”, *Culture, Medicine and Psychiatry*, vol. 1 (1977), 9-23; G. Lewis, *Knowledge of Illness in a Sepik Society* (London, The Athlone Press, 1975), 146-51; E.J. Cassel, *The Healer’s Art: A New Approach to the Doctor-Patient Relationship* (New York, Lippincott, 1976), 47-83; and H. Fabrega, *Illness and Shamanistic Curing in Zinacantan: An Ethnomedical Analysis* (Stanford, Stanford University Press, 1973), pp. 91-93.

12 C.G. Helman, “‘Feed a Cold, Starve a Fever’: Folk Models of Infection in an English Suburban Community, and their Relation to Medical Treatment”, in Curren and Stacey (eds), *Concepts of Health, Illness and Disease*, p. 214.

13 I. Wolffers (ed), *The Role of Traditional Medicine in Primary Health Care*, Papers Presented at a Workshop at the Third International Conference on Traditional Asian Medicine in Bombay, India, in January 1990 (Amsterdam, VU University Press, 1990).

14 Hays, *The Burdens of Disease: Epidemics and Human Response in Western History*, p. 1.

is no more than the sum total of abnormal reactions of the organism or its parts, to abnormal stimuli.<sup>15</sup> For medical anthropologist John Janzen, health and disease are the “A and non-A” of the larger medical definitional category.<sup>16</sup> It is in this complementary sense of “health as absence of disease” and “disease as lack of health”, that I have used the term in this thesis. This is also the indigenous healers’ understanding of the concept. As Hlathikhulu puts it, “if a person has problems associated with ancestral visitations, then he/she is ill because that person is in reality not healthy. There is no need for laboratory tests to confirm this before it can be accepted as valid knowledge”.<sup>17</sup>

#### 4.2.2 Poverty and Tuberculosis

Perhaps more prevalent and more rampant than any other disease of poverty, reflecting not only the poor socio-economic conditions of the people involved, but also the historical factors that led to its taking root in that vulnerable group, was tuberculosis (TB). This is also one of the sensitive indicators of the health status of a population because wherever it is prevalent, it almost invariably bears relation to a poor standard of living that is often accompanied by overcrowding. In his study of the history of this disease of poverty, Randall Packard concludes that, although the epidemic was shaped by the rise of industrial capitalism in the period since 1948, tuberculosis was in many ways related to the politics of apartheid.<sup>18</sup> Particularly critical of the National Party government’s TB control measures which largely involved the application of exclusionary policies such as population resettlements and bantustanisation, Packard argues that the policies were in fact designed to keep the disease not only out of the purview of white voters but also beyond the statistical boundaries of the so-called “white South Africa”. The statement by the regional director of State Health Services for Natal, D.H. Hooley, that the inadequacy of the department’s TB control measures could be blamed on the lack of medical leadership in general,<sup>19</sup> could hardly have been accurate, because under the conditions of poverty described above, where the majority of the population could not access medical services, better medical leadership would, by itself, do very little towards addressing the scourge confronting black South Africans at the time.

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15 Sigerist, *Civilization and Disease*, p. 1

16 J.M. Janzen, “The Need for a Taxonomy of Health in the Study of African Therapeutics”, *Social Science and Medicine*, vol. 15 (1981), p. 185.

17 Interview with Ngaka Hlathikhulu, 14/8/2005.

18 Packard, *White Plague, Black Labor*, p. 292.

19 GES 2828 PA10, Correspondence between D.H. Hooley and Dr C.A.M. Murray, Secretary for Health, 9 April 1968.

Since the *tubercle bacillus* is the ultimate aetiological factor, it stands to reason that vast numbers of people harbour the bacillus without necessarily having tuberculosis. The difference between harbouring the *tubercle bacillus* and actually showing the symptoms of tuberculosis depends on the extent of poverty, including inadequate housing, overcrowding, malnutrition,<sup>20</sup> and so forth, to which the individual is exposed.<sup>21</sup> Whereas the introduction of chemotherapy, Bacillus Calmette Guerin (BCG) as well as the anti-tubercular drugs such as isoniazid (INH) in the early 1950s might have saved the lives of many patients, the historical records reveal that the apartheid era was marked by dramatic changes in the epidemiology of the disease. For example, when measured by official notifications, the incidence of African cases of TB had increased from 200 per 100 000 in 1952 to nearly 450 per 100 000 by the mid 1960s.<sup>22</sup> According to Professor J.R.V. Reid of the faculty of medicine at the University of Natal, as a symptom of the poverty that most of them were experiencing, blacks were ten times more liable to tuberculosis than whites.<sup>23</sup> The reason for this was that, since the government's policies of social engineering in the 1960s, the social and economic conditions under which Africans lived and worked had actually deteriorated.<sup>24</sup> Between 1950 and 1965, when the official TB notifications showed signs of declining, the critical factor was the mass removal of millions of Africans to the already overcrowded bantustans. As people were removed from urban areas, where treatment was better, the bantustans were turned into reservoirs of half-treated patients with every possibility of relapse.<sup>25</sup> Added to this was the fragmentation of the health services resulting from the state's bantustan programme, with each national state having its own health service and potentially using different drug regimens. All this compounded the problems of TB control in the 1960s and 1970s. As Randall Packard so eloquently explains:

Although patient defaulting from ambulatory treatment programs has been a common problem of tuberculosis control programs in Africa, the inequitable distribution of health and social services in South Africa – combined with the pattern of racial segregation and control enforced by the Nationalist

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- 20 Malnutrition is key to tuberculosis. By weakening the immune system it makes the onset of active TB much more likely. Admittedly overcrowding does explain the rapid spread of infection, but it is malnutrition more than any other single factor that allows the disease to produce such devastating effects. For a more detailed elaboration on the role of malnutrition in TB see Packard, *White Plague, Black Labor*, p. 266; WHO, *Apartheid and Health*, pp. 141-161.
- 21 GES 2817, P 32E, 10 December 1949.
- 22 Packard, *White Plague, Black Labor*, pp. 249-50.
- 23 GES 2827 PA2, Correspondence between Prof. J.V.O. Reid and Senator J.H. Loock, 20 May 1969.
- 24 *The Rand Daily Mail*, 8 June 1960. See also SAIRR, *Race Relations Survey, 1960*, p. 244.
- 25 GES 2828 PA10, Letter from Dr C.A.M. Murray (Secretary for Health) to Hooley, Natal's Regional Director of State Health Services, 7 March 1968.

government and the fragmentation of local health services – exacerbated these problems, decreasing the likelihood that black cases would be effectively cured and increasing the number of half-cured chronic cases who were sources of infection to others.<sup>26</sup>

Again, there was state manipulation of TB statistics to serve an apartheid agenda; and this even affected the disease notification records. For instance, although the medical superintendent of the Charles Johnson Hospital in the Kwazulu bantustan believed that tuberculosis was on the rise due to the combined effects of resettlement, poverty, malnutrition and overcrowding, official statistics have consistently demonstrated a *decline* in tuberculosis from 64 000 new cases reported in 1975 to 55 300 in 1976.<sup>27</sup> Indeed, the chairman of the South African Tuberculosis Association (SANTA) believed that the actual number of cases was 5 to 10 times that which was officially recorded.<sup>28</sup> According to the 1977 *Epidemiological Comments*, it was officially stated that, “when reviewing the number of monthly notifications of all forms of tuberculosis, a fairly consistent decline was observed beginning in August 1975”.<sup>29</sup> Important though this observation might be, it remained conveniently silent about the effects of Transkeian independence in 1976 on the extent of TB notifications. And it was this kind of deliberate under-reporting of TB cases that gave the impression that the epidemic was being brought under control,<sup>30</sup> thus allowing tuberculosis to gain a foothold among the people involved, because facilities to manage it were at best poor and in most cases, non-existent.

It should, however, be reiterated that tuberculosis is not only a medical problem whose solution was dependent on drugs alone. In the United Kingdom, where TB was such a menace before the Second World War, it was virtually vanquished even before the latest drugs were prescribed, simply because people had access to good food, good home conditions, reasonable security and improved economic conditions.<sup>31</sup> Aware that the principal cause of the high incidence of tuberculosis among the black people was rapid industrialisation and urbanisation at a time when housing and nutrition were hopelessly inadequate and overcrowding was the order of the day, and mindful that adequate housing and good nutrition were the only

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26 Packard, *White Plague, Black Labor*, p. 285. See also, SAIRR, *Race Relations Survey, 1960*, p. 244.

27 *The Star*, 28 January 1978.

28 *The Sunday Times*, 28 January 1978.

29 *Epidemiological Comments*, February 1977.

30 The political motive involved in deliberate under-reporting of TB cases among black South Africans has been evident ever since. This was a ploy by the Nationalists to keep hidden from white voters and international observers the extent of the adverse health effects of apartheid policies.

31 FOOSA, *Friends of the Sick Association 25 Years of Service*, (UNISA Documentation Centre, acc. 63, 1975), p. 3.

important safeguards against tuberculosis, the government was well placed to provide these. However, the preoccupation with apartheid, which dictated that black housing should only be provided in the bantustans where Africans were resettled in overcrowded areas, certainly led to a limited availability of health care facilities. There can be no denying that when Africans suffering from TB were resettled into bantustans they were beyond the benefits of advances in chemotherapy. It is for these people that indigenous medicine offered relief and eventual cure.

#### 4.2.3 Poverty and sexually transmitted diseases (STDs)

The relationship between apartheid and disease is no longer in any doubt. In recognition of this truism, Shula Marks and Neil Andersson are unequivocal in their specific focus on *Diseases of Apartheid*.<sup>32</sup> Although existing literature on South African medical history suggests that venereal diseases, particularly syphilis, have been matters of public and political controversy for centuries,<sup>33</sup> and therefore cannot be attributed solely to apartheid, there is reason to believe that the increasing burden of venereal diseases borne mainly by black South Africans since 1948 can be attributed to conditions resulting from the direct implementation of that policy; this then suggests that apartheid made a bad situation worse. For example, as pointed out in the previous chapter, by virtue of the systematic enforcement of influx control and single sex hostels for migrant labourers and the impact this had on African family life, the Nationalists perpetuated and encouraged (sometimes by legislative instruments) the living and working conditions that were more conducive to the spread of sexually transmitted infections. And there is an established consensus among researchers that in the same way as there is a relationship between tuberculosis and AIDS, there are significant connections between STIs and HIV/AIDS.<sup>34</sup> However, the historical tendency to attribute the prevalence of sexually transmitted infections on the sexual immorality and promiscuity of Africans reflects a complete disregard for the impact of the social conditions that produced these diseases. Mamphela Ramphele has also examined the connections between the NP policies and the

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32 S. Marks and N. Andersson, "Diseases of Apartheid", in J. Lonsdale, *South Africa in Question* (Cambridge, African Studies Centre, 1988), pp. 172-199.

33 A. Jeeves, "Introduction", *South African Historical Journal*, no. 45 (2001), p. 2. See also A. Jeeves, "Public Health in the Era of South Africa's Syphilis Epidemic of the 1930s and 1940s", *South African Historical Journal*, no. 45 (2001), pp. 79-102; K. Jochelson, "Sexually Transmitted Diseases in Nineteenth and Twentieth-Century South Africa", in P.W. Setel et al (eds), *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa* (London, Greenwood Press, 1999), p. 217.

34 C. Hunt, "Migrant Labour and Sexually Transmitted Disease: AIDS in Africa", *Journal of Health and Social Behaviour*, vol. 30 (1989), 353-73; K. Jochelson, "HIV and Syphilis in the Republic of South Africa: The Creation of an Epidemic", *African Quarterly* 6 (1991), 20-34.

diseases associated with the disruption of the African family unit.<sup>35</sup> Simionne Horwitz has shown that although there are still a number of in-depth historical studies that focus on the multi-faceted relationship between labour migration and earlier disease outbreaks in southern Africa,<sup>36</sup> there is no doubt that the disruption wrought by migrant labour on social relationships was as significant in the period before 1948 as it was during apartheid. Both medical and biological science have contributed a great deal towards the goal of totally eradicating syphilis, but its persistence as well as the even greater incidence of other STIs requires the contribution of other healing alternatives such as indigenous medicine. In order to finally eradicate sexually transmitted diseases, it is necessary to learn what factors operate to prevent and discourage afflicted people from availing themselves of penicillin. This study concurs with Wood's view that, "for many populations today, the primary obstacle to freedom from syphilis is poverty".<sup>37</sup> Following the discovery of penicillin in the 1940s the eradication of syphilis was optimistically anticipated but given the conditions of poverty described in chapter three, most of them emanating from the social disruption of the apartheid period, it is understandable why the disease is still such a problem among Africans. It is time that the significance of cultural beliefs regarding sexuality in African societies is recognised; the continued exclusion of indigenous healers in the fight against syphilis and other sexually transmitted infections will be pursued at the country's peril.

#### **4.2.4 Poverty and malnutrition**

The importance of nutrition for maintaining health was contested for many years by conventional doctors in the United States who argued that nutritional factors could not reverse (or cure) chronic diseases. However, a growing body of clinical evidence suggests that certain whole foods and nutritional supplements help maintain positive health and assist in the prevention or cure of a variety of diseases. In addition to a growing consensus in the South African medical literature on the period under review that the health problems of the majority of black South Africans were largely exacerbated by the prevalence of malnutrition,<sup>38</sup> there is also a strong body of biomedical evidence showing that malnutrition and parasitic infections increase HIV susceptibility (not only to opportunistic infection after HIV infection, but also to

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35 Ramphele, *A Bed Called Home*, p.15.

36 Horwitz, "Migrancy and HIV/AIDS: A Historical Perspective", p.103.

37 Wood, *Human Sickness and Health: A Biocultural View*, p. 241.

38 Unterhalter, "Inequalities in Health and Disease: The Case of Mortality Rates for the City of Johannesburg, South Africa", *International Journal of Health Services*, vol. 12, no. 4 (1982); Yach and Harrison, "Inequalities in Health: Determinants and Status in South Africa".

HIV transmission), just as they increase susceptibility to other infectious diseases.<sup>39</sup> Although malnutrition as a condition may be difficult to define, it is less so to measure. For example, when a child is severely malnourished, the adverse health effects are readily observable to anyone with even rudimentary medical training. What has also been established is that its relationship with infection is synergistic, in the sense that not only are malnourished people more likely to contract and to die from infectious diseases, but that the infection itself causes further malnutrition.<sup>40</sup> According to the United Nations Children's Fund (UNICEF), all infections have a nutritional impact in that they depress the appetite, decrease the body's absorption of nutrients and induce the body's rejection of food through vomiting, or even drain away nutrients through diarrhoea. As a result, malnutrition and infection become joined in a self-reinforcing cycle.<sup>41</sup>

If Thomas McKeown's conclusions are taken seriously, the relationship between adequate nutrition and infectious diseases can no longer be overemphasised. As pointed out earlier, he suggests that having accepted that to a degree, changes in the character of infectious diseases and reduction of exposure are some of the influences on the decline of the infections (and excluding biomedicine which has proved ineffective) we are left with the possibility that response to infectious diseases was largely modified by improved nutrition.<sup>42</sup> McKeown argues that this conclusion is consistent with the increase in food supplies resulting from advances in agriculture and transportation during a period of noticeable population expansion. Although malnutrition encompasses overall food insufficiency, specific nutritional deficiencies – and their opposite, over-consumption – it is important to realise that under apartheid the primary causes of poor nutrition were economic and environmental, both of which were politically determined. Historically, it was during the 1950s that malnutrition gained an unprecedented prominence as a major malady afflicting black South Africans. The problem became so pronounced that by the end of the decade certain Holy Cross doctors referred to a characteristic “new deadly trinity” in their reports; they were referring to tuberculosis, wounds and malnutrition.<sup>43</sup> Although it is very difficult to go beyond generalisations to a specific estimate of the role played by nutrition in determining the

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39 Natrass, *The Moral Economy of AIDS in South Africa*, pp. 28-29.

40 S. Asthana, “Economic Crisis, Adjustment and the Impact on Health,” in D.R. Phillips and Y. Verhasselt (eds), *Health and Development* (London, Routledge, 1994), p. 56.

41 UNICEF, *The State of the World's Children 1984* (Oxford, Oxford University Press, 1983), cited in Asthana, “Economic Crisis,” p. 56.

42 McKeown, “Food, Infection, and Population”, p. 38.

43 Wylie, *Starving on a Full Stomach*, p. 180.

outcome of an infectious disease,<sup>44</sup> sociological studies have revealed that the severity of infections normally depends on the nutritional condition of an individual at the time of exposure.<sup>45</sup> Its relationship with enteritis is well acknowledged by Wittman and Jansen, who rightly point out that the condition is not reflected as much by the incidence of kwashiorkor as by the incidence of severe gastroenteritis in malnourished children.<sup>46</sup> In 1961, in an effort to measure the extent of malnutrition in South Africa, the National Nutrition Research Institute sent out questionnaires to medical practitioners asking for reports on black child patients. According to figures provided by *The Rand Mail* at the time, replies were received relating to 200 000 patients, of whom 44 509 suffered from deficiencies associated with malnutrition; the table below illustrates this.

**Table 4.1 Deficiencies associated with malnutrition, 1961**

Condition	Cases
Kwashiorkor	4,470
Marasmus	3,478
Pellagra	3,132
Tuberculosis	9,360
Gastroenteritis	15,404 <sup>47</sup>

I have reiterated in this study that the accuracy of statistics relating to black South Africans under apartheid is almost always suspect, therefore, wherever they are available, such statistics should be used with the necessary caution; at best they are estimates. The severity of malnutrition among black people was also revealed in another article when *The Rand Daily Mail* reported in 1962 that about 9 000 malnourished children were being admitted every year to the Baragwanath Hospital.<sup>48</sup> The significance of this revelation lies in the fact that it depicts the situation in an urban health facility (Baragwanath Hospital in Soweto) where the wages of the local community were relatively much better and the people had better access to health

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44 That the health of an individual has a profound bearing on his reaction to infectious diseases has recently been proved by the HIV/AIDS epidemic, whereby the existence of untreated or partially treated STIs renders the individual more vulnerable to infection.

45 McKeown, *The Role of Medicine*, p. 60.

46 W. Wittman and J.D.L Hansen, "Gastroenteritis and Malnutrition", *South African Medical Journal*, vol. 39, No.1 (1965), p. 223.

47 *The Rand Daily Mail*, 13 October 1961.

48 *The Rand Daily Mail*, 28 June 1962. The name of the hospital, one of the largest in the southern hemisphere, is now Chris Hani Hospital.

facilities than was the case in resettlement bantustans. Besides the acute unavailability of health services in the rural bantustans, there was also no record of people living and dying under conditions of malnourishment. Available evidence suggests that for every child admitted with a deficiency disease, about 30 more were being treated as outpatients.<sup>49</sup> In 1977, Stein also found that 34% of black children presenting with bacterial meningitis in Soweto had overt signs of malnutrition. Although it did not appear high on the list of major causes of death in infants and children, malnutrition was no doubt an important contributing factor, particularly because rather than being disease-specific, most deaths are caused by a combination of poor nutrition and repeated bouts of different infections.<sup>50</sup> The tragedy about malnutrition is that medical treatment is virtually always irrelevant, because malnutrition leads to illnesses that are not curable by medical science. As Bryant so aptly remarks:

The great weapons of modern medicine are aimed at the pathophysiology of disease and its susceptibility to pharmaceutical, immunological, or surgical attack. Health services are designed to deliver these weapons mainly through the hands of doctors. The dismal fact is that these great killers of children – diarrhea, pneumonia, malnutrition – are beyond the reach of these weapons. If children sick with these diseases reach the physician, there are sharp limits to what he can do. Diarrhea and pneumonia are often not affected by antibiotics, and the frequent presence of malnutrition makes even supportive therapy difficult or futile. And even these interventions by the physician, whether or not they are therapeutically effective, are only sporadic ripples in a running tide of disease.<sup>51</sup>

In contrast to its relationship with disease, the connection between malnutrition and apartheid is not difficult to establish. In contrast to other developing countries, what made malnutrition unacceptable in South Africa was the fact that available food resources during the 1960s and 1970s was perfectly sufficient to adequately feed the country's entire population, provided there was a fair and equitable distribution of these resources.<sup>52</sup> Yet malnutrition in South Africa occurred and became more rampant not only at the time when the country's economy was booming but also at the time when South Africa was the major exporter of food on the continent.<sup>53</sup> Ironically, this was the time when newspapers carried such articles as, "Too much food – South Africa's dilemma." This was the time when it was frequently reported in the print

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49 SAIRR, *Race Relations Survey 1962*, p. 202.

50 H. Stein and S.C.E. Mouton, "Neonatal Mortality in a Black Urban Community", *South African Medical Journal*, vol. 55, No.1 (1979), p. 413.

51 Bryant, *Health and the Developing World*, p. 39.

52 O'Meara, *Forty Lost Years: The Apartheid State and the Politics of the National Party, 1948-1994*, pp.173-176. See also *The Star*, 20 February 1971; WHO, *Apartheid and Health*, p. 161; Van Rensburg et al, *Health Care in South Africa: Structure and Dynamics*, p. 120.

53 SAIRR, *Race Relations Survey 1963*, p. 204.

media that surplus milk powder was being fed to animals,<sup>54</sup> the period during which, by the Minister of Agricultural Economics and Marketing's own admission, about 4 million pounds of butter was exported to Britain at a loss.<sup>55</sup> With a clearly stated objective of maintaining prices, it was reported that more than 10 000 litres of milk were being pumped into the sea on a daily basis, while at the same time tons of surplus fruit were dumped to rot.<sup>56</sup> That all this was done after technical tests conducted at the Pretoria General Hospital by the Council for Scientific and Industrial Research (CSIR) had already revealed that a pint of milk per child per week was sufficient to prevent malnutrition, is deplorable to say the very least.<sup>57</sup> According to other reports, this was the period when about 23 million bags of surplus maize was being stored prior to being exported. And when exporting was often done at a loss.<sup>58</sup> It is instructive to learn that in 1979-80 the country's white farmers exported a surplus of maize worth R226 million, an amount which was estimated to represent about R350 for each malnourished child in South Africa.<sup>59</sup> Although it was estimated that 350 000 tons of animal, fish and plant protein were available in 1951 against a total requirement of 327 000 tons, malnutrition and under-nutrition persisted among black communities especially in the impoverished rural reserves.<sup>60</sup> Some reports pointed out that in spite of the claims that there were shortages of meat and dairy products, white South Africans were consuming these in excess, thus masking the acute shortage among the country's black population.<sup>61</sup>

Other reports reveal that although scurvy can easily be prevented by eating sufficient citrus fruit, which the apartheid state exported on a massive scale in the 1970s, the disease still occurred in 3 per 1 000 black South Africans in the vicinity of Durban.<sup>62</sup> The connection between apartheid-created poverty and malnutrition can best be made by examining the moral

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54 *The Star*, 20 February 1971.

55 SAIRR, *Race Relations Survey*, 1962, p. 202.

56 Seedat, *Crippling a Nation: Health in Apartheid South Africa*, pp. 27-28. See also *The World*, 7 November 1976 and SAIRR, *Race Relations Survey*, 1962, p. 204.

57 *The Star*, 17 September 1962.

58 *The Rand Daily Mail*, 13 November 1962. See also *The Star*, 16 August 1962; and SAIRR, *Race Relations Survey* 1962, p. 205.

59 Ben Wisner, "Commodity Relations and Nutrition Under Apartheid: A Note on South Africa" *Social Science and Medicine*, vol. 28, no. 5 (1989), p. 444.

60 *The Cape Times*, 15 May 1951.

61 *The Sunday Times*, 16 May 1951. See also *The Cape Times*, 15 May 1951. In fact according to the Minister of Agricultural Economics and Marketing in February 1962, the products that were exported at a price below the domestic prices during the previous 12 months included, butter, cheese, mutton, eggs, maize, groundnuts etc. See RSA, *Hansard, House of Assembly Debates*, 19 February 1962, 3, cols 854-55.

62 WHO, *Apartheid and Health*, p.146.

correctness of the argument that the South African Market Control Board had kept prices beyond the reach of many people in order to prevent food from flooding the domestic market.<sup>63</sup> Closely analysed, there is no doubt that the primary objective of the marketing boards and regulations was to maintain the prosperity of the white farming community, whose electoral support after 1948 was vital to the National Party. Marketing regulations kept domestic prices high, allowing the state to subsidise agricultural exports in order to make them competitive in very difficult world markets. Despite the fact that the Nationalists had eliminated the government food programmes developed by the Smuts government during the war, a wide range of local food programmes, supported by government food subsidies, were introduced during the NP period. As Packard puts it, these programmes, like efforts at housing, must be viewed against the background of the government's commitment to a vision of the African worker as a member of the functioning rural-based society that supported the worker's family.<sup>64</sup> This explains why in spite of the state subsidisation of the cost of some basic foodstuffs, the gesture still remained insufficient to prevent the kind of widespread malnutrition described in this thesis.

In the absence of a "free market" in foodstuffs in South Africa, there is every reason to blame the state of affairs on the government of the day, because its largely illiberal policies of apartheid precluded any effort to prevent this wastage when there was such a dire need among black communities. Indeed, state-mandated marketing boards regulated prices and production in a wide range of foodstuffs for the specific purpose of raising and maintaining white farm incomes at the expense of domestic consumers, particularly the poorest of the poor, most of whom were Africans. Black farmers benefited very little, if at all, from these measures. With the state doing nothing to prevent the waste of nourishing food, the impression was created among the victims of malnutrition that it allowed and supported the market control boards or it liked what they were doing.<sup>65</sup> Admittedly, big business was not united on this matter of food prices. As one of the country's largest buyers of food to pass on to their workers in the compounds, the mining industry had a direct interest in lowering food prices and had always protested against the effects of the marketing legislation in raising farm prices. Be that as it

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63 From as far back as the mid 1930s, a range of legislation had been passed to institute control over the marketing of agricultural products such as meat, maize, wheat and dairy products. This culminated in the government's appointment of the National Marketing Board. The product control boards, which were also established in terms of the legislation had authority to fix product prices in conjunction with the minister. Therefore if things went awry in the area of the Board's jurisdiction, the government had to take the responsibility.

64 Packard, *White Plague, Black Labor*, p. 266.

65 Personal communication with Sop Ntuli

may, it cannot be denied that there was a clear alliance of interests between the big agricultural producers and co-operatives on the one hand and the state on the other; it appears that this could not be compromised by lowering food prices in the interests of the politically disadvantaged majority, whose welfare was neither critical for the maintenance of white supremacy nor a threat to white security.

What was even more revealing about white attitudes to the plight of black South Africans was that in advising government to tackle the problem of malnutrition among black communities, Professor Reid also couched his recommendations in the language of apartheid by emphasising the benefits that would accrue for government rather than for the poverty-stricken people.<sup>66</sup> In a letter to Senator J.H. Looock, Reid pointed out to government that:

A concentrated attack on the problem of malnutrition *would bring us great credit in the eyes of the outside world, and in the eyes of other African States.* We have seen recently what considerable benefit accrued to South Africa from Professor Barnard's achievements, and there is no doubt that the opinions of people are very much modified when they see such achievements. Health and medicine are matters of great concern in the modern world ... if the world could see that South Africa was making a deliberate and successful effort to eliminate malnutrition as far as it possibly could, they would recognise the good, and the goodwill of South Africa, there would be a genuine acceptance that we intend good, and that our policies bring positive good to all ...<sup>67</sup>

Clearly recognising that the cost involved in addressing malnutrition and its effects is usually greater than the cost of a large-scale programme of its prevention, Reid wisely advised the Verwoerd administration to put the elimination of malnutrition high on the government's agenda if it hoped to manage the burden of infectious diseases such as tuberculosis, syphilis, pneumonia and gastroenteritis that were prevalent in the black population at the time.<sup>68</sup> Besides the research undertaken by McKeown, these diseases have been identified as having links with malnutrition and under-nutrition by scholars such as Robert Rotberg, Ann G. Carmichael, Carl Taylor, Michelle McAlpin and others.<sup>69</sup> Some critics may argue that Reid's intentions were merely to draw attention to the extent of malnutrition among black South

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66 Even the prime minister, Hendrik Verwoerd, in explaining the benefits of government provision of nutritious food for Africans in 1960, emphasised the country's productivity rather than the improved health standards of Africans. See SAIRR, *Race Relations Survey, 1960*, p. 246.

67 GES 2827 PA2, *Correspondence between J.V.O Reid and Senator J.H. Looock, 20 May 1969.*

68 GES 2827 PA2, *Correspondence between J.V.O. Reid and Senator J.H. Looock, 20 May 1969.*

69 R.I. Rotberg, "Nutrition and History", in Rotberg and Rabb (eds), *Hunger and History: the Impact of Changing Food Production and Consumption Patterns on Society*, pp. 51-66. See also, in the same publication, A.G. Carmichael, "Infection, Hidden Hunger, and History"; Taylor, "Synergy Among Mass Infections, Famines and Poverty "; McAlpin, "Famines, Epidemics, and Population growth, the Case of India".

Africans; without being prescriptive, he clearly believed that it was in the power of government to deal with the problem. He probably knew very well that it would be futile to approach Verwoerd's government with liberal and somewhat humanitarian arguments, or even to argue that the apartheid state had a duty to address the health needs of the blacks. He therefore used arguments that he could expect to have some effect. Convinced that the National Party was worried about world opinion and growing international hostility to apartheid, he tactfully appealed to the government on that basis. However, others might argue that his advice was couched in language that implied that white concerns about malnutrition, like their concerns about disease and overpopulation, were not informed as much by a genuine and humane desire to improve the quality of life of black South Africans as by a cynical desire to either save costs or to buy foreign acceptance of government policies. There were also suggestions that his motives might have been to mask white fears about the growing black population. "My calculation", concluded Reid emphatically, "is that if we could convert all those who are malnourished into a well-nourished people quickly, we would have a population 10 million less, in 31 years time [1969 to 2000], than is now predicted".<sup>70</sup> Although some might argue that Professor Reid's good intentions were unrealistic in that he expected that better nourished people would practise birth control, it is difficult to resist the temptation to characterise his interest in the numerical importance of the black population as being closely related to the population control programmes introduced later by the NP government. But be that as it may, it should be pointed out that although malnutrition has not the same effects on every disease (it is marked in diarrhoea, measles, and tuberculosis but less significant in whooping cough), in general it is a major determinant of infection rates and of the outcome of infections. As the World Health Organisation has concluded: "one half to three quarters of all statistically recorded deaths of infants and young children are attributed to a combination of malnutrition and infection" and "an adequate diet is the most effective vaccine against most of the diarrhoeal, respiratory and other common infections".<sup>71</sup>

#### 4.2.5 Poverty and kwashiorkor<sup>72</sup>

70 GES 2827 PA2, Correspondence between J.V.O. Reid and Senator J.H. Loock, 20 May 1969.

71 WHO, "Better Food for a Healthier World", *Features*, 19 (1973), and Moses Behar, "A Deadly Combination", *World Health* (Feb/Mar 1974), p. 26, both sources cited by McKeown, "Food, Infection, and Population", p. 38.

72 Kwashiorkor is a Ghanaian word meaning "second-child disease". It occurs when the child is weaned and shifted to a diet that has sufficient calorie intake to satisfy hunger but distressingly insufficient to meet the critical protein requirements demanded by the growth phase of the child. For an overview see C.S. Wood, *Human Sickness and Health: A Biocultural View* (California, Mayfield Publishing Company,

Protein Energy Malnutrition (PEM) describes mainly undernourished children between the ages of one and three years. The two types of PEM that are commonly distinguished are kwashiorkor and marasmus. In both, the child weighs significantly less than the expected standard for his or her age and has wasted muscles. Although marasmus is apt to occur under conditions of extreme social disruption, such as famine, drought and so forth, kwashiorkor is found primarily in children who consume insufficient protein for their growth and maintenance needs.<sup>73</sup> This happens particularly to children who have been weaned because another child has arrived (*o gatletšwe*).<sup>74</sup> The afflicted child develops the condition reflecting a painfully distended belly, stick-like arms and water-swollen legs; sad pictures of children thus afflicted are found hanging in virtually every health care facility around the country.<sup>75</sup> Available evidence suggests that of the 1 102 African children suffering from kwashiorkor admitted to the King Edward VIII Hospital in Durban from July 1958 to June 1959, about 394 of them died of the condition.<sup>76</sup> However, by declaring kwashiorkor a notifiable disease on 12 September 1962, the South African government officially acknowledged the disease as a valuable indicator of overall nutritional status. The incidence figures for 1963 alone clearly indicate that kwashiorkor was mainly an African problem rather than a “European” problem as the table below clearly illustrates:

**Table 4.2 Kwashiorkor incidence, 1963**

Racial group	Cases
White	5
Coloured	230
African	7, 170 <sup>77</sup>

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1979), p. 73.

73 Interview with Dr Magampa, 4/2/2000.

74 Interview with Matron, Muriel Mabindiza, 1/12/2004.

75 In an interview with Dr Magampa he noted with concern all the cases he has had to deal with and all the pictures he had ever seen in clinics and public hospitals showing marasmus and kwashiorkor, none of them were white children or from any other racial group in the country; all were Africans.

76 SAIRR, *Race Relations Survey, 1962*, p. 202.

77 Wylie, *Starving on a Full Stomach*, p.222.

It is interesting to note that while in 1962 there was a high number of officially reported cases of kwashiorkor throughout South Africa, the notification rate for white children was 0 per 1 000, while the rate for Africans was 112 per 1 000.<sup>78</sup> In his speech at the occasion of opening a six-bed CSIR Nutrition Clinic for adults at the African section of the Pretoria General Hospital in December 1963, the minister of health, Albert Hertzog, acknowledged the existence of malnutrition among Africans, Indians and Coloureds.<sup>79</sup> While this acknowledgement of the problem might have laid the minister open to the charge of being too sympathetic to Africans, Hertzog avoided this by explaining, as most white people assumed to be the case, that malnutrition was the fault of Africans themselves. Like many white people at the time, he argued that most African diseases were caused by wrong feeding habits.<sup>80</sup> Admittedly, ignorance existed in some communities, but this constituted only one factor among many complex problems, the majority of which were closely associated with government apartheid policies. In 1967 for instance, the National Nutrition Institute (NNRI) of the CSIR conducted a survey to determine the incidence of Protein-Calorie Malnutrition (PCM) and also found the incidence of kwashiorkor, marasmus and therefore Protein Calorie Malnutrition, to be very high.<sup>81</sup> The increasing notification rates among Africans must be understood within the context of the resettlement programme the government was undertaking at the time. This was the period when about 3,5 million people were relocated into the homelands, where resources were already under severe strain due to poor agricultural production. The startling contradictions involved in this exercise were revealed by Diana Wylie, who also drew attention to the impact of the government's resettlement policies and how these hindered any preventive efforts:

The government was simultaneously engaged in two mutually reinforcing exercises: it was resettling people in areas too impoverished and too densely populated to support their new populations, and it was collecting statistics on how many children were afflicted with protein malnutrition.<sup>82</sup>

Against the background of growing poverty and social controls, a few food programmes and subsidies made very little impact on the severity of kwashiorkor. However, as in dealing with

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78 SAIRR, *Race Relations Survey 1964*, p. 309.

79 *The Rand Daily Mail*, 4 December 1963. The minister pointed out that there were 0.3 per 1 000 cases among Asiatics, 2 per 1 000 among Coloureds and 10 per 1 000 Africans. The ministers's silence on the white cases was a clear indication that the problem was virtually unknown in that racial group.

80 *The Rand Daily Mail*, 10 December 1963.

81 For the full picture of the findings see GES 2827 PA2, Correspondence between Reid and Look (Figures on malnutrition in South Africa), 20 May 1969.

82 Wylie, *Starving on a Full Stomach*, p. 223.

other health statistics relative to the black communities, in 1968 the government withdrew its mandate to be notified of all kwashiorkor cases on the dubious grounds that a general picture of the incidence had already been ascertained. What was not said, however, was the fact that the “general picture” revealed such a disparity in incidence that notifications had virtually become an embarrassment to the apartheid state.<sup>83</sup> In 1976, the Department of Health noted that about 286 district surgeons had reported 48 783 cases of kwashiorkor, 37 855 of pellagra and 1 008 of beri-beri.<sup>84</sup> According to an article in the *Financial Mail*,<sup>85</sup> the underlying cause of all these was poverty, unemployment, ignorance, the migrant labour system and the overcrowded and underdeveloped bantustans. It soon became evident that until the political restraints that were distorting the economy had been removed, the by-products of apartheid on the black population would remain a national responsibility.

### **4.3 Diseases associated with poor environmental sanitation**

#### **4.3.1 Poverty and typhoid**

The scarcity of clean water supply and contamination of water where it was available, added to the general lack of appropriate sanitation and sewage disposal systems in the rural bantustans, made water-borne diseases the most important health problems of apartheid South Africa. In fact clean water and proper sanitation are the most basic public health issues the government could and should have addressed, even if they were unwilling to confront the much more expensive issue of poverty. Like all diseases of poverty, the prevalence of typhoid reflects the poor quality of rural sanitation and the supply of clean water. Typhoid is transmitted by the faeces or urine of infected individuals either directly by flies or indirectly by water. Therefore, in times of drought, when most streams are either slow moving or stagnant, the risk of typhoid infection is even greater.

Since there was no waste disposal system for the majority of rural black South Africans, typhoid was one of the major notifiable diseases during the period under review. The government’s failure to provide adequate sanitation and clean water to the majority of these

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83 Packard, *White Plague, Black Labor*, p. 269. See also *The Rand Daily Mail*, 15 September 1968.

84 Helen Suzman Papers, A 2084/H63, Undated newspaper clipping.

85 *The Financial Mail*, 11 January 1980.

communities has received some academic attention in the work of Jeanette Mills.<sup>86</sup> Her conclusions on the relationship between sanitation and health are supported by the findings of Von Schirding, Yach and Mathee.<sup>87</sup> Other studies on the incidence of typhoid fever in the late 1950s and early 1960s also revealed that in the majority of resettlement villages in the bantustans, typhoid had virtually reached epidemic proportions.<sup>88</sup> For example, it was estimated that at least one in every 750 boys between the ages of 5 and 14 years in Venda contracted the disease in 1977. These grim statistics were alarming in the light of the fact that the homeland was barely two years away from gaining so-called “independence” from Pretoria, thereby importing into the new “national state” system a relatively sick population. Nor did Venda have the necessary medical infrastructure to cope with and then eradicate the disease. The irony of South Africa’s medical history is perhaps brought home by the revelation that by the end of the 1970s, the homeland of Kangwane, essentially housing less than 1% of the country’s population, was responsible for 20% of notified cases of typhoid.<sup>89</sup> A study conducted by the Department of Health in 1979 also found the incidence of typhoid in the homelands of Venda, Gazankulu and Kangwane to be six times higher than in the country as a whole.<sup>90</sup> On the basis of data relating to all cases occurring in Cape Town in the 1970s alone, black South Africans were seven times more at risk from typhoid fever than whites.<sup>91</sup>

The relationship between the incidence of typhoid, particularly in the Eastern Cape, and the NP’s apartheid policy, was further revealed by the discovery that in the resettlement camps of Sada and Dimbaza in the Ciskei, the rates in 1977 were even higher than those in Limehill at the end of the 1960s. During the same period the worst ravages of the disease were experienced in the Butterworth and Kentani areas as well as in Nqamakwe, Idutywa, Willowvale and Umtata. In view of the known drought conditions in these areas of the Transkei, it would surely have been anticipated that steps would be taken to prevent the outbreak in the first place and then to make sure that the disease was not allowed to spread. Yet judging from reports by hospital authorities in the Transkei, they had made attempts to

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86 J.J. Mills, *A Sociological Study of Water and Sanitation-Related Diseases as a Socio-Political Phenomenon in South Africa* (PhD thesis, UNISA, 1987).

87 Y. von Schirding, D. Yach and A. Mathee, “Health Aspects of Sanitation, with Special Reference to South Africa”, *CHASA: Journal of Comprehensive Health*, vol. 4, nos. 3-4 (July-November 1993), p. 73.

88 GES 2827 PA2, Letter from G.A. Joubert (regional director, State Health Services), to Secretary for Health, 31 January 1969.

89 De Beer, *The South African Disease*, p. 52.

90 Department of Health, *Annual Report of the Department of Health 1979* (Pretoria, Government Printer, 1980).

91 WHO, *Apartheid and Health*, pp. 126-27.

alert the government to embark on immunisation campaigns but their efforts were ignored. This aroused criticism for a white government that appeared to be responsive only to the health concerns of its constituency, the white voter, the maintenance of whose security was the declared goal of the National Party government. For example, the annual report for notified cases from the early 1960s up to the end of the decade shows a marked increase of cases from 252 in 1961 to 534 in 1968.<sup>92</sup> By the late 1970s, more than 3 000 cases of typhoid were reported annually.<sup>93</sup> This latter figure must however be viewed with circumspection, because it could well be inaccurate in the light of the government's tendency at the time to under-report embarrassing statistics. Although the rate of fatalities varied from year to year, it is noteworthy that the incidence of typhoid fatalities increased from 0.3% for 1965-66 to 1.2% for 1976-77.<sup>94</sup> This is again the period corresponding with the government's intensification of the population removals and the resettlement of these people in the most unsanitary rural areas, a process that was discussed in the previous chapter. Proper sanitation, rather than immunisation programmes carried out in an unsanitary environment, could offer a far more lasting solution to the problem of typhoid.<sup>95</sup>

A striking feature of typhoid fever records is the relative constancy of notification cases since the period corresponding with the Nationalists' take over of the reins of power. Perhaps Rudolph Virchow's conclusions from his studies of the disease in nineteenth-century Europe remain valid for the South Africa of the apartheid period, when he remarked that "political powerlessness and economic insecurity lead, through a complex web of interactions, to a preponderance of illness and early death".<sup>96</sup>

### 4.3.2 Poverty and gastroenteritis

The synergism between enteritis and malnutrition has been well documented in South Africa.<sup>97</sup> Both the incidence and the prevalence of gastroenteritis in a given community is a fair reflection of that community's socio-economic status. Having reported 112 deaths in 1966

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92 GES 2827 PA2/10, Correspondence between G.A. Joubert, (CRHO) and the Secretary for Health, 31 January 1969.

93 Thompson, *A History of South Africa*, p. 204.

94 Department of Health, *Annual Report of the Department of Health, 1978* (Pretoria, Government Printer, 1979).

95 GES 2827 PA2, See also Von Schirding at al, "Health Aspects of Sanitation, with Special Reference to South Africa", p. 77.

96 R. Virchow, quoted by Botha, "Poverty and Disease: A Case Study of Diarrhoeal Disease", p. 1, cited in Wilson and Mamphela, *Uprooting Poverty: The South African Challenge*.

97 W. Wittman and J.D.L. Hansen, *South African Medical Journal*, vol. 42 (1968), p. 223; J.N. Scragg and L.J. Rubidge, *South African Medical Journal*, vol. 51 (1977), p. 265.

alone, a newspaper article commented, “disease is killing kids like flies.”<sup>98</sup> At the national level the incidence of the disease was almost impossible to measure since only the most seriously affected black children were taken to hospital and only the worst cases were actually admitted, while among white babies the first signs of infective diarrhoea often resulted in early admission.<sup>99</sup> But since the problem of gastroenteritis is only partly a medical one, the infective element is less important in determining the incidence and mortality than other socio-economic factors such as malnutrition. André Botha has demonstrated that not only was there a relationship between the incidence of gastroenteritis and poverty but also that the duration of the disease was much longer in poor children than was the case among the privileged ones.<sup>100</sup>

### 4.3.3 Poverty and cholera

The often inappropriate reference to cholera as a tropical disease, which would suggest that it is natural in a given area, gave the state a convenient (but groundless) excuse to deflect the responsibility for creating the circumstances in which cholera could flourish. Admittedly, cholera did not appear in South Africa to any significant extent until the late 1970s and early 1980s. Nor was the inadequate supply of clean water a problem unique to apartheid South Africa; it was a common problem in developing countries. Since there is no doubt about the connection between migrant labour and the spread of infectious diseases in general, there can be little doubt the relationship between migrant labour and the spread of cholera. A 1975 survey sponsored by the World Health Organisation found that only 22 % of the rural population in developing countries enjoyed access to safe water against 77% of city dwellers.<sup>101</sup> However, while accepting that the scarcity of clean piped water in the rural areas could not be blamed entirely on apartheid (but was inherited from previous administrations), it may still be argued that the Nationalist policies of social engineering and population resettlement inevitably exacerbated the problem.<sup>102</sup> The first cholera outbreak since the 1974 case in the gold mines,<sup>103</sup> began in the squalid conditions of resettlement areas of the northern Transvaal homelands of Lebowa and Gazankulu, before spreading to Natal, the Orange Free

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98 *The Star*, 20 January 1966 (Newspaper clipping in GES 2827 PA2).

99 WHO, *Apartheid and Health*, p. 125.

100 A. Botha, “Poverty and Disease: A Case Study of Diarrhoeal Disease”, pp. 6-11, cited in Wilson and Ramphela, *Uprooting Poverty: The South African Challenge*, p. 113.

101 Harrison, *Inside the Third World*, p. 291.

102 Hazel Friedman, “Cholera: A Social Disease?” *Work in Progress*, no. 23 (1982), p. 6.

103 M. Isaacson *et al*, “The Recent Cholera Outbreak in a South African Gold Mining Industry: A Preliminary Report”, *South African Medical Journal*, vol. 48 (1974), p. 2557.

State and then to Soweto.<sup>104</sup> In dealing with the problem, missionary societies had set up a network of small hospitals serving a predominantly African rural population. And it was these mission hospitals that played a crucial role in the provision of curative biomedicine in the bantustans. Among other criticisms levelled at the government's handling of the epidemic, Dr Liz Thompson of the University of Cape Town disparagingly referred to the health campaign that consisted of distributing posters and pamphlets to people who were illiterate, and expecting rural blacks to boil water before use when they did not have fuel. And how, she asked, could they keep human waste away from water supplies when there was no sanitation?<sup>105</sup> As Dr Jerry Coovadia, of the Natal Medical School remarked:

Cholera is only a different shade on the canvas of ill-health. The cause of cholera is not to be found in biology, but in poverty. Inadequate and non-existent sanitation and the lack of piped clean water are the immediate causes of the spread of the disease. But the roots of cholera lie in an unequal distribution of resources – too much for some, very little or next to nothing for others. Many of us have been saying for years now that serious diseases which are preventable have been among black South Africans all the time.<sup>106</sup>

Although a vaccine was already available against cholera in the apartheid years, it remained ineffective because it lasts for less than six months and has been found to be only successful in 50% to 60% of the people vaccinated. It was also found to be unwise to vaccinate vast numbers of people against cholera for fear that it would give them a false sense of security against the disease.<sup>107</sup> If explosive outbreaks of cholera were even experienced in the urban areas where there was relatively better water supply but poor sanitation, then the situation was assuredly worse in homelands such as Kwandebele, where the provision of infrastructure for supplying water lagged far behind the influx of people into the territory. In villages such as Borolo (Majakaneng), where the people and their livestock shared their drinking, cooking and washing water from Morwe, the river running through the village and flowing into the Elands (Moutse), the risk of cholera remained high. As Papi puts it:

Cows, goats, sheep and even donkeys used to drink in Morwe. Women washed clothes, boys used to swim and catch fish in the same river. Without any option, women went on to draw water from the same river for household use, including cooking and drinking.<sup>108</sup>

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104 *The Rand Daily Mail*, 2 December 1981.

105 SAIRR, *Race Relations Survey, 1982*, p. 530.

106 N. Andersson and S. Marks, "The State, Class and the Allocation of Health Resources", *Social Science and Medicine*, vol. 28, no. 5 (1989), p. 675.

107 A. Zwi, "Cholera - A Tropical Disease" *Work in Progress*, no. 16 (1981), p. 22.

108 Personal communication with Papi Lekotoko, 7/11/2004.

Admittedly, there was very little the government of the day could do to prevent people from contaminating the water in the manner described here. Catching fish and using the river as a swimming pool might well be seen as the source of the health problems; as adaptive and coping strategies, these practices should also be understood as people's responses to their desperate conditions of poverty and general deprivation. Although there was no outbreak of cholera in Kwandebele during the period under review, the ever present risk of an outbreak was a source of alarm to a community underresourced in many ways. White insensitivity to the plight of rural Africans is illustrated tellingly by Dr C.S. Garbers, president of the CSIR, who blamed the outbreak of cholera, on the fact that many rural blacks, "preferred drinking dirty water out of muddy pools rather than the safe chlorinated water supplied by the authorities."<sup>109</sup> This view clearly ignored the fact that people did not choose to live in unhygienic conditions but were condemned by the political and economic policies of the apartheid state to live in areas where healthy living was utterly impossible.

#### **4.3.4 Poverty and diarrhoeal diseases**

Diarrhoea is not a disease *per se* but a symptom of a problem in the gastro-intestinal tract. It may result from many diseases, all of which come from the use of and contact with polluted water. Since comprehensive cause-specific infantile mortality rates are not available for black South Africans for the period 1948-1976, studies have relied on the selection of magisterial districts involving urban blacks in order to determine the cause-specific infantile mortality. Based on this information, diarrhoeal diseases were in many cases found to constitute the most important cause of infantile mortality. Although in the settled urban parts of South Africa the rates were low, there is no question that diarrhoea was a constant problem for rural communities, particularly those that had been relocated in one or other of the resettlement camps of the homelands, because of the generally contaminated sources of drinking water to which many were exposed. As pointed out above, the African data with regard to diarrhoeal mortality is not accurate enough to report statistically. However, the following table of the total average per year, expressed per 1 000 population reveals a huge discrepancy between the White, Asian and Coloured rates, which suggests that although absent, the figures for Africans were even more dismal.

**Table 4.3 Childhood diarrhoea mortality rates in South Africa, 1968-1979**

Infants (up to 1 year)	White	Asian	Coloured
1968-1973	1.84	10.94	60.42
1974-1979	1.13	5.46	37.86

#### Children (1-4 years)

1968-1973	0.09	0.67	5.93
1974-1979	0.10	0.35	4.11 <sup>110</sup>

## 4.4 Other conditions traceable to deficient medical services

### 4.4.1 The infant mortality rates (IMR)

The infant mortality rates measure the number of children who die before their first birthday out of every thousand live births. Thus, besides being an excellent indicator of society's quality of health, the infant mortality rate is increasingly being used as one of the most reliable barometers for the population's general standard of living and a community's well-being. The infant is extremely vulnerable in the first year of life and mortality rates are usually high when there is poor housing, poor sanitation, exposure to infection and little awareness of the causes of disease. It is also influenced by the prevalence of such preventable diseases as diarrhoea and pneumonia, which in the case of black children was fuelled by high levels of malnourishment.<sup>111</sup>

For practical reasons, developing countries experience higher infant mortality rates than developed ones. Similarly, the standard and quality of health existing in developing countries is markedly different from that found in the developed countries. It is thus not surprising that the infant mortality rates are high in most developing countries; this is generally a reflection of the poverty of the economy in those countries. In the absence of reliable national statistics for African mortality (since for quite some time there was no legal requirement to register African births and deaths) regional statistics for specific magisterial districts merely provide a clue to the extent of the problem. In 1962, according to the 1962 Town Council of Umtata, the report of the municipal cemetery shows that almost half the burials in the last six months of that year were African children under one month old.<sup>112</sup> A glimpse of the country's infant mortality for the period 1950-1970, which includes the decade of economic boom, may be gained from the

110 Von Schirding et al., *Health Aspects of Sanitation With Special Reference to South Africa*, p.76.

111 Kelly, *Finding a Cure: The Politics of Health in South Africa*, p. 21.

112 *The Star* 23 January 1963.

following table

**Table 4.4 Infant mortality rates per 1 000 live births, 1950-1970**

<b>Year</b>	<b>Whites</b>	<b>Blacks</b>
1950	35.7	285 <sup>113</sup>
1960	29.6	101.2 <sup>114</sup>
1970	21.1 <sup>115</sup>	123.9 <sup>116</sup>

Although the statistics involving black South Africans during apartheid must always be used with utmost caution, for at best they are almost always estimates, there is general consensus among researchers that infant mortality rates among blacks were almost three times as high as those for whites. Therefore, by using the much more reliable white mortality figures, it is easy to estimate those of black infants. If the mortality rate for blacks in 1960 was three times that for whites, it may be argued that the benefits of the economic boom were not evenly shared. According to available although scant evidence, these mortality rates increased to five times that for whites within the space of a decade. While some studies have recorded mortality figures ranging from 200 to 450 infant deaths per 1 000 live births,<sup>117</sup> a 1966 survey reported that “half the children born in a typical bantustan in South Africa died before reaching the age of five years.<sup>118</sup> Thus, even using the minimal infant mortality rate figure of 150 per 1 000, this still suggests that at least 100 000 black South African babies were dying each year. It is interesting to note that these mortality rates are even higher in the 1960s than those reported at Pholela in the early 1940s. The experience at Pholela showed that applying the most basic and inexpensive methods of primary care and disease prevention could lower those rates significantly even in populations with high rates of poverty and little formal education. Therefore, had it not been a preoccupation with other apartheid-related concerns, with the

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113 H. Lever, *South African Society* (Johannesburg, Jonathan Ball, 1978), p.40.

114 Department of Statistics, *Report No.07-03-04: Bantu Deaths in Selected Magisterial Districts 1968-1971* (Pretoria, Government Printer, 1975).

115 Wells, *Health, Healing and Society*, p.2.

116 Department of Statistics, *Bantu Deaths in Selected Magisterial Districts 1968-1971*.

117 United Nations Unit on Apartheid, *Facts and Figures on South Africa*, Publication no.16/72 (August 1972), p. 29.

118 J.R. Friedman, “Basic Facts on the Republic of South Africa and the Policy of Apartheid”, *Objective Justice* (United Nations Office of Public Information, Winter, 1977-78), p. 33.

economic boom of the 1960s onwards, South Africa could have done better in this area. In a developing country such as Ghana, where a thorough investigation was carried out in the 1960s, an infant mortality rate of 110 per 1 000 was reported. If this figure was applied to a relatively wealthier South Africa, it would save the lives of at least 30 000 black infants every year.<sup>119</sup>

Between 1970 and 1973, a broad investigation was carried out to determine the actual black infant mortality rate using the annual reports of the medical officers of Health (MOH). According to the reports, almost all of them revealed black infant mortality figures ranging from 68 per 1 000 for Johannesburg, through to 188 per 1 000 for Grahamstown in 1970 and 170 per 1 000 for Bloemfontein in 1972; this puts the average at well over 120 per 1 000.<sup>120</sup> The results of a study of infant mortality rates over the period 1970-1983 were no better. The study found that the infant mortality rate at national level was 12.6 per 1 000 for whites and 86 for urban blacks in 34 magisterial districts in the early 1980s.<sup>121</sup> The significance of these figures lies in the fact that they are for urban areas, where black wages and medical services were better. In the rural bantustans, where these services were relatively poor, the rates were even more grim. For example, if Soweto is excluded from the foregoing study, the urban black rate becomes 102/1 000 for 1983.<sup>122</sup> In real terms however, the infant mortality figures in the urban areas are not an accurate barometer because they do not take into account the impact of population resettlements that were intensified in the 1960s and 1970s. The boast by health officials is that the African infant mortality rate in Johannesburg had been more than halved during the period 1958 to 1962, with reference to a drop from 132.7 per 1 000 in 1958 to 61.2 per 1 000 in 1962. They then ascribe this decline to better housing and mass immunisation, but clearly this does not take into account the effects of shifts in government policy towards the reserves and the impact of the various influx control measures of the time. Irwig and Ingle's 1980 study found an infant mortality rate of 130 per 1 000 in the Transkei bantustan.<sup>123</sup> If the situation was so bad in the "model bantustan", where health services were expected to be better in apartheid terms, it stands to reason that in bantustans such as Kwandebele and

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119 Laurence, *Race, Propaganda and South Africa*, p. 121.

120 Ibid., pp. 120-21.

121 A.A.B. Herman and C.H. Wyndham, "Changes in Infant Mortality Rates Among Whites, Coloureds and Urban Blacks in the Period 1970-1983" *South African Medical Journal*, vol. 68 (1985), p. 215.

122 C. Wyndham, "Mortality Rates of Black Infants in Soweto Compared with Other Regions of South Africa" *South African Medical Journal*, vol 70 (1986), p. 282.

123 L.M. Irwig and R.F. Ingle, "Childhood Mortality Rates, Infant Feeding and the Use of Health Services in the Rural Transkei" *South African Medical Journal*, vol. 66 (1984), p. 613.

Lebowa the rates were very likely to be worse. It was pointed out in chapter three that the operation of influx control ensured that the homeland areas, where there was more unemployment and generally low household incomes, received from the urban areas only the most vulnerable segments of the population. The following table illustrates the existence of an inverse relationship between gross domestic product and infant mortality.

**Table 4.5 Gross Domestic Product vs Infant Mortality Rate**

Country	Infant Mortality Rate	GDP (US Dollars)
South Africa	117 per 1 000	1340 per capita
Botswana	97 per 1 000	410 per capita
Guyana	40 per 1 000	630 per capita
Malaysia	75 per 1 000	860 per capita <sup>124</sup>

#### 4.4.2 The Child Mortality Rates (U5MR)

The child mortality rate refers to the rate per thousand children dying before their fifth birthday. Unlike the infant mortality, the child mortality reflects the main environmental factors affecting the health of children, such as nutrition, sanitation and communicable diseases of childhood.<sup>125</sup> Although several studies have linked the level of maternal education with child health and child mortality,<sup>126</sup> in apartheid South Africa, the capacity to care for and nurture children in the adverse social conditions that characterised many rural communities depended not so much on the education of the mothers as on the availability, the accessibility, and the affordability of other health-promoting factors. In situations such as existed in many black families bottle-feeding had to replace breast-feeding much earlier in order to free the mother to look for work and augment her migrant husband's meagre wage. For rural villages

124 WHO, *Apartheid and Health*, p.25.

125 Interview with Matron Mabindiza, 1/12/2004.

126 J.G. Cleland and J.K. van Ginneken, "Maternal Education and Child Survival in Developing Countries: The Search for Pathways of Influence", *Social Science and Medicine*, vol. 27 (1988), 1357-1368.

such as Borolo referred to above, the availability of clean water for the hygienic preparation of powdered milk was even more critical. Used for this purpose, clean water is therefore critical to the mother's capacity to nurture the child within acceptable health standards. A closer examination of the most common causes of child deaths between blacks and whites also reveals striking racial differentials. For example, while for whites the common killers were peri-natal problems associated with breathing at birth, for black children, pneumonia and gastroenteritis remained predominant in the period under review.<sup>127</sup>

Like the infant mortality rates, overall mortality figures in South Africa covering the period under investigation are at best averages, which do not only cover wide variations between one area and another, but are also based on very incomplete samplings. Therefore, without seeking to downplay the debate around the reliability of the infant and child mortality figures provided by the medical officers of health, the 7.71 per 1 000 in 1960<sup>128</sup> and 6.01 per 1 000 in 1970<sup>129</sup> for the White population compares very favourably with the mortality figures of the populations of the developed countries during the same period. In contrast the mortality figures for the black population, though unavailable for the entire country and grossly inaccurate where available, have always been higher and reflect the general mortality situation in the rest of the developing world.

#### **4.4.3 Life expectancies of black and white South Africans**

Another important demographic factor that is also considered to be a reliable measure of the level of general health of a population, second to mortality and morbidity rates is the life expectancy.<sup>130</sup> This may be defined as an average number of years from birth which members of a population group may be expected to live.<sup>131</sup> With very few exceptions, in the majority of pre-industrialised and industrialised societies, females live longer than males. After World War II female life expectancies continued to rise to about seven years or longer than that of men and this difference was attributed to men's behaviour relating to participation in the industrial market economy (smoking, alcohol, work and traffic accidents).<sup>132</sup> Based on the

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127 Interview with Matron Mabindisa, 1/12/2004.

128 Department of Statistics, *South African Statistics 1968* (Pretoria, Government Printer, 1969), p. 20.

129 Department of Statistics, *South African Statistics 1974* (Pretoria, Government Printer, 1975), p. 325.

130 Alta van Wyk, "Significant Trends," *South African Panorama*, vol. 33, no. 7 (July 1988), p. 20.

131 Interview with Matron Mabindisa, 1/12/2004.

132 WHO, *World Health Annual Statistics* (Geneva, WHO, 1992).

understanding that cumulative differential lifetime exposure to health-damaging or health-promoting physical and social environments is the main explanation for the variation in health and life expectancy,<sup>133</sup> there can be little doubt that the constant exposure to a number of risk factors at different stages of an African males's life during apartheid lay at the root of the shorter life expectancies of this population group. The following table gives an indication of the impact of apartheid by indicating huge discrepancies that existed between blacks and whites, with whites having the longer life expectancy.

**Table 4.6 Life expectancies at birth**

Period	Whites (Male/Female)	Africans (Male/Female)
1959-1961	64.73 / 71.67	44.0 / 46.0 <sup>134</sup>
1969-1971	64.50 / 72.28	49.0 / 51.0 <sup>135</sup>

From the following table, it is clear that although there has been a steady increase in life expectancy for both black and white South Africans, the discrepancies between these groups remained considerable. What is even more revealing is the fact that while it is generally accepted that women outlive men everywhere except in Bangladesh, Maldives and Nepal,<sup>136</sup> in apartheid South Africa, white men outlived even black females by about 20 years. One explanation for this may be that the significant role played by indigenous medicine in childbirth during the period under review clearly implies that very few African women enjoyed the advantages of modern obstetric services during pregnancy and childbirth. According to Matron Mabindiza, many African women died in childbirth largely because of complications for which modern medicine had long offered solutions.<sup>137</sup> Consequently, the average duration of life for white South Africans compares favourably with that of citizens of the developed countries, while the average duration of life for Africans, despite the steady increase, remained similar to that of most developing nations. Although the following table reflects a much lower life expectancy in South Africa's neighbouring countries as compared to that of black South Africans, I still insist that the relative wealth of South Africa at the time

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- 133 Great Britain Department of Health, *Variations in Health* (London, Department of Health, 1995), p. 158.  
134 Department of Statistics, *South African Statistics 1968*, p.18. See also, SAIRR, *Race Relations Survey 1959-1960*, p.241.  
135 Department of Statistics, *South African Statistics 1974*, p.323.  
136 N.D. Lewis and E. Kieffer, "The Health of Women Beyond Maternal and Child Health" in Phillips and Verhasselt, *Health and Development*, 122-137, p. 124.  
137 Interview with Matron Mabindiza, 1/12/2004.

does not permit this kind of comparison.

**Table 4.7 Life expectancies in selected developing countries 1965-1970**

Country	Average life expectancy
Lesotho	43.5 Years
Mozambique	41.0 Years
Swaziland	41.0 Years <sup>138</sup>

#### 4.5 Some culturally defined conditions/syndromes

As will be demonstrated in chapter six, health beliefs constitute an integral part of religious belief systems and explanations for the causes of health problems are central to this belief system. Africans generally classify causes of diseases into natural diseases, or diseases of God, diseases resulting from ancestral spirits because of neglect of some ritual, as well as diseases or illnesses caused by active, purposeful interventions by a human agent (a witch).<sup>139</sup> These are illnesses and conditions among Africans about which modern medicine can do very little if anything; require cultural methods of treatment which is the competency of indigenous healers. As Simon Malope puts it, “it is impossible to think about *malwetši a batho* (illnesses of people) as opposed to illnesses of God, without at the same time thinking about the services of an indigenous healer”.<sup>140</sup> Indigenous healing is always imbued with a religious basis and is enhanced by rituals. According to Justice Mgidi, stress associated with poverty and powerlessness leads to the majority of these culture-bound syndromes, such as *mafofonyane* (spirit possession) and the need for *ukuthwasa*.<sup>141</sup> Because most of these conditions cannot be addressed through modern therapeutic techniques, the indigenous healer has always been the only practitioner of choice.<sup>142</sup> Because the indigenous healer first determines the cause of a given problem – particularly when the cause appears to be something other than natural – before attempts are made to deal with the illness, patients often find him more reassuring than they would reasonably expect from the modern doctor.

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138 A.R.P. Walker, “Studies Bearing on Coronary Heart Disease in South African Population”, *South African Medical Journal*, Vol.47, No.3 (1973), pp.85-90.

139 Hammond-Tooke, *Rituals and Medicines: Indigenous Healing in South Africa*, p. 73.

140 Interview with Simon Malope, 11 December 2006, Borolo, Mpumalanga Province.

141 Interview with Justice Mgidi, 11/10/ 2006, Kameelrivier “B”, Mpumalanga Province.

142 E.L. Kharlson and K.E.M. Moloantoa, “The Traditional Healer in Primary Health Care: Yes or No?”, *Nursing RSA/Verpleging*, vol. 1, no. 2, 26-29, p. 27.

According to Robin Horton, this type of theoretical explanation is regarded as a coping mechanism which reduces anxiety.<sup>143</sup> The indigenous diviner is actually the only channel through which the ancestral spirits communicate.<sup>144</sup> Modern medicine had always been preoccupied with the question of why African patients often default or are lost to hospital treatment. And yet modern medicine remains reluctant to accept that such patients may have changed to indigenous medicine either because modern medicine was perceived to be ineffective, or the patient was relocated away from the health facility, in the process of implementing other apartheid programmes.

Other conditions that are deemed suitable for treatment exclusively by the culture's indigenous healer involve problems of sexual dysfunction and sterility. According to Hlathikhulu, some indigenous healers even specialise in barrenness, a condition for which modern medicine during the period under review could offer very little assistance.<sup>145</sup> In an investigation of the Hausa of the West African savannah, Murray Last found that "loss or lack of children is the commonest cause for seeking treatment by spiritual possession ... of getting oneself in harmony with the disease spirits".<sup>146</sup> Besides these, there are numerous other illnesses that generally afflict poverty-stricken societies that modern medicine does not consider treatable; many of these are treated with varying degrees of success by the use of indigenous therapies.<sup>147</sup>

#### 4.5 Conclusion

In conclusion, it is not out of place to reiterate that in all human societies, epidemics do not occur in a vacuum but are often the culmination of social and political developments that are incompatible with the promotion of health or the prevention of disease. For example, epidemics such as tuberculosis, syphilis and now HIV/AIDS all occur and spread within a particular socio-economic context. From this assertion, it may be concluded that the

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143 R. Horton, "African Traditional Thought and Western Science", *Africa*, vol. 37, no. 1 (1967), 50-71, p. 60.

144 Hammond-Tooke, *Rituals and Medicines*, p. 51.

145 Interview with Ngaka Hlathikhulu Ngobeni, 14/8/2005.

146 M. Last, "The Presentation of Sickness in a Community of Non-Muslim Hausa", in J.B. London (ed), *Social Anthropology and Medicine* (New York, Academic Press, 1976), 104-149, p. 129.

147 For an indepth exploration of these diseases and conditions, see, Ngubane, "Some Aspects of Treatment Among the Zulu", London, *Social Anthropology and Medicine*; Shai-Mahoko, *The Role of Indigenous Healers in Disease Prevention and Health Promotion*; L.F. Snow, "Voodoo Illness in the Black population", N. Klein (ed), *Culture, Curers, and Contagion: Readings for Medical Social Science* (California, Chandler & Sharp, 1979), p.179.

relationship between health and social well-being is reciprocal. If this is true, then the prevention or treatment of disease must necessarily begin with the disease-producing factors and influences rather than trying to treat the symptoms. This understanding clearly distinguishes the approach of the practitioners of indigenous medicine from those of modern medicine in that the main concern of indigenous practitioners is the whole patient and his environment. With regard to the system of taboos and fortification, they contribute in very significant ways to the prevention of disease.

It has become clear in this chapter that black South Africans manifested the disease profile of developing agrarian societies, while the disease profile of their white counterparts was characteristic of modern, industrialised and urbanised societies. Whereas official explanations for the dismal health conditions presented here tended to associate the health problems of black South Africans with the traditional health profile of developing countries in general, the fact that in this country there were marked discrepancies between the health of the different racial groups confirms the contention held throughout this thesis that the adverse health situation in South Africa during the period 1948-1976 was directly and sometimes indirectly related to the Nationalist policies of apartheid. Although medical services in themselves do not guarantee a healthy population, it can hardly be contested that certain kinds of medical intervention have been extremely significant in the reduction of disease and mortality in the population. A classic example of this was the eradication of smallpox. And although tuberculosis, typhoid, syphilis and other infectious diseases are still major killers of the poor worldwide, there is no question that with government commitment to preventive rather than curative measures, these diseases of poverty can be addressed. Furthermore, through population-based interventions such as the development of water and waste-disposal systems, the introduction of mass immunisations and major improvements in levels of nutrition, mankind has managed to control and in some cases prevent major and lethal infectious diseases that have troubled societies over the years.<sup>148</sup>

Ironically, however, in spite of all such advances, apartheid has ensured that black South Africans still had to confront most of these preventable diseases that are associated with poverty. For much of the mid-twentieth century, cancer was the disease which carried the awe, symbolism and threat that tuberculosis possessed a hundred years before. However, the arrival of AIDS from the mid 1970s introduced a sinister new contestant for cancer's crown

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148 Phatlane, "Poverty and HIV/AIDS in Apartheid South Africa", p. 74.

with an epidemic that poses an even greater demographic danger than tuberculosis and cancer combined. It is the contention of this study that without a deliberate mobilisation of all role players in health care, both modern doctors and indigenous healers, no health care system, no matter how developed and equitable it is, can deal effectively with the burden of illness in a society with a history of division and inequality such as South Africa. NP policies of apartheid created conditions that trapped the majority of the black population in poverty and ill health. To manage these more is needed than modern medicine and its curative inclinations.

This chapter sought to establish a link between apartheid-created poverty and disease. In doing this, it argues that through deliberate social policies of population resettlement, the job colour bar, influx controls and migratory labour discussed in chapter, which in turn resulted in overcrowding and physical impoverishment, particularly in the rural bantustans, the National Party government laid a firm foundation for tuberculosis, typhoid, gastroenteritis, cholera, diarrhoea, and many other diseases that afflicted the majority of the population. Though most of these diseases were largely preventable and treatable, they remained great killers of black South Africans because the apartheid policies provided an easy grip in a population already caught up in poverty and malnutrition inherited from the pre-apartheid period. Existing scientific evidence suggests that it is possible to be infected with tuberculosis but not become ill, because of a strong immune system. But one becomes ill when the body's defences weaken, due largely to malnutrition and other aspects associated with poverty.<sup>149</sup> In the South African context, this partly explains the tragedy of tuberculosis, as the handmaiden of HIV/AIDS which, though not directly resulting from apartheid policies, it was nevertheless given a head-start by apartheid policies of relocation and poor housing for Africans. Although TB can be cured, the cure depends on the patient taking a full, regular course of treatment without any interruption. But if the patient stops the treatment because of relocation to a rural bantustan, for example, where there were often no facilities, lack of transportation and other impediments, the bacteria would almost inevitably develop resistance to the medication, thus resulting in a more serious form of the disease. At this stage, follow-up sputum tests to check one's progress are also essential, but logically, having been forcibly removed from the necessary facilities, such follow-up would be impossible. Admittedly, the health problems of black South Africans under apartheid were not confined to infectious diseases, but it is these that have been given the most attention in this chapter primarily because they reflect the

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149 Interview with Dr Magampa, 4/2/2000.

pervasiveness and degree of ill health and poverty in South Africa.

Thus, one may say, in the same way that infectious diseases throughout history have tended to disproportionately decimate the most vulnerable sections of the population, apartheid has, through the creation of impoverished bantustans and many other instruments of social control, provided the framework within which the contemporary epidemic of HIV/AIDS now fulfils this role. It is within the same context that diseases of poverty such as tuberculosis, gastroenteritis, typhoid fever and many others occurred. Explanations for the rapid spread of HIV/AIDS should be understood in the same manner. Apartheid created for the majority of black South Africans a social and economic environment fraught with risks, one in which any infectious disease could rapidly develop into an epidemic. Given the disruptive consequences of the migrant labour system on the African family unit, it is no coincidence that the current HIV/AIDS statistics involving black South Africans are so alarming. Both the living and working conditions of black South Africans from 1948 to 1976 encouraged a pattern of behaviour that facilitated the spread of HIV/AIDS and also thwarted preventive efforts that might have proved successful elsewhere. Therefore like other diseases and conditions discussed in this chapter, the epidemic of HIV/AIDS and the disproportionate way in which it decimates the black population more than the white population suggests some continuity rather than a break with previous experiences of epidemics. Unlike previous epidemics, in South Africa AIDS is also a symptom of a history of dispossession and oppression which, though first recognised in the early 1980s, nevertheless had its roots in the period under review here. And it is a problem of such proportions in South Africa primarily because it is linked to inequality and poverty, features that have been characteristic of the country for a period of over 40 years. Indeed, poverty increases an individual's vulnerability to HIV and other infections by decreasing access to good nutrition, by limiting access to health care, by limiting access to treatment for sexually transmitted infections (STIs) as well as by necessitating migration for employment. Poverty also makes it more likely that women will engage in survival sex to provide for their children.<sup>150</sup> The sad reality is that in spite of the availability of some drugs that can at best delay the progression from HIV to AIDS, it has been reported that some poverty-stricken HIV patients were reselling their drugs in order to get money for food.<sup>151</sup> The implication here is that for most people in these circumstances, the

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150 A.S. Patterson, "Introduction: The African State and the AIDS Crisis", in A.S. Patterson (ed), *The African State and the AIDS Crisis* (Aldershot, Ashgate, 2005), p. 3.

151 *The Saturday Star*, 13 July 2002.

need to take survival drugs competes with the urgent need to buy other survival items like food. The dilemma of the people in this situation is captured in the desperate remark: “It is better to die in 15 years time of AIDS than in 5 days time of hunger”.<sup>152</sup> Of course it would be irresponsible in the extreme to ignore the impact of the ineffective policies and prevention strategies of the post-1994 governments, as well as the contradictory messages of the political leadership in the proliferation and spread of HIV/AIDS in South Africa. An increasing volume of evidence point to the failure of the post-apartheid government’s efforts to deal with the disease. Therefore without suggesting that apartheid is responsible for the alarming HIV/AIDS figures in South Africa, my inclusion of HIV/AIDS in the thesis on poverty, health and disease during apartheid is merely informed by its close links with inequality and poverty. In this way, the impact of the ineffective state policies on AIDS in the post-apartheid period cannot be overemphasised. Though it fall outside the scope of this thesis, my brief reference to HIV/AIDS in this study is mainly intended to emphasise the long term impact of apartheid on health and disease among black South Africans. It would seem, however, that if the epidemic has anything to change in terms of man’s concern with disease, it would probably be the thinking that it is acceptable that the rural poor (black) should die for lack of health care; health care that the urban wealthy (white) have always taken for granted.

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152 Phatlane, “Poverty and HIV/AIDS in Apartheid South Africa”, *Social Identities: Journal for the Study of Race, Nation and Culture*, p.86.

## CHAPTER 5

### THE IMPACT OF APARTHEID ON MEDICAL RESEARCH, EDUCATION AND PRACTICE

Racial relations cannot improve if the wrong type of education is given to the Natives. They cannot improve if the result of Native education is the creation of frustrated people who as a result of the education they received, have expectations in life which circumstances in South Africa do not allow to be fulfilled immediately; when it creates people who are trained for professions not open to them. What is the use of subjecting a Native child to a curriculum which in the first instance is traditionally European ...? What is the use of teaching a Bantu child mathematics when it cannot use it in practice ...? Education must train and teach people in accordance with their possibilities in life ...<sup>1</sup>

#### 5.1 Introduction

The health of the country's population is a significant test of the effectiveness of that country's health services. If the services are poor the health of the population is more likely to be poor too. Throughout the Western world doctors are perceived to be the best qualified to ensure people's health; hence inadequate supply of doctors signifies the virtual collapse of the health services. Yet the philosophers of ancient times (with whom this study agrees) believed that doctors would not be in great demand in a society that was well governed. And it was Plato himself who considered the need for many doctors and hospitals as a sign of a sick society.

It would be remembered that just prior to apartheid, the National Health Services Commission had already noted that a national health service could not be planned, still less be carried out, without taking into account the numbers of medical and other necessary personnel available at the time and in the near future. According to the commission, availability of personnel, rather than finance, was the main limiting factor.<sup>2</sup> In spite of this warning, more than half of the country's doctors still practice in the private sector, therefore serving the medically insured and affluent 20% of the population. Historically, it was the colonisation of the Eastern Cape

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1 H.F. Verwoerd, quoted in UG, *House of Assembly Debates*, vol. 83 (Pretoria, Government Printer, 1953), cols 3576-3586. For an exploration of the implications of this statement on black education see Brian Rose and Raymond Tunner (eds), *Documents in South African History* (Johannesburg, AD. Donker Publisher, 1975), pp. 258-267.

2 UG 30-44, The Gluckman Report.

that led to the establishment of a number of hospitals and South Africa's first medical school in 1858, while the discovery of diamonds and the concomitant explosive growth of squalid, overcrowded towns during the second half of the nineteenth century necessitated the establishment of the first nursing school in the country.<sup>3</sup> Yet no analysis of the health problems of black South Africans and of the causes of their poverty can ignore the consequences of the philosophy and practices of the NP's education system. Indeed, the radical changes to South Africa's educational policy after 1948 had a profound impact not only on education in general but also on black medical education in particular. Education does not exist in a vacuum but reflects the broad social, economic and political structure of the country it serves. As pointed out in chapter two, the issue of black medical education had already been the subject of government commissions and academic comment long before the coming to power of the Nationalists.<sup>4</sup> Therefore, much as it might be convenient to blame poverty for the low number of African medical personnel, it is important to note that in terms of medical education blacks have actually been the victims of their marginal position in national politics since Union. After 1948 the ideology of apartheid not only compounded the inherent inequalities in the provision of health care along race, gender and class lines, but also the development of human resources for health along similar lines. Indeed, the Nationalists institutionalised and systematically excluded blacks from the few medical training facilities that whites could count upon, primarily because official policy would not permit this. This has indeed led to the manifold dilution of the benefits of medical science for a major section of the community. Snyman refers to the growing gap between the vast store of benefits which modern medicine had to offer and the translation of this into actually available medical care and concludes that this gap was one of the most potent political forces leading to the socialisation of medicine.<sup>5</sup>

Thus, the fundamental explanation for the poor health status of black South Africans as revealed in the previous chapter was the fact that the country's health structure within the apartheid context was fragmented and poorly distributed in relation to health needs. It was a

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3 P.W. Laidler, *South Africa: Its Medical History 1652-1898: A Medical and Social Study* (Cape Town, Struik, 1971).

4 UG 1928, *Report of the Committee Appointed to Inquire into the Training of Natives in Medicine and Public Health* (Loram Committee Report); B.K. Murray, "The 'Liberal' University: Questions of Discrimination at Wits 1922-39", *Wits History Workshop*, 5-9 February 1981; Charlotte Searle, "Second-Class Doctors and the Medical Assistant in South Africa", *South African Medical Journal*, vol. 47, no. 4 (1973).

5 H.W. Snyman, cited in J. Marshall (ed), *Essays on Tropical Dermatology*, vol. 2, pp. 447-48.

health system characterised by one sector of the population (for the most part urban and white) having a first rate health care system, comparable with the best in the world, co-existing side by side with another sector of the population (largely rural and black) with a typical Third World health structure.<sup>6</sup> Since medical manpower constitutes one of the critical components of this health profile, the scarcity and sometimes total lack of medical personnel and health care facilities within this structure was a major constraining factor in the development of South Africa's health system during the period under review. Although this problem has frequently been attributed to the geographic maldistribution of the health personnel rather than their total absence, this chapter seeks to show that the most critical determinant of availability of medical manpower for black communities during this period was in many ways the NP government's commitment to apartheid in education. Scholars like Muriel Horrell,<sup>7</sup> Bruce Murray and others,<sup>8</sup> have frequently exposed the forms of discrimination in education, and have shown that these aberrant systems were in place in South Africa long before the advent of apartheid. Clearly exposing the irrelevance of the country's medical curriculum to the local situation, Howard Phillips was even more blunt by suggesting that the training offered by South African medical schools over the years had been more useful abroad than locally.<sup>9</sup> With this in mind, this chapter will focus on the contribution that apartheid itself made in furthering these discriminatory practices both in the production of the health personnel and in the practice of medicine during the period 1948-1976. While it is understandable that members of the medical profession usually deploy themselves not where their services are needed the most, such as in the rural areas,<sup>10</sup> but rather where the people can afford such services (the urban areas), it is contended here that the problem of inadequate supply of health manpower in the rural areas was largely a function of apartheid.

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6 P.N. Pillay, "The Distribution of Medical Manpower and Health Care Facilities in South Africa", Second Carnegie Inquiry into Poverty and Development in Southern Africa, Conference Paper no. 167, 13-19 April 1984, p. 19.

7 M. Horrell, *African Education: Some Origins and Development Until 1953* (Johannesburg, SAIRR, 1963); M. Horrell, *Bantu Education to 1968* (Johannesburg, SAIRR, 1969); M Horrell, *A Decade of Bantu Education* (Johannesburg, SAIRR, 1964).

8 Murray, "The 'Liberal' University"; E.J. Murphy, *Bantu Education in South Africa: Its Comparability with the Contrasting Objectives of African Self-Development or White Domination* (PhD thesis, University of Connecticut, 1973); F.E. Auerbach, *The Power of Prejudice in South African Education* (Cape Town, A.A. Balkema, 1966); A.N.P. Lubbe, *Bantu Education in the Republic of South Africa* (Johannesburg, Erudite Publications, 1969).

9 H. Phillips, "Home Taught for Abroad: The training of the Cape Doctor, 1807-1910", Deacon et al., *The Cape Doctor*, pp.105-131.

10 Considering the high unemployment rate in the rural areas, it was logical that people who could afford a fee for service medical care would be in the urban areas. Therefore, without a conscious and perhaps deliberate state encouragement, the medical manpower tends to be concentrated in certain geographical areas and not in others.

## 5.2 Apartheid and the provision of medical personnel

### 5.2.1 The training of African nurses

In the words of Joseph Lister, the father of the antiseptic movement, the greatest discovery made by medical science during the nineteenth century was “the discovery of the professional trained nurse who has helped the medical practitioner to revolutionise the care of the sick, to extend his own sphere of usefulness, to increase his personal income and to apply his scientific discoveries to patient treatment”.<sup>11</sup> Indeed, the nursing service, as the extended arm of medicine is the largest single service in the hospital and nurses are therefore the largest occupational group in the health sector. Although professional training for White nurses in South Africa dates back to the 19<sup>th</sup> century through the work of Sister Henrietta Stockdale, such training was not available to blacks until towards the close of the century. It is interesting to note that with the adoption by the Cape colonial government of legislation providing for the registration of medical practitioners, dentists, nurses and midwives etc, Act No 34 of 1891, South Africa became the first country in the world to pass a law recognising the legal status of nursing in South Africa. Without any reference to race, this law had a profound influence on the training of black nurses in subsequent years. It became possible from 1891 for black women to qualify as professional nurses.<sup>12</sup> Although according to Shula Marks,<sup>13</sup> in the first part of the twentieth century, the majority of professionally trained nurses in South Africa were still white, a number of factors beyond the scope of this thesis helped to accelerate the training of black nurses in subsequent years. These included the Loram Commission in 1928,<sup>14</sup> and the Gluckman Commission in 1944, both of which brought pressure to bear on the authorities to step up the training of black nurses in an effort to provide adequate health services for their own people.<sup>15</sup> With the Nursing Act, No.45 of 1944, the South African Nursing Council (SANC) and the South African Nursing Association were established.<sup>16</sup> Under the control of SANC, nursing education for blacks increased. By the time of the NP victory in 1948 there were 1 646 black student general nurses and 164 student midwives, but

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11 Joseph Lister, quoted by Searle, *The History of the Development of Nursing*, p. 283.

12 T.G. Mashaba, *Rising to the Challenge of Change: A History of Black Nursing in South Africa* (Cape Town, Juta, 1995), p. 9.

13 Marks, *Divided Sisterhood*, p. 78.

14 UG 35-28, The Loram Committee Report, 35/1928.

15 UG 30-44, The Gluckman Report, 1942-1944.

16 Mashaba, *Rising to the Challenge*, p. 33.

by 1954 the number had risen to 1 900 and 250 respectively.<sup>17</sup> The more industrialised the country became, the more the need arose to train an increasing number of black nurses to cope with the unabating incidence of disease in black communities. The most problematic areas were those of malnutrition, infantile gastroenteritis and tuberculosis. According to Grace Mashaba, by 1965 there were 35 training schools and 31 training hospitals for black nurses in South Africa.<sup>18</sup>

During this period, nursing education was being carried along on the crest of the wave of medical, educational and technological advances. There was also an expansion of health services for black people, although within the framework of the National Party's apartheid ideology. Ironically however, in the forefront of those agitating for the segregation of the nursing profession was the well-respected Charlotte Searle,<sup>19</sup> who somewhat surprisingly subscribed to the idea that there should be a separate syllabus for black nurses, under the pretext that there should be more attention paid to the "civilising aspect" of their training.<sup>20</sup> It was felt at the time that the existing mission hospitals were not suited to fulfil this apartheid role. Consequently, in 1964 the apartheid government accepted responsibility for the capital expenditure of mission hospitals and from 1970 assumed full control, taking them over from missionary supervision with a view to transferring these hospitals into the rural bantustans. In keeping with apartheid policy, the education and training of black nurses was transferred almost completely from the mission authorities to the state and provincial authorities. Although in 1970 the educational standard for admission to nurses' training was raised from standard VIII to standard 10 (matric), there was still no university offering a degree course for black student nurses.<sup>21</sup> Similar to the case of medical education however, within the nursing profession the apartheid division based on skin colour continued to characterise both training and practice. This explains why by the 31 December 1970, of the 36 931 registered nurses in South Africa 24 808 were White while only 12 123 were Black.<sup>22</sup>

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17 E.W. Petersen, "African Nurse Training – Ten Years of Progress", *Medical Proceedings*, vol. 4 (1958), 327-36.

18 Mashaba, *Rising to the Challenge of Change*.

19 Both as a director of Nursing Services in the Transvaal and as a leading member of the South African Nursing Council and the South African Nursing Association, Searle played a crucial role in training and upgrading the qualifications of even those she had once argued were "incapable of becoming 'true nurses'". See Shula Marks, *Divided Sisterhood*, pp. 180-81.

20 Marks, *Divided Sisterhood*, pp. 98-99.

21 Mashaba, *Rising to the Challenge of Change*, p. 64.

22 Searle, "Second-Class Doctors and the Medical Assistant in South Africa", p. 512.

### 5.2.2 Debates about medical assistants

There has always been the recognition that even if a sufficient output of doctors were possible for all sections of the population, it would be undesirable to have doctors handling all aspects of health services. This would be grossly uneconomical because many aspects of medicine do not require the unique expertise of the doctor, but are safely and efficiently performed by less highly trained personnel at far less cost to the consumer.<sup>23</sup> With this in mind the idea of introducing a category of health worker called a “medical assistant” dates back to the pre-apartheid period. It will be remembered that since the publication of the Loram Committee Report in 1928 the whole question of medical training for black South Africans had been a matter of national debate.<sup>24</sup> While the Loram Committee insisted that blacks were to be trained to the same standards required of white doctors, it soon became evident that people like Sir Edward Thornton, the Union’s senior health officer at the time, had other ideas. Thornton proposed instead that blacks should be trained not as medical practitioners but as auxiliary medical officers. While this approach might have relieved the shortage of medical manpower among Africans, it was the reasoning and motivation in support of the idea that discredited the value of such a category of health worker – it was couched within the segregationist framework. A scheme such as this, Thornton contended, would not only help to keep down costs but would also ensure that blacks would not be able to compete with white doctors in urban areas.<sup>25</sup> However, arguing that the problems of health and disease were the same among blacks as well as whites, thus requiring the same skilled treatment, the committee contended that blacks would not accept anything inferior. As a compromise, the committee maintained that since the training of black doctors would be a long and slow process, a crash-course programme should be launched for training medical assistants.<sup>26</sup> These assistants would practice under delegated authority from a medical practitioner. However, available evidence suggests that until the 1970s, this idea of medical assistants or so-called “second-class” doctors had still not received widespread support, particularly within the nursing profession. Nurses argued that they were bound to receive instructions for the care of the patients only from registered medical practitioners or dentists, not from any other person. They argued that these were the only persons authorised by law to practice medicine or dentistry, and taking

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23 The principles of primary health care recognise the contribution of other health care providers other than an expensive, highly trained and sophisticated medical practitioner. Similarly, the idea of utilisation of indigenous healers, to be discussed in the next chapter, seeks to point to the existence of an alternative health resource that could be exploited in the interest of the consumer.

24 See UG 35-1928, *Report of the Committee Appointed to Inquire into the Training of Natives in Medicine and Public Health*, pp. 4-7.

25 UG 35-1928, Loram Committee Report, Appendix 3.

26 UG, 35-1928, Loram Committee Report, 8-9 and 19-22.

instructions from less qualified people was unacceptable.<sup>27</sup> Nevertheless, the nursing profession supported the idea of a health assistant as proposed by the Snyman Commission for purposes of follow-up work on tuberculosis patients, control of environmental health hazards, for immunisation campaigns, and for general health education.<sup>28</sup> Be that as it may, the idea of medical assistants, which involves a shorter period of training, was not entirely without merit if it was designed to address the acute shortage of health manpower, particularly among rural black communities. Perhaps what discredited the idea was the fact that it was suggested as an alternative to quality health care and was a provision made specifically for black South Africans rather than for all population groups. It is within this context of alternative practitioners that this study suggests the utilisation of indigenous healers as alternative providers of health care. There seems to be consensus in the literature that indigenous healers may be an indispensable element in the success of the provision of primary health care.<sup>29</sup>

### **5.2.3 The training of African doctors**

Although the gross inequalities with regard to health care personnel in South Africa pre-dated the coming to power of the National Party, as these had already been acknowledged by the Gluckman Commission as early as the 1940s, when they took over from the United Party in 1948, the Nationalists also neglected their duty to provide adequate and equal opportunities for medical education to the African population. In chapter two of this study I referred to the work of the Loram Committee and earlier efforts to provide a separate medical training facility for Africans. Although the change in government did not automatically jeopardise the plans that were already under way, the Nationalists undertook to provide funds for such a school for Africans in Durban on condition that it would be an exclusively “black medical institution”, in line with the apartheid programme. In fact much of the funding behind the University of Natal’s black medical school came from the Rockefeller Foundation, with a grant that lasted for the crucial first five years of the institution’s existence. Rockefeller’s interest stemmed from his ties with the medical school’s senior official, John Grant, who was closely involved in social medicine in South Africa and particularly Grant’s collaboration with George Gale, the Secretary for Public Health since the mid-1940s (until his resignation in the early 1950s to

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27 Searle, “The Second-Class Doctor and the Medical Assistant in South Africa”, p. 511.

28 Ibid., p. 512.

29 See I. Wolffers (ed), *The Role of Traditional Medicine in Primary Health Care* (Amsterdam, VU University Press, 1990); Makoa, *Collaboration Between Traditional Healers and Nurse Practitioners in Primary Health Care in Maseru Health Service Area - Lesotho*; O. Akerele, “The Best of Both Worlds: Bringing Traditional Medicine up to Date”, *Social Science and Medicine*, vol. 24, no. 2 (1987), pp. 177-81.

become the Natal Medical School's first Dean), as well as with the Karks and others. Indeed, without these initiatives, which were launched before 1948, and without the co-operation of E.G. Malherbe, vice chancellor and principal of the University of Natal, it is doubtful that a black medical school would ever have been established at the time. Prior to 1960, universities in South Africa could be grouped into English language universities and Afrikaans universities. Though Africans could register for studies at the open universities of Cape Town and the Witwatersrand, the University College of Fort Hare, which did not offer medical courses, was the only institution devoted exclusively to African higher education.<sup>30</sup> The eventual opening of the Natal Medical School in 1951 under the control of the University of Natal,<sup>31</sup> meant in effect that the open universities (Wits and UCT) could not legally admit black students any longer.<sup>32</sup> But because there was no legislation yet preventing this, the Wits Medical School continued to admit eligible black applicants until 1966. In demonstration of a total disregard for university autonomy, and under the ineptly-named Extension of University Education Act of 1959, the Nationalist government legislated that those blacks who wished to train at the universities of Cape Town and the Witwatersrand had to first obtain ministerial dispensation.<sup>33</sup> Ironically therefore, the legislation was designed not to extend university education, but to shut the doors of mixed universities to black medical students.

For the period 1948-1976, then, the Natal and the Wits medical schools produced a combined total of 271 African medical graduates.<sup>34</sup> But in the period since the establishment of the Natal Medical School, in other words the period from 1951 to 1976, when most blacks obtained their medical training at the school, only 218 blacks had qualified, a figure representing a paltry 1% of the total number of white doctors over the same period.<sup>35</sup> It is therefore evident that this school was not a significant addition to the existing medical training avenues for Africans.

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30 A.L. Mawasha, "Turfloup: Where an Idea was Expressed, Hijacked and Redeemed", in M. Nkomo et al (eds), *Within the Realm of Possibility: From Disadvantage to Development at the University of Fort Hare and the University of the North* (Cape Town, HSRC, 2006), p. 66.

31 For a brief account of early developments at this school see, Sidney and Emily Kark, *Promoting Community Health: From Pholela to Jerusalem* (Johannesburg, Witwatersrand University Press, 2001), pp.177-190.

32 SAIRR, *Survey of Race Relations, 1961*, p. 261.

33 UG, *House of Assembly Debates* (Pretoria, Government Printer, 1959), see also SAIRR, *Survey of Race Relations, 1961*, p. 261.

34 Seedat, *Crippling a Nation: Health in Apartheid South Africa*, p. 85.

35 WHO, *Apartheid and Health*, p. 224.

In order to understand the impact of apartheid in the production of black medical graduates, Philip Tobias has conveniently divided the period into 1946-1951, when Wits alone was training black doctors; the period from 1951 to 1966 when both Wits and Natal were doing the training, and thirdly, the era from 1967-1976 when Natal was the only institution producing black medical doctors. For the first period, according to Tobias, the average annual output was 13.2, while for the final period, the average output had virtually dropped to 11 per annum.<sup>36</sup> If statistics are anything to go by, these figures suggest that in the period before 1976 there was a sharp decline in the absolute number of black medical graduates each year, despite the country experiencing one of the highest annual increases in the black population. But if one notes the alarmist words of De Wet Nel, the minister of Bantu Development at the time, this was not surprising: "If the non-whites are allowed to enter the universities, most of the students in the near future will be non-white, with full control ... As long as the National Party remains in power, it will strive for university apartheid".<sup>37</sup>

Thus, upon the recommendations of a number of government commissions at the end of 1973, the minister of Bantu Education, M.C. Botha, requested G.J. Rousseau and other officials in his department to draw up a coordinated report on all previous investigations regarding the training of Africans in medicine. Subsequently, the Rousseau Report, which appeared in 1974 recommended the establishment of an independent inter-ethnic university for Africans. The site was to be the newly completed Garankuwa Hospital bordering the Bophuthatswana bantustan. In October 1974 cabinet formally approved the establishment of the Medical University of Southern Africa (MEDUNSA), the establishment of which was duly approved by parliament in 1976.<sup>38</sup> Subsequently, with Pretoria keeping a tight control on student selection and staff appointments, it can hardly be denied that the character of the new university was that of an apartheid institution with limited academic freedom or institutional autonomy. The university held little threat for white domination within and through the medical profession, given the number of medical schools available to whites at the time. In fact, within the cloisters of the profession, it can be concluded that the ideology of white supremacy remained unaffected by the creation of this exclusively African medical institution. Important though this institution was, there is no question that the number of doctors it produced annually did not keep pace with the growth of the black population. If one takes into

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36 Tobias, "Medical Education for Africans and Others", *Auricle*, May 1974, p. 4.

37 *The Argus*, 3 October 1959.

38 L. Taljaard, "An Historical Overview: Medunsa and Black Medical Education", *Journal of the Dental Association of South Africa*, vol. 42, no. 10 (1978), p. 581.

account the number of medical schools available to whites throughout the country, *vis a vis* the total white population, it stands to reason that MEDUNSA alone would do very little to relieve the need for health personnel among black communities.

Be that as it may, it is contended here that in the light of the strong prejudice against practitioners of indigenous medicine by modern doctors, it would be logical to expect a medical institution dedicated to the medical education of Africans to conscientise its graduates about the place of indigenous medicine in their culture, through modification of their training.<sup>39</sup> Awareness of the role of indigenous healers would no doubt provide modern doctors with insights into why, and at what stage in the illness episode, patients consult with indigenous health care providers. This would also help them to understand aspects of patient dissatisfaction with modern medicine.

### **5.3 The impact of Bantu Education**

Until 1953, Africans in South Africa were experiencing the same general process of educational and social development that had been characteristic of the rest of Africa despite a comprehensive system of racial segregation, great inequities between Black and White, and stringent curbs on African upward mobility. The content and structure of education for Africans was similar to that of education for Whites and showed many similarities to those available in other parts of Black Africa.<sup>40</sup> But after 1953 the reality of white control meant that African education was used to pursue developmental goals defined by the ruling elite. The supply of medical personnel to meet the health needs of any community depends largely on the number of training facilities available to them. From 1953 however, the NP government provided such training facilities strictly on a racial basis – a strategy to ensure that Africans were prepared for their rightful place in the country’s economy. I have pointed out in chapter one that although I do not condone the rendering of public services on a racial basis, the fact that “race” formed such a backdrop to all allocations during apartheid means that an historical analysis of services by racial groups remains painfully unavoidable. On the basis of available medical records for the period from 1948 to 1976, it stands to reason that South Africa’s medical education reflected the problems of apartheid in general, with its race and class

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39 Jacobs, “The Role of Traditional Medicine in a Changing South Africa”, p. 74.

40 Murphy, *Bantu Education in South Africa*, p. 4.

divisions manifested in gross inequalities.<sup>41</sup> Without doubt, education is a major determinant of the occupation an individual will eventually follow,<sup>42</sup> his or her income category, as well as the type and quality of the house in which he or she will live. And if this is indeed the case, then education is a significant indicator of a person's socio-economic stratum,<sup>43</sup> which directly determines the type, quality and efficacy of the health care for which he will qualify as well as the diseases and other health risks to which he or she will be exposed. Some of the most devastating effects of apartheid can be attributed to Bantu Education, which differentiated between black and white education to fulfil a strategic agenda.<sup>44</sup> Closely analysed, it is clear that this state-controlled education system formed a crucial part of Verwoerd's social engineering campaigns because it served not only as a vehicle for the promulgation of the doctrines of the Nationalist policy but also as an instrument of exclusion of Africans from medical education. Viewed in this light, Philip Tobias' remarks are even more illustrative of the problems black South Africans faced when he writes that "nowhere else in apartheid South Africa were the constricting and stultifying effects of the so-called Christian National Education policy more dramatically apparent than in medical education".<sup>45</sup>

Health care is an important vector of modernity in two senses, namely, directly for its powerful practical effects in curing or alleviating illness, and symbolically for its representation of a society's capacity to mobilise the agents and institutional structures that can implement biomedical science to human benefit. Thus, with biomedical doctors leading the charge against illness, medical education is a particularly strategic component of a society's health effort and an index of modernisation. It will be remembered that one of the Sauer Commission's recommendations was the removal of mission control over African education primarily because of the kind of ideas Africans were exposed to from their mission teachers.<sup>46</sup> Little wonder, then, that in the Bantu Education Commission Report, under the

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41 Terreblanche, *A History of Inequality in South Africa*, p. 391. See also Seekings and Nattrass, *Class, Race and Inequality in South Africa*, p. 90.

42 E.G. Malherbe, *Into the Seventies: Education and the Development of South Africa's Human Resources* (Athlone, Esquire Press, 1966) and Malherbe, "Education for Leadership in Africa" (Durban, Natal Technical College, 1960). (Mimeographed).

43 The 1961 Education Panel, "Education and the South African Economy", (Johannesburg, Witwatersrand University, 1966).

44 See Jonathan Hyslop, *The Classroom Struggle: Policy and Resistance in South Africa, 1940-1990* (Pietermaritzburg, University of Natal Press, 1999). See also Brian Bunting, *Education for Apartheid* (London, Christian Action, n.d.).

45 P.V. Tobias, "Apartheid and Medical Education: The Training of Black Doctors in South Africa", *Journal of the National Medical Association*, vol. 72, no. 4 (1980).

46 R.H. Philpott, "The Need for Alternative Medical Education in South Africa", *Critical Health*, vol. 25 (1988), p. 7.

chairmanship of W.W.M. Eiselen, that was tabled in 1951, the commission argued for a separate education system controlled by the central government rather than the provinces.<sup>47</sup> The result was the promulgation in 1953 of the Bantu Education Act (Act No. 47 of 1953), which provided for a differential syllabus strictly designed to prepare Africans for his special place in society, that is, either for working within the framework of white domination or for participation in self-governing African societies or bantustans.<sup>48</sup> Thus, as part of the apartheid blueprint, the system ensured that both teaching hospitals and medical schools in South Africa were not only unequal but also segregated along racial lines.

Although elsewhere in the world a school certificate would serve as a ticket out of poverty and the curse of manual labour, this was not the case in South Africa. Commentators have rightly pointed out that the failure of black education as a tool to aid equal opportunity was not as much a result of the government not giving it sufficient attention (as a matter of fact, the Nationalists did so on a grander scale than all previous governments),<sup>49</sup> but as a diabolic device to maintain and promote existing inequalities. Even the curriculum itself, cynically emphasised values that were consistent with working in a subordinate position in a white-dominated system, with very little if any attention paid to such values as individual initiative and self-reliance. In short, it may be said that education was designed to promote African service to white interests, albeit under segregated conditions that allowed a semblance of African self-management within a system of firm white control. Historically, if any Nationalist could be singled out as the author of the disabilities of the new system, it would be the architect of grand apartheid himself, Hendrik Verwoerd. As minister of Native Affairs at the time and therefore responsible for shaping “African education” in accordance with apartheid objectives,<sup>50</sup> he declared unequivocally:

The school must equip the Bantu to meet the demands which the economic life of South Africa will impose on him. There is no place for him in the European community above the level of certain forms of labour. Within his community however, all doors are open ... Until now, he has been subjected to a school system which drew him away from his own community and misled him by showing him the green pastures of European society in which he is not allowed to graze....<sup>51</sup>

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47 Davenport, *South Africa: A Modern History*, p. 337.

48 E.J. Murphy, *Bantu Education in South Africa: Its Comparability with the Contrasting Objectives of African Self-Development or White Domination* (PhD thesis, University of Connecticut, 1973), p. v.

49 Hyslop, *The Classroom Struggle*.

50 See F.K. Peters, *Mathematics and the Sciences in Bantu Education* (Johannesburg, SAIRR, 1969) Mimeographed.

51 UG, *House of Assembly Debates*, vol. 83 (Pretoria, Government Printer, 1953), col. 1287.

Critics of the government's policies have therefore with justification charged that the separate and largely inferior schooling system for blacks was also not providing suitably qualified medical student material.<sup>52</sup> The stringent admission criteria at medical schools were clearly part and parcel of the exclusionary strategies inherent in the very goal of a school system that excluded blacks from mathematics classes, and yet made mathematics a prerequisite for admission to medical schools.<sup>53</sup> With this in mind, there can be no question that Bantu Education actually promoted and exacerbated existing inequalities as further reflected in the following table showing per capita expenditure for black and white school children and thus illustrating unequal allocation of funds:

**Table 5.1 Per capita education expenditure 1953-1974<sup>54</sup>**

Year	Expenditure(White)	Expenditure (Black)	Discriminatory ratio
1953	R100	R18	5.5:1
1963	R140	R12.50	11.1
1972	R220	R20	11:1
1974	R470	R29	16:1 <sup>55</sup>

Although, as already mentioned, reliable expenditure figures for black pupils from the mid 1970s are hard to find, it is interesting to note that the foregoing figures compiled by Patrick Laurence compare very favourably with the statistics revealed by Bromberger and others, showing the diminishing per capita expenditure per black pupil after the promulgation of the Bantu Education Act:

**Table 5.2 Diminishing per capita expenditure on black education**

Year	Per capita expenditure
1953	R17.08 <sup>56</sup>
1955	R15.68

52 Editorial, *Critical Health*, no. 25 (December 1988), p. 3.

53 SAIRR, *Race Relations Survey 1964*, p. 312. If Hendrik Verwoerd's speech to the Union parliament, quoted at the beginning of this chapter, is strictly adhered to, then no black applicant would ever be admitted to any medical school even when there were no other admission criteria apart from mathematics.

54 Laurence, *Race, Propaganda and South Africa*, p. 126.

55 Ibid., p. 126.

56 Hyslop, *The Classroom Struggle*, p.56

1959	R13.80
1962	R11.56 <sup>57</sup>

The NP government was constrained by several factors from providing adequate finance for black education. First, it miscalculated when assuming that black South Africans would contribute towards their education by means of taxation and direct contribution and took the step of transferring the economic burden onto the shoulders of black communities. As a result, the state expenditure on black education decreased steadily after 1953. According to Jonathan Hyslop, the National Party's own racist ideology generated strong political pressures against expenditure in Black education while the new policy enabled the state to reconcile its need for a new mass education system with its unwillingness to pay for it.<sup>58</sup> With the foregoing figures clearly in mind, the 1955 announcement by the minister of Health, J.F.T. Naude, that South Africa was spending £8 million pounds a year on Bantu Education, which was more than what was being spent on black education by any other country on the continent,<sup>59</sup> should therefore be seen as yet another attempt by the Nationalists to deflect both national and international attention away from the gross inequalities between black and white South Africans by comparing a relatively wealthy country with the much poorer newly independent states of Africa.

Although ratios of medical manpower and resources are useful in international comparisons as indicators of development of the country's services, used uncritically in the South African situation such ratios may be misleading in that they may obscure the realities of the country's racial problems. In the first place, such ratios may fail to clarify the quality and appropriateness of the manpower to the health needs of the population they serve. A study of the available literature shows that medical education for black South Africans failed to advance numerically with the growth of the population. For example, after government had shut down the doors of the Wits Medical School to black applicants in 1966, all South African medical schools combined produced diminishing numbers of black medical practitioners, as reflected in the following table:

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57 N. Bromberger, *Government Policies Affecting the Distribution of Income 1940-1980* (Cape Town, Juta, 1982), p.177.

58 Hyslop, *The Classroom Struggle*, p. 55.

59 *The Cape Times*, 17 October 1955.

**Table 5.3 Combined medical graduates in 1967**

<b>Racial group</b>	<b>Medical graduates</b>
White	328
Asian	31
Coloured	17
African	11 <sup>60</sup>

These figures translate into the reality that for every one million whites 92 doctors were produced in apartheid South Africa. In the case of Asian and Coloureds respectively, for every one million 55 and 9 doctors qualified per million people. For every one million Africans only 0.9 medical doctors were produced.<sup>61</sup> These figures can clearly not be compared with the number of indigenous healers for every one million Africans. Although research in this area still needs to be carried out there is no question that if in every community such as Borolo (referred to in chapter six), there were more than three indigenous healers of some sort at any time, then the ratio of indigenous healers to the population in general is higher than that of medical practitioners. For instance, Tobias's figures suggest that of the combined black population only 4 African medical doctors graduated as compared to 92 whites per million population. The 1969 figures were even more revealing because while the output of white doctors had risen from 92 to 98 per million whites, that of Africans had dropped from 0.9 to 0.5 per million population.<sup>62</sup> In other words, between 1967 and 1969 the output of white doctors had not only kept pace with the increase of the white population, but the doctor-population ratio had actually improved. In contrast, the already dismally low output of African

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60 Tobias, "Apartheid and Medical Education" See also, Tobias, "Medical Education for Africans and Others", p.4.

61 Ibid.

62 Tobias, "Medical Education for Africans and Others", p. 4

doctors dropped both in absolute terms and in relation to the size of the population. Thus, used uncritically, the ratios may be very misleading. For example, in 1970 South Africa had one doctor for every 1 900 people, which represented an excellent ratio compared with that of the rest of the continent.<sup>63</sup> Yet on closer scrutiny, it is apparent that the information on the number of doctors available for each racial group is not revealed. In the three years before the student revolts of 1976, the situation had not improved at all. Of the 540 medical graduates countrywide, the following disparities could still be observed:

**Table 5.4 Medical graduates in 1973**

Racial group	Medical graduates
White	440
Asian	47
Coloured	19
African	15

Once again, when these figures are matched against the total population of 23 million at the time, and against the totals for each racial group, the picture that emerges is grossly misleading because it shows an overall improvement. For example, in terms of this, whites have improved from 92 doctors per million population in 1967 to 111 doctors per million white population in 1973. In contrast however, even although the 0.9 African doctors per million population represented an improvement of the 0.5 doctors per million black population in 1969 referred to above, this figure for 1973 was in fact back to what it had been in 1967. So much so that, by 1976 when the whites, who comprised less than one-fifth of the total population had gained 88.4 per cent of all new doctors trained in the country since 1968, the African group comprising about 70.4 per cent of the total population had gained only three per cent of all doctors trained during the same period.<sup>64</sup> And of these doctors, very few if any

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63 M.R. Gardee, "An Aspect of Community Medicine: The Medical Care Implications of Manpower and Other Resources, with the Rural Black Population as an Example", *South African Medical Journal*, vol. 52, no.9 (1977), p. 364.

64 Although B.K. Murray's article, "The 'Liberal' University: Questions of Discrimination at Wits 1922-39" also deals in detail with the earlier version of racial discrimination in medical education in South Africa, for this part of the study, I have drawn heavily on Philip Tobias' studies which he published in article form in a number of journals. These include Tobias, "Medical Education for Africans and Others"; Tobias, "Apartheid and Medical Education: The Training of Black Doctors in South Africa"; Tobias, "Apartheid and Medical Education: The Training of Black Doctors in South Africa". For the earlier period, see, B.K. Murray, "The 'Liberal' University: Questions of Discrimination at Wits 1922-39"; Bozzoli, *Town and the Countryside in the Transvaal*.

were qualified in preventive medicine, a sphere of medicine that was more suited to the health needs of Africans. It is interesting to note that between 1946 and 1976, the number of specialists (in fields best suited for health needs of whites) as a percentage of all doctors in South Africa had risen from 13.6 to 24.6 per cent.<sup>65</sup> Although the doctor to patient ratios for apartheid South Africa did not directly reflect the availability of health care for the different racial groups, because many blacks were also treated by white personnel, such ratios nevertheless did reflect the discrepancies in the availability of facilities for medical training.

#### **5.4 Absurdities of apartheid medical education**

While segregation still offered Africans some hope that through education and adequate assimilation of Western civilisation they could become the equals of whites, apartheid dashed such false hopes by ensuring through Bantu Education that Africans did not receive the education that could eventually bring them to a position of equality. In fact racial discrimination in medical training was not limited to access to medical schools, as pointed out above, because available evidence suggests that even for those who registered at the mixed universities despite the odds, discrimination persisted in regard to access to facilities. Perhaps one of the most absurd aspects of apartheid medical training, confirmed by all the medical practitioners I interviewed for this study, was that while white medical students could attend ward rounds at both black and white training hospitals during the clinical years of training, black students were not permitted to attend ward rounds at white hospitals nor examine white patients.<sup>66</sup> Nor could white patients be used for clinical demonstration in the teaching of black medical students; failing this black students would have to leave the lecture theatre.<sup>67</sup> The other absurd feature of apartheid medical education was that black medical students were not allowed to dissect white bodies in anatomy classes nor could they attend post-mortem examinations during pathology. For these and other reasons, one could argue that black medical students did not receive equal medical education even in the training institutions. And since they were by law permitted only to doctor over their own people, the effects of their limited training would be borne by their own black communities, not the whites.

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65 Seedat, *Crippling a Nation: Health in Apartheid South Africa*, p. 85.

66 Interview with Dr Magampa, Watervaal "B", Mpumalanga, 14/2/2000. This fact is corroborated in documented source material. See, Seedat, *Crippling a Nation*, p. 88; Wells, *Health, Healing and Society*, p. 36.

67 WHO, *Apartheid and Medicine*, p. 225, See also, Wells, *Health, Healing and Society*, p. 36; Seedat, *Crippling a Nation*, p. 88.

## 5.5 Absurdities of apartheid medical practice

It is interesting to note that the contradictions in medical education referred to above did not end in medical schools, but persisted even into practice after the students had graduated. Perhaps one of the most revealing aspects of apartheid medicine was the fact that since blacks could not operate on white patients, the country's pioneering heart surgery might not have legally been performed had Dr Chris Barnard been black; furthermore the operation would not have been performed legally in South Africa, had the donor been black and the recipient of the heart been white.<sup>68</sup> In *An Ambulance of the Wrong Colour* mentioned earlier, the authors expose these and other absurd aspects of apartheid medicine where ambulances were legally forbidden from carrying a sick patient to a hospital if the designated 'colour' of the ambulance and the patient did not correspond.<sup>69</sup> Occasionally however, it was the whites rather than blacks who suffered the consequences. For example, when a white child was badly injured in a Johannesburg street in 1975 the ambulance service was merely summoned with the information that "a 'boy'" had been hurt; as blacks were usually called "boys" (even if they were adults), an ambulance for black people was sent. But since this was not allowed to carry a white patient, the injured child was left on the street where he bled to death before an ambulance of the appropriate colour could reach the scene.<sup>70</sup> Indeed, the financial implications of sending the politically wrong ambulance to accident scene only to send them back for the ones of the right colour was another example of the blatant misdirection of the country's resources alluded to in chapter three, resources which could have been more meaningfully deployed elsewhere in the health service.

On 20 May 1960 regulations for the blood transfusion services were gazetted in terms of which blood donor societies were organised into separate racial divisions so that blacks and whites were bled separately to ensure separate record keeping of the blood so donated.<sup>71</sup> Interestingly, this measure was intended to protect whites from receiving blood from black donors while the reverse was hardly the case.<sup>72</sup> On the basis of research carried out in the 1970s, Nurse and Jenkins concluded that there is no good serogenetic reason for the labelling

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68 Laurence, *Race, Propaganda and South Africa*, p. 120.

69 Baldwin-Ragaven, et al, *An Ambulance of the Wrong Colour*, p. 42. For a particularly graphic account of an incident of "ambulance apartheid", see Seedat, *Crippling a Nation*, p. 73.

70 Laurence, *Race, Propaganda and South Africa*, p.119.

71 SAIRR, *Race Relations Survey, 1959-1960*, p. 245. See also Baldwin-Ragaven, et al, *An Ambulance of the Wrong Colour*, p. 42.

72 Interview with Dr Magampa, 14/2/2000.

of containers of human blood with the race of the donor.<sup>73</sup> Other anomalies included the total disregard for cultural sensitivities in the area of organ transplants. For example, the more traditional societies would not easily consent to the harvesting of any body parts from their loved one who had passed on. To deal with this problem, such organ removals from black people were often done without the next of kin of the deceased being consulted.<sup>74</sup>

With apartheid medicine being essentially curative, urban-biased, high-tech and hospital based, there is no doubt that a gross misdirection of resources was involved in the process of transporting patients to hospitals of the “right colour”.<sup>75</sup> For instance, in most of the rural areas, with the exception of the former mission-run hospitals which were transferred to the bantustans in the early 1970s as a ploy to legitimise the health authorities of those ethnic constructions, there were very few if any hospitals with sophisticated technology for black people; seldom was there any equipment of the standard that most whites could count on. For this reason, critical black patients in need of specific technology had to be transported on dusty and bumpy roads from rural to urban hospitals that were almost always hundreds of kilometres away.<sup>76</sup> Due to this uneconomic exercise, resources made available as a result of the economic boom, which could arguably be used to promote the well being of the people, were being misdirected to maintain apartheid. Other absurdities of the system included the legal prohibition of black doctors from treating white patients, while the reverse was not the case. Black doctors were also prevented from serving in a senior specialist capacity even in those hospitals that were designated for African use according to the apartheid scheme, because this would in most cases place such black doctors in a position of authority over junior white doctors, interns or white medical students; because of this situation several African doctors left the country, thus contributing to the brain drain of the scarce medical skills the country could ill afford at the time.<sup>77</sup> In 1969 the Department of Bantu Administration issued a circular to the effect that black medical doctors would no longer be granted consulting rooms and offices in the African townships on the grounds that such communities were

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73 G.T. Nurse and T. Jenkins, “Genetically Determined Hazards of Blood Transfusion Within and Between Races”, *South African Medical Journal*, vol. 47, no. 1 (1973), 56-61, p. 61.

74 Baldwin-Ragaven, et al, *An Ambulance of the Wrong Colour*, p. 42.

75 For a full review of the critical role played by an ambulance as a life-saving facility, see R.G. Saner, “Ambulance Services and Modern Medicine: A Review in the Light of Newer Concepts”, *South African Medical Journal*, vol. 47, no. 3 (1973), pp. 577-580.

76 Interview with Matron Mabindiza, 1/12/2004

77 SAIRR, *Race Relations Survey, 1969*, p. 235; Seedat, *Crippling a Nation: Health in Apartheid South Africa* p. 69.

situated in “white areas”.<sup>78</sup> Effectively, this meant that since white doctors could not live in the townships, blacks needing emergency medical attention at night were, through government action, denied this privilege. Perhaps even more absurd was the restriction on black doctors from treating their own patients in provincial hospitals if this involved being placed in a position of authority over white nurses.<sup>79</sup> For example, in September 1972 a Coloured doctor at Oudtshoorn Hospital was prevented from performing an emergency caesarean operation on one of his patients because the theatre staff were white. In consequence to this, the operation was only performed two hours later when a white doctor had been summoned; the patient died three days later.<sup>80</sup>

## **5.6 Economic self-sufficiency and SA’s suspension from the WHO**

In my examination of South Africa’s economic development in chapter three, I have pointed out that by the late 1960s and early 1970s, the country’s relative economic capacity did not justify the occurrence of such diseases of poverty and underdevelopment observed in chapter four. Indeed, in the light of the country’s economic well-being one could hardly find any justification for the high infant and child mortality figures among one section of the population, while the other fared much better. Hence my contention is that the root cause of the health problems of black South Africans was the operation of apartheid in all its ramifications.

The pursuit of apartheid, which ran concurrently with the Cold War, occurred within the context of a changing world order whereby a growing number of independent African states within the World Health Organisation were united by a common antagonism against discrimination. The health body gave them the platform to speak with one voice in condemnation of Pretoria’s apartheid policies. Consequently, in 1962, the WHO Regional Committee for Africa adopted the World Health Assembly resolution (WHA 17-1950), article 7 of the WHO constitution, to suspend South Africa and to prevent it from exercising its voting and other privileges within that health body.<sup>81</sup> Indeed this committee found that by

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78 *The Star*, 16 June 1969.

79 SAIRR, *Race Relations Survey*, 1973, p. 352.

80 *The Sunday Times*, 10 September 1972. For similar incidents, see also *The Cape Times*, 20 March 1972.

81 NAD, GES 2166 168/33B, Report of Minutes of the 12<sup>th</sup> Session of WHO Regional Committee for Africa, p. 8. See also, NAD, GES 2130 143/33D, Letter from Secretary for Health, M.C. Marr, to the Secretary for Foreign Affairs, 23 December 1968.

subjecting indigenous communities to racial discrimination, often to the detriment of their physical, mental and social well being, South Africa was clearly contravening the principles, aims and objectives of the WHO constitution.<sup>82</sup> In point of fact, the WHO constitution was specifically amended as follows to address the issue of apartheid South Africa:

7(b) If a member ignores the humanitarian principles and objectives laid down in the constitution, by practising a policy of racial discrimination, the Health Assembly may suspend it or exclude it from the World Health Organisation. Nevertheless, its rights and privileges as well as its membership may be restored by the health Assembly on the proposal of the Executive Board following a detailed report proving that the state in question has renounced the policy of discrimination which gave rise to its suspension.<sup>83</sup>

That South Africa should get embroiled in such ideological problems at the time the health problems of poor communities were receiving international attention was most unfortunate. Particularly so because the country's scientific research work had been recognised by the WHO experts as being critical towards addressing the health problems of the poor in many parts of the developing world. For example, South Africa's research into poliomyelitis had led to the designation of the Poliomyelitis Research Foundation in Johannesburg as the WHO Centre for the African Region.<sup>84</sup> Similarly, the South African Institute of Medical Research had also been designated as a WHO research laboratory, initially for influenza, but later for all virus diseases, to which majority of the poor were vulnerable.<sup>85</sup>

The decision to suspend South Africa from the WHO was far from unanimous. Historians have since debated this and many have argued that it was primarily the profitability of Western investments in South Africa and Western preoccupation with the struggle against communism, that may have been in the short term interest of the apartheid state.<sup>86</sup> Others have claimed that it was largely the effectiveness of the country's foreign propaganda campaign, so well tuned to the Cold War fears and prejudices of Europeans and Americans, that South Africa was seen as an indispensable member of the "free world" in its unremitting struggle against international communism.<sup>87</sup> Portrayed as such, it is understandable why countries such as France openly

82 NAD, GES 2166 168/33B, Report of Minutes of the 12<sup>th</sup> Session of the WHO Regional Committee for Africa, p. 7.

83 NAD, GES 2166 168/33B, Letter from Bekker to Kempff, 18/9/69.

84 GES 2166 168/33B, Report of Minutes of the 12<sup>th</sup> Session of WHO Regional Committee for Africa.

85 Ibid.

86 J. Barber and J. Barratt, *South Africa's Foreign Policy: The Search for Status and Security 1945-1988* (Bergville, Southern Books Publishers, 1990), pp.50-53; D. Geldenhys, *The Diplomacy of Isolation: South African Foreign Policy Making* (Johannesburg, Macmillan, 1984).

87 Thompson, *A History of South Africa*; M. Ballinger, *From Union to Apartheid: Trek to Isolation* (Cape Town, Juta, 1969).

condemned the adoption of a resolution against such a valuable ally against the communists. Lack of unanimity was also demonstrated by the stance of the United Kingdom's representative, Dr Fendall who also pointed out that his government would not support any proposal for the exclusion of any member from the WHO for fear that this action would prejudice the health rights of those populations which it was the duty and responsibility of the WHO to protect.<sup>88</sup> Despite this lack of unanimity however, verbal attacks against South Africa's policies continued unabated within the United Nations and its various agencies, to the extent that by 1975 the Medical Association of South Africa (MASA) was forced to quit the World Medical Association (WMA) after its delegation had been refused a visa by the Japanese government to attend the association's session in Tokyo.<sup>89</sup> Whatever its other effects might have been, there is no question that by being excluded from such important organisations as the WHO and the WMA, South African health professionals and academics were denied the benefits of collaboration with the wider world community on matters of health and disease that could have benefitted the poor.

While the resolution suspending South Africa could arguably be regarded as a blow to apartheid, it soon became evident that it was even more punishing to the country's medical scientists than to the arrogant and unrelenting regime. For example, since the country's chief sources of medical research funds were often pruned down to the limits imposed on the CSIR by Pretoria, South Africa's medical scientists increasingly depended on WHO grants to carry out their work. Now with that window of opportunity closing before their eyes for purely political and ideological reasons, there was no question that the future of medical research was in jeopardy. Largely owing to the arrogance of a country that had experienced the kind of economic boom that South Africa had been through then, it was scarcely surprising that in response to the WHO resolution, Pretoria instructed all CSIR grantees to stop accepting any form of financial assistance from the WHO.<sup>90</sup> Among the academics already involved in WHO-sponsored research projects was T.H. Bothwell of the Wits Medical School. On the basis of his outstanding researches on "iron deficiency anaemia in pregnant women" as well as on "the storage of iron content in livers from persons suffering from nutritional anaemia", Bothwell had been selected to receive a WHO grant for his research in collaboration with that

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88 NAD, GES 2166 168/33B, Report of Minutes of the 12<sup>th</sup> Session of WHO Regional Committee for Africa.

89 *The Rand Daily Mail*, 9 July 1981.

90 NAD, GES 2130 143/33D, Letter from Secretary for Public Health, M.C. Marr to Secretary for Foreign Affairs, 23/2/68.

health body on “the incidence and causation of nutritional anaemia”.<sup>91</sup> However, when Bothwell received the WHO agreement form for the grant he was instructed to decline the offer on political grounds. Professor J.D.L. Hansen of the University of Cape Town’s Department of Medicine and Child Health found himself in the same dilemma. From August 1965 he too received a WHO grant to pursue his research on “the interaction of nutrition and infection” in collaboration with the National Nutrition Research Institute of the CSIR. But on political grounds, he was also instructed to return the WHO funds already in his hands.<sup>92</sup> Viewed against the background of the nutritional problems suffered by black people at the time and the effect this had on their health status as pointed out in chapter four, there is no doubt that both Bothwell and Hansen’s research projects were very critical to addressing the issues of nutrition and infection in this country. In demonstrating the country’s economic self-sufficiency, which is echoed in this study, the South African representative to the WHO Regional Committee, M.C. Marr, advised the organisation to put its money where the need was greatest:

Since South Africa was fortunate in possessing financial and technical resources to deal with its own problems, government (SA) considered that the organisation’s (WHO) resources should be where the need was most urgent – for the countries such as the newly independent African states which needed help in establishing their health services on a sound basis.<sup>93</sup>

Despite the argument by government officials that South Africa’s health problems were problems associated with development and industrialisation, the implications of Marr’s statement were that South Africa’s health services were already so sound by 1965 that the country hardly needed any more financial backing from outside, if that foreign backing entailed the revocation of apartheid. In a nutshell, Marr’s statement belied official rhetoric that South Africa’s health problems should be tolerated because it was still a developing country, whose problems were not dissimilar to developmental problems elsewhere. In other words, this was an open admission by Pretoria that unlike the newly independent African states to the north, South Africa had the necessary financial muscle to provide quality health care to all sectors of the population but was prevented from doing so by apartheid considerations and the maldistribution of resources. The tendency of comparing the health status of blacks in the country to those elsewhere on the continent and then claiming that South Africans are better

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91 NAD, GES 2130 143/33D, Letter from vice President of the CSIR, Professor W.H. Craib, to the Secretary for Health, B.M. Clark, 23 August 1965

92 NAD, GES 2130 143D, *Letter from the Vice President of the CSIR to the Secretary for Health*, 23/8/65.

93 D.M. Sher, “The First Five-Year Plan”, B.J. Liebenberg and S.B. Spies (eds) *South Africa in the 20<sup>th</sup> Century* (Pretoria, Van Schaik, 1994), p. 417.

off than is rejected as pure propaganda

Be that as it may, available evidence suggests that despite the political opposition to South Africa's continued presence as a voting member in the WHO, the agency continued to offer research grants to South African medical scientists who were conducting projects aimed at the health needs of some of the country's poorest communities. With its increasing focus on primary health care and the health needs of developing countries, leading up to the Alma Ata Declaration of the late 1970s, the WHO evidently had a better sense of South Africa's most pressing health and medical research needs than did most of the country's medical scientists, health bureaucrats and politicians.

## **5.7 Conclusion**

By way of conclusion, the elimination of race, class and gender inequalities in occupations, education and training requires a long term programme that should be premised on a balance between need and resources. The development of human resources for health should be seen more broadly in the context of the development of the human resources capacity of the nation as a whole. There can be no doubt that the educational system introduced by the National Party government ensured that whites enjoyed innumerable advantages over blacks in acquiring the skills necessary for occupations in the upper bracket. The fact that the medical profession falls in this category explains why blacks were not prioritised in terms of medical training facilities. In fact, Verwoerd's statement prefacing this chapter is unequivocal as regards the government's plans and understanding of the role of black South Africans within the apartheid economy. The fact that there were fewer training institutions for Black health personnel clearly suggests that the government was not committed to providing an equitable health service for all sections of the population. The training of black nurses, however, progressed well and a large number of nurses soon entered the profession. Since the nursing profession posed no significant threat to the hegemony of white medical control, it was easy and perhaps convenient to train more nurses and to channel them to work among the black communities in the bantustans. The same could not be allowed to happen with the training of doctors, however, who posed more of a challenge to white medical professionals. When MEDUNSA was finally established the government continued to exert its influence with

regard to student selection.<sup>94</sup> In the event the medical school did not produce sufficient numbers of medical practitioners to pose a threat to white monopoly within the South African Medical and Dental Council. This chapter has set the tone for the one that follows, which focuses on Africans' coping alternatives when faced with official neglect in terms of the provision of adequate health manpower for all sections of the population.

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94 For a full overview of the university's admission criteria, see p. 14, paragraph 1 of sub-section 19, of RSA, *Government Gazette*, 16 June 1976 (Medical University of Southern Africa, Act No.78 of 1976), p. 14.

## CHAPTER 6

### BLACK SOUTH AFRICANS AND THEIR COPING ALTERNATIVES: THE CASE OF KWANDEBELE

Belief in the supernatural is considered eccentric in the Western world unless the magical beliefs happen to be your own. As often as not, the person whose superstition prevents him from walking under a ladder is the same one who scorns fear of witchcraft. Roman Catholics, who think nothing of gaining spiritual strength by symbolically eating the body and drinking the blood of Christ, will stare in astonishment at the African who believes he is immunising himself against evil by rubbing lion's fat into his skin.<sup>1</sup>

#### 6.1 Introduction

The success of man as a species is a consequence of his ability to call into play a wide range of adaptive potentialities. According to Rene Dubos, "adaptation" signifies fitness to a particular environment or possession of attributes making it possible to function effectively and to reproduce abundantly in this environment.<sup>2</sup> On this basis it is possible to challenge Giliomee's thesis that the growth of the African population occurred in spite of apartheid and not because of it. However, according to Dubos, adaptation is often bought at a high price and its consequences may be unfavourable in the long run. They can become adjusted to conditions and habits that will eventually destroy the values most characteristic of human life. For example, elsewhere I have referred to prostitution as a coping and survival strategy resorted to by abandoned wives of migrant workers and other poverty-stricken individuals.<sup>3</sup>

Apartheid undoubtedly caused vast and unnecessary human misery but its victims found ways to adapt and it would therefore be misleading to visualise black South Africans as being simply helpless in the face of discrimination and oppression. Furthering this adaptation debate in a classic work, *Women of Phokeng*, Belinda Bozzoli has demonstrated vividly how, despite the overwhelming apartheid odds, black South African women have asserted their "dignity, class capacity, cultural patterns, and gender identity".<sup>4</sup> In medicine too, as pointed out in this thesis, every society had its own method of managing illness that has evolved from

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1 H. Holland, *African Magic: Traditional Ideas that Heal the Continent* (London, Viking, 2001), p. 1.

2 R. Dubos, *Man Adapting* (New Haven, Yale University Press, 1965).

3 Phatlane, "Poverty and HIV/AIDS in Apartheid South Africa", p. 82.

4 Bozzoli, *Women of Phokeng: Consciousness, Life Strategy, and Migrancy in South Africa, 1900-1983*, p. 3.

generation to generation. Available evidence suggests that illness and responses to it are closely related to a social system. Throughout the world, each society naturally functions within the constraints of its own unique system of social structure, language, and communication, beliefs, customs, attitudes, behaviours and cultural norms.<sup>5</sup> As could be expected, black South Africans too have over the years developed both individual and group strategies of coping with their health problems. This in turn enabled them to retain their sense of individual dignity and group identity as a people in the face of grinding apartheid-created poverty, oppression and constant insecurity. Politically, they have resisted subordination through political organisation and the armed struggle of the liberation movements, through workers' action, and through the youth uprisings.

On matters of health, black South Africans were also not short of alternatives to modern medical care. Since disease is a universal human condition, all societies have developed their own individual strategies of coping with and sometimes adapting to the illness of their members. The introduction of the science of modern medicine in South Africa, as in the rest of the African continent, did not take place in a vacuum. Instead, besides faith healing,<sup>6</sup> Africans always had recourse to indigenous systems of health maintenance, involving both the prevention of illness and the cure of disease.<sup>7</sup> It will therefore be argued in this chapter that indigenous medicine as an established part of African culture has, for the majority of Africans under apartheid, been the major way of coping with and/or struggling against illness. Though there is some consensus between historians and anthropologists that the advent of biomedicine and missionary influences have affected the nature of indigenous medicine, in my view such influences have hardly dented its popularity and credibility among its clients.<sup>8</sup> In fact, contrary to conventional biomedical claims, Steven Feierman writes that, "healers of all kinds – whether doctors or 'traditional healers' – have been less influential

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5 E.S. Ataudo, "Traditional Medicine and Biopsychosocial Fulfilment in African Health", *Social Science and Medicine*, vol. 21, no. 12 (1985), p. 1345.

6 A. H. Anderson, *Tumelo: The Faith of African Pentecostals in South Africa* (Pretoria, Sigma Press, 1993); A.H. Anderson, *Moya: The Holy Spirit in an African Context* (Pretoria, Unisa, 1991); A.H. Anderson, *Bazalwane: African Pentecostals in South Africa* (Pretoria, Unisa, 1992); E.K. Lukhaimane, *The Zion Christian Church of Ignatius (Engenas) Lekganyane, 1924 to 1948: An African Experiment with Christianity* (MA dissertation, University of the North, 1980); C.R. de Wet, *The Apostolic Faith Mission in Africa, 1908-1980: A Case Study in Church Growth in a Segregated Society* (PhD thesis, University of Cape Town, 1989); M.E. West, *Bishops and Prophets in a Black City: African Independent Churches in Soweto* (Cape Town, David Philip, 1975).

7 S. Feierman, "History of Pluralistic Medical Systems: Change in African Therapeutic Systems", *Social Science and Medicine*, vol. 13B (1979), pp. 277-284.

8 M. Wallace, "'Making Tradition': Healing, History and Ethnic Identity Among Otjiherero-Speakers in Namibia, c. 1850-1950", *Journal of Southern African Studies*, vol. 29, no. 2 (2003), pp. 355-56.

than we commonly think in shaping states of health or in healing the sick”.<sup>9</sup> Of course under minority white rule, open acknowledgement of the contribution of indigenous medicine among traditional societies had always remained an emotive issue from the modern medical point of view.<sup>10</sup> For many of its detractors, mere mention of the term “indigenous healer” still conjures up fearsome images of the traditional “witchdoctor”, who has been personified by the influential opinion makers as a crafty, deceitful and unscrupulous antagonist of modern medicine, hell-bent on exploiting an ignorant and unsuspecting population.<sup>11</sup> Yet on the basis of both anthropological and sociological research in the developing countries, it has been established that in spite of advances in modern medical technology, over 80 % of Africans, both rural and urban, depend on the services of indigenous healers for their health care needs.<sup>12</sup> Since values, attitudes, behaviour and beliefs are all part of society’s well being, health and illness, indigenous medicine has developed within the socio-religious and cultural foundations of black communities; it is therefore part of the religious structures of these societies. In this way, indigenous medicine plays an important part of the people’s way of life as far as coping with any ailment is concerned. Although the various categories of healers may vary in their ability to influence health and disease, there can be little doubt that they have provided comfort and culturally acceptable explanations of disease to their patients for centuries.<sup>13</sup> In this chapter, an attempt is made to examine the health-care alternatives of indigenous communities in one particular bantustan. Admittedly, then, it is neither practical nor advisable to attempt a generalisation of the findings in this connection. However, it is possible to suggest that material conditions of poverty and general deprivation in one bantustan may well be mirrored in others, and to a limited degree, even in other black areas throughout the country. A specific focus on Kwandebele will provide a fair indication of what

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9 S. Feierman, “Struggles for Control: The Social Roots of Health and Healing in Modern Africa”, <http://www.jstor.org>, p.73, accessed on 12 October 2006.

10 The long history of suppression and marginalisation of indigenous medicine in South Africa has made it difficult for Africans to acknowledge publicly their patronage of indigenous healers.

11 NASA, TES 7159 56/76, Correspondence from Secretary of Public Health to Secretary for Finance, 3 February 1928.

12 E.M. Mankazana, “The Case for the Traditional Healer in South Africa”, *South African Medical Journal*, vol. 56 (1979), p. 1003; O. Okerele, “The Best of Both Worlds: Bringing Traditional Medicine Up to Date”, *Social Science and Medicine*, vol. 24, no. 2 (1987), pp.177-181; C. Anyanam, “Availability, Accessibility, Acceptability and Adaptability: Four Attributes of African Ethnomedicine”, *Social Science and Medicine*, vol. 25, no. 7 (1987), pp. 803-811; W.. Bichmann, “Primary Health Care and Traditional Medicine – Considering the Background of Changing Health Care Concepts in Africa”, *Social Science and Medicine*, vol. 13B (1979), pp. 175-182.

13 H. Fabrega and P.K. Manning, “Illness Episodes, Illness Severity and Treatment Options in a Pluralistic Setting”, *Social Science and Medicine*, vol. 13B (1979), pp. 41-51; H. Ngubane, “Clinical Practice and Organization of Indigenous Healers in South Africa”, in S. Feierman and J.M. Janzen, *The Social Basis of Health and Healing in Africa* (Berkeley, University of California Press, 1992), pp. 366-75.

transpired elsewhere in the country under apartheid.

## 6.2 Kwandebele: A dumping ground-cum bantustan<sup>14</sup>

Kwandebele, a small bantustan north-east of Pretoria became the tenth and last of Pretoria's experiment with ethnic "compartmentalisation" of South Africa. The fundamental role of these ethnic constructions as reservoirs of cheap African labour and "dumping grounds" for the "superfluous" Africans, has been well established in the literature.<sup>15</sup> Critics of the bantustan policy have charged that established only in 1970 as an afterthought in the policy of separate development, with a large non-Ndebele component among its population, the creation of Kwandebele ran counter to the traditional Verwoerdian ideals of ethnic purity.<sup>16</sup> I have also argued elsewhere that the creation of Kwandebele was motivated primarily by Pretoria's desire to put together and control those people who had been rendered stateless by the strict enforcement of other apartheid laws throughout the country.<sup>17</sup> This small bantustan was the product of legislation that restricted squatting and abolished tenant farming and then in turn confirmed and intensified the displacement of Africans living on White-owned farms throughout the country. The government made renewed efforts to implement its "high apartheid" resettlement policies, tightening influx control laws to clear the "black spots". In the process Kwandebele became the convenient destination for many people, irrespective of their ethnic affiliations.<sup>18</sup> This mass exodus of black people from different ethnic backgrounds

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14 The expression "dumping ground" was first used by the victims of the government's resettlement policies to describe the ruthlessness with which government officials treated them. They uprooted them from one place and then literally "dumped" them at another without the necessary preparation for the new area to receive them in terms of infrastructure. As an African woman so "dumped" explained: "... when they came to us they came with guns and police ... They did not say anything, they just threw our belongings in government trucks ... We did not know, we still do not know this place. And when we came here, they dumped our things, just dumped our things so that we are still here. What can we do now, we can do nothing ..." Quoted in Thompson, *A History of South Africa*, p.194. For other scholars using the expression "dumping grounds" see also, Belinda Bozzoli, *Women of Phokeng*, p. 198. For similar uses of the concept, see also, speech by former Minister of Education, Kader Asmal at the 3<sup>rd</sup> Consultative Conference convened by the Council on Higher Education in 2001, cited in Nkomo, *Within the Realm of Possibility*, p. 1.

15 S. Bekker and R. Hamphries, "State Control Over African Labour", in W.G. James (ed.), *The State of Apartheid* (New York, Lynne Rienner Publishers, 1987); C. Desmond, *The Discarded People: An Account of Forced Resettlement in South Africa* (Harmondsworth, Penguin, 1970); M. Lacey, *Working for Boroko: The Origins of a Coercive Labour System in South Africa* (Johannesburg, Ravan Press, 1981); G. Mare, *African Population Relocation in South Africa* (Johannesburg, SAIRR, 1980); M. Nash, *Black Uprooting from White South Africa: The Fourth and Final Stage of Apartheid* (Braamfontein, SACC, 1980); Surplus People Project, *Forced Removals in South Africa*, vols.1-5 (Pietermaritzburg, Surplus People project, 1983).

16 *The Rand Daily Mail*, 29 July 1980. See also RSA, *Hansard*, August 1983, col.1858 (Pretoria, Government Printer, 1983).

17 S.N. Phatlane, "The Farce of Homeland Independence: Kwandebele, The Untold Story", *Journal of Asian and African Studies*, vol. 37, no. 3-5 (2002), 401-421.

18 D. Nielsen, "'Bringing Together that Which Belongs Together': The Establishment of Kwandebele and

to a supposedly Ndebele “homeland” could obviously not have been foreseen within the earlier versions of “grand apartheid”.<sup>19</sup> In the early 1970s, despite its initial reluctance to create a separate Ndebele homeland, Pretoria made several adjustments to the traditional homeland policy and lumped together people of different ethnic origins into a single territorial unit; and then conveniently called it Kwandebele. According to Derrick Nielsen, this move reflected the apartheid government’s desperate attempts to manage emerging socio-economic and political realities in the country through the application of an existing policy.<sup>20</sup>

For the purposes of this study, the background to the establishment of Kwandebele is important because it helps to explain why the bantustan was so under-resourced in terms of health and medical services as compared to other bantustans. Kwandebele is also important for other reasons too. The fact that not only people of Ndebele extraction made up the population of this bantustan leads us to the conclusion that the almost complete reliance of the residents on faith healing and indigenous medicine for their health maintenance had very little to do with being Ndebele, but had everything to do with the worth of indigenous therapies, and in some cases, the impact of apartheid-created poverty. In short, the issue here is not how backward the Ndebele beliefs and value systems were, but how black South Africans, here and under similar circumstances elsewhere in the country, have coped with their health problems.

### **6.2.1 Medical services in Kwandebele**

According to Cedric de Beer, the extent to which any community utilises public health facilities depends on the availability, accessibility and affordability of these facilities; their appropriateness to the health care needs of that community also plays a role.<sup>21</sup> Similarly, M.R. Gardee has also suggested that any health care system should serve four main purposes, namely, the promotion of health in the absence of disease; the prevention of disease; early detection of symptoms and care of the symptomatic patient and finally, rehabilitation.<sup>22</sup> Available literature suggests that at the time of its proclamation as a bantustan in the early

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the Incorporation of Moutse”, Seminar presented to the Wits Institute for Advanced Social Research, 11 March, 1996, p. 8.

19 D.A. James, *Kinship and Land in an Inter-Ethnic Rural Community* (M.A. Dissertation, University of the Witwatersrand, 1987), p. 51.

20 Nielsen, “Bringing Together that Which Belongs Together”.

21 De Beer, *The South African Disease*.

22 M.R. Gardee, “The Medical Care Implications of Manpower and Other Resources With the Rural Black Population as an Example”, *South African Medical Journal*, vol. 52, no. 9 (1977), p. 364.

1970s, there already existed within the confines of what became the geographical boundaries of Kwandebile, some Bapedi communities of Borolo (1931),<sup>23</sup> Senotlelo, Maganagobušwa, Mokgwaneng, and many others, around whom the homeland was eventually constructed.<sup>24</sup> While there is no question that medical services provided for this mixed bag of people were grossly inadequate, it is important to note that the setting up of this new bantustan did not bring with it the benefits that, in the case of other bantustans, often accompanied their creation. It will be remembered that the apartheid government wished to use health services in the bantustans for sinister reasons other than the provision of health care. The dream that never happened was that once Africans had access to modern medicine they would give up their indigenous practices and superstitious beliefs. As one missionary has noted: “The usefulness of the medical arm of the missionary service is indisputable. It breaks down opposition, dissipates prejudice, and wins its way to the hearts and homes of the high and low, rich and poor”.<sup>25</sup>

Initially, the bantustan health services were more functional to the apartheid government in a number of respects. They served to enforce dependency of the bantustans on Pretoria; to give credibility to such ethnic constructions; to stimulate ethnicity and tribal separateness; to focus attention away from Pretoria and place it onto bantustan authorities when health issues might be embarrassing for the state. Above all, as has been shown, they served to divert attention away from Pretoria by manipulating tuberculosis statistics after the African relocations. This manipulation was done by excluding the bantustan cases from the “South African” figures. For all practical purposes, the immediate spin-off for the apartheid state in creating bantustan health services was that it could concern itself chiefly with the health problems of white South Africans and thus shrug off responsibility for the health of the black people.<sup>26</sup> In terms of apartheid logic, health and other welfare problems in the bantustans were understood to be, “the concern of foreign states, and Pretoria never meddles in the affairs of its neighbours”.<sup>27</sup>

Unlike earlier versions of the bantustan system, where “homelands” were designed to develop into fully-fledged black states in order to justify Pretoria’s exclusion of their citizens

23 NASA, URU 1218 20/94, Constitution of a New Tribe of Natives to be Known as Bapedi-Ba-Borolo, 1931-1931.

24 Personal communication with Joel M. Seloane, Vaalbank, Mpumalanga, 25/10/2006.

25 J.S. Dennis, *Christian Missions and Social Progress*, (Oliphant, Anderson and Ferrier, 1989).

26 A. Zwi, “Piecing Together Health in the Homelands”, Second Carnegie Inquiry into Poverty and Development in Southern Africa, Carnegie Conference Paper no. 187, Cape Town, 13-19 April, 1984, p. 14.

27 RSA, *House of Assembly Debates*, col 887 (Pretoria, Government Printer, 1983).

from any political rights in South Africa, by the 1970s, in the case of Kwandebele, this was no longer the goal. Instead it became a convenient destination for the victims of Pretoria's resettlement policies elsewhere, and continued to receive newcomers, especially women and children, who were settled in what later became the settlements of Siyabuswa, Mathyszenloop, Kwaggafontein, Vlaklaagte, Tweefontein, Allemansdrift, Kamielrivier, Leeufontein and others. And yet, no form of basic medical care was made available prior to or immediately after the people had arrived.<sup>28</sup> For example, the homeland hardly had a hospital within its borders. Instead, the entire bantustan was served by seven clinics and the 650-bed Philadelphia hospital in Moutse, a former mission hospital that was situated (politically) within the Lebowa bantustan.<sup>29</sup> Ironically, had there been strict adherence to the Verwoerdian logic of ethnic purity, this supposedly Pedi hospital would only have been allowed to admit Pedi patients from Kwandebele, and not the Ndebeles as well. Then too, a particularly striking biomedical tendency in South Africa was to reprimand the patient for wasting time with "witchdoctors" instead of coming straight to the modern practitioner, clinic or hospital. As Muriel Mabindiza reflects:

It was almost fashionable to blame patients for wasting time with indigenous healers before coming to the hospital. But you could now understand that with the scarcity of public health facilities and transport problems in remote rural areas, sometimes these people had no option but to use the available resources (witchdoctors). Despite being a Matron, we too had (still have) our household witchdoctor whom we consult at least once a year for the annual ritual of fortification (*go thea motse*). This is standard practice by most Africans irrespective of one's level of Westernisation.<sup>30</sup>

Indeed, no amount of reprimand, according to Harriet Ngubane, had deterred patients from seeking the services of an *inyanga* or *isangoma* when they considered that circumstances warranted it.<sup>31</sup> Also sharing Mabindiza's conclusion that it is standard practice for Africans to fortify their homes with indigenous muti, the deputy director of Health Services in Limpopo, Dr Morwamphaga Nkadimeng, himself a proud client of ngaka Tsiane, confirms that Tsiane's patients range from teachers, nurses, medical doctors and medical specialists of all kinds; church leaders of most denominations, all avail themselves to the services of indigenous healers, particularly with regard to the annual fortification ritual.<sup>32</sup> Thus, asked why he had to

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28 Personal communication with Sop Ntuli.

29 Interview with former Hospital Matron Thembeke Muriel Mabindiza, Philadelphia Hospital, Dennilton.

30 Ibid. See also Ngubane, "Clinical Practice and Organization of Indigenous Healers in South Africa" Feierman and Janzen, *Social Basis of Health and Healing in Africa*, p. 367.

31 Ngubane, "Aspects of Clinical Practice and Traditional Organisation of Indigenous Healers in South Africa", p. 361.

32 Personal communication with Dr Morwamphaga Nkadimeng, Limpopo Province, 4/3/2005.

travel from as far as Limpopo to consult with Ngaka Tsiane in Kwandebele, one of Tsiane's patients replied that, like his grandfather in the 1960s, "Tsiane is extraordinarily gifted because he combines traditional song and dance in the process of diagnosis, which results in a striking enigmatic accuracy". It is interesting to note that even a modern medical practitioner, Dr Victor Ramathesela also attests to the practical utility of Ngaka Tsiane as a highly respected, dependable ngaka who dominates indigenous healing in Kwandebele.<sup>33</sup>

By reprimanding patients for seeking out the services of indigenous healers, modern medical professionals often achieve the opposite of their intended objective; they merely encourage patients to use multiple health care practitioners for the same condition without sharing this crucial information with either of them – usually for fear of offending them or the embarrassment of been ridiculed. This may lead to health complications, especially if they take herbs that interact with biomedical treatment. According to Matron Mabindiza, it is important that health care providers have some knowledge of indigenous medical systems and that their healing procedures must be viewed non-judgementally.<sup>34</sup>

### **6.2.2 Faith healing as a coping alternative**

Religion, which is often an integral part of people's lives, becomes even more important during times of illness. Therefore, faith healing became a mechanism that helped Africans to cope with their health problems during the period under review. The extent to which the majority of Africans found relief from their health problems through indigenous churches, even prior to apartheid, has been well documented.<sup>35</sup> It is therefore hardly surprising to note that the majority of Kwandebele residents, like Africans in many other parts of the country have over the years relied on the healing services offered by independent African churches. Either disillusioned with modern health care services, or unable to access those services, Africans have found solace and comfort in faith healing. However, in the same way that there is no record of all the people whose lives were saved through indigenous healing, faith healing as a success story is an area that still needs historical investigation. The fact that the two largest African churches in the country, the Zion Christian Church (ZCC) and the International Pentecostal Holiness Church (IPHC) were founded primarily on their ability to heal the sick (many of whom were pronounced as incurable by modern medical practitioners)

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33 Personal communication with Dr J.R. Victor Ramathesela, Chief Executive Officer of HIVEX Ltd, Rivonia Road, Gauteng Province, 10/3/2005.

34 Interview with Matron Mabindiza, 1/12/2004.

35 Lukhaimane, *The Zion Christian Church*; Anderson, *Moya: The Holy Spirit in an African Context*.

suggests that the age-old role of faith healing as a coping alternative in African health care merits serious academic attention.

Perhaps the primary reason why the history of medicine has been so closely connected with that of religion is that they both share a common objective: the well-being of the individual and his protection against evil forces.<sup>36</sup> Indeed, like indigenous societies elsewhere, black South Africans have always sought supernatural explanations for most occurrences, including sickness. As pointed out above, besides spreading the gospel and the so-called converting “heathens” to Christianity, the missionaries were also preoccupied with healing the sick and thereby trying to win Africans away from their indigenous cultures and institutions. This explains why a number of mission hospitals and clinics were established in the rural areas, to cope with the level of ill health that was evident at the time.<sup>37</sup> Available evidence suggests, however, that even though the missionaries enjoyed the full backing of the state in their efforts to socialise Africans into Western modes of behaviour, they nevertheless remained responsible for the running costs of their own health facilities.<sup>38</sup> For reasons alluded to elsewhere in this study, in the early 1970s the apartheid government took over the mission hospitals and attached them to bantustan health authorities.

The significance of African initiated churches lies in their ability to recruit membership from the mission churches. As Simon Maimela so aptly puts it:

African Pentecostalism draws its membership primarily from among marginalised and underprivileged blacks who are struggling to find dignity in a society dominated by racial and class interests. The racial character of church membership in South Africa goes back to the colonial period during which white people monopolised power both in church and society, thus denying blacks the opportunity of becoming creative agents of their history and identity.<sup>39</sup>

According to Anderson, these African- initiated churches grew in popularity among black South Africans particularly because they have been able to adapt to and fulfil African religious aspirations rather more relevantly than churches whose origins are in Europe. On close analysis it becomes evident that faith healing is merely a reinterpretation of orthodox

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36 Personal communication with Sop Ntuli, 7/11/2004.

37 NASA, TES 7159 56/76, Correspondence from Secretary of Health to Secretary for Finance, 3 February 1928.

38 Ibid.

39 S.S. Maimela, “Foreword”, in A. Anderson, *Tumelo: The Faith of African Pentecostals in South Africa* (Pretoria, Unisa Press, 1993), p. viii.

Christianity in such a way as to be reconcilable with traditional African culture. Though prophets are themselves not indigenous healers in our present context, they nevertheless have much in common with indigenous healers, including a shared theory of health and disease and a similar means of divination, although in their case it is the Holy Spirit rather than ancestral spirits, that aids them.<sup>40</sup> According to David Hammond-Tooke the ability of the Holy Spirit to “work” in the minds of worshipers and provide guidance has also been an impetus for the fissiparous tendencies that are characteristic of Protestantism; this has led to the extreme proliferation of small Zionist sects, so much so that it has been estimated that there are more than 3 000 of them in the country.<sup>41</sup> Members of various indigenous pentecostal-type churches confirm that they attend the church because it heals them and continues to help them cope with their health problems where modern health care services have failed.<sup>42</sup> In conversation with some members of the International Pentecostal Holiness Church, it became very apparent that many people flocked to this church since the early 1960s primarily because it offered a solution to their health problems, about which both modern and indigenous healers had proved helpless. As Justice Mgidi puts it:

When I first went to IPHC, I actually took my very sick wife out of Muelmed Hospital in Pretoria. She had been bleeding continuously and she had been in and out of that hospital for months without any relief. But it took us only one weekend at the church in Silo (around Zuurbekom in Johannesburg) and she was completely healed. I too found relief from the many ailments that I had thought were part of life itself, including smoking.<sup>43</sup>

According to one member of Jehovah’s Witnesses group, patients’ religious beliefs should be respected and incorporated into their care because some religions have beliefs that conflict with modern medicine, such as blood transfusions. It is therefore contended here that if a patient is resistant to certain forms of treatment because they believe only God can address the problem, it would be strategic for the practitioner to incorporate the patient’s faith into the treatment.

### **6.3 Indigenous medicine as alternative medicine**

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40 J.E. Bereda, *Traditional Healing as a Health Care Delivery System in a Transcultural Society* (M.A. Dissertation, UNISA, 2002), p. 8.

41 Hammond-Tooke, *Rituals and Medicines*, p. 51.

42 Interview with Justice Mgidi, 11/10/ 2006.

43 Ibid.

### 6.3.1 African vs Western perceptions of disease-causation

It is well known that the earlier debates about the existence of contagion and the nature of its processes lasted until the scientific discoveries made by Louis Pasteur and his model of specific aetiology. In order to explain the origins of disease and then cope with its ramifications, each society has evolved a set of beliefs and practices that are deeply entwined within their own culture. Thus as a multi-ethnic and therefore multi-cultural society, South Africa is characterised by a multiplicity of overlapping and competing beliefs and value systems.<sup>44</sup> Although the country's social and economic structures are deeply rooted in Western culture and generally reflect a highly technological world view that can be described as "First World", the majority of its population are of non-Western origin with a world view reflecting what may be termed a "Third World" perspective.<sup>45</sup> The world view of Western cultures has its roots in the scientific revolution alluded to above, according to which the "germ theory" is used to explain the cause of disease.<sup>46</sup> The theory embodies the notion of disease as resulting from the invasion of the human body by germs, whose elimination should entail the breaking of the link in the causal chain through drug interventions.<sup>47</sup>

Unfortunately, the country's health care system has been constructed both officially and legally around this scientific model, yet this has not been accepted by everyone as the only health resource. Arthur Kleinman has reviewed numerous studies on multicultural research and concluded that people often seek answers to questions relating to their day-to-day worldly problems. Unlike the scientific approach where there is no need to search for a cause if a condition responds to symptomatic treatment, Africans insist on understanding the underlying cause of their affliction.<sup>48</sup> If answers cannot be found using the biomedical model, as is often the case, they invariably turn to alternative sources and the most accessible and affordable of these is indigenous medicine.<sup>49</sup> To reiterate: while physical symptoms and bodily changes are the means by which sick people know they are ill,<sup>50</sup> Africans insist on an

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44 M. L. Arthur, *A Fundamental Pedagogical Perspective on Multicultural Education with Special Reference to Tertiary Institutions* (M.A. Dissertation, UNISA, 1992), p. 1.

45Ibid.

46 F. Capra, *The Turning Point: Science, Society and the Rising Culture* (London, Flamingo, 1982), p. 12. See also, R.M. Coe, *Sociology and Medicine* (New York, McGraw Hill, 1978), p. 131.

47 B. Kriel and S. Beuster, "Health and Health Care Systems", *South African Medical Journal*, vol. 5 (1977), p. 167.

48 A. Kleinman, *Patients and Healers in the Context of Culture* (Berkeley, University of California Press, 1979), p. 67.

49 Interview with Ngaka Tsiane, 8/11/2004.

50 It is often said that the only way to recognise the presence of the virus causing AIDS is by observing the body's reaction to it.

explanation for their illness. Admittedly, modern medicine also provides some measure of explanation through the germ theory and other kinds of physiological explanation, but because patients understand and explain disease in very different ways, they seek and provide different kinds of questions and answers. This invariably prompts patients to turn to alternative belief systems. The problem of causality of biological illness is at the heart of a society's system of beliefs and indigenous societies see the ultimate causes of diseases as psycho-social agents invested in man. In terms of this view, man has the capacity to mobilise the power that exists in the universe and he is himself vulnerable to attacks by others using that power.<sup>51</sup> Thus, for most Africans throughout history, serious illness has either been attributed to witchcraft or ancestral wrath.<sup>52</sup> Added to this, social psychologists maintain that it is not only difficult to alter one's beliefs and prejudices, but almost impossible to lose them all.<sup>53</sup> Ruch puts it even more bluntly: "the African today is no longer at ease, standing halfway between two contrasting cultures, not having given up his old traditions and yet not having absorbed fully the Western culture".<sup>54</sup> According to Hlathikhulu, the foregoing argument does not suggest that indigenous explanations of disease causation totally exclude the existence of microbial cases of infection. On the contrary, they acknowledge these, even though they attribute the germs to man.<sup>55</sup> In the view of Ngaka Mmamoraka Phalane, a typical African fails to understand why such a minute creature as a virus should want to harm

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51 Although I derived this information from personal conversation with Sangoma trainees of Ngaka Tsiane and Hlathikhulu, as well as a number of indigenous healers in Kwazulu-Natal and Limpopo Provinces, in my own experience as an African, having lived among Africans all my life, I can confirm that this view of "African science" is shared by the majority of Africans, educated and illiterate, Christian and non-Christian alike. This view maintains that some people have the capacity to harm others through the evil manipulation of "indigenous science" that has not yet been fully researched by historians. A careful study of anthropological research in this field clearly reveals that much illness is associated with deliberate actions by malevolent people and creatures. This cannot merely be dismissed as superstition. Elsewhere in this study, I have also referred to the findings of a judicial Commission of Inquiry into witchcraft, headed by Victor Ralushai, which also confirmed the phenomenon of "witchcraft" as a reality that cannot merely be wished away. For a more detailed exposition of this phenomenon, see, E.E. Evans-Pritchard, *Witchcraft, Oracles and Magic Among the Azande* (Oxford, Clarendon Press, 1937); E.E. Evans-Pritchard, *The Azande: History and Political Institutions* (Oxford, Clarendon Press, 1971), E.E. Evans-Pritchard, *The Institutions of Primitive Society: A Series of Broadcast Talks* (Oxford, Blackwell, 1954); A. Ashforth, *Witchcraft, Violence, and Democracy in South Africa* (Chicago, University of Chicago Press, 2005); M. Gaskill, *Witchcraft: A Seventeenth-Century English Tragedy* (Cambridge, Harvard University Press, 2005); P.J. Steward, *Witchcraft, Sorcery, Rumors and Gossip* (New York, Cambridge University Press, 2004).

52 Interview with Ngaka Tsiane, 8/11/ 2004. Understandably, when people experience conditions of stress and repression, it is natural for them to explain their conditions in ways that would enable them to cope and then adjust to their problems. In fact, emotional survival often depends on being able to regulate personal feelings, beliefs and actions so that anxiety remains at a manageable level.

53 R.E. Spector, *Cultural Diversity in Health and Illness* (Connecticut, Appleton Century-Croft, 1985), p. xi.

54 E.A. Ruch, "African Attitudes to Knowledge", *Mohlomi Journal of Southern African Historical Studies*, vol. 1 (1976), p. 11.

55 Interview with Ngaka Hlathikhulu, 14/8/ 2005.

man with whom it shares nothing in common. “If the creature is said to have caused the illness”, so runs the argument, “then it must have been manipulated by some cultural being who is probably envious of the culprit’s well-being”.<sup>56</sup> In this way, a person seeking an explanation for tuberculosis might have great difficulty accepting that a tiny organism (the tubercle bacillus) has invaded his body. Instead he would rather hypothesise that his problem is related to some metaphysical force.<sup>57</sup> According to Shula Marks, many Africans are adept at adopting and adapting those aspects of Western medicine that work for them, without allowing them to undermine their belief in the efficacy of the indigenous remedies and belief systems.<sup>58</sup> Available evidence suggests that even in “advanced” societies, patients are seldom satisfied with the explanation that their illness is the result of a chance encounter with an opportunistic microscopic organism. For them the world consists of pain, fever and chills. Scientifically oriented victims seek answers in possible violations of their culture’s health rules, such as not having eaten properly, having not slept enough or having permitted themselves to be chilled. Thus, Africans, lacking the germ theory, would seek answers in culturally-defined explanations.<sup>59</sup> It is therefore contended in this study that since the mobilisation of healing processes depends upon the perception of the origins of the problem, the significance of prevailing indigenous beliefs should not be downplayed in exclusive favour of Western microbial explanations.

### 6.3.2 Historical suppression of indigenous medicine

From the available literature on indigenous medicine, it is apparent that its evolution in Africa was markedly different from that of countries that had never known colonialism. According to John Janzen, in Africa the colonial powers were primarily interested in the establishment of Western- modeled institutions regardless of what may have pre-existed among the conquered societies.<sup>60</sup> Perhaps this explains why in his, *A History of the Nigerian Health Services*, Ralph Schram,<sup>61</sup> does not mention the indigenous healers who were serving the Nigerian people prior to British colonisation. Like most of his contemporaries, Schram wrote

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- 56 Interview with Ngaka Mmamoraka Phalane, at Makushwaneng, Zebediela, Limpopo, 14/9/2003. It is interesting to note that a study of African cosmological beliefs conducted among medical students at the Medical University of Southern Africa (MEDUNSA), also revealed persistence of the belief that diseases are caused by evil forces and envious enemies. For an overview of this assertion see J. Elliot, “Black Medical Students and African Cosmological Beliefs”, *Africa Insight*, vol. 14 (1981), pp. 87-88.
- 57 Interview with Ngaka Hlathikhulu, 14/8/ 2005.
- 58 Marks, *Divided Sisterhood*, p. 80.
- 59 Wood, *Human Sickness and Health: A Biocultural View*, p. xvii.
- 60 J.M. Janzen, “Pluralistic Legitimization of Therapy Systems in Contemporary Zaire”, *Rural Africana*, vol. 26 (1974-75), 105-122, p. 109.
- 61 R. Schram, *A History of Nigerian Health Services* (Ibadan, Inbadan University Press, 1971).

as if indigenous ways of coping with illness had never existed. In contrast to such writers however, Shula Marks argues very persuasively that prior to the advent of colonialism African societies, both in South Africa and elsewhere on the continent, had their own healing practices which were intimately bound up with their cosmology and understanding of evil.<sup>62</sup> The tragedy was that as the germ theory of specific aetiology gained predominance, all such non-Western beliefs and value systems that were thought to be based on magic and witchcraft were systematically suppressed.

According to the historical record, the suppression of indigenous healing in South Africa dates back to the Cape Medical Act of 1891.<sup>63</sup> This trend was intensified in the twentieth century when the authorities in Bloemfontein urged that the practice of 'witchcraft' be stopped, and that further legislation be promulgated for the prosecution of indigenous healers found accusing others of witchcraft.<sup>64</sup> However, available evidence suggests that unlike elsewhere in the Union where about 2 000 indigenous healers were literally rendered illegal, Natal and Zululand were notable exceptions. Here indigenous healers continued to receive a measure of recognition under the Native Code.<sup>65</sup> However, although healers in these areas could apply for licences, available evidence suggests that such applications required the approval of the minister, which was often very difficult to obtain under the prevailing circumstances. And for those who received such licences, each indigenous healer was expected to pay an annual fee of £1 in Zululand and £3 in Natal.<sup>66</sup>

However, as the influence of missionary teaching reached all corners of the Union, indigenous healing, wherever it was practised, soon came under severe pressure. It would appear it was the missionaries' brief to convert and then teach Africans that indigenous healing was both evil and un-Christian and therefore should be shunned.<sup>67</sup> When this view reached both the providers of health care and the health authorities, a form of government-sponsored conflict of interests developed between modern and indigenous medical practitioners. As the Union's secretary of Public Health so pompously proclaimed:

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62 Marks, *Divided Sisterhood*, p. 78.

63 NSA, TES 7159 56/76, Correspondence from Secretary of Public Health to Secretary for Finance, 3 February 1928.

64 C. Dennis, "The Role of Dingaka Tsa Setswana from the 19<sup>th</sup> century to the Present", *Batswana Notes and Records*, vol. 10 (1978), 53-66, p. 59.

65 NASA, TES 7159 56/76, Correspondence from Secretary of Health to Secretary for Finance, 3 February 1928.

66 Ibid.

67 D. Kruger, "Towards an Understanding of a Xhosa Diviner" *The Leech*, vol. 48 (1978), pp. 7-13.

The continued activity of Native witchdoctors and herbalists means that the policy of utilising hospitals, doctors and nurses as a civilising agency and to bring the benefits of European medicine to the Native peoples as inaugurated by Sir George Grey in British Kaffraria in 1858 is not being successful.<sup>68</sup>

He made no attempt to hide his displeasure of the rate at which the majority of Africans still patronised indigenous healers in spite of government and missionary efforts to halt this practice, which was, after all, attributable to the Union government's failure to provide adequate medical care to the black people. He continued:

So far as preventing and curing disease is concerned, the Native peoples would be much better without them. It is not very creditable to the government or to White civilisation in South Africa that this state of affairs has been allowed to continue for so long and that so little has been done to bring medical aid within the reach of the great body of the Natives of the Union.<sup>69</sup>

Admittedly, these sentiments and the hostile attitudes towards indigenous medicine no doubt pre-dated apartheid and had nothing to do with the post 1948 NP government. However, it was certainly the apartheid government that subsequently declared all healing systems other than biomedical ones, including the allied medical professions, as illegal.<sup>70</sup> It is also interesting to note that despite public protest against the decision, the South African Medical and Dental Council remained adamant about their rejection of any non-registered healer to perform an act pertaining to the medical profession.<sup>71</sup> There was some public protest against this decision and the protest enjoyed sympathy even from unexpected quarters. The United Party's De Villiers Graaff, for example, also vehemently protested:

Where are the freedom-loving men and women that we should allow a mere handful of Medical Council members to apply for government protection to dictate to the whole nation that only their drugs and methods of treatment must be the only ones used in treating illness, when so often these methods fail. Things have gone so far along the road to absolute dictatorship that into the legislation is written a protective clause, which prevents any legal action whatsoever being taken against the council by the people who may suffer ill effects and damage from their methods of treatment.<sup>72</sup>

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68 NASA, TES 7159 56/76, Correspondence from Secretary of Public Health to Secretary for Finance, 3 February 1928.

69 Ibid.

70 E. Pretorius, "Alternative (Complementary?) Medicine in South Africa", *South African Journal of Sociology*, vol. 24, no. 1 (1993), p. 15.

71 S.D. Edwards, "Traditional and Modern Medicine in South Africa: A Research Study", *Social Science and Medicine*, vol. 22, no. 11 (1986), 1273-1276, p.1275. According to Engela Pretorius, a clause was also included in the modern medical code which prohibited any cooperation between modern and alternative medical practitioners. See, Pretorius, "Alternative (Complementary?) Medicine in South Africa", p.15. See also Government Notice R2278 (1976) as amended in Notices R884 (1977), R394 (1987) and R2543 (1987).

72 Unisa Archives and Documentation Centre, Sir De Villiers Graaff Collection, File no. 51, Legislation

Perhaps this explains why as minister of health in 1963, Albert Hertzog expressed sympathy with those healers outside the formal health care system, when he argued that medical science should not just reject the cures of so-called “quacks” without investigation. The minister cited the case of a woman who had been cured of eczema by a naturopath after the biomedical doctors had failed to help her with modern drugs.<sup>73</sup> The criticism by the medical profession was very blunt and disparaging:

If Albert Hertzog wants to consult naturopaths nobody will stop him. But for the Minister of Health to make virtually a public plea for quack doctors shows how unorthodox is his attitude to the medical profession of which he is the official head in this country. Medical research workers have spent thousands of man hours investigating the claims of amateur healers and doctors continue to spend precious time trying to undo the damage so often done by them. But here is a minister of health suggesting that they should receive more attention because like any garden wall gossip, he knows of a certain case.<sup>74</sup>

Similarly, Professor Douw Steyn, former head of the department of pharmacology at the University of Pretoria argued for a proper scientific study of indigenous remedies. “Make no mistake” stated Professor Steyn, “there are some very good *boererate* (folk remedies) and many African herbalists have excellent remedies. The trouble is that many of these remedies are not properly handled and have caused deaths. If we could examine these remedies properly, we could refine them for controlled and effective use”.<sup>75</sup> However, when legitimisation of other alternative forms of health care were finally formalised in terms of the South African Council for the Associated Health Professions, practitioners of indigenous medicine were still excluded and ignored. Unlike the homeopaths, acupuncturists and so forth, deep-seated prejudices precluded any form of acceptance of indigenous medicine by the medical profession. Interestingly, however, as I have pointed out above, this exclusion and marginalisation of indigenous medicine did very little to dent the image of indigenous healers, nor did it change the Africans’ perceptions of them or the efficacy of their therapies.<sup>76</sup>

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Against Indigenous Healing, 25/1972.

73 *The Rand Daily Mail*, 4 December 1963.

74 *The Rand Daily Mail*, 4 December 1963.

75 Ibid.

76 Interview with Ngaka Tsiane, 8/11/ 2004.

### 6.3.3 Determinants of patient-therapeutic choices

Indigenous medicine constitutes an important means through which indigenous communities cope with illness and disease. Therefore, one way of understanding cross-cultural medical beliefs is from an instrumental point of view. As spelt out above, this involves learning how people structure their explanations for the onset and course of ill-health as well as how these explanations determine the choice of therapeutic strategies. It is asserted in this study that in the African context, it is the underlying cause rather than the pathological process that is a major factor in illness. For this reason, understanding the role of the practitioners of indigenous medicine in the cure and prevention of disease should not rest on pathological concepts but on the hierarchy of other forces that are thought to belong to every being.<sup>77</sup> Marja and Lloyd Swantz have found that Africans generally make a distinction between European and African diseases. Thus, when it comes to the choice of therapy in the onset of disease, they would go to a modern medical practitioner (GP) only if they believed they had a European disease; they would consult an indigenous healer if they were convinced that their malady was an African disease (*Sejeso, Sefola*).<sup>78</sup> The so-called European diseases are actually “natural” diseases which others may regard as diseases caused by God and have nothing to do with another human being or ancestral wrath (*mokhuhlane*).<sup>79</sup> There is a general consensus among Africans that even some European diseases can be alleviated by the administration of indigenous herbs.<sup>80</sup> However, some diseases are believed to be strictly within the domain of indigenous medicine. These include chronic conditions, complaints related to psychosocial disorder, problems associated with reproduction such as infertility as well as those diseases that are deemed to be magical in origin.<sup>81</sup> It is for this reason that I concur entirely with Shula Marks’s view above that the majority of Africans are adept at adopting and adapting those aspects of Western medicine that work for them, but at the same time do not allow this to undermine belief in the efficacy of the indigenous remedies.<sup>82</sup> There is no doubt that much of the appeal of practitioners of indigenous medicine, in contrast to the modern doctors, derives from the fact that they share an understanding and interpretation of

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77 Shai-Mahoko, *The Role of Indigenous Healers in Disease Prevention and Health Promotion Among Black South Africans*, p. 27.

78 M.L. Swantz and L.W. Swantz, “Wholeness and Healing in African Traditional Religion”, *Luthern World*, vol. 22, no. 4 (1975), pp. 309-312.

79 Interview with Ngaka Tsiane at Ga-Klopper, Mpumalanga, 8/11/2004 and Richman Ndlovu at Kwamakhutha, Kwazulu Natal 9/7/2005.

80 M. Gelfand, *Witchdoctor: Traditional Medicine Man in Rhodesia* (London, Harvill Press, 1964), p. 28.

81 J. De Jong, “Traditional Medicine in Sub-Saharan Africa: Its Importance and Potential Policy Options”, The World Bank, Working Papers: Population, Health and Nutrition, July 1991, p. 5.

82 Marks, *Divided Sisterhood*, p. 80.

the social origins and significance of these diseases with their patients. In the view of most Africans, a simple herbal remedy known in Sepedi as *hlonya* is thought to be more effective in the treatment of cough (*mokhuhlane*) than any known Western drug.<sup>83</sup> It therefore stands to reason that with the onset of *mokhuhlane*, Africans always turn to *hlonya* in preference to any modern drug or doctor whose services are often priced way beyond the reach of ordinary black South Africans. According to Robin Horton, this type of coping mechanism absorbs the cause while at the same time it reduces anxiety.<sup>84</sup> Concurring with Horton, Du Toit also maintains that when a system fails to offer explanations for a given set of symptoms, anxiety and chaos invariably ensue, while witchcraft often comes in as part of the convenient explanation of the “why” and not the “how” of the occurrence.<sup>85</sup> Given the acute absence of adequate health care facilities in Kwandebele in the period under review, the pattern of health care seeking behaviour almost always involved a situation where patients would move from one therapy to another and then to another, in the process of deciding whether a particular condition was an “illness of God” or an “illness of persons” or even an illness caused by a non-human being or spirit.<sup>86</sup> The normal pattern of patients moving from one treatment to another, such as from an indigenous healer to hospital and from hospital to some religious group, is a type of diagnostic trial and error that was sometimes influenced more by the patient’s poverty than by a well thought-out conviction on therapeutic effectiveness. David Dunlop and Dayl Donaldson’s study of health financing in Ethiopia set out to analyse the pattern of health care utilisation in terms of the provider and concluded that the proportion of people who reported illness to an indigenous healer was very similar to that which Gernamo Mwabu had found in Meru, (Kenya),<sup>87</sup> namely that the majority of patients who reported illness had consulted indigenous healers at first contact.<sup>88</sup> Similarly, there is persuasive evidence that during the period under review, the majority of the residents of Kwandebele consulted indigenous healers first, albeit for different reasons.

The limited literature on indigenous healing in South Africa reveals that the individual’s educational status or level of Westernisation is irrelevant when it comes to the choice of

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83 Personal communication with Ngaka Tsiane’s sangoma trainees, Ga-Klopper, Mpumalanga, 8/11/ 2004.

84 Horton, “African Traditional Thought and Western Science”, *Africa*, vol. 37, no.1 (1967), p. 60.

85 B.M. Du Toit, “Religion, Ritual and Healing Among Urban Black Africans”, *Urban Anthropology*, vol. 9, no. 1 (1980), 21-32, p. 32.

86 Interview with Ngaka Tsiane, 8/11/ 2004.

87 G.M. Mwabu, “Health Care Decisions at the Household Level: Results of a Rural Health Survey in Kenya”, *Social Science and Medicine*, vol. 22 (1986), pp. 315-319.

88 D. Dunlop and D. Donaldson, *A Study of Health Financing, Issues and Options* (Washington DC, World Bank, 1987).

therapy. A visit to the isangoma or inyanga is usually a clandestine activity that hardly anyone would openly admit or even discuss. It is secret and private not because Africans are ashamed of it but because Christians of all denominations are forbidden by church dogma to consult with indigenous healers and therefore people have to do so under the cover of darkness.<sup>89</sup> As Msongelwa Ntuli so aptly puts it, “it is ironical that some so-called educated and Christianised Africans cast aspersions to anything germane to indigenous healing, yet they consult indigenous healers surreptitiously”.<sup>90</sup> Echoing the same sentiments expressed by Ntuli, Hurst argues, “these visits are kept secret and are denied as they would interfere with the image of the educated bantu”.<sup>91</sup> Such may be the extent to which Christianity and modern medicine have succeeded in depicting indigenous medicine as something to feel shameful about. However, also researching on the same subject of choice of therapeutic intervention in the 1970s, Le Roux found that the clientele of indigenous healers was not limited to the marginal and illiterate classes. For example, in his test group of 43 black senior psychology students, 17 (39.5%) clearly indicated that they had personal experience of an indigenous healer.<sup>92</sup> A household survey conducted in Ibadan has also revealed that roughly 70 % of both the highly educated and the less privileged members of the community used indigenous medicine to varying degrees.<sup>93</sup> In explaining the reasons for this discrepancy, Cheetham and Griffiths argue that modern medical practitioners almost always emphasise the treatment of the disease rather than the treatment of the sick person, and this has been their weakness for ages.<sup>94</sup> Hence, in Hlathikhulu’s words, “whether or not the medical profession acknowledges it, we indigenous healers are more successful in the treatment of mental illness than so-called modern psychiatrists”. For example, while it is one thing to live with a neurotic who behaves in strange ways, it is quite another to have to cope and restore to sanity an individual who becomes dangerous to himself as well as to society during his psychotic break with reality. “What would a psychiatrist do with a violent insane like this man?” asks Hlathikhulu emphatically, pointing me to one of his wild and hamstrung mental patients.<sup>95</sup>

Obviously, his brain chemistry will not permit him to respond to any kind of

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89 Personal communication with Papi Lekotoko, 7/11/2004.

90 Personal communication with Isaac Msongelwa Ntuli, 10/7/ 2005. Kwamhlanga, Mpumalanga.

91 A. Hurst, cited in J. Krause (ed), *Encyclopedic Handbook of Medical Psychology* (Durban, Butterworth, 1976), p. 121.

92 A.G. Le Roux, “Die Psigiatrisese Betekenis van die Toordokter in die Bantoeenkultuur”, cited by Van Rensburg and Mans, *A Profile of Disease and Health Care in South Africa*, p. 185.

93 De Jongh, “Traditional Medicine in Sub-Saharan Africa: Its Importance and potential Policy Options”, p. 6.

94 R.W.S. Cheetham and J.A. Griffiths, “Changing Patterns in Psychiatry in Africa with Special Reference to South Africa”, *South African Medical Journal*, vol. 58 (1980), p. 166.

95 Interview with Ngaka Hlathikhulu, 14/8/ 2005.

talking cure or counseling that psychiatrists rely on. But we indigenous healers can easily disarm him by forcing him to drink a bowl of herbal liquid infused with some roots.<sup>96</sup>

It is for this reason, and others peculiar to Kwandebele during the period under review, that one may reach the conclusion that in this bantustan, modern medicine failed to offer any therapeutic advantage over its competitor, indigenous medicine, not because of its lack of efficacy, but largely because of the people's unwavering faith in the effectiveness of the latter, perhaps exacerbated by issues of inaccessibility and cost of modern medicine. Other determining factors in the choice of therapeutic intervention at the onset of illness include the fact that while it was one thing for a sick person in villages like Borolo to decide against a long and arduous journey by foot to a distant public health facility (Pieterskraal Clinic) or the nearest surgery of a modern medical practitioner (Dr Phil Maepa in Siyabuswa, about 15 km away) it was quite another to take a short walk to a nearby indigenous healer whose services could be paid in cash or in kind.<sup>97</sup> According to an indigenous healer, Enicar Mkhonto, many Africans prefer the services of an indigenous healer primarily because they feel more comfortable with a person who speaks their language and is often more familiar with the African social context.<sup>98</sup>

#### **6.4 Indigenous medicine as preventive medicine**

For all practical purposes, there is no society that does not have beliefs and practices relating to the avoidance of illness. Available historical evidence suggests that although Africans have no codified laws of collective hygiene and no positively postulated principles of public health, their unwritten rules and regulations governing public health were enmeshed and intertwined in a particular code of living which consists of a complex socio-magico-religious system known as taboos. An historical reflection on this system emanating from personal hindsight as an African, suggests that as a system of avoidances, taboos have been used to great effect to regulate human conduct among Africans and to ensure a healthy living behaviour both spiritually and morally.<sup>99</sup> Thus, in contrast to the more curative-inclined modern medicine, indigenous medicine often relies on these taboos and may be said to be

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96 Interview with Ngaka Hlathikhulu. This procedure including the herbal mixture was confirmed by indigenous healers in Kwazulu-Natal, such as Bongiwe Mhlongo (Kwamakhutha), Theresa Ndlovu (Kwamakhutha), Libelephi Maqchaba (Umbumbulu) and Fikisiwe Makhanya (Kwamakhutha).

97 Personal communication with Papi Lekotoko, 7/11/2004.

98 Interview with Ngaka Enicar Mkhonto, Greater Tubatse Municipality, Praktiseer, Limpopo, 14/9/ 2003.

99 Interview with Ngaka Tsiane, 8/11/2004.

more preventive, and thus more appropriate for poor communities. One may also suggest that in their capacity as diviners, mediators and arbiters in matters of health and illness, the role of indigenous healers within African societies is primarily to enforce the strict observance of these taboos, including adherence to ancestral beliefs and ritual ceremonies, all of which sustain social cohesion and help in disease prevention.<sup>100</sup>

The historical role of taboos as coping alternatives in the absence of orthodox medical facilities cannot be doubted. They permeate every aspect of African life from birth to the grave and there is no doubt that their observance from childhood inculcates the correct pattern of public behaviour, notwithstanding the illogical reason often given for their observance. For example, “after a haircut, the hair should never be left in the open because it is taboo to let one’s hair be blown out by the winds”. In explaining the rationale behind this taboo, Gumede maintains that the consequences of such negligence are that the *Thekwane* (*hamerkop* bird) will catch hold of the hair and build her nest with it, with the result that one’s hair would never grow again.<sup>101</sup> For practical hygienic reasons, this taboo ensures a proper disposal of the hair after a crop, because if left lying loose, the hair could be tossed about by the wind and might get inhaled. It then settles on the delicate mucous membranes of the nostrils, throat and larynx where it may cause upper respiratory irritation and coughing.<sup>102</sup>

In order to cope with their health problems and perhaps adapt to conditions of apartheid neglect, Africans make a distinction between socially acceptable and unacceptable behaviour. In terms of this, falling ill is often assumed to be a consequence of actions which have deviated from the accepted behavioural pattern.<sup>103</sup> For this reason other taboos having a significant bearing on public health include teaching boys never to urinate into streams or wells, because if the crab drinks one’s urine you immediately experience a gender change.<sup>104</sup> This taboo protects open sources of water supply from contamination. For obvious reasons, if a single carrier contaminated a common source of water, diseases like typhoid would flare up and assume epidemic proportions in a situation where there are few public health facilities to deal with the problem. Taboos such as this control water borne diseases like cholera, typhoid, bilharzia and so forth. A former Matron of the Nkhensane Hospital, Bertha Johanna Nkondo,

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100 G.L. Chavunduka, *Traditional Healers and the Shona Patient* (Gwebo, Mambo Press, 1978), p. 19.

101 Gumede, *Traditional Healers: A Medical Practitioner’s Perspective*, p. 129.

102 Ibid.

103 Interview with Ngaka Tsiane, 8/11/2004.

104 Gumede, *Traditional Healers: A Medical Practitioner’s Perspective*, p. 130.

tells of how typhoid once claimed the lives of an ignorant Phatlane family in Kgotwane (a rural village around present day Moloto), in the early apartheid years. According to Bertha, typhoid flared up after a stream they relied upon as the only source of water for drinking and other household necessities, had been contaminated with human waste. Without the benefit of present day explanations of how typhoid occurs, and the general ignorance of the theory of specific aetiology, an innocent indigenous healer in the village, Ngaka Mpagane, was wrongfully accused as having been magically behind the mysterious deaths.<sup>105</sup> This story is told in almost the same words by Richard Phahlane who agrees with Bertha Nkondo that at the time, it was believed that Ngaka Mpagane had used his magic tricks to wipe out the family which had earlier accused him of practising witchcraft in the area.<sup>106</sup> Understandably, ordinary people living under severe stress and poverty occasionally resort to forms of magic as part of their coping philosophy. A random mixture of common sense and prescription drugs usually does it for white people, enabling them to struggle through bad times without recourse to murder and mayhem. As Heidi Holland puts it:

If the Western wonder anti-depressant drug Prozac were available to Africans beset by poverty and its attendant ills, it would be welcomed as veritable magic by those with no knowledge of science.<sup>107</sup>

For indigenous communities, anything mysterious, especially death, is attributed to the workings of supernatural forces, often dubbed “indigenous science”.<sup>108</sup> In the opinion of Harriet Ngubane there is good reason to believe that even though it reflects traditional understandings of the causes of misfortune, the problem of ritual homicides is an outcome of social change arising within the modern rather than the traditional context.<sup>109</sup> In other words, although the traditional conceptual framework prescribes ritual killing, it is a means, in terms of that framework, of coping with troubles which in the traditional order were quite

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105 Personal communication with Bertha Johanna Nkondo, Waterval “B”, Mpumalanga, 24/12/2005. Needless to say many indigenous healers were wrongfully accused and torched to death largely because of ignorance of the “germ theory” of disease causation. In this particular case it was only after Bertha Nkondo qualified as a nurse and knew better about disease causation that she realised that typhoid had killed those people, not Ngaka Mpagane and his magic.

106 Personal communication with B.R. Phahlane, 11 December 2006, Borolo (Majakaneng, Mpumalanga Province).

107 Holland, *African Magic: Traditional Ideas that Health a Continent*, p. 198. The author here argues that prior to the technological advances of the developed world, belief in witchcraft served as a way of accounting for inexplicable misfortune, just as it does in many African communities today to explain away certain individual failure. Therefore compounded by poverty, such behaviour can be even more dangerous.

108 Personal communication with Simon Malope, 11/10/2006.

109 H. Ngubane, “The Predicament of the Sinister Healer: Some Observations on ‘Ritual Murder’ and the Professional Role of the Inyanga”, in M. Last and G.L. Chavunduka (eds), *The Professionalisation of African Medicine* (Manchester, Manchester University Press, 1986), p. 200.

exceptional rather than the norm. Unlike modern medicine which is heavily oriented toward cure of diseases rather than their prevention, indigenous medicine, through its use of taboos, is more oriented toward prevention of disease. In fact, the prevention of as much disease as possible and the positive promotion of health require a health service underpinned by a philosophy which recognises the dynamic and holistic nature of health. It would realise the futility of what McKinlay has so aptly characterised as “attempting to save an increasing number of people drowning in a river without refocusing upstream in an attempt to prevent them from falling into the water in the first place”.<sup>110</sup>

## **6.5 1976 and all that!**

### **6.5.1 Indigenous medicine in a changing political climate**

I have alluded to the decade of the 1970s as one marking the beginning of the end of apartheid. While the 1950s and 1960s were characterised by the apartheid government’s tight control over political, economic and social structures, in the second half of the 1970s the regime showed clear signs of weakness and disintegration. In spite of increasing criticism of an irrational policy that clearly ran counter to the demands of the economy at the time, available evidence suggests that the majority of its beneficiaries continued to support and defend the policy they regarded as necessary for their own survival and identity.<sup>111</sup> In the aftermath of the economic boom referred to in chapter three, and as industry expanded, there were not enough whites to meet the growing demand for skilled jobs in the country. At the same time, the low and deteriorating standards of black education meant that the skills shortage could not be met from that source alone. Then too, because of political and economic isolation South Africa was dubbed a “pariah state”, and encountered problems in finding markets for its manufactured items. The limited size of the domestic market, mainly because of the low wages earned by the majority of the population, presented another problem. According to Terence Moll, the South African economy failed because of industry’s dependence on unskilled low wage black labour and the constraining effects of a range of shortsighted and ill-directed state economic policies.<sup>112</sup> This is perhaps what some scholars

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110 J.B. McKinlay, “A Case for Refocussing Upstream: The Political Economy of Illness”, *Behavioural Science Data Review*, June 1974.

111 W.J. Filander, *The Nationalisation of Coloured Education in the Transvaal* (M.Ed Dissertation, UNISA, 1977), p. 57.

112 T. Moll, “Did the Apartheid Economy Fail?”, *Journal of Southern African Studies*, vol. 17, no. 2 (1991), p. 271. See also Lipton, *Capitalism and Apartheid: South Africa, 1910-1986*, p. 30.

had in mind when they claimed that apartheid made “economic nonsense”.<sup>113</sup>

It stands to reason that ideology and dogma could not indefinitely ignore material and economic realities on the ground. Thus, the mid 1970s marked a turning point in the history of South Africa in that events that had seemed only long term possibilities, occurred and brought fundamental changes in the balance of power in the region. This is the period during which the disintegration of the Portuguese empire and the imminent end to white rule in Rhodesia and Namibia, threw the alliance of repression formed against Africans by the white regimes and their imperialist supporters into complete disarray.<sup>114</sup> Effectively, this meant the collapse of the security wall that had separated white South Africa from the rest of black-ruled states of Africa. Compounding these problems, while the regime was still digesting the possible long term implications of the Portuguese defeat, and less than three months after the last South African troops left Angola, the Vorster administration was caught off guard by the Soweto youth uprisings on 16 June 1976. Although the rebellion began as a protest against the imposition of Afrikaans as a medium of instruction in black schools,<sup>115</sup> there is no question that this was merely a spark for the explosion. The real combustible situation had been developing since 1948. It soon became evident that the 1976 uprising was in fact the result of an accumulation of black grievances that included a dire shortage of housing, low wages, lack of public health facilities, the job colour bar, labour migrancy, influx controls and much more. The events of 1976 forced the National Party to concede the one political advantage to which Verwoerd had been so determined to cling, namely, its own belief in the morality of “grand apartheid”.

The connections between health care and social control, including reform and repression were complex and continuous throughout the period under review. Yet the link between disease and public discontent and the palliative role that health care could play in this was never lost on the apartheid state. For example, in the wake of the black working class militancy in 1972-74 and the youth uprisings of 1976, a new Health Act (Act 63 of 1977), designed to promote the health of all sections of the population, was adopted. Effectively, the

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113 Brits, “Afrikaners and the Genesis of Apartheid”, p. 8.

114 B.M. Magubane, *The Political Economy of Race and Class in South Africa* (New York, Monthly Review Press, 1990), p .ix.

115 D. O’ Meara, *Forty Lost Years: The Apartheid State and the Politics of the National Party* (Randburg, Ravan Press, 1966); Thompson, *A History of South Africa*; Lipton, *Capitalism and Apartheid in South Africa, 1910-1986*; G.M.Gerhardt, *Black Power in South Africa: The Evolution of an Ideology* (Los Angeles, University of California Press, 1978).

new health legislation not only replaced the Public Health Act of 1919 but also consolidated all health-related legislation promulgated since then. Closely analysed, numerous events had combined to give rise to this legal reform. In the first place, according to Van Rensburg,<sup>116</sup> in South Africa as elsewhere in the world, during the 1970s there was a systematic shift in the direction of self-reliance, private initiative and privatisation in order to remove the financial burden from the state. Whereas the private sector had previously been tolerated with considerable suspicion and much state control, this time the private sector was expressly requested to take a greater part in health care provision. Be that as it may, it stands to reason that even though the original bill was drafted in 1971 in response to the ongoing inefficiency of the fragmented public health system, the mid-1970s were characterised by escalating political and labour unrest manifesting in massive strikes, rising opposition to apartheid and student unrest, all of which put the government under intense pressure to reform. I have argued in this study that these developments were not unrelated to the unbearable conditions of poverty that the majority of black South Africans were experiencing at the time. Thus in response to changing internal and external pressures, a new strategy was devised to make apartheid more acceptable to sectors of the black population and to the world community by resurrecting some of the medical rhetoric of the 1940s that the apartheid government had rejected for ideological reasons.

### **6.5.2 Historical arguments for and against indigenous medicine**

“For too long”, declared Halfdan Mahler of the World Health Organisation, “traditional and ‘modern’ medicine have followed their own separate paths in mutual antipathy. But their aims are surely identical: the improvement of human health and, hence, improvement of the quality of life”.<sup>117</sup> Although most modern medical personnel believe that modern medicine is far superior to all other medical systems – despite the fact that it has failed to address the common cold – the veritable mountain of literature reviewed in this study has also revealed that practitioners in other cultures have been treating patients with varying degrees of success for centuries. In fact, other evidence points to the fact that several modern drugs including quinine, were discovered in native “medicine kits”.<sup>118</sup> Since the WHO recommendation that member states utilise the human resource of indigenous healers, a number of African

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116 H.C.J. Van Rensburg, “The History of Health Care in South Africa”, H.C.J. Van Rensburg (ed), *Health and Health Care in South Africa* (Pretoria, Van Schaik Publishers, 2004), p.87.

117 H.T. Mahler, “The Staff of Aesculapius”, *World Health*, no.3 (November 1977).

118 G. Galanti, *Caring for Patients from Different Cultures* (Philadelphia, University of Pennsylvania Press, 2004), p.186.

governments have taken serious steps towards legitimating this healing alternative. Yet in apartheid South Africa, the state-sponsored medical profession expressed a strong prejudice against indigenous cultures, including its healing modalities. Similar to other criticisms against indigenous healing, the view that indigenous healers are associated with witchcraft appears to be more of a reflection of unfavourable Western attitudes, disguised as so-called scientific grounds to suppress indigenous healing. As Torrey has remarked:

This combination (doctor and witch) simply does not exist anywhere except in our minds. All cultures have people who play the role of doctors or healers, and most cultures have people who play (or at least suspected of playing) the role of witch. But the two are never the same. Just as in our (Western) culture we distinguish between doctor-healers (and such sub-types of doctors and psychiatrists) from witches, so in other cultures they make similar distinctions.<sup>119</sup>

Perhaps one of the greatest arguments against indigenous medicine, which I regard as unfortunate, is the lack of scientific proof of its efficacy. This includes the fact that their potions are not standardised and therefore they are not dispensed to patients in specified doses or in strictly regulated quantities. Among other arguments often deployed against indigenous therapies is the fact that some procedures used by indigenous healers have been found to be harmful. One of the most common example is the healers' administration of renal enemas on children with infectious diarrhoea, which often leads to dehydration and sometimes deaths of such children.<sup>120</sup> Edward Green and Lydia Makhubu have also warned against the dangers of induced vomiting (*go phalatša*) resulting from indigenous healers' herbal preparations, such as purgative herbs to clean out the chest of TB patients.<sup>121</sup> But even that suggests that rather than isolate indigenous healers, the apartheid government still had a duty and indeed moral obligation to regulate these and protect the public against such identified practices. It is limitations such as these that should have served as sufficient grounds for state intervention rather than simply pretending that such practices do not exist. Similarly, intervention would influence indigenous healers to sterilize their instruments (razors) properly, particularly in this age of the HIV/AIDS pandemic or even encourage them to use new instruments for each case of immunisation (*go phatša, le go lomega*). Intervention would teach healers about the dangers of enemas in general particularly in the treatment of

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119 Torrey, quoted in Sodi, "Towards Recognition of Indigenous Healing: Prospects and Constraints", *Chasa: Journal of Comprehensive Health*, p .8.

120Interview with Matron Mabindiza.

121 E.C. Green and L.M. Makhubu, "Traditional Healers in Swaziland: Towards Improved Cooperation Between the Traditional and Modern Health Sectors", *Social Science and Medicine*, vol. 18, no. 12 (1984), p. 1074.

childhood diarrheal disease, by advocating instead the use of oral rehydration therapy.<sup>122</sup> Part of the intention of this study is to warn against the danger of romanticising the efficacy of herbal remedies when in some cases such remedies have proved toxic. Be that as it may, there are undoubtedly strong reasons for the persistence of indigenous medicine in spite of attempts to eradicate it as well as advances in modern medical technology. That practitioners of indigenous medicine provide a holistic approach with attention falling on the whole person, has been well established in the literature.<sup>123</sup> Collectively, indigenous healers have been found to be capable of treating three types of disorders: acute self-limiting diseases, non-life threatening chronic diseases in which management of the illness is a larger component of the clinical management than biomedical treatment, and secondary somatic manifestation of minor psychological disorders.<sup>124</sup> According to Green and Makhubu, indigenous healers know how to calm a patient's fears by explaining how and why he became ill, and may perhaps even make sense of his interpersonal problems.<sup>125</sup> Essentially because the treatment of disease plays an insignificant role in the care of these disorders, the indigenous healer's holistic approach stands him in good stead when compared to biomedical practitioners.

Encouragement of increased collaboration between indigenous healers and biomedical practitioners should be promoted to help minimise the chance of exposing patients to any danger. However, a large body of literature in medicine and social sciences involves descriptions of conflict between modern and indigenous medical systems. Closely analysed, the root cause of negative attitudes towards indigenous medicine seem to have been based on the tendency to use Western standards to measure the worth of indigenous therapies, which seeks to suggest that indigenous healing lacks a scientific base.<sup>126</sup> At a conference organised by the University of the Witwatersrand Centre for Health Policy, Professor Heyl, of the South African Medical and Dental Council (SAMDC) remarked unequivocally:

We just do not know enough about the practice of the traditional healer to really assess his value ... Council (SAMDC) steeped as it is in the scientific method and a quest for more knowledge and better skills to create a sound basis for medical practice, cannot condone such haphazard and unscientific

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122 Interview with Dr Magampa, 14/2/2000.

123 Rosch and Kearney, "Holistic Medicine and Technology: A Modern Dialectic", *Social Science and Medicine*, vol. 21, no. 12 (1985), pp.1405-1409.

124 A. Kleinman and L.H. Sung, "Why do Indigenous Practitioners Successfully Heal?", *Social Science and Medicine*, vol. 13B (1979), 7-26, p. 24.

125 Green and Makhubu, "Traditional Healers in Swaziland", *Social Science and Medicine* (1984), p. 1074.

126 See the works of Robin Horton, "African Traditional Thought and Western Science", *Africa*, no. 37 (1967); Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to Present* (New York, W.W. Norton, 1997).

procedures.<sup>127</sup>

Yet by professor Heyl's own admission, the South African Medical and Dental Council did not have enough knowledge about indigenous healing, therefore, as a member of that council, he was clearly not qualified to give an opinion on the usefulness, or lack of it, of indigenous therapies. In the light of his own declared ignorance and inadequacy of SAMDC's understanding of the indigenous healing process, it would have been logical for the Council not to shun, but to investigate this form of health care to establish its strengths and weaknesses and then begin to argue on that basis. Of course value judgements have to be made to decide if any form of therapy is beneficial or harmful. But criticism of effective indigenous therapies by unqualified Western skeptics, based largely on their historical prejudice against indigenous healing, can only provide further ammunition to other critics of indigenous medicine and thus undermine all efforts to regulate the craft in the interests of the general public.

In view of the fundamentally different paradigms and behavioural correlations that distinguish indigenous and biomedical therapeutic systems, effective formal collaboration that actually enhances the health of the people cannot be expected to evolve unaided. According to Sodi, Heyl's remark above clearly suggests that members of the biomedical profession would be reluctant to relinquish their familiar authoritarian role and recognise the historical contribution of indigenous healers to their collective objective of preserving health and curing disease.<sup>128</sup> However, in a functional analysis of indigenous healing, Rappaport and Rappaport,<sup>129</sup> share the view held by Jerome Frank,<sup>130</sup> that in spite of their history of hostility, there is room for coexistence between practitioners of the two medical systems. In fact the extent to which indigenous medicine is practiced in the country is such that it can no longer be ignored by those involved in the strategic planning and development of the country's post-apartheid health care system. In my view, if practitioners of indigenous medicine can be trained in simple hygiene, general modern health concepts, health education, environmental sanitation, referral and record-keeping, they can play a meaningful role in health care and thus fill the vacuum created by the shortage of manpower and the high cost of training

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127 T. Sodi, "Towards Recognition of Indigenous Healing: Prospects and Constraints", p. 7.

128Ibid.

129 H. Rappaport and M. Rappaport, "The Integration of Scientific and Traditional Healing", *American Psychology*, vol. 36, no. 7 (1981), p.775.

130 J.D. Frank, *Persuasion and Healing: A Comparative Study of Psychotherapy* (London, Johns Hopkins Press, 1973), p. 59.

modern health care workers. The fact that they belong to the same culture as their patients means that they share common beliefs and values, and more importantly, they often do not have communication barriers. They are also unhampered by inadequate transportation problems in remote rural areas so often experienced by practitioners of modern medicine.<sup>131</sup> Similarly, while modern medicine, particularly hospitalisation serves to increase a feeling of alienation of the patient from his family, indigenous healing is inextricably woven into the fabric of community. In the South African context, integration and registration of practitioners of indigenous medicine may also be possible, but only after a period of official government recognition. This may take several forms at various levels and in various contexts. Recognition should entail an array of relationships between indigenous healers, government officials and medical personnel at all levels. An awareness of the role of indigenous healers will no doubt provide the medical profession with insights into why and at what stage in the illness episode, patients consult the formal health care facility, where available. On the other hand, a much fuller grasp of patient expectations will assist health care providers to assess health-seeking behaviour, including compliance or the lack thereof.<sup>132</sup>

It is interesting to note that by 1976 the Dingaka Society of Botswana had already received official government recognition, with a clear mandate to regulate the practice of indigenous healing in that country. This included the issuing of licences to those competent to practice.<sup>133</sup> In contrast, in South Africa, a major barrier to formal collaboration between the two systems arose from existing political and structural realities; national approaches to health care are dominated by ideologies and strategies articulated by a minority and are designed to cater for the health needs of a few.<sup>134</sup> Thus, a precondition for recognition is the creation of an enabling legal environment for collaboration between indigenous healers and the biomedical profession. Admittedly in terms of the Traditional Health Practitioners Act (Act. 35 of 2004) which is calculated to regulate indigenous medicine in South Africa, indigenous healing seems to be undergoing a remarkable renaissance.<sup>135</sup> This act also sought to establish the Interim Traditional Health Practitioners Council of South Africa to provide for a regulatory

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131 Dheyongera, "Prospects and Scope for Traditional Medicine in the Health Care System of Developing Countries", p. 16.

132 Interview with Dr Magampa, 14/2/2000.

133 M. Last, "The Professionalisation of African Medicine: Ambiguities and Definitions", in M. Last and G.L. Chavunduka (eds), *The Professionalisation of African Medicine* (Manchester, Manchester University Press, 1986), p. 1.

134 Good, *Ethnomedical Systems in Africa*, p. 25.

135 <http://www.doh.gov.za/docs/legislation/acts/2004/act35.pdf>. Accessed on 25 October 2006.

framework to ensure the efficacy, safety and quality of traditional health care service. It also sought to provide for the management and control over registration, training and conduct of practitioners, students and specified categories in the traditional health practitioners profession.<sup>136</sup>

Of course other opposing views are borne out of fear that after years of suppression, such recognition would give legitimacy to indigenous healing and thereby provide an excuse for government not to provide adequate modern health care facilities to the historically underserved areas.<sup>137</sup> The history of the medical profession itself shows that even when it was generally desired, unity among all biomedical practitioners could never have been achieved unaided. Nor were the divisions of interests eliminated in the process of unification. What is not in doubt is that the legislation which endowed the medical profession with state-sanctioned authority and provided an integrated system of registration of all practitioners, represented the convergence of the interests of the profession and the state. In the present situation, one may argue, it is around the issue of HIV/AIDS that the interests of the state and those of modern and indigenous healers must converge to hasten collaboration and the recognition of indigenous medicine. Certification and licensure should be the final stage in the process. It is important to note that Reverend Halland has identified the following five stages in the development of rapport between two conflicting ideologies:

- \* Complete rejection
- \* Coldness to lukewarmness
- \* Strained acceptance
- \* Peaceful co-existence
- \* Active co-operation on either side.<sup>138</sup>

It is not clear whether in South Africa such integration of indigenous medicine into the official health service would be pursued purposefully in an atmosphere of goodwill, or whether there would be a degree of hostility. Admittedly, an historians cannot, without ceasing to be an historian, speculate about the future, yet it can be hoped nonetheless, that

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136 Ibid.

137 M. Freeman and Motsei, "Planning Health Care in South Africa – Is there a Role for Traditional Healers?" *Critical Health*, 40, (1992), pp. 1125-1130.

138 Reverend Halland, quoted by Gumede, *Traditional Healers: A Medical Practitioner's Perspective*, p. 232.

under the current political leadership such recognition of indigenous medicine and its ultimate integration into the formal health care system will no doubt occur within the framework of the African renaissance, so robustly pursued by President Thabo Mbeki.<sup>139</sup> It is perhaps in this context that the words of the nineteenth century German philosopher, Arthur Schopenhauer are particularly relevant: “all truth goes through three steps: first it is ridiculed, second, it is violently opposed, and finally, it is accepted as self-evident”.<sup>140</sup>

## 6.6 Other coping and survival strategies of Africans

From the information recounted in chapter three, there can be little doubt that apartheid formed the basis of the majority of the health problems of black South Africans in the period 1948-1976. I have, for example, pointed out that the long absences of men from their homes, and their wives' dependence on inadequate remittances and the constant fear of abandonment have imposed great strains on marital relationships. These stresses called for creative responses and resourcefulness on the part of those on the receiving end in order to enable them to cope and thereby survive in an otherwise repressive environment. According to Eddie Koch, “the concept ‘culture’ must be broadened to include not only the products of specialised intellectual work (books, philosophy, painting, etc), but also the general social activity whereby all men and women give creative expression to the material conditions that surround them”.<sup>141</sup> Thus, when the development of capitalism creates conditions of existence that are lived and experienced along class and gender lines, then the basis for the growth of a class culture exists. Therefore, the need to find ways of survival under these circumstances would exert pressure (on classes that share the same conditions of exploitation) to respond collectively to develop conceptions of the world that correspond to this collective activity. There is evidence in this connection that for those black women who were abandoned by their husbands, brewing and selling beer and sexual relationships with returning migrants were some of the means to survival.<sup>142</sup> Scholars have debated this issue of beer brewing and

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139 I have stated elsewhere in this study that in terms of the ANC's National Health Plan for South Africa, the current government encourages the mobilisation of all human resources in health care, including indigenous healers to meet its goal of “a better life for all”.

140 Arthur Schopenhauer, quoted by J. Marti and A. Hine, *The Alternative Health and Medicine Encyclopedia* (Detroit, Visible Ink Press, 1998), p. xii.

141 E. Koch, “‘Without Visible Means of Subsistence’: Slumyard Culture in Johannesburg 1918-1940”, in B. Bozzoli (ed), *Town and Countryside in the Transvaal: Capitalist Penetration and Popular Response* (Johannesburg, Ravan Press, 1983), p. 154.

142 HPW, AD843/RJ Aa12.14.1, “Evidence of the South African Institute of Race Relations to the Native Laws Commission of Enquiry (Fagan Commission, 1946-48), p. 65, cited in Jochelson, “Sexually Transmitted Diseases in Nineteenth and Twentieth-Century South Africa” in Setel et al (eds), *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa* (London, Greenwood Press, 1999), p. 223.

have concluded that for the majority of abandoned women who were excluded from the formal sector of employment by apartheid's rigid sexual and racial division of labour, it was the only way to establish an independent livelihood.<sup>143</sup> However, besides alcohol's numbing and diminishing effect which makes life more tolerable for those who have to struggle daily for the bare necessities of living, it is important to recognise the role of liquor as a useful instrument of oppression in the hand of the oppressor. No doubt a heavy alcohol consumption was in many ways functional to the apartheid state in that it exacted a heavy physical and moral toll on the people who drank it, and thus served as an effective strategy to diminish political awareness among Africans. This explains why shebeens and beer halls were the main targets by arsonists during the 1976 youth uprisings. However, as a means of coping with poverty, the ability to brew beer and to generate an income sufficient to bridge the gap between survival needs and wages has been revealed by Ellen Hellman.<sup>144</sup> I have also pointed out earlier that the behaviour of people is often an adaptive response to their material situation. Poverty and the adverse social circumstances the majority of black South Africans found themselves in under apartheid had a great deal to do with the high incidence of alcoholism and the predominant role played by an urban social institution called "shebeen" among African communities. Though the problems associated with alcohol are not peculiar to the poor, or indeed to black South Africans, their effects are nevertheless considerably more devastating for the poor because of their greater vulnerability. Though there are no national statistics of alcoholism, from press reports and casual observation in areas where poor people live, there is no doubt that the apartheid-created insecurities experienced by the black South Africans during the period under review have been exacerbated by alcohol. Of course, poverty also breeds boredom, because one of the striking features of the research findings of the Carnegie Inquiry was the extent to which, under the conditions prevailing in the rural areas, including the resettlement camps of the apartheid era, there was virtually nothing to do. There were no fields to till, no cattle to be tended and virtually no recreational facilities. As Wilson and Ramphela have noted:

There is not the rich traditional social structure with the concomitant rituals of kinship and neighbourliness that is to be found in the anthropologists' reports of earlier societies, fifty or even thirty years ago. Boredom hangs like a dark

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143 Jochelson, "Sexually Transmitted Diseases in Nineteenth and Twentieth-Century South Africa", Setel, *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa*, p. 224. For an historical overview of beer brewing as Africans' means of survival, see Ellen Hellmann, "The Importance of Beer Brewing in an Urban Native Yard", *Bantu Studies*, 8 (1934), 39-60.

144 E. Hellmann, *Rooiyard: A Sociological Survey of an Urban Native Slum* (Oxford, Oxford University Press, 1948).

cloud. And closely associated with it, despair.<sup>145</sup>

Eddie Koch had also found that these shebeens, around which the beer trade operated were accompanied by a constellation of other cultural activities. For example, the process of brewing and selling beer involved black women in extensive mutual assistance, such as feeding and looking after one's children if one was arrested during police raids for illicit beer brewing.<sup>146</sup> Women also organised *stokvels* (*mogodišano*), which was a kind of voluntary association in which the members would take turns to receive a weekly subscription paid by all the members of the association. Afterwards, the pooled money would be used to organise a party where non-members paid an entrance fee, the proceeds of which went to the organiser.<sup>147</sup> In addition to these survival strategies, Africans also had a well developed system of mutual assistance called *mafisa* whereby families with enough cattle would temporarily give their much more poorer relatives some cattle for milk. Indeed, this system has sustained poor African families before and during the decades of apartheid misrule and beyond. Even the burial societies whereby black people attempted to ensure a decent burial for themselves and their families have their roots in conditions of poverty and deprivation associated with segregation and racial discrimination.<sup>148</sup> As a strategy to cope with their state of impoverishment, many Africans make a small monthly subscription fee so that when death strikes their loved ones will, in spite of their poverty, still receive a decent burial. Prostitution has been another survival and coping strategy for many women. Karen Jochelson has argued that though sexual relationships outside of marriage might be regarded as prostitution, many informal relationships established by abandoned wives of migrants, nevertheless became long term and stable.<sup>149</sup> In fact, prostitution in its strictest sense is actually foreign to African culture. The whole idea of informal relationships (*vat en sit*) rather than marriage, and the growing acceptance of illegitimate births reflected changes in marriage customs and sexual mores caused primarily by poverty and contact with foreign cultures. Even the idea of boyfriend and girlfriend that is so normal in Western culture is foreign to Africans who through certain cultural rituals encourage girls to take pride in their virginity at marriage.<sup>150</sup> With regard to health care in the period under review, Africans, both in the urban and in the rural areas of the country, had a wide range of options for dealing with illness, from self-help

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145 Wilson and Ramphele, *Uprooting Poverty: The South African Challenge*, p. 160.

146 Koch, "Without Visible Means of Subsistence", p. 161.

147 Hellmann, *Rooiyard: A Sociological Survey of an Urban Native Slum*, p. 25.

148 Personal communication with Sop Ntuli, 7/11/2004.

149 Jochelson, "Sexually Transmitted Diseases in Nineteenth and Twentieth-Century South Africa", p. 224.

150 Personal communication with Sop Ntuli, 7/11/2004.

to indigenous and to modern health care. Even these choices represented highly rational responses to the constraints they faced. Over the years, Africans have used cultures,<sup>151</sup> such as male initiation, to limit chances of infection with sexually transmitted infections. And the whole process of male initiation depends on the good services of indigenous healers.<sup>152</sup> It is cultures such as these, that could be used to great effect in the management of the HIV/AIDS epidemic,<sup>153</sup> and this can be done within the context of collaboration between modern and indigenous practitioners. But of the different illnesses afflicting Africans in conditions of impoverishment which both modern doctors and indigenous healers are competent to handle, there were those illnesses that remained within the domain of indigenous medicine, about which the modern GP could do nothing.<sup>154</sup> As pointed out above, these included both diseases that were deemed to be “magical” in origin and those that were perceived to be caused by social problems.

## 6.7 Conclusion

In conclusion one may say that as there were no biomedical doctors and therefore inadequate health care services in Kwandebele, this does not mean that the bantustan residents who became ill were completely unattended. If biomedical practitioners are to provide optimum assistance to patients from all cultures, it is imperative that they first understand those cultures. Sadly, most medical curriculums in this country contain very little, if any information about African cultures. Ideally, medical professionals should be taught to recognise the value of what other systems have to offer so that they can combine the best of each to reach the ultimate goal of providing effective health care for all the people of the country without exception. As the situation stands, very few programmes focus on therapeutic intervention strategies to empower medical graduates to be optimally effective when dealing with African people in their various geographic localities.<sup>155</sup> In this chapter I have briefly sketched the circumstances and the reasons for the establishment of Kwandebele, pointing out that at the time of its establishment, the government’s original plans for bantustans had undergone dramatic changes. Because of these, the creation of a viable “national state” in the

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151 It should be borne in mind that there is no single African culture, but a diversity of cultures within and between different African communities. There is even not a single Pedi culture or a single Xhosa culture for that matter.

152 Personal communication with Simon Malope, 11/10/2006.

153 Interview with Justice Mgidi, 11/10/2006.

154 Personal communication with Simon Malope, 11/10/2006.

155 G. Henderson, *A Practitioner’s Guide to Understanding Indigenous and Foreign Cultures: An Analysis of Relationships Between Ethnicity, Social Class and Therapeutic Intervention Strategies With Third World Peoples from Other countries* (Springfield, Charles Thomas Publishers, 1989).

1970s had ceased to be Pretoria's priority. Instead the need to put together and control all those black people who had been rendered "stateless" by the application of other apartheid laws, was a more decisive imperative in the establishment of Kwandebele. This explains the bantustan's acute lack of resources, including biomedical services, which then created space for indigenous medicine to entrench itself as an alternative for coping with disease and illness. In this small bantustan faith healing and indigenous medicine both played a major role in mitigating the impact of apartheid medicine by filling a significant gap created by official neglect.

## CHAPTER 7

### CONCLUSIONS

The final injustice, the ultimate injustice, is injustice of health care. If your neighbour has a bigger house than you, it may not be just, but you can live in a small house. If your neighbour has a big car and you have to walk, it is unjust; or if your neighbour can eat cake and fancy food and you have to get on scraps, that's bad. But it is nothing compared to whether your neighbour has an unfair consumption of health care. If you are in a position to gobble up the health care which would have saved your neighbour's life, this shows the ultimate injustice.<sup>1</sup>

Looking back over the ground that has been covered in this study, there is nothing particularly unusual about the history of South African medicine relative to other sub-Saharan countries on the same level of political and economic development. South Africa is not the only country to have experienced colonialism, segregation and discrimination of one group by another. It is clearly not the only country where the politically dominant group used its political control of the state apparatus to raise barriers against other groups and to capture the lion's share of public resources. Nor could all the health problems experienced by black South Africans in the period 1948-1976 be solely attributed to the accession to power of the National Party and the insincerity of apartheid ideologues like H.F. Verwoerd and M.D.C. de Wet Nel, the vice chairman of the Native Affairs Commission. In fact, history books are crammed with names of men whose misguided devotion to false ideals led their nations to destruction. Adolf Hitler was one such person. While he sincerely believed in the "master race" and its *lebensraum*, apartheid ideologues like De Wet Nel, with whom an interesting comparison may be made, also believed in a living space for "all South Africans", although nicely split up into Black *lebensraum* and White *lebensraum*. While Hitler wanted to protect the Germans in Sudetenland, Austria and Czechoslovakia, De Wet Nel suggested in January 1959 that Britain hand over the protectorates of Lesotho, Botswana and Swaziland to South Africa. "Give me five years and I will give you a new map of Europe", said Hitler emphatically. And he did it for a short period. Similarly, in a speech in Bloemfontein in 1958, Nel challenged his Afrikaner audience, "Give me two years and I will show you a new map of South Africa,"<sup>2</sup> and by 1976 the entire surface area of what legally constituted the

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1 R.A. Lambourne, "Modes of Health and Salvation: Secular and Christian" *Contact*, no. 1 (1971), p. 1.  
2 *The Natal Mercury*, 4 November 1959.

geography of the so-called “white South Africa” was totally different from what it had been in 1958. Thus one may conclude that, while Hitler believed in the master race, Afrikaner nationalists like Nel and Verwoerd also believed in the Afrikaner nation’s divine mission to shape South Africa’s racial destiny.

Notwithstanding the foregoing, there is however one feature of South Africa’s history that is unique and therefore deserved some attention in this thesis. Nowhere else in the post-war world has there been as much political repression and domination legally enforced for so long, against so many, yet by so few. Hence the contention in this study that it was essentially this unique feature that lay at the root of the insecurities of the economically and politically dominant white minority. As Sampie Terreblanche put it:

By overemphasising the alleged injustices done to Afrikaners by British imperialism and foreign capitalism, and exaggerating the dangers of *swart oorstroming* (‘black swamping’), Afrikaner ideologues succeeded in creating a ‘syndrome of victimisation’ - ie, the idea that the existence and interests of the Afrikaner volk were endangered by other population groups. In this way the NP succeeded in mobilising Afrikaner ethnic power by portraying Afrikaners as the wrongful victims of a double onslaught: the first was their exploitation ‘from above’ by British colonialism and foreign capitalism, and the second the danger ‘from below’ of Afrikaner culture being swamped by an ‘uncivilised’ African majority.<sup>3</sup>

This insecurity, to a significant degree, determined state action and formulation of policy in the period under review and beyond. This also explains why South Africa became a divided society of a special type, in which state-manufactured ethnic groups were allocated differential rights and privileges that not only ensured different statuses in life but also offered the various race groups different life chances. The tendency to place South Africa on the same level of economic development as the rest of sub-Saharan Africa,<sup>4</sup> and then proceed to compare its performance in various spheres of social and economic life with the performance of those underdeveloped African states, does not stand honest scrutiny. The bulk of the evidence reviewed here revealed that unlike those developing countries, apartheid South Africa was relatively rich in natural resources and economic stature but that its wealth benefitted only a small white minority who lived in ostentatious affluence while surrounded by abject poverty. What also set South Africa apart from the rest of the developing world was that since 1948 this unique system of racial differentiation and its associated macro-economic

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3 Terreblanche, *A History of Inequality in South Africa 1652-2002*, p.298.

4 H. Goosen, “Primary Health Care and Disease Prevention”, *South African Panorama*, vol. 33, no. 7 (1988), p. 8.

policies have not only determined access to basic societal needs which have an indirect bearing on health such as housing, clean water and sanitation, but have also determined access to such social services as health care, education, income and occupation as a matter of government policy. The fact that important determinants of population health levels are essentially political and economic explains why apartheid medicine has been technically ineffective in improving health standards in the South African environment during the period 1948-1976.

The primary contention of this thesis has been that to promote a society with a social structure conducive to good health needed more than just the elimination of apartheid. It required the recognition that practitioners of indigenous medicine were also providing valuable health care to the majority of the country's population. It also required all influential opinion-makers to use their individual and collective power to change the features of the country's social order which were premised upon the exclusion of other race groups from the decision-making processes. It stands to reason that in apartheid South Africa, like elsewhere, medicine was clearly a political process, because political decisions determined the distribution of health care across groups in the population, the amount of resources made available for it and the access that individuals had to the health care system. For example, it was one thing for Nationalist politicians to point proudly to the surgical successes of Dr Chris Barnard and to the comparable skills of his talented colleagues throughout the country, skills that have rightly earned them worldwide respect and recognition. It was clearly quite another to be so blinded by the heavy fall-out of praise that they ignored the evils in a policy that was as politically bankrupt as it was counter-productive to the health of the country's black majority. This was particularly so because of the shocking socio-economic and living conditions the government forced upon Africans, particularly those in the countryside who were living in the so-called bantustans. Little did the pioneers of the heart surgery recognise the contradictions that within a short distance from where "the world's little miracle" happened, black children were dying of malnutrition and its related preventable illnesses.

Also central to the argument in this thesis was that the apartheid government had demonstrated a strange reverence for population numbers and an unwavering faith in its ability to put people into ethnic categories; all this as a survival strategy to avoid the white minority being "swamped" by the black majority. Closely analysed however, it seems that contrary to conventional rhetoric, apartheid was not meant to be an evil system consciously

calculated to keep black South Africans in perpetual poverty. Instead, the inequalities that inevitably flowed from its implementation were mere outcomes of a combination of white survival strategies. This also goes some way to explain why supporters of apartheid have consistently pointed to numerous illustrations in history in an effort to prove that different races could not live harmoniously together in an integrated society and that polarisation was the solution to inevitable racial friction. De Wet Nel spelt out the extent of white fears of racial integration: “The policy of integration in South Africa was a slow but sure process for the destruction of the European in South Africa and created a condition where the Bantu would soon become a semi-civilized barbarian”.<sup>5</sup> It was views such as these that exacerbated and intensified racial polarisation which found expression in many ways and was fundamentally critical to the unequal distribution of the country’s political power and economic resources.

From the evidence presented in this study and the literature on international experience reviewed here, it is evident that the main determinants of the health of a nation are access to and the quality of food, clean water, proper housing, level of education, and also the state of the infrastructure such as sewerage systems, roads and power sources, all of which were not readily available to black South Africans, particularly in the rural areas. In addition to these, this study proposes the increasing utilisation of all role players in the health care system, including practitioners of indigenous medicine who could provide essential health care to rural communities who could thus have access to services they could afford. Modern medicine does not have the answers for all health problems; people from different backgrounds and under different environments have different health needs. In fact, it was no coincidence that the primary health care strategy cracked up since the Alma Ata declaration of 1978 was accompanied by the rediscovery of African medicine, whereby, practitioners of indigenous medicine who had long been used as informants by anthropologists, were now considered as potential allies in the struggle against disease. In this way, Africans, apart from their technological borrowings from the West, could now lay claim to a cultural authenticity long obliterated by decades of colonial rule. The medical histories of most developed countries reviewed in this thesis show declining mortality which began to be noticeable in the national aggregate statistics of those countries due not to the discovery of new drugs to deal with various diseases, but mainly due to the successes of the politically and ideologically

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5 *The Sunday Times*, 23 March 1956.

negotiated movement for public health.<sup>6</sup> In some cases, modern medicine may even be irrelevant and inappropriate. Hence the argument in this study that in view of the role played by cultural beliefs in explaining the cause of disease, in view of the importance of belief in determining patient choice of therapy and in view of the power of belief in aiding therapeutic effectiveness, indigenous medicine is better placed to deal with the health problems of the poor. Of course underlying the choice between a subordinate or autonomous role of an indigenous practitioner are divergent assumptions as to how and why indigenous medicine works. For example, indigenous medicine is useful because it has techniques and drugs that can be usefully added to the stock already in use and because it has personnel who have valuable local insight and experience in African health problems. Indigenous medicine works through a heightened placebo effect and therefore cannot be divorced from its cultural context without losing its efficacy. As in the majority of the developing countries, the post-apartheid South Africa needs to acknowledge the historical contribution of indigenous medicine and explore its potential within the context of primary health care. Yet it would be suicidal to suggest that in the light of the foregoing argument in favour of indigenous medicine, the biomedical model should be discarded as ineffective and inadequate. Instead, in spite of the strong argument presented in this study, it would be futile and misleading to attempt to compare the effectiveness of indigenous healing with that of modern medical science in the cases of frank pathology. Indeed, very few if any of the acknowledged advantages in the approach of the indigenous healer would measure up to the immunisation techniques that have virtually eradicated smallpox, poliomyelitis, tetanus, diphtheria and other dreaded diseases. Few informed people would be willing to trade the efficacy of one or two injections of penicillin in the treatment of such formerly devastating diseases as syphilis and gonorrhoea for even the all-encompassing ministrations of the indigenous healer. In other words, despite its contribution to the general well being of the majority of Africans under the constraints wrought by apartheid as argued in this study, it would be misleading to suggest that indigenous medicine has persisted until the present largely because it is more effective than modern medicine. Factors other than modern medicine's lack of effectiveness have been critical in determining the patient's choice of indigenous medicine and one of the contentions of this study is that there is much that modern medicine can learn from indigenous healers. By working closely together, the two systems can go a long way towards resolving the many health problems confronting the majority of the country's population in the post-apartheid period.

South Africa did not lack the necessary warning about the importance of public health measures in the period before 1948. The Gluckman Commission was very clear about the underlying causes of ill health when it stated as early as the 1940s that:

Unless there are vast improvements made in the nutrition, housing and health education of the people, the mere provision of more “doctoring” will not lead to any real improvement in the public health.<sup>7</sup>

Yet despite the commission’s somewhat revolutionary proposals in terms of their emphasis on quality preventive and curative primary health care, the report was sadly ignored – first by the Smuts administration and then by the National Party, for reasons that had nothing to do with the health of the people. The all but complete eradication of typhoid, cholera and smallpox in the developed countries each testify in different ways to the importance and effectiveness of various aspects of the large scale strategic public health measures. Provision of a sufficiently clean water supply was essential in the case of both typhoid and cholera in many countries.<sup>8</sup> Other important contributors are preventive health measures such as health education, immunisation programmes and campaigns to eradicate carriers of parasitic diseases. Why then were most of these easily preventable and treatable diseases such great killers of black South Africans during the period under review, in spite of this experience?

I have argued that the inadequacy of apartheid South Africa’s health care services stems from the fact that these services were largely hospital-based, urban biased and more curative than preventive. In this way they were designed to be more responsive to the health needs of the dominant white minority while they remained virtually non-existent to a larger percentage of the country’s rural population, who often needed them the most. The reason for this is that this curative level of care is more tertiary and it often constitutes a last chance level which cannot improve the health of the nation *per se*, because it caters for those who are already ill. Only at this level does the quality of health care as measured by health personnel, health institutions, sophisticated technology and drugs play a major role. And besides, there are illnesses and handicaps about which doctors can do very little, if anything at all. The importance of indigenous medicine lies in its emphasis in understanding the cause of disease,

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7 Union of South Africa, UG, no.30-1944, *Report of the National Health Services Commission on the Provision of an Organised National Health Service for all Sections of the People of the Union of South Africa, 1942-1944* (Pretoria, Government Printer, 1944), p. 181.

8 S. Szreter, “The Importance of Social Intervention in Britain’s Mortality Decline c. 1850-1914: A Re-interpretation of the Role of Public Health”, in B. Davey et al (eds), *Health and Disease: A Reader* (Buckingham, Open University Press, 1995), 191-199, p. 198.

because every time man increases his ability to discover defects in human biology, the complexity of disease also grows. Therefore, a system of medicine based exclusively upon knowledge of disease and not its underlying cause, cannot guarantee health for everyone in a country where the majority live far from health care facilities. Even while there is hope that some of the diseases which are now obstinate will eventually yield to new discoveries, there are always damaged people for whom new cures come too late. Then too, the improved skills that save the lives of people severely injured in car crashes often results in the survival of people who have such severe brain damage that they are beyond help with available resources. And this is what happened to most malnourished black children who survived childhood diseases but were still confronted with the dehumanising aspects of apartheid in the labour market, in terms of job colour bar and other strategies of exclusion.

It can therefore be concluded that the poor quality of health of black South Africans during the period 1948-1976, derived directly from the apartheid government's neglect of the usefulness of alternative medicine. The health of the majority was subordinated to the political and ideological concerns of the dominant white minority, largely because the latter had the franchise and therefore their interests were critical for the maintenance of white supremacy. Commenting on the significant role played by health care in apartheid South Africa, Shula Marks and Neil Andersson have identified the allocation of health care resources as a powerful legitimating tool as much for the self-image of the rulers as in their relationship with the ruled.<sup>9</sup> Used in this sense, health care reinforced and reproduced racial discrimination because it formed part of the political contract between the ruling party and the rest of the white population in terms of which health care, like the vote, was a kind of bounty in exchange for support. This was possible because health services everywhere reflect existing social relationships and may act to legitimate those relationships. And it is precisely for this reason that the philosophy underlying health care is so difficult to divorce from the wider ideological underpinnings of a social order. For example, the nature and distribution of health care in apartheid South Africa were not only the outcome of ideological, economic and political struggles and decisions, but were also in turn acting upon those struggles and decisions.<sup>10</sup>

Against this background, Elizabeth van Heyningen has rightly observed that control of

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9 Marks and Andersson, "Issues in the Political Economy of Health in South Africa", p. 183.

10 WHO, *Apartheid and Health*, p. 211.

disease is one means by which a dominant establishment may assert its authority and impose its ideology in a society.<sup>11</sup> This explains why health care has been one of the key areas for South Africa's propaganda machine during apartheid. Deborah Posel on the other hand, has argued that the principal function of state ideology is "to depict the exercise of power in terms which legitimise it as morally right."<sup>12</sup> Here Posel refers to the way the myth of total separation of the races actually masked the apartheid regime's real goal, which was to sustain the benefits of white domination. It is also contended in this study that the high cost in human life emanating from this process was borne mainly by black South Africans. It is for this reason that I have also argued that both implicitly and explicitly, the ideology of racism and the deliberate manipulation of ethnicity, helped to reproduce a social system which perpetuated the powerlessness and the insecurity of black South Africans in order to protect white power, privilege and prosperity. And there could be no meaningful solution to the medical ills of South Africa until there was fundamental revamping of the entire political system. Though I also admit that the health of the people could not await such a long-term goal as the eradication of apartheid, I nevertheless concede that for modern medicine to be successful there needs to be some radical modification of attitudes, particularly by practitioners of modern medicine, towards other providers of health care outside the formal health care structures.

As pointed out earlier, the National Party government had not necessarily set about maintaining a relatively high black mortality level and their low life expectancy, except that the quality and availability of health services were closely related to race, region and in some cases, social class. Yet by consciously and purposefully excluding blacks from public affairs, the Nationalists condemned the rest of the white voters to becoming more and more ignorant about what was happening on the other side of the racial frontier, sometimes at their own peril. As Reverend Thema so aptly put it:

By destroying the bridges between us and them, the whites will one day find themselves without any means of action and co-operation with the blacks, like the man who lost his glasses and who is so short-sighted that he can only look for them once he has found them...<sup>13</sup>

Available evidence clearly suggest that officials and politicians knew very well what was going on with regard to the health of black South Africans but they sought to hide it from the

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11 Van Heyningen, *Public Health and Society in Cape Town*, p.ii.

12 D. Posel, *The Making of Apartheid*, p. 69.

13 Reverend Thema of Pretoria, quoted by Giniewski, *Bantustans: A Trek Towards the Future*, p. 58.

white electorate (primarily because they did not want their supporters to start doubting the wisdom and sustainability of apartheid ideology) and international observers. It is therefore contended here that it was not ignorance that left the black majority in penury and sickness, but shrewd calculation and policies of “white survival”. The government’s failure to adopt health policies that acknowledged the place of indigenous healing in health care reduced its opportunities for learning about its strengths and weaknesses. In this way, the government stood in a weaker position to discourage the use of certain techniques and substances that are now known to be harmful and to encourage the use of those that have long been identified as valuable and effective, especially with regard to mental illness. Indigenous medicine has retained its hold on the people because of the general deficiencies and sometimes total absence of modern medical care in some communities. Of course, even in places where modern medicine existed, sick people frequently sought answers and explanations that modern medicine was not equipped to give. This therefore suggests that even when modern medicine is highly effective and readily available to the whole spectrum of classes and ethnic groups in a society, there would always be a strong demand for health-related support from outside the formal medical system.

I have also argued in chapter three that in the development of policies to deal with the challenges to white power, the apartheid government overestimated the importance of the military in all efforts to maintain white supremacy, at whatever the cost and consequences.<sup>14</sup> To this end I referred particularly to the government’s huge expenditures in favour of the military in an effort to strengthen the regime’s security apparatus. On the other hand, the government’s population control policies, which included the promotion of black family planning and the encouragement of white immigration were identified as other strategies used for the attainment of the same goal of ensuring the maintenance of white supremacy. However, I have also argued that, policies like the creation of impoverished bantustans such as Kwandebele, the shifting of populations and its potential health implications, the creation of non-viable “independent” black states (TBVC), vulnerable as they were to the much dreaded communist influences, the strict enforcement of the job colour bar, the migrant labour system and the influx control strategies, all ran counter to this stated objective in that in the final analysis, they in many ways did more to undermine rather than enhance the

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14 P.W. Botha coined the phrase, “Adapt or die” in the 1980s as an advice to his white countrymen, to deal with the situation at hand. For a full overview of this see A. Seegers, “Apartheid’s Military: Its Origins and Development” in W. Jemes (ed.), *The State of Apartheid* (Colorado, Lynne Rienner Publishers, 1987), pp. 143-172.

desired white security. They undermined white security because they increased black resentment of apartheid and more than ever before, they stimulated the black man's resolve to confront the system, thus culminating in Sharpeville, the armed struggle, Soweto, the ultimate state of ungovernability of the mid 1980s and the eventual demise of apartheid itself. Others were even beginning to predict a terrifying future for South Africa resulting from its own policy of "bantustan independence". Just as Desmond Tutu warned B.J. Vorster about the impending youth riots in 1976, an indigenous healer, Credo Mutwa, offered a warning to the Nationalists:

History has shown us time and time again that a colony soon grows to become stronger than the parent state which created it, and white South Africa is going to be surrounded by these Bantu states. I have already spoken about the Bantu's capacity for revenge. Do the white men in South Africa really believe it won't happen?<sup>15</sup>

Despite this warning, and even though it was expected that white abdications of power in other parts of the African continent would have provided an example of what might happen at their own doorstep, the Nationalists chose to ignore these lessons, to their own peril. From the mid 1970s however, the white man's fear of the "black peril", perceived or real, was fanned by the tumultuous collapse of the Portuguese empire on our country's frontiers. From this time onwards, it soon became evident that the need for more security was not just panic, born of despair, but a rational fear based on years of contact with a more prolific community. Fear is one of the unalterable realities of human nature; it provokes instinctive reactions in individuals, as in groups.<sup>16</sup> Therefore the reaction of the South African government in Soweto as well as in dealing with black discontent in other parts of the country since 1976, should be understood in this context.

If apartheid was indeed born of fear and prejudice as suggested above, then it could not be expected to yield the basic human freedoms and political and economic rights for all that post-war international opinion demanded. For practical reasons, there could be no right and justice without full integration of the black population into the political and economic life of South Africa as a whole. In the final analysis, apartheid held greater danger to the survival of the white community in the context of the international, the African and internal positions of South Africa than the philosophy of a non-racial integrated society. The question which no

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15 Credo V. Mutwa, *My People: The Writings of a Zulu Witchdoctor* (Johannesburg, Penguin Books, 1977), p. 330.

16 Giniewski, *Bantustans: A Trek Towards the Future*, p. 88.

Nationalist had attempted to answer in the process of trying to maintain white security was how black South Africans, who were crowded in the impoverished bantustans, could reasonably be expected to earn a decent living and not yearn for political rights in the wider South Africa. Perhaps mindful of these future realities which Verwoerd chose to ignore at his peril, the cornerstone of the Tomlinson Report was that the tribal system of land tenure must give way to individual ownership if the reserves were to be rehabilitated to produce a maximum of food for people involved to feed themselves properly.<sup>17</sup> On the contrary however, Verwoerd insisted on tribal holding of land, inefficient and extravagant though the system might be. It soon became evident that even if the “national states” were to be cut away from the rest of the country, a still smaller percentage of the population would be white and the African group would continue to outnumber all the other races combined. One may well ask how a numerically superior group could be expected to live in harmony in a society in which only a white minority had political rights. An interesting contradiction here was that the denial of even limited black political representation in parliament was contrary to the letter and spirit of the Nationalist Party’s need to safeguard white interests, but instead it endangered the very white security that they genuinely sought to achieve. No wonder, in the aftermath of the Soweto uprisings, that the dominant view in informed liberal and left academic opinion maintained that nothing short of violent revolution and guerrilla warfare with outside support had realistic prospects of destroying apartheid.<sup>18</sup> Thus, to yet another hungry and grief-stricken black South African, burying yet another child, dead from malnutrition in a country which was exporting vast quantities of food, the solution lay in the removal of apartheid by any means: “violence means suffering and death. Apartheid means suffering and death. But at least violence comes to an end, while apartheid goes on forever, unless we stop it with violence”.<sup>19</sup>

These observers obviously ruled out the possibility of evolutionary change because the South African government could not be expected to make any real evolutionary changes without precipitating its own downfall in the process. By 1976 however, it was already apparent that apartheid was slowly collapsing, largely because as a strategy primarily calculated to maintain the domination of a minority, it was failing to match the survival strategies of the majority who obstinately refused to act victim.

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17 The Tomlinson Report. See also *The Argus*, 8 October 1959.

18 P.L. van der Berghe (ed), *The Liberal Dilemma in South Africa* (London, Croom Helm, 1979), p.13.

19 Laurence, *Race, Propaganda and South Africa*, p. 123.

I have also argued here that South Africa's health care service, based as it was solely on the Western model of care, was not suited to the health needs of the black population in that it was more curative and less preventive. By being curative orientated, it was more responsive to the health needs of the white minority and less so to those of the black majority. It was perhaps in view of this inappropriate and uneconomic approach to health care that the Director General of WHO remarked that: "half of the health care expenditure in the western world is directed to people who will die within the next twelve months."<sup>20</sup> By being curative, South African medicine was largely disease and hospital oriented rather than health and community oriented. This is what Illich meant when he said that medicine was too narrowly concerned with disease rather than with the people. Part of the argument in this thesis was that what exacerbated the problem was the NP government's denigration of African cultures as well as African views on matters of health and disease. Perhaps the main explanation for this was that contrary to African understanding of disease, the "germ theory" tends to remove disease from its social context by seeking to define it only as a biological phenomenon. Yet anthropological and sociological research has revealed that a more complete understanding of disease must deal with its social as well as its biological aspects, its cultural meanings as well as its statistical incidence.<sup>21</sup> There is also a considerable historical literature affirming the role of socio-economic structures in the production of disease that needs attention. Alan Jeeves has also observed in this connection that research on disease that stops at the laboratory door is inadequate. But equally incomplete is an agenda that attends to the social and political dimension, while neglecting the biological aspects.<sup>22</sup> Quite often however, the modern medical profession is prone to adopt the scientific values of objectivity which tends to direct attention away from the political, economic and social dimensions of disease. And the modern practitioner is almost always bound to seek vindication of his germ theory, even in situations where the patient feels that there is more to his problem (*mafofonyane* or some other culture bound diseases) than just what the modern doctor deals with. Hence the argument in chapter six that when matters as central to culture, society and individual well being as health and health care are involved, the need for a plural approach is particularly evident. Largely because of the government's insistence on curative rather than preventive

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20 K.R. Cox, "Who Owns the Problem of Health Care Costs?", *Medical Journal of Australia*, vol. 2 (1977), p. 730, quoted by Savage, "The Political Economy of Health in South Africa," p. 147.

21 E. Fee, "Sin Versus Science: Venereal Disease in Twentieth-Century Baltimore", in E. Fee and D.M. Fox, (eds), *AIDS: The Burdens of History* (Berkeley, University of California Press, 1988), p. 121.

22 A. Jeeves, "Introduction", *South African Historical Journal*, no. 45 (2001), p. 9.

medical services, the conditions that contribute to the onset, persistence and recurrence of the people's common diseases were left largely unaffected by the advances in modern medicine referred to above. While the curative medical services that were mostly available to the urban population were not without merit, it is important to recognise that in reality they comprised only part of what was required to bring about an improvement in the health of the South African population as a whole. Probably more important was a political commitment to attack the African health problems at their root. Poverty, malnutrition and the unsanitary living conditions of rural existence had to be tackled rather than being exported to the underresourced bantustans. Criticism of the medical model must not be interpreted as disregard for certain benefits it has to offer. The thesis is primarily about pursuing the larger health questions for which modern medicine can offer only a partial answer or no answer at all.

I have pointed out in chapter four that though the connection between food and disease is also not an easy one to make, there can be little doubt that adequate nutrition and improved environmental sanitation are critical to improving the health and well-being of people, particularly where an impoverished population lacks the wherewithal to address these root causes of their afflictions. I have also referred to one of the widely held myths about malnutrition in South Africa – that it was the product of ignorance and overpopulation of the African people. A concerted attempt was made to dispel this myth and I have argued in this connection that the prosperity of the white man had more to do with the impoverishment of the black man through the migrant labour system with its associated problems of low wages and family dislocations and with it, the disruption of their social support systems. I have also suggested that what was in fact more critical about malnutrition was lack of access to employment which better education could afford, because without an income, one cannot talk of quality health care or quality medicine. As one South African worker expresses it:

Without food or money, no medicine or medical services will help us. We cannot eat medicine. It is taken before or after meals, but without work we are without meals.<sup>23</sup>

Malnutrition and the infections which invariably accompany it have dominated the disease patterns of black South Africans. Apartheid is often blamed for all these, because it ensured that the health care apparatus reflected and reinforced the monopolisation of economic resources by a minority white population. As a policy therefore, apartheid has played a

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23 *Inqaba Ye Basebenzi*, no. 2, April 1981, pp. 38-39.

central role in this process in that it legalised the separation of blacks from the production of adequate food. At the same time it controlled their entry into the economy even as units of labour. The fact is that what I have referred to in this study as “diseases of poverty” constituted the bulk of the health problems of the politically powerless black majority. This also explains the low priority they were accorded under apartheid. Instead of blaming the general inequality in the state’s allocation of resources, the high birth rate among blacks was frequently cited as the chief cause for the racially unequal incidence of poverty in the country during the period under review. Similarly, the justification for the state’s greatly increased expenditure on population control has been that if black population growth could be slowed down, ill health would not be widespread and resources could therefore be used more effectively. While this study challenges this analysis, it concurs with Shula Marks and Neil Andersson’s conclusion that, in the absence of meaningful social security for black South Africans, adult labour was the only saleable asset, therefore the kind of population control as was driven by the Nationalists in the 1970s could be nothing but cynical at best and suicidal at worse.

Similarly, the study contends that the systematic marginalisation of indigenous healers had more to do with apartheid’s denigration of African cultures, their beliefs and value systems than with issues of efficacy of biomedical therapies. According to Clifford Geertz, if culture is both the stage and the script for the drama of illness and treatment, then how sick people and those around them respond to illness is part of a cultural code that is learned, often without noticing.<sup>24</sup> It is for this reason that the primary contention of this study is that the integration of indigenous medicine and its practitioners into the national health care system is a long overdue solution to the health problems of black South Africans. This is particularly so in those rural areas where modern health care facilities had in many cases remained virtually non-existent throughout the apartheid period. Though one might concede that black people had always used the services of indigenous practitioners even without state recognition, and therefore such recognition is not critical to the resolution of the problems at hand. But it is important to realise that government too, has a duty and perhaps an obligation to protect the consumer of indigenous medicine from unqualified practitioners and charlatans. When the South African Medical and Dental Council (SAMDC) was established in 1928 its declared objective was to protect the public and to serve the interests of medical professions under its control in so far as these interests coincided with this objective. Its primary function has

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24 C. Geertz, *Interpretations of Culture* (New York, Basic Books, 1973), p. 29.

always been to recognise qualifications, lay down minimum standards for training, carry out inspections on training, investigate complaints of improper conduct against registered persons and to mete out disciplinary action against those found guilty.<sup>25</sup>

Since there are different types of practitioners of indigenous medicine with very little if any standardisation of their qualifications, recognition and integration would ensure that all practitioners register with a common organisation through which there would have to be state-sponsored programmes to regulate and validate an individual's credentials before entering practice. Another aspect, other than training, is the problem of sanctioning behaviour in the absence of any institutional framework. Whereas cases of professional misconduct among practitioners of modern medicine can be dealt with more professionally by the Health Professions Council of South Africa (HPCSA), the same could not even be imagined for practitioners of indigenous medicine unless there was state-sanctioned institutional co-operation to link them and co-ordinate their services. Similarly, there would be very little, if anything, to prevent anyone expelled from the group to continue practising if registration with an umbrella body does not have the same legal and bureaucratic significance as that of modern practitioners. Since there are already a number of regional sectoral organisations linking indigenous healers in each province, what needs to be done is to co-ordinate them and have them affiliated with one national organisation with the powers to regulate herbal products and prevent unscrupulous practitioners and quacks. The post-apartheid government's envisaged Traditional Health Practitioners Council, is a calculated attempt to deal with this problem.<sup>26</sup> Only in this way, will practitioners of indigenous medicine know and appreciate their limits and competencies. However, there seems to be a thinking in modern medical circles that indigenous healers should be trained to "modernise" their healing practices by having modern practitioners teach them what they don't already know. Such beliefs mistakenly assume that the indigenous healer needs some training but has nothing to contribute towards improving the knowledge and practice of the modern practitioner. As Hlathikhulu laments, "It is ironic that some social scientists who believe in aspirin cannot explain how it relieves pain, yet they demand that indigenous healers explain their medications before they can consider such medicine as valid".<sup>27</sup>

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25 *South African Panorama*, vol. 33, no. 7 (1988), p. 28.

26 *Sunday Tribune*, 5 October 2003.

27 Interview with Ngaka Hlathikhulu, 14/8/2005.

It is this kind of inconsistent and one-sided judgement that often leads to the reluctance of some practitioners of indigenous medicine to participate in the primary health care initiative. Instead of integration and cooperation, based on mutual trust and respect for each other's value systems, there has been persistent hostility and overt antagonism between the two systems. In discussions about integration, the indigenous healer is seldom pictured as a health provider with adequate knowledge that can be of benefit to the modern practitioner. Yet, according to both Tsiane and Hlathikhulu, indigenous healers have a treasure of knowledge concerning the medical uses of many herbs which should be preserved and protected. According to them, certain sources of their concoctions and pharmacopoeia are eagerly and exploitatively sought after in view of the HIV/AIDS predicament.<sup>28</sup> This is what probably makes indigenous healers more sceptical of the intentions of the integrationist:

We are expected to surrender our herbal knowledge without proper recognition of our skill and knowledge. Once our herbs have been found to be effective in treating HIV/AIDS and improve the immune system of patients, it will be claimed that it is modern medicine that discovered the remedy and we will not feature anywhere.<sup>29</sup>

For the success of any integration programme therefore, the participation of both parties should be canvassed with the knowledge that each has information to contribute as well as to gain. Quite evidently, it would be naive to suggest that indigenous medicine is a panacea for all the health problems of the rural African communities with limited resources, but it is important to realise that given its widely acknowledged successes in treating mental illness,<sup>30</sup> and psychosomatic disorders that puzzle psychiatrists, this form of health care does have selective potential for improving health care delivery in the post-apartheid South Africa. Admittedly, no form of unorthodox health care should be endorsed unconditionally merely because of its long existence. Instead, such endorsement should take into account Paul Rosch and Helen Kearney's warning:

... it is wise to question, to exercise discrimination and to adhere to scientific principles in evaluating various modalities as they appear, but it is also equally essential not to summarily dismiss them because they have no basis in terms of previous training, experience, or because their apparent effects cannot be justified.<sup>31</sup>

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28 Interviews with diNgaka, Tsiane and Hlathikhulu, 14/8/2005. See also, J.S. Mbiti, *Introduction to African Religion* (Johannesburg, Heinemann, 1991).

29 Interview with Ngaka Bongwiwe Mhlongo and Philani Vezi, 9/7/2005, Kwamakhutha, Kwazulu-Natal.

30 *Rand Daily Mail*, 5 May 1975.

31 P.J. Rosch and H.M. Kearney, "Holistic Medicine and Technology: A Modern Dialectic", *Social Science and Medicine*, vol. 21, no. 12 (1985), p. 1408.

Modern health professionals could have a better appreciation for health problems of all population groups in the country if they understand that treatment modalities are intricately tied to certain beliefs and value systems within cultures. Therefore, as long as Africans seek treatment from both modern and indigenous practitioners, it is prudent to strive for the collaboration of the two providers of health care. Since indigenous medicine harbours enormous potential that remained largely unexplored throughout the apartheid period, it is recommended here that wherever it can be mobilised, it would be illogical to wait until modern hospitals are built adequate drugs are supplied, enough medical manpower and expensive technology has reached all corners of the country, before health care services are provided to all sections of the population. As Mabogunje rightly remarks:

To wait until there are adequate numbers of western-trained doctors before a significant segment of the population can have access to health is to be guilty of inhibiting the release of vitally needed and latent productive capabilities.<sup>32</sup>

Of course integration of the two medical systems should not mean moving the indigenous healer into a hospital practice setting any more than it should mean moving the modern doctor to the healer's practice setting. Integration may mean referral from medical practitioner to a sangoma for *thwasa*, as well as referral from a herbalist to an internist for appendicitis.

It is interesting to note how throughout the nineteenth century, commentators were almost all agreed on the inherent biological and cultural inferiority of the African people, although there was a considerable diversity of opinion about the precise nature and degree of that inferiority. Perceptions of the inability of the indigenous people to respond to the challenges posed by their contact with Western civilisation played a critical role in such debates. According to the official view of South African history, until the advent of the white man Africans stagnated in a world of ethnic rivalries,<sup>33</sup> and wild superstition, from which they were redeemed through the beneficent policies of apartheid. Thus, making use of the "dual economy model" of South African society, the propaganda suggested that the problems of black South Africans were analogous to those of the rest of the developing world, which were problems associated with

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32 A.L. Mabogunje, "The Development Process," cited by O.Y. Oyeneye, "Mobilizing Indigenous Resources for Primary Health Care in Nigeria," *Social Science and Medicine*, vol. 20, no. 1 (1985), p. 68.

33 Confirming this, it is interesting to note that *The Argus* and *The Cape Times* of the 3 and 4 May 1959 respectively carried similar articles. De Wet Nel was quoted as saying, "If it were not for the Afrikaner, the Bantu would long have exterminated one another. The moment the white man disappears from the face of Africa, the black nations would be at each other's throats".

development. According to this view, it was against such problems that white South Africans, including medical men and nurses, were valiantly battling. As a government-sponsored publication puts it:

Persuading the Bantu peoples of South Africa to accept modern medicine has been a big task, involving a painstaking campaign ... It has not been merely a question of bringing the medicine, the vaccines or the mobile units to the Bantu people, or indeed, bringing the Bantu peoples to the doctors, the nurses and the hospitals. The real struggle has been against ignorance, superstition, mistrust, fear and witch-doctors. Gradually, however, the Bantu is being weaned away from the centuries-old superstitions and belief in witch-doctors, and the future is hopeful.<sup>34</sup>

Quite clearly, this distorted version of South African history deliberately sought to undermine and downplay the relationship between white prosperity and black impoverishment. I have attempted to show in this study how central the migrant labour system is to our understanding of South Africa's disease patterns and how its maintenance through apartheid's other instruments of social control such as influx control and the Group Areas Act had implications for the health of those on the receiving end of the policy. During this period, interpretations of malnutrition as the alpha and omega of African health problems, had tended to undermine the political and economic factors. Similarly, the apartheid system was built on a model of racial separation supported by the same ideology of the superiority of the white minority over the black population. The regime then founded its segregationist practices on differences believed to be insuperable; that is, on the belief in the absolute inferiority of all "non-whites" especially the black majority. It is interesting to note that from 1948 to 1976 and beyond, the ethical struggle of the black majority clashed with the silence of some democratic Western powers toward the regime in Pretoria. It would seem that the South African white elite regarded that passive response to "white power" as tacit support for the ideology of apartheid. Although I have pointed out elsewhere that the main preoccupation of Western societies during much of the period of apartheid was war against international communism, the action taken by the World Health Organisation to suspend South Africa from the activities of this health body may have achieved the opposite of the desired effect. By isolating South Africa and not keeping it abreast with international developments in the health field, this no doubt impacted on the health of the very population groups they genuinely sought to protect. Such international isolation also did nothing to influence local developments in that responses to African health problems continued to be based on ethnic categories, albeit with limited

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34 Department of Information, *Report from South Africa*, 1972, p. 27.

resources.

It was largely for this reason that both the medical and official opinion at the time also tended to treat the bantustans as if they were still capable of autonomy from a money economy. For example the focus on soil erosion helped to keep the idea of the political causes of African poverty at bay, with a somewhat misguided assumption that since African culture was rural, the cure for African problems like hunger lay in rural areas (hence the bantustans and influx control). It was this diversionary nature of the orthodox medical version of South African history that allowed the malnutrition syndrome to provide a useful defence against spending money on African rural health. Perhaps an aspect that still cries out for historical attention is an examination of nutrition, reflecting the intimate bond between nutrition and health. This must indeed be the cornerstone of any consideration of human health and disease. Though good nutrition does not by itself guarantee good health, poor nutrition is nonetheless guaranteed to produce poor health. Hence the argument in this thesis, that the major portion of the health problems of black South Africans throughout the apartheid period should be traced to malnutrition.

The view that Africans were people without science also proved a useful argument for the government to use to excluding black people from the mainstream of society. In the same way the “sanitation syndrome” justified segregating cities at the turn of the twentieth century. In Diana Wylie’s view, the National Party represented the pinnacle of pride in modern science that had been building over the course of the twentieth century. She argues that while it might be conventional to blame the coercive policies of apartheid on these ideologues, a closer scrutiny of the ways in which they justified their acts reveals ideological roots that lay deeper in time than 1948. The malnutrition syndrome for example, had played its part in preparing the ideological ground for the evolution of segregationist attitudes toward Africans into the institutions of apartheid. It did so by propagating an image of an ignorant, non-scientific Africa, dominated as it were, by popular attitudes in the 1950s that helped accommodate even non-National Party supporters to the policies of apartheid.<sup>35</sup>

Against this background, it is interesting to note how even people who were not supporters of the National Party could be easily reconciled to its policies largely because of stories they believed about the African past, their culture and about their own identity. Throughout the

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35 Wylie, *Starving on an Empty Stomach*, p. 234.

apartheid period, but more specifically after the pioneering heart surgery, pride in Western technological and scientific achievement undermined even the limited respect for African culture that had existed earlier in the century. This explains why even the biomedical doctors joined other experts in saying that African culture and ignorance were the cause of increased African poverty. They used this as justification for their own failure to cure most of the diseases that were presented to them during this period. This increased denigration of African culture was further aided by the fact that it coincided with the apartheid government's politicisation of African poverty in the post-war period.

Admittedly, South Africa and the rest of the developing world had its own fatal and incapacitating diseases that were brought under effective control through the superior knowledge and skill of modern medical practitioners. In spite of Illich's arguments to the contrary alluded to earlier,<sup>36</sup> few will dispute this conclusion. There can be no question that Western medical intervention represented progress towards a more developed social order. However, more often than not, such progress hindered the recognition of the negative health consequences of European presence in Africa. It presented modern medicine as an example of the constructive and beneficial effects of European rule and claims to legitimacy. Yet historical research has revealed hard facts that the spread of such diseases as tuberculosis and syphilis among African communities was closely associated with European contact.<sup>37</sup>

I have argued in this study that the decline of apartheid was a steady process beginning in the 1970s and culminating in the repeal of apartheid laws in the next decade. From historical records it is clear that very few causes in the world in the period 1948-1976 mobilised such support in the wider world as the condemnation of apartheid and the struggle for its elimination. It remains difficult to understand how apartheid was able to endure for as long as it did in spite of such concerted opposition. If the capitalists were, as it was assumed, the real creators and sustainers of apartheid, one wonders why it endured despite the eventual realisation by many that it was in fact economically unsound. Apartheid was initially formulated for the benefit of Afrikaners, it ultimately became evident in the 1970s that it was unable to serve the interests of the growing Afrikaner business class. The shortage of skilled labour and government restrictions on blacks performing these skilled jobs no doubt

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36 Illich, *Limits to Medicine, Medical Nemesis: The Expropriation of Health*.

37 M.J. Azevedo, "Epidemic Disease Among the Sara of Southern Chad, 1890-1940", in G.W. Hartwig and K.D. Patterson, (eds), *Disease in African History: An Introductory Survey and Case Studies* (Durham, N.C, 1978), p. 134.

antagonised more grass-roots Afrikaners. According to Stanley Greenberg, by the mid 1970s, the state machinery which was in fact the centerpiece of apartheid ideology could not effectively manage the squatter areas that came to dominate the major metropolitan cities, the spreading disorders that dominated the townships and the growing labour surpluses that characterised the rural bantustans. In fact, the whole system of influx control was internally contradictory in that it created pressures it could not contain and involved rising economic and political costs it could not meet.<sup>38</sup> With regard to medicine, this period heralded the breakdown of the barriers that had been constructed to keep out disease.<sup>39</sup>

The most critical explanation for why apartheid endured, despite everything, is that even though South Africa faced perpetual criticism (especially within the United Nations and other bodies) about its commitment to apartheid, it was protected from more than verbal assault by both the extent and profitability of western investment within its borders and western preoccupation with the struggle against communism. For the historian Leonard Thompson, apartheid endured because before the second half of the 1970s, no powerful economic interest was fundamentally opposed to it.<sup>40</sup> Prior to apartheid white industrial workers had benefitted from an economic system that gave them a virtual monopoly not only of skilled jobs and high wages, but also of workers' legal participation in the industrial bargaining process denied to their black counterparts. White bureaucrats on the other hand depended on a system that provided them with sheltered employment. Farmers also had good reason to be satisfied with a government that gave them generous subsidies and ensured their supply of cheap labour, while at the same time helped them to dispose of it when there was a surplus or in times of recession. Hence the argument that although apartheid imposed costs on the different sectors of business, it also benefitted all of them. This explains why in spite of heavy criticism to specific actions of the government, such as job reservation and influx control,<sup>41</sup> all sectors of white society, accommodated apartheid before 1976. Scholars have also debated this topic and have persuasively demonstrated that until 1976 the international opposition to apartheid, though strong in rhetoric, was very weak in substance.<sup>42</sup> According to some historians, this was primarily because the South African government had mustered an effective propaganda response to the challenges prompted by changes in the world order since the end of the

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38 Greenberg, *Legitimizing the Illegitimate: State, Markets and Resistance in South Africa*, p. xviii.

39 Packard, *White Plague, Black Labor*, p. 319.

40 Thompson, *A History of South Africa*, p. 206.

41 *The Natal Mercury*, 6 November 1959.

42 Thompson, *A History of South Africa*, p. 206.

Second World War. It has been well documented that in response to mounting opposition to apartheid since Sharpeville, the South African foreign propaganda was well tuned to the Cold War fears and prejudices of Europeans and Americans. The country was portrayed as a stable and indispensable member of the “free world” in its unremitting struggle against international communism.<sup>43</sup> Apartheid endured because powerful interests in both the United States and Western Europe were loathe to disturb the status quo in South Africa. With their Cold War perspective, they were prone to exaggerate the communist menace and with their business perspective, they tended to assume that economic growth was bound to erode and destroy apartheid.<sup>44</sup>

For Merle Lipton, fear and hysteria were politically useful to the government in Pretoria and the Nationalists were skillful in stirring them up. Until the second half of the century there were not yet models of whites living securely under black rule. The upheaval which accompanied the emergence of independent African states temporarily exacerbated white fears of security under black government.<sup>45</sup> The astute use of the Nationalist organs and censorship of opposing views enabled them to stir up fear and racism which, while it helped to consolidate their own base, also greatly neutralised and deepened the division among their opponents. With this in mind, the view that the failure to stop the Nationalists from implementing apartheid labour policies demonstrates that the capitalists must have wanted these policies, may seem unfair. This view, as Lipton points out, overlooks the importance of fear. Quite clearly, the capitalists were demoralised by a daunting problem of confronting an efficient and ruthless government, equipped with a full range of modern methods of coercion and propaganda, and with little respect for the rule of law.<sup>46</sup>

For other scholars however, the defence of civilisation has been a far more prevalent justification for white domination in South Africa than Afrikaner self-determination. As Terreblanche further argues,

The National Party regarded the different African ethnic groups as heathen nations to be Christianised and civilised by Afrikaners. White English-speakers were portrayed as people with dubious moral standards, permeated by the materialistic and egotistic values of capitalism.<sup>47</sup>

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43 Ibid., p. 219.

44 Ibid., p. 218.

45 Lipton, *Capitalism and Apartheid: South Africa, 1910-1986*, pp. 294-295.

46 Ibid., p. 299.

47 Terreblanche, *A History of Inequality in South Africa 1652-2002*, p.299.

If this was indeed the case, it is understandable why the collapse of Afrikanerdom's confidence in apartheid (because of the changing social and economic position of Afrikaners) was responsible for the relaxation of apartheid measures from the late 1970s through the early 1980s. Post 1976, the civil rights movement in the US had made significant gains, to the extent that black American activists were beginning to espouse the cause of black South Africans. While at the same time Afrikaner solidarity, which had been key to the electoral successes of the National Party since 1948 was collapsing. Ironically, economic success itself was eroding the very Afrikaner nationalist movement. Hence my argument that in the post 1976 period, Afrikaner confidence in and commitment to apartheid was fast diminishing. There is another perspective which maintains that Afrikaners contributed to social change not because confidence in apartheid had diminished, but largely because confidence in the Afrikaner self had increased. Such explanations maintain that whereas in the 1960s the overwhelming majority of the Afrikaners had placed ethnic above class interests, by the end of the 1970s Afrikaner class divisions had become more marked and more potent.<sup>48</sup> This perspective confirms the view held throughout this study that apartheid was the product of the group inferiority complex among Afrikaners. And as Katherine Manzo puts it, "could be removed like a scaffolding once the edifice it was designed to protect was strong enough to stand without it".<sup>49</sup>

As an historically contingent set of practices which differed substantially from segregation, its predecessor, by being based on the unique postulate of difference rather than on the postulate of identity, apartheid was in many ways devised as a survival strategy to maintain white supremacy and to ensure the continuation of the political dominance of the minority over the majority. However, as a survival strategy, apartheid ultimately failed primarily because it was fundamentally flawed. The heavy-handed tactics of the apartheid state demonstrated in Soweto and elsewhere, were only attempts to force a state of peace and control, and yet it resulted in a violent and often ungovernable country within a decade. The forced identification with ethnic groupings and the cultivation of a diversity of local "nationalisms" could only result in racial intolerance and distrust. In the final analysis, black South Africans were bound together not by common identity and goodwill, but by a common hatred for a collective enemy. To some extent, apartheid failed because it ignored the lessons

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48 Thompson, *A History of South Africa*, p. 223.

49 K.A. Manzo, *Domination, Resistance and Social Change in South Africa: The Local Effects of Global Power* (London, Praeger, 1992), p. 205.

of history and the consequences of poverty among black South Africans were bound to be felt by the rest of the country's population in one way or another. I venture to suggest that it was Martin Rein's warning that the apartheid planners have failed to heed:

People must not be allowed to become so poor that they offend or are hurtful to society. It is not so much the misery and plight of the poor but the discomfort and cost to the community which is crucial to this view of poverty. We have a problem of poverty to the extent that low income creates problems for those who are not poor.<sup>50</sup>

The immortal words of the former President of the United States, John F. Kennedy, are even more relevant, "If a free society cannot help the many who are poor, it cannot save the few who are rich". Hence my argument that, as an artificial system, apartheid could simply not have endured forever. It was artificial because the differences between men are simply differences within a unity. Underlying all differences of race or colour, there exists a common humanity. Historically, this uniqueness of man was recognised by the Stoic Philosophy before the Christian era. Cicero for example, writing half a century before Christ, declared unequivocally:

There is no resemblance in nature so great as that between man and man, there is no equality so complete, there is only one possible definition of mankind, for reason is common to all.<sup>51</sup>

But if there was no racial bar preventing a black mind from appropriating the intellectual and scientific heritage of the West, then in aid of what, one may ask, was the country having separate medical schools and separate education systems, separate blood banks, separate ambulances, separate health authorities and other institutions for different races? This is the question that will remain unanswered for many years to come. With the benefit of hindsight however, it is self-evident that no differentiation based on race alone was meant to offer a lasting solution to the fears of the white minority in this country, nor could it provide them with the necessary security that they all yearned for.

Geography, race and class were major determinants of the availability of health resources under apartheid. But as the economy developed and became more sophisticated towards the end of the apartheid period, and its labour needs became more complex, class, not race, began to be more important in the distribution of resources. In this way, unlike in the 1950s and

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50 M. Rein, "Problems in the Definition and Measurement of Poverty", in P. Townsend, *The Concept of Poverty* (London, Heinemann, 1971), p. 46.

51 Quoted by Eric Nkondo, "Editorial," *Educamus*, October 1980, p. 3.

1960s, apartheid ceased to be a “distribution regime”. It was not a static system dedicated purely to racial privilege. Of course such privilege was at the core of it, but the system began to change in significant ways towards the end of the 1970s and the beginning of the 1980s, as the white rulers began to see that if they were going to hold on to power they needed allies in the black communities. Hence, from the late 1970s, the government began to ease the operation of the pass laws and influx control in order to provide more security for existing black city dwellers. The idea developed in the Riekert Report was to privilege those Africans with a permanent stake in the cities in order to try to convert them into allies who would support further efforts to exclude the rural poor. Thus, the entire strategy of divide and rule meant more political and economic privileges for Coloured and Indian communities, black workers and city dwellers in the formal sector, and the elite bureaucrats who ran the bantustans. The strategy did not work as intended but had significant effects; perhaps to reiterate the point mentioned above, the whole edifice of pass laws and influx control was swept away by the Botha reforms of the mid 1980s, when the country was in the grip of a vicious kind of civil war; then followed the eventual displacement of the Nationalists in the early 1990s.<sup>52</sup> Jeremy Seekings and Nicoli Nattrass have demonstrated that the decline in racial discrimination since the second half of the apartheid era, and further de-racialisation after its end, have not led to reduced levels of inequality. On the contrary, this time it was class, rather than race that formed the basis of inequality and therefore of poverty. By drawing attention to the importance of class, however, the authors do not suggest that the people were located in the class structure independent of the country’s racialised history. Nor do they suggest that there were no cultural differences between people with different traditions and racial classifications. What they in fact posit is that people were either rich or poor, enjoyed good or bad health and had at least some attitudes that depended primarily on the work they did.<sup>53</sup>

The recent idea of integrating modern and indigenous systems of health care no doubt derives primarily from the growing realisation that some indigenous therapies are effective and valuable, while others are not. But since the same is also true of modern medicine, if Illich’s critique,<sup>54</sup> is taken seriously, a combination of all that works from both sides is a prerequisite towards formulating a new health paradigm necessitated in large measure by the emergence

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52 Seekings and Nattrass, *Class, Race, and Inequality in South Africa*.

53 Ibid., p. 268.

54 Illich, *Limits to Medicine, Medical Nemesis*.

of the AIDS pandemic. Findings in psychological research show that the effectiveness of the indigenous healer is based mainly on the extent to which his value system matches the value system of the patient.<sup>55</sup> This explains the contention in chapter six of this study that since the two systems are hypothesising from radically different points of view, they should continue to be functionally perceived as different and yet complementary health resources. The inescapable reality is that in spite of how it is perceived by the modern profession, and how it is treated bureaucratically, indigenous medicine will continue to occupy pride of place among its African clients, not only because it is affordable and accessible, but essentially because it is socially sanctioned and culturally acceptable. After all, it is their value and utility in the eyes of the communities they served throughout the period of apartheid neglect, rather than their recognition by the state, that gives legitimacy to practitioners of indigenous medicine. It seems unavoidable that if the patients themselves are not convinced that a particular form of treatment is sound and has the potential to ease their pain, all intellectual arguments about scientific validity of the knowledge on which it is based, will be of little avail. If the patient believes that a particular system of medicine is insufficient for treating his condition, it probably will be. The mind has a powerful effect on the body and can influence both illness and health. To treat patients successfully it is extremely important to take their beliefs into account, whether they are about the causes of disease or how it should be treated. The fact of the matter is that if indigenous medicine is accepted not because of its proven efficacy but often because it offers both social and mystical explanations of the cause of disease, then integration has practical advantages even for modern medicine as well. Besides assisting practitioners of indigenous medicine to appreciate and accept that their counterparts have the necessary technological expertise, the absence of which might mean the difference between life and death to the patient, integration could also make the services of indigenous healers more available for primary health care projects than could be achieved without them. Therefore, in the interest of the consumers of health care, cooperation between the practitioners of modern medicine and those of indigenous medicine has become even more critical in the current age of the HIV/AIDS pandemic. Like lions which must always be part of a pride, their lack of co-operation will only give credence to the Sepedi proverb: *Tau tša hloka seboka di šitwa ke Nare e hlotša*.<sup>56</sup>

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55 E. Buch, "The Struggle for Health", *Critical Health*, no. 21 (1987), p. 54.

56 Because of lack of cooperation individual hunting lions can barely overcome even a limping buffalo.

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