FROM 'NATIVE HEALTH' TO PRIMARY HEALTH CARE: TRANSFORMATION IN RURAL HEALTH CARE SERVICE PROVISION IN THE FORMER TRANSVAAL, 1930s-1990s.

by

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ABSTRACT

This thesis focuses on the transformation of healthcare services for the blacks in the former Transvaal during the period from the 1930s to 1990s. The thesis argues that over this period the healthcare of rural blacks from Union to Republican governments had incipient features of primary health care – haphazardly driven by progressive-minded individuals within the state, by missionaries, as well as other stakeholders, motivated by concerns over the socio-economic conditions of the blacks. Although the concept of primary health care did not exist in popular public health parlance during the Union era, prototypical concepts such as 'native health', 'preventative health' or 'community health' were used interchangeably to describe and formulate a variety of initiatives meant to deal with health challenges caused by diseases such tuberculosis, malaria, syphilis, HIV/AIDS and other poverty-related diseases. A brand of 'Community-Orientated Primary Care' was popularised by Sidney Kark to refer to his initiatives at the Pholela Health Centre, a model primary health care project of the early 1940s. The model inspired the establishment of similar health centres in the rural areas of the Transvaal and other provinces, as part of the broad sweep of social medicine from the 1940s.

This thesis also argues that the road to the full embrace and implementation of primary health care was characterised by many challenges emanating from the state's reluctance to support its implementation, as that had the potential of upsetting the policy of racial discrimination. Opposition to the state's reluctance to implement a national healthcare system based on the precepts of primary health care emerged and intensified from the time the National Party came into power in 1948. Aspects of the healthcare system of the former Transvaal were also uniquely influenced by some former medical students of the University of Natal Medical School who, from the late 1960s to the early 1970s started to use their newly acquired skills and experience to deliver community health care services in parts of the Transvaal. Although the historic Alma Ata Conference of 1978 added impetus to the popularity of the concept of primary health care, its full implementation in South Africa was wobbled by the reluctant apartheid state. As expected, primary health care became a

battleground of political wrestling between the state and liberation movements and other stakeholders. It was only after the 1994 general elections that the concept was declared a national policy, to be prioritised by all government departments.

Although several scholars have dealt with progressive healthcare initiatives during South Africa's twentieth century, a focus on the rural Transvaal offers a new opportunity to revisit key developments in the country's public health history, and to reflect on the layered and indeterminate nature of the emergence of primary health care, with particular emphasis on the contribution of educated African healthcare professionals and grassroots movements. Like the Pholela and the National Health Service Commission initiatives which have been covered extensively in the literature, a history of the development of the public health system in the Transvaal offers a vista to understand the colonial origins and changing fortunes of rural primary healthcare over the course of an eventful seven decades in South Africa.

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ABBREVIATIONS

AES	-	Army Education Scheme
AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	African National Congress
AZAPO	-	Azanian People's Organisation
BCM	-	Black Consciousness Movement
BCP	-	Black Community Programme
BMCU	-	Black Allied Mining and Construction Workers Union
BPHC	-	Bureau of Primary Health Care
CBR	-	Community Based Rehabilitation
CHAP	-	Community Health Awareness Programme.
COPC	-	Comprehensive Primary Care
CORRE	-	Community Rehabilitation Research and Education
COSAS	-	Congress of South African Students
CRW	-	Community Rehabilitation Workers
DDT	-	Dichlorodiphenyltrichloroethane
DHA	-	District Health Authority
DSS	-	Democratic Surveillance System
GNP	-	Gross National Product
GNU	-	Government of National Unity
GOBI	-	Growth Monitoring, Oral Rehydration, Breast Feeding and Immunisation
HFA	-	Health for All

HNEC	-	Health and Nutrition Education Centre
HRSA	-	Health Resources and Service Administration
HWA	-	Health Workers Association
IMF	-	International Monetary Fund
MEC	-	Member of Executive Committee
MEDUNSA	-	Medical University of South Africa
MRC	-	Medical Research Council
MTW	-	Models That Work
NAMDA	-	National Medical and Dental Association
NCC	-	National Crisis Committee
NGO	-	Non-governmental Organisations
NHS	-	National Health Service
NPPHCN	-	National Progressive Primary Health Care Network
PAC	-	Pan Africanist Congress
PHA	-	Provincial Health Authority
PHC	-	Primary Health Care
PPPs	-	Public-Private Partnerships
RCMS	-	Rural Cooperative Medical Systems
RDP	-	Reconstruction and Development Programmes
RENAMO	-	Mozambique National Resistance Movement
SACC	-	South African Council of Churches
SACP	-	South African Communist Party
SAIMR	-	South African Institute of Medical Research
SAMDC	-	South African Medical and Dental Council

SANA	-	South African Nurses Association
SASO	-	South African Students' Organisation
STIFL	-	Swiss Tropical Institute Field Laboratory
TB	-	Tuberculosis
UDF	-	United Democratic Front
UHC	-	Universal Health Coverage
UNICEF	-	United Nations Children's Fund
USSR	-	Union of Soviet Socialist Republics
WDHC	-	West District Health Centre
WHA	-	World Health Assembly
WHO	-	World Health Organisation
WRF	-	Wits Rural Facility

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I hereby declare that the thesis has been constructed out of my own historical knowledge and interpretation of a variety of sources relevant to the research topic, and it was never submitted to any other academic institution.

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND

As is now well known, the health conditions and health care system in South Africa before the 1990s was heavily influenced by racial discrimination that evolved in a context of colonial and apartheid social, economic and political disparities. The provision of health care services proved to be a battleground between those who wanted to strengthen and maintain racial discrimination and those who wanted to see a progressive approach based on a national health system that would ensure equity in the provision of health services.[1] While the different stakeholders tussled over appropriate approaches to healthcare in a divided society, the health conditions of the masses continued to suffer.

In the rural Transvaal, like other provinces, the areas reserved for blacks were characterised by underdevelopment, poor healthcare infrastructure, scarcity of arable land, lack of clean drinking water and other related undesirable conditions, which led to poor health outcomes for the rural black populations. Colonial transformation, poverty and underdevelopment exposed generations of blacks in the reserves (later Bantustans/homelands) to a variety of diseases such as malaria, tuberculosis, sexually transmitted diseases (syphilis and gonorrhea), and other poverty related ailments. Although discrimination was clear, the provision of basic services to deal with the health challenges faced by black communities was characterised by ambiguities.

Indeed, as many historians have shown, the provision of healthcare services among Africans went through different phases of transformation beginning from the interwar years onwards.[2] A combination of internal concerns about the wider implications of

[1] S.M. Tollman and K.A Kautzky, 'A Perspective on Primary Health Care in South Africa: Primary Health Care in Context', *South African Health Review*, 2008(1), 2008, p. 20.
[2] A. Digby, 'Vision and Vested Interests' National Health Service Reform in South Africa and Britain during the 1940s and Beyond, *Social Science Medicine*, 2 (3), 2008; G. Ncube, "Robert A. Askins and healthcare reform in interwar colonial Zimbabwe: The influence of British and trans-territorial colonial models", *Historia*, 63, 2, November 2018, pp 62-92; O. Olumwullah, *Disease in the Colonial State: Medicine, Society and Change among the AbaNyole of Western Kenya* (Greenwood Press,

poor health, the motivations of progressive-minded doctors, and international reform impulses coming from, among other sources, the League of Nations Health Organisation, (which led to the holding of the Pan-African health meetings in Johannesburg in the early 1930s), created conditions for the gradual implementation of piecemeal basic health care policies in selected localities. In Britain, the Peckham Health Centre, which emerged in the 1920s, influenced the emergence of similar initiatives in South Africa, for instance, at Pholela in the northern rural area of Natal.[3] The innovative concept of social medicine that became popular in the early 1940s through the works of John Ryle, the United Kingdom's first Professor of Social Medicine, and got appeal in South Africa after his visit in early 1948, which had allowed him an opportunity to share his ideas with the South African medical fraternity.[4] The widening influence of his ideas led to a number of developments, including the training of health workers at various centres across the country.

By that time however, it had become clear that healthcare provision models were tending towards reform because of a combination of social, political and economic conditions, as well as new ideologies and concepts of health, which were emerging and gaining wider influence around the globe.[5] In addition to the League of Nations Health Organisation, global impetus for healthcare transformation came from other organisations such the International Labour Organisation and Hygiene Services, two international organisations which were able to collect and report information relating to epidemics and vulnerable populations. The League's work to improve health and eradicate poverty around the world was continued by the United Nations' World Health Organisation after the Second World War.[6]

In South Africa, since World War 1, the increasing incidence of ill health and poverty conditions among the rural blacks had become an issue of concern within the Union

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Westpoint, 2002); G.O. *Ndege, Health, State and Society in Kenya* (University of Rochester Press, New York, 2001)

[3] Digby, 'Vision and Vested Interests', p. 488.

[4] S. Marks, 'Reflections on the 1944 National Health Services Commission', *South African Historical Journal*, 66 (1), p. 183.

[5] S. Coghe, 'Inter-imperial learning and Africann Healthcare in Portuguese Angola in the Interwar Period', *Social History of Medicine*, 28(1), 2015, pp. 134-154; Ncube, "Robert A. Askins and healthcare reform in interwar colonial Zimbabwe".

[6] B. Fetter, 'Health Care in Twentieth Century Africa: Theories and Policies, the League of Nations', *Africa Today,* 40(3), 1993, pp. 15-16.

government circles. It was feared that the diseases that were wreaking havoc among black communities with increasing intensity might spread to the white community or disrupt colonial commercial enterprises in the mining and farming sectors. As a result, the Union authorities saw the need to establish a division of 'native health', whose primary mandate was the provision of healthcare services in African communities. Increasingly, the Union government would regard the health of the rural blacks in South Africa as a challenge that required a modicum of state attention.

The concept of 'native health' was invented to describe and frame the health of blacks as a separate arena in terms of government policy of racial segregation.[7] The Union government authorities tasked the Department of Native Affairs, which was responsible for the improvement of health of the blacks, to establish the Native Medical Service. This would be a separate health unit, whose focus would be the health of blacks in the rural areas where poverty and disease were increasing at alarming rates. The state believed that blacks were illiterate and primitive, which "…dominates their outlook on all matters relating to disease".[8] As a result, the state believed that the study of blacks' ideas and ways of dealing with diseases might help them to benefit from scientific medicine, which was considered by the state as the best way of dealing with health challenges experienced by this subject race.

As time went on, some individuals from both government and the non-governmental health fraternity embraced other reformist concepts such as social medicine, community health, community-orientated primary care, and ultimately primary health care.[9] Approaches underpinned by these concepts included varying degrees of community involvement, the establishment of clinics and health centres or health units, and first-line care and prevention of the diseases where possible. The fully-fledged concept of primary health care gained popularity after the Alma Ata conference, which was held in the Soviet Union in 1978.

[7] H.S. Gear, 'Native Health and Medical Service', *South African Medical Journal*, XVII (11), 12 June 1943, p. 168.
[8] G.W. Gale, 'Native Medical Ideas and Practices', *South African Medical Journal*, October 1934, p. 748.
[9] A.H. Jeeves, "Public Health and Rural Poverty in South Africa: "Social Medicine" in the 1940s and 1950s" Accessed from http://wiredspace.wits.ac.za/bitstream/handle/10539/8819/ISS-208.pdf?sequence=1&isAllowed=y, on 30 October 2018.

The concerns of particular individuals within the state and other reform-minded individuals within the country were a response to the objective conditions on the ground. The period from the 1920s/1930s witnessed the rapid influx of black migrant labourers from the so-called black reserves in the rapidly emerging cities and towns, especially in the Transvaal where Johannesburg was the leading urban centre. As many scholars have shown, the poor working and living conditions in these cities and towns caused massive health problems for the migrant workers who acted as conduits for the transmission of diseases between towns and rural areas.[10]

In the urban Transvaal, Johannesburg's mines and compounds were notorious for disease outbreaks. Because of the fear of the wider implications of these health problems, both government and non-state organisations saw the need to do something to resolve these problems. Even General Jan Smuts expressed concern about the escalating venereal diseases and other related diseases in South Africa's urban conurbations such as Johannesburg, because of migrant labourers.[11] The African reserves in the rural Transvaal were not spared by these increasingly problematic maladies as city and countryside became common markets for the pathogen.

As healthcare ideas and approaches evolved, there emerged several initiatives on how to deal with some of these challenges, including the idea of healthcare centres, with the most iconic being the one established by Sidney and Emily Kark in April 1940, at Pholela, in the Natal Midlands. This initiative became the pet project of the Karks, who had been recruited by Harry S. Gear, the Deputy Chief Medical Officer of the Union.[12] Shortly afterwards, a further two health demonstration centres were established at Bushbuckridge in the Eastern Transvaal and Umtata in the Eastern Cape.[13] The Pholela model, as well as the British National Health Service model

[10] H. Coovadia et al, "The Health and Health of South Africa: Historical Roots of Current Challenges, Health in South Africa" Accessed from www.thelancet.com, 374, on 10 March 2014; R. Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa*, University of California Press, 1989.
[11] K. Jochelson, *The Colour of Disease: Syphilis and Racism in South Africa, 1880-1950*, p. 93.
[12] M. Susser, 'A South African Odyssey in Community Health: A Memoir of the Impact of the Teachings of Sidney Kark', in *American Journal of Public Health,* 83 (7), July 1993.
[13] D. Harrison, 'The National Health Service Commission, 1942-1944 – its Origins and Outcome', *South African Medical Journal*, 83, p. 682.

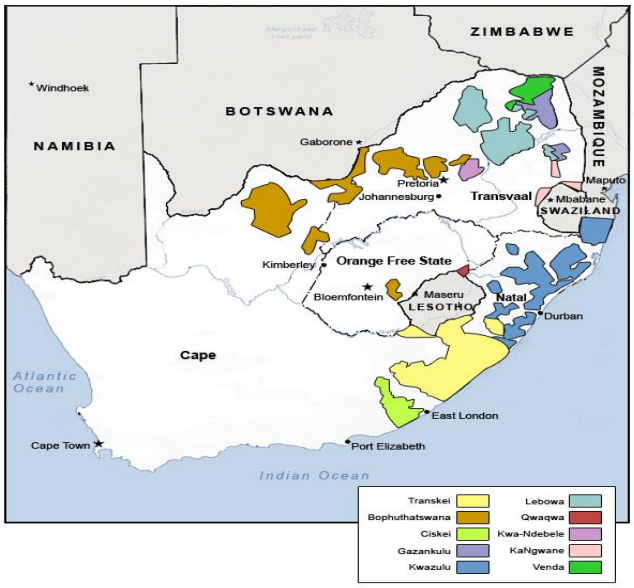
both influenced South Africa's National Health Service Commission of 1942-44, chaired by Henry Gluckman. At the end of its investigation, the much-vaunted Commission recommended the establishment of about 400 comprehensive health centres based on the Pholela model.[14] Over the years, many other centres based on the Pholela model were established across the Transvaal in areas such as Bushbuckridge, Tzaneen and other places throughout the province.

This thesis focuses on the transformation of healthcare services for the blacks in the former Transvaal during the period from the 1930s to the fall of apartheid. The thesis illustrates that over this period, the healthcare of the rural blacks in the Transvaal witnessed the evolution of incipient features of primary health care – haphazardly driven by the state and missionaries, as well as other stakeholders from the black educated elite, motivated by some of the concerns noted above. Although the concept of primary health care did not exist in popular discourse until the 1970s, kindred concepts such as 'native health', 'preventative health' or 'community health' were regularly used to describe the various initiatives put in place by different actors to deal with a variety of health challenges faced by African communities.

The thesis argues that the road towards the full embrace and implementation of primary health care as South Africa's main healthcare delivery concept was characterised by many challenges emanating from the state's reluctance to support the full implementation of progressive healthcare, as that had the potential of upsetting the policy of racial discrimination. However, black people's opposition to the state's reluctance to implement a national healthcare system based on the precepts of primary health care emerged and intensified from the time the National Party came to power in 1948. More than other previous works, the thesis makes these developments much more explicit and regards them as part of the whole story of healthcare development in twentieth century South Africa.

[14] A. Digby, 'Evidence, Encounters and effects of South Africa's Reforming Gluckman National Health Services Commission, 1942-1944, *South African Historical Journal*, 64(2) pp. 1-19.

Map 1: *South Africa's four provinces and black reserves or Bantustans during the apartheid era*.



Source: http://African history.oxfordre.cm/10.1093/acrefore/9780277734.001.001/acrefore-9780190277734-e80.

Moreover, the thesis further notes that the healthcare system of the Transvaal was also uniquely impacted upon by the former black medical students of the University of Natal Medical School who, from the late 1960s and early 1970s, started to use their knowledge, skills and experience to launch community healthcare centres across the region. Although the historic Alma Ata Conference of 1978 made primary health care the policy of choice worldwide, its full implementation in South Africa was wobbled by a reluctant apartheid state. As expected, primary health care became a battleground of political wrestling between the state and liberation movements and other stakeholders. It was only after the 1994 general elections that the state unambiguously embraced the concept as national healthcare policy, which was prioritised in all government departments.

Although several scholars have dealt with progressive healthcare initiatives during South Africa's twentieth century, a focus on the rural Transvaal offers a new opportunity to revisit key developments in the country's public health history,and to reflect on the layered and indeterminate nature of the emergence of primary health care, with particular emphasis on the contribution of educated African healthcare professionals and grassroots movements. Like the Pholela and the National Health Service Commission initiatives which have been covered extensively in the literature,

a history of the development of the public health system in the Transvaal offers a vista to understand the colonial origins and changing fortunes of rural primary healthcare over the course of an eventful seven decades in South Africa..

There were many turning points in that process. The advent of apartheid was one such turning point. Although there was no shortage of progressive ideas even then, the state was motivated by the desire to strengthen and maintain segregationist and later, apartheid policies, which became popular among whites since the1948 general election. According to Keegan Kautzyky and Stephen M. Tollman,

> During the apartheid era, two developments proved particularly damaging to the country's health care and systems development: the racial fragmentation of health services and the deregulation of the health sector.[15]

However, the state's desire to implement its apartheid policies did not deter those who wanted to see progress and the development of healthcare services among the black people. There were institutions, most of which were of missionary origin, as well as individuals, whose objective was the provision of healthcare services. Gradually, therefore, health centres were established to deliver basic community healthcare services across the region. If these did not satisfy the health needs of the people, they certainly helped to highlight what was required to satisfy those needs.
Meanwhile, traditional healers also continued to play a role in the provision of health services to the black communities. Their continued involvement in the provision of cures in African communities elicited the negative attitude of the medical fraternity and the state. Although traditional medicine was condemned and outlawed by the Union government, and denigrated by the missionaries, it remained a source of succor for large portions of the black population even after the development of modern health services. African populations utilised the indigenous medical system because they regarded it as acceptable and functional.

Over time, there were half-hearted attempts to integrate the traditional and modern healthcare systems to enhance capacity. This happened in the context of the

[15] K. A. Kautzky, and S. M.Tollman, 'A Perspective on Primary Health Care in South Africa Primary Health Care: In Context', *South African Health Review*, 2008(1), 2008, p. 20.

homelands dispensation. The tentative Africanisation of the healthcare system aided the process of relative integration of the two systems. For instance, one of the founders of Ithuseng Community Healthcare Centre in Lenyenye, Tzaneen, Mankuba Ramalepe, revealed that during the early 1980s her Centre organised educational training sessions for traditional healers in and around Lenyenye and the isolated areas of the former Lebowa, Venda and Gazankulu homelands, about the treatment of a variety of diseases.[16]

However, such cases were neither routine nor national policy, and the apartheid context stifled any comprehensive integration. The National Party government never co-operated with traditional healers on matters of healthcare service provision. In some instances, the traditional healers were accused of supporting the anti-apartheid forces. The approach taken by the apartheid state had a negative impact on the envisaged national health system for all South Africans. For example, all health centres that had emerged around the country from the 1940s, buoyed by Gluckman's efforts of creating a National Health Service, had been stifled by the mid-1960s.[17]

Global and local developments during the 1970s influenced new developments in healthcare service provision among black communities in South Africa as a whole. These developments compelled the government to seek ways of adapting to the new circumstances, of which health care of the blacks was not an exception. The segregationist state's provisional interest in health reforms became evident when it promulgated Health Act 63 of 1977, which aimed at rationalising health organisation and promoting primary health care through statutory means.[18] Despite this new initiative, however, the existing segregationist apartheid apparatus remained dominant to such an extent that any attempt to reform the healthcare system and deliver equitable health services to all racial groups continued to be defined by fragmentation and contestation.

[16] Interview with M. Ramalepe, Non-Governmental Organization, Community Health, Tzaneen, 21 April 2013.
[17] H.C.J. van Rensburg et al, *Health and Health Care in South Africa, Van Schaik, Pretoria, 2004,* p. 417.
[18] van Rensburg et al, *Health and Health Care in South Africa,* p. 87.

Indeed, by that time it had become abundantly clear that the apartheid government could not continue to contain the various forces that were pro-reform. The impetus given to primary healthcare by the Alma Ata Declaration of 1978 resulted in a great deal of pressure being exerted on the South African authorities. Indeed, as the two scholars K. A. Kautzky and S.M. Tollman have argued,

> Attended by 132 nations and many governmental and non-governmental organisations (NGOs), the conference introduced and enthusiastically endorsed the philosophy and practice of PHC as the means to achieving universally available health care and of attaining 'Health for all'. While there is little evidence of any meaningful impact on the South African public health service at the time, the endorsement of PHC at Alma Ata was profoundly significant in highlighting the contrast of the regressive health policies.[19]

In the Transvaal, many healthcare stakeholders started to use the principles of primary healthcare in organising and delivering services in the rural areas and townships.

The developments of the late 1980s, which included the unbanning of black political organisations as well as the release of the most prominent political leaders from prison, created some optimism about the possibility of reform in the social services cluster. Indeed, activists emphasised the development of healthcare services via the comprehensive primary health care model. Unsurprisingly, during the negotiations that occurred during the transition to a new democratic South Africa, primary health care emerged as a favoured model of healthcare delivery.

Indeed, after the fall of apartheid, the idea of primary healthcare became a significant priority, particularly in the implementation of the Reconstruction and Development Programme (RDP), with the poor rural communities in the former homelands being the main target.[20] When the Government of National Unity came into power after the 27 April 1994 general elections, primary health care became the guiding principle of

[19] Kautzky, and Tollman, 'A Perspective on Primary Health Care in South Africa', p. 20.
[20] See 'ANC Health Policy, A National Health Plan for South Africa', Prepared by the ANC with the Technical Support of the WHO and UNICEF, May 1994.

the restructured national Department of Health. Although it felt like a new beginning, the seeds of that beginning had been sown quite earlier in the history of the country – and this thesis seeks to illustrate this.

1.2 Literature review

The advent and development of progressive healthcare ideas is not virgin territory as many scholars have considered this issue from different angles. Their findings form the building blocks of this thesis. A book titled *The Community is My University* by Selina Maphorogo and Erika Sutter is one of the most important memoirs used in this research. Among other things, the book gives useful overviews of the Elim Care Group project whose operational model was the enrolment of community participation in the prevention and treatment of trachoma in the rural Transvaal. A co-authored memoir by a white ophthalmologist and a black community worker, the book details how their partnership allowed them to mobilise the poor rural populations, especially women, in order to improve their lives and prevent poverty and diseases. Their views are based on the lessons and experiences learned from the Elim Care Group project, which has existed since the 1960s. Maphorogo and Sutter emphasise the involvement of community nurses and the surrounding communities in the delivery of basic community health in the former Transvaal.

Despite its empirical character, this book is contributes a great deal of historical knowledge regarding the role played by community partnerships with healthcare institutions in the prevention of diseases. However, although it is an important study, Maphorogo and Sutter's work presents a description of events associated with the initiatives of only one institution, Elim Hospital, in containing mainly one disease, trachoma, (although HIV/AIDS became a later pre-occupation). Moreover, the book is just a memoir, which focuses on a specific locality and only on certain aspects of a wider and complex issue of healthcare.

H.C.J. van Rensburg edited collection entitled *Health and Health Care in South Africa* is an account of the evolution and impact of Western medical care in South

Africa, and its influence on the poverty-stricken rural areas of the former Transvaal.[21] The book gives an overarching overview, capturing both the local and international contexts. Emphasising historical context, Van Rensburg's explains that:

> The nature and variety of contemporary national healthcare systems and the uniqueness of a specific country's health care system can only be comprehended when the historical context from which a system developed is considered.[22]

Influenced by ideas on the social determinants of health, the book explores the social, political, economic and cultural determinants as crucial factors in the development of primary health care and health care in general. The book further gives an overview of the commissions and various legislations on health matters, which were passed since the establishment of the Union of South Africa in 1910. These government initiatives were an attempt to transform the South African health system, based on the white and black dichotomy. The book also refers to the Pholela model, which is regarded as "…the golden era of primary healthcare in South Africa".[23] Unlike Selina Maphorogo and Erika Sutter, Van Rensburg gives an overview of the development of versions of primary health care since the early 20th century. Other areas of focus include the links between disease and poverty, healthcare in the reserves and homelands, traditional healers, the role of nurses and medical practitioners, the missionaries and health legislation until 1994.

In their book entitled *Uprooting Poverty: The South African Challenge,* Francis Wilson and Mamphela Ramphele make the important point that "Poverty is like illness, it shows itself in different ways in different historical situations, and it has diverse causes?"[24] In line with its telling title, this book covers the effects of social, economic and political inequalities on health in South Africa. It further explores, in relative detail, the experiences of health centres in the rural areas of the Transvaal, the connections between poverty, migrant labourer and disease, the involvement of

[21] van Rensburg et al, *Health and Health Care in South Africa*, p. 6.
[22] van Rensburg et al, *Health and Health Care in South Africa*, p. 6.
[23] van Rensburg et al, *Health and Health Care in South Africa,* p. 416.
[24] F. Wilson and M. Ramphele*, Uprooting Poverty: The South African Challenge*: The South African Challenge, USA, 1989, p. 14.

foreign donors in healthcare delivery, as well as the experience of primary health care in other parts of the developing world.

In the South African context, and indeed Africa as a whole, there is no way in which the history of rural healthcare could be completed without reference to the contribution of the missionary societies of Christendom from Europe. Their role in health matters can be traced back to the 18th century when these missionaries came to South Africa with the aim of "civilizing" the blacks as they were considered uncivilised.[25] In his book *Christian Doctor and Nurse: The History of Medical Missions in South Africa, 1799-1976,* Michael Gelfand details the contribution of missionaries in the establishment of clinics, hospitals and schools in colonial South Africa. He argues, among other things, that the poverty and poor health among the rural communities in the black reserves, and later the homelands, was one of the factors that compelled missionaries to intervene. He notes the increasing awareness during the 1930s of the existence of tuberculosis, malaria and other diseases of poverty in areas like Zebediela Estate, Sekhukhuneland and other localities of the Transvaal as one of the developments that prompted missionaries to act.

Gelfand traces the long history of missionary involvement in rural healthcare from the earliest times to the 1970s when missionary hospitals and clinics were placed under the homeland administrations, a move which affected negatively on the development of community healthcare. He also makes reference to developments in the Transvaal homelands such as Lebowa, Venda, Gazankulu, KwaNdebele and Bophuthatswana.[26] Gelfand also explored the relationship between missionaries and traditional healers, which he regards as significant in the development of the healthcare of the rural blacks. He regards the earlier negative perception of it as one of the issues that hampered the development of healthcare in the countryside.[27]

Gelfand's work provides pointers to empirical data on the history of the contribution of the missionary health institutions in the Transvaal. Although his book contains material that contributes to the historical knowledge of healthcare in the rural

[25] Wilson & Ramphele, *Uprooting Poverty: The South African Challenge*, p. 14.
[26] M. Gelfand, *Christian Doctor and Nurse: The History of Medical Mission in South Africa from 1799-1976,* Sandton: Aitken Family, 1984, pp. 28-29.
[27] Gelfand, *Christian Doctor and Nurse,* p. 310.

northern Transvaal, most of Gelfand's work is known to be celebratory and triumphalist.[28] It is also outdated.

Another important text is the book by Vanessa Noble, entitled *A School of Struggle: Durban's Medical School and the Education of Black Doctors.*[29] The book covers the experiences of black students at the University of Natal Medical School and their efforts against segregation. The segregation at this institution was aimed at promoting racial division in the medical fraternity. However, this institution was the first to train Africans, Indians and Coloured students as doctors, separate from the white students.[30] Noble argues "In fact, like any other institutions with a changing mix of students and staff over many decades, the medical school's history is one that could claim significant advances or successes in a number of areas, but also deep disappointments, ambiguities, tensions and divisions."[31] The growing health needs and challenges caused by poverty, unemployment and associated diseases fanned the interest of the black students who embarked on medical studies, with the aim of involving themselves in the promotion of community health care.

The book covers the contributions of the medical students such as Stephen Bantu Biko, who formed the South African Students Organisation (SASO) in the early 1970s; Dr Mamphela Ramphele who contributed through the development of community health care centres in Natal and in the Eastern Transvaal; Dr Aaron Motswaledi who was one of the people who started the Health and Nutrition Centre at Jane Furse in Sekhukhuneland, and later became Minister of Health; Nkosazana Dlamini Zuma who also played a role in community development projects and also became the first Minister of Health in the Government of National Unity from 1994 to 1998; and Dr Elliot Kgoadi-Molaba, who became a Minister of Health in the Lebowa Homeland government.

There were also other doctors and health professionals who contributed immensely to the development of primary health care through projects such as National Medical

[28] See for instance, T. Ranger, 'The Ambiguities of Medical Mission in Southeast Tanzania', *Social Science and Medicine'*, 15(3), (1981), pp. 261-277.
[29] V. Noble, *A School of Struggle: Durban Medical School and the Education of Black Doctors*, p. 1.
[30] Noble, *A School of Struggle*, p. 2.
[31] Noble, *A School of Struggle*, p. 2.

and Dental Association (NAMDA) and National Progressive Primary Health Care Network (NPPHCN). The creation of the Medical University of South Africa (MEDUNSA), which played a major role in the promotion of community health schemes, was a result of the influence of the University of Natal Medical School. The book also covers the negotiation process in the early 1990s between the National Party and African National Congress (ANC), which paved way for the transformation of health services in order to cater for the needs of all racial groups in South Africa, with primary health care as a priority.[32]

The *South African Health Review* of 1995*,* which is a joint publication by the Health Systems Trust and the Henry J. Kaiser Family Foundation, is another important source that covers health trends in South Africa from a social, political and economic perspective. The *Review* highlights poverty, and disease as some of the main challenges faced by a severely fragmented health service sector. Although apartheid worsened the unequal distribution of health services, the South African state's health policies were based on racial discrimination since the inception of the Union government in 1910, and even before.[33] The health of the blacks was regarded as a separate issue and the concept of 'native health' was regularly used by the colonial government to describe the health challenges and measures to overcome these challenges separately from the whites.[34]

The *Review* further highlights the efforts of progressive medical professionals and bureaucrats such as Henry Gluckman, Sidney Kark and Harry Gear who started to make efforts to address the prevailing health disparities from the 1930s and 1940s.[35] The different anti-apartheid movements and their partner organisations from social medicine, and the research units of University medical schools, would later take forward these initiatives to address segregated healthcare. Some of these health organisations included the National Medical and Dental Association and the National Progressive primary health care Network formed in the 1980s.[36] Although it makes an important contribution to the history of healthcare in South Africa, the *Review*

[32] Noble, *A School of Struggle*, p. 303.
[33] J. Reddy, *South African Health Review 1995*, pp. 53-54.
[34] Reddy, *South African Health Review*, p. 55.
[35] Reddy, *South African Health Review*, p. 66.
[36] Reddy, *South African Health Review*, p. 285.

does not specifically focus on the rural areas in the Transvaal per se, except for illustrative purposes.[37]

Randall Packard's *White Plague*, *Black Labor: Tuberculosis and Political Economy of Health and Disease in South Africa,* examines the history of tuberculosis in South Africa from about the mid-nineteenth century. Packard argues that the disease is associated with socio-economic conditions in which blacks were victims of tuberculosis as most of them were living in poverty. As migrant labourers in the mining towns and cities, particularly in the Rand gold mines, blacks were exposed to the tuberculosis infection and carried the disease back to their rural homelands. Packard maintains that,

> In the absence of more profound improvements in the social and economic conditions under which blacks lived and in fact a significant deterioration in the conditions of rural Africans, a reservoir of infection and disease grew within the rural and peri-urban areas of the country.[38]

He associated the disease with low wages, overcrowding and slum conditions where blacks lived.[39] Although the disease was on the radar of reformers such as Gluckman and George Gale during the 1930s and 1940s, it continued to decimate vulnerable African victims due to the country's political economy. It only got worse with the advent of HIV/AIDS as tuberculosis became one of the opportunistic infections in cases of HIV/AIDS.[40]

Packard's book provides rich analysis of the link between health and society, based on social, political and economic conditions that influenced the spread of tuberculosis in the rural and urban township areas of the blacks. Although he focused little on the rural areas of the blacks in the Transvaal, his book is one of the most outstanding works ever published on the history of tuberculosis in South Africa.

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[37] Reddy, *South African Health Review*, p 39.
[38] R. M. Packard, *White Plague, Black Labor: Tuberculosis and Political Economy of Health and Disease in South Africa*, University of California Press, 1989, p. 318.
[39] Packard, *White Plaque, Black Labor*, p. 318.
[40] Packard, *White Plaque, Black Labor*, p. XVII.

Shula Marks' article in the 1997 edition of the *American Journal of Public Health* focuses on the history and contemporary practice of community healthcare in South Africa, with the experimentation with social medicine during the 1940s and 1950s being the major themes. The article highlights the pioneers of the progressive thinking of the time, which nearly changed the trajectory of the country's healthcare system with its focus on preventative community healthcare rather than curative health services.[41] Community health came to be seen as part of the welfare of the family and the two could not be separated since the wellbeing of the community including the prevention of diseases, ensures the wellbeing of families. The article also covers the establishment of about 40 healthcare centres across the country during the years 1946-1948 in the aftermath of the National Health Services Commission, also known as the Gluckman Commission of 1944.

D. Harrison has also traced the origins and outcomes of the historic Commission.[42] Harrison has emphasised that "The foundation of the NHS would be health centres that provided complete primary healthcare to the communities they served."[43] The strength of Harrison's work lies in his ability to link the early community health centre initiatives by some individuals from the state's health service departments in the 1940s and the establishment of health centres in the Eastern Transvaal and Transkei in the Eastern Cape.

Although the Gluckman Commission has recently started to divide opinion among historians of South African healthcare,[44] generally there is consensus that it was one of the major highlights of South Africa's decade of possibilities – the 1940s.[45] The Commission highlighted a productive confluence of local and international reformist ideas on healthcare for the poor. Although the British academic and guest of South Africa, John Ryle, criticised the pursuit of social medicine without comprehensive anti-poverty, welfare and environmental health programmes, there was optimism

[41] See Shula Marks, 'South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics', *American Journal of Public Health*, 87, 1997, pp. 452-459.
[42] Harrison, 'The National Health Service Commission, 1942-1944', p. 679.
[43] Harrison, 'The National Health Service Commission, 1942-1944', p. 679.
[44] See for instance debates between Shula Marks, Anne Digby and Bill Freud: Shula Marks (2014) 'Reflections on the 194 National Health Services Commission: A Response to Bill Freud and Anne Digby on the Gluckman Commission', *South African Historical Journal,* 66 (1), pp. 169-187.
[45] For more see, S. Dubow and A. Jeeves, *South Africa's 1940s: Worlds of Possibilities,* Cape Town: Double Storey, 2005.

among the leading officials that the health centre service proposed by the Gluckman Commission would achieve desired results.[46]

The Pholela Health Centre experiment – the model that was adopted by the Gluckman Commission as an example to be replicated elsewhere in the country – has obviously received a great deal of historical review. In addition to the memoir by the founders of the scheme – Sydney and Emily Kark[47] – many historians have taken turns to explore and report on its many progressive aspects and its legacies. According to Shula Marks, the community-based health centre model pioneered by the Karks in Natal in the early 1940s emerged from an enabling intellectual context and a web of relationships that the Karks had exploited to their advantage.[48] Many historians have told the many innovations of the Pholela centre, including home visits, welfare clubs, community surveys, and the running of a polyclinic, among others, in detail.[49]

Other schemes that echoed the Pholela model, including the Grassy Park Health Centre ("the peri-urban Pholela") and the Valley Trust (a nutrition-based healthcare centre) have received thorough historical probing.[50] Moreover, scholars have also focused on the legacies and lessons of the progressive era in general and the Pholela model in particular, for post-apartheid South Africa.[51] About the lessons provided by Pholela, Alan Jeeves had lamented that:

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[46] For more details on this debate see, A. Jeeves, 'Health, Surveillance and Community: South Africa's Experiment with Medical Reform in the 1940s and 1950s', *South African Historical Journal*, 43, (2000), pp. 244-266.
[47] Sydney and Emily Kark, *Promoting Community Health: From Pholela to Jerusalem*, (Johannesburg: Wits University Press, 1999).
[48] Marks, "South Africa's Early Experiment in Social Medicine".
[49] See for example, A. Jeeves, 'Public Health and Rural Poverty in South Africa: "Social Medicine'in the 1940s and 1950s", accessed from: http://wiredspace.wits.ac.za/xmlui/bitstream/handle/10539/8819/ISS-208.pdf?sequence=1&isAllowed=y; S. Marks, "South Africa's Early Experiment in Social Medicine".
[50] H. Phillips, 'The Grassy Park Health Centre: A Peri-Urban Pholela?', in S. Dubow and A. Jeeves (eds.), South Africa's 1940s. Worlds of Possibilities (Cape Town: Double Storey Books, 2006), 108–28; A. Digby and H. Sweet, A. Digby and H. Sweet, 'Social Medicine and Medical Pluralism: the Valley Trust and Botha's Hill Health Centre, South Africa, 1940s to 2000s', *Social History of Medicine*, Vol. 25, No. 2 (2012), pp. 425-445.
[51] See for example, 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*, 83, (1993), pp. 1043-1050; H. Phillips, 'The Return of the Pholela Experiment: Medical History and Primary Health care in Post-apartheid South Africa', *American Journal of Public Health*, 104, (2014), pp. 1872-1876.

> Still, the special lessons learned at Pholela are not well remembered in the South African medical community. Yet those lessons, only some of which could be discussed above, still resonate powerfully fifty years later as the country moves into the post-apartheid era and contends with a medical system seriously compromised by decades of NP misrule and incapable in its present form of serving the health needs of the people. For the 1990s and beyond, the creation of an effective health-care that reaches the country's poor depends on the restoration of that approach, more than it does on an extension of curative medicine, important though the latter certainly is.[52]

However, as Howard Phillips has noted in a much recent review of the initiative, the Pholela experiment did hold some appeal among the post-apartheid healthcare reformers; alas, the 'second coming' of Pholela has been lackluster as the post-apartheid dispensation has failed to make it the basis of a reformed public healthcare system.[53] The jury is still out on the planned National Health Insurance scheme.

In South Africa, the desire to deliver adequate health services through the training of proper health care personnel has been a serious challenge over the years since the establishment of the Union in 1910. Karin A. Shapiro's article titled 'Doctors or Medical Aids - The Debate over the training of Black Medical Personnel for the Rural Black Population in South Africa in the 1920s and 1930s' is one piece that grapples with the issues under review. This article focuses on the debate related to the training of black medical professionals with emphasis on the role played by progressive liberals.[54] According to Shapiro, many of these progressive liberals "viewed individualized, curative, and hospital based medicine as less effective than preventative and community medicine in eradicating diseases such as those associated with unhealthy living conditions, poor nutrition, and inadequate immunization".[55]

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[52] A. Jeeves, *Public Health and Rural Poverty in South Africa: "Social Medicine" in the 1940s and 1950s,* p. 11.
[53] Phillips, "The Return of the Pholela Experiment".
[54] K. A. Shapiro, 'Doctors or Medical Aids - The Debate over the training of Black Medical Personnel for the Rural Black Population in South Africa in the 1920s and 1930s', J*ournal of Southern African Studies*, 13 (2), 1987, p. 235.
[55] Shapiro, 'Doctors or Medical Aids', p. 234.

According to Shapiro, C.T. Loram and Sir Edward Thornton, an educationist and public health expert respectively, were passionate about the training of black medical personnel to overcome the mounting health problems for the rural and urban black migrants in the Transvaal. Like other scholars, Shapiro regarded the prevalent socio-economic conditions in the rural areas as a 'menace' to South Africa in terms of its probable eventual shortage of labour, most particularly in the mines and in the farms.[56] Shapiro highlights the role played by the liberal institutions in the training of black doctors such as the non-European branches of the University of Witwatersrand Medical School and University of Cape Town Medical School.[57] The efforts of the progressive minded individuals from the state and non-governmental organisations to continue with training of black doctors were hampered when the Rockefeller Foundation's donation for black medical education was not fully embraced by the state.[58] As Anne Digby has noted in a separate study, the stakes of conservative elements within the medical fraternity opposed the scheme.[59]

The article entitled 'The Emergence of Community Health Worker Programme in the Late Apartheid era in South Africa: A Historical Analysis' by Nadja van Ginneken et al, examines the re-emergence of interest in community health workers as the most important component of primary health care from the 1970s-1994.[60] In the article, van Ginneken refers to the role played by the Alma Atta Conference of 1978 where community health workers initially gained global support. Van Ginneken et al maintain that: "They were seen as a key element of the strategy to achieve WHO's goal, set in 1975 of 'Health for All' by the year 2000."[61] The focus of this article is mainly on the historical analysis of community health workers in the late era of apartheid.

Due to their active role in their promotion health care services in the rural areas, non-state actors such as ideologically driven individuals have also received attention.

[56] Shapiro, 'Doctors or Medical Aids',p. 236.
[57] Shapiro, 'Doctors or Medical Aids',, p. 242.
[58] Shapiro, 'Doctors or Medical Aids', p. 249.
[59] A. Digby, 'Vision and Vested Interests', pp. 485-502.
[60] N. van Ginneken et al, 'The Emergence of Community Health Worker Programmes in the late Apartheid Era in South Africa: A Historical Analysis', *Social Science and Medicine*, 71 (6), 2010, p. 1110.
[61] van Ginneken et al, 'The Emergence of Community Health Worker Programmes in the late Apartheid Era in South Africa: A Historical Analysis', p. 1110.

Van Ginneken et al give examples of primary health care projects including those initiated by Mamphela Ramphele and Mankhuba Ramalepe near Tzaneen, and Selina Maphorogo and Erika Sutter at Elim near Louis Trichardt.[62] The study highlights the many political and financial challenges that were faced by these initiatives. Although the 1990s were characterised by the implementation of a variety of health plans that resulted in the provision of free primary health care services, the community health workers project, mainly focusing on the prevention of HIV/AIDS, struggled due to lack of funds.

The notion of the health services to all racial groups in South Africa had been a challenge since 1910. Access to health services based on disparities in the socio-economic and health profiles of the different race groups played a secondary role in healthcare policy considerations, hence the fragmentation of healthcare service delivery.

Max Price conducted an analysis of health trends in his article titled 'Health Care as an Instrument of Apartheid Policy in South Africa since 1948'.[63] Price believes that the National Party Government legalised racial segregation to prevent any possible domination of whites by blacks. He saw the introduction of demarcation of different ethnic areas into homelands as a way of separating political rights between blacks and whites. According to Price, "…the bantustans have functioned as a dumping ground for millions of people who were not 'needed' by the 'whites' economy'."[64] He indicated that although the government continued to pass apartheid policies, as it was reflected in the Tricameral Parliament of the early 1980s, it was concerned with the possible spread of the diseases as both racial groups were working in close contact with each other. In many instances, blacks were preparing their food and looking after their children on a daily basis. Price regarded the state's expansion of the health services for blacks in the urban areas in the 1970s as an attempt to pacify them politically.[65]

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[62] van Ginneken et al, 'The Emergence of Community Health Worker Programmes in the late Apartheid Era in South Africa'.
[63] M. Price, 'Health Care as an Instrument of Apartheid Policy in South Africa', *Health Policy and Planning,* 1 (2), 1986, p. 159.
[64] Price, 'Health Care as an Instrument of Apartheid Policy in South Africa', p. 159.
[65] Price, 'Health Care as an Instrument of Apartheid Policy in South Africa', p.163.

Price viewed the taking over of the missionary health institutions by the state in the early 1970s and transfer of some to the homelands as contributing to the fragmentation of health services. He regarded the state's unequal funding of the homeland health departments as being motivated by political reasons as Lebowa and Kwazulu continued to receive low funding in the 1980s due to their refusal to accept independence as compared to independent Venda and Bophuthatswana, which accepted independent offers from the state.[66]

Although Price's article gives a good analysis of political and economic determinants of different health services of blacks and whites from 1948 to1980s, his coverage of the Transvaal rural areas is minimal. He stressed the relationship between tuberculosis and independent and non-independent homelands in terms of the state's allocation of funds without mentioning other disease notifications in the rural areas of the Transvaal. It is despite the gaps that the article is contributing immensely to historical knowledge on health of the blacks in general.

Other studies that were found to be relevant include, M. Coetzee et al's 'Malaria in South Africa: 110 years of learning to control the disease', Anderson et al.'s 'Apartheid in the 1980s', Goovadia et al.'s 'The Health and Health System of South Africa: Historical Roots of Current Public Health', E.H.A. Koumans' 'Infant and Child Mortality in the Elim District of Northern Transvaal, 1976-1986' S.L. Kark et al.'s 'Pholela Health Centre: A Progress Report', S.M. Tollman, 'Community-Orientated Primary Health Care: Origins, Evolution, Applications', M. Susser and V. Padayachi Cherry's 'Health and Health Care Under Apartheid', and M.E. Concha's 'The Introduction of a Training Programme for Community Workers – The Wits/Tintswalo Model Wits Rural Facility C77'.

One of the common features of the literature on primary health care or universal health care in South Africa is the conclusion that it could have developed very early had it not been for the consolidation of apartheid. According to L. Spencer "In South Africa, early lessons in primary health were lost to sight and have been rediscovered

[66] Price, 'Health Care as an Instrument of Apartheid Policy in South Africa', p.166.

towards the late 1980s.''[67] The concept only started to receive serious attention from 1990 when it was considered a priority by the National Party government, which was under pressure from anti-apartheid organisations.

Based on the literature used in this thesis, one can say that more still needs to be done on new case studies, such as the Transvaal, in order to gain a fuller understanding of the history of health service provision in South Africa. The available literature focuses on universal or community health care initiatives pioneered by progressive-minded individuals from the 1920s. Prominent coverage is normally given to Loram Commission of 1928, the remarkable works of Sidney and Emile Kark in the community health and health centre initiatives at Pholela in Northern Natal in the 1930s, the role of Secretary of Health, Eustace H. Cluver, Harry S. Gear as Deputy Chief Health Officer from 1938 to 1940, George Gale as Secretary of Health and Chief Medical Officer from 1946 to 1952 and Dean of Durban School from 1952 to 1955. These individuals also contributed to the Gluckman Commission in the early 1940s.[68]

As a result, the story of healthcare development in the Transvaal is not given adequate attention in the available works. Unlike in Natal, the Transvaal primary health care story is not linked to prominent individuals such as the Karks or the Stott family of the Valley Trust, but it evolved through the efforts of a variety of stakeholders and individuals, amongst others, Mamphela Ramphele and Selina Maphorogo – two black women who made their mark on the region's healthcare history. Missionary and state actors also made their mark through the establishment of healthcare centres, healthcare projects, and clinics, with emphasis on the northern and eastern Transvaal areas.

Although there has been relatively wide coverage of primary health care in the country, there is no comprehensive coverage of its development in the Transvaal. As a result, this thesis seeks to expand the view by including the undocumented and isolated information into a single monograph that may contribute immensely to new

[67] L. W. Spencer, 'Primary Health Provision in Terms of Community need in South Africa', *Israel Journal of Medical Services,* 19 (8), August 1983, pp. 703.
[68] Marks, 'South Africa's Early Experiment in Social Medicine', p. 453.

knowledge on South Africa's healthcare.

1.3 Significance of the study

In the context of this literature, this thesis explores the evolution of incipient aspects of primary health care as it developed among the blacks in the former Transvaal between the 1930s and the 1990s. The study traces the flow and ebb of aspects of social, economic and political changes that influenced the development of primary healthcare services in the outlying areas of the expansive Transvaal.

The transformation of primary health care of the blacks in the former Transvaal since 1930 could be studied in the context of the interaction of social, economic and political determinants. The challenges associated with these determinants were responsible for the prevailing state of impoverishment, which contributed to the rise of diseases such as tuberculosis, STIs, kwashiorkor, measles, polio and other disease associated with poverty. As H.C.J. van Rensburg has stated:

> The influence of socio-economic class on the phenomenon of disease, health and health care is relevant in different respects. Without doubt, people's class position is closely linked to the measure of education their children receive, the house in which they live, the occupations they pursue, and the income they earn.[69]

Land deprivation and migrant labour were the two main contributory factors to poverty among the rural blacks in the former Transvaal and elsewhere in the country. The resultant state of ill health compelled a number of individuals, state representatives and non-governmental organisations, to act – in some cases, through piecemeal initiatives.

The missionary-driven primary health care

The missionary-driven primary health care is studied in reference to the role played

[69] H.C.J. van Rensburg, *Health Care in South Africa: Structure and Dynamics*, p. 111.

by the missionary organisations in the provision of healthcare services among the rural black communities. These faith-based organisations of European origin were greatly influential in the lives of the rural black communities from the 18th century onwards. Although their main objective initially was to proselytise and educate blacks along the western education system, they soon realised that health services were also crucial as most blacks were suffering from poverty related disease.

Since the successful delivery of comprehensive healthcare services sometimes requires collective effort, missionary organisations worked together in the prevention and treatment of diseases in the rural areas. Sometimes this entailed collusion with the state. Michael Gelfand pioneered the study of cooperation among various missionaries in the Northern Transvaal such as the Helena Franz Mission Hospital, in Bochum, Groothoek Hospital in Zebediela, Knobel Hospital in the western area of Polokwane, St Ritas Hospital in Sekhukhuneland, Elim Hospital near Louis Trichardt and other health care institutions throughout the rural areas of the Transvaal.[70]

Cases of cooperation were also evident among other stakeholders as it was the case with Dr Mamphela Ramphele of the Ithuseng Community Health Centre and a Catholic Mission Station at Ofcolaco, outside Tzaneen. On the other hand, the relationship between the missionaries and the traditional healers was strenuous due to the negative perception missionaries held against the traditional medical system. Although many black communities were converted to Christianity, they continued to consult with traditional healers. Some did so secretly in fear of being expelled from the churches.

Despite this, traditional healers continued to provide basic treatment to the black communities, while also referring their patients to the missionary health institutions for the treatment of complicated disease cases that were beyond their capacity. The takeover of the missionary institutions and placing them under the homelands, controlled by the government since 1973, had a negative impact on the provision of non-state primary healthcare services. This situation was aggravated by a severe shortage of health care personnel with fragmentation of health centres,

[70] Gelfand, *Christian Doctor and Nurse,* pp. 28-29.

maladministration and limited availability of funds and other health resources. As a result, most of these missionary health institutions had to close down. In the Transvaal, this closure affected places such as the former homeland areas of Venda, Gazankulu and Lebowa.

The state and health care in African communities

Racial dynamics and political determinants were always influential in determining the nature and efficacy of the healthcare system in the country. Indeed, H.C.J. van Rensburg has underscored the point:

> There is general agreement among authors regarding the important relationship between a country's health care system and its political system. In fact, the prevailing political and government systems, the constitutional and statutory dispensations, political ideologies, policies and institutions, the demands and pursuits of political parties and pressure groups and the political changes and resolutions occurring in societies are generally reflected in the health care system.[71]

Political determinants had a tremendous influence on the economic climate of the country, which in turn influenced health conditions. In the South African context, the transformation of primary healthcare and health care in general could be explained in relation to the political situation of the time since the establishment of the Union of South Africa. The period from the 1930s onwards witnessed the consolidation of racial discrimination orchestrated by the state, and intensified by the apartheid regime. The white and black relations greatly influenced the political, social, economic and health pattern of South Africa for many decades. This thesis reflects on how these political relationships determined the health policy, and the implications of such policy on health development in the Transvaal.

From the government side, the point of departure was the period from the 1930s when the deteriorating socio-economic conditions of the blacks in the rural areas

[71] van Rensburg, *Health Care in South Africa: Structure and Dynamics*, p. 9.

compelled certain individuals or officials in the Department of Health to begin some initiatives to deal with these challenges. It was due to the innovative nature and impact of the first community health centre at Pholela in Natal that its model was adopted by the National Department of Health. Later, the ambition was to propagate this model across the country. Indeed, aspects of the model were adopted in the rural areas of the Transvaal, most particularly the Northern Transvaal where poverty and related diseases were rife.[72]

The Gluckman report presented to the United Party Government after 1944 provided a window of opportunity to significantly reform healthcare services in the country. However, the failure of the National Party government to recognise the Gluckman Report dealt a severe blow to the efforts of Gluckman and other members of the commission to solve rural health challenges.

However, the years following the inception of apartheid provoked severe resistance from anti-apartheid organisations such as the African National Congress, the Pan Africanist Congress, the South African Communist Party and other anti-apartheid organisations. This thesis reflects on the resistance of the 1950s to the 1980s and the political developments of the early 1990s and their impact on the transformation of health care among blacks.

In the context of these developments, the 1978 Alma Ata Conference on primary healthcare, is of particular significance. Indeed, the establishment of the Browne Commission in 1986 to investigate the health conditions of the blacks should be understood against this key international development and its impact on the internal politics of healthcare in South Africa. The government went further to formulate the National Health Plan of 1986, which will be discussed later in the thesis. However, as the thesis illustrates, these policy initiatives were too little and too late.

[72] Kautzky and Tollman, 'A Perspective on Primary Health Care in South Africa', pp.18-19.

1.4 Research methodology

This study is based on a variety of primary and secondary sources available from educational, governmental and non-governmental institutions. The primary sources, such as the archival sources, were collected from the National Archives in Pretoria, Elim Hospital Care Groups Archives near Louis Trichardt, Archives of Malaria stations in Tzaneen, the University of Witwatersrand Historical Archives and Limpopo Provincial Archives in Polokwane. The information available from these sources is mostly in the form of memoranda, reports and other correspondence.

The primary sources used in this thesis also included oral interviews. As for oral interviews, the people's reconstruction and interpretation of events of the past within the prescribed period in relation to the research topic were considered. The respondents involved included the founders, health project coordinators, health workers and other interested parties who were directly and indirectly involved in the health matters of the rural blacks, both from governmental and non-governmental organisations. The information collected from these respondents was carefully and rigorously selected and analysed to extract valuable content needed to strengthen the quality of the thesis.

Some of the most important respondents interviewed included Selina Maphorogo, one of the first care group coordinators of Elim, Mankuba Ramalepe, who partnered with Mamphela Ramphele in the establishment of Ithuseng Community Health Centre in Lenyenye outside Tzaneen, Phillip Kruger from the Department of Health and other respondents who served in the former homelands' institutions and non-governmental organisations, and after this era. The traditional healers like Peter Ramafoko, Hitler Letsoalo and Jan Ramothoala also provided valuable information regarding their experiences as informal or traditional community health workers. These respondents explained the health care of the blacks in relation to political, economic and social conditions as contributory to ill health and diseases. They explained the missionary-driven primary health care in relation to the racial discrimination and marginalisation. They also regarded attempts to implement equitable health reforms as being a slow process hampered by the unpreparedness of the government to implement health reforms, which was destined to protect the

racial discrimination over the years.

The secondary sources included a variety of texts such as journal articles collected from Witwatersrand University Library, Witwatersrand Medical Campus in Park Town, Doornfontein Campus of the University of Johannesburg, the Limpopo Hospital and University Library in Mankweng Township near the University of Limpopo, the Merensky Library at the University of Pretoria, and the Institute of Race Relations in Johannesburg. Other articles were accessed online.

1.5. Chapter breakdown

The thesis is made up of eight chapters and a conclusion. Chapter 1 is the overall introduction to the study, and sets the scene by spelling out the focus of the study, locating the study in the available literature and explaining the importance of the case study. Chapter 2 provides the context by detailing the socio-economic conditions of blacks in South Africa, which exposed them to a great deal of ill-health. The chapter looks at the impact of dispossession and domination of health from the early parts of the twentieth century. Chapter 3 focuses on initial attempts to address the health challenges through the pioneering community health centre initiative. The chapter also addresses the contribution of progressive ideas and the context in which they emerged. Although this initiative would later experience problems, it indicated the possibilities.

Chapter 4 addresses the role of missionaries in healthcare development in the Transvaal. It underscores the fact that in the absence of comprehensive state efforts, missionaries filled an important gap, although their position was also an ambiguous one. Chapter 5 addresses the advent of the apartheid era and the negative impact it had in disrupting existing initiatives and fragmenting the healthcare sector through the introduction of homelands. Chapter 6 profiles the response of blacks to apartheid healthcare policies and practices. The chapter looks at both political and therapeutic responses, in particular the fact that blacks continued to adopt a hybrid approach by using traditional medicine together with limited Western medicine.

Chapter 7 addresses the late apartheid era and the healthcare reform in the context of global changes in healthcare delivery ideas. In particular, the chapter looks at how the apartheid regime reformed the health system in the context of the 1978 Alma Ata Conference on primary health care and heightened black resistance internally. The chapter argues that the intransigent regime only made piecemeal changes. Chapter 8 looks at developments in the 1990s and the restructuring of the healthcare system during a period of transition from apartheid to democracy. It details renewed emphasis on primary health care as the main framework for healthcare development in the country. The last chapter is the overall conclusion to the study, which restates the fitful development of primary health care for blacks in South Africa.

CHAPTER TWO: CONTEXT: THE SOCIO-ECONOMIC CONDITIONS OF BLACKS AND HEALTH DURING THE TWENTIETH CENTURY

2.1 Introduction

The history of healthcare in twentieth century South Africa should be studied in the context of the political, social and economic relations between blacks and whites. The stark differences in health profiles and inequality in the provision of healthcare are embedded in a long history of colonial exploitation, including land alienation, labour migration and general socio-economic discrimination. This chapter explores the colonial impoverishment of blacks during the early 20th century and assesses the effects of these developments on their health and health care provision. The poverty that resulted from the consolidation of colonial rule in South Africa since the dawn of the century exposed black Africans to a variety of diseases of poverty and ecological disequilibrium, such as malaria, tuberculosis, and STIs. Although these health challenges were most severely felt among the blacks, they were at times prevalent among poor whites in the farms around the Lowveld areas of the Transvaal, where many died of malaria during the early stages of white settlement.

The health challenges of the Transvaal forced white farmers, missionary societies and the government to intervene by devising rudimentary initiatives to provide basic healthcare services in the affected areas. This chapter therefore seeks to explain how the socio-economic conditions caused health crises, which in turn forced the state to consider the need to provide rudimentary healthcare services to the rural black population, especially from the 1930s.

2.2 Socio-economic changes and health of the blacks

The health of the blacks has been a challenge since the establishment of the Union of South Africa in 1910. Even before this period, poverty and diseases associated with it had started to increase exponentially. This was, in many ways, a direct result of the minerals revolution, the upheavals associated with colonial migration and segregation. By the 1930s, blacks in South Africa were already reeling under a variety of laws that aimed at subjugating non-whites as the modern South African

state asserted its control. Some of these laws included the Natives Land Act of 1913, the Native Affairs Act of 1920, the Natives Urban Areas Act of 1923 and the Industrial Conciliation Act of 1924.[73] As the Union consolidated itself, blacks found themselves isolated and marginalised in almost all spheres of life. Colonial land and labor policies, which reflected a desire by the state to acquire land in order to compel blacks to work on the white farms, gradually reduced blacks to a ready pool of workers who could be exploited willy-nilly by the emerging white capitalist classes, with the backing of the state. As a result, many blacks were pushed into the migrant labour system.[74]

As many scholars have shown, this scenario had long-term negative effects on the health of black South Africans for many years to come. Many blacks became victims of a variety of diseases related to labour migration and poverty, aggravated by poor nutrition, lack of proper housing in the mining compounds, poor water provision and the severe inadequacy of related basic needs of life.[75]

The territorial reorganisation of the country initiated by the Union government from 1913 irrevocably changed the fortunes of the different racial groups in the country. In that year, the Union government passed the infamous Natives' Land Act, which divided the country into racial zones. The enacting of this legislation left blacks precariously holding on to only 7.3 per cent of South African land.[76] The scheduled areas covered by this land, called Reserves, were insufficient for the African peasantry to produce the necessary amount of food for their living and health. As many generations of scholars have showed, this Act entrenched the practice of territorial segregation along races. The Act prohibited blacks from buying or leasing land outside the reserves. The negative effects of the 1913 Natives' Land Act became worse when the government introduced the system of labour tenancy during the 1920s, which added to the state of impoverishment among the blacks.

[73] T. R. H Davenport and C. Saunders, *South Africa: A Modern History*, p. 271.
[74] P. Maylam, *A History of the African People of South Africa: From the Early Iron Age to the 1970s*, p. 144.
[75] H.C.J. Kautzky and S.M. Tollman, 'A Perspective on Primary Health Care in South Africa', *p*. 18.
[76] Maylam, *A History of the African People of South Africa*, p. 144.

The majority of the Africans, mostly in the eastern and northern Transvaal, were negatively affected to such an extent that they found it difficult to sustain themselves economically. Their landlessness, poverty, and periodic natural disasters such as drought created conditions that allowed a variety of diseases to thrive. The poor state of nutrition worsened the state of health of many African communities in the reserves. In fact, the Natives' Land Act of 1913 singularly contributed to the severe impoverishment of the blacks in the rural areas of South Africa in general. According to Colin Bundy:

> There exists a vast and depressing body of evidence as to the nature and extent of underdevelopment in the Reserves (and particularly in the Ciskei and Transkei) in the forty years that followed the 1913 Act: the details abound of infant mortality, malnutrition, diseases and debility; of social dislocation expressed in divorce, illegitimacy, prostitution and crime; of the erosion, desiccations and falling fertility of the soil; and of the ubiquity of indebtedness and material insufficiency of the meanest kind.[77]

The situation on the white-owned farms was equally deplorable as the wages offered by white farmers were generally low to such an extent that it was difficult for the labourers to sustain themselves and their families.[78] In the northern Sekhukhune area of Transvaal, the relations between the farm owners and workers were considered unworkable and bitter because of the poor conditions. One of the farm owners in this area observed that:

> It is an undesirable fact to every Native that wages of farm labourers are far low compared with the wages of those people who do lighter work in the mines, in towns and elsewhere not in the farms. Whilst wages are very low for any man who is a taxpayer and a head of one or two even three families, etc., it is with much toil that he obtains this and a toll that will need assistance of his whole family, which will do all this work under a very rough treatment to a great majority of our European farmers. Unfortunately, some of our poor

[77] C. Bundy, *The Rise and Fall of the South African Peasantry*, p. 221.
[78] University of the Witwatersrand Historical Archives, AD, Box 843, File B64, 7, Miscellany Native Farm Labour, circa 1930s, Unpaginated.

> people work for nothing absolutely except for feeding their stock and ploughing their own land which is usually done after the boss's land has been done and usually late in the season. Much cheating is done on this poor labourer's stock and great unfairness practiced on their lands, i.e. havoc played by the master's stock.[79]

Apart from the wage issue, farm workers were forced to work for long hours.[80] Some of these workers traveled long distances to their homes every day, a situation which exposed them to accidents and attacks. Their housing and bedding were disgraceful and un-hygienic, and the education of black farm children was in some cases discouraged by the farm owners. Partly due to these generally poor working conditions, black farm workers found themselves exposed to a variety of diseases of poverty such as tuberculosis, small pox, malnutrition, disabilities, and cholera. The general absence of health centres or clinics on the farms condemned many affected blacks to early death due to lack of treatment.[81]

Generally, the health services of the Union were poorly organised. Different authorities managed a divided curative and preventative health services system. The onset of the influenza pandemic in 1918-1919, exposed these weaknesses.[82] This devastating pandemic paved way for public health reforms in all levels of the government in the Union. The passing of the Public Health Act in 1919 enabled the creation of a national Department of Public Health that was responsible for preventative and curative health services, with a modicum of basic coordination.[83] As H.C.J. van Rensburg has noted:

> It is important to note that the promotive and preventative emphasis of the 1919 Act brought about more definitive structuring for public health and

[79] University of the Witwatersrand Historical Archives, AD, Box 843, File B64, 7, Miscellany Native Farm Labour, circa 1930s, Unpaginated.
[80] University of the Witwatersrand Historical Archives, AD, Box 843, File B64, 7, Miscellany Native Farm Labour, circa 1930s, Unpaginated.
[81] University of the Witwatersrand historical Archives, AD, Box 843, File B64, 7, Miscellany Native Farm Labour, circa 1930s, Unpaginated.
[82] H.C.J. van Rensburg et al, *Health and Health Care in South Africa*, p.71.
[83] H. Phillips, 'The Local State and Public Health Reform in South Africa : Bloemfontein and the Consequences of the Spanish 'flu' Epidemic of 1925', *Journal of South African State,* 13(2), January 1987, p.10.

> primary health care. The organizational purpose of the 1919 legislation, namely to coordinate the supply of health care at the national level, was in principle gradually defeated by an ever-deepening polarization between preventative and curative services.[84]

The years following this development witnessed the rise of liberal ideas in healthcare provision as some experts became vocal about the need to reorganise the health of blacks and put it on a sound footing. Liberals such as C.T. Loram, a former Inspector of Education in Natal, and Edward Thornton, who became Secretary for Public Health in1932 -1938, supported the tackling of African health through the training of black doctors, nurses and medical assistants.[85] For its own reasons, the Department of Native Affairs was also concerned about the state of ill-health among blacks and therefore supported this idea. However, this Department envisaged the creation of a Native Medical Service that would see blacks being trained separately from whites.[86]

As the voices calling for the provision of healthcare among the Africans became increasingly vocal, tentative attempts were made by the Department of Native Affairs to remedy the situation. In the1930s, two 'native health units' were established, one in the Pholela District in Natal, and another one at the Maviljan farm in the Bushbuckridge area in the Eastern Transvaal.[87] These first units became important models in the evolving health system. In addition to being centres of treatment, they became important institutions that offered glimpses into the dire health situation in the surrounding areas.

For example, an investigation by the unit in Bushbuckridge revealed a very high incidence of various diseases such as syphilis, tuberculosis, nutritional disorders and severe problems regarding birth and mortality rates.[88] The few Health Assistants deployed in the reserves managed to take records of affected people in order to facilitate home visits by them. Although during the initial stages there was lack of

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[84] van Rensburg et al, *Health and Health Care in South Africa*, p. 415..
[85] K.A. Shapiro, 'Doctors or Medical Aids', p. 235.
[86] Shapiro, 'Doctors or Medical Aids', pp. 234-235.
[87] South African National Archives, GES Box 2957, File PN. 4, Native Health Services, 29 March 1941, p. 1.
[88] South African National Archives, GES, Box 2957, File PN. 4, Native Health Services, 29 March 1941, p. 1.

cooperation by the local communities, which frustrated progress in some instances, considerable progress was made through rudimentary education and the provision of basic healthcare services by health assistants.[89]

In 1934, the Minister of Public Health convened a Nursing Conference in Cape Town to look into a variety of issues, including the gathering of information about the health challenges that existed in the Union's four provinces. Various provincial delegates presented their concerns regarding health challenges in their areas, of which the Farmers' Association and residents from White River in the Transvaal, made significant presentations. During the conference, the representative of the Farmers' Association, Mr Motimer, expressed his concern regarding the isolation and scattered nature of the rural population and demanded that the state should make provision for small local clinics in each district, each with a trained European nurse and black assistant.[90]

It was also during the conference that one of the delegates from White River in the Eastern Transvaal expressed his feelings about the poor rural public health services run by the state. He implored the state, through the Minister of Health, to accept any item of health-related expenditure in his budget estimates. The plight of both whites and blacks was strongly expressed, and similar demands for local clinics, nurses and doctors and other equipment were highlighted as a way of trying to deal with the various health challenges of the Eastern Transvaal.[91]

Although the minister appreciated the farmer's demands, it became evident that the state experienced vast difficulties in fulfilling such promises because of the isolation of these outlying rural areas. It also became evident that the majority of the blacks, particularly those outside the white farming communities, would still have serious health service problems. Nonetheless, the conference created an opportunity for the state to realise the importance of health challenges experienced by a variety of rural black communities. This further encouraged state intervention as it started to see a

[89] South African National Archives, GES, Box 2957, File PN. 4, Native Health Service, 29 March 1941, p. 2.
[90] South African National Archives, GES, Box 2957, File PN. 4, Conference on Rural Nursing: Meeting of the Continuation Committee, 27 September1934, pp. 3-4.
[91] South African National Archives, GES, Box 2957, PN. 4, Conference on rural nursing: Meeting of the Continuation Committee, 27 September1934, p. 4.

community health care system as a priority in the provision of healthcare services in the Transvaal rural areas, as well as other provinces in the country.

Some noises about the improvement of health service provision for the rural blacks had become common in state circles by the mid-1930s. The statement issued by the Minister of Health in June 1934, that he intended to institute special rural health services in the black areas, signified the fact that some kind of attention was being paid to African healthcare, even though tentatively so.[92] Prior to the issuing of this statement, many black girls had expressed their interest in training as medics and be provided with certificates as basic caregivers. As and when they got trained successfully, these nurses were distributed across the various districts, including the missionary institutions where clinics were beginning to play a significant role in the provision of first level care to the surrounding rural black communities.[93]

However, these modest attempts were pitted against the rising tide of diseases across rural South Africa. Scholars such as R. M. Packard, H.C.J. van Rensburg, and K. Jochelson have addressed this issue compellingly, and there is thereforre no need to repeat the whole story here, except highlighting the state of affairs in the Transvaal. Because of its warmer micro-climate, malaria was a lingering concern in the Lowveld area of the Transvaal. Due to this problem, farmers in the area would normally migrate to the high-lying areas like Haenertsburg during summer, and return to the Lowveld area during winter in order to mitigate their susceptibility to malaria. As a result of intermittent disruptions during epidemic times, this parasitic disease prevented smooth agro-economic development in the fertile Lowveld areas.[94]

Among white settlers, general ill-health became a concern especially in relation to the ‘poor whites problem’, mostly the impoverished Afrikaner-speaking descendants of the original Trekboers. The minerals revolution of the late 19th century, led to the establishment of mining towns and cities across the country. This development

[92] University of the Witwatersrand Historical Archives, AD, Box 1715, File HLP, South African Institute of Race Relations, Native Girls and the Nursing Profession, p. 1.
[93] University of the Witwatersrand Historical Archives, AD, Box 1715, File HLP, South African Institute of Race Relations, Native Girls and the Nursing Profession, pp. 1-2.
[94] Interview with P. Kruger, Malaria Control Directorate, Limpopo Department of Health, 01 July 2017.

compelled most of these rural Afrikaners to migrate to these urban industrial centres to look for better livelihood. When the country experienced the Great Depression in 1929, the migration of many rural Afrikaners continued, and intensified in the 1930s because of the deterioration of conditions across the country. In the urban areas, these rural Afrikaners became simply known as poor whites because many of them were living in conditions of destitution.[95] The fact that these unskilled whites found themselves competing with the blacks in the labour market alarmed the state and some white mine owners who were generally influenced by the idea of persevering white civilisation and superiority.[96]

The 'Carnegie Commission of Inquiry into the Poor White Problem, 1929-1932' drew the attention of the Department of Public Health to the fact that poverty among the whites required urgent attention.[97] Thereafter, the Afrikaner nationalists and moderate politicians and intellectuals played a crucial role in persuading the Union government utilise healthcare as an instrument for the rehabilitation of poor whites. The Afrikaner nationalists also used the event such as the 1934 *Volkskonkres* to lobby the state. The idea of expanding health services for the poor whites was also supported by some of Members of Parliament and opposition parties. For example, Dr. E.P. Bauman introduced the State Medical Service Bill in 1935 that required the Carnagie Commission "…to investigate the 'Urgent necessity' of establishing a State Medical Service comprised of full-time salaried practitioners in medical, dental, hospital, nursing and all auxiliary services."[98] Bauman also acknowledged that both blacks and whites in the rural and urban areas were lacking adequate medical services. As a result, he appealed for cooperation between all branches of health services within the Union of South Africa. The appalling health conditions of the poor whites alarmed the state and some white sympathisers, mostly the English-speaking population from Britain who were generally influenced by the idea of 'Eugenics' which is a science of breeding better human beings with the aim of preserving white

[95] J. Iliffe, *The African Poor: A History*, p. 117.
[96] S. Klausen, 'Poor Whiteism' Maternal Mortality, and the Promotion of Public Health in South Africa: The Department of Health's Endorsement of Contraceptives Services, 1930-1938', *South African Historical Journal* 45, November 2001, p. 71.
[97] Klausen, 'Poor Whiteism', Maternal Mortality, and the Promotion of Public Health in South Africa', p. 58.
[98] Klausen, 'Poor Whiteism', Maternal Mortality, and the Promotion of Public Health in South Africa', p. 72.

civilisation and superiority throughout the world.[99] These developments forced the hand of the Department of Public Health to not only acknowledge the severity of the problems across the racial divide, but to also begin to do something about these challenges.[100]

Challenges differed according to locality. The northern Transvaal had a known reputation for high levels of poverty associated with underdevelopment, unemployment and periodic droughts. The area had very few secondary and tertiary economic activities. It was merely a large labour reserve that was largely bypassed by the economic boom brought about by the minerals revolution. Generally, the period from the 1930s was marked by an increased population pressure on the rural areas as the effects of the 1913 Act started to be felt, together with other conditions creating a demographic shift. This resulted in overcrowding, malnutrition and stress related diseases, which led to the further deterioration of their state of health.[101]

The changing political landscape since the formation of the United Party Government in 1934 also worsened the socio-economic problems of the blacks as the battle for the domination of the state increasingly manifested itself between the English and the Afrikaners. This political battle made life difficult for blacks to such an extent that they remained economically marginalised.

When the Afrikaner nationalists gained state power in 1948, blacks found themselves increasingly segregated economically, socially and politically, as the level of segregation increased under the so-called apartheid policy. As separate development became a major policy platform of the state, the appalling conditions of life among blacks continued to worsen during the 1950s and 1960s. Resistance to segregation and demands for change increased apace.[102]

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[99] Klausen, 'Poor Whiteism', Maternal Mortality, and the Promotion of Public Health in South Africa', , p. 71.
[100] Klausen, 'Poor Whiteism', Maternal Mortality, and the Promotion of Public Health in South Africa', p. 58.
[101] C. de Beer, *The South African Disease: Apartheid Health and Health Services*, p. 3.
[102] H. Coovadia, et al, 'The Health and Health System of South Africa: Historical Roots of Current Public Health Challenges', p. 283. *Health in South Africa 1*, www.thelancet.com, 374, 15 August 2009, accessed on 10 March 2014.

During the apartheid years, the link between socio-economic conditions and diseases became abundantly clear in the rural areas. The better collection of data also shined the spotlight on the severe conditions. For instance, from 1976 to 1988, surveys were conducted in Elim District in the Northern Transvaal to determine the trends in infant mortality and the requisite need for comprehensive health services.[103] These surveys were conducted using a simple or direct method where reliance was based on the available obstetric histories from hospital and clinic statistics or records. These records were obtained from the Elim Hospital Health Ward. From the data gathered, it was discovered that with regard to mortality rates in Elim and the surrounding rural areas, there was no improvement in health during the period under discussion.[104] One of the major reasons for this was the poor socio-economic conditions of the Tsonga and Venda communities staying in the area. This scenario was not an exception, as similar conditions existed in other rural areas across South Africa.[105]

However, in other measures the Travsvaal was hardest hit by diseases. Some statistics collected during the mid-70s from the homelands of Venda, Gazankulu and KaNgwane revealed that incidents of typhoid were six to seven times higher than the corresponding rate for the whole of South Africa.[106]

Cedric de Beer's account of poverty and diseases in the homelands during the 1970s points to the absence of job opportunities and malnutrition as some of the major determinants of poor health.[107] Hunger was regarded as the main factor in the pattern of diseases that were causing ill-health and ultimate deaths. This conclusion was made on the basis of surveys conducted across the country, including in areas such as Limehill, in Natal.[108] A survey conducted in 400 schools in the Lebowa Homeland in the Transvaal in 1982, led to a revelation by the then Lebowa Minister of Health, Dr. Mphahlele, that about 100, 000 children were malnourished.[109] In

[103] E.H.A. Koumans, 'Infant and Child mortality in the Elim District Northern Transvaal, 1976-1986 and a comparison of trends', *South African Medical Journal ,* 81(4), February 1992, p. 203.
[104] Koumans, 'Infant and Child mortality in the Elim District Northern Transvaal', p. 203.
[105] Koumans, 'Infant and Child mortality in the Elim District Northern Transvaal', p. 203.
[106] van Rensburg et al, *Health Care in South Africa. Structure and Dynamics*, p. 66.
[107] de Beer, *The South African Disease: Apartheid Health and Health Services*, p. 55.
[108] de Beer, *The South African Disease: Apartheid Health and Health Services*, p. 54.
[109] de Beer, *The South African Disease: Apartheid Health and Health Services*, p. 56.

Gazankulu Homeland, Dr E Sutter from Elim hospital estimated that: "… between 120-200 out of every thousand children born in the territory die before they reach the age of one year."[110] The surveys conducted in other homelands revealed similar incidents of poverty and malnutrition as the main causes of death among the school children.[111]

De Beer also highlighted under-nutrition as the cause of tuberculosis, considered responsible for many deaths in the homelands.[112] He explained that the disease was affecting many children in the reserve areas as well. De Beer went further to state that:

> Those homeland dwellers who survive the child killers and TB will still grow up in every unhealthy circumstance. About 70% of the people who live in Gazankulu are infected with bilharzia - a direct result of relying on rivers for water and washing. In the same territory, thousands of people are continually being infected and re-infected with trachoma, a blinding eye disease which occurs where hygiene is poor.[113]

Apart from tuberculosis and bilharzia, it was discovered that typhoid, which was a water-borne disease, was showing increasing notification throughout the homelands during the second half of the 1970s, of which, Transkei, Ciskei, Venda and Bophuthatswana were excluded in the available records as they were subsequently granted independence.[114]

G. M. Davies, who had extensive experience of health challenges faced by areas surrounding the Jane Furse Memorial Hospital, also emphasised the role played by socio-economic conditions and severe poverty in disease causation. Davies maintained that poor water supplies, ignorance regarding the boiling of water before drinking, failure to adhere to the advice given by health workers, nurses and other health practitioners were responsible for a significant amount if ill-health. This

[110] de Beer, *The South African Disease: Apartheid Health and Health Services*, p. 56.
[111] de Beer, *The South African Disease: Apartheid Health and Health Services*, pp. 55-56.
[112] de Beer, *The South African Disease: Apartheid Health and Health Services*, p. 56.
[113] de Beer, *The South African Disease: Apartheid Health and Health Services*, p. 56.
[114] de Beer, *The South African Disease: Apartheid Health and Health Service*s, pp. 56-57.

situation was worsened by apathy towards the digging of the pit latrines, which created conditions for the spread of diseases such as cholera and diarrhoea in areas near the hospital and the rest of Eastern Transvaal. Davies also reported the prevalence of other common infections in the area, includeding tuberculosis, pneumonia, malaria and syphilis.[115]

2.3 The impact of malaria on the health of the blacks

The existence of malaria in the Transvaal has been documented in relation to the Voortrekker movement to Mozambique under Louis Trichardt in 1837-1838 when 20 out of 53 of his trek party, including himself and his wife, died of malaria.[116] The Director of Malaria Control in the Limpopo Department of Health explained that in 1920 the white settlers who came to the Lowveld were attracted to the area of Tzaneen due to the availability of fertile soil and high annual rainfall, which favoured the growth of crops and fruit trees. However, many of these settlers died of malaria to such an extent that they took precautionary measures by building their houses on the upper slopes and on top of the mountains.[117]

The infection rate of malaria could be linked to the availability of a Duffy antigen in the red blood cells of individuals. Antigen is a substance produced by the body when attacked by malaria. According to J.H.S. Gear et al, studies revealed that people living in a hyper endemic malaria region such as tropical Africa experienced less *plasmodium vivax* malaria parasite.[118] This parasite has antigen which is absent in most of the African indigenous populations, particularly those living in tropical African countries. On the other hand, this antigen is commonly found in the red blood cells of the European or white races, and this explains why the disease easily affected most of them during colonial era.[119]

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[115] Witwatersrand University Historical Archives, AB, Box 1690, File 76, G. M. Davies, Thaba ea Thuso: An Account of the Jane Furse Memorial Hospital, 13 September 1983, pp. 2-3.
[116] M. Coetzee et al, 'Malaria in South Africa: 110 years of learning to control the disease', *South African Medical Journal,* 103 (10), October 2013, p.770.
[117] Interview with P. Kruger, Malaria Control Directorate, Limpopo Department of Health, 24 March 2016.
[118] J.H.S. Gear et al, *Malaria in Southern Africa*, p. 35.
[119] Gear et al, *Malaria in Southern Africa*, p. 35.

However, this did not mean that malaria was not an issue among Africans. Indeed, many studies have documented its prevalence across space and time. The social disabilities such as poverty among the rural population resulted in a variety of epidemics of which malaria and Tuberculosis (TB) were common especially during the late 1930s and early 1940s. The problem of malaria existed most particularly in the Lowveld and other specific areas of the Transvaal, and this was worsened by the socio-environmental changes brought by colonial occupation. The state realised that swift precautionary measures were needed in order to prevent this disease as it affected both whites and blacks indiscriminately. The Lowveld region became a potential malaria-risk area because of high annual rainfall and high temperature, which favoured the fast breeding of malaria-carrying mosquitos. The Department of Public Health was therefore instrumental in the provision of Quinine Hydrochloride to the Tzaneen Malaria Station in 1939 as an attempt to control the disease.[120]

Photograph 1: *The buildings of malaria station in Tzaneen, 1932.*

Source: M. Coetzee et al, 'Malaria in South Africa: 110 years of learning to control the disease', *South African Medical Journal,* 103 (10), October 2013.

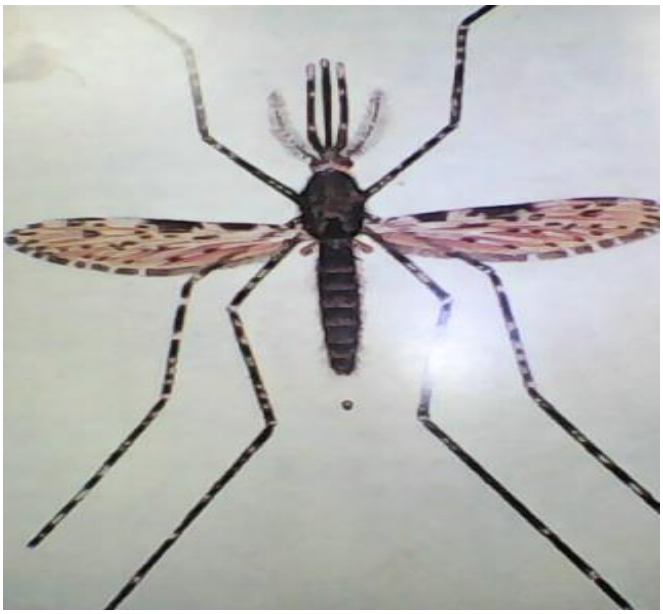
[120] South African National Archives, GES, Box 2659 File 37/56b Department of Public Health, Malaria Tzaneen 15 July 1939, p. 1.

Due to the extensive threat of malaria epidemics in the Union, the government invited Dr. Watsen in 1929 and Professor N.H. Swellengrabel from Europe in 1930 to visit the country and investigate the problem.[121] Swellengrabel was a world-renowned malariologist from the University of Amsterdam. The two visitors were requested to investigate the extent of the disease and make recommendations. Dr Siegfried Annecke of the Health Department and Botha de Meillon of the South African Institute for Medical Research in Johannesburg accompanied Swellengrabel on a tour of the Lowveld to investigate the extent of malaria in the area.[122] Focus was directed at the malaria risk areas like the Northern Transvaal, Eastern Transvaal and Natal. The finding that the malaria-causing mosquitos would normally rest indoors after feeding on humans, led to the recommended that indoor pyrethrum sprays should be used at regular intervals per week. Although the indoor pyrethrum proved effective, it was later modified to residual insecticides for indoor walls and roof surfaces. Both methods proved effective in the control of malaria in the Transvaal and Natal.[123] Quinine supplies were distributed throughout the entire rural areas through traditional authorities after realising that approaching the rural population directly might deter them from accepting malaria pills.[124]

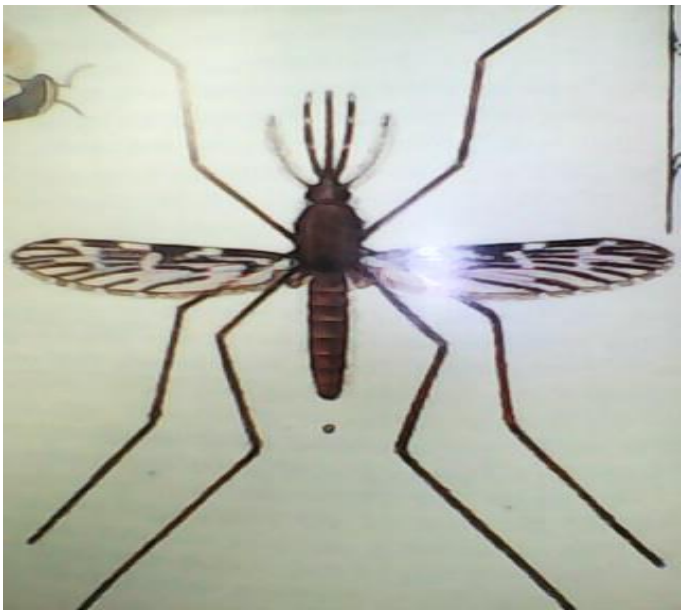
Swellengrabel also recommended the establishment of a malaria station in Tzaneen. The state took up this recommendation and mandated the South African Institute of Medical Research (SAIMR) to erect the station in 1932 under the leadership of De Meillon and Annecke, who would carry out research and control respectively. Another malaria research station was established in Eshowe, Natal, in 1934.[125]

[121] Coetzee et al, 'Malaria in South Africa: 110 years of learning to control the disease', p. 771.
[122] Coetzee et al, 'Malaria in South Africa: 110 years of learning to control the disease', p. 771.
[123] Coetzee et al, 'Malaria in South Africa: 110 years of learning to control the disease', p. 771.
[124] Interview with P. Kruger, Malaria Control Directorate, Limpopo Department of Health, 24 March 2016.
[125] Coetzee et al, 'Malaria in South Africa: 110 years of learning to control the disease', *South African Medical Journal*, 103(10), October 2013, p. 771.

I**llustration 1**: *The two malaria transmitter mosquitos.*



Anopheles gambiae



Anopheles funestus

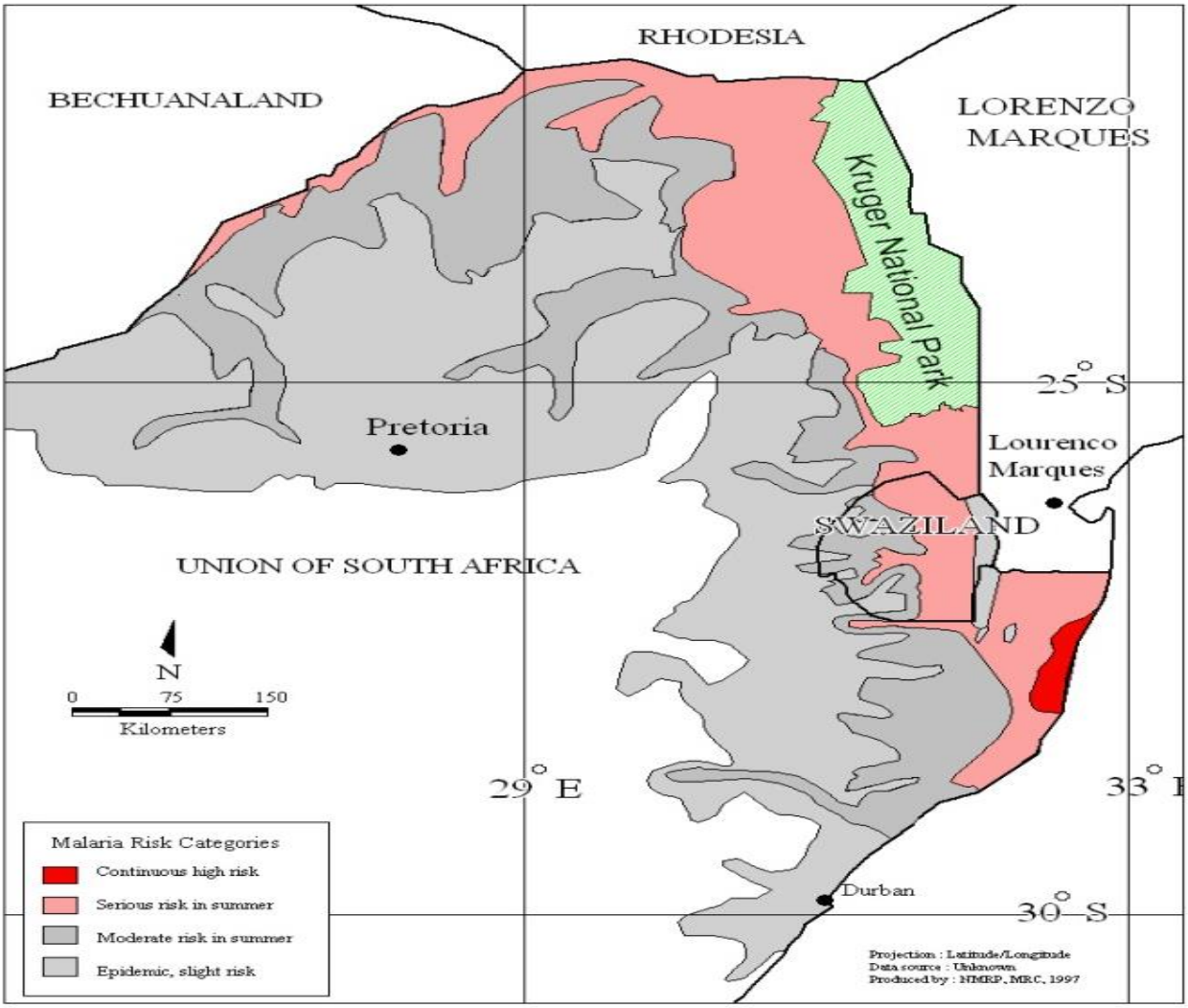
Source: J.H.S. Gear et al, *Malaria in Southern Africa*.

Although attempts were undertaken to control the disease in the Transvaal, incidents of this disease continued to be experienced, most particularly in the black rural communities. In Tzaneen, it was realised that the surrounding rural areas were still the most highly affected as malaria-related diseases and death rates were escalating during the 1930s.[126]

In mitigation, the Department of Public Health attempted to implement a malaria control policy throughout the Union where malaria was prevalent. In terms of this policy the magistrates were to receive stocks of preventative medicines through an approved depot system in the area. The provision of quinine and tonic pills with insecticidal spray pumps and other insecticides was recommended in the Lowveld areas, including the Nylstroom Magistracy and other identified areas. The so-called Native Commissioners remained administratively in charge of malaria prevention in black communities. Careful and constant supervision was carried out to prevent and control the disease in these assigned areas.[127]

[126] Coetzee et al, 'Malaria in South Africa: 110 years of learning to control the disease', p. 771.
[127] South African National Archives, GES, Box 2659, File 45/26, Malaria Distribution and Sale of Medicines and Materials, 27 December 1939, pp. 1-2.

Map 2: *Malaria risk areas in South Africa, 1938.*



Source: M. Coetzee et al, 'Malaria in South Africa: 110 years of learning to control the disease', *South African Medical Journal*, 103 (10), October 2013.

The above map clearly illustrates the area along the north-eastern coastal region of Natal (Kwa-Zulu Natal today), bordering Mozambique, as being the major hotspot – "continuous risk area". The "serious risk" area stretches from the west of the "continuous risk" area to the north along the Kruger National Park to the north along the border with Rhodesia (Zimbabwe) and to the western areas bordering Bechuanaland (Botswana). To the west of the serious risk areas lies the moderate risk area, followed by the light risk areas in the interior plateau of the former Transvaal.

The Transvaal anti-malaria campaigns and other educational activities were launched in an attempt to overcome the diseases. However, these measures were at times met with opposition in black communities as they tended to be against their beliefs and freedoms. For example, at one point the general manager of Letaba Estates in the district of Letaba expressed his bitterness about the defiance of Chief Mohlaba and his people to remove their kraals as a way of controlling malaria.[128] These acts of defiance continued throughout the 1940s, as state disease control measures continued to clash with community sentiments.

However, according to some accounts during the 1930s in the Transvaal, many indigenous black people of Venda, and Mopani had acquired immunity against malaria, with more than 60% infected with the disease probably having inherited immunity genetically from their parents who had gained immunity through repeated exposure.[129] According to some views, however, if these people get bites repeatedly from malaria carrying mosquitos, approximately after six months, they lose such immunity and can be exposed to the disease and death. This meant that health services were still required. In an interview, Kruger noted that the many deaths of people in Sekhukhuneland and Mokopane reported in the 1930s could have been a result of lack of immunity and prophylactic preventive measures.[130]

As malaria control efforts evolved, the Tzaneen Magistrate suggested that the Department of Public Health should control the depot system in Tzaneen and the surrounding rural areas, including white farms and black rural villages.[131] In the absence of proper health facilities, the use of the Magistrate system proved to be a successful conduit for the distribution of quinine and tonic pills. The Tzaneen Magistracy was also used as a depot for stocking and distribution of insecticidal

[128] South African National Archives, GES, Box 2659, File 37/56, Malaria: Distribution and sale of Medicines and Materials, 11 March 1941, p. 1.
[129] Interview with Phillip Kruger, Malaria Control Directorate, Limpopo Department of Health, 24 March 2016.
[130] Interview with P. Kruger, Malaria Control Directorate, Limpopo Department of Health, 24 March 2016.
[131] South African National Archives, GES, Box 2659, File 45/26, Malaria: Distribution and Sale of Medicine and Materials, 27 November 1939, p. 1.

spray pumps and chemicals. The depot system would be reviewed froim time to time as control measures evolved.[132]

The report issued by the senior malaria officer in August 1945 for the year ending 30th June 1945 revealed the state's realisation of the need to deal effectively with malaria and other related diseases. The preventative or control measures were carried out from 1 September 1944 through the engagement of the staff of the malaria station based in Tzaneen. Although the work was to be effected throughout the province, the main focus was based on the districts of Waterberg, Groblersdal and Potgietersrus with Naboomspruit as a work station. It was on the instructions of the Senior Malaria Officer that a series of lectures were given to a class of black school teachers at Vaalkop and Platreef in the district of Potgietersrus.[133]

Apart from the organised lectures, where schools were targeted, the malaria officer realised the need to extend awareness to the rest of the household members of the communities. This was realised when numerous households were visited with the sole aim of giving advice on the best means of avoiding malaria fever in the controlled areas, most particularly in the district of Potgietersrus in the middle of April 1945. These measures were taken after receiving evidence of the breeding as well as the number of the new reported infections along the lowest sections of the Mogalakwena River.[134]

In 1945 Annecke recommended the utilisation of dichlorodiphenyltrichloroethane (DDT) throughout the malaria areas in the Transvaal. This was in line with international trends of the time. When the disease more or less disappeared in the 1950s after the application of DDT, efforts were made to shift attention to other diseases which were also threatening the rural population. Such diseases included among others bilharzias, smallpox and tuberculosis. Although the malaria headquarters were moved to Pietersburg in 1955, the Tzaneen Malaria Station remained as the most important centre to guard and control any possible incidence

[132] South African National Archives, GES, Box 2659, File 45/26, Malaria: Distribution and Sale of Medicine and Materials, 27 November 1939, pp. 1-2.
[133] South African National Archives, GES, Box 1913,File 38/32, The Annual Report for year ending 30 June 1945, Malaria Distribution and sale of Medicines and Materials, 01 August 1945, pp. 1-2.
[134] South African National Archives, GES, Box 1913, File 38/32, The Annual Report for year ending 30 June 1945, Malaria Distribution and sale of Medicines and Materials, 01 August 1945 , p. 4.

of malaria in the Lowveld. The increase of this disease in the period 1967 to 1972 increased the volume of work at Tzaneen to such an extent that additional research projects were increased. Further attempts to overcome the new challenges were also initiated with the utilisation of assistants from other countries of the world which were already advanced in dealing with the prevention and control of the disease. It was through lectures by the Senior Malaria Officer's staff that their work was extended by assisting with field work and demonstrations. Lectures were arranged inter alia at Mphahlele's location in the Pietersburg district. Similar duties were carried out in the municipal areas of Potgietersrus, Naboomspruit, Nylstroom and Warm Baths.[135]

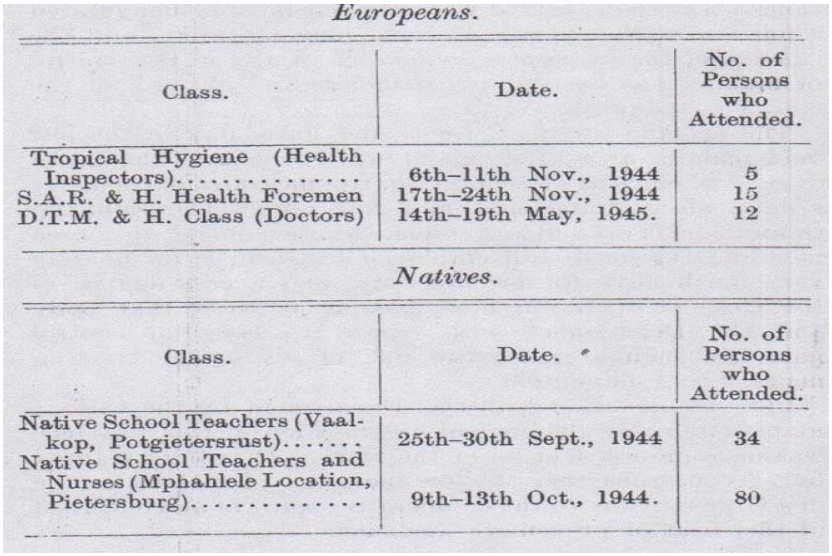
Photograph 2: *Annecke (above) and his malaria team (below) at malaria station in Tzaneen, circa 1940s.*

Source: D. Richard, *Man van Ysterhout: Die Verhaal van Dr. Siegfried Annecke en die Stryd teen Malaria*.

[135] Department of Health, National Institute for Tropical Disease, Tzaneen, 1940s, p. 1.

The scheme for the direct control of malaria was also carried into Groblersdal magistrate district, the Elands River Valleys, Rust-der-Winter irrigation scheme in the Hammanskraal region, Crocodile-Komatipoort River valleys, near Eastern Transvaal, and Groblersdal and Olifants River valleys during the mid-1940s. The Farmers and the public in each magisterial area were able to organise themselves into Farmers' Association or units in which were provided with insecticides and labourers for spraying.[136] Malarial classes were held for both blacks and whites as depicted in the following image (Illustration 2):

Illustration 2. Malaria classes in Eastern Transvaal, during the 1940s.



Europeans.

Class.	Date.	No. of Persons who Attended.
Tropical Hygiene (Health Inspectors).....	6th–11th Nov., 1944	5
S.A.R. & H. Health Foremen	17th–24th Nov., 1944	15
D.T.M. & H. Class (Doctors)	14th–19th May, 1945.	12

Natives.

Class.	Date.	No. of Persons who Attended.
Native School Teachers (Vaalkop, Potgietersrust).....	25th–30th Sept., 1944	34
Native School Teachers and Nurses (Mphahlele Location, Pietersburg).....	9th–13th Oct., 1944.	80

Source: Annual Report of the Department of Public Health for the Year ended 30th June 1945, Government Printer, Pretoria, June 1946.

Malaria as one of the killer diseases worldwide has attracted attention where the use of DDT in both developed and less developed countries was encouraged. This intervention contributed immensely to a temporary decline of the disease during the 1960s. An account of the existence of malaria incidence in Africa during the 1960s revealed that:

> Moreover, since 1967 there was a noticeable change in the ostensibly effective control over malaria. Factors such as world-wide inflation, economic

[136] Annual Report of the Department of Public Health for the Year ended 30th June 1945, Government Printer, Pretoria, June 1946, p.19.

> and energy crises, resistance of malaria vectors to existing insecticides and the high cost of alternative insecticides hampered the long-term continuation and lasting success of anti-malaria campaigns.[137]

Since the disease is regarded as a tropical disease, the areas that found themselves vulnerable in South Africa were the former Transvaal Lowveld and the northern parts of Natal. As a result, the former black homelands such as the then Lebowa, Venda and Gazankulu in the Transvaal were severely affected. Due to the growing prevalence of this disease in these areas, many rural blacks became victims of poor health and death.[138]

A report on the high prevalence of malaria in the northern and eastern Transvaal in 1969 showed an average of 223 cases. The average cases for the year 1969 could be associated with high rainfall in the reporting areas.[139]

The period since the 1970s also witnessed an upward trend in the incidents of malaria in South Africa. Despite government efforts to deal effectively with the disease, its tendency to fluctuate on an annual basis became a worrying factor. Arguably, the disease was stimulated by a variety of factors like climate variability, population migration, ecological change, agricultural developments and government control policy. Selina Maphorogo, who was an assistant nurse and the first Care Group Motivator at Elim Hospital, believes that in the northern Transvaal, including the homelands of Venda and Gazankulu, the disease was worsened by the existence of migrant farm workers from the neighbouring states like Mozambique and Zimbabwe in the 1980s.[140] Kruger also indicated that one of the reasons why malaria could not disappear completely was due to the frequent movement of people across borders with limited or no screening measures.[141]

Moreover, DDT seemed to be a double-edged sword insecticide that tended to be toxic to the soil, had negative effects on human and plant life, and poisonous to the

[137] H.C.J. van Rensburg et al, *Health Care In South Africa: Structure and dynamics*, p. 185.
[138] van Rensburg et al, *Health Care In South Africa: Structure and dynamics*, p. 185.
[139] Report by the Department of Health for the Period ended 31 December 1970, Government Printer, Pretoria 1972, p. 14.
[140] Interview with S. Maphorogo, Elim Care Group Centre, Waterval Louis Trichardt, 10 March 2007.
[141] Interview with P Kruger, Limpopo Provincial Department of Health, 24 March 2016.

environment in general. This public concern led to its banning in the 1970s. During the mid-1980s, Pyrethroids were introduced to replace DDT in environmentally-sensitive areas like game parks.[142] An interview with Q.E. Mabunda, a Deputy Director of Limpopo Department of Health, revealed that the switch to pyrethroids could also be associated with the Western countries' desire to sell their preventative brands for financial or economic gains even though they were ineffective as compared to DDT.[143] The public outcry over DDT could have been the result of orchestrated influence from the western countries regarding the alleged negative effects of DDT.[144] In 1996 the use of DDT was stopped completely, a situation which led to the increase of cases of malaria as reflected on the illustration 3. It was primarily due to the ban of DDT that cases of malaria increased from 6,000 in 1996 to 64,400 in 2000.[145]

The illustration (Illustration 3) below generally illustrates that malaria incidents have been fluctuating over the indicated years. From 1971, immediately after the banning of DDT, malaria cases continued to be reported: in 1978 and 1985, the reported cases were above 5000. The alarmingly high rates started to grow rapidly from 1996, reaching the highest peak of above 11000 in 1999. Although the cases dropped after that, the number still remained significantly high until 2015.

As the control measures ebbed, the disease re-emerged in areas previously declared malaria-free. This was partly a result of regional migration of people from malaria areas like the former northern, north-eastern and eastern parts of Transvaal and Natal, and from neighbouring countries. The re-emergence of malaria in areas that had been free of the disease for sometime resulted in high fatalities due to lack of immunity.[146]

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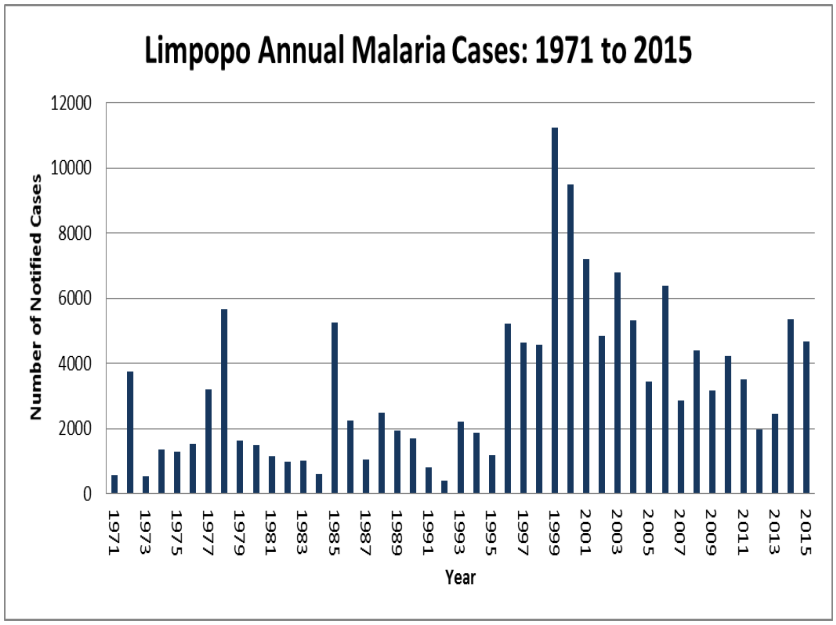
[142] Q.E. Mabunda, *Malaria Trends in Limpopo*, Presentation of MRC Malaria Conference, August 2015.
[143] Mabunda, *Malaria Trends in Limpopo*, Presentation of MRC Malaria Conference, August 2015.
[144] Interview by W. Maepa with Q E. Mabunda, Malaria Institute of Tropical Diseases, Tzaneen, 27 January 2016.
[145] Mabunda and P. S. Kruger. Malaria Trends in Limpopo, Presentation of Malaria Control in Limpopo, South Africa, Emperors Palace, 24 March 2009.
[146] Interview with P. Kruger, Limpopo Provincial Department of Health, 24 March 2016.

Illustration 3: *Trends in malaria cases in the northern Transvaal between 1971-2015.*



Source: Department of Health, Limpopo, Medical Research Council Malaria Conference, August 2015.

2.4 Tuberculosis and health of the blacks

Another menacing disease that resulted from poor socio-economic conditions of the blacks in the rural areas of South Africa was tuberculosis (TB). This disease is caused by a virus called Mycobacterium tuberculosis which was discovered during the 19th century.[147] Infected people experience several symptoms such as continuous coughing, weight loss, physical weakness, shortness of breath, continuous stress and other related fevers. The disease became a serious threat to human lives following the industrial revolution and urbanisation. According to H.C.J. van Rensburg, "There is sufficient evidence that tuberculosis was introduced into South Africa by the former European colonisers, yet it was only during the 1800s that the disease became established here on a significant scale."[148] TB mortality among the rural blacks in South Africa increased exponentially from the beginning 20th century as a result of the minerals revolution and other socio-economic changes associated with colonial transformation. As a large labour reserve which also acted

[147] de Beer, *The South African Disease; Apartheid Health and Health Services*, p. 1
[148] H.C.J. van Rensburg et al, *Health Care in South Africa: Structure and Dynamics*, p. 180.

as a passage for migrants going to the emerging industrial and mining towns such as Johannesurg, the rural Transvaal was not spared of the rising TB menace.[149] It emerged and grew as a disease of inequality. According to Shula Marks and Neil Anderson, "Throughout the world, tuberculosis remains one of the most significant health indicators of poverty, and the differential pattern associated with classification by skin colour of the Republic of South Africa is witness to the continuing discrimination by skin colour in the country."[150]

The migration of blacks from the reserves to the mines made them vulnerable to different infectious diseases, which they carried back to the reserves. Van Rensburg's explains that TB is a 'social disease' that reflects the general health status of a population. He also considers climatic factors as crucial in accounting for particular trends of tuberculosis prevalence among the black communities. Poor conditions of work in mines, and overcrowding in mining compounds and urban townships, all accounted high TB morbidity and mortality among black communities. As van Rensburg argues, TB:

> … is more specifically associated with the lower socio-economic strata, where inadequate housing, overcrowding, unhygienic living and working conditions, malnutrition and undernourishment are significant casual factors.[151]

The above helps us explain why the TB menace worsened during the early 1930s. The Great Depression of 1929 led to economic challenges that had negative effects on health. The socio-economic challenges of the Great Depression exposed many black communities to a variety of diseases of poverty like tuberculosis, malnutrition and other related diseases. According to Randall Packard,

> This means that where there is a lot of TB in any society, there must be a lot of malnutrition. Overcrowding also helps the disease. If lots of people sleep in

[149] de Beer, *The South African Disease; Apartheid Health and Health Services*, p. 2.
[150] S. Marks and N. Andersson, 'Issues in the Political Economy of Health in Southern African Studies', *Journal of Southern African Studies*, 13(2), January 1987, p. 179.
[151] van Rensburg et al, *Health Care in South Africa: Structure and Dynamics*, p. 180.

> one room or crowd into trains or buses, then they are more likely to breathe in germs coming from people who are already sick.[152]

The 1930s witnessed the rising tide of tuberculosis disease. A considerable number of factors contributed to the escalation of this disease. Many researchers identified overcrowding and malnutrition as the main determinants accounting for rural black vulnerability to tuberculosis infection.[153] Poverty, which was a severe challenge among the rural as well as urban blacks, was also seen as the most important contributory factor. The prevalence of disease was explained by George Gale and Sydney Kark at Pholela Primary Health Care Centre in Natal in the following way:

> The influence of social economic factors is still felt in all spheres of the unit's activities. One example of such an influence is the disintegration of family life by the withdrawal of large numbers of men to the towns with the inevitable spread of venereal disease. A further even more important influence is the rapid progress of soil erosion. The devastating process dwarfs all the Unit's efforts to encourage increased production of protective foodstuffs. Such are but two factors beyond the powers of a Health Unit to combat, no matter how clearly their detrimental influence on health may be realized.[154]

This observation applied to pretty much all the areas of the country.

The existence of tuberculosis could also be linked to the history of the migrant labour system. The migration of blacks to the Witwatersrand which started in 1886, increased from the rural areas of the Transvaal during the 1930s. Population growth and the deterioration of rural areas during the 1920s and the 1930s led to the massive rural-urban migration as the growing foreign investments offered employment opportunities where blacks were expected to serve as cheap migrant labourers in the gold mining industries. The undesirable living conditions such as overcrowding, slums, congested hostels and inadequate sanitation left many of them infected by a variety of diseases, with tuberculosis being the main threat to their

[152] Packard, *White Plague, Black Labor*, p. 242.
[153] Packard, *White Plaque, Black Labor*, p. 242.
[154] U, Hornd, *A Survey of Race Relations in South Africa (SAIRRS),* 1971, p. 256.

lives. The migrant labour system left many subsistence resources in the rural areas of the blacks unutilised as children, women and older people remained and were powerless to cultivate small patches of lands and look after their stock. The migrants could only come home once a year with little money earned from the mines. The poverty of the rural communities increased disease vulnerability, including the infections brought by the migrants from the mining industries.[155] Dr A.B. Xuma, a medical doctor who later became the president-general of the African National Congress (ANC), noted how "many mothers were to walk long distances to do odd jobs in order to supplement their husbands' low wages. The babies' circumstances are left in the care of children barely older than they for feeding and general care".[156]

The deteriorating social and economic conditions alarmed officials, leading to the convening of a Tuberculosis Conference held in Cape Town on 6-7 February 1939. The conference recommended the provision of increased numbers of hospital beds.[157] However, the problem continued unabated.

The period from the 1940s was marked by a severe deterioration of the socio-economic conditions of the rural blacks in the Transvaal and this accelerated the prevalence of pulmonary tuberculosis. Available evidence shows that this was a result of poor socio-environmental conditions such as poor housing and inadequate.[158]

When the National Health Service Commission was appointed to look into the health and health care delivery crisis in South Africa, one of the major concerns was the rising tide of tuberculosis in a context of lack of adequate medical care and poor nutrition among the rural and urban blacks.[159] The Commission noted that in the whole of the Transvaal, tuberculosis hospitals for the blacks were experiencing severe shortages of beds for patients, leading to high mortality rates. When the

[155] H. Coovadia et al, The Health and Health of South Africa: Historical Roots of Current Challenges, Heath in South Africa 1, www.thelancet.com, 374, 5 September 2009, accessed on 10 March 2014, p. 819.
[156] Packard, *White Plaque, Black Labor*, p. 242.
[157] Packard, *White Plaque, Black Labor*, p. 244.
[158] South African National Archives, GES, Box 2659, File 38/*32,* Malaria Distribution and sale of Medicines and Materials, 01 August 1945, p. 4.
[159] Packard, *White Plaque, Black Labor,* p. 224.

Commission's report was finally issued, it recommended the increase of beds for tuberculosis patients, the improvement in the provision of nutrition, housing and health education and increasing of nurses and doctors in the rural black communities.[160] Randal Packard argued that although the Commission emphasised the provision of adequate preventative and curative health care services for blacks, little was said about provision of food and housing to alleviate poverty and disease like tuberculosis.[161]

Consequently, by the 1950s the state was still battling with the TB menace in poor communities. According to the 1959 Annual Report of the Department of Health, "During the year the number of beds available for tuberculosis patients has been increased by a further 492 to a total of 20274, and also the out-patient schemes have been increased during the year from 229 in 1957 to 302."[162] Immunisation and radiological services were also boosted in an effort to curb the menace.[163] For example, Clara Mahlatji, a female teacher at St. Theresia Catholic Missionary Primary School located south of Pietersburg (Polokwane) revealed that the immunisation process was in action during the late 1960s and early 1970s. Government health care teams visited her school and other schools in the Mankweng Circuit, situated in the former Lebowa homeland.[164] According to Mahlatji, most of the affected learners were from the poverty-stricken families. She explained that poor nutrition was mainly responsible for poor health among the majority of learners. Other factors including a lack of basic common services, traditional belief system, and lack of health education were responsible for poor health among the majority of the learners. However, the prevention of this disease remained a difficult challenge as some of the responsibility was left in the hands of the teachers who were not qualified in the field of public health.[165]

[160] Packard, *White Plague, Black Labor,* p. 247.
[161] Packard, *White Plague, Black Labor,* p. 247.
[162] Annual Report of the Department of Health, Year ended 31st December 1959, The Governmental Printer, Pretoria 28/1962, p. 2.
[163] Annual Report of the Department of Health, Year ended 31st December 1959, The Governmental Printer, Pretoria 28/1962, p. 2.
[164] Interview with Clara Mahlatji, Subiaco Catholic Mission Centre, Ga-Molepo, 05 September 2014.
[165] Interview with Clara Mahlatji, Subiaco Catholic Mission Centre, Ga-Molepo, 05 September 2014.

The period from the late 1950s and early 1960s witnessed a marked increase of the black population in the country. The number of people requiring hospital treatment for a number of ailments such as TB also increased. According to the Annual Report of the Department of Health for the Year ended 31 December 1961, "The number of beds available for tuberculosis patients increased from 20,274 beds in1960 to 24,332 at the end of 1964".[166] As the statistics in the table below (Illustration 4) show, during the early 1960s black people carried the highest burden of TB cases as compared to whites, coloureds and Asiatics across the country.

Illustration 4: *The number of beds for tuberculosis patients in six regions, for various population groups in 1964*.

Region.	Whites.	Bantu.	Colou-reds.	Asiatics.	Total.
Eastern Cape...	74	3,684	5	18	3,781
Western Cape..	118	2,601	2,593	—	5,312
Natal.....	167	5,047	76	245	5,535
Northern Trans-vaal.....	—	2,709	—	—	2,709
Southern Trans-vaal.....	50	5,408	—	—	5,458
O.F.S.....	38	1,487	12	—	1,537
TOTAL.....	447	20,936	2,686	263	24,332

Source: Annual Report for the Year Ended 31 December 1961, Government Printer, Pretoria 1966.

Official statistics on the existence of tuberculosis in South Africa show that this disease was mainly affecting males, the poor, the young and the non-white population groups. These statistics furthermore indicate that notification rates rose steadily over the course of the 20th century and reached a peak in the 1960s. However, the disease showed a decline in the 1970s.[167] This can be a false picture

[166] Annual Report for the Year Ended 31 December 1961, Government Printer, Pretoria 1966, p. 12.
[167] Annual Report of the Department of Health, Year ended 31st December 1959, The Governmental Printer, Pretoria 28/1962, p. 2.

in light of the exclusion of data from black homelands. Health system for black communities during this period was ill-equipped due to lack of commitment to control the disease, inadequate health services, inaccessible treatment and affordability. As a result, the provision of primary health care services to a variety of black communities in the rural areas remained a difficult task.[168]

A survey of the cause and extent of tuberculosis, conducted by Caroline Ntoane and Kgathatso Mokoetle, who were researchers of Witwatersrand University Department of Community Health between 1977 and 1982, showed that blacks in the Transvaal, including those staying on the white farms were experiencing a growth in the tuberculosis epidemic.[169] The two researchers emphasised that the main cause of this trend was the problem of socio-economic conditions of the blacks, including lack of adequate nutrition.

Conditions among children had been deteriorating from the 1960s when Prime Minister H.F. Verwoerd withdrew the feeding scheme. This aggravated malnutrition, which increased the prevalence of infectious diseases due to poor immunity. In an interview, Mahlatji also indicated that the inadequacy of primary health care institutions like clinics, lack of community involvement, and the shortage of public health care teams in rural areas, worsened the situation. Poor family structures caused by the migrant labour system also compounded the situation.[170]

The growing prevalence of tuberculosis and other infectious diseases during the 1960s and 1970s was also a result of the imposition of the homeland system, which created a new chapter in the socio-economic history of South Africa. Marx Price's assessment of the impact of homeland policy on health of the rural blacks revealed that:

> …the Bantustans have functioned as dumping grounds for millions of people who were not 'needed' by the ''white' economy. Thus large numbers of unemployed, aged and sick Africans, as well as children and those raising

[168] A. Kanabus, Information about Tuberculosis: History of TB in South Africa, ***TB facts.org,*** 2015, accessed on 1 May 2015, Unpaginated.
[169] F. Wilson and M. Ramphele, *Uprooting Poverty: The South African Challenge*, p. 117.
[170] Interview with Clara Mahlatji, Subiaco Catholic Mission Centre, Ga-Molepo, 05 September 2014.

> them have been removed from 'white' areas. The social costs of supporting all these economically 'surplus' people are thus 'exported' to the Bantustans.[171]

The policy had a tremendous effect on population re-distribution in the homelands, which created problems such as overpopulation, unemployment, poverty, illiteracy and social ills.[172]

Because of these socio-economic conditions, the homelands remained massive breeding grounds for the typical diseases of poverty. Such diseases included tuberculosis, typhoid, cholera, measles and nutritional deficiency syndromes. During the mid-1970s, the TB notification rate in the Transkei was 489 per 100 000.[173] Other homelands, including Lebowa, Venda, Kwazulu, Bophuthatswana, and Gazankulu were also showing similar growth rates of tuberculosis infections. The situation in the homelands was worsened by socio-economic and political inequalities, and backlogs in respect of healthcare service delivery. This state of affairs had a profound adverse effect on the state of health of the rural communities, which found themselves isolated and marginalised.[174]

J.V.O. Reid also highlighted the effect of malnutrition on tuberculosis in 1970. In an address entitled 'Malnutrition', published by the South African Institute of Race Relations, Reid pointed out the causes of malnutrition in which he mentioned amongst others, poverty, ignorance and drought.[175] He also regarded the enforced distribution of blacks into reserves as a contributory factor to the problem, with the surveys showing a lack of stability in the families. According to Reid, "the death rate for African children in the reserves was 25 times that of white children. Tuberculosis, which had a link with malnutrition, was ten times as common among Africans as whites."[176]

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[171] M. Price, 'Health Care as an instrument of Apartheid Policy in South Africa', *Health Policy and Planning*, 1(2), 1986, p. 159..
[172] van Rensburg et al, *Health Care in South Africa: Structure and dynamics*, p. 181.
[173] van Rensburg et al, *Health Care in South Africa: Structure and dynamics*, p. 181.
[174] van Rensburg et al, *Health Care in South Africa: Structure and dynamics*, p. 181.
[175] U. Hornd, A Survey A of Race Relations in South Africa, *(SAIRRS*), 1971, p. 256.
[176] Hornd, A Survey A of Race Relations in South Africa, *(SAIRRS*), 1971, p. 256.

In July 1970, *The Star* newspaper of Johannesburg also reported growing tuberculosis cases in the reserves in Pietersburg district where there was evidence of drought, crop failures, and scarcity of fuel, meat and milk. The absence of fathers from their homes as a result of the migrant labour system had exacerbated the problem.[177]

Indeed, the years from 1969 to1971 were marked by severe droughts countrywide. The population in the so-called 'Homelands' were severely affected. Many white farmers left their farms because of crop failures; consequently, many black farm workers were left unemployed and impoverished. It was due to this prevailing state of black impoverishment that the Minister of Bantu Administration and Development introduced several relief measures. Provision of poverty relief was also made through road building and other construction projects which offered employment to between 8 000 and 12 000 people at different periods. Initially, these labourers were paid 25 cents a day and given a free meal; later the wages were increased to 30 cents a day. Besides public works programmes, there were other relief measures. In the Transkei homeland for instance, pre-schools and schools were provided with vitamin fortified food.[178]

The provision of supplementary feeding assistance was also launched in territories such as Venda, Lebowa and Gazankulu homelands, situated in the Northern Transvaal. In these territories, soup, powdered milk, mealie-meal and oranges were distributed. This assistance was also extended to the mission schools.[179] However, these measures did not dent the twin crises of disease and poverty. A symposium held at the then University of the North (now the University of Limpopo) on 28-29 October 1976, shinned the spotlight on the increasing incidence of traumatic and infectious diseases in South Africa in general, and in the homelands in particular.[180] It was pointed out that a number of tuberculosis and related diseases were becoming exponential problems that were to a great extent ravaging the rural black communities. Pulmonary tuberculosis was still by far the most prevalent infectious

[177] Hornd, A Survey of Race Relations in South Africa, *(SAIRRS*), 1971, p. 256.
[178] M. Horrel, A Survey of Race Relations in South Africa, (*SAIRRS),* 1970, p. 257.
[179] Hornd, A Survey of Race Relations in South Africa, *(SAIRRS*), 1971, p. 256.
[180] J. Grous, *Physical factors which influence health: Symposium on health services for developing community*, 28 and 29 October 1976, p. 2.

disease in most rural communities in the homelands. The increasing population density probably caused by the apartheid homeland policy was considered as a major contributory factor to the problem of overcrowding and ill-health.[181]

In order to deal with this challenge, a variety of recommendations were made in the paper. It was emphasised that the healthcare needs of developing communities should be considered a priority. The paper also recommended the development of preventative, promotive and rehabilitative services. It was also emphasised that clinics and other community health care centres should be established in the rural communities and that "… they should actually be felt as "belonging" to those who are served by them".[182]

However, the interventions continued to be piecemeal, and the problems continued. The 1978/1979 visit at Bochum Hospital in Lebowa by the Regional Directorate of Health Services from the then Pietersburg reported the great fluctuation of TB patients consultations, while at Knobel Hospital the turnover was satisfactory. At Mogalakwena Hospital, the Medical Officers from the South African Defense Force treated a high number of TB patients, as the TB section was always full. The military staff also treated patients at Kgapane on 11 July 1978, 25 October 1978 and 03 May 1979.[183]

The late 1970s and early 1980s were marked by increasing political instability and racial tension as the government continued to pass further legislations aiming at consolidating apartheid. The Medical Research Council revealed that the tuberculosis notification in South Africa during the early 1980s showed that a high proportion of blacks in the homelands were infected with infectious pulmonary tuberculosis. The estimates also showed that in Lebowa, Venda and Ciskei, the number of tuberculosis cases was showing a remarkable increase in 1982. In Lebowa alone, the statistics showed that officially-notified tuberculosis was 766 in

[181] Grous, *Physical factors which influence health: Symposium on health services for developing community*, 28 and 29 October 1976, pp. 2-3.
[182] Grous, *Physical factors that influence health: Symposium on health services for developing community*, 28 and 29 October 1976, p. 4.
[183] Limpopo Provincial Archives, Medical and Preventative Services, Tuberculosis Consultant Report July1978/June 1979, p. 1.

one of the hospitals visited, with an estimated 300 to 400 new cases.[184] The alarming increase of TB cases also became evident in 1986 when the Director General of the Department of National Health and Population Development, Dr E.P. Retief, reported that "there were some 60 000 new cases identified annually".[185]

Mankuba Ramalepe, as one of the founders of Ithuseng Health Centre, revealed that the migrant labour system had also continued profound contributor to the state of poverty, disease and death in most black communities in the vicinity of Tzaneen in the 1970s-1980s. She emphasised the link between rural-urban migrations to the prevailing socio-economic problems when she remarked that "men only came home during Decembers when money was available. Farmers were collecting women with trucks to go and work on their farms under undesirable conditions with low wages."[186] Ramalepe used her experience to network with other women in the communities as a way of empowering them with the knowledge and skill of preventing diseases.[187]

One can therefore argue that high incidence of tuberculosis among the rural black population in the Transvaal and elsewhere throughout South Africa was to a large extent determined by their socio-economic conditions associated with poverty caused by inequality. Lack of access to adequate health care services compounded the problem.

2.5. Syphilis and health of the blacks

When sexually transmitted syphilis was introduced into South Africa by European settlers, sailors and soldiers, the disease was initially confined to small groups. However, it started to spread with the discoveries of mineral fields and the emergence of mining towns and other urban centres. Although Karen Jochelson distinguished between venereal syphilis which is transmitted sexually, and endemic

[184] Interview with P. Mamogobo, 7517 Anaconda Street, Serala View, Polokwane, 29 January 2015.
[185] N. Andersson and S. Marks, 'Apartheid in the 1980s', *Social Science Medicine,* 27(7), 1988, p. 673.
[186] Interview with Mankuba Ramalepe, Non-Governmental Organization, Community Health, Tzaneen, 21 April 2013.
[187] Interview with Mankuba Ramalepe, Non-Governmental Organization, Community Health, Tzaneen, 21 April 2013.

syphilis which is transmitted without sexual contact, until in the late 19th and early 20th centuries doctors continued to insist that the disease was transmitted sexually. In the Transvaal and Cape Colony the reports issued by various district surgeons indicated that many people were infected with the disease of which large numbers of rural black population were highly infected with the disease, while in the northern Transvaal its intensity was reported among the pauper Boers and blacks.[188]

The disease was reported in the Waterberg, Soutpansberg, and Middelburg districts in 1895, while in the Northern and Western Transvaal the disease was said to be widespread. The disease was also reported by doctors as common among the Ndebele and Basotho tribes in the West and South-West parts of the Soutpansberg district as well as among the Shangaan and Bavenda groups.[189] Like other diseases, venereal infection was spread by the migrant labour system during the 1920s as the entire region channelled men to the mines and large cities where their way of life depended on woman who offered them sex, food and companionship. These routes included a road from Basotholand, Mpondoland, Transkei, Ciskei, Zebediela in the North-Eastern Transvaal, to the Johannesburg mining industries. This venereal disease attracted concerns from the mining industry officials who complained about the increasing dependence of the black mine workers on prostitutes, and as a result, helping to spread the disease from urban to rural areas.[190]

The aftermath of the First World War since 1918 came with social, political and economic challenges which affected countries worldwide. The destructions of the war compelled the victorious powers to create the League of Nations as a world organisation in 1920, which aimed at the maintenance of world peace and security on social, economic and political matters. One of the major challenges faced by these powers was prevalent diseases like tuberculosis, kwashiorkor, syphilis, and other poverty related diseases, which compelled them to create League's own Health Organisation. Although this health service did not have a direct health care service, it played a major role in the collection and reporting of information related to epidemics and health challenges faced by communities around the world. As a

188 K. Jockelson, *The Colour of Disease: Syphilis and Racism in South Africa*, pp. 11-12.
189 Jockelson, *The Colour of Disease: Syphilis and Racism in South Africa*, p. 12.
190 Jockelson, *The Colour of Disease: Syphilis and Racism in South Africa*, pp. 98-99.

result, colonial or settler governments were urged by the League to publicise health challenges in their respective colonies or territories. Since the Union of South Africa formed part of the Allied war group during the war, it also benefited from the League of Nations' Hygiene Service.[191]

Syphilis gets worse over a period by spreading from the sexual organs to the skin, bones, muscles and brain. This disease affected both blacks and whites, and as a result, the South African Medical Community started to be concerned about the speed at which this disease was spreading. The Public Health Act passed by the Union government in 1919 mandated the Department of Public Health (DPH) with the responsibility of combating epidemics including syphilis. The Act allowed for the first time the DPH to extend medical treatment of patients locally and outside the major municipalities, most particularly in the white rural areas. It was also due to this Act that the DPH was able to establish an infectious diseases hospital in the Transvaal and a TB hospital in Durban.[192]

Syphilis was also felt at Bushbuckridge and Acornhoek in the Eastern Transvaal during the early years after the establishment of the Union government. This compelled the District Surgeon, Dr. Wasserman, who lived in Pilgrimsrest to make fortnight visits to the two centres as they had no resident doctor. The authority to visit these areas was given in terms of the Section 4 of the Public Health Act of 1919, which was amended in 1927. It was through the efforts of Wasserman that the majority of syphilitics were accommodated in the clinics at Achornhoek and Bushbuckridge, and also through the utilisation of local medical missions, with the assistance of the resident nurses.[193]

Further threats of syphilis occurred during the early 1920s when the state passed the 1923 Native (Urban Areas) Act which was amended in 1930, 1937 and 1945. According to this Act, the residential segregation was declared a national policy aiming at the prevention of the influx of blacks in the urban areas. During the early

[191] B. Fetter, 'Health Care in Twentieth Century Africa; Theories and Policies, The League of Nations ', *Africa Today,*40(3), 1993, p. 15.
[192] A. Jeeves, 'Public Health in the Era of South Africa's Epidemic of the 1930s and 1940s', *South African Historical Journal,* 45(1), November 2001, p. 79
[193] South African National Archives, GES, File 3/62 Native Health Units-Bushbuckridge, 1941, p. 3.

month after the outbreak of the Second World War in 1939, the Department was further requested by the expert committee on health matters to prepare for the compulsory registration of blacks in order to safeguard white communities from being infected by the blacks.[194] According to Allan Jeeves,

> The advocates of this proposal hoped that segregation would keep disease bottled up in the black areas, while whites continued to benefit from cheap black labour, with the medical system deployed to prevent 'diseased natives' from spreading infection to whites.[195]

Although the early treatment efforts of the DPH focused on the control of syphilis among whites at the expense of the black population, the escalation of this disease continued to be a cause for concern among the white population. This problem compelled the white civic groups, farmers associations, women's organisations and local governments to demand action from the DPH so as to fully protect whites from infection by blacks as they perceived blacks to be the reservoirs of infection.[196]

The syphilis epidemic had been rising silently during the late 1920s; and it topped other venereal diseases among the black patients. This escalating prevalence of the disease became a challenge to the Department of Public Health since medication was too expensive to deal effectively with this situation as the clinics and hospitals were limited in their capacity to accommodate the patients. In the Bridgeman Memorial Hospital which was opened in July 1928, the situation was complicated by the exponential growth of patients with venereal disease.[197] According to the Witwatersrand Committee for Health Work, among the blacks:

> An examination of the records of the Hospital from July 14th to September 14th, 1928, shows that out of 57 admissions there were 19 cases in which Venereal Disease was present. 10 cases of Syphilis in the mid-wifery section:

[194] Jeeves, 'Public Health in the Era of South Africa's Epidemic of the 1930s and 1940s', p. 81.
[195] Jeeves, 'Public Health in the Era of South Africa's Epidemic of the 1930s and 1940s', p. 86.
[196] Jeeves, 'Public Health in the Era of South Africa's Epidemic of the 1930s and 1940s, p. 83.
[197] Wits University Historical Archives, AD 843, B89. 1. 7 Nursing Services. Rural Nursing Memorandum on the Need for Out-Patient of Venereal Disease among Non-Whites Europeans on the Witwatersrand, SAIRR, 1928, pp. 1-2.

> 5 cases of congenital Syphilis in the New-born section: 5 cases of Gonorrhea in the Gynecological section.[198]

The report by the Union Department of Health for 1926/7 noted that black outpatient treatment of venereal diseases such as syphilis and gonorrhea at Rietfontein remained a challenge due to its distant location from Johannesburg. Since blacks were not permitted to travel on the Orange Grove trams, this deterred them from submitting themselves at the early stage of the diseases.[199] According to the report,

> …absence from work even for an hour involves serious financial loss and in most cases results in loss of employment. Employers, when they become suspicious that their Native servants are victims of Venereal disease, dismiss them summarily, leaving the next employer to find out for himself that the Native is suffering from a contagiously contagious disease.[200]

The report also highlighted that mission clinics were entirely treating women and children as the clinic staff were mostly women nurses, while the black male patients were without adequate clinic provisions. The situation was worsened by the inadequate resources that were needed by the clinics for effective treatment of the diseases.[201]

The report also revealed that the prevalence of veneral diseases was growing in the rural areas in the Northern Transvaal as depicted in the statistics (Table 1) below:

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[198] Wits University Historical Archives, AD 843, B89. 1. 7 Nursing Services. Rural Nursing Memorandum on the Need for Out-Patient of Venereal Disease Among Non-Whites Europeans on the Witwatersrand, SAIRR, 1928, pp. 1-2

[199] Wits University Historical Archives, AD 843, B89. 1. 7 Nursing Services. Rural Nursing Memorandum on the Need for Out-Patient of Venereal Disease among Non-Whites Europeans on the Witwatersrand, SAIRR, 1928, p. 3.

[200] Wits University Historical Archives, AD 843, B89. 1. 7 Nursing Services. Rural Nursing Memorandum on the Need for Out-Patient of Venereal Disease among Non-Whites Europeans on the Witwatersrand, SAIRR, 1928, p. 3.

[201] Wits University Historical Archives, AD 843, B89. 1. 7 Nursing Services. Rural Nursing Memorandum on the Need for Out-Patient of Venereal Disease among Non-Whites Europeans on the Witwatersrand, SAIRR, 1928, p. 3.

Table 1: STI cases *reported by the Union Department of Health, 1926/1971.*

Name of hospital	Syphilis (in-patients)	Syphilis (out-patients)	Gonorrhea	Total
Bochem (Bochum)	1,168	10,220	11	**11,399**
Elim	621	293	2	**916**
Jane Furse	170	8,510	4	**8,684**

Source: Wits University Historical Archives, AD 843, B89. 1. 7 Nursing Services. Rural Nursing Memorandum on the Need for out-Patient of Venereal Disease among Non-Whites Europeans on the Witwatersrand, SAIRR, 1928.

The above statistics in the Table show there was variability in the incidents of syphilis between Bochem, Elim and Jane Furse hospitals during the late 1920s. Bochem (Bochum) Hospital had the highest number of patients with syphilis, followed by Elim and Jane Furse Hospitals. The period from the 1930s was marked by the rising tide of syphilis among blacks, both in the rural and urban areas. The high level of poverty among the blacks was considered by many observers, mostly from the medical fraternity, as the major cause of spread of this disease. The socio-economic factor in this respect, like in other infectious diseases, remained the major determining factor. The high levels of rural poverty and inequality pushed many blacks into the migrant labour system on the farms and gold-mining industries where they found themselves exposed to a variety of infectious diseases such as STIs.[202]

The inadequacy of medical services exacerbated the challenge. A memorandum to the Secretary for Public Health, in 1933, highlighted the existing inadequacy of the medical and health services in the black areas throughout the Union of South Africa. Syphilis and tuberculosis were singled out as the most notorious diseases in the country. It was also noted that ignorance and the absence of facilities for treatment

[202] Jeeves, 'Public Health in the Era of South Africa's Epidemic of the 1930s and 1940s', p. 83.

were worsening the blacks' sufferings from such periodical epidemics, which caused the infant mortality rate amongst the blacks to be alarmingly high. [203]

Kark's explanation of this disease in most of his writings highlights the socio-economic determinants fuelled by racial segregation policies during the 20th century, as the main factor. This state of unfavourable socio- economic conditions compelled most of men to migrate from the rural to urban industrial centres to look for jobs. The demographic imbalances emanating from this migration led to the engagement of these migrants in alcohol abuse and extra-sexual relations during their absence from home. Kark used the Pholela data to suggest that "…most of the women with syphilis were infected through contact with their husbands, while most men were infected through contacts away from home"[204]

When the disease continued to escalate, the growing concern from the department led to the consultation with A.J. Orenstein, who was a Director of the Health Department of the then largest gold mining group to collect data about the infectious diseases in the major mine recruiting areas.[205] The fact that the collection of statistics was aimed at blacks only ensured that the prevention of syphilis remained a challenging task faced by the state. According to Allan Jeeves, "In January, 1937, Thornton bluntly told the CPH that…it was difficult to understand' why the government could not gather vital statistics for the black population on the same basis as for whites".[206]

The mid- 20th century's rapid increase of syphilis in places such as Pholela was viewed by many health observers, both from within government and outside government circles as a racially-driven phenomenon. Sidney Kark's explanation in this regard can be found in his *Social Pathology of Syphilis in Africans* where he argues that "…it was the enforced migrant labour system – 'a social pathology' – that

[203] South African National Archives, GES, Box 2705, File 3/62, Medical and Health Service for the Natives, 1938, p. 1.
[204] L. Myer, 'Community: The Social Pathology of the HIV/AIDS Pandemic', *International Journal of Epidemology,* 32(2), 2013, p. 190.
[205] A. Jeeves, 'Public Health in the Era of South Africa's Epidemic of the 1930s and 1940s', *South African Historical Journal,* 45(1), November 2001(1), p. 85.
[206] Jeeves, 'Public Health in the Era of South Africa's Epidemic of the 1930s and 1940s', *South African Historical Journal,* 45(1), November 2001, p. 85.

was fundamentally responsible for the epidemic spread of Syphilis through South Africa."[207] A similar explanation was used by Anne Digby whereby she links syphilis at Pholela to the regular migration of men to the industrial centres in Pietermaritzburg, Durban and Johannesburg where men became absent from their homes for approximately the rest of the year, and returned with all kinds of infections.[208]

This was the basis of Kark's innovative approach to community healthcare and social medicine. As one visitor to his Pholela healthcare centre, Meryl Susser, pointed out:

> The highlight for some was Sidny Kark's lecture on the social pathology of syphilis (later to become a classic paper of social pathology). Many of us came to understand that an integrated view of medicine in a societal context must be multidisciplinary.[209]

2.6 The advent of the HIV/AIDS epidemic and health among blacks

The period from the 1980s was marked by the emergence of another threatening disease called HIV/AIDS in South Africa. Since it was rapidly spreading and taking away the lives of many South Africans, it became a serious challenge to the medical fraternity on how to deal with this pandemic. The complexity of this disease, which mostly spread from one individual to another through sexual activity or the exchange of bodily fluids such as blood through other means, created fear among the majority of the South Africans.

HIV/AIDS epidemiologists initially regarded the existence of syphilis and other sexually transmitted diseases (STDs) as being behind the emergence of the immunodeficiency pandemic. Their studies linked the conditions under which HIV/AIDS and the STDs occur in relation to the views of Sidney Kark and his team during the early 1940s. These epidemiologists also viewed HIV/AIDS as a societal

[207] Myer, Commendatory: The Social Pathology of the HIV/AIDS Pandemic, *International Journal of Epidemology,* 32(2), 2013, p. 190.
[208] A. Digby, 'Evidence, Encounters and Efforts of South Africa's Reforming of Gluckman National Health Service, 1942-1944', *South African Historical Journal,* 6(2), 15 February 2012, p. 9.
[209] M.A. Susser, 'South African Odyssey in Community Health; A Memoir of the Impact of the Teachings of Sidney Kark', *American Journal of Public Health,* 83(7), July 1993, p. 1040

challenge fuelled by socio-economic conditions. Landon Myer et al explained the spread of this disease in relation to social mobility, noting that:

> Epidemiological studies of highly mobile groups, such as truck drivers, itinerant traders, and seasonal labourers, have associated individual mobility with increased risk of HIV/AIDS infection. In addition, there is ecological evidence to suggest that both within and between countries, high levels of population mobility are associated with increased prevalence of HIV. They widely regarded the economic discrimination of women as responsible for their inability to avoid exposure to high-risk infections. They also believed that the spread of this disease was exacerbated by the upheavals between the countries of the world, stigmatization and denial by the infected people.[210]

When the first cases of HIV/AIDS were reported in South Africa during the early 1980s, it was not taken seriously as many people believed that it only affected homosexuals who belonged to the European or American groups. Since it was believed that the disease was affecting only those small groups, the public did not take enough precations in the earlier stages. The government's view was based on the beliefs that it was easy to control the homosexuals as they were handful and easy to contain. As for the HIV/AIDS in the black townships and rural communities, government's lack of interest was motivated by the racial policy of apartheid to such an extent that no government intervention through preventative or treatment measures for the first five years after incidents of the diseases were reported.[211]

According to Louis Grundlingh, the government's justification of its failure to take action was given by the Department of Health's spokesperson, Dr. George Watermeyer, when he said that:

> It is to our advantage that we were able to learn from the international campaign. In the rest of the world the early start to the campaign could have

[210] Meyer et al, 'Commendatory: The Social Pathology of the HIV/AIDS Pandemic', *International Journal of Epidemiology,* 32(2), 2003, p. 190.
[211] L. Grundlingh, 'Government Responses to HIV-AIDS in South Africa as Reported in the Media,1983-1994', *South African Historical Journal* 45*,* November 2001, p. 127.

been “too early, too heavy”. The explicit nature of the international campaign could have resulted in resistance.[212]

The government’s lack of action was further highlighted by Grundlingh when he said that “Watermeyer’s statement was a somewhat lame excuse for inaction as the international campaign indeed demonstrated the opposite in any HIV/AIDS prevention and education programme one should be explicit about the dangers of the disease.”[213]

The rather belated acknowledgement by the authorities that HIV/AIDS was not simply a homosexual issue but a public problem was an indication that the disease was there to stay and that serious measures had to be taken to prevent it. It was also clear that the population group that would find itself severely affected would be the blacks as the disease was later considered one of the diseases of poverty.

The rapid spread of HIV/AIDS can certainly be linked to the migrant labour system and poverty. The long entrenched migrant labour system had a huge impact on the spread of HIV/AIDS in most rural areas of the former Transvaal, most particularly the former homeland areas of Lebowa, Venda and Gazankulu in the 1980s. The practice of having multiple sexual partners among the blacks, which was deemed culturally acceptable, accelerated the spread of the disease. It has been pointed out that “the male migrants usually had sexual partners (either common in mining hostels) or female in towns as well as in their rural home and many men established second families in urban areas.”[214]

Although the AIDS awareness campaign was launched several years since the early 1980s, the state envisaged intensified awareness campaigns from January to April 1988 by engaging advertising and liason consultants, and private sectors. This programme was part of a large spectrum of primary health care and family planning

[212] *Financial Mail*, 26 February 1988 quoted in L. Grundlingh, Government Response to HIV/AIDS in South Africa as Reported in the media1983-1994, *South African Historical Journal 45* (November 2001), p. 126.
[213] Grundlingh, ‘Government Responses to HIV-AIDS in South Africa as Reported in the Media’, *South African Historical Journal,* 45, November 2001, p. 126.
[214] Coovadia et al, ‘The Health and Health of South Africa’, p. 822.

clinics run by the Department, provincial and local health authorities. The research statistics revealed that:

> According to the research conducted before and after the first phase of the campaign, awareness of AIDS among Blacks increased by 21 per cent. Aids has shifted 22 percentage points in Black perception as the most serious disease facing the Black community overtaking tuberculosis.[215]

The Aids cases and deaths increased between 1982 and 1988 as depicted in Table 2 below. The emergence of the HIV-AIDS epidemic during the 1980s further aggravated the existing health problems caused by the number one killer diseases such as tuberculosis as the two fast became co-morbidities. Lethargic government attention left many black communities isolated and marginalised and by so doing exposed them to a worsening state of poverty and eventual exposure to HIV/AIDS which caused multiple premature deaths. This state of affairs was to a large extent caused by a dysfunctional health system caused by blatant state neglect of the needs of blacks. As Hoosen Coovadia et al have noted, "before 1994, political, economic and land restrictions policies structured society according to race, gender and age-based hierarchies, which greatly influenced the organisation of social life, access to basic resources for health and health services."[216] This scenario created a high risk of vulnerability to tuberculosis and HIV/AIDS in the rural black areas.

At Elim, like other HIV/AIDS infected rural areas in the Northern Transvaal, attempts were made to deal with its threat in the 1980s. The role of Care Groups in this respect became a crucial factor in the development of primary healthcare to deal with HIV/AIDS cases.

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[215] Report of the Director-General for National Health and Population Development for the Year 1988, 09 May 1989, p.17.
[216] Coovadia et al, 'The Health and Health System of South Africa: historical roots of current Public Health Challenges', *Health in South Africa* 1, www.thelancet.com, Vol.374, 15 August 2009, accessed on 10 March 2014, p. 817.

Table 2: *Annual South African AIDS cases and deaths between 1982 and 1988.*

Year	Cases	Deaths
1982 1983 1984 1985 1986 1987 1988	2 4 8 8 23 38 55	2 1 3 10 14 26 25 (9 September 1988)
Total	138	81

RSA case fatality rate: 58.7%

Origin

Transvaal	85
Cape	25
Nata	26
Orange Free State	2
Total:	**138**

Source: Adapted from the Report of the Director-General for National Health and Population Development for the Year 1988, 09 May 1989.

When the incidents of HIV/AIDS were escalating in the then Northern Transvaal, most particularly during the early 1990s, members of the Care Groups felt challenged. They started to utilise their skills to deal with it as they done with other diseases in the past. The fast spreading of HIV/AIDS in this area was associated with poverty, unemployment and food shortages, which made many women to be vulnerable to unsafe sex and exploitation by the migrants from major towns and cities.[217] Selina Maphorogo explained that the causes and spread of this disease was associated with high rates of poverty in the area with the result that many women found themselves engaged in sex for money and other material compensations as a way of overcoming poverty, hence the activities of unsafe or

[217] M. Tlakula, 'The Elim Care Groups Conflict in Community Development Styles', *Journal of Social Development in Africa,* 133(2), 1998, p. 61.

unprotected sex.[218] This approach was used by other rural community health centres in the Transvaal like Ithuseng, Bushbuckridge and Hlatlolanang as well.[219] Details on these will follow in the subsequent chapters.

2.7 Conclusion

The Union government established in 1910 had immense influence on the general socio-economic conditions of the blacks. The implementation of the laws governing non-white affairs since the establishment of the Union government generally speaking impacted negatively on the lives of the blacks, most particularly in the rural areas. The South African Party, the National Party and the United Party government policies made the lives of blacks difficult. This state of affairs was reflected in the way they were segregated and marginalised in all aspects of life. Of great significance was the 1913 Natives' Land Act which deprived blacks of their land to such an extent that they ultimately found themselves forced to become labourers for the whites, both on the farms and mines under severe living conditions. The low wages paid to blacks made it difficult to sustain themselves and their families in the reserves.

It is therefore clear that poverty, which resulted from such undesirable socio-economic conditions of the blacks, became a major cause or underlying factor for a variety of diseases of poverty like malaria, tuberculosis, sexually transmitted diseases, cholera, malnutrition, smallpox and other poverty-related diseases. Poor conditions under which blacks lived, with poor housing, poor nutrition, poor working conditions on the farms, shortage of clean drinking water, poor wages, poor infrastructure, absence of rural-based clinics or community health centres and the general government marginalisation of the blacks worsened the lives of blacks in rural communities.

When these diseases erupted, it was the blacks who found themselves vulnerable because of their state of poverty. When tuberculosis and HIV/AIDS were first

[218] Tlakula, The Elim Care Groups Conflict in Community Development Styles, *Journal of Social Development in Africa,* 33(2), 1998, pp. 60- 61.
[219] Interview with Selina Maphorogo, Elim Care Group Centre, Waterval Louis Trichardt, 10 March 2007.

reported, they were regarded as white plagues, but the blacks were the ones who became more vulnerable while the incidence of the diseases among the whites were few and decreasing. This decline among the whites occurred as a result of their easier access to nutritional resources and quality healthcare services than blacks. Since the state showed no serious commitment to improve health conditions of the rural blacks, incidents of poverty, diseases and mortality kept on rising. Although the newly-formed democratic South Africa since 27 April 1994 considered such diseases as a priority on its national health policy based on primary health care, health challenges would still remain unresolved for some time.

CHAPTER THREE. THE ROLE OF COMMUNITY HEALTH CENTRES

3.1 Introduction

In South Africa, the system of health centres was part of a practical solution to the health challenges associated with poverty and other conditions of deprivation. The system was regarded by those in the medical fraternity as the best way of effective provision of health care services to the needy rural communities and remote peri-urban health centres. Grassy Park, situated in the Western Cape, a region with a social and cultural population composition and economic circumstances vastly different from that of rural Zululand and Eastern Transvaal fell within this category.[220] The clinics, in partnership with community-based hospitals became crucial as community healthcare centres in which members of the community were involved.

This chapter will focus on the contribution of governmental and non-governmental organisations in the development of community healthcare centres in the rural areas, of which the Pholela Community-Orientated Primary Care in Natal, as the first health centre in South Africa, was significant. The establishment of this centre by the Union Health Department became influential in the establishment of other health centres in Natal and other provinces in the country. The chapter will also outline how the centres such as Hlatlolanang Health and Nutrition Education Centre at Jane Furse in Sekhukhuneland, Elim Care Group Centre within Elim Hospital near Louis Trichardt, Masana in Acornhoek in the Eastern Transvaal, emerged and contributed to the provision of the necessary healthcare services in the surrounding rural areas. The inception of a variety of projects through the involvement of the rural communities, particularly women, became crucial in the prevention of diseases associated with poverty. Focus will also be on the successes and challenges associated with the activities of these centres throughout the black rural areas in the former Northern Transvaal. The establishment of health centres such as Ithuseng Health Centre at Lenyenye outside Tzaneen, which was also remotely inspired by Pholela, will be dealt with in Chapter 7.

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[220] H. Phillips, 2005. 'The Grassy Park Health Centre: A Peri-Urban Pholela? in Saul Dubow and Alan Jeeves (eds.), *South Africa's 1940s: Worlds of Possibilities,* Cape Town: Double Storey Books, p. 109.

3.2 The impact of Pholela Health Centre and Gluckman Report

The idea of establishing health centres in South Africa can be traced back to the 1920s when a Consultative Council on Medical and Allied Services appointed by the British government issued a report proposing a scheme of health services based on community health care centres.[221] The idea received resounding support from the Assistant Medical Officer of Health of the Union of South Africa, L.G. Haydon, and other health officials, including Sir Edward Thornton, who had knowledge about health centres in French West Africa. The system was considered as a possible model in the provision of comprehensive healthcare in South Africa. This idea was motivated by the poor state of health among the blacks, which was a great concern of some in the Union government because of the fear that contagious and communicable diseases could spread. There was also fear of the possible collapse of the black labour force, both on the farms and factories. The model was considered useful for the extensive and cheap service delivery for blacks.[222]

Early attempts to strengthen the health service delivery system through health centres were also supported by the Loram Committee of 1928, which envisaged a 'Native Medical Service'.[223] This initiative also occurred as a result of the influence of his friend James McCord, the founder of the Zulu Hospital in Durban, when he heard the news

> … that a similar scheme had been started at the South African College (named the University of Fort Hare after 1951) under its principal, Alexander Kerr.[224]

The Committee's recommendation for the establishment of 'rural health units' or 'village health centres' for the blacks was a clear indication that such health centres were necessary in the provision of basic healthcare services. Although the government of the day rejected the recommendation by the Committee, it

[221] Harrison, 'The National Health Service Commission- its origins and outcomes', South African Medical Journal. 83(9). 1942-1944', p. 682.
[222] H.C.J van Rensburg et al, *Health and Health Care in South Africa*, p 416.
[223] van Rensburg et al, *Health and Health Care in South Africa*, p 416
[224] J. Parle and V. Noble, *The People's Hospital: A History of McCordss, Durban, 1890s-1970s*, p. 59.

nonetheless laid a strong foundation for the future transformation of health care through the system of health centres and black medical aides.[225]

Despite a general negative disposition within the Union government, some health practitioners and other health officials in the government felt that the idea should be encouraged and promoted.[226] Further efforts to promote meaningful reforms in the health care of the blacks were proposed during the early 1930s when Harry S. Gear returned from India and China, and was appointed as an Assistant Health Officer of the Union Health Department. Gear's intention of establishing health units similar to those in China and India also served as a basis for an expanded discussion of the possibility of a native medical service offering some basic healthcare.[227] This period of the rise of the health centres movement is regarded by H.C.J. van Rensburgh as the "golden era of Primary Health Care in South Africa."[228]

Momentum continued to build through the 1930s to the early 1940s when countrywide schemes began to emerge under the auspices of the Department of Public Health. The aim was to address the health of whites and blacks, particularly in the rural areas. Proposals for the establishment of health centres also made provision for supplementary training of health personnel such as doctors and nurses to perform promotive and preventative health services.[229] Training was to be extended to the Health Assistants, who would undertake home visits and family and community health education.

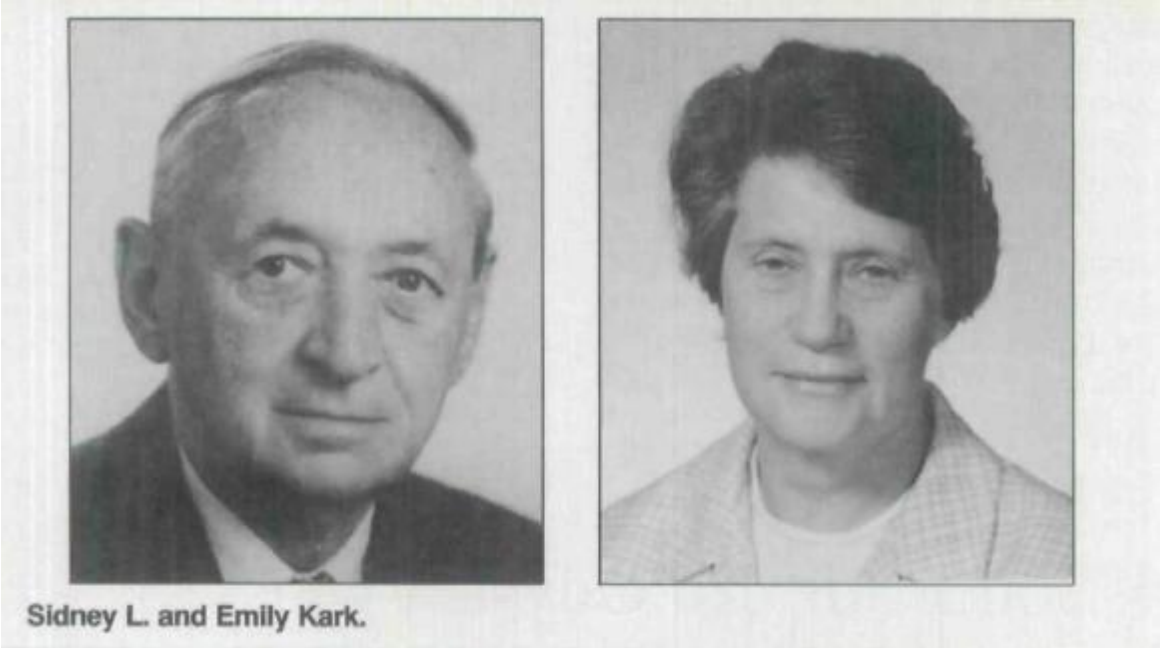
Gear's ideas were realised when he, together with Sydney Kark and Emily Kark, established the first comprehensive health care centre in 1940 at Pholela in the Natal Midlands. The Pholela health care model became a forerunner to community-oriented primary health care in the Zululand "native areas".[230] Several other centres which provided preventative and curative services to several communities in Natal

[225] Harrison, 'The National Health Service Commission, 1942-1944- .Its origins and outcome', *South African Medical Journal,* 83, September 1993, p. 682.
[226] van Rensburg et al, *Health and Health Care in South Africa*, p 416.
[227] Harrison, 'The National Health Service Commission, 1942-1944', p 682.
[228] van Rensburg et al, *Health and Health Care in South Africa*, p. 416.
[229] Annual Report of the Department of Health for the Year Ending 30 June 1950, p. (v).
[230] S. Kark and J. Cossed, 'The Pholela Health Centre: A Progress Report', *South African Medical Journal,* 26 (6), 9 February 1952, p. 101

rural areas were Tongaat which served Indians and blacks, Nottingham Road, Geilima and Botha's Hill. In the Transvaal, centres which served the surrounding areas of the blacks were Lady Selbourne in Pretoria, Evaton near Vereeniging, Randfontein, Bushbuckridge, White River, Groblersdal and Elis Ras.[231]

The Pholela model was therefore influential in the establishment of a variety of health centres in other rural areas of the blacks throughout the Union of South Africa. The model was used by many community health advocates and practitioners in the planning of their health care projects as the idea was translated into practice in the health programmes of Ithuseng, Hlatlolanang, Elim Care Groups and other health centres established since 1940.[232]

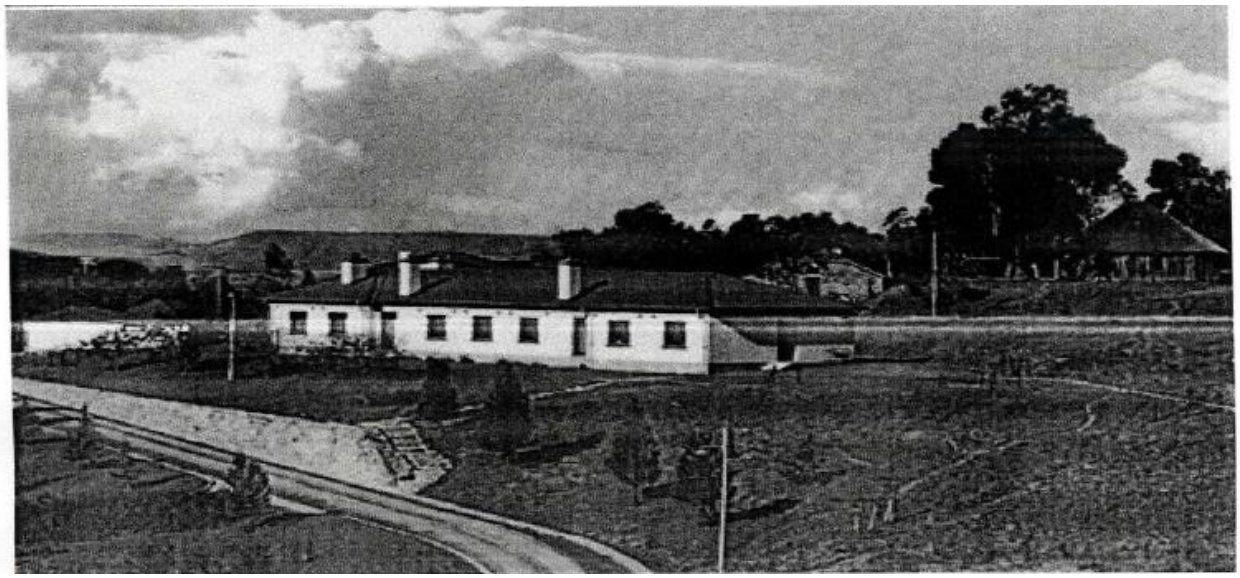
Photograph 3: *Photographs of Sidney Kark and his wife Emily Kark, circa, early 1940s.*



Source: M.A. Susser, 'South African Odyssey in Community Health; A Memoir of the Impact of the Teachings of Sidney Kark', *American Journal of Public Health,* 83(7), July 1993.

[231] South African National Archives, GES, Box 2703, File 1/62A. Social Medicine in South Africa. Native Affairs: Fact Paper VIII, 1947, P 1.
[232] Kark and Cossed, 'The Pholela Health Centre: A Progress Report', *South African Medical Journal,* 26 (6), 9 February 1952, p. 101.

Photograph 4: *The buildings of Pholela Health Care Centre, 1942.*



Source: S. Kark and E. Kark, *Pholela Health Centre in the 1950s,* apps.nml.nih.gov, Accessed on 13 January 2015.

Keegan's explanation of the role and objective of the Pholela model emphasised that the initiative was a means of establishing additional appropriate health care services most particularly in the disregarded or previously neglected areas of the blacks. The Pholela model became innovative in the integration of curative and preventative health care services to the surrounding rural population. This became the first model in terms of which, socio-economic problems are identified, rather than individual people alone, to ensure that the Community Oriented Primary Health Care services were effectively implemented.[233]

The uniqueness of the model was also evident in its focus on the determinants that influenced population health in general, targeting hygiene and sanitation, to address the health needs of the vulnerable and high risk groups most particularly women and children. Emphasis was also placed in the primary health care services on immunisation, school feeding schemes, the establishment of household and community food gardens, child growth monitoring, breastfeeding and body food supplementations, communal child care services and family planning.[234]

[233] K.A. Kautzky and S.M. Tollman, 'A Perspective on Primary Health Care in South Africa', p. 19.
[234] Kautzky and Tollman, 'A Perspective on Primary Health Care in South Africa', p. 19.

Dr Sydney Kark facilitated the recruitment and training of local individuals as health assistants and community educators, to see to it that the provision of health education, promotion and skills development at all villages and households were well facilitated. The Pholela staff took comprehensive strides by empowering the families in the surrounding communities to complete health reviews and to discuss health histories and general conditions in relation to the circumstances in the households and communities. It was from these intervention strategies that a unique family plan for health care was established. It was due to these developments that Pholela Health Centre provided the National Department of Health with a model of comprehensive community healthcare approach. As a result, the model paved way for the endorsement of the model as well as its recommendation to other provinces with specific consideration of the rural black areas, which were to be given priority.[235]

The inception of Pholela Community Health Centre had far reaching influences in the establishment of a variety of such similar centers in other South African provinces. The expansion of this approach was ensured by the appointment of Dr Kark as a technical advisor of the newly-formed National Health Service Commission in 1942 led by Dr Henry Gluckman. This Commission had the specific aim of coming up with a model for providing basic health care services to all communities in South Africa. The work of the commission has been studied by many historians. Anne Digby has pointed out that:

> Indeed, Gluckman had already negotiated a contingency government fund of 50 000 pounds to set up health centres through administrative process without any organized review of the work of the earliest ones such as Pholela. More health centres became opening at Grassy Park in Cape Town (1947), Lady Selborne and Tongaat (1946) and Cradock and White River (1947), each targeted specific racial groups with preventative, promotive and curative medicine.[236]

[235] Kautzky and Tollman, 'A Perspective on Primary Health Care in South Africa', p. 19.
[236] South African Government Papers, UG 53-1948, Report of *Department of Public Health,* 15 February 2012, p. 18.

The idea of community health centre establishment in rural black areas of the former Transvaal can also be explained within the context of the need for the National Health Service (NHS) plan that would cater for all people of South Africa. Gluckman regarded the health centres as the foundation of the NHS that requires the commitment and support of the entire parliamentarians.[237] This endeavour was motivated by the concerns, most particularly from the medical fraternity, who saw the need for health reforms for all South Africans. This growing interest became evident during the early 1940s, of which Gluckman's Commission eventually became an important force to be reckoned with. The explanation of the initiators of the idea appeared in the journal: *The Centre for the Study of Health Policy,* which stated that:

> It is true that a number of health workers organizations that stand somewhere left of centre in South Africa's limited legal range of political views have supported the call for a National Health Service. These included the National Medical and Dental Association (NAMDA) and the Health Workers Association (HWA).[238]

The establishment of this National Health Service was supported by political radicals, professors of medicine and community health enthusiasts at some universities and the South African Medical and Dental Council.[239] Most of these health professionals were subscribed to the idea of social medicine, which was pioneered in the late 1930s when preventative rather than curative medicine was emphasised, with particular concentration on "…proper sanitation, improved water supplies, adequate nutrition particularly for infants and school children, mass immunisation programmes and health education."[240] This resounding support for the idea was a clear indication that the government would have no excuse to oppose or reject this plea.

Further action took place in 1941, when the Federal Council of the Medical Association of South Africa circulated the discussion document called *Planning for*

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[237] South African National Archives, BAO, Box 5817, File No. 104/315, National Health Service, Conference held on 20 January 1945 in the Cathedral Hall in Cape Town Convened by Suth African Institute of Race Relations, 16 February 1945., p. 2.
[238] E. Buch et al, *A National Health Service for South Africa Part 1*: *The Case for Change*, p. 1.
[239] Buch et al, *A National Health Service for South Africa Part 1*: *The Case for Change*, p. 1.
[240] A. Digby, 'Evidence, Encounters and Efforts of South Africa's Reforming of Gluckman National Health Service Commission, 1942-1944', p. 2.

Health in South Africa, drafted by committee in which Dr Harvey Pirie, Dr Francis Dauberton and Professor Raymond Dart were instrumental. The document clearly outlined the need for organised health services based on progressive and democratic lines as the state of health was in chaotic state. These developments of 1941 laid a strong foundation in the establishment of Gluckman Commission in 1942.[241]

The initiative for the provision of inclusive and preventative health services based on community health centres finally received attention when Henry Gluckman, who was the member of parliament for Yeoville in Johannesburg was tasked by the parliament in February 1942 to establish a Commission of Inquiry to investigate and recommend on the best way of adopting adequate health services for all people of South Africa irrespective of race. Bill Freud acknowledged Gluckman as a competent figure to deal with health issues:

> Gluckman's 20 year career as a parliamentarian was dominated by his interest in health issues and the chairmanship of the commission was recognition for the importance of the issues that he raised at the time when Britain, still really the source of foreign ideas for South African institutional change was also earnestly contemplating major changes to its national health regime.[242]

Freud also made reference to some remarkable members of the Commission like Gluckman's friend, George Gale, who was a reforming progressive civil servant and specialist in the values involving experimental health centres. This system of experimental health centres was supported by Harry Gear, who was the Chief Health Officer in the Department of Health. Other members of the commission who were highly articulate included Sydney Kark and his wife Emily.[243]

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[241] Buch et al, *A National Health Service for South Africa Part 1*: *The Case for Change*, p. 2.
[242] B. Freud, 'The South African Developmental State and the first attempt to create a National Health System: Another look at the Gluckman Commission of 1942 to 1944', *South African Historical Journal*, 64 (2), 18 June 2012, p. 181.
[243] Freund, 'The South African developmental state and the first attempt to create a national health system', p. 171.

The significance of the Gluckman Commission was realised when emphasis of involvement of the communities on a variety of health activities was considered a priority. H.C.J. van Rensburg stated that:

> In 1944 Gluckman's Commission argued that the solution to South Africa's problems lay in the advancement of public health and that it could only be achieved through vast improvements in the nutrition, housing and health education of the population. The proposed National Health Service, based on Primary and Preventative health care provided by community-based health care would best facilitate this objective.[244]

The agents travelled to all provinces of South Africa, particularly the rural areas, where more than 1 000 people of different races were interviewed, which included members of the African Peoples Organisation, Food and Canning Workers' Union, Farmers' Organisations, the Communist Party, Transvaal and Natal Indian Congress, Suid-Afrikaanse Vrouefederasie, Trade Union Council of South Africa, representatives of the Chinese Community and the Transkei Bunga. Amongst the prominent figures interviewed by the commission were Professor Batson, the inventor of the poverty datum line, important bureaucrats such as Douglas Smit and George Gale, trade unionists William Ballinger, Ray Alexander, anthropologist Eileen Krige, and the progressive doctor, Sydney Kark.[245]

The implication regarding this scenario is that the envisaged National Health Service Commission by Gluckman had been absorbed into the provincial system based on hospital, which temporarily curtailed any hope for the solution of health care challenges mostly based in the black rural communities. Nadja van Ginneken, the author of an article titled 'Evidence, Encounters and Effects of South Africa's Reforming Gluckman, National Health Service Commission, 1942-1945' relates the

[244] H.C.J. van Rensburg et al, *Health Care in South Africa: Structure and Dynamics*, p. 247.
[245] Freud, 'The South African Developmental State and the first attempt to create a National Health System', p. 171.

Gluckman Commission to the United Kingdom's Beveridge Report of 1942.[246] Van Ginneken states that:

> The ambitious 1942 National Health Service Commission and Gluckman Report set out to provide "unified healthcare to all sections of South Africa" They addressed both the social and biomedical causes of disease responding in part to concerns regarding the effects of poor health on black migrant labourers and miners' productivity to the 'homeland' governments.[247]

Reference was also made to the influence of the Soviet Union Model of modern social medicine practice which Gluckman party borrowed from in the formulation of a National Health Service proposal. Since the Report addressed both social and economic causes of disease, the government realised the need to recommend the establishment of such health care centres.[248]

The National Health Service attracted the interest of civil servants in the Union departments of Public Health, Native Affairs and Social Welfare. This interest was featured in the medical services of the blacks for many years since 1945, with coverage of the topics like malnutrition, shortage of hospitals, lack of impact in health education and statistical information on the prevalence of diseases and deaths among the blacks in the reserves.[249]

The 1940s could be regarded as a turning point in the history of health center developments in South Africa. This was made possible by the preparedness of the United Party government under General Jan Smuts to accept health reforms for the blacks within the Union of South Africa. This period was described as 'the golden age era of the primary health care in South Africa', as the government of the day started to relax some of the health legislation whereby Smuts Government agreed to

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[246] N.van Ginneken et al, 'The Emergence of Community health worker Programmes in the late apartheid era in South Africa: An Historical Analysis', *Social Science and Medicine*, 71(6) 23 June 2010, p. 1110

[247] van Ginneken et al, 'The Emergence of Community health worker Programmes in the late apartheid era in South Africa', pp. 1110-1111.

[248] Freund, 'The South African Developmental State and the first attempt to create a National Health System, 64 (2), p. 171.

[249] Digby, 'Evidence, Encounters and Effects of South Africa's Reforming Gluckman, National Health Service Commission 1942-1945', p. 190.

separate public health from Ministry of the Interior, which enabled Henry Gluckman to become a Minister of Health and Housing in February 1945. As a result, the South African Department of Health started to commit itself to a system of health units which was intended to form the basis of the black medical service with the specific aim of providing comprehensive health care for the blacks in the rural areas.[250]

When some elements within the Union government supported the hospital-led health care system during the early 1940s, Gluckman viewed it as a way of obstructing an envisaged unified national health service. The support of free hospital admission by the Secretary of the Transvaal Administration paved way for further proposals for health reforms which would allow hospitals to possess a network of clinics for blacks and whites.[251] Although the Transvaal became the first province to adopt Public Hospital Ordinance in July 1946, its support became questionable as the provincial legislature on request by the Transvaal public viewed it as a different document from the one earlier envisaged by Pentz. The conflicting views on how the free hospitalisation system should function, delayed any possibility of implementing equitable health services to all South African citizens. This division led to the suspension of the provision of free hospitalisation due to ideological divisions within the member doctors of Medical Association of South Africa.[252]

The devolution of health centres from National Department to regional offices in 1952, made centres to become less accessible due to fragmentation and reduced funding from donors.[253] According to Anne Digby,

> In Natal, only six of the nine health centres continued, in the Orange Free State one centre was listed as a clinic for non-whites, whilst in the Transvaal none of the six early centres were found in later provincial reports, although other evidence indicated that at least one of them survived.[254]

[250] Harrison, 'The National Health Service Commission, 1942-1944', p. 682.
[251] Digby, 'Vision and Vested Interests: National Health Service Reform in South Africa and Britain during the 1940s and beyond, *Social History of Medicine* 21(3), December 2008, p. 492.
[252] Digby, 'Vision and Vested Interests', p. 493.
[253] Digby, 'Vision and Vested Interests', p. 490.
[254] Digby, 'Vision and Vested Interests', p. 491.

An interview conducted with Mankuba Ramalepe of the Ithuseng Health Centre revealed that the establishment of Ithuseng as well as other community health care centres in the homelands of Gazankulu, Venda, Bophuthatswana and Lebowa was influenced by the models contained in Gluckman's Report. Ramalepe confessed that Gluckman's inspiration motivated him to work very hard, despite a lack of financial assistance from the government. It was despite these constraints that some Non-Governmental Organisation health centres managed to flourish and later attracted donors from other countries like Germany, the United States of America, Britain and other interested outside funding organisations.[255]

The emphasis of Gluckman's Report on health as encompassing preventive and curative services played a vital role as the foundation of the Primary, Secondary and Tertiary health care system in South Africa. However, despite the National Health Service's Commission progressive and attractive recommendations, mixed reactions were evident, most particularly among some white policy makers. In fact, the Report would not receive the support from the majority of the whites who viewed it as a threat to their historical policy of racial discrimination. Many commentators viewed the failure of the radical recommendations of the National Health Service Commission as being finally caused by the coming to power of National Party government in 1948. The strengthening of apartheid laws was a clear indication that the idea of unitary health for all was far from being accomplished. As a result, the recommendations of the Report were finally halted by the government.[256] However, although the coming to power of the National Party government marginalised any attempt of improving and developing the health conditions of the blacks in the reserves, the idea of community health centres prevailed in one form or another, though under difficult circumstances as it was in the case of Ithuseng in Lenyenye as well as other governmental and non-governmental community health centres.

The changes after 1948 were also influenced by the rightwing ideology-driven National party government, which saw the country's black majority as a threat to the life of the White South Africans in general. The National Party therefore attempted to

[255] Interview with M. Ramalepe, Non-Governmental Organization, Community Health. Tzaneen, 21 April 2013.
[256] Digby, 'Evidence, Encounters and Effects of South Africa's Reforming Gluckman, National Health Service Commission 1942-1945', pp. 203-205.

limit all efforts and recommendations of the National Health Service Commission. As a result, it became impossible for health of the blacks in the rural areas to improve holistically.[257]

However, the original model centre, Pholela, continued to expand. In 1954, several staff from the health centres which were part of the Institute of Family and Community Health located in Durban joined the Natal University Medical School to inaugurate a Department of Social, Preventative and Family Medicine, which also at a later stage became ineffective due to a lack of government support.[258] Since Pholela Health Centre was serving only the rural black communities, the Institute was aimed at providing health services to a wide variety of racial and economic groups. The Institute received support from Natal Provincial Administration and the Durban Municipality, and its facilities were available for the training in health centre practice to the black students of Natal Medical School.[259] The functioning and activities of the health centres were curtailed when some were closed down while others were placed under provincial administrations in 1958, after which they became ordinary clinics. By 1960 both Institute of Family and Community Health, and the Natal University Department were closed down, leaving little hope for any further effective implementation and development of health centres.[260] Mankuba Ramalepe has stated categorically that several efforts to develop health centres for the rural blacks were gravely affected by the government's efforts to discourage their existence or improvement.[261]

George Gale had commented approvingly about health centres, saying:

> The Health Centres Service of the Union has no counterpart, as far as I am aware, in any other country….. If Health Centres can show, as I believe ultimately they will, a high degree of efficiency in preventing as well as

[257] S. Tollman, 'Community Orientated Primary Care: Origins, Evolution and Applications', *Social Science Medicine*, 32 (6), 1991, p. 635.
[258] Tollman, 'Community Orientated Primary Care', p 635
[259] Annual Report of the Department of Health, by the Medical Officer–in-Charge for the Year Ending 30 June 1950, p. iv.
[260] Interview with M. Ramalepe, Non-Governmental Organization, Community Health, Tzaneen, 21 April 2013.
[261] Tollman, 'Community Orientated Primary Care: Origins, Evolution and Applications', p. 635.

> alleviating ill-health, South Africa will have made a significant contribution not only to the meeting of her own needs but also to international medicine.[262]

However, the development of community health care centres, which was considered a meaningful way of dealing with a variety of health related challenges, remained a gradual process and unsystematic process that was worsened by the coming to power of the National Party government in 1948.

3.3 Elim Care Groups and primary health care

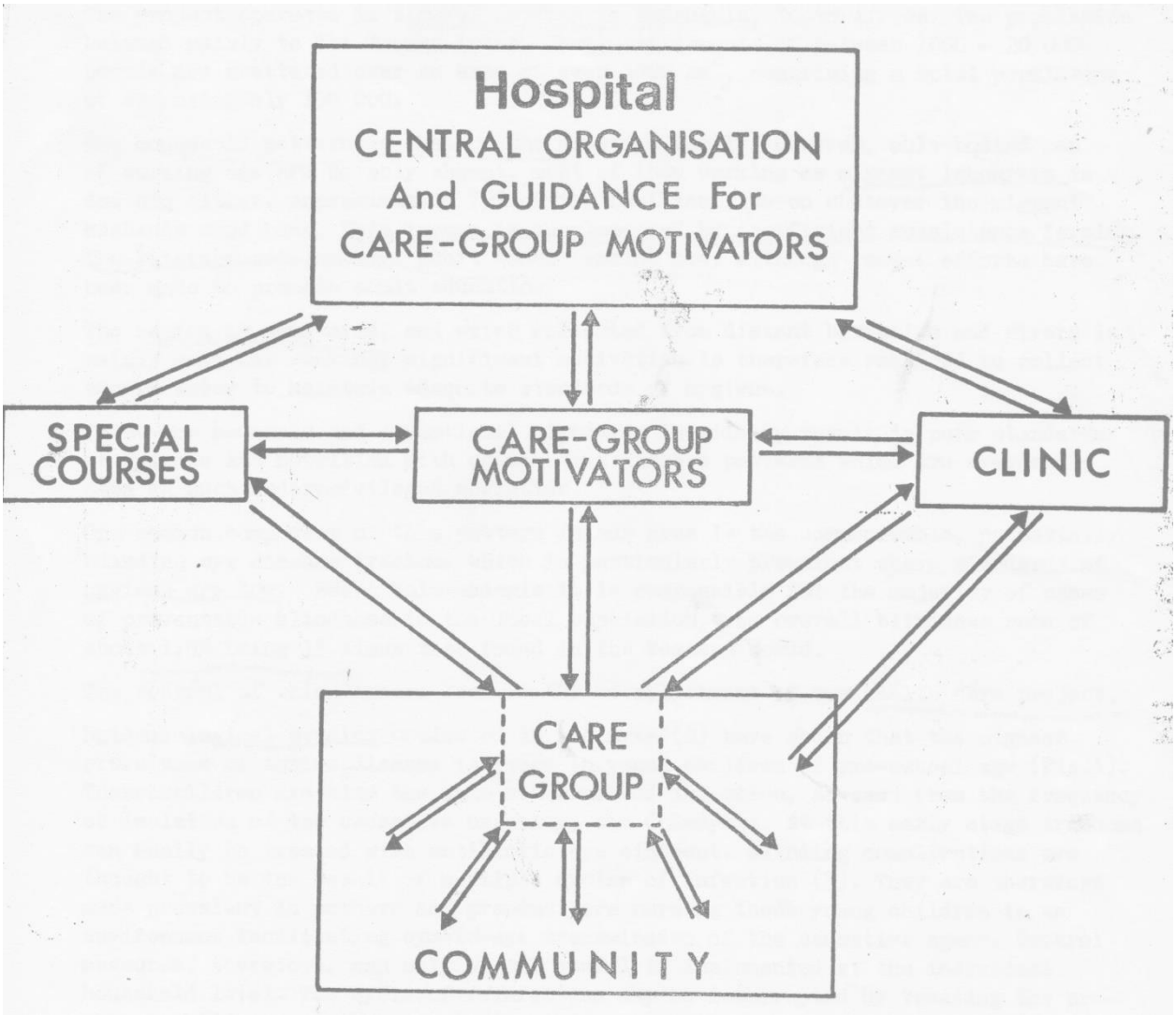
The role of Elim Hospital in the provision of primary health care services could be discussed in the context of the diseases of poverty and the involvement of missionary establishments in rural disease control efforts. The area where Elim is situated is in the far north of the former Transvaal, with tropical climate of high annual temperature and rainfall. The area fell within the former homeland of Gazankulu, with the Tsonga as the major ethnic group, though the Venda people were also found due to the sharing of boundary with the Venda homeland. The historically fragmented nature of health centres made the general health services inaccessible to the needy communities. The area was popular for the prevalence of multiple tropical diseases, of which malaria and eye disease called trachoma, were rife. This pattern of ill-health and disability was related to similar conditions found in other developing countries worldwide. Since one of the principles of primary health care is community involvement, the communities in the area stood up and came up with ways of preventing diseases, with the involvement of hospital health teams comprising of nurses and doctors. The clinics, which were situated outside the hospitals, had already been taken over by the hospital in the 1950s.

Since trachoma was a common disease which was well known to the community, it was therefore "…used as a means of introducing the concept of community participation in primary health care."[263] The flow pattern of the Care Group system incorporated trained medics and nurses in the local clinics and hospital, Care

[262] Tollman, 'Community Orientated Primary Care', p. 635.
[263] Limpopo Provincial Archives, Box 65, File 11/14/1, Primary Health Care Routine Enquiries, 1981, p. 1.

Groups, the community and training through health education.[264] The system is clearly reflected in the following flow pattern (illustration 4 below):

Illustration 4: *A model flow pattern of the Care Groups at Elim, Gazankulu Homeland, 1970s.*



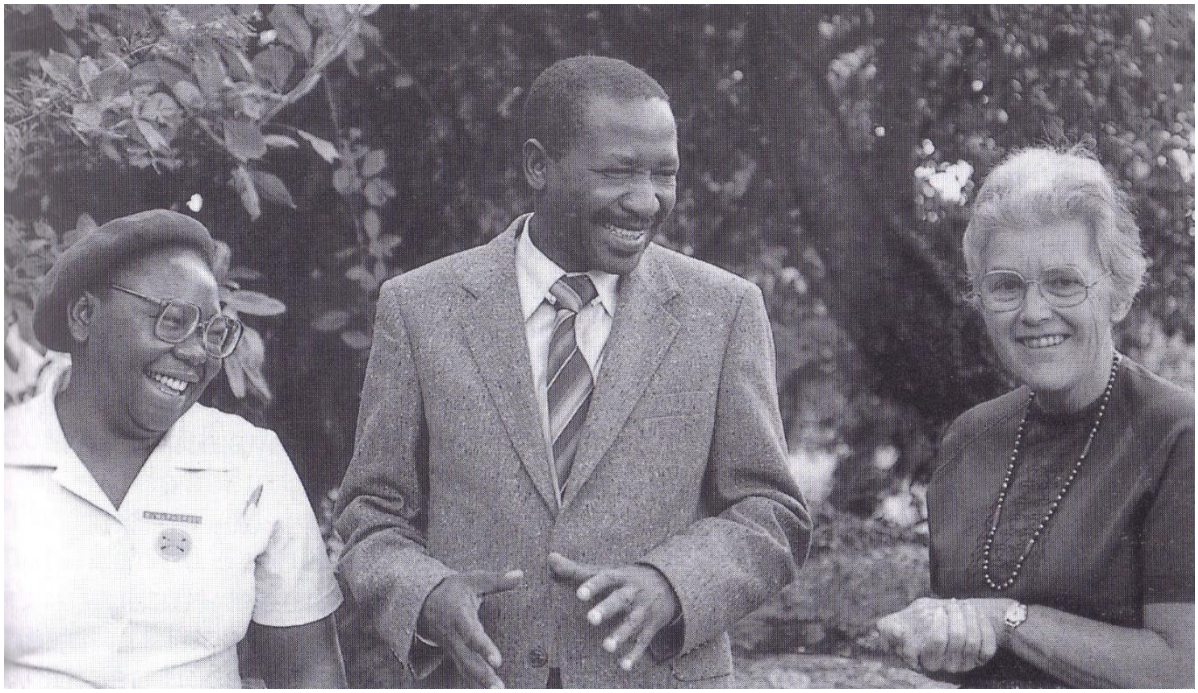
Source: Limpopo Provincial Archives, Box 65, File 11/14/1, Primary Health Care Routine Enquiries, 198.

The high notification of trachoma in the early 1970s provoked a great deal of concern by the hospital doctors because of the deterioration of health of the children. Apart from trachoma, malnutrition was common as most of these rural communities were

[264] Limpopo Provincial Archives, Box 65, File 11/14/1, Primary Health Care Routine Enquiries, 1981, p. 2.

poor and unemployed.[265] The establishment of the first Care Group, which was a community non-governmental organisation, should be studied with reference to the role played by a local black woman healthcare worker, Selina Maphorogo, who was one of Elim Hospital's team motivators from. Her contribution to the formation of Care Groups, whereby the community was organised in the formation of primary health care projects, was also motivated by her position as an assistant nurse in the eye department of the hospital. Other main contributors included Erika Sutter, an eye doctor, Peter Kok who was concerned with community outreach programmes and Carel IJsselmuiden who led the project.[266]

Photograph 5: Erika Sutter (right) and the first two Care Group Motivators, Selina Maphorogo (left) and Andrew Radebe (middle), in the early 1970s.



Source: S. Maphorogo, *The Community is my University*.

The random survey regarding the local epidemiological pattern of trachoma in the region served by Elim Hospital indicated that pre-school children aged 2-4 years were the most infected in the community in 1970. Treatment of young children was

[265] S. Maphorogo, *The Community is my University,* pp. 27-28.
[266] Maphorogo, *The Community is my University,* p. 227.

given a priority as findings proved that women, including men who were most of the time absent from their homes as migrant labourers were less infected with the disease. The project was established in 1976 by a group of village women in the community. The training of the Care Groups was carried out by the hospital-based co-coordinators and motivators on how to prevent trachoma and its spread to other members of the community.[267]

During training emphasis was placed on how to apply tetraclyn eye ointment to the infected children, and generally on the improvement of hygienic practices. These hygienic practices included the digging of refuse pits, building toilets to reduce the fly population, and washing face and hands regularly to avoid possible infections. The Care Groups were provided with the slogan 'cleanliness is the best medicine' in the prevention of diseases without resorting to curative care.[268]

The care group projects were not only confined within the rural areas of Elim. The far-northern area of the Transvaal which accommodates the Venda population group also adopted a similar approach as they shared a geographical boundary with the Shangaan's in the vicinity of Elim. According to one of the founders of Elim Care Groups, Dr E. Sutter:

> In Gazankulu and Venda community participation has been enlisted through the so-called care groups. They differ from health committees and village health workers described elsewhere in that they are unpaid volunteers recruited from all sections of the community and act within their own village as a group rather than as individuals.[269]

Several congresses and meetings between Venda and Gazankulu government representatives were held at Elim in 1979 to discuss health matters related to the Venda clinics located in the Vuwani Area. It was during the meeting held on 12 July 1979 that the issue of the takeover of the clinics from Gazankulu government was

[267] E. Sutter and S. Maphorogo, 'Elim Care Group: A Community Project for the control of Trachoma', *Community Eye Health,* 14 (39), 2001, p. 47.
[268] Sutter and Maphorogo, 'Elim Care Group', p. 48.
[269] E. Sutter, Elim Hospital Archives, Community Participation in the Prevention of Disability, Community Health, September 1982, p. 67.

discussed, leading to the decision that "...Venda will now have to look after the clinics whose patients will still use Elim as their nearest hospital."[270] Dr E. Sutter from Elim Hospital indicated that there were fourteen Care Groups which were operating in the Vuwani area and emphasised the importance of providing the motivators who should work together with the Elim team appointed by the hospital for a while through training. She also suggested that the team must be mobile and wear badges to identify themselves."[271]

Selina Maphorogo made mention of the link between the successes of the Valley Trust located on the coast of Natal and Elim, irrespective of the fact that both areas were experiencing poverty, malnutrition and underdevelopment. The poor soil fertility associated with high rainfall variability added to the economic strains in these areas. The Care Group members in the vicinity of Elim and other Gazankulu areas were taught to follow the Valley Trust model as a way of preventing malnutrition and diseases associated with it.[272] In particular, they were taught the method of digging trenches and filling with grass and organic domestic refuse 30 centimeters deep and about 10 cm of subsoil; the final replacement of topsoil and the planting of leguminous crops and vegetables, which produced successful results.[273]

Selina Maphorogo's description of the significant effect on Elim Care Groups of the Valley Trust became evident when she stated that:

> Today the Valley of a Thousand Hills is one big vegetable growing area. People have enough food, there is no more malnutrition, and the people have an income from selling the surplus crops. The Health Centre is now a training institution for agricultural development.[274]

[270] Limpopo Provincial Archives, Box 122, File 7/2/3/1, Minutes of Meetings in Connection with Health Aspects ETC, File opened 03 May 1978, p. 1.
[271] Limpopo Provincial Archives, Box 122, File 7/2/3/1, Minutes of Meetings in Connection with Health Aspects ETC, File opened 03 May 1978, p. 1.
[272] Limpopo Provincial Archives, Box 122, File 7/2/3/1, Elim Hospital Health Ward Care Group Project, Report for the Year 1978, 27 April 1979.
[273] Maphorogo, *The Community is my University,* p. 77.
[274] Maphorogo, *The Community is my University,* p. 77.

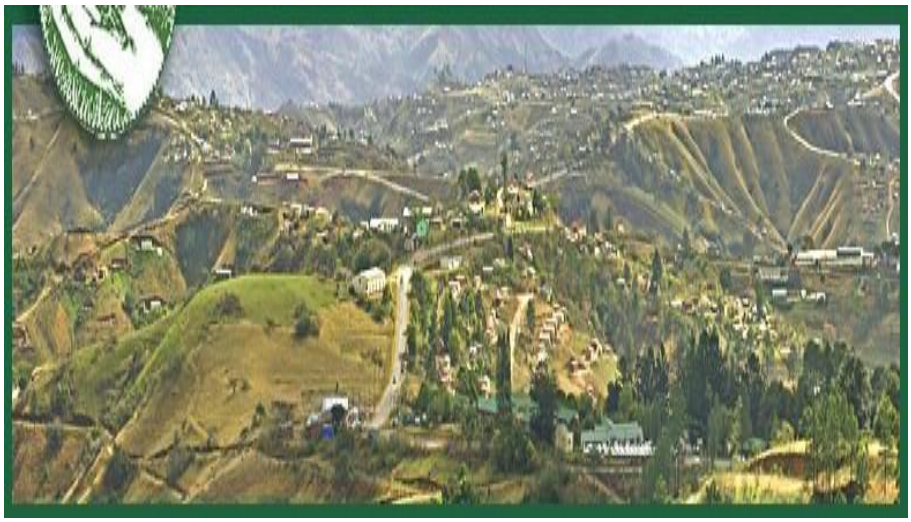
As a training centre, the Valley Trust became influential with its gardening methods, attracting other impoverished rural areas including the Northern Transvaal. This enabled Elim Care Groups to send people to the Valley Trust for training along these effective methods of gardening as Elim was one of the areas located on the drought-stricken area of the Northern Transvaal. The results of the application of the gardening methods learned from the Valley Trust Health Centre were realised when the Care Group members started to produce healthy and nourishing vegetables, with other members of the community being encouraged to learn similar methods. The success of the methods learned became evident when the communities managed to produce fresh and green vegetables irrespective of the severe drought experienced during the 1980s.[275]

The oral information obtained from Maphorogo revealed that she, together with the Care Group members advised the families to organise themselves into groups so that loans could be granted to fence their gardens as their crops were usually damaged by goats, chickens and other domestic animals. She stated that members of these communal gardens were flourishing and enabled to earn money which was also helpful in the repayment of loans. The use of cheap methods of water purification using chemicals such as 'javel', which was a chlorine-containing bleaching fluid, was taught by the Care Groups to the communities to such an extent that the cholera disease, which was causing many deaths, disappeared completely since the 1970s.[276]

Care Group motivators also worked closely with chiefs and traditional healers. Although some of the chiefs showed their eagerness to appreciate the work of the Care Groups, some were suspicious of their involvement with the people in the communities. Maphorogo said that such suspicious attitudes occurred most particularly in places where chiefs played a strong and influential role among their people. The suspicions were based on the belief that the Care Groups would eventually possess more power in the communities than the chiefs.[277]

[275] Maphorogo, *The Community is my University,* pp. 77-78.
[276] Interview with S. Maphorogo, Elim Care Group Centre, Waterval Louis Trichardt, 10-March-2007
[277] S. Maphorogo, *The Community is my University,* p. 131.

Photograph 6: *Valley Trust Community Health Centre as a PHC project in the rural northern Natal (above and below).*



Source: Valley Trust Community Health Centre, www.valleytrust.org.za, Accessed on 13 January 2016.

On the other hand, the health workers found themselves in a situation where most members of the communities were still accustomed to the traditional medical system, where the traditional healers and *sangomas* were dominant. It became evident that the respect as well as positive approach by the health workers led to the mutual relationship between the two groups. This was witnessed when the traditional healers confessed that they could not treat tuberculosis, and referred most of these

patients to the hospitals for treatment.[278] According to Maphorogo, working with *sangomas* was initially difficult but the relationship improved gradually after one of the *sangomas* was taught by the health workers how to treat diarrhoea successfully by mixing oral rehydration fluid.[279] Apart from experiences of working with *sangomas*, the rich families proved to be another challenge experienced by the health workers during the home visits. This was supported by the remark made by one of the rich families when said: "What is this poor woman coming to do here, what is she going to teach? We have everything here in this house."[280] It was despite these remarks that eventually the good work of the health workers earned the respect and warm receptions by these well-to-do families.

Photograph 7: *Cooperation between community health workers and traditional healers.*

Source: S. Maphorogo, *The Community is my University.*

Overall, the Care Groups played a significant role in the remarkable improvement in vegetable gardening modeled on the example of the Valley Trust in northern Natal.

[278] Maphorogo, *The Community is my University,* pp. 132-133.
[279] Interview with Selina Maphorogo, Elim Care Group Centre, Waterval Louis Trichardt, 10 March 2007
[280] Maphorogo, *The Community is my University,* p. 134.

Despite high levels of unemployment and poverty, the Care Groups significantly improved basic public health. Improved water supply, better housing and improved hygienic standards were among other important factors that added value to the successes.[281] As Selina Maphorogo explained:

> Later, once the Care Groups proved to be successful and became well known, the Health Department was forced to become more flexible and accommodate this unconventional working force in its Primary Health Care programme to some extent. Indeed the Department even attempted to take them over as 'shop windows' nevertheless, the Care Groups remained autonomous.[282]

The Care Groups largely operated on the basis of the philosophy that quality of life is to a great extent determined by social and human values and development, with personal and environmental hygiene as key components. The preventative health skills taught to communities in the northern Transvaal helped greatly in the improvement of dignity and self-respect among members of the communities served by the Care Groups.

3.4 Witwatersrand University (Wits) Community Rehabilitation Programme

The contribution of Wits University in the provision of primary health care in the eastern Transvaal rural areas of the blacks should be viewed in the context of many contributory factors. The 1946 to 1947 Report pertaining to the activities of health centres at Bushbuckridge district situated in the eastern Transvaal stated that "Government and lack of interest hamper progress throughout the area. Poverty may be also a direct result of indolence".[283] According to some statistics (Illustration 5) below, the female wage earners generally exceeded the male population of the same group as reflected by population figures for the ages between 30-39 and 40-49. This distribution occurred as a result of little employment opportunities locally, and men had to flock to the farms and towns where they worked for a short period to

[281] Sutter & Maphorogo, 'Elim Care Group', p. 247.
[282] Sutter & Maphorogo, 'Elim Care Group', p. 246.
[283] South African National Archives, GES 1917, File 47/32, Annual Report, Bushbuckridge Health Unit, 9 September 1947, p. 5.

accumulate money in order to pay tax.[284] The impoverishment of the population also reflected itself in terms of low levels of cleanliness of the homes and surrounding areas, which favoured the increase of diseases such as whooping cough and other infectious diseases. It is however noticed that poor attendance at the clinics and persuading people by health assistance to visit clinics was a difficult task.[285]

Illustration 5. *The distribution of village population statistics at Bushbuckridge in relation to age health services*.

Age Distribution:

Mu - Mukutung : Bh - Bluehill : Kw.- Kwapelandaba : Si - Singomula :

	0-1	2-4	5-11	12-19	20-29	30-39	40-49	50-59	60 & over	Total
Mu										
M	5	11	14	14	18	8	3	2	4	70
F	6	10	13	17	12	13	2	2	4	80
Bh										
M	3	11	14	26	18	5	3	6	7	93
F	3	10	22	20	24	4	7	6	6	102
Kw.										
M	5	12	26	26	11	9	6	2	6	103
F	9	9	19	19	21	9	5	8	4	103
Si										
M	6	8	11	9	7	10	5	2	5	63
F	6	8	8	13	13	12	4	2	9	85

	Mukutung	Bluehill	Kwapelandaba	Singomula
No.of families	21	19	26	19
Total population	150	195	206	148
Births	5	5	14	12
Deaths	2	-	2	-
No. of attendances at clinic	123	463	192	197
No. of home visits	236	600	927	893
Live Stock	52	101	decreased during year.	84

Native Health Assistants:
Mukutung: P. Sepalela
Bluehill: A.D.Munisi
Kwapelandaba: Frank Mbowana
Singomula: B. Chimsalazo.

Source: South African National Archives, GES 1917, File 47/32, Annual Report, Bushbuckridge Health Unit, 9 September 1947.

[284] South African National Archives, GES 1917, File 47/32, Annual Report, Bushbuckridge Health Unit, 9 September 1947, p. 5.
[285] South African National Archives GES 1917, File 47/32, Annual Report, Bushbuckridge Health Unit, 9 September 1947, p. 5.

One key area where the Wits initiative seemed to focus on was rehabilitation. From 1976 a UN initiative had started several models of Community Based Rehabilitation (CBR) and Workers Training Programmes in the developing world. In 1983 the United Nations Programme of Action laid principles for developing the CBR for the disabled people. The four principles of the programme focused on the improvement of the life of the disabled people, developing their ability to participate in decision making within the community, and enabling them to participate in social and economic development in society, and to receive educational, health and social services assistance and support. The extent of the world 'disabled people' was also explained by Professor M. E. Concha, who was the Director of Community Rehabilitation Research and Education (CORRE), when he said that, it is generally accepted that about 10% of the world's population is disabled in some way."[286] Witwatersrand University became one of the interested tertiary institutions to take an initiative in conducting research programmes in the rural areas in the eastern Transvaal where disability was widespread.

The establishment of the unit called the Community Rehabilitation Research and Education in 1987 was motivated by the existence of disability in Mhala District of Gazankulu. The multi-disciplinary training for rehabilitation workers involved communities. The significance of the unit was explained by Concha, thus:

> The CORRE programme was established to initiate innovative solutions to the delivery of rehabilitation in disadvantaged communities to train relevant personnel and to research the effectiveness of the service then delivered by the trainees, called Community Rehabilitation Workers (CRWs).[287]

It was through the work of Professor Concha that the unit, since its inception managed to establish other new educational programmes and to conduct further research among the loweveld communities.[288] The Community Based Rehabilitation Unit became one of the most important components of primary healthcare since it

[286] M. E. Concha, 'The Introduction of a Training Programme for Community Rehabilitation Workers-Wits/Tintswalo Model', *South African Journal of Occupational Therapy*, 23 (2), November 1993, pp. 38-39.
[287] WRF, C/77, The Community Research and Education Programme, May 2002, Unpaginated.
[288] WRF, C/77. The Community Research and Education Programme, May 2002, Unpaginated.

was set to promote equity in health service delivery. The rehabilitation work was conducted through the utilisation of community health workers to ensure that people with disabilities and other related diseases were dealt with effectively and efficiently. Efforts were also made to see to it that the affected members of the community were able to access health services and opportunities to achieve full integration within the community. One would therefore argue that the Community Based Rehabilitation programme shared similar principles with the primary health care as reflected in its activities and functions.[289]

The visit by a trainer/coordinator of the Community Based Rehabilitation Workers Project, Melanie Alperstein, visited Tintswalo Hospital in 1991 to ensure that the training programme was running effectively. The work of such trainers in rehabilitative primary health ensured the success of the project. The wider reach of the Community Based Rehabilitation Workers programme at Tintswalo Hospital was boosted when the occupational therapist saw the need to extend the project to other villages in the area. Further efforts to empower the communities on primary health care or community health care matters were made when university students were selected from eight villages and one from rural townships to commence the training in February 1991. At the end of training students were awarded a diploma in community rehabilitation.[290]

The Witwatersrand Rural Facility (WRF) was a facility for the University of Witwatersrand which was established in 1989, twelve years after the inception of Alma Ata Conference on primary health care. This facility was established in terms of a suggestion of the Department of Community Health of the University which saw the need to establish out-reach research programmes from the urban to rural communities with specific forms prevailing on the central Lowveld of the former north-eastern Transvaal. It was after the collaboration with the faculty of Health that

[289] WRF, C/68, Speech presented at the Community Rehabilitation Workers Graduation Ceremony by Jimmy Ledwaba, Deputy Director; Rehabilitation and Services, Northern Province 01 December 1999, p.1.
[290] WRF, C/68, Speech presented at the Community Rehabilitation Workers Graduation Ceremony by Jimmy Ledwaba, Deputy Director; Rehabilitation and clinical Services, Northern Province, 01/ 12/ 1999, pp. 1-6.

ultimately the facility was instituted near the Kruger National Park.[291] The facity was established by Professor John Gear who was appointed as a Director of Community Health in the Faculty of Public Health, after Sidney and Emily Kark were invited to the the Wits Medical School to advise on the establishment of this facility.[292]The facility was "…developed in considerable measure along lines inspired by the Karks work at Pholela."[293] The facility became a permanent rural base for students, staff and researchers of the University.[294]

The involvement of the Wits Medical School occurred after the Anglo-American Chairman's Fund made provision for funds to the faculty of rural health development. For a variety of reasons, the government encouraged various medical schools to be actively involved in the development of a cheap and affordable rural community health system to all populations with specific aim of eradicating disease. It was also through the Wits University Department of Community Health that the Mhala district, which was located in the vicinity of Acornhoek and Bushbuckridge in the Gazankulu homeland, was exposed to such health service development.[295]

The mission statement of the facility stated that:

> Wits should, through a permanent presence in a typical rural area create a multi-disciplinary endevour which will inform society of rural needs which will provide a venue for experimental, learning from postgraduate and undergraduate students from a variety of faculties, which will alert Wits graduates to the challenges and rewards of working in such a rural area and immediate communities but South Africa as a whole.[296]

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[291] WRF, Participatory research sustainable livelihoods: A Guide for field projects on adaptive strategies, circa 1990s, p. 1.
[292] S. Marks, 'Response to Anne Digby, 'Debating the Gluckman Commission: A Final Rejoinder', *South African Historical Journal,* 67(1), 18 November 2016, p. 90.
[293] Marks, 'Response to Anne Digby: Debating the Gluckman Commission: A Final Rejoinder', *South African Historical Journal,* 67(1), 2015, p. 90.
[294] WRF, Participatory research sustainable livelihoods: A Guide for field projects on adaptive strategies, circa 1990s, p. 1.
[295] E. Buch, *Do the primary health care nurses in Gazankulu provide second class cheap health care to the poor?* Carnegie Conference Paper, 197, 13-19 April 1984.
[296] WRF, C96/235, 1996 Review of the Wits Rural Facility, Report of the Committee, 1996, p. 1.

The main aim of the facility was to improve the lives of the people in the Lowveld areas including Bushbuckridge and Acornhoek. Tintswalo Hospital which is located at a small country town of Acornhoek in the north eastern Transvaal became an important centre that offered rehabilitation services. This area was targeted because the majority of the people were living under severe poverty conditions, with poor infrastructure, housing, healthcare and other related socio-economic hardships. As part of the homelands of Lebowa and Gazankulu, the areas were socially, economically and politically marginalised by the then National Party government. Malnutrition and diseases such as tuberculosis and malaria were also very common. Since the facility became a training and research centre, the need for the establishment of community health programmes and primary healthcare centres became imperative. The utilisation of the Tintswalo Hospital which became a partner of the Wits Rural Facility remained crucial in the community health development of the area. Since primary health care is a community-orientated programme, the facility also realised that the involvement of ordinary community members through training and awareness campaigns by health workers from Wits/Tintswalo Rural Facility was significant.[297]

In 1993, coordinators from homelands such as Lebowa, Venda, Bophuthatswana and Gazankulu, attended training in rehabilitation held at Alexandra Health Centre outside Johannesburg.[298] This training programme was motivated by the experiences of a variety of socio-economic and socio-political challenges of the disabled or handicapped people. The programme was also based on community development approach, with special attention paid to the economic development of the disabled people for their ultimate integration as part of the communities, most particularly in the outlying rural areas. The training period was scheduled for two years. Since the training was attended by

The participation of Rural Action Group coordinators during training of the local grass roots was also crucial in widening ideas about primary health care in the homelands. During the training session one of the coordinators openly commended the progress

[297] WRF, Participatory research sustainable livelihoods: A Guide for field projects on adaptive strategies, circa 1990s, p. 1.
[298] WRC, C/77, Report on a visit to CBRW Training Program-Tintswalo Hospital N-E Transvaal, 22-26 July 1991, p.15.

made by the occupational therapist, who worked at the local hospital.[299] This was an affirmation of the fact that the rehabilitation was growing rapidly and successfully in the provision of health services to the local communities. The work of community Based Rehabilitation as an outreach programme spread to Winterveld areas in the North-West of Pretoria were the health services were also mostly needed. Tintswalo Hospital and Alexandra health centres remained the most significant pilot training programmes for rehabilitation of the disabled rural population of the Transvaal since their inception. These programmes continued to be assessed by the South African Medical and Dental Council (SAMDC), under the auspices of the University of the Witwatersrand Occupational Therapy Department. In an attempt to sustain the training program carried out by training coordinator, Theresa Lorenzo saw to it that the CRW curriculum was being amended and developed. It was also due to the contribution of Lorenzo that language and culture of the communities, most particularly the Shangaan population was adhered to. This was further capacitated through her proposal for the recruitment of the Shangaan speaking people who were able to speak English as a second language in order to effectively translate particular technical information of the course to facilitate understanding of certain concepts related to the community rehabilitation.[300]

Lorenzo's willingness to work with community members to sustain the programme had far-reaching implications in the history of the Wits Rural Facility programme since the 1990s. This idea could be supported by the following statement:

> There is more than enough expertise in medical rehabilitation, and as Theresa is fast discovering this is not the most important part of a Community Rehabilitation Worker's job description. Teaching counseling and social work skills are also vitally important. In the interest of sustainability an appropriate local person should be recruited as soon as possible. At present everything rests with Theresa who will at some stage leave the area.[301]

[299] WRF, C/77, Report on community based Rehabilitation Workshop, 23rd and 24th June 1993, pp 15-18.
[300] WRF, C/77, The Wits/ Tintswalo rehabilitation workers training program, pp. 3-4.
[301] WRF, C/ 77, The Wits/ Tintswalo rehabilitation workers training program, p. 4.

The explanation regarding the impact of the Community Rehabilitation Work was reflected in the experience of Marist, who was a facilitator of this Rehabilitation programme in the village of Bushbuckridge District in 1989. Marist's experience was about one of the villagers, Maria, who was paralysed during an attack on her as she was on her way from work in August 1989. Crime was rife in the area. The regular visits by Marist ultimately led to Maria being able to walk and actively engaged in the normal daily life activities and accepted as a valued member of the community. Moreover, Maria was encouraged to become involved in assisting other disabled members of the community to walk or perform certain normal activities in the community.[302]

The further commitment of the Wits Rural Facility was reflected in the Statement of Intent of Occupational Therapy issued in 1994. The statement was based on the provision of quality health services to meet the needs of all rural populations within the primary health care approach. The involvement of the community after training programmes had been instituted and facilitated was considered a priority. The growing prevalence of disability in the rural areas forced government to take initiatives in policy development whereby health coordination, monitoring, advise, management and supervision were encouraged.[303]

The contribution of the CBR and other Wits community based programmes, which focused mainly on the poverty-stricken rural black population in the Transvaal, influenced the provision of primary health care services for many years since their inception. This approach had immense influence on governmental health cadres, progressive and non-governmental organisations which utilised the programmes to develop primary health care services of the rural communities in the entire eastern Transvaal.

3.5 Hlatlolanang Community Health and Nutrition Education Centre

Hlatlolanang, which was a health and nutrition centre, was situated at Jane Furse in the Makhuduthamaga Municipality of the Greater Sekhukhune District of the

[302] WRF, C/77, The Impact of CBR Rehabilitation Workshop, 23rd and 24th June 1993, pp.15-18.
[303] WRF, C/77, The Impact of CBR Rehabilitation Workshop, 23rd and 24th June 1993, pp.15-18.

Limpopo province. The centre, which became a dominant institution in the area, was established in 1991 by the "mothers" or women section of the Lutheran Church. The name Hlatlolanang derived from the Bible, Galatians 6.2 meaning "help carry one another's burdens''. The centre was established after the Sekhukhune District was identified as nodal area by the National Party government with the purpose of ensuring that the Rural Development Strategy is implemented. The feasibility of such a location was based on the minimisation or equal distance between varieties of villages.[304] Its role in the provision of health care services and the prevention of diseases could be explained in relation to the various factors which influenced its establishment.

Hlatlolanang was also influenced by the experience of other countries. The knowledge learned from these countries enabled the centre to build a strong foundation in educating the neighbouring communities in Sekhukhuneland. The education and training of these communities was based on nutrition, planting crops, immunisation and other health related preventative measures. Such experiences were considered essential in the strengthening of health management and other health services of which primary health care was considered a meaningful priority. R. M. Mazibuko made reference to Zimbabwe as a neighbouring country where a well-organised Health Information System contributed immensely in the establishment of training needs for the relevant health personnel to implement effective primary health care services, most particularly in the rural areas.[305]

With the help of the Department of Health As a result, Hlatlolanang played a significant role as a primary health care centre since its inception in 1991. The experience of Mankuba Ramalepe of Ithuseng Community Project revealed that Hlatlolanang occurred as a result of the lessons learned from Ithuseng Community Health Centre in Lenyenye. According to Ramalepe, the centre was founded by Rosslyn Mazibuko, with Dr. Aaron Motswaledi as one of the directors of the centre. Unlike Ithuseng Community Health Centre, Hlatlolanang was registered with the Department of Social Development, an indication of government tentative efforts

[304] Hlatlolanang Health and Nutrition Centre, 1991, p. 2.
[305] R. M. Mazibuko, 'From Our Correspondent: Primary health care implementation: Experiences from South Africa', *Community Development Journal*, 28 (3), July 1983, p. 277.

towards assisting in the alleviation of poverty and other related challenges in the entire district of Greater Sekhukhune. Jane Furse, as a semi-rural area was therefore considered as a central area that could provide accessibility to the surrounding rural population.[306]

H.C.J van Rensburg regarded the problem of fragmentation as one of the factors that impeded the smooth development of primary health care in the homelands. Van Rensburg went further to indicate that "the problem of fragmentation occurs where the health care system of a country is divided or segmented according to different internal factors such as race, authority structure and geographical area". As geographical fragmentation contributes to uncoordinated social and economic services, Sekhukhuneland as a whole found itself the victim, which made life difficult for the population. This scenario could also be supported by the view of Van Rensburg when he stated that "Geographic fragmentation may occur, where a country is split into numerous small geographic parts of regions, each with its own say in health care and with little or insufficient co-ordination between the regions and at the central level". It should realised that the population distribution pattern of fragmentation occurred as a result of the physical factor related to rugged mountains as well as historical factors related to the past conflict with the Boers and the British during the 19th century.[307]

Poverty alleviation was considered as a key factor to overcome a variety of socio-economic challenges of the impoverished rural communities in South Africa and it became one of the objectives of Hlatlolanang during the 1990s. In Sekhukhuneland poverty was aggravated by annual rainfall which was exceptionally low.[308] These conditions were also caused by high rainfall variability where the population was depending on the available water from the rivers, most of which were non-perennial. This created disease vulnerability to these rural populations with bilharzia and cholera as the common diseases. In their explanation of problem of water as a contributory factor to a variety of diseases, Wilson and Ramphele stated that:

[306] Interview with M. Ramalepe, Non-Governmental Organization, Community Health. Tzaneen, 21 April 2013.
[307] van Rensburg et al, *Health Care in South Africa: Structure and dynamic*, p. 33.
[308] Interview by W. Maepa with P. Mamogobo, 7517 Anaconda Street, Serala View, Polokwane, 29 January 2015.

> Without clean and drinking water, life can be very precarious. In one Venda village in the Northern Transvaal it was reported that in the twelve months preceding a survey in 1982, ten of the thirty babies born to 86 households had died from comparisons with another village which had access to uncontaminated water piped from sealed fountains and where no babies died, it seems reasonable to conclude even from so small a sample, that the purity of the water significantly affected the children's health. In Kwazulu-Natal a dietician who travelled the length and breadth of the reserves in order to describe conditions and health status in different parts, commented again and again how muddy and dirty the water was.[309]

The establishment of Hlatlolanang was therefore motivated by the escalating statistics of patients with poverty related diseases in the area.

Pam Mamogobo testified about the issue of scarcity of water in Sekhukhune in the 1980s, stating that the problem had been experienced over the years where most of the village people found themselves sharing it with animals, a situation that caused a lot of diseases and deaths.[310] At Ga-Malekana, Ga-Masha, and other villages along the Steelpoort River (Tubatse River), many people were affected by cholera during 1982 and many village populations lost their lives. The dependence on the river was due to the fact that the available boreholes could not effectively support the village people as the pumps were manual and at times went dry. Although nurses in the area were advised to boil the water before drinking, it became evident that in most cases a plea was ignored, and resulting into ill health and other stomach related diseases like diarrhea.[311]

One of the challenges faced by Hlatlolanang Health and Nutrition Education Centre (HNEC) was HIV/AIDS, which affected most of the women, children and youth since its discovery in the 1980s. Similar to other black homelands of northern and eastern Transvaal, the spread of this disease was influenced by the migrant labour system, as most of men were working in Gauteng towns and cities, where they contracted

[309] F. Wilson and M. Ramphele, *Uprooting Poverty: The South African Challenge*, p. 48.
[310] Wilson and Ramphele, *Uprooting Poverty: The South African Challenge*, p. 48.
[311] Hlatlolanang Health and Nutrition Centre, 1991, pp. 2-3.

the disease and brought it to their homes most particularly during the holidays. It was due to this disease that HNEC organised Early Childhood Development Projects, Household Food Security Projects and Nutrition Education. [312]

The importance of educating members of the communities remained one of the objectives of the health care centres as learned from the experiences of Alma Atta Conference on primary health care since 1978. Although the Jane Furse hospital was considered important in the provision of health care services in the surrounding rural villages as a central place, it was recognised that the potential role of the community, not only the medical people was crucial. This realisation regarding the involvement of the communities was also experienced during the early 1990s when there was a major thinking from medical fraternity regarding the prevention of the spread of diseases.[313]

The childhood development project was organised through facilitation in the provision of grants as well as food parcels to the impoverished families where the relevant beneficiaries were carefully identified. Further attempts by Hlatlolanang to improve community health development became evident when the facilitators organised awareness campaigns on socio-economic rights, children's rights and domestic abuse. These steps were taken as a reaction against the socio-economic challenges and poverty related diseases in the communities. One would also realise that the experience of the Valley Trust, Elim Care Groups, Ithuseng and other community centres were influential as it was witnessed by the Hlatlolanang Health and Nutrition Education Centre's attempt to establish Household Food Security Project in the targeted villages around Sekhukhuneland. This was also witnessed when the project agitated the establishment of gardens where vegetables and other related crops were cultivated under the guidance of the experienced facilitators. In order to ramify such knowledge, the centre continued to engage the community members through training as a way of developing outreach workers that would also educate other villages throughout the district.[314]

[312] Hlatlolanang Health and Nutrition Centre, 1991, pp. 2-3.
[313] Hlatlolanang Health and Nutrition Centre, 1991, pp. 2.-3.
[314] Hlatlolanang Health and Nutrition Centre, 1991, p. 3.

> Hlatlolanang had a major contribution to attempts to alleviate poverty in Sekhukhuneland since its inception in the 1990s. The growth of the centre, especially its ability to employ more permanent staff was crucial in the alleviation of poverty. Further growth was reflected in its provision of facilities for workshops, seminars and conferences, which did much to ensure the raising of funds for the centre. The centre had a "hall accommodates 300-seated people, and a seminar room that accommodates 30-seated people. Meals are served from the kitchen facility with a dining hall accommodating up to 100 people".[315]

The tremendous impact of the centre on community health was recognised when it received awards sponsored by Sowetan newspaper, M-Net and Multi-Choice kaleidoscope in 1996 as a way of appreciation and inspiration regarding the development of primary health care in the area. The former President Nelson Mandela and Duke of Kent visited the centre in April 1999. The two prominent figures appreciated the good work done in the alleviation of poverty and the development of primary health care of the rural population of Sekhukhuneland.[316]

3.6 Conclusion

The explanation pertaining to the circumstances surrounding the development of the community health centres in the rural areas of the blacks in the former Transvaal was determined by a variety of social, political and economic conditions. One can therefore realise that it was due to the fragmentation of rural health services that primary health care, which was mainly based on the prevention of the diseases, became the best option in dealing with health challenge in the rural areas of the blacks. As a result, most of the rural blacks found themselves isolated from the rest of South Africa, as the health services were to a great extent reserved for white population groups. The poor infrastructure, unemployment and other undesirable conditions left the population in these areas marginalised and poverty-stricken. It was in this context that the diseases of poverty became a menace.

[315] Hlatlolanang Health and Nutrition Centre, 1991, p. 5.
[316] Hlatlolanang Health and Nutrition Centre, 1991, p. 2.

These challenges motivated many interested parties, organisations and individuals, mostly from the medical fraternity to join hands in attempts to ease the problems. The influence of Pholela led to the establishment of National Health Services Commission, the emergence of initiatives such as the Elim Care Groups, the Wits Rural Facility in the eastern Transvaal, the Ithuseng Community Health Centre in Lenyenye near Tzaneen, the Hlatlolanang Health and Nutrition Education Centre, and other governmental and non-governmental initiatives. The National Party government's reluctance to accept equitable political, social and economic development among rural blacks was a major challenge. The limited or no government intervention in financing the community health centres negatively affected their growth, while diseases and poverty increased. In some instances the organisers of health care projects in these centres were forced to resort to the missionaries and other foreign donors, of which in some instances these funds dried out, leaving the organisers frustrated.

One would therefore argue that although attempts to reform South African health system through the establishment of health centres was made, the deliberate lack of interest by the state impeded such progressive ideas, as evidenced in many years under nationalist government. Most of these centres remained less functional or weakened, while others were forced to close down. However, despite these challenges the idea of community health centres continued to dominate health matters as it was reflected in the new attempt by the state to seriously transform the country's health policies that would provide equal health since the early 1990s, the endeavour which finally became a reality after the inception of the new democratic South Africa on 27 April 1994.

CHAPTER FOUR: MISSIONARIES AND HEALTHCARE DELIVERY IN BLACK COMMUNITIES

4.1 Introduction

Missionary medicine was a pioneer of health services in many parts of rural colonial Africa. As Michael Worboys has noted, colonial medicine advanced and presented itself as a "broader enterprise than I[mperial] T[ropical] M[edicine]"as it included "missionary activity, modernization, and protection of the health and welfare of indigenous peoples". In other words, it was "mission and mandate".[317] In Africa, missionary explorers such as the Scottish-trained doctor, David Livingstone, and medical pioneers such as Albert Schweitzer and Albert Cook are some of the key names that often feature in discussions about the role of medical missions in Africa. Albert Schweitzer believed that "Medical mission was penitential, a means of 'righting the injustice and cruelties that in the course of centuries Africans have suffered at the hands of Europeans. Other mission doctors often imagined illness as a manifestation of spiritual corruption, regarding Africans as inherently diseased and sinful".[318] On his part, the colonial Ugandan healthcare pioneer, Albert Cook, believed that the medical mission was there to attend to the physical sufferings of the Africans, caused by the diseases, which could be solved through a hybrid spiritual and medical approach.[319]

The dual missionary mandate of "healing bodies" and "saving" souls was developed in the colonial frontier as a pragmatic approach to the missionary evangelical enterprise.[320] This chapter outlines the activities of various missionary groups in pioneering 'native health' services in the rural Transvaal during the twentieth century. Across the length and breadth of colonial Africa, missionaries made their mark as

[317] M. Worboys, 'The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940', *Osiris* 2(15), 1991, p.207.
[318] S. Doyle, 'Missionary Medicine and Primary Health care in Uganda: Implications for Universal Health care in Africa', in Medcalf, A., et al, (Eds). *Health for All: The Journey of Universal Health Coverage*, Hyderabad (India): Orient Blackswan, 2015, Ch. 9
[319] Doyle, 'Missionary Medicine and Primary Health Care in Uganda', Ch. 9.
[320] D. Hardiman, *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa,* Amsterdam: Rodopi, 2007.

providers of frontline healthcare services in under-served African communities. However, in South Africa the turn towards apartheid stifled missionary activity in the provision of healthcare services. But as this chapter seeks to show, in the case of the rural Transvaal, when the apartheid state took over the running of medical missions, a variety of missionary groups (there were legion) had – for all their ambiguity – already started entrenching themselves as providers on community-based healthcare services in some localities.

Because of their public image as crusaders of religious modernity and anti-indigenous advocates, missionaries have largely received negative reviews in critical post-colonial literature as they are regarded as part of the broader colonial enterprise. Indeed, quite often missionaries found themselves at loggerheads with indigenous medical systems, which has been a refuge for many blacks even long before colonisation or the arrival of the missionaries on African soil. However, the negative image of medical missions in the literature is being revamped as scholars underscore their critical importance in challenging and forcing the colonial state to adopt certain policy initiatives that would eventually benefit African communities. In Tanganyika, for example, medical missions pioneered "maternal and child healthcare".[321] In colonial Uganda, medical missions played an important role in the "development of a system of primary health care".[322] In South Africa, missionary medical enterprises do not feature quite prominently in the historiography due to the fact that their work was overshadowed when the segregationist apartheid state took over the provision of medical and educational services in its consolidation of a separate development policy. However, what they had done before deserves attention.

4.2 The advent of missionaries in South African society – an overview

In the South African context the role of the missionary societies in the provision of health services can be traced back to the late 18th century when the London Missionary Society became the first to be established after Britain annexed the Cape

[321] M. Jennings, 'Healing of Bodies, Salvation of Souls': Missionary Medicine in Colonial Tanganyika, 1870s-1939', *Journal of Religion in Africa,* 38 (1), 2008, pp. 27-56.
[322] Doyle, 'Missionary Medicine and Primary Health care in Uganda', Ch. 9.

in 1795. Subsequently, other European missionary societies followed suit. This was part of the broader European self-given mandate to civilise the 'uncivilized' and redeem the 'heathens' from wallowing in sin and darkness. The redemptive narrative was the mainstay of the evangelical activities of European origin, including the British, Dutch, German, American, Swedish, and Roman Catholic denominations.

As colonialism started to transform African societies, need became even greater. In the rural Transvaal, the so-called 'reserves' became prime targets of missionary activity. The involvement of these missionary in health service provision filled the health gap left by the state, whose commitment as lethargic. Missionary institutions saw it fit to establish community medicalcentres for the provision of medical support to the communities. Keegan Kautzky's work has highlighted the significance of Elim and Gelukspan in the Transvaal which became the 'seedbed' of the community-based health and development initiatives which enjoyed the active involvement of rural communities.[323] The Care Groups in Elim was one of the most highly effective community health initiatives, which played a major role in the treatment and prevention of eye diseases such trachoma. The different missionary groups and their activities in the Transvaal are discussed below.

4.2.1 Dutch missionaries and healthcare in the Transvaal

Dutch missionary involvement in the health of the black people in the Transvaal can be traced back to 1908 when the *Nederduidz Gerformeerde Kerk* was established at Bochum. Although their main objective was to convert black people to Christianity, health came to be considered by the Dutch missionaries as crucial arena of missionary enterprise. This interest emerged as a result of the prevailing state of poverty and ill-health among the Bahananwa communities under Malebogo, who were marginalised by the Transvaal government when their land was taken and given to the white farmers. As the disease of poverty like tuberculosis was increasing, the 'NG Kerk' saw the need to erect a clinic within the church to overcome the problem. The clinic eventually developed into a hospital which is now called Hellen Franz. The success of the Dutch Missionaries at Bochum paved way

[323] K. A. Kautzky and S. M. Tollman,.'A Perspective on Primary Health Care in South Africa: Primary Health Care: In Context', *South African Health Review*, 2008 (1).

for additional community health centres throughout the Transvaal. The opening of George Steggman Hospital at Saulspoort near Rustenburg in 1938 and a clinic at Gelukspan were other developments that extended the tentacles of Dutch medical missionary enterprise. [324]

Reverend Abram Rousseau was one of the missionaries of the Dutch Reformed Church (DRC) who contributed much in the pioneering of the missionary work in Sekhukhuneland from 1926 to 1940. His gravely illness, when he was serving in the Anglo-Boer War of 1989-1902, motivated him to accept an offer to serve in the evangelist and healing mission after he prayed and was healed (Jordan 2013, 184).[325] Rousseau's work was a broad social responsibility as he managed to build schools and hospitals in the entire Sekhukhuneland area. One of the Dutch missionary hospitals established as a result of his inspiration was Maandagshoek, followed by several other missionary hospitals and congregations from 1946 to 1956.[326] According to G.J. Jordaan's description of the 'integral mission' of the Dutch missionary work, "The different "mainline" churches responded to the needs that they saw, such as sickness and illiteracy, with the resources they had, such as modern health care and education".[327]

In 1940 Dr. S.I. Le Roux started a mission station at Groothoek near Zebediela Estate which became one of the most important hospitals in the area.[328] The missionary health services were extended to the southern portion of Sibasa District of Vendaland where large populations of the Venda and Shangaan-speaking people were residing. Tshilidzini Mission Hospital was established in 1956. Other mission stations established by the 'NG Kerk' in the Transvaal included the Ratanang Mission Hospital near the old Bourke's Luck Gold Mine, Haakdoorndraai about 400 miles from Potgietersrus (Mokopane), a 50-bed tuberculosis treatment centre at

[324] M. Gelfand, *Christian Doctor and Nurse: The History of Medical Mission in South Africa from 1799-1976,* 1984.
[325] G. J. Jordaan, 'The Contribution of the Pioneer Missionary, Reverend AJ Rousseau – 1925 to 1940 to the Dutch Reformed Church (DRC) Mission in Sekhukhuneland', *Dutch Reformed Theological Journal*54 (3 &4), September and December 2013, p.184.
[326] Jordaan, 'The Contribution of the Pioneer Missionary, Reverend A J Rousseau – 1925 to 1940 to the Dutch Reformed Church (DRC) Mission in Sekhukhuneland', p. 192.
[327] Jordaan, 'The Contribution of the Pioneer Missionary, Reverend A J Rousseau – 1925 to 1940 to the Dutch Reformed Church (DRC) Mission in Sekhukhuneland', p.192.
[328] Gelfand, *Christian Doctor and Nurse*, p. 28.

Mogalakwena Mission Hospital completed in 1960, Knobel Mission Hospital near Pietersburg District in 1961, Mandagshoek near Burgersfort in Sekhukhuneland and Metse-A-Bophelo near Trichardsdal in the Tzaneen District.[329]

The Dutch missionary hospital at Tsimanyana, situated about 25km north-east of Groblersdal in Sekhukhuneland also played a prominent role in the provision of primary health care in the surrounding rural communities. These were communities afflicted by the twin evils of disease and poverty. In an interview Pam Mamogobo related her experience of poverty that prevailed in the area during the1960s and 1970s, partly as a result of high unemployment levels and unequal access to resources. As a purely rural and mountainous area, most of the members of these communities were forced to work on the white farms in Groblersdal and Roetan, where they were earning 'below bread level' salaries. Migrants from neighboring countries also added pressure over scarce resources and opportunities.[330]

The medical missionary activities were felt even beyond the boundaries of the Transvaal. Other Dutch Missionary institutions included Thusong Hospital on the farm Shiela in 1968, Elizabeth Ross Mission Hospital in the north-eastern Free State; Nompumelelo Hospital near Ciskei Homeland in 1962; and other hospitals in Zululand. The 'NG Kerk' was of course in competition with other missionary societies who were also keen to establish similar health institutions in order to fulfill their twin aim of saving souls and healing bodies.

4.2.2 The Swiss missionaries and healthcare in the Transvaal

The roots of Swiss missionary activity in Southern Africa can be traced back to the 19th century when its major evangelist work featured in some localities in the region, with the prominent earliest one being the Valdezia settlement on the vicinity of the Soutpansburg mountain range, near Louis Trichardt. Since its inception in the 19th century, Swiss missionary work pre-occupied itself with a variety of issues including

[329] Gelfand, *Christian Doctor and Nurse*, p. 28.
[330] Interview with P. Mamogobo, Polokwane, 21 January 2016.

ethnographic work, knowledge production, and health.[331] Henri-AlexandreJunod and his son are some of the key names; while Elim is a key Swiss missionary endeavour in the history of rural South Africa. Like other missionary denominations, the Swiss considered healthcare to be a useful componentof Christian values.

Elim Mission Hospital is the most popular Swiss Missionary establishment in the Transvaal. It originated in the 1890s as part of the activities of the Mission Romande, which sponsored the founder of the hospital, Dr Georges Liengme.[332] According to Hines Mabika, “The Swiss took advantage of the local authorities' negligence, and implemented their own model of medicalization of African societies, understood as the way of improving health standards”.[333] The Elim Mission Hospital was pioneering in running a model of rural eye care service, serving a large community afflicted by trachoma. Since this eye disease was classified as one of the diseases of poverty, the initiative of the hospital to provide preventative and promotive health activities was to a large extent directed towards community needs, most particularly the ordinary poverty-stricken rural population. Elim became the centre of a community health care initiative called the Elim Care Groups. Valdezia clinic predated Elim Mission Hospital. The Swiss spread their tentacles to a number of localities in the Transvaal especially where the Tsonga people were found. They set-up stations in areas such as Shiluvane (near Tzaneen) and Masana (in Bushbuckridge).

Like other institutions of missionary origin, Masana started as a church aiming at spreading Christianity to the natives in the surrounding district. However, existing health challenges paved way for the establishment of a clinic in 1934, with the help of resident missionary Reverend A.A. Jaques, assisted by Miss A. Berry.[334] The establishment of the Masana Hospital (now known as Mapulaneng Hospital) added impetus to the contribution of Swiss missionary activities on health matters. The hospital was established in 1937 as a result of the increasing demand for health care services by surrounding communities. Swiss missions remained an important player

[331] P. Harries, *Butterflies and Barbarians: Swiss Missionaries and Systems of Knowledge in South Africa*, Ohio University Press, 2007.
[332] H. Mabika, ‘History of Community Health in Africa. The Swiss Medical Missionaries' Endeavour in South Africa’, *Gesnerus* 72(1), 2015, p. 135.
[333] Mabika, ‘History of Community Health in Africa’, p. 135.
[334] Gelfand, *Christian Doctor and Nurse*

in the provision of health services until the take-over of such healthcare institutions by the apartheid state.

4.2.3 The Berlin missionaries and healthcare in the Transvaal

The Berlin Missionary Society of the Lutheran Church from Germany was one of the European missionary societies that directed their focus on the southern African region from the 19th century onwards. Just like other missionary establishments, its primary aim was the conversion of Africans to Christianity as Africans were generally perceived as being heathens and uncivilised. In order to facilitate its work properly, a variety of dioceses were established to serve the Africans through Christian education. The health services were considered at a later stage when it was realised that poor health, poverty, diseases were becoming a menacing threat to the African communities.

P. N. Mehlape, a long serving member of the Lutheran Church and a historian, revealed that there were seven dioceses which emerged from the Berlin Missionary Society. These dioceses included the Scandinavian Lutheran missionaries who worked among the Zulu communities in the South-Eastern diocese in Zululand; the Moravian Lutheran Missionaries who worked among the Tswana speaking people under Western diocese; the Northern Diocese for the Bapedi and the Venda in the Northern Transvaal; the Cape-Orange Diocese for the Coloureds in the Cape; the Botswana diocese for the Tswana people in the West; the Eastern diocese for the Swazi's and the Central diocese for Johannesburg and surrounding areas. [335]

One of the most important Berlin Mission Stations was Masealama, situated about 50kms from Polokwane. This missionary centre was established during the early 1920s. The missionaries in this area saw the need to extend their services from religion and education to community health development; hence a health centre was established.

[335] Interview with Mehlape P N. Lutheran Church, Mankweng Township, Sovenga, 24 March 2007.

Photograph 8: *Lutheran Missionary Health centre buildings at Masealama, Mankweng Area.*

Photograph credits: Photograph taken by author.

Other health centres were established throughout the entire rural areas of the Northern Transvaal. These health centres were subsequently closed during the 1990s due to financial constraints as most of the overseas donors withdrew their funding. Masealama Health Centre was also forced to close down during the early 2000s when the German donors and other funders withdrew their donations.[336]

4.2.4 The Methodist missionaries and healthcare

The Methodist Christian Church, as one of the protestant churches had its origin from Scotland, founded by Reverend John Wesley during the 18th century. John Wesley was supported by his brother, Charles Wesley and the lay people in the preaching ministry in churches, homes and open spaces.[337] Methodism was introduced in South Africa in the early 19th century and eventually planted in Warmbath before spreading to other areas in the Transvaal, such as Soutpansberg,

[336] Interview with P. N. Mehlape, Lutheran Church, Mankweng Township, Sovenga, 24 March 2007.
[337] M.W. Leleki, 'The Methodist Church and Society in Transvaal (1948-1976)', Dissertation submitted in fulfillment of the requirements for MAGISTER ARTIUM in the Faculty of Theology, University of Pretoria, 2003. .

Waterberg, and Sekhukhuneland.[338] The Methodist missionary interest in healing matters in Southern Africa was motivated by the poverty and racial inequalities and resultant diseases among the blacks. This was an opportunity for them to evangelise through making meaningful change in people's lives. Dr. Robert Douglas Aitken spearheaded the health activities of the Methodist Church in South Africa and the Northern Transvaal communities. His arrival at Gooldville, in Sibasa area, in the Vendaland in January 1933 marked the beginning of his missionary work, which was also based on spreading Christianity with education and health care as part of the church's mission. His studies as a scientist, botanist, and medical doctor, paved way for his work serving the needs of various black communities in and around Sibasa.

In order to achieve his goals of providing healthcare services to the blacks, he converted some of the buildings left by a doctor who had stayed there for many years, to create a consulting room and dispensary. Further developments were made, including the renovation of dilapidated mission house and its extension into what became known as the Donald Frazer Hospital.[339]The role of Methodist Church in the Northern Transvaal since 1930s had far-reaching implications in the development of community health care services of the rural blacks, at least in their area of focus.The number of clinics, hospital beds, nurses and nurses' homes, doctors funding and infrastructure expanded between the 1950s and 1960s.

4.2.5 Catholic missionaries and rural health

The Roman Catholic Missionary work, like other European churches had its objective of civilising and converting the so-called 'uncivilised world' into Christianity. However, education and healthcare also fast became major priorities as reflected in many colonies in Africa. In South Africa, the Roman Catholic Church managed to accumulate many followers in all four provinces since the Union Government came into being in 1910. In the Transvaal, the church's mission expanded rapidly in rural communities. This expansion was evident among the Venda, Tsonga, Pedi, Ndebele, Tswana and the Swazi speaking populations, most of who were residing in segregated areas where poverty was rife and state neglect quite prominent. The

[338] https://Methodist.org.za) accessed on 28 June 2018.
[339] Gelfand, *Christian Doctor and Nurse*, p. 225.

establishment of Catholic clinics and schools within the church's lands allocated by the government was significant.

By the 1930s in the Transvaal, many Catholic missions with schools and health centres were already in existence.[340] Although the main catholic centres were located in the urban areas, their missionary work had spread to the surrounding rural villages where their social services were desperately needed due to high levels of poverty and disease. The St. Vincent Hospital in Warmbath was one of the main Catholic hospitals which played a major role in the provision of medical services to the surrounding Tswana, Pedi and other ethnic and racial groups who migrated to this area in search for jobs. The name St. Vincent was considered because of sisters of charity, who had St. Vincent as an apostle of destitute and the poor as their auxiliary nurses and midwives. The hospital had a long history as it played a major role in the provision of medical services to South African Defense Force servicemen who were injured during the Second World War. The provision of nurses as well as the training of additional nurses to run the hospital stimulated the development of community health in the area and elsewhere in the Northern Transvaal.[341]

Apart from St. Vincent Hospital in Warmbath (presently Bela-bela), other mission stations adopted similar models, but most popular in the form of clinics and schools. At Subiaco, located about 45km east of Pietersburg, was a primary school and a clinic which were crucial in the provision of services to the surrounding villages of Ga-Molepo and Ga-Mothapo. The takeover of missionary social services in 1973 however, led to the closure of the clinic during the 1980s, while the school remained. Other places include Motse Maria near Pietersburg, Glen Cowie in Sekhukhuneland, and many other Catholic health centres in the Transvaal.

4.2.6 The Anglican missionaries and Healthcare

The Anglican Missionaries also played a vital role in the development of community health services in the Transvaal. Although their contributions were minimal as compared to other missionary organisations, Jane Furse Memorial Hospital, located

[340] Gelfand, *Christian Doctor and Nurse,* p. 231.
[341] Gelfand, *Christian Doctor and Nurse,* p. 223.

east of Groblersdal in Sekhukhuneland emerged as the most important health institution that played a vital role in the provision of health services throughout Sekhukhuneland over the years since its establishment. The growth of this hospital was associated with the growing population in the rest of Sekhukhuneland, during the 20th century, which subsequently influenced the need for additional clinics in the area. Pam Mamogobo has argued that although racial discrimination was still a stumbling block in the improvement of health services in the area, the efforts of these missionary doctors and other staff members played an immense contribution in the development and growth of black communities in Sekhukhuneland.[342]

Photograph 9. *The older buildings of Jane Furse Memorial Hospital.*

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Source:www.outdoorphoto.community.com, Jane Furse Hospital Boiler // Outdoor Photo Gallery, Accessed on 22 August 2016.

4.2.7: The state takeover of missionary health institutions

Although the above discussed missionary enterprises had done a great deal of groundwork in the area of health service provision, these efforts were frustrated by

[342] Interview with P. Mamogobo, 7517 Anaconda Street, Serala View, Polokwane, 21 February 2016.

the state's intervention in health matters from the 1970s onwards. From that period, the apartheid state started the process of taking over missionary health institutions like clinics and hospitals. The takeover of missionary hospitals and other health centres occurred in 1973 when missionary institutions were placed under the homelands under the jurisdiction of the Department of Bantu Administration and Development. Since the homelands were financially dependent on the Central Government, it became a clear the apartheid state would be in total charge. Although requests for building more hospitals in the homelands were made, the shortage of funds, doctors and nurses remained crucial challenges. Some of the hospitals formerly run by missionaries closed down due to lack of enough resources.

4.3 Conclusion

This chapter has shown that the Transvaal province was a very popular destination for missionary establishments that competed with each other in proving health services to the needy blacks. These faith-based organisations of European origin were instrumental in the building of clinics and hospitals. With financial support from Western countries, and streamlined services, missionaries were able to sustain their programmes effectively. Their successes were also made possible by their ability to train nurses and other members of the communities as health workers responsible for the prevention of diseases. These missionary efforts were ultimately hampered when their institutions were taken over by the apartheid government in 1973, and placed under homelands. By the time this happened however, missionaries had set themselves a reputation as being providers of frontline community healthcare.

CHAPTER FIVE: THE ADVENT OF THE APARTHEID ERA AND CHANGES IN RURAL HEALTH CARE, 1948 – 1977

5.1 Introduction

This chapter explores the impact of the advent of apartheid on the healthcare service provision for rural blacks in the Transvaal since the 1950s.

As has been noted earlier, the economic conditions of blacks, which resulted in the increase in the disease burden, had during the 1930s and 1940s, prompted the Union Department of Health to attempt to restructure the healthcare services in order to improve provision and access. This resulted in tentative steps being taken towards the creation of a national health care service system. However, the separate development policies of the new apartheid masterminds led to the disruption of this process. This chapter explores these developments and comments on their nature and impact.

5.2 Apartheid and healthcare in historiographical perspective

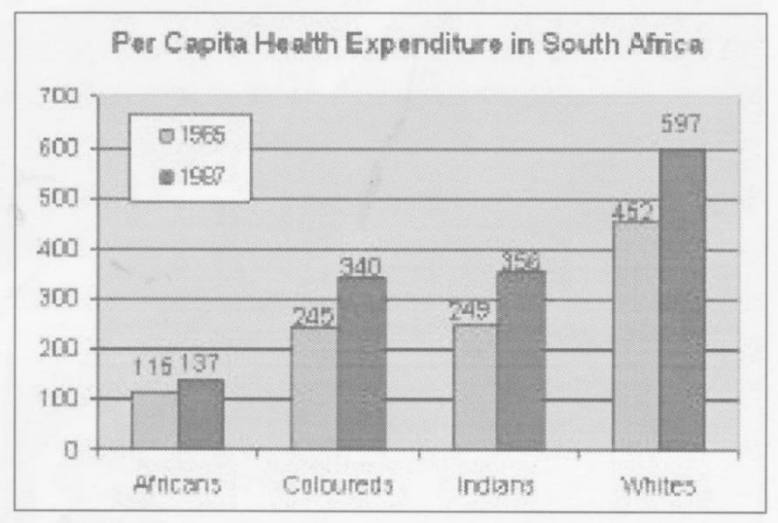
Apartheid health policies have been subject to continuing scholarly interest and there is a large body of historical work on this period. Scholars have been roundly critical of apartheid health policies, which not only reversed earlier gains in healthcare development, but also led to further deterioration of health conditions in the country. In his book titled *South African Disease: Apartheid and Health Services,* Cedric de Beer makes an interesting analysis of the relationship between social injustice and ill health in South Africa during segregation.[343] The racial discrimination and apartheid policies since the 1948 election created conditions for the increase of diseases associated with poverty. Tuberculosis was among the most notorious of those diseases, which caused a great deal of ill-health and high mortality among blacks due to the migrant labour system in the Transvaal mines. De Beer refers to the spread of this disease from the mines to the rural areas and the failure of the apartheid authorities to put in place adequate measures. De Beer further

[343] C. de Beer, *The South African Disease: Apartheid and Health Services,* Trenton, N.J., Africa World Press, 1984.

emphasises how apartheid marginalised blacks socially, economically and politically, particularly in the homelands, a situation that fostered the occurrence of diseases at alarming rates.[344] Tackling these diseases through community or primary health care, with the establishment of clinics, hospitals and community health centres, did not receive enough attention, as the focus of the apartheid state was to divide the country into several ethnic republics.[345]

Simone Horwitz's chapter contribution *"Health and Health Care under Apartheid"* highlights some of the major negative features of apartheid health care system during the period of its entrenchment from 1948 to the 1970s in relation to the inequality of health services between blacks and whites. Because the health of blacks was devolved to newly created homeland administrations, health workers battled to deal with overcrowding of the black patients in the poorly resourced homeland health institutions. This inequality is clearly indicated in Illustration 6 below, which shows a low level of African (black) expenditure between 1965 and 1987, followed by the coloureds, and then Indians, with the whites showing the highest per capital expenditure. The underfunded blacks were exposed to the diseases of which tuberculosis spread by the mine workers also increased ill-health and death.[346]

Illustration 7. *Per Capita Health Expenditure in South Africa, 1948-1970s.*



Source: S. Horwitz, *Health and Health Care under apartheid*.

[344] de Beer, The *South African Disease, Apartheid and Health Services*, p. 55.
[345] de Beer, The *South African Disease, Apartheid and Health Services*, p. 58.
[346] S. Horwitz, *Health and Health Care under apartheid*, p. 1.

The article written by Shula Marks and Neil Andersson entitled 'Issues in the Political Economy of Health in Southern Africa', and published in a special edition of the *Journal of Southern African Studies,* adopts a political economy approach to black health during apartheid. The two scholars show that the poor health profile of blacks was linked to their socio-economic status, which came about because of active policy of discrimination and neglect by the apartheid state. The National Party's short-lived health reform strategy was designed to cool down black discontent as violence surged in the context of increases in preventable diseases.[347]

Anne Digby has also analysed the effects of apartheid on the health care system for blacks. Although acknowledging the negative developments of this period, Digby also shines a spotlight on the innovative, integrated health care policies adopted by some homeland governments from the 1970s to the 1990s, as they attempted to extend primary health care services to the remote rural areas. Digby highlights the the prioritisation of health care and expansion of a network of clinics and other health centres in the homelands and the assistance in the provision of resources to promote preventative health services.[348] Nevertheless, her analysis also highlights the little funds allocated by the state to the homelands administrations, which had a negative impact on the prevention of the diseases such as cholera, malaria, polio, typhoid, tuberculosis, and HIV/AIDS during the 1980s.[349]

A common denominator of much of the recent literature is that the roots of South Africa's contemporary healthcare challenges and the dysfunctional system that is failing to address the challenges can be traced back to, mostly, the period of racial subjugation and apartheid.[350]

By the time the right-wing Afrikaner Nationalist Party took over power in 1948, various forms of racial discrimination against blacks had been in existence for a long time. However, from the early 20th century the process got intensified and codified.

[347] S. Marks and N. Andersson, 'Issues of Health in Southern African Studies', *Journal* of *Southern African Studies*, 13(2), p.178.
[348] A. Digby, 'The Bandwagon of Golden Opportunities'? Healthcare in South Africa's Bantustan Periphery', *South African Historical Journal*, 64(4), pp. 827-828.
[349] Digby, 'The Bandwagon of Golden Opportunities bantustan Periphery', p. 833.
[350] H. Coovadia et al, "The Health and Health System of South Africa: Historical Roots of Current Public Health Challenges", *Lancet*, 374 (2009), pp. 817-834.

From 1913, the Union government passed a series of legislation and policies that set into motion processes of discrimination. As noted by Van Rensburg in his book *Health Care in South Africa: Structure and Dynamics*:

> In the field of health care, apartheid likewise existed long before 1948 in the form of separate health authorities and separate hospitals, wards, clinics and consulting rooms for whites and non-whites and unequal treatment of the respective colour groups also manifested itself in the form of, for instance, unequal provision for and access to care, differential availability and quality, and the disproportionate distribution of manpower, services and facilities according to race or colour.[351]

However, the 1948 elections, which led to the victory of National Party under Dr. D.F. Malan, brought about an entirely new dynamic. The period after 1948 had a significant impact on the political, social and economic situation of black people who suddenly endured new forms of marginalisation and ideological separation from whites. A variety of segregationist apartheid laws were passed in order to strengthen and legitimise racial segregation through legal means. These legislative policies were reflected through separate residential areas, schools, amenities, marriages, recreational places, churches, health facilities, property ownership and other spheres of life. Gradually, blacks found themselves as victims of the renewed form of legislated segregation, which condemned them to the reserves and, later the homelands.

Some of the repugnant apartheid laws included the Immorality Act, Act No. 21 of 1950 which prohibited sexual relations between blacks and whites, the Suppression of Communist Act No. 44 of 1950 which deemed communist Party and other related formations as unlawful, the Group Areas Act No. 41 of 1950, which made provision for separate residential areas between various racial groups, the Population Registration Act No. 30 of 1950 which classified the South Africans into racial groups, and Bantu Authorities Act No. 68 of 1951 which attempted to keep South Africans apart whereby blacks were confined to different ethnic areas called

[351] H.C.J. van Rensburg et al, *Health Care in South Africa: Structure and Dynamics*, p. 64.

homelands. Other laws included the Separate Representation of Voters Act No. 52 of 1951, the Natives Laws Amendment Act of 1952, the Natives (Abolition of Passes and Co-ordination of Documents) Act, No. 67 of 1952, the Native Labour (Settlement of Disputes) Act of 1953, the Public Safety Act of 1953, the Criminal Laws Amendment Act No. 8 of 1953, the Bantu Education Act No. 47 of 1953 and the Reservation of Separate Amenities Act No. 49 of 1953. These pieces of legislation had a direct and indirect impact on the development of health of the black people since they promoted unequal allocation of the resources such as infrastructure, education, jobs, public amenities such as parks and beaches, and health facilities.[352]

The repressive and oppressive attitudes of the National Party government were entrenched massively during the 1950s; hence the slow pace in the development of community healthcare services by those in the medical field who supported reform measures as they were restricted by legislations.

5.3 Fragmentation of health care services in the homelands

The creation of the homelands or Bantustans was aimed at transforming or extending the old 'African reserves' where blacks were placed on separate lands based on different ethnic groups as depicted in the table below (Table 6).[353] These fragmented ethnic groups consisted of a,

> … chain of 91 blocks of territory stretching from the Northern Cape, through the Transvaal, Zululand and Natal to the Transkei and Ciskei. Nearly seven out of 15 million Africans lived there in 1970, and this had swelled to almost 13 million by 1985.[354]

This new territorial alignment had a negative impact on the health services of the homelands. As a result, the Department of Health and Welfare in the homelands realised that the only way to manage this challenge was through the implementation

[352] South African History on Line: *Towards a People's History*, The History of Separate Development in South Africa, www.sahistory.org.za, 19 September 1917, Unpaginated.
[353] Digby, 'The Bandwagon of Golden Opportunities'? p. 828.
[354] Digby, 'The Bandwagon of Golden Opportunities'?, pp. 828-829.

of comprehensive and integrated community-based health care services, with the prioritisation of promotive and preventative medicine.[355]

Illustration 8: *A list of homelands in relation to population and per capita income in the 1970s and early 1980s.*

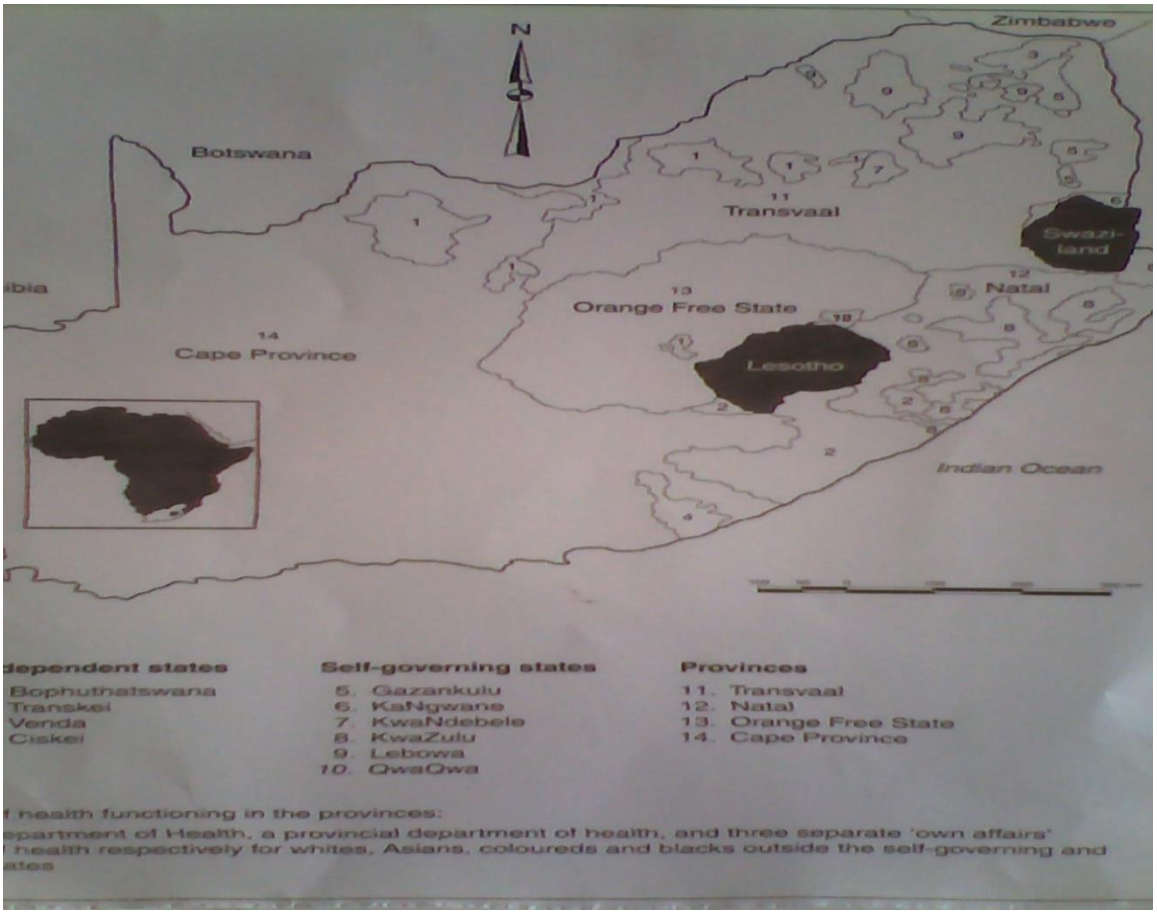
Bantustan	*'Self-government' or * 'independence'*	*Delegated power over healthcare*	*Designated African population group*	*De facto population in 1970 (000s)*	*Per capita income in 1976*
Bophuthatswana	1972*1977	1975	Tswana	884.2	381
Ciskei	1972*1981	1975	Xhosa	523.6	262
Gazankulu	1973	1976	Shangaan/ Tsonga	267.4	338
KaNgwane	1981	1984	Swazi	NA	293
KwaNdebele	1981	1984	Ndebele	NA	NA
KwaZulu	1977	1977	Zulu	2,096.9	357
Lebowa	1971	1976	N. Sotho	1,084.3	279
QwaQwa	1974	1977	S. Sotho	24.7	209
Transkei	1969*1976	1973	Xhosa	1,733.9	281
Venda	1973*1979	1976	Venda	264.5	270

Source: A. Digby, 'The Bandwagon of Golden Opportunities'? Healthcare in South Africa's Bantustan Periphery', *South African Historical Journal,* 64(4), December 2012

The creation of homelands intensified the fragmentation of the country's healthcare services, with dire consequences for the rural black population. It was through the 1960s and 1970s that such 'black spots' as popularly known by the historians, were created, namely: the ten homelands of which Venda, Transkei, Bophuthatswana, Ciskei became fully independent. The remaining six included: Lebowa, KwaZulu, Gazankulu, Qwaqwa, KaNgwane and KwaNdebele which remained self-governing states, with other departments still under the control of central government in Pretoria. This arrangement was aiming at the eventual complete independence that would disprove all blacks from being citizens of the Republic of South Africa but of the respective homelands where they could practice their own political, social, cultural and economic affairs.[356] This arrangement caused fragmentation as depicted in the map below (Map. 3):

[355] Digby, 'The Bandwagon of Golden Opportunities'?, p. 829.
[356] van Rensburg et al, *Health Care in South Africa. Structure and Dynamics*, p. 65.

Map 3: *Apartheid in South Africa's political boundaries, with four provinces, four independent homelands and six self-governing homelands.*



Source: H.C.J. van Rensburg et al*, Health and Health Care in South Africa*.

The 1970s were associated with rapid population growth in the homelands which, in turn, created overcrowding and other social ills which created many diseases associated with poverty. As van Rensburg has stated:

> These desperate conditions have since converted the homelands into lasting reservoirs of poor health and disease - principally, the typical diseases of poverty and poor living conditions such as diphtheria, typhoid, cholera and respiratory ailments, measles, malaria, bilharzias, trachoma, gastro-enteritis, nutritional deficiency disease, especially Kwashiorkor and Marasmus.[357]

[357] van Rensburg et al, *Health Care in South Africa. Structure and Dynamics*, p. 66.

The general implication of the situation in the homelands, both self-governing and independent was that there was a need to improve health care services in these areas, which were mostly rural. The fact that the homelands were financially depending on the central government made it impossible to effectively provide health services to their populations as the allocated budget was usually insufficient and tightly controlled. In order to remedy the situation, Gazankulu, Kwazulu and Bophuthatswana committed themselves to a community medicine approach based on preventative primary healthcare rather than purely hospital-based curative medicine. In 1977 the Gazankulu government introduced a Five-Year Health Service Plan which was to be piloted in 18 health centres with the specific objective of providing comprehensive primary health care services to everyone in the homeland. It became evident that this endeavour could not be easily achieved due to insufficient funds to sustain health care services in the entire homeland. According to Cedric de Beer:

> Between 1976 and 1977, the South African government's contribution to Gazankulu's health budget declined from R6,3 million to R5,7 million. The 1981 budget was 7-million of which 68% was earmarked for existing hospital services and another 10% for existing clinics and health centres.[358]

The lack of funds was also felt in other homelands throughout the country as it happened in Bophuthatswana when in 1981 the report by a senior official revealed that 400 villages were without clinics. A similar situation was reported by the head of the Department of Community Medicine of Natal Medical School. The report reflected that Kwazulu homeland could not manage to build additional 200 clinics due to insufficient budget allocated by the South African government.[359]

Selina Maphorogo explained that the introduction of the 1977 Service Plan in Gazankulu was influenced by the promulgation of the 1977 Health Plan by the National Party government. She indicated that other homelands in South Africa were

[358] de Beer, *The South African Disease: Apartheid Health and Health Services*, p. 58.
[359] de Beer, *The South African Disease: Apartheid Health and Health Services*, p. 58.

influenced by the Gazankulu Service Plan despite the South African government's reluctance to effect meaningful health reforms for the rural blacks.[360]

To remedy some of its glaring deficiencies, the state deployed army personnel to deal with aspects of healthcare delivery in rural villages. The medical section of the South African Force had played a vital role in the community health development since 1945 as the incidents of diseases among blacks were escalating due to post-war economic constraints. [361] The military medical officers were mostly used where there were staff shortages. For example, when the officers of the health service from Pietersburg (Polokwane) visited several hospitals in Lebowa in 1978, they found that a military medical officer was left in charge of St. Ritas Hospital near Jane Furse in Sekhukhuneland while the Superintendent was on leave. At Metse-a-Bophelo the staff shortages were resolved with the addition of two military medical officers.[362]

In Lebowa, Venda, KwaNdebele and Bophuthatswana as well as other areas where the majority of blacks resided, soldier doctors were sent to the schools, hospitals and clinics to perform health services to the needy as a result of a shortage of doctors and nurses. One should note however that the use of these soldier doctors was also aimed at pacifying the black communities as the resistance against apartheid was showing an upward trend; nonetheless it helped a great deal in the provision of health services in the context of shortage of regular personnel. Their provision of food parcels, medicines, vaccinations, campaigns and other immunisation services was crucial.[363]

The fragmentation of the homelands had a negative impact on the lives of the homeland population in relation to the provision of primary health care services. This state of affairs became evident with regard to the scattered distribution of clinics and hospitals, which, in turn, impacted on the provision of primary health care services. It is crucial to note that hospitals, as health care centres, played a crucial role in the

[360] Interview with S. Maphorogo, Elim Care Group Centre, Waterval, Louis Trichardt, 10 March 2007.
[361] de Beer, *The South African Disease: Apartheid Health and Health Services*, pp. 59-60.
[362] Limpopo Provincial Archives, Box 21, File16/2, Medical and Preventative Medicine, The Visits to Lebowa Hospitals January to July 1978, 14 August 1978, pp. 1-3.
[363] W. Maepa's personal experience as a former Lebowa homeland citizen during the 1970s and 1980s.

support and the provision of community-based healthcare services as well as to create a balance between curative and preventative health service delivery.[364]

The regionalisation process in the homelands aggravated challenges in the development of basic healthcare services. Hospitals remained crucial in the provision of basic healthcare services as doctors, nurses and other health practitioners were supposed to know the various health challenges as well as other related issues pertaining to social, cultural, economic and status of the surrounding population. The homeland system was significant in the division of people in terms of ethnic groups, and by so doing, aggravating unequal access to health services.

The experience of Shiluvane Hospital, situated near Tzaneen in the Northern Transvaal, was typical example of the effect of regionalisation in the homelands which aggravated such imbalances. The hospital was controlled by Lebowa government from 1976-1981 and was later handed over to Gazankulu homeland by the South African government. Such intervention created divisions as the area was inhabited by both the Pedi and Shangaan-speaking population. The frustration became evident when the Lebowa Department of Health established Dr C.N. Phatudi Hospital, about five kilometers north east of Shiluvane Hospital, a situation that compelled the Pedi hospital staff and patients to be transferred to the new hospital. The challenges that already existed in terms of community health service delivery were accelerated by such divisions, thus hampering the expected positive implementation of primary health care programmes already in place.[365]

The experience of fragmentation of health services in the two districts, Mapulaneng and Mhala, situated side by side by the apartheid homeland system also illustrated how the development of health services to the already impoverished rural communities of the former Transvaal was undermined. Mhala belonged to Gazankulu homeland which was inhabited the majority of the Shangaan ethnic group, while Mapulaneng was given to Lebowa with the Sotho-speaking majority. The homeland policy in these two districts created many problems because it broke up health services and created divisions and social ills between the people. A study

[364] van Rensburg et al, *Health Care in South Africa. Structure and Dynamics*, pp. 228-230.
.[365] E. Buch et al, *A National Health Service for South Africa Part 1*, pp. 48- *49.*

conducted by the Institute for Development Studies of the Rand Afrikaans University during the early 1980s at the Mhala has showed that the homeland had widespread of poverty associated with problems of land, food, water, transport and education, which in turn created poverty-related diseases.[366]

Map 4: *The homeland districts of Mhala and Mapulaneng (Bushbuckridge).*

Source: E. Buch et al, *A National Health Service for South Africa Part 1: The Case for Change.*

Tintswalo Hospital was situated in the Mhala District of Gazankulu homeland while Masana was located in the Mapulaneng District of Lebowa as reflected on the above map. The geographical location of the two hospitals depicts how fragmentation impacted negatively on the provision of health services to communities. Before homelands were created there was a coordination and communication of services to all people in the region without ethnic segregation, but this scenario changed

[366] Buch et al, *A National Health Service for South Africa Part 1*, pp. 26-27.

thereafter. Since the two homelands overlap and penetrated each other in terms of human settlement, confusion always existed as the Shangaan population, who happened to be located closer to Masana Hospital were frustrated when they had to travel long distances to Tintswalo Hospital situated in the north-eastern corner of the district bordering Mapulaneng District of Lebowa. On the other hand, the Pulana people of Lebowa experienced similar problems when they had to travel to Masana which was located far south of the district.[367]

According to Cedric de Beer and Eric Buch in their paper titled *Health and Health Care in Mhala:*

> The hospitals no longer co-ordinate policy, for example, when health workers at Tintswalo approached Masana for working together in the care of the TB patients, they were told,"Gazankulu can do what it wants to, but Masana will follow Lebowa's policy." During the polio epidemic, health workers at Tintswalo wanted to run a joint immunization campaign with Masana. But they were told that they should run their own immunization campaign, and Masana, in turn would run its own. Even in the face of an epidemic, the fragmentation of health services was carried on.[368]

This state of affairs led to the administrative and financial constraints in the two homelands. The clinics in the area found themselves supporting communities belonging to the two different authorities, thus complicating the administration and management of both homelands' Departments of Health. In the publication entitled: *A National Health Service for South Africa Part 1: The Case for Change*, de Beer et al explained that:

> In addition, attempts to cooperate in the development of Tuberculosis programmes and a mass immunization campaign in the face of a polio

[367] Buch et al, *A National Health Service for South Africa Part 1,* p. 49
[368] C. de Beer and E. Buch, 'Health and Health Care in Mhala', Paper presented at The Second Carnegie Inquiry into Poverty in Southern Africa, April 1984, p. 38.

epidemic in the area in 1982, both floundered on the fact the hospitals were answerable to different authorities.[369]

The fragmentation in this respect also frustrated the system of home visits to the patients by the nurses and other health care teams to either side of the districts. The referral system of patients to the hospitals worsened and further complicated the provision of community health services. Mapulaneng and Tintswalo Hospitals represented a clear illustration of how the homeland system destabilised the intended ideas of primary health care, which was seen as a viable way of solving a variety of health problems of rural blacks in the area.[370]

5.4 The politics of the early 1970s and Health Act 63 of 1977

Since the social organisation of South African medicine was mainly white-centred, the training of nurses and doctors was done at different or separate institutions, which also created unequal provision of health services, finances, and other resources relative to health matters. This political norm became an inevitable breeding ground for unequal physical capacities, physical quality and the poor quality of care offered by the state.[371] The opening of Durban Medical School in 1951 was aiming at the training of black students–Africans, Indians and coloureds, who were from different provinces of South Africa. Although the institution was segregated from the white medical students which had a separate campus, the medical degree offered to blacks was recognised on an equal basis, with those provided by the country's white medical schools, and the degree also allowed students to register with the South African Medical and Dental Council, which was responsible for the regulation of practice of medicine in South Africa. Most of the former students of the institution produced the most prominent leaders who played significant roles in the resistance against apartheid. Some of these leaders included: Dr. Aaron Motswaledi, Professor Malegapuru Makgoba, Dr Nkosazana Dlamini Zuma, Dr. Frank Mdlalose, Dr Mamphela Ramphele, and Dr Ben Ngubane.[372] On the other hand, the Medical University of South Africa (MEDUNSA), which was opened in the late 1970s also

[369] Buch et al, *A National Health Service for South Africa Part 1,* p. 49.
[370] Buch et al, *A National Health Service for South Africa Part 1*, p. 49.
[371] Buch et al, *A National Health Service for South Africa Part 1*, pp. 47-48.
[372] V. Noble, *A School of Struggle*, pp. 2 & 4.

played a major role in the provision of community health care services of the blacks, both in the rural and township areas in the Transvaal. Although MEDUNSA was a creation of another apartheid medical institution, the aim of the state was to alleviate the shortage of black doctors as the state hoped to create black health professionals in health sciences.[373]

Cedric de Beer commended that: "The Township revolts of 1976-77 forced the government onto defensive for the first time in many years"[374] Kathleen Dennil argued that the economic recession in the 1970s was also influential in the state's move to the direction of self-reliance and privatisation of health to overcome financial challenges. A comprehensive approach, with preventative community-based health care was considered a priority by the state.[375] This became evident when the Health Act 63 of 1977 was promulgated with the aim of rationalising health organisations and promoting community health care services by statutory means. It was in this respect that the state saw the need to emphasise preventative health care as well as the establishment of community health centres.[376]

It was also during the second half of the 1970s that Marais Malan, *The Star's* Science Editor, indicated that: "South African medicine must be directed out to the millions more from the point of view of preventive health rather than costly outlay for curative services for the few."[377] Malan also referenced the warning from an expert in the medical field, Professor I.W.F. Spencer who held the chair in comprehensive and community medicine at the University of Cape Town, and was a former deputy medical officer of health in Johannesburg. Other important issues raised by Spencer included training of community members to adapt comprehensive care and organising funds to cater for the needs of the rural areas due to their less access to the urban health services.[378]

[373] Noble, *A School of Struggle*, pp. 251 & 256.
[374] de Beer, *The South African Disease*, p. 29.
[375] K. Dennil et al, *Aspects of Primary Health Care, p. 30.*
[376] de Beer, *The South African Disease*, p. 29.
[377] Witwatersrand University Historical Archives, AD, Box 1912, File 112.19, Health, 77c. *The Star* 29 July 1976.
[378] Witwatersrand University Historical Archives, AD, B0x 1912, File 112.19, Health, 77c. *The Star* 29 July 1976.

This renewed state interest in promoting primary and community-based healthcare was to be developed through health education. The prevention and treatment of a variety of diseases, family planning and other related health issues did much to stimulate a desired interest from community health service providers, both from governmental and non-governmental organisations. Van Rensburg argued that "In this sense, the Act of 1977 brought about no renewal in primary health care provision; rather, it reaffirmed the *status quo* established earlier. Also, little was realised in terms of the envisaged large-scale establishment of community health centres."[379]

The 1977 health legislation was a significant step by government to initiate some overdue healthcare reforms for all South Africans. The National Department of Health took the responsibility to coordinate health services, including those in the homelands, by establishing the national health laboratory service to promote family planning, safe and favourable environment as well as the promotion of research facilities and medical legal services. The population growth rate among blacks remained a significant challenge in relation to the provision of health care services; thus, the promotion of family planning was considered a possible solution. Other related preventative measures suggested by the state included the prevention of pollution, unhygienic conditions and communicative diseases. This idea could be supported by Van Rensburg when he stated that:

> In looking back on the Health Act of 1977, one could argue that it indeed effectuated greater clarity in the delineation of the three tiers of government and of their respective duties, powers and responsibilities. It also took concrete steps to effect centralized policy. Formulation with decentralized implementation thus moved towards greater coordination among the three authority levels. Furthermore, it clearly aimed to shift the emphasis in health care towards stronger preventative and promotive approaches, i.e. the PHC approach was indeed realized as the cornerstone of the new policy.[380]

[379] van Rensburg et al, *Health Care in South Africa*: Structure and Dynamic, pp. 247-248.
[380] van Rensburg et al, *Health Care in South Africa*: Structure and Dynamic, p. 73.

Although little was achieved in bringing about meaningful health reforms, the step taken in the promulgation Act 63 of 1977 was a clear indication that the pressure by the marginalised black people compelled the state to come to its senses. One would also argue that the state's action in this regard was the beginning of its preparedness to embark on the road to health for all, even though it was doubtful as to whether it would abandon racialised health care in favour of unitary health for all races as a solution to the existing health challenges.

One should also bear in mind that many Health Acts were passed in the past by the Boer Republic and the Union government to solve health challenges in the country of which the 1977 Health Act was number 63. When this Act was promulgated, there were no new hopes as it provided for the co-ordination of services and functions of health authorities in order to maximise the utilisation of resources in a more effective service for all population groups.[381] Van Rensburg explained that:

> As early as 1897, the Public Health Amendment Act 23 of 1897 identified measures regarding the supply of clean water, building inspection, abattoirs' diaries, disposal works, cemeteries, non-white residential areas, unhealthy and obtrusive practices and the prevention of transmittable diseases, as components of health care.[382]

5.5 Conclusion

Based on the above discussion, one can argue that the intensification of racial discrimination towards the end of 1940s which led to the entrenchment of apartheid and its popular laws became a thorn in the minds of many progressive governmental and non-governmental organisations throughout the country. The progress already made by the Gluckman's National Health Service Commission, with its desire to transform South Africa's health care system to accommodate health for all racial groups, was wobbled by the advent of apartheid. The National Party government

[381] J. Gilliland et al, 'The New Health Act and its Effects on Community Health Care', *South African Nursing Journal*, October, 44 (10), 1977, p. 10.
[382] van Rensburg et al, *Health Care in South Africa*: Structure and Dynamic, p. 247.

regarded any attempt to equalise different racial groups as a threat to social, political, economic and cultural lives of whites in the country.

When multiple apartheid laws were passed during the 1950s, the resistance from black political organisations was also intensified as a reaction against the worsening state of poverty and diseases among the blacks. The contribution of the African National Congress, which strongly agitated for intense resistance against apartheid led to the formation of the Congress Alliance of the early 1950s and the launch of the Defiance Campaign in 1952, which culminated into the establishment of the most famous Freedom Charter in 1955. The significance of this Freedom Charter became evident when it called for the creation of the preventative health care system under state control, and free medical care for all South African citizens. The creation of the homeland system for different black ethnic groups in the 1960s and 1970s, on the other hand provoked further black resistance activities as it was evident with the defiance actions of the early 1970s agitated by the emergence of the Black Consciousness Movement under Steve Biko, which in turn culminated into the 1976 Soweto Uprising.

One can also argue that the state's promulgation of the Act 63 of 1977, which emphasised the promotion of preventative measures against poverty and diseases, was a clear indication that the state was pressurised to come up with more meaningful health reforms to accommodate all racial groups in the country. However, the state's minimal interest that weakened the full implementation of the objectives of the Act in favour of primary health care. As Anne Digby stated, "Although there had been a weak push to improve primary healthcare in the South African Health Act of 1977, most money continued to be channeled into secondary and tertiary rather than primary healthcare."[383] The Act never received any support from the ANC as its Secretary General, Alfred Nzo, reported during the International Conference held in Brazzavile, People's Republic of Congo, that: "we unapologetically denounce this Act as having absolutely nothing to do with the comprehensive and adequate delivery of health care, that must invariably include

[383] Digby, 'The Bandwagon of Golden Opportunities'? p. 850.

promotional, preventive, curative and rehabilitative activities".[384] The response of black communities and organised groups to apartheid healthcare and politics, is covered in detail in chapter 6 and 7 below.

[384] World Health Organisation, *Apartheid and Health, Part I: Report of an International Conference held at Brazzaville, Congo*, 16-20 November 1981, p. 10.

CHAPTER SIX: RESPONSES TO APARTHEID HEALTH POLICIES – POLITICAL AND THERAPUEATIC

6.1 1ntroduction

The impact of the changes made in the healthcare system by the apartheid state elicited a diversity of responses from Africans, ranging from organised political activity to trying other existing therapeutic practices. This chapter adopts a broad approach in outlining these responses, looking at both the political and therapeutic aspects. The chapter therefore considers the role of organised political groups such as the African National Congress (ANC), South African Students' Orgnaisation (SASO), as well as healthcare initiatives developed by, mainly, blacks or with a great deal of their participation and support.

6.2 Political response

The overt racialisation of service provision during the early apartheid period prompted the ANC and its young, militant leadership to work harder to force the state to implement desegregation in all spheres of life including health services. After the formation of the Congress Alliance in the early 1950s that the ANC launched its Defiance Campaign in 1952. This campaign was followed by the establishment of Freedom Charter in 1955, which also laid specific procedures for the transformation of health care.[385] The Charter also propagated broader restructuring and transformation of South African social structure, including the social health system that would provide health services on equal basis as stated in the following:

> All people shall be entitled to participate in the administration of the country.
> The rights of people shall be the same regardless of race, colour or gender.
> All apartheid laws and practices shall be abolished.[386]

[385] van Rensburg et al, *Health and Health Care in South Africa,* p. 101.
[386] van Rensburg et al, *Health and Health Care in South Africa,* p. 113.

The significance of the charter became evident when it stated that:

> A preventative health scheme shall be run by the state; free medical care and hospitalization shall be provided for all, with special care for mothers and young Children. The aged, the orphans, the disabled and the sick shall be cared by the state; rest, leasure and recreation shall be the right of all...and laws which break up families shall be repealed.[387]

The fact that the charter expressed the need for equality in the provision of health care services for all racial groups with emphasis on community involvement, helped to create a fertile environment for future transformation of South African health care system. It acted as a foundation for transformed health care, most particularly after the 1994 general election when the full restructuring of South African health system along primary health care became a possibility.[388]

Further black resistance to the general social and health policies of the apartheid era was felt in the 1960s with common demonstrations and stay-aways. When South Africa became a Republic on 31 May 1961 after the referendum convened by the Prime Minister H F. Verwoerd, political turmoil, and unrests intensified. The retaliated with oppressive, repressive measures and by banning orders against demonstrators, most particularly after Sharpeville and Langa incidents; attitudes hardened on both sides. In 1962, the experiment in community-based health initiated by Gluckman's system of health centres in the 1940s was abandoned, a development which strengthened the government's curative healthcare based on racial discrimination. These services catered for urban areas of whites where secondary and tertiary health services already existed.[389] The international objection against the state's repressive attitudes led to the application of economic sanctions, with resultant flight of foreign capital. This scenario also had a direct impact on the rising tide of unemployment, poverty and diseases which were mostly notifiable among the blacks.[390]

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[387] J. Dominisse, 'Health and Health Care in Post-apartheid South Africa: A Future Vision'', *Journal of the National Medical Association*, 80(5), 1988, p.325.
[388] van Rensburg et al., *Health and Health Care in South Africa,* p. 101.
[389] van Rensburg et al. *Health Care in South Africa: Structure and Dynamics*, p. 247.
[390] van Rensburg, *Health and Health Care in South Africa,* p.101.

Black's resistance to apartheid policy was also accompanied by their desire to initiate their own community health care projects. One prominent example of such projects emerged at Lenyenye outside Tzaneen, when Mamphela Ramphele and Mankuba Ramalepe established Ithuseng Health Centre. The National Party government targeted the centre, as Ramphele was branded as an anti-apartheid activist.[391]

In the early 1960s, the government's crackdown on black political organisations, most particularly the African National Congress and Pan Africanist Congress intensified. This became evident when in 1962, the experiment in community-based health care was abandoned and by so doing, strengthened the government's curative health care based on racial discrimination. These services catered for urban areas of whites where secondary and tertiary levels of health provisions already prevailed.[392]

Nevertheless, the National Party government's choice of repressive actions could not permanently prevent continued resistance activities by the black political organisations and trade unions. According to Cedric de Beer:

> It was an uneven and protracted struggle. Only in 1964 could the government claim complete, if temporary, victory. The choice of repression rather than tentative reform heralded a period when little new thinking or action was taken to improve the health services available to the majority of the population.[393]

The effects of apartheid laws were felt in various communities in the Northern Transvaal. Selina Maphorogo's experience in relation to the Afrikaner-dominated Nationalist government since 1948 revealed that the main aim of the government was to revive tribalism in order to enforce the policy of divide and rule. The work of the Care Groups was, at times, met with challenges due to the effect of apartheid policies. The relationship between the Care Group members towards white service staff at Elim Hospital provoked suspicions as the Africans usually kept themselves at

[391] van Rensburg et al. *Health Care in South Africa*, p. 65.
[392] van Rensburg et al, *Health Care in South Africa*, p. 247.
[393] C. de Beer, *The South African Disease: Apartheid Health and Health Services*, p. 29.

a distance from the whites due to prejudice or racial discrimination. Maphorogo also explained that the increased good relations with the white Swiss staff were made possible by the fact that the staff often happened to deliberately ignore the apartheid laws. Apart from the general distrust along colour lines in the area, it was evident from Maphorogo's experience that although the general implication was based on the idea of 'good Africans and bad whites', there were many whites of Boer and British ancestry who were good and whole-heartedly prepared to help in the provision of primary or community healthcare services in the surrounding rural areas of Gazankulu homeland since the 1960s.[394]

It was in this context that the Black Consciousness Movement (BCM) and its student organisation, South African Students' Organisation (SASO) played a crucial role in the agitation for the provision of preventative health services to the rural blacks. It was through the efforts of Steve Biko as a leader of SASO at the Natal Medical University that blacks in and around the university were conscientised to fight against apartheid policies. A prominent SASO leader, Mamphela Ramphele, contributed immensely to the establishment of Zanempilo Community Health Centre near King Williamstown and Ithuseng Community Health Centre in Lenyenye outside Tzaneen in the early 1970s. Ramphele encouraged other SASO activists to be actively involved in the development of health services.

The establishment of the Ithuseng Community Health Centre can be explained with reference to the historical background of Mamphele Ramphele during her early career as a medical practitioner. Ramphele's experience in community health care matters was first recognised in 1975 when she founded the Zanempilo Community Health Centre in Zinyoka village, located outside King William's Town. This Community Health Centre was one of the first black-established primary health care initiatives outside the public sector in South Africa. It has been stated in her autobiography that:

> During this time, she was also the manager of the Eastern Cape branch of the Black Community Health Program. She travelled extensively in the Eastern Cape branch of the Black Community projects. In addition to her medical

[394] Maphorogo, *The Community is my University,* pp. 22-23.

> duties, Ramphele also became the Director of the Black Community Programme (BCP) in the Eastern Cape when Biko was banned. In August 1976 Ramphele was detained under Section 10 of Terrorism Act, one of the first persons to be detained under this newly promulgated law.[395]

As a member of the Black Consciousness Movement (BCM) and a prominent leader of its student organisation, South African Students' Organisation (SASO), Ramphele encouraged other SASO activists to be actively involved in the development of health services and other practical programmes in the black communities in order to redress to increase health services in the homelands, and help deal with the inadequacies created by the apartheid system.[396]

Photograph 10: *Mamphela Ramphele the founder of Ithuseng Primary Health Care Centre in Lenyeye outside Tzaneen.*

Source: http://lindiwilsonproductions.co.za, Out of Despair-Ithuseng, Accessed on 14 July 2016.

In April 1977 Ramphele was banished to internal "confinement" in Lenyenye, Tzaneen, where she secured a refuge in the Roman Catholic Church with the help of

[395] M. Ramphele, *South African History Online: A People's History*, http://www.sahistory.org.za/people/dr-mamphela-aletta-ramphele. Accessed on 10-04-2014, Unpaginated.
[396] Noble, *A School of Struggle*, p. 248.

Father Mooney.[397] As a medical doctor she possessed healthcare experience to effectively carry out or organise the work of community health services in the area.[398]

The Ithuseng Community Health Centre became one of the popular community-orientated projects during the 1970s. As part of the Lebowa self-governing state or homeland, Lenyenye where the centre was established area suffered a severe lack of health services. The general socio-economic conditions, with high levels of unemployment and poverty, worsened the situation. The population found itself competing for access to resources within the neighbouring Gazankulu homeland, which was also experiencing similar socio-economic challenges. Ramalepe said about the centre:

> It serves an impoverished rural population of approximately 100 000 people, a mixture of Tsonga and North Sotho-speakers who have been living for decades in an area that has in more recent years been arbitrary divided into parts of Lebowa and Gazankulu.[399]

The Ithuseng Community Health Centre was served by three hospitals which were understaffed and plagued by general conditions of ineffectiveness in the provision of health services. Ramphele and Mankuba Ramalepe, the two women who came up with initiatives of solving health challenges in Lenyenye and the surrounding rural communities, established the centre in 1981. The centre was a private or non-governmental clinic that was aimed at the provision of primary health care services.[400]

Ramalepe stated that these conditions became the breeding ground for the growing incidence of a variety of diseases that required immediate attention through preventative and curative measures. The diseases like tuberculosis, malnutrition and malaria were experienced in Lenyenye and the surrounding rural areas. As a result,

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[397] Ramphele, *South African History Online: A People's History*, http://www.sahistory.org.za/people/dr-mamphela-aletta-ramphele. Accessed on 10-04-2014, Unpaginated.
[398] Interview with M. Ramalepe, Non-Governmental Organization, Community Health. Tzaneen, 21 April 2013.
[399] Interview with M. Ramalepe, Non-Governmental Organization, Community Health. Tzaneen, 21 April 2013.
[400] Wilson and Ramphele, *Uprooting Poverty*, p. 288.

the primary health care measures became crucial in the control or eradication of these diseases, with the involvement of the community members.[401]

When establishing the centre, Ramphele involved community members, similar to the way Elim Care Groups were instituted. Community involvement was a crucial factor in the development of primary health care as it has been witnessed in other rural communities in South Africa and abroad. Ramphele realised that the root causes of poor health and high incidents of disease prevalence, was poor nutrition, lack of proper housing, poor water supplies, illiteracy, unemployment, migratory labour and family disorganisation. She reiterated that the members of the communities themselves through positive willingness and preparedness could only overcome these challenges.[402]

Ramalepe, the co-founder of the project emphasised that the centre mostly served children and women. She indicated that the prevailing socio-economic problems were aggravated by the prolonged absence of men from their homes. Although women and children worked ad hoc for neighbouring white farmers, they were paid very low wages.[403]

Ramalepe also mentioned the crucial relationship between Carnegie Commission from United States America and the Ithuseng Community Health Centre. This was also reflected in the Carnegie Conference Papers, which stressed the relationship between medical services, health and poverty that severely affected the South African black reserves. The commission's findings revealed that the lack of proper health care workers was a stumbling block in the development of primary healthcare projects. Emphasis was also placed on the effects of such problems on the provision of primary healthcare services in relation to the prevention of a variety of diseases as well as other issues related to immunisation and sanitation. Apart from the influence of the Carnegie Report, the principle of Gluckman's Commission of 1942-1944, which recommended the establishment of unitary health system for all South

[401] Interview with M. Ramalepe, Non-Governmental Organization, Community Health, Tzaneen, 21 April 2013.
[402] Wilson and Ramphele, *Uprooting Poverty*, pp. 288-289.
[403] Interview with M. Ramalepe, Non-Governmental Organization, Community Health, Tzaneen, 21 April 2013.

Africans based on the community health centres, was also influential in the establishment of Ithuseng. The notion of 'health for all by the year 2000', which was also expressed during the Alma Ata Conference on primary health care, was influential. Apart from the influence of Alma Atta Conference, the role of Pholela Health Centre initiated by Sydney Kark and Emile Kark, which also impacted on the African National Congress policy principle of Bathopele (people first) after 1994 general election, was also crucial.[404]

Although Mamphela and Ramalepe contributed greatly in the establishment and development of Ithuseng Health Centre, it soon became evident that their work would not be without challenges. This has been reflected in the reactionary attitude of National Party government to guard against any social, political and economic development where Ramphele was involved. This attitude was motivated by the fact that Ramphele was targeted as she was already banned and placed under house arrest in Lenyenye where her movements or activities were closely monitored by the government security agents.[405]

Since Ithuseng Health Centre was a non-governmental organisation, the state felt threatened as the Department of Health did not cooperate with the centre. This lack of cooperation led to the government establishing its own clinics or health centers as a way of competing against or marginalising the Ithuseng Health Centre. It was also realised that apart from the challenges from the government, at times certain members of the communities accused the members of the center of misusing or mismanaging the funds. Ramalepe stated that the attitude of these community members was "motivated by jealousy and by so doing hampering the smooth development of primary or community health services in the area".[406] As the name explains itself, the organisers started to look out for alternative financial assistant that were not aligned to the government. To make matters worse, the Lebowa homeland government never contributed by way of financing the clinic as the homeland was a self-governing state within the jurisdiction of the South African government. It

[404] Wilson and Ramphele, *Uprooting Poverty*, p. 291.
[405] Interview with M. Ramalepe, Non-Governmental Organization, Community Health, Tzaneen, 21 April 2013.
[406] Interview with M. Ramalepe, Non-Governmental Organization, Community Health, Tzaneen, 21 April 2013.

became an obvious factor that there was no way possible for the homeland to assist as it received financial assistance from the government as well as orders on how and where the funds should be directed or used.[407]

The funders, who were sympathetic towards Ithuseng, were from within and outside the country. The South African Council of Churches (SACC) under Desmond Tutu and his group played a vital role in the funding of Ithuseng throughout the apartheid era even though it remained a difficult task as it was closely monitored by the government. Other donors included the Kaiser Family Foundation from the United States of America, the European Union, Christian Aid from London, and *Broad Van die Wereld* from Germany. It was through the intervention of these organisations that the health delivery services were carried forward and this did a great deal in the reduction or alleviation of poverty and diseases among the communities in the area.[408]

The dormancy of the homelands in assisting the health center was in relation to the general understanding of the National Party government that they must be used to further the racial fragmentation of South African health care, most particularly those of the black rural communities. Van Rensburg pointed out that:

> The presence of “independent” health authorities in the homelands created an intermediate level of responsibility and administration which put the South African government in a position to negate its own responsibility in respect of poor health and poor health services in the homelands, and then to blame the homeland authorities for both.[409]

This system of health centers resembled models of micro-development similar to those practiced in the Latin America, which in turn might be vital to South African rural areas of the blacks. Although meaningful strides were evident, challenges still

[407] Interview with M. Ramalepe, Non-Governmental Organization, Community Health, Tzaneen, 21 April 2013.
[408] Interview with M. Ramalepe, Non-Governmental Organization, Community Health, Tzaneen, 21 April 2013.
[409] van Rensburg et al, *Health Care in South Africa*, p. 67.

at Ithuseng and other rural areas where such health developments were needed. F. Wilson and M. Ramphele pointed out that:

> Signs of hope, whether in Tiakeni, Ithuseng, the Valley Trust, or elsewhere, are very real, but they are at the same time breathtakingly fragile. The fundamental problem facing all who are concerned with real development is how to multiply and then to nurture a whole range or network of small organizations which together can transform the wider environments.[410]

The implication is that Ithuseng was located in a small locality of Lenyenye, while other distant rural areas, including those of Gazankulu homeland that shared a boundary with Lebowa were not covered.

The Roman Catholic Mission Station located outside Lenyenye was also crucial in the financial assistance to Mamphela in her endeavour to develop socio-economic conditions of the community. This Catholic Mission located at Ofcolaco under Father Calvin was very influential as the available clinic at the mission helped in the provision of a variety of health services to the Metz area as well. Ramalepe stated that it was a positive attitude of Father Calvin that Ithuseng found itself more strengthened to forge ahead with its activity of preventing diseases of poverty in the area. However, the assistance was short-lived as the government considered nationalising all the mission stations. The government's decision in this regard was determined by its need for control as a basis for financial assistance.[411] This move was also motivated by Dr. P. Allan, a Secretary of Public Health when he stated that: "They want assistance, but they want own control."[412] He clearly envisaged the state to incorporate or absorb the missionary institutions due to its increasing financial assistance.[413] Since this decision was taken within the context of the homelands, it became obvious that the political implications would restrict the mission stations from acting independently as they used to do before nationalisation.

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[410] Wilson and Ramphele, *Uprooting Poverty*, p. 291.
[411] Interview with M. Ramalepe, Non-Governmental Organization, Community Health, Tzaneen, 21 April 2013.
[412] Digby, 'Evidence, Encounters and Effects', p. 191.
[413] Digby, 'Evidence, Encounters and Effects', p. 191.

The activities of the centre were also based on the mutual relationship between the various primary health care providers and members of the community. This relationship was aimed at the creation of conducive and pleasant environment for community health development through the encouragement of the utilisation of indigenous health knowledge. The creation of such a sound relationship was considered on the basis of doctor-patient, nurse-doctor, nurse-patient and patient-patient relations. Other areas of emphasis included the role of immunisation in relation to traditional forms of prevention against ailment, and the promotion of rehydration treatment for diarrhea and other related diseases. Emphasis was also placed on the development of traditional medication and the need to link it with scientific or Western medical system.[414]

Ramalepe argued that although the relationship was a challenging experience, the training of the traditional healers ultimately produced positive results. She also indicated that by the 1980s, much improvement had been realised as it was evidenced by the cooperation showed by the traditional healers. Further evidence of cooperation was realised when they were guided on how to use more water to treat dehydration caused by the traditional medications given to the patients.[415]

An attempt to improve the health of the village population and the eradication of poverty was also realised when the idea of self-help or self-reliance similar to the one adopted by Julius Nyerere of Tanzania after independence, was encouraged. This idea was considered as a way of trying to limit the dependency on foreign or outside financial assistance. This strategy was implemented with collective involvement of the community through the establishment of co-operative brickyards, day-care centres, gardening, sewing and knitting. Wilson and Ramphele emphasised the influence of the Valley Trust model and Carnegie Foundation, which were instrumental in the improvement of health of the community.[416]

According to Ramalepe, the general attitude of the communities towards the new health improvements was positive. She further stated that Chief Maake cooperated

[414] Wilson and Ramphele, *Uprooting Poverty*, p. 289.
[415] Interview with M. Ramalepe, Non-Governmental Organization, Community Health. Tzaneen, 21 April 2013.
[416] Wilson and Ramphele, *Uprooting Poverty*, p. 290.

with Ithuseng community health agents as the projects relieved poverty, with the result that malnutrition was drastically reduced. [417]

The health improvements generated by these new developments in the area also led to Local Tribal authorities encouraging the establishment of development committees to manage community projects. By the 1980s the state was also beginning to assist with funding of the projects and the construction of roads, a clear indication that the state's attitude was gradually changing as the projects like Elim Care Groups and other centres expanded through nutrition education and training of health workers.[418]

Nkosazana Dhlamini-Zuma, another medical student activist who believed that the communities should work very hard to liberate themselves from political, economic and social marginalisation from the white rulers, also supported this ideal.[419] SASO also started many community projects aimed at improving literacy skills, helping communities to develop better houses, and providing clean water and sanitation schemes whereby various villages in Natal were initially targeted. It was also due to the efforts of the Black Community Programme (BCP), which generated funds locally and internationally, that Durban benefited from these funds to alleviate poverty and related diseases. While students offered their community health services voluntarily during the weekends to the low-income areas of Natal, their duties were also extended to other provinces of the country. According to Vanessa Noble:

> There are even examples of Durban SASO students giving up their university holidays to travel further inland to do volunteer work, such as teaching literacy skills and providing basic health care services at the Mabopane clinic for people living in Winterveld and impoverished African settlement near Pretoria. [420]

Despite SASO's bold initiatives, their efforts were limited by shortage of staff, financial resources, operational problems, lack of expertise and the banning orders

[417] Wilson and Ramphele, *Uprooting Poverty*, p. 291.
-[418] Wilson and Ramphele, *Uprooting Poverty*, p. 290
[419] Noble, *A School of Struggle*, pp. 248-249.
[420] Noble, *A School of Struggle*, p. 250.

during the early 1970s.[421] SASO's involvement in the self-help projects like literacy and health formed part of its black consciousness ideology, which urged blacks to be proud of themselves, and to be independent and free themselves from oppression by the whites.

The homeland system has already created health services, which were expensive and inefficient due to their geographical fragmentation, with poor infrastructure. This state of affairs was aggravated by the economic recession of the early 1970s. On the other hand, the health costs, caused by health technology influenced self-reliance and privatisation as a way of dealing with these unfavourable economic conditions.[422]

It should also be noted that the growing social, economic and political disillusionment of blacks culminated in unrests during the 1970s and 1980s. The outbreak of the Soweto Uprising on16 June 1976 was the result of tension that already existed, including the activities of the Black Consciousness Movement under Steven Bantu Biko. It was also due to the 1976-77 revolts in the country that the government was compelled to seek ways to adapt to the new circumstances of which the health sector became one of the areas to be considered. The continuing division of health care services intensified dissatisfaction by blacks to such an extent that the government saw a need to introduce health reforms.[423]

6.3 Therapeutic response

6.3.1 The role of traditional healing

In the context of inadequate service provision, the significance of the traditional healers in the provision of community health care remained vital and entrenched. This practice has been going on before and after colonialism by the Europeans, and it is still a crucial factor in recent times. The advent of colonialism brought with it the Western medical system which sought to suppress the traditional healing system,

[421] Noble, *A School of Struggle*, p. 252.
[422] K. Dennil & K.R. Nkosi, *Primary Health Care in Southern Africa,* p. 7.
[423] C. de Beer, *The South African Disease*, p. 29.

resulting in serious conflict between these competing groups. In his article on the socio-lingual aspects of missionary medicine in Colonial Mwinilunga, colonial Zambia, Walima T. Kalusa details the attitude of African agents or auxiliaries of the Western missionaries towards the traditional medical system. These African health practitioners of colonial or missionary medicine had ambiguous to African medical beliefs in their championing of their employers' biomedical ideas.[424] Stephen Phahlane noted that there were different belief systems in each African culture. He stressed that indigenous healers have been custodians of their culture that helped them to maintain the health of their communities.[425] Julie Parle and Vanessa Noble remarked about the relationship between the traditional healers and the Western health practitioners in Africa during the early 1920s.They argue in the book *The People's Hospital: History of McCords, Durban, 1890-1970s* that the missionary health practitioners' activity in African communities was aiming at the promotion of the superiority of the Western, Christian-based and scientific medicines, and general understanding of the physiology and hygiene. Although some conflicts of interests between the two health systems existed elsewhere in Africa, James McCord, who was the founder of McCord Hospital in Natal, praised his friendly relationship with the indigenous healers as he at times assisted them with medicines for malaria, syphilis and cold diseases as per their request.[426]

In South Africa, including the rural areas of the Transvaal, such conflicts and accommodation were evident as well. Competition existed in the missionary institutions where the health practitioners like doctors, nurses and other community health workers found themselves involved. Although such conflicts, it was evident that the traditional healing system was a historical force that could not be completely marginalised by the Western medical system. Missionary establishments actually continued to be sites of therapeutic and cultural exchange between the two systems. Perhaps this was the case because (African) nurses acted as advocates between Western and traditional practices.[427]

[424] W.T. Kalusa, 'Language, Medical Auxiliaries, and the Re-interpretation of Missionary Medicine in Colonial Mwinilunga, Zambia, 1922-51', *Journal of Eastern African Studies*, 1(1), March 2007, p. 58.
[425] P. S. Phahlane, 'Poverty, Health and Disease in the Era of High Apartheid: South Africa, 1948-1976', PhD Thesis, University of South Africa, November 2006, p. 8.
[426] Parle and Noble, *The People's Hospital*, pp. 30-31.
[427] V. Ehlers, 'Nurses as advocates between Western and Traditional health practices in RSA', *Health S.A Gesondheid*, 5 (2), 2000, p.29.

However, at times missionaries seemed to be oblivious of this. Missionaries, both from the protestant and Catholic traditions continued to view the traditional healthcare system with suspicion. As a result, these groups saw it necessary to advocate against traditional healers' way of practice as it was associated with heathenism and witchcraft. The increasing incidents of the diseases, illness and deaths among the black population during this period were associated with the black man's concept of diseases and therefore saw the need to salvage the situation. Missionaries were convinced that the traditional healers' practices could only be eradicated through Christian teachings and acceptance of the Western healthcare system as the only civilised and effective way of preventing and curing the diseases. Gelfand explained that:

> They felt there could be no more effective approach than through Christian doctor and nurse, who could convert and guide them to the paths of truth. The desire to eradicate these "heathen" beliefs encouraged the entry of Christian priests and doctors into the African field, which, for many years, was considered by both Protestant and Catholic to be one of the world's greatest strongholds of "heathenism".[428]

Efforts to eradicate the traditional healthcare practices were very entrenched. Lack of interest in the traditional healing system was reported in the Society of NeuroInterventional Surgery Final Report which noted that:

> … it is clear that the Swiss mission hospitals have to be considered as committed representatives of scientific biomedicine - and thus as not very concerned (or interested in) existing African , vernacular medical cultures.[429]

In the Transvaal, most particularly in the rural areas, missionaries also outlawed the traditional healing system as they were influenced by repressive political ideology of Smuts regime and later apartheid system. The traditional medical system was accused of heathenism, barbarism and uncivilised as their medicines were

[428] Gelfand, *Christian Doctor and Nurse*, p. 299.
[429] Society of Neuro-Interventional Surgery Final Report: *Working Paper Research Project*: *History of Health Systems in Africa*, 2008-2010, p. 9.

associated with human substances as medical ingredients and ritual murders.[430] Hammond-Tooke also associated them with way of competing over access to resources. It was also believed that power was conceptualised as residing in supernatural beings or ancestors and that the diseases were brought by these dead ancestors as a token of dissatisfaction against the living relatives. The religion of the black South Africans and Africa in general was therefore deemed involving ancestral spirits and witches.[431]

According to H.C.J. van Rensburg, "All traditional healers were therefore regarded as "witch doctors'' who exploited the ignorance and superstitiousness of the unenlightened natives.''[432] The general perception of the missionaries on the black people was based on their provision of health and nursing services with ultimate aim of converting them into Christianity. It was in this respect that training of the nurses by the European missionaries was also aimed at challenging the traditional healers who were for many years responsible for the provision of community health care services.[433]

When the National Party came to power in 1948, the indigenous medical system suffered further degradation. Stephens Phahlane argues that:

> … black South Africans should nevertheless not be viewed as mere helpless victims of circumstances, but as people who also demonstrated 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.[434]

In the Catholic Church, like other Christian missionary churches in the homelands church members were not allowed to perform their cultural rituals or consult

[430] P. R. Ulin, *Traditional healers and primary health care in Africa*, pp. 1-2.
[431] W. D. Hammond-Tooke, *The Bantu-Speaking People of Southern Africa*, p. 160.
[432] van Rensburg et al, *Health care in South Africa*, p. 320.
[433] Ehlers, 'Nurses as advocates between Western and Traditional Health Practices in RSA', *Health SA Gesondheid,* 5 (2), 2000, P. 30.
[434] S.N. Phahlane, "Poverty, Health and Disease in the Era of High Apartheid: South Africa, 1948-1976", (PhD Thesis, University of South Africa, 2006), p. 6.

traditional healers as they were associated with evil practices. The church elders were to report such incidents to the priests with the result that the culprits were excommunicated from the church for a considerable number of years. In the Transvaal and the rest of South Africa, such laws were actively practiced to such an extent that many blacks became victims. During the 1960s, the Catholic Churches in the vicinity of the then Pietersburg and other places in the Northern Transvaal continued to exercise these regulations whereby many rural blacks fell victim for allowing their children to attend traditional circumcision schools to perform cultural rituals. Although such regulations are still practiced in many Christian Churches, most of them have been drastically weakened and ineffective. The beating of traditional drums, which was associated with heathenism throughout the period of the white rule, is now allowed to accompany the hymns especially where the service is rendered in black languages as it is the case with Roman Catholic Church and other Christian churches.[435]

Despite criticism against traditional healers and their medical system, they continued to provide community health services as the population considered it acceptable and functional to their lives. Their function was based on their ability to perform health services as birth attendants, herbalists, the faith healers and prophets. It was also believed that these traditional healers were to a large extent having close links with their God through the ancestors. Susan C. Campbell explained that:

> The herbalist's knowledge is based on years of experience assisting a Sangoma or an experienced herbalist. These technicians are able to diagnose in many instances recommend and treat with herbal remedies, but lack the psychic or spiritual ability that fires the possessed healers. Herbalists are important contributors to the primary health care system and often support the work of the healers.[436]

The role of traditional healers could also be explained in the context of spiritual guides in healing the diseases. It is generally believed by most of the blacks that in

[435] W. Maepa's personal experience as a Catholic member since 1970, 15 February 2015.
[436] S.S. Campbell, *Called to Heal: Traditional healing meets modern medicine in Southern Africa today*, p. 1.

the process of healing, the ancestors of the dead people are spiritually guiding the traditional healers to diagnose the diseases. This could be supported by the testimony of one of the traditional healer who stated that:

> The healers describe the ancestors as spirits, much like the guardian angels. I enjoyed their stories but thought of the ancestors as just a colourful aspect of the culture, until I experienced explicit dreams myself. My deceased maternal grandfather, both grandmothers and my father began giving me direct instructions. As the healers had said, it was not frightening in any way.[437]

The role of herbalists in the utilisation of traditional health knowledge was based on the years of experience in assisting sangomas or traditional healers. The work of these herbalists was to diagnose the disease, recommend and treat with herbal remedies. Although herbalists lacked psychic or spiritual ability as compared to the traditional healers or sangomas, their mutual relations contributed much in the healing of a variety of diseases. As Susan Campbell has correctly argued, "herbalists are important contributors to the primary health care system and often support the work of the healers."[438]

The Traditional Birth Attendance has long been one of the vital features of the traditional way in the provision of community health services. This practice or skills were reflected in the Bapedi, Bavhenda, Batsonga and Batswana rural communities. Evidence has shown that this practice was generally a characteristic of the developing countries, of which South Africa was not an exception. Since the rural areas of the blacks were disadvantaged due to the political, social and economic disparity between South African racial groups, the rural areas found themselves negatively affected as they were exposed to a variety of diseases that affected their life expectancy and mortality rates. An account by Lea Molapo and Tiisetso Makatjane revealed that the high maternal mortality and unhygienic conditions of the rural communities was the result of their reluctance to practice modern health facilities as they preferred natural and family settings based on the general

[437] Campbell, *Called to heal*, p. 38.
[438] Campbell, *Called to heal*, p. 1.

understanding of traditional healing system and the utilisation of the traditional medicines.[439]

Langford Lethlaku, a Deputy Director in Community Health Education and Immunisation in the former Bophutatswana government argued that the traditional medical system had always been given conscientious. These practitioners were very careful not to disregard or ignore their black patients as they were aware that they were always consulting the traditional healers as a "second opinion" after having consulted the modern doctors. This was confirmed by many traditional healers and black patients. Most patients also believed that failure to consult traditional healers before consulting the modern doctors in clinics, hospitals and private health institutions might lead to less chances of surviving death.[440]

Lethlaku further explained that: "In addition to the normal healing functions the traditional medicine-man has also got protective functions. These included protection against ill-wishers, protection of the home against any contingencies, protection of the ploughing fields and the cattle kraal."[441]

The experience of Hitler Letsoalo, a traditional healer who has been practicing traditional medicine, explained that the Traditional Birth Attendance has been the most effective way of providing the pregnant mothers with the required traditional medicines until the final delivery of the child. He further indicated that this practice was conducted by the elderly married women who were informally trained by other experienced or skilled women, using the relevant traditional knowledge. According to Hitler, although mortality occurred, it was minimal as most of the children who survived were not easily affected by childhood diseases. Since the traditional midwives were members of the communities, their knowledge of health history of their patients was crucial in the success of conducting the delivery process of the mothers. The process was to a large extent different from the professional midwives

[439] B.C. Nindi, 'Ethnomedicine in South Africa', Issue 4 of NUL, *Journal of Research*, 1993, p. 19.
[440] L.M. Letlhaku, Paper IV: Cultural Factors Influencing Health, *Symposium: Health Services for the Developing Community*, p. 4.
[441] Letlhaku, Paper IV: Cultural Factors Influencing Health, *Symposium: Health Services for the Developing Community*, p. 4.

as the professional midwifery's health practice is purely academic, carried out by the professional doctors and nurses.[442]

Jan Ramothoala, a traditional healer at Moletji in the north-east of Polokwane emphasised that the role of traditional healers remained a crucial refuge for many black communities. He indicated that his observation as a traditional healer since the early 1980s convinced him that many blacks supported it because diseases like tuberculosis, sexually transmitted diseases, children's diseases and mental diseases were successfully and permanently healed. The other important reason in this respect was that the diagnosis of the diseases remained the responsibility of the traditional healers, whose main function was to tell the patients about diseases, unlike in the Western system where the patient is asked by health practitioner regarding the diseases he is suffering from. Ramothoala reiterated the importance of divine bones and ancestral powers as it is commonly known by other traditional healers countrywide.[443]

However, other traditional healers including Peter Ramafoko revealed that their relations with the Western health centres like hospitals and clinics were never cordial, while Jan Ramothoala and Mankuba Ramalepe said it was to a certain extent satisfactory as the traditional healers used to refer patients to them, while the nurses and doctors could not refer patients to them. Jan Ramothoala stated that some of the whites were aware that traditional system is working as they used to consult secretly for fear of being victimised by the law. Although the missionaries tried over the years to destroy the traditional system in support of the government, the system survived and continued to flourish even in recent times mostly in the black rural communities. Although the government's reform made provision for the increase of clinics and other health centres from the 1980s, many blacks continued to utilise the traditional healers and their indigenous medicines.[444]

The state's negative attitude towards the traditional medical system became evident when it promulgated the 1974 Health Act which was seen by many blacks as an

[442] Interview with H. Letsoalo, Laastehoop (Podile), Ga-Molepo, 20-July-2015.
[443] Interview with J. Ramothwala, A Traditional Healer, 30-May 2015.
[444] Interview with J. Ramothwala, A Traditional Healer, 30-May-2015.

attempt to restrict the practice and recognition of traditional medical system. This Health Act was amended in 1982 when traditional healing and other related medical practices were regarded as illegal.[445] Despite the government's restrictions, the black communities, both in the rural and urban areas continued their traditional healing practices as they considered it effective in the total or permanent eradication of diseases. The enforcement of bio-physiological conditions that was based on the objective demonstration of scientific method did not compel black people to abandon their ethnomedicines which was perceived in terms of cultural beliefs and values in the treatment of a variety of diseases.[446] Although the African National Congress made several attempts to integrate the two health systems since 1994, full integration has never been reached.

According to S. A. Rankoana, the traditional medical system is physically and economically accessible and affordable than the biophysical system. Many traditional healers throughout the former rural areas of the Transvaal shared this belief. Rankoana explained that:

> Most of the members of Dikgale Society still have a strong belief in traditional medicines (ethnomedicines) and it is not uncommon to see patients in hospital taking biomedicine during the day and resorting to ethnomedicine during at night. Patients then maximized their chances of recovery. The rational for this attitude is that biomedicine treats only the symptoms of disease while ethnomedicine has the capacity to address the root cause of the illness which is often perceived to be supernatural. For this reason, healing rituals are often performed for patients at home while they are in hospital to receive biomedical care.[447]

[445] Campbell, *Called to heal: Traditional healing meets modern medicine in Southern Africa today*, p. 3.
[446] S.A. Rankoana, Plant-based medicines of Dikgale of the Nothern Province, *South African Journal Ethnology*, 2001, 24(3), p. 100.
[447] Rankoana, Plant-based medicines of Dikgale of the Nothern Province, *South African Journal Ethnology*, 2001, 24(3), p. 100.

6.4 Conclusion

The response of the Africans to the changes in the healthcare system during the apartheid period ranged widely as demonstrated in the chapter. The political response illustrated the changes and modernisation of African society, which required engagement with the apartheid system using the tools of modern civic engagement. On the other hand, the continuation of the use of traditional healing cemented the emergent pluralism. Although the colonial/apartheid state was generally against African traditional healing, its deep roots and the failure of the state to provide adequate healthcare ensured the robust continuation of the system.

The next chapter looks at the late apartheid period and the developments from that period, as well as the responses they elicited from black organised groups, especially the UDF and AZAPO.

CHAPTER SEVEN: PRIMARY HEALTH CARE DURING THE LATE APARTHEID ERA, 1978 TO 1980s

7.1 Introduction

The period from the late 1970s to the early 1980s marked the growing popularity of the primary health care concept worldwide due to the growing concern over the escalating state of poverty, diseases and fragmentation of health services, particularly in the developing countries. The 1978 Primary Health Care Conference, held at Alma Ata in the former Union of Soviet Socialist Republics (USSR), was a major reason behind this. These global developments paved way for discussions about progressive healthcare to take place between the state and health professionals, both within South Africa and internationally. Within South Africa at that time, the political landscape was characterised by the intense growth of resistance to apartheid by the democratic movements that continued the work of the banned anti-apartheid organisations such as the African National Congress (ANC), the Pan Africanist Congress (PAC) and the South African Communist Party (SACP).

Professional formations such as the National Medical and Dental Association of South Africa (NAMDA) and other UDF/ANC-aligned health formations also put pressure on the state to reform health policy and address the country's health challenges. The mounting pressure from these different directions forced the state to come up with new initiatives to reform the country's national health system that would satisfy all racial groups. This chapter will therefore explore these developments and the developments they set into motion, leading to the development of the tenets of primary health care in South Africa.

7.2 The Alma Ata Conference and primary health care

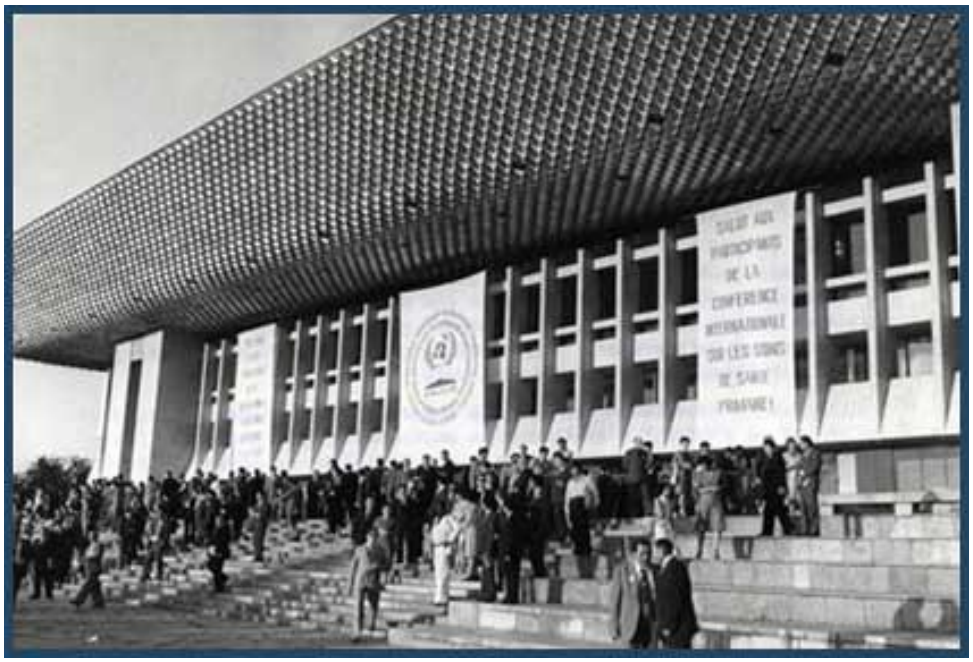
The escalating state of poverty and diseases in the so-called Third World provoked a serious desire for collective action to overcome these challenges. This state of affairs became a source of a worry across the world countries during the 1970s. Of great concern was the rising poverty as the main contributory factor to the escalation of ill-health, diseases and deaths that mostly targeted the underdeveloped and

developing countries of the world.[448] The meeting of countries at Alma Ata in Russia in 1978 was a turning point in these countries' endeavours to deal specifically with health development based on the primary health care. However, it should be emphasised that aspects of primary health care existed many years before Alma Ata conference but with limited efforts to implement it in full. As was noted earlier in the thesis, during the early 1940s the rise of the social medicine movement led to the initiation of the system of health centres or health units as the bases of 'native medical service'. Indeed, many scholars, including Van Rensburg regard this period as a "Golden Age of primary healthcare, along with the Health centre initiative."[449]

However, it was during the 1978 conference at Alma Ata that the idea gained global popularity. The conference had tremendous influence on the health system development of many countries, including South Africa.

[448] World Health Organisation, Global Strategy for Health for All by the Year 2000, *Health for All Series*, 3, 1981, p. 19.
[449] H.C.J. van Rensburg et al, *Health and Health Care in South Africa*, p. 416.

Photograph 11: *The building where Alma Ata Conference on Primary Health Care was held, 1978. Above (outside view), below (inside view).*



Source: World Health Organisation, International Conference on Primary Health Care, 1978, apps.nml.nih.gov. Accessed on 13 January 2015.

The decision to convene the Alma Ata Conference was an effort initiated by the World Health Organisation and the United Nations Children's Fund (UNICEF). As co-sponsors of the conference, the two bodies declared primary health care as a crucial

way of developing healthcare systems throughout the world, which would cater for all races and classes. Emphasis was placed on the reliance of the readily available means where community involvement or participation in healthcare improvement and disease prevention was considered a priority. Community participation was also based on delivery and decisions about health care services that would suit the communities in relation to their own local circumstances. The convenors of the conference came up with the most popular and influential definition of primary healthcare, which appealed to many countries across the world.[450] The conference defined primary health care as:

> Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.[451]

The conference was attended by 134 countries, with the exclusion of South Africa, due to its apartheid policy. However, despite the non-attendance of South Africa, the philosophy and principles declared during the conference had impact on the country's health care system for many years. The principles of primary health care declared during the conference did appeal to many health care institutions and workers in the country. Aspects of primary healthcare were therefore promoted among both government and non-government organisations which had responsibility over clinics, hospitals, community, and other health care institutions. Primary health

[450] World Health Organization, Geneva 1978, *Report of the International Conference on Primary Health Care Alma Ata*, USSR, 6-12 September 1978, p 3.
[451] World Health Organization, Geneva 1978, *Report of the International Conference on Primary Health Care Alma Ata*, USSR, 6-12 September 1978, p 3.

care was especially promoted for the benefit of the vulnerable and poverty-stricken rural black populations.[452]

Although the South African government was not part of the conference due to its racial policies, the members of NAMDA, who fought tirelessly to achieve equitable health services to all South Africans, were invited. Some of the most prominent members included Dr. Aaron Motsoaledi, Dr. Joe Phaahla, and Dr. Peter Kgaphola. [453] Their presence encouraged them to organise funds from abroad. Since NAMDA was associated with the activity of anti-apartheid activities, the organisation realised that there was no way in which they could get state financial support. As a result, they resorted to foreign funders whereby the funds were channeled through the South African Council of Churches. The efforts of religious leaders such as Frank Chikane, Dean Farisani, Dean Mminele, Father Smangaliso Mkhatshwa, and Desmond Tutu, aided this initiative, as they were actively involved in supporting primary health care projects for the blacks.[454]

The principles of Alma Ata were adopted and used by many health institutions and individuals in the planning of their healthcare initiatives. Mankuba Ramalepe of the Ithuseng Community Health Centre revealed that the model was used throughout the rural areas of the Transvaal and the activities of Elim Care Groups, Ithuseng Health and Nutrition Centre and Zanempilo Clinic testified to that.[455]

The principles of self-determination, self-reliance and ‘health for all’, as expressed during the conference, served as a counter-narrative to the regressive and separate health policies imposed by nationalist government since 1948. The moral values associated with Alma Ata resolutions provided a practical revolutionary vision of establishing primary health care programmes, globally and locally.

[452] K. Kautzky and S.M. Tollman, *A Perspective on Primary Health Care in South Africa. School of Public Health, University of Witwatersrand,* p. 2.
[453] Interview with N. N. Makgoga, Deputy Director, Limpopo Provincial Department of Health, 08-September.2017.
[454] Interview with N. N. Makgoga, Deputy Director, Limpopo Provincial Department of Health, 08-September.2017.
[455] Interview with M. Ramalepe, Non-Governmental Organization, Community Health, 09 February 2015.

Until that time, the state had failed to promote these initiatives in favour of maintaining apartheid policies on heath matters as well. However, the effect of Alma Ata was apparent during the 1980s, with a range of organisations taking the fight for healthcare services to the state's doorstep. One such example was the National Progressive Primary Health Care Network (NPPHCN), which was formed in 1987 and grew to become a strong opponent of apartheid and homeland health service systems. Their fight was guided by the four principles of the conference, which included commitment to socio-economic development, community accountability, concern with worker practice and the need for comprehensive care. The PPHCN created a strong foundation and platform upon which the apartheid health system could be challenged.[456] The activities of this organisation will be fully discussed in chapter eight.

In the meantime, various attempts to transform primary health care ideas into practice were undertaken by individuals and organisations in the Transvaal during the 1970s and 1980s. In the Transvaal, the flowering of primary healthcare was witnessed at Elim Hospital, the Alexandra Health Centre, Tintswalo/Wits Health Systems Development Unit, as well as in other places run by non-governmental Organisations (NGOs). These community-based centres, with community involvement in the provision of primary health care services to the sub-districts, paved way for the future district-based system of the 1990s.[457]

The establishment of Lesedi Clinic in Soweto in the 1980s, initiated by Nthato Motlana, a local physician businessman and community leader, was another crucial step in the provision of primary health care services to the black communities in the Transvaal. It was also due to the influence of primary healthcare movements that Minister of Health Dr. Rina Venter and the Director-General Dr. Coen Slabber eventually relented and also started to implement primary health care in the 1980s and 1990s[458] Mankuba Ramalepe's oral account indicates that the little or no success in this attempt was due to the fact that the nationalist government could not cooperate or show any positive attitude on the matter due to a variety of reasons. It

[456] Kautzky and Tollman, *A Perspective on Primary Health Care in South Africa*, p. 22.
[457] Kautzky and Tollman, *A Perspective on Primary Health Care in South Africa*, pp. 22-23.
[458] Kautzky and Tollman, *A Perspective on Primary Health Care in South Africa*, p.23.

was for this reason that such efforts, ultimately, floundered as the government did not put its full weight behind them.[459] Table 3 below shows the number of clinics in the homelands, relative to the population.

Table 3: *The provision of clinics in the homelands during the late 1970s and late 1980s.*

	Late 1970s		Late 1980s	
HOMELAND	**NUMBER OF CLINICS**	**CLINICS PER 10 000 OF THE POPULATION**	**NUMBER OF CLINICS**	**CLINICS PER 10 000 OF THE POPULATION**
Bophuthatswana	130	1, 18: 10 000	162	0,9: 10 000
Ciskei	54	1, 14: 10 000	98	1,3: 10 000
Gazankulu	39	1, 17: 10 000	53	1,1: 10 000
KaNgwane	-	-	46	1,2: 10 000
KwaNdebele	-	-	28	1,2: 10 000
KwaZulu	122	0, 45: 10 000	187	0,5: 10 000
Lebowa	111	0,8 : 10 000	133	0,3: 10 000
QwaQwa	7	0,78: 10 000	18	0,9: 10 000
Transkei	131	0,73: 10 000	219	1,3: 10 000
Venda	39	1,08: 10 000	55	1,2:10 000

Sourfce: H.C.J. van Rensburg et al*, Heath Care in South Africa: Structure and Dynamic*

The above table reflects the dramatic increase of clinics in the homelands between the 1970s and 1980s.There is a positive correlation between the number of population and the number of clinics since the homeland with high population show the high number of clinics as reflected among others, in Bophuthatswana and Transkei respectively. These statistics also correlate well with the increased health initiatives since Alma Ata as well as the increased anti-apartheid activism from political and health fraternity. It is also interesting to note that statistics for

[459] Interview with M. Ramalepe, Non-Governmental Organization, Community Health, 09 February 2015.

KwaNdebele and QwaQwa, which show the lowest number of clinics in the 1980s, are not indicated in the 1970s as they were established in the early 1980s.

The period after the Alma Ata Conference is also associated with the 'Health for All' (HFA) principle which also became instrumental in the development of primary health care throughout the world. This principle played a major role in the formation of health policies and programmes in health sectors. The 'Health for All' principle was seen as crucial on account of the social, economic, ecological and biomedical conditions of the world countries, most particularly, in the third world and developing countries. In South Africa, the principle became a significant guideline in the desired implementation of equity in the health service delivery. The general understanding that health services should be promotive, preventative, curative and rehabilitative could not be easily ignored even by the racist states. Community involvement or participation was considered as the most important cornerstone of primary health care which needed planners in health programmes and funding agencies.[460] The form and degree of implementation in apartheid South Africa was a matter of general concern.

Although the 'Health for All' principle is associated with the period since the Alma Atta Conference, Elim Hospital was already a symbol of a successful health system that provided health services to people, regardless of class, race and religion since its inception.[461] Other missionary institutions, particularly after Alma Atta, felt a need to transform the South African health system to cater for all racial groups. The notion of equalising health services was motivated by Alma Ata's emphasis that health services should be accessible to all races. This desire was based on the provision of appropriate health care services that would be in accordance with the real needs and challenges of the smaller communities. The emphasis by Alma Ata that health care must be provided at the site closest to where people live and work was also instrumental in the development of primary health care services in most of the rural areas.[462] Van Rensburg and Fourie noted that:

[460]J.H. Bryant, Ten Years After Alma Ata, *World Health*, The Magazine of the World Health Organization, August/September 1988, p. 10.
[461] Society of NeuroInterventional Surgery, *Final Report*: Working Paper, Research Project. History of Health System in Africa, 2008-2010. p. 5.
[462] H.C.J. van Rensburg et al, *Health Care in South Africa: Structure and Dynamics*, p. 5.

> With the real needs of all communities as the main criterion in provision and allocation, a shift in emphasis towards primary, preventative community-based health care- thus a shift in emphasis from disease and the ill person towards health and its health person-should prove particularly appropriate and promotive equality in the South African situation.[463]

The climate of opinion provided by Alma Ata led to the realisation – and sometimes acknowledgement – of the shortage of health personal in rural areas. As van Rensburg pointed out, "In 1986, there were only six physicians in KwaNdebele, 14 in QwaQwa, 25 in Venda, and 29 in KaNgwane to see to the health care needs of the local population concerned." Apart from the shortage of physicians, the Department of National Health and Population Development also confirmed the grave shortage of nurses in the homelands of Venda, Lebowa, Bophuthatswana and Gazankulu since the late 1970s.[464]

The Department of National Health and Population Development indicated that "in 1978, Venda had a nurse-population ratio of 1: 1667, which improved to 1:548 in 1985''. The survey also indicated health improvements in the Transvaal and other homelands outside this province.[465]

Although the Alma Ata conference motivated a majority of countries to work on building equitable health care systems based on primary health care, the Transvaal rural areas of the blacks continued to experience inadequate health services due to the state's racial policies.

The negative effects of fragmentation on the resource allocation for community health service delivery were also seen during the early 1980s when reliance on vaccines was considered a possible way of preventing the rising notification of infectious diseases. This preventative method became popular due to the rising incidents of the hepatitis B virus, with the Sub-Saharan African states being vast reservoirs of these infectious diseases in the area. Since the primary health care

[463] H.C.J. van Rensburg & A. Fourie, Inequalities in South African Health Care, Part 11.Setting the Record Straight, *South African Medical Journal,* 84, February 1994, pp. 100-101.
[464] van Rensburg et al, *Health Care in South Africa: Structure and Dynamics*, p. 301.
[465] van Rensburg et al., *Health Care in South Africa: Structure and Dynamics*, p. 301.

programmes were already available in most areas on the continent, the vaccine became a much-needed preventative way of dealing with this disease and other infectious diseases. Since the disease was mostly affecting the infants, vaccination during the childhood stage remained imperative.

The World Health Organisation was instrumental in the recommendations of the first dose to be offered to children immediately after birth. However, the effective prevention of the disease was hampered by fragmentation of the clinics and hospitals which were located far from rural communities which were often characterised by poor road conditions.[466]

In the rural Transvaal, hepatitis was discovered to be a serious challenge. Vaccines were also administered to infants to prevent diseases like polio, which can be dangerous if children are not immunised or vaccinated at childhood stage as the disease could easily lead to permanent disability.[467]

The World Health Organisation was also influential when it encouraged other countries to be cautious regarding prevention of hepatitis disease. The year 1989 was marked by long campaigns in the supplementation of the expanded programme on immunisation with the hepatitis vaccine. The Republic of Venda, which became independent in 1979, was targeted. This area which consisted of entirely black rural communities was found to have been affected by hepatitis B. The survey conducted in 1986 revealed that 29 312 adult black male mineworkers of rural origin were affected by the hepatitis B virus carrier at a rate ranging from 5, 5% to 14,06%. The survey also found that Venda, together with its neighbouring homelands of Gazankulu and Lebowa, already had some basic primary health care programmes which enabled the World Health Organisation and primary health care programmes on immunisation to function effectively, with vaccine age coverage for children ranging from 12 to 23 months. Between December 1988 and February 1989 serum samples from 1296 women attending either various rural antenatal clinics in Venda

[466] B. D. Schoub et al, 'Intergration of hepatitis vaccination into rural African Primary Health Care programme', *British Medical Journal*, 302, 9 February 1991, p. 302.
[467] Schoub et al, 'Intergration of hepatitis vaccination into rural African Primary Health Care programme', p. 302.

or the major regional hospital, Tshilidzini Hospital, were tested for hepatitis B markers.[468]

When the Department of Health introduced the primary health care programme in 1989, the distribution and administration of immunisation was boosted and expanded. This intervention strategy led to building of many more clinics in the rural communities through 57 fixed health care delivery points which consisted of three hospitals, 2 health centres, two maternity centres and 50 clinics. The Growth Monitoring, Oral Rehydration, Breast Feeding and Immunisation (GOBI), a strategy initiated by World Health Organisation and United Nation Children Fund (UNICEF), was also embraced as part of the 'Health for All by the year 2000'.[469]

Public health nformation was distributed to all community health workers, using numerous community meetings, radio messages by well-known leaders from state health departments and other forms of awareness campaigns. Since Hepatitis B is more serious than hepatitis A, severe cases of ill-health and death were common among infants in Venda.[470]
Acording to B.D. Shoub et al,

> Sub-Saharan Africa is a vast reservoir of hepatitis B virus infection, and routine immunisation programmes need to be implemented urgently, adding another vaccine to prevent a disease that is largely invinsible during infancy and childhood requires considerable planning to devise effective strategies.[471]

Immunisation was extended to other rural areas in the Transvaal, including KaNgwane homeland in the eastern Transvaal.[472]

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[468] B.D. Schoub et al, 'Integration of hepatitis vaccination into rural African Primary Health Care programme', *British Medical Journa*l, 302, 9 February 1991, p. 314.
[469] Schoub et al, 'Integration of hepatitis vaccination into rural African Primary Health Care programme', p.314.
[470] Schoub et al, 'Integration of hepatitis vaccination into rural African Primary Health Care programme', p. 314
[471] Schoub et al, 'Integration of hepatitis vaccination into rural African Primary Health Care programme', p. 315.
[472] Schoub et al, 'Integration of hepatitis vaccination into rural African Primary Health Care programme', p. 315.

Hepatitis immunisation in Venda was, to a certain extent, influenced by Section 30 of the Browne Commission, which encouraged mobile clinic-based preventative health care during the early 1980s.The understanding in this respect was that adequate immunisation coverage was considered the best way of dealing with this disease as successful results were already achieved in other homeland communities even though challenges pertaining to fragmentation existed. This understanding was explained by de Beer who remarked that: "The effect of fragmentation is such that even if the political will existed to create such programmes, the number of different authorities that would have to be involved in their formulation and implementation would remain a formidable obstacle."[473]

A study conducted in 1990 by the Centre for the Study of Health Policy in the Department of Community Health at the University of Witwatersrand, at Malamulele district of the former Gazankulu homeland, situated in the Northern Transvaal revealed severe socio-economic status and health service accessibility problems. According to the study, the two villages, for example were "… situated approximately 150km from Tzaneen and 130km east of Louis Trichardt. Maphophe and Matiyane are 6km and 12km respectively from the nearest clinic and 35km and 45km from the nearest hospital."[474] Since the incidents of poor health problems were prevalent among the aged, the focus was specifically based on all people over the age of 60 years. Among other issues investigated were the Gastro-intestinal and urinary systems, oral health status, physical independence and haemoglobin concentration. The results in this respect revealed that these health needs were not met as communities were unable to access diagnosis, health treatment and other related primary health care services.[475]

An account in the study regarding the possible reasons for the existence of health problems in these villages as per the researchers was stated thus:

> It is our belief that the main reasons that saw few of the aged in Maphophe and Matiyane receive care is the relatively high transport costs and the

[473] E. Buch et al, *A National Health Service for South Africa Part 1: The Case for Change*, p. 46.
[474] N. Sonderlund et al, 'Unmet health care needs in the aged in two rural South African communities', *South African Medical Journal*, 77 (5), May 1990, p. 464.
[475] Sonderlund et al, 'Unmet health care needs in the aged in two rural South African communities', p. 464.

> inadequate quality and availability of care. We believe that appropriate services should be developed to meet these health needs, possibly including care-of-the aged days at local clinics and at pension pay-out points.[476]

7.3 The Browne Commission

In the context of mounting pressure, the Commission of Inquiry into health services was appointed under the chairmanship of Gerald W. G. Browne in 1980. The Commission was given the mandate to:

> … to assess the effectiveness of the whole spectrum of health services in relation to the present and future community to be served, to identify problem areas and to recommend the directions in which the health services should be developed.[477]

In addition, the Commission was also tasked with coming up with ideas on how to rationalise and promote health services as well as reducing the costs of services, with the black communities being given priority as problem areas. It was after 1984 that the working committeees published eight interim reports, and the final report was adopted in 1986. The adoption of this final report by government, as a policy document, brought new hope for fundamental health changes despite dismal failure of previous efforts by the government.[478]

The commission found that the statistical data regarding the births and the deaths had always been a challenge for the state in the planning of health in the country since the inception of homeland system. The Commission also highlighted the inadequacy of health in both quality and quantity. Neil Anderson and Shula Marks maintained that:

> There are still no serious attempts to obtain comprehensive birth and death registration. Basic indicators, like infant mortality (which are extremely useful

[476] Sonderlund et al, 'Unmet health care needs in the aged in two rural South African communities', p. 465.
[477] Browne Commission 1986, Final Report of the Commission Inquiry into Health Services, 20 March 1986, p. 9.
[478] van Rensburg et al. *Health Care in South Africa: Structure and Dynamics,* p. 75.

> for assessing the impact of health services), cannot be calculated for the whole country. If anything, the picture has become more obscure as the census reports have become more sophisticated, with the exclusion of further groups of people in the Bantustans from the official figures.[479]

The inhabitants of the homelands system were excluded from the official figures, a situation which in turn disadvantaged them as they could not benefit from the wealth of the country. When some of these homelands like Transkei, Ciskei, Venda and Bophuthatswana became independent states, the services in these separate states were fragmented and weakened since they were redefined as independent entities within the country. The central state continued to control the health budget for the homelands and used this as a political tool to pressure them to accept independence.[480] For example, Gazankulu, "…which refused independence in 1976, received 6.3 million rand for health in 1975 and only 7 million rand in 1981. Yet Venda which accepted independent status, received consecutive increase of 40% in 1979 and 92% in 1980."[481]

Section 30 of the Report of the Browne Commission recommended the need for mobile clinics, which would predominantly offer immunisation and contraceptives to black farm workers and their families as part of a comprehensive primary health care programme.[482] Since the early 1980s were characterised by increases in the black population in the homelands, the Browne Commission saw the need to put more emphasis on the importance of preventative and curative health services that would be accessible and affordable rather than the more expensive secondary and tertiary health services. It was in this respect that the Commission saw the role of professional nurses as vital in the provision of primary health care services to the black communities. Such professional nurses would take up additional public health duties including home visits, especially in antenatal and post-natal care, child guidance, health education and family planning.[483]

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[479] N. Andersson and Shula Marks, 'Apartheid and Health in the 1980s', *Social Science Medicine*, 27(7), 1988, p. 669.
[480] Andersson and Marks, 'Apartheid and Health in the 1980s', p. 667.
[481] N. Anderson et al, 'Apartheid in the 1980s', *Social Science Medicine*, 27(7), 1988, p. 677.
[482] Buch et al, *A National Health Service for South Africa Part 1*, p. 15.
[483] Browne Commission, Final Report of the Commission of Inquiry into Health Services, 20 March 1986, pp. 27-28.

The Commission also recommended that urgent attention be given to the supplementary health service personnel as well as training of blacks in this field. This decision was based on the expected rapid growth of the black population in the years following 1984. The training was, therefore, considered a priority and was geared for the attainment of certificate and diploma courses to meet the much-needed manpower, most particularly in the black communities as the population statistics of the blacks were exceptionally high as compared to other racial groups.[484] This was reflected in the number of enrolled black nurses, as illustrated in the following table:

Table 4: *Persons registered or enrolled in the various nursing categories in South Africa, 31 December 1984.*

Category	Black	Coloured	Indian	White	Total
Registered Nurses (incl. single qualified midwives)	25331	5242	1228	30544	62345
Enrolled nurses	14154	3269	473	3192	21088
Enrolled nursing Assistants	23014	7074	427	8541	39056

Source: Browne Commission, Third Interim Report of the Commission of Inquiry into Health Services Professional Matters, Government Printer, 28 October 1985.

The Commission further noted with concern the fragmentation of health services in the homelands, the lack of emphasis and support for preventative primary health care, the general shortcomings of the government's health policy and shortage of

[484] Browne Commission, Third Interim Report of the Commission of Inquiry into Health Services Professional Matters, Government Printers, Pretoria, 28 October 1985, p. 41.

black health personnel in the homelands. The Commission's highlighting of the occurrence of the socio-political challenges was an indictment of race based health care policies of the apartheid state.[485]

The Commission's final report gave high hopes for the establishment of equity in the provision of health services. Mamogobo, who served as a community nurse at various rural black communities in the Transvaal homelands from 1983-2002, indicated that when the final report was issued with its recommendations, most black nurses and health practitioners were relieved and hoped that the implementation of health equity was imminent. Alas, much to the surprise of many health practitioners in the homelands, there emerged similar reluctance from the government to do away with its racial policies. Instead of implementing meaningful reforms that would create non-racial, equitable and unitary health system in the country, the government dilly-dallied.[486]

Consequently, during the 1980s the general state of poverty and escalation of diseases had continued in the central and the northern Transvaal homeland the fragmentation of the system also continued. The National Health Service Facilities Plan of 1980 established three different levels of health care provision, each under executive responsibility representing different components of the health care system. These developments made provision for the three classification levels as their own affair. This classification further strengthened separation of health based on racial identity with the result that the Department of National Health and Population Development took control of primary and community health care in black communities, particularly in the rural areas.[487]

The National Health Facility Plan was adopted by most of the independent and self-governing homelands during the 1980s. The revamping of Health Act of 1977 and the National Health Plan by the government gave new hope that steps were being taken to effect transformation in healthcare and fulfil the WHO's ambition of achieving health services for all by the year 2000. In line with these new efforts, rural

[485] Browne Commission, Third Interim Report of the Commission of Inquiry into Health Services Professinal Matters, RP/61/1986, Government Printer, Pretoria, 28 October 1985, p. 41.
[486] Interview with P. Mamogobo, 7517 Anaconda Street, Serala View, Polokwane, 21 February 2016.
[487] van Rensburg et al, *Health Care in South Africa: Structure and Dynamics*, p. 248.

clinics were extended, and other health-related agencies were also given some support. Various organisations, most particularly of non-governmental types, played a crucial role in this respect. One of these organisations was the Health Services Development Unit of Wits Medical School which carried out a Mass Immunisation Campaign in the Gazankulu homeland where polio was threatening infants. The role of the Wits Medical School attracted many tertiary institutions in the country as they started to establish new professorships and similar health units or departments as a reflection of the transformation in academic orientation in the promotion and upliftment of Community-Orientated Primary Health Care.[488]

7.4 The Segregated Health Legislation since the mid-1980s.

During the late 1970s and early 1980s, the government started making some strategic reforms which included the introduction of the Trcameral Parliament. The National Party government reform initiatives under the presidency of P.W. Botha in the early 1980s were triggered by the pressure associated with the escalating state of ungovernability, violence, mass actions and other defiance strategies of anti-apartheid forces. The escalating resistance against apartheid by the black masses during the early 1980s worsened poverty and poor health amongst the majority of the rural black population. The publication of the World Health Organisation monograph in 1983 titled: *Apartheid and Health* brought awareness which whipped up the rising political discontent in almost all spheres of life in South Africa.[489] Neil Anderson et al maintained that:

> The National Party's short-lived reformist strategy–designed to neutralise the African, Indian and Coloured discontent and to restructure apartheid to meet the changing demands of the economy-has politicized almost every aspect of social life and has further fuelled black aspirations for their legitimate share of political and economic power. Better struggles have developed around education communities in the country. The bitter struggles have developed

[488] F. Lund, 'Prevention or Cure: Community Health Service in the Rural South', *Indicator SA* 3(2), Spring 1985, p. 1.
[489] Anderson et al, 'Apartheid in the 1980s', *Social Science Medicine,* 27 (7), 1988, p. 667

around education, wages, housing, transport and unemployment, all of which have threat consequences for the health of the people.[490]

Resistance against the state's new approach emerged from Natal medical students who viewed this new apartheid strategy with suspicion. The new policy developments by the state were regarded by the students as: "…crucial part of the state's 'divide-and-rule strategy, as it introduced limited representation in South African's parliamentary structure for Indian and coloured representatives, while African representation was excluded."[491] Since these students were from different parts of the country, their activities in the agitation for reform of health policies were spread to their respective provinces, most particularly in the homelands, through community-orientated primary health care initiatives. The prolonged protests of the 1980s by the medical students spread throughout the country, usually in the form of class boycotts against the repugnant Bantu Education system.[492]

The high notification of diseases of poverty among blacks in the early 1980s was aggravated by the intense drought of the early 1980s, coupled with economic recession, capitalisation of white agriculture and continued forced removal of blacks, which was later modified into the so-called 'new regional strategy' or 'optional spatial distribution'. In the Transvaal, many blacks were resettled in small overcrowded areas which made them difficult to practice agriculture to support their families effectively. This strategy was implemented in Lebowa, Venda, Gazankulu, Bophuthatswana and other black rural areas. Poor nutrition and poverty left many blacks exposed to exploitation by farm owners who were confined to the government legislation to effect low wages. This situation left many blacks physically weakened and impoverished, with the consequence being the diseases of poverty like tuberculosis, HIV-AIDS and malnutrition.[493]

The political developments of the 1980s had a profoundly negative impact on the development of primary health care or the healthcare of blacks in general, both from the rural and urban areas. The proposed legislation was aimed at realignment of

[490] Anderson et al, 'Apartheid in the 1980s', *Social Science Medicine*, 27 (7), 1988, p. 667.
[491] V. Noble, *A School of Struggle: Durban's Medical School and the Education of the Blacks Doctors*, p 269.
[492] Noble, *A School of Struggle*, pp. 266-267.
[493] Anderson et al, 'Apartheid and Health in the 1980s', *Social Science Medicine*, 27(7), 1988, p. 668.

relations between white and coloured communities who were already strained by the removal of the coloureds from the so-called 'common voters' roll' in 1956.[494] The senate which was appointed by the National Party government to enforce this constitutional change was influenced by the National Party's policy of Grand Apartheid as a way of enforcing racial segregation.[495]

Since blacks were excluded from the new arrangements, this remained a clear indication that political and social conditions of blacks were in jeopardy. It soon became evident that the development of health care for blacks in the urban and rural areas was far from being achieved major priority. Cedric de Beer et al. stated:

> As far as health care was concerned, it was decreed that most aspects of health were to be considered "own affairs" but some, including all health care for Africans, would be defined as "general affairs". The constitutional position of the homelands was not affected by this development. Thus were created three additional "own affairs" department of health, leaving South Africa in the unique position of having fourteen government departments of health, in addition to the four provinces and approximately eight hundred local authorities all responsible for planning and implementation of health care.[496]

This division of health services between 'own affairs' and 'general affairs' affected health service delivery in general. In the Transvaal, the institution of such division had a negative impact on the development of primary health care of the rural black communities. Mankuba Ramalepe revealed that constitutional changes affected her severely as a leader of community or primary health care developments in Lebowa homeland. She viewed the new political arrangement as an extension of apartheid in the health environment as the National Party controlled the finances.[497] She would have preferred a system that would create non-racial and unitary health system as emphasised by the WHO at Alma Ata in the late 1970s.

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[494] R. H. du Pre, *Separate but Unequal: The Coloured People of South Africa- Political History*, pp. 175-178.
[495] du Pre, *Separate but Unequal: The Coloured People of South Africa- Political History*, pp. 175-178.
[496] Buch et al, *A National Health Service for South Africa Part 1: The Case for Change*, p. 49.
[497] Interviews with M. Ramalepe, Non-Governmental Organization, Community Health, Tzaneen, 21 April 2013.

The insufficient budget allocated for the health of the homeland population, together with fragmented health centres and hospitals, further made it difficult for the impoverished rural communities to access health care services. One example of such division or fragmentation was reflected in the homelands of Lebowa and Gazankulu in the south eastern part of Tzaneen where Shiluvane hospital is located. Since the hospital served both the Shangaan and the Pedi-speaking population, it became a focal point of political tension as one ethnic group was barred from using the hospital. This was illustrated when patients from the Lebowa side were always complaining of being ethnically segregated by the Shangaan. Although an attempt to establish Dr. C.N. Phatudi Hospital near Tickyline, a few kilometres from Shiluvane, was finally realised, such division remained a considerable problem to the effective development of health care in the area throughout the apartheid era.[498]

When cholera and typhoid became threatening diseases in the rural areas during the 1980s, the South African government showed little or no concern despite the possibility of such diseases spreading into white settlement areas.[499] This scenario might have been caused by the intensity of resistance by the black student uprisings, mass actions, boycotts, violent activities, civil disobedience, and militant activities by the liberation movements and the growing marches by the unionist movements.[500] The disparity in the provision of health care service index showed that infant and parental mortality were exceptionally high in the rural areas of blacks than urban areas. To make matters worse, the number of nurses, doctors and clinics available to rural blacks and the amount of money budgeted for health needs were exceptionally lower than those allocated for whites.[501] Since this racial disparity was entrenched in legislation, an attempt to create health for all people of South Africa proved difficult to be achieved. This is also reflected in the following statement:

> So long as epidemic diseases remained in the countryside, there was little incentive for the state to any action, as is shown by its reaction to the

[498] Interview with M. Ramalepe, Non-Governmental Organization, Community Health. Tzaneen. 21 April 2013.
[499] A. Anderson and S. Marks, 'The state, class and allocation of health resources in South Africa', *Social Science Medicine,* 28(5), 1989, p. 519.
[500] Rensburg et al., *Health Care in South Africa*, p 101.
[501] Anderson and Marks, 'The state, class and allocation of health resources in South Africa', p 519.

> outbreak of typhus epidemics in 1917-73, 1933-35 and 1945, and more recently.[502]

Many rural-based hospitals in the homelands were encouraged to pay more attention to the promotion of primary health care through community involvement as it happened in Elim, Jane Furse, St. Vincent, St. Ritas, Tshilitzini and other hospitals in the homelands. The WHO also took important steps to encourage national governments to spend at least 5 per cent of their Gross National Product (GNP) on health of the populations, particularly the less developed countries. This occurred in the general understanding that states were the only institutions having capacities and resources to solve health challenges of their communities.[503]

When the National Health Plan was formulated in 1986, the government wanted to achieve its health mission prescribed by the appeal for equal health services for all South African inhabitants.[504] The plan purported to eradicate the confusion created by the tricameral health system and reduce the barriers created by this system in the early 1980s.[505] This Health Plan also emphasised fulfilment of mental, physical and social well-being of all South Africans based on the prevention of diseases and the general promotion of health services through community involvement to secure clean and healthy environments. The Plan also endeavoured to close the gap between the curative and preventative health services through integration processes.[506] The new health plan differed with the health reforms of the early 1980s because it went through a number of changes whereby hospital services were divided into academic hospitals, African hospitals and multiracial hospitals. The three hospitals were placed under the administration of provinces. While the preventative and promotive services continued to be administered by "own affairs", it was since April 1988 that these services were handed over to the provinces as well.[507]

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[502] Anderson and Marks, 'The state, class and allocation of health resources in South Africa', p 519.
[503] Lund, 'Prevention or Cure? Community Health Service in the Rural South', pp 11-13.
[504] Subcommittee: Primary Health Care, Strategy for Primary Health Care in South Africa', *Nursing RSA, 7,* 1994, p 9.
[505] Buch et al, *A National Health Service for South Africa Part 1: The Case for Change*, p 39.
[506] Subcommittee: Primary Health Care, Strategy for Primary Health Care in South Africa, *Nursing RSA, 7,* 1994, p 9.
[507] Buch et al, *A National Health Service for South Africa Part 1: The Case for Change*, p 40

It became clear that the apartheid government did not ignore the ideal of progressive organisation such as PPHCN, which was active at the time, but chose not to act within the prescriptions of these organisations. However, it chose to use its own interpretation by introducing the new health plan of 1986. However, one can state that the new plan was just a modification of the health plans of the early 1980s as segregated health services were not completely eradicated. The state continued to use defensive mechanism by coming up with further health policy changes as a way of defence against escalating demands for health reforms from progressive organisations.

It was due to the efforts and policies issued by the National Health Plan of 1986 that a further resolution was accepted on 20 February 1989 when the National Health Policy Council realised that the partnership between the state and private sector, based on the National Health Services Facilities Plan, with its emphasis on primary health care, was crucial in the promotion of health services and the general prevention of the diseases. The council believed that firm government commitment and National Strategy were required for the new health reforms to be successful. These policy guidelines were considered crucial in the implementation and adoption of health care delivery services that would be organised into unitary health structures.[508]

It was therefore clear from this this policy initiative of the late 1980s that the state was pressurised by the escalating massive resistance from anti-apartheid structures to implement meaningful health reforms that would accommodated all racial groups equally.

7.5 The response of black organised groups: UDF, NAMDA and AZAPO

When SASO was banned in 1977, the potential value of students was carried forward by the United Democratic Front (UDF) which was aligned to the ANC. Several other progressive organisations continued with the initiatives that were

[508] Subcommittee: Primary Health Care, Strategy for Primary Health Care in South Africa, *Nursing RSA, 7,* 1994, p 9.

geared towards the promotion of equal health care services for all South Africans. It was during this era that the National Medical and Dental Association (NAMDA) which was formed in 1982 as well as other UDF/ANC-aligned health structures continued to denounce apartheid-aligned organisations like National Medical Association of South Africa (NMASA). NAMDA supported the idea of community-orientated primary health care and fiercely criticised the segregated health services in the country. This is underscored by Vanessa Noble who states that:

> These organizations publicly criticised the abusive and unethical practices of apartheid in medicine, demanded accountability for health professionals (especially those complicit in the death of political detainees such as Steve Biko) and campaigned at both national and international levels for health policy changes. In addition, they provided desperately needed primary-level, heath care services for many black communities around the country. This includes trauma and counselling for political prisoners, detainees and their families and emergency medical services for victims of state violence, such as civilians injured during the clashes with the police that erupted in the townships during the 1980s.[509]

In the Transvaal, the establishment of NAMDA branch in the early 1980s was influenced by anti-apartheid activities of the Durban Medical students from which its membership was drawn from. These doctors were employed in homelands like Venda, Gazankulu and Lebowa where they continued their progressive healthcare projects mostly in the rural and township areas. In Lebowa, most of these graduates found themselves performing duties at Groothoek Hospital in Zebediela, south of Polokwane. Some of these doctors included the prominent figures such as Kgoadi-Molaba, Jerry Mamabolo, Lucas Monyamane, and Lelau Mohuba and Kgaphola who later joined the organisation. These doctors found themselves working under severe unfavourable conditions due to shortage of resources as in some cases they found themselves treating patients in open spaces and under the trees using blankets in the purely rural areas where clinics and hospitals were not available. Doctors often found themselves using their cars to transfer patients to the hospitals as there were

[509] Noble, *A School of Struggle*, p. 267.

no ambulances. Although these doctors tried by all means to pressurise the government to effect meaningful transformation to improve health care services of the blacks, they received minimal support. Kgoadi-Molaba, a member of NAMDA, stated that he remembered two meetings he attended in Polokwane and Tzaneen in the early 1990s. According to him, NAMDA never had white members except a number of Indian doctors. Molaba indicated that a NAMDA branch in Transvaal had no support. After 1994 NAMDA was replaced by Health Professional Council which is still active recently.[510]

The contribution of AZAPO's Community Health Awareness Programme (CHAP) was motivated by the major health crisis experienced by Transvaal Province in July 1982, when there was an outbreak of cholera and polio epidemics. The CHAP aimed to overcome the imbalances and inadequacies created by the apartheid government where there was no equal access to healthcare and other related services. It should also be noted that the effort of AZAPO on community health matter was associated with the 1978 Alma Atta Conference on primary healthcare. Since the Alma Atta Conference stressed that countries should establish health care centres, with community health projects through community involvement. The Alma Atta model was considered useful as it was suitable for the developing countries in the provision of health and well-being of the communities most particularly the poverty-stricken rural populations. Due to the Alma Atta influence, the health projects created by CHAP and AZAPO demonstrated similar intention in the general provision of health and well-being of the entire black communities in the Transvaal.[511]

[510] Interviw with E. Kgoadi – Molaba, Gamphahlele, Seleteng, 15 October 2017.
[511] M. Hayman. South African History Online: Towards a People's History, 1943 – 2012, www.sahistory.org.za/people/dr-abu-baker-asvat, Accessed on 14 February 2016, p. 3.

Photograph 12: *Abu Baker Asvat treating children with polio in the Transvaal region in 1982.*

Source: M. Hayman. South African History Online: Towards a People's History, 1943 – 2012, www.sahistory.org.za/people/dr-abu-baker-asvat , Accessed on 14 February 2016.

In March 1984, the AZAPO Health Secretariat issued a twenty page handbook on health. The handbook marked a significant contribution to the prevention of diseases among the blacks. According to the *South African History Online,* the handbook "…. gave clear and simple advice on preventative and primary care".[512] Other important information or content of the book focuses on children's health, breast feeding, cholera prevention, first aid and the prevention of venereal diseases and other related sexually transmitted diseases. The fact that the book stressed the rights of patients was a clear indication that the organisation was intending to eradicate any form of inequalities in health and the environment as cherished by the nationalist's policies of grand apartheid since the 1948 general elections. Since the book was written in English, Sepedi, IsiZulu and SeSotho, it attracted many blacks to develop

[512] Hayman. South African History Online: Towards a People's History, 1943 – 2012, www.sahistory.org.za/people/dr-abu-baker-asvat , Accessed on 14 February 2016, p. 3.

an understanding and desire to be involved in the health of the black communities in order to overcome the challenges of apartheid.[513]

The CHAP's contribution was also realised when Asvat introduced mobile health clinic programmes in order to reach the health needs of the isolated black communities. Asvat became instrumental in the involvement of health teams, which travelled throughout South Africa to provide preventative measures against diseases. The team involved the core group of volunteers, nurses, dentists, optometrists, and social workers of which AZAPO health workers like Thandi Myeza, Jenny Tissong and Ruwalda Halim became prominent health activists. The primary health care services provided included blood pressure testing, urine samples and other related tests and diagnosis of diseases. Apart from using mobile clinics, Asvat saw the need to establish permanent clinics, and this became evident when he set up a primary health care clinic in Alexandra in February 1986. This development inspired the building of other community health clinics in the rural areas as well. Alexandra primary health care model became a health centre where nurses from other provinces were trained in the provision of preventative primary health care services, and many health centres including Ithuseng, Hlatlolanang, Elim Hospital and others health organisations copied the model.[514]

The involvement of the wife of Walter Sisulu (well-known leader of ANC), Albertina Sisulu was also significant in the promotion of preventative health care. Asvat employed her at his clinic in Soweto where she worked as a nurse. Soweto Clinic, together with Alexandra Clinic played an influential and inspiring role to the health workers in the rural areas to provide similar preventative measures in the Transvaal and elsewhere in the country.[515]

One other contribution of AZAPO was realised towards the end of 1984 when new health projects were established in partnership with Black Allied Mining and Construction Workers Union (BMCU) at Penge mine in the south-eastern Transvaal

[513] Hayman. South African History Online: Towards a People's History, 1943 – 2012, www.sahistory.org.za/people/dr-abu-baker-asvat , Accessed on 14 February 2016, .p. 3.
[514] Hayman. South African History Online: Towards a People's History, 1943 – 2012, www.sahistory.org.za/people/dr-abu-baker-asvat , Accessed on 14 February 2016, p. 3.
[515] Hayman. South African History Online: Towards a People's History, 1943 – 2012, www.sahistory.org.za/people/dr-abu-baker-asvat , Accessed on 14 February 2016, p. 4.

against the asbestosis which caused ill-health and deaths among the black mine workers than white mine workers. These anti-asbestosis campaigns promoted awareness of the danger of the mines to the surrounding black population as the mine dumps could easily be eroded by rivers or spread by winds to other areas. The settlements located along the Oliphant River were severely affected since the river was the main source of water for drinking, cooking and cleaning purposes.[516] Although regulations to enforce safety measures existed, they were not seriously enforced or in most cases deliberately ignored. According to Cedric de Beer:

> When an investigation into factory conditions took place, the workers at the factory, or their union, have no right to know the results of the investigation. Workers have no way of knowing any malpractice that may have been turned up in the investigation.[517]

Asvat used his role as a Secretary of AZAPO and his political position to reduce the impact of anti-asbestosis by urging blacks to reduce the use of asbestos products, and by calling for the overall closure of the mines.[518]

The influence of CHAP mobile clinic was also felt at Bradford in the Orange Free State, where Winnie Mandela was banished by the National Part government in 1977 for her active involvement in the anti-apartheid activism. Winnie Mandela continued to provide community health services through the organisation Operation Hunger which provided food and transportation to the Bradford community and the surrounding rural areas. It was also through CHAP's clinics that attention was given to women's health, where in April 1985 AZAPO teamed up with Ikageng Women's Group to provide monthly health clinics. These clinics provided preventative health services to the women and children, which included the testing for cervical cancer, diabetes and malnutrition. The establishment of mobile clinics in Winterveld north of Pretoria did much to inspire medical students to start their own free clinics. AZAPO under Asvat also created partnerships between medical and political structures in

[516] Hayman. South African History Online: Towards a People's History, 1943 – 2012, www.sahistory.org.za/people/dr-abu-baker-asvat , Accessed on 14 February 2016, p. 4.
[517] C. de Beer, *The South African Disease: Apartheid Health and Health Services*, p. 35.
[518] Hayman. South African History Online: Towards a People's History, 1943 – 2012, www.sahistory.org.za/people/dr-abu-baker-asvat , Accessed on 14 February 2016, p. 4.

order to work towards the improvement of family life in general. Asvat also demonstrated his understanding that eradication of poverty and homelessness could also be achieved through involvement of other individuals and political structures outside AZAPO during the 1980s. These structures included National Crisis Committee (NCC) and Peoples Education Committee. Asvat was instrumental in the provision of primary health care to the homeless in the squatter camps around Johannesburg and called for the expansion of such initiatives to the rural areas in the Transvaal.[519]

Despite the eviction order to bulldoze MacDonald Farm, the ultimatum issued against Asvat to leave his clinic within a week and several attempts against his life, his legacy of the eradication of poverty and provision of primary health care services received outstanding support, most particularly from the black communities. His contribution was also appreciated by medical practitioners, nurses and health workers who also pursued the programme which became popular in South Africa till today. Many commentators believed that his death on 27 January 1989 deprived the black South Africans of the doctor who saved them from the ill-health and diseases of poverty. Asvat's contribution had far-reaching implications in the history of the primary health care in South Africa. During the inaugural Abu Baker Asvat Memorial Lecture held in Johannesburg on 22 February 2012 Asvat was described as "…an activist, community worker, medical doctor, father, husband and brother to all peace-loving people of Azania."[520] The inaugural lecture was delivered by Dr Mosibudi Mangena, the Honorary President of AZAPO and former Minister of Science and Technology who honoured the contribution of Asvat as a doctor, political activist and a principled man.[521]

[519] Hayman. South African History Online: Towards a People's History, 1943 – 2012, www.sahistory.org.za/people/dr-abu-baker-asvat, Accessed on 14 February 2016, p. 4.
[520] G. Nodoba, Memory of Azapo's Health Secretariat Abu Baker 'Hurley' Asvat (23/02/1943-27/01/1989) *Inaugural* Abu Baker Memorial Lecture, University of Limpopo, 22 February 2012, Unpaginated.
[521] Nodoba, Memory of Azapo's Health Secretariat Abu Baker 'Hurley' Asvat (23/02/1943-27/01/1989) *Inaugural* Abu Baker Memorial Lecture, University of Limpopo, 22 February 2012, Unpaginated.

Photograph 13: *Dr Mosibudi Mangena during the Dr Abu Baker Asvat Memorial Lecture, Johannesburg, 25 February 2012.*

Source: W. Maepa's personal collection from M. Mangena, 10 February 2016.

AZAPO, like other non-governmental organisations tried by all means to agitate for the improvement of health services for the blacks throughout the 1970s and 1980s, but its efforts proved difficult as it was classified as anti-apartheid organisation by the government. Despite these challenges, AZAPO carried on with the activities of CHAP in the early 1990S when the country was involved in the negotiations for social, political and economic transformation.[522]

Mathatha Tsedu, who was an investigative editor of *Sowetan* newspaper, expressed his experience regarding CHAP's community health services at Radingoane village in Sekhukhuneland. He explained the extent to which he was impressed by the quality of health services offered by the CHAP's doctors to the community free of charge. His intention in this respect was against the general myth of associating black doctors with money mongers who were charging exhorbitant prices when treating patients. He wanted to justify the competence, dedication and quality health services rendered by CHAP's doctors at Radingoane clinic. Tsedu went further explaining that:

[522] CHAP, Strategic Planning Meeting /Workshop, Protea Gardens Hotel, Berea-Johannesburg, 21-22 November 1992, Unpaginated.

> If that was your view of black doctors too, you need to take a trip to the Northern Transvaal and meet the young and not so young men and women of the Community Health Awareness Programme (Chap).[523]

AZAPO doctors, who worked for CHAP, were tasked to identify the rural areas which were not receiving health care services during the early 1990s. Radingoane village situated in Sekhukhuneland was one of the areas identified for the building of a clinic.The clinic was established after the youth in the village requested CHAP to assist as health conditions were rapidly deteriorating. It was also after the discussions with the community and the chief of Radingoane that the community offered its local government offices as the centre for clinic establishment while the Radingoane committee offered clerical staff from the community.[524] Tsedu also stated that Smith Senku Radingoane, the vice-secretary of the Radingoane clinic committee told him that:

> The clinic has been a tremendous service to our people and surrounding villages. Right now we get people from Mphanama, GaMaila, Mohlaletsi, Seroka, GaPhahla and other places. Some people walk over 20km to see the doctors here.[525]

According to Dr. M.S. Sathekge, one of the reasons for AZAPO doctors' involvement was the fact that Radingoane community was deliberately denied health services because of their support to the movement while a neighbouring village received health services. Sathekge also stated that the village people received quality health services by the best AZAPO doctors such as himself, Dr. M.S. Mashilo, Dr. D. Monyebodi and Dr. E. Malerotho, who were treating the patients on Sundays only. As a result, many patients from the neighbouring villages flocked to Ga-Radingoane for quality services. The quality health services were also made possible by the supply of a certain donor medical company from Polokwane. Sathekge stated that the establishment of Hlatlolanang Health and Nutrition Centre

[523] M. Tsedu, 'Caring for the Sick Medicine Men and Women Enforces Policy of Human Rights: Forget that Myth about Doctors', *Sowetan,* 17 September 1993, p. 14.
[524] Tsedu, 'Caring for the Sick Medicine Men and Women Enforces Policy of Human Rights: Forget that Myth about Doctors', *Sowetan,* 17 September 1993, p. 14.
[525] Tsedu, 'Caring for the Sick Medicine Men and Women Enforces Policy of Human Rights: Forget that Myth about Doctors', *Sowetan,* 17 September 1993, p. 14.

was politically motivated; it wa attempt to counter AZAPO'S free and quality health services at Radingoane village.[526]

The success of the project prompted CHAP to consider building a permanent clinic in the village. Although lack of electricity and permanent nurses were some of the challenges faced by the clinic and the community, community involvement, especially in the absence of doctors during the week, made a huge impact in the development of community health services to the Radingoane and the surrounding communities.[527]

The Strategic Planning Meeting/Workshop organised by CHAP was held on 21-22 November 1992 at Protea Hotel in Berea, Johannesburg, where the delegates emphasised various strategies to promote preventative and community based primary health care for the poor black South Africans. In their papers they stressed issues like the global overview of health care in relation to CHAP, the organisation of community health projects, transformation of the health system, health maintenance by community itself, promotion of preventative measures, community health awareness programmes through media, involvement of health workers through training and the establishment of more clinics and hospitals.[528] Members were also advised to encourage participation in other preventative measures in areas where no clinics were running by identifying resources, persons and groups to run the health projects. Members also decided that CHAP will continue with its operation at Radingoane clinic in Sekhukhuneland and Soweto clinics in Johannesburg.[529] Other meetings of this nature were organised by CHAP with the aim of providing primary health care to the disadvantaged black communities through community health awareness and outreach programmes, and media campaigns.[530]

[526] Interview with M. S. Sathekge, 87A Hans van Rensburg Street, Polokwane, 20 August 2018.
[527] Tsedu, 'Caring for the Sick Medicine Men and WomenEnforces Policy of Human Rights: Forget that Myth about Doctors', *Sowetan,* 17 September 1993, p. 14.
[528] CHAP, Strategic Planning Meeting /Workshop, Protea Gardens Hotel, Berea, Johannesburg, 21-22 November 1992, Unpaginated.
[529] Strategic Planning Meeting /Workshop, Protea Gardens Hotel, Berea-Johannesburg, 21-22 November 1992, Unpaginated.
[530] Community Awareness and Outreach Programmes Board of Trustees and Excom Minutes, Karos Johannesburg, 14 February 1993, pp. 1-2.

AZAPO'S activities at villagelevel had far-reaching positive consequences on the image of the organisation as the village people, including the chief, continued to support AZAPO'S political interests including voting for the organisation during elections. This support has continued until the recent past. It was only after 1994 that Hlatlolanang improved in terms of medical staffing and medical provision that AZAPO's health activity was halted.[531]

7.6 Conclusion

The Alma Ata Conference on primary health care influenced countries across the world to focus on resolving healthcare challenges through preventative measures and community involvement. Although South Africa was not formally part of the Alma Ata conference due to its apartheid policy, the principles of this international conference had some impact on the state's new health reform initiatives despite the state's failure to adopt the conference resolutions holistically. The intensification of resistance and violence, protests and militant activities that followed after Alma Ata also put pressure on the state to establish commissions to modify apartheid instead of eradicating it in all spheres of life. The inception of Browne Commission and Tricameral Parliament in the early 1980s was aimed at bringing about stability. However, these moves aggravated mass political activism through protests, militant and violent activities with the hope of equalising social, political and economic life of all racial groups of which health services were not exception. The health profile of blacks continued to experience challenges despite these reform efforts created by the Alma Ata reform momentum, as well as international pressure for reform. There continued to be isolated efforts towards the implementation of primary health care initiatives in the Transvaal. This was done by institutions and individuals on the ground.

It was only towards the end of the 1980s, with the coming to power of F.W. de Klerk as the new president that the new hope was gradually becoming a reality when he announced that he was going to implement massive and meaningful reforms for the eventual establishment of a new democratic South Africa, though under severe

[531] Interview M.S. Sathekge, 87A Hans van Rensburg Street, Polokwane, 20 August 2018.

political, social and economic instability. This hope was reflected in the new health policy initiatives to equalise and integrate all previously segregated health systems, including those of the homelands. It was in this respect that the concept ‘primary health care’ continued to be popularised as it was seen by many as the best and affordable means of solving health problems of the blacks, most particularly those residing in the rural areas.

In the final analysis, therefore, one can argue that throughout the years of apartheid, between 1948 and the late 1980s, the failure to implement primary health care by apartheid government and the slow pace of health reforms in general was caused by the fact that these reform initiatives embodied progressive ideas that were anti-thetical to apartheid ethos of separation. As such, the reforms had a limited impact on the improvement of health of the blacks and primary health care in general.

CHAPTER EIGHT: THE EARLY 1990s AND THE RESTRUCTURING OF THE SOUTH AFRICAN HEALTH SYSTEM

8.1 Introduction

The 1990s were a turning point in the history of the health care system in South Africa since the creation of segregated political, social and economic system after Union Government in 1910. The turn of political events towards gradual democratisation created an atmosphere conducive for transformation in the country's health system, as new hopes for the attainment of a long-awaited health for all seemed to be fast approaching from the horizon. This chapter examines these shifts, beginning with a look at the impact of the new leadership of the ruling National Party government in 1989, when F. W. de Klerk became a new President of the Republic of South Africa. The chapter looks at this new leadership's preparedness to enact serious and meaningful reforms initiated by De Klerk's predecessor, P. W. Botha and his cabinet. The new government's preparedness to engage the previously banned black political organisations like the African National Congress (ANC), the South African Communist Party (SACP) and the Pan Africanist Congress (PAC), was a new milestone in the political history of the country. This gave hopes for the total transformation of healthcare system so that it could offer adequate health services for all racial groups. A new path for healthcare development would be in line with the popular notion of 'health for all by the year 2000' as envisaged by the Alma Ata conference in 1978.

The chapter will also focus on the reaction of the previously banned organisations and other non-governmental organisations to the new government's healthcare initiatives. To all intents and purposes, the initiatives of the de Klerk administration turned out to be limited and did not fully meet the high expectations of the majority of the blacks who were 'smelling' freedom. Needless to say, this led to the continuation of conflict and friction that accompanied the negotiation process for the implementation of democratic government.

Furthermore, the chapter will also analyse the restructuring process of South Africa's health system by the newly formed Government of National Unity that came into

power after the 1994 general elections. The post 1994 government's initiatives were based on the restructuring and integration of different health departments created by apartheid. The new government embarked on a new comprehensive health policy programme which aimed at addressing the imbalances of the past apartheid era, in order to eradicate poverty and related diseases. The Government of National Unity considered the District Health System as the best approach in dealing with the health challenges of the newly formed nine provinces. Greater focus will be on the former homeland areas of Lebowa, Venda and Gazankulu, which occupied a large part of the former Northern Transvaal.

8.2 The politics of the early 1990s and health legislation

The election of F.W. de Klerk as a new State President in 1989 was a turning point in the political landscape of South Africa. The willingness of the new reformist president to accept the mass democratic movement's demands for the new political, social and economic reforms, proved to be a significant development in the history of the country. In his opening address to parliament on 2 February 1990, de Klerk announced the major reforms. His announcement included the unbanning of the African National Congress (ANC), the South African Communist Party and other political organisations, which were banned by previous administrations for their anti-apartheid activities. Although uncertainties regarding the possibilities of effective implementation of these reforms were flooding the minds of many black South Africans, high hopes and expectations were predominant. These new expectations were also felt in the healthcare fraternity, most particularly from the progressive organisations, which struggled for years to persuade the government to transform the national health policies.[532]

The first step taken by the new government was aimed at redirecting the healthcare system from curative hospital-based to preventative primary health care system that would accommodate all racial groups. The different health authorities of the central health departments and homelands redirected their efforts towards the provision of comprehensive health care services in the previously disadvantaged black

[532] B.J. Liebenberg and S B Spies, *South Africa in the 20th century*, p. 525

communities, both in the rural and township areas.[533] The pressure felt by the government to do away with apartheid related policies, which were obstacles for many years, had forced the state's hand to act decisively. This move by the government was largely influenced by the principles of the World Health Organisation and Alma Ata Declaration of 1978, which considered primary health care as a priority in solving the many socio-economic problems in the rural areas of the blacks.[534] Internal pressure proved to be the catalyst.

The state's willingness to implement meaningful reforms based on preventative and primary health care services was part of the negotiation process during the 'road to democracy'. These efforts put specific emphasis on health education, environmental and community health and family planning, as the cornerstones of a comprehensive primary health care system. Other issues included health budget and community health centres. It was also in the early 1990s that the state continued its process of effecting changes in its health policy of which the Health Act No. 116 of 1990 became the first healthcare legislation passed by the new South African government to transform health for all citizens. This Act empowered the Minister of Health to exercise his powers decisively in the delivery of health. Of great significance were the effective strides he undertook to finance the non-independent homelands directly through the national Health Department. It was also during his budget speech of May 1991 that he regarded the local authorities as significant in the development of the primary health care model that would be vital for effective health service delivery in the former homelands. Although the recommendations of this Act were not implemented, it reflected signs of meaningful intention by the government to equalise health services to all racial groups in the country.[535]

Dr Elliot Kgoadi–Molaba, an employee of the former Lebowa homeland appreciated the Act for attempting to equalise salaries of both whites and blacks working in healthcare sector. Although attempts to equalise the two racial groups' salaries were supported by the government, the process was too slow as many whites in the health fraternity continued to earn higher salaries than their black counterparts. The

[533] H.C.J. van Rensburg et al, *Health and Health Care in South Africa*, p. 418.
[534] H.C.J. van Rensburg et al, *Health and Health Care in South Africa*, p. 418.
[535] J. Reddy, *South African Health Review* 1995, p. 76.

Act was finally repealed since the government showed no full commitment to implementing the legislation.[536]

The Health Act 116 of 1990 was followed by the National Health Service Delivery Plan of 1991, which paved way for the government to continue funding the former homelands as well as a series of national forums that were dealing with themes related to the development of primary health care, including training of health personnel and research projects. According to the *South African Health Review of 1995,*

> These were ineffectual as far as changes within the Department of Health were concerned. However, they served the purpose of drawing diverse people and opposing groups together and fostered a process of interaction and dialogue. The forums allowed frustrations to be aired publicly, and contributed to future-orientated thinking.[537]

Rina Venter, Minister of National Health, announced the new health dispensation in parliament on 13 May 1991. According to her, the new dispensation was,

> … a completely new management style with more say for the community and the repeal of bureaucratic measures which in the past had resulted in rigid decision-making processes. This means that the established culture within the health authorities will have to be modified considerably. In terms of this dispensation all health services will be managed by at the lowest possible level of government; primary health care clinics are expanded; academic hospitals are granted management autonomy and a National Policy Advisory Council for academic hospitals is to be constituted to advise the Minister on policy matters.[538]

[536] Interview with E. Kgoadi – Molaba, Ga – Mphahlele, Seleteng, 03 December 2016.
[537] J. Reddy, *South African Health Review* 1995, p. 76.
[538] Witwatersrand University Historical Archives, AD, ox 1912, File 112.46, Health 1992, New Management Style in Health Services, RSA Policy Review August 1991, p.14.

Photograph 14: *Dr Rina Venter, Minister of National Health, 1989-1994.*

Source: Witwatersrand University Historical Archives, AD, Box 1912, File 112.46, Health 1992, New Management Style in Health Services, RSA Policy Review. August 199.

Furthermore, the state president, de Klerk, emphasised the need for the health profession in the country to adapt to the new pattern suitable to the Third World realities where health related economic challenges and many needs in the country needed immediate attention. It was during the South African Nursing Centenary Conference held in Bloemfontein on 19 September 1991 that de Klerk, in his opening remarks, reiterated that:

> Nursing management too, has to be closely examined as a matter of urgency. The challenge facing your profession is to participate in a process of viable

> change and to create an affordable health-care system which lives up to the values to which you, as health professionals, subscribe.[539]

During the same conference, the Director of Community Health Care Services of the Department of National Health and Population Development, Iris Roscher, also made remarks about major deficiencies in the country's maternal healthcare service. Amongst other innovations, she emphasised the need for nurses to have background knowledge of family circumstances for the effective and appropriate treatment of common diseases and injuries.[540]

The state's further plans to put more emphasis on primary health care, which was community based rather than hospital based, were not without challenges. Although lacking in many respects, the hospitals for the blacks in the urban areas usually played a vital role in the provision of medical services, and enjoyed control over the available health resources than the rural based health centres. H.C.J. van Rensburg, who noted the undesirable dominance of curative hospital care, explained the scenario as follows:

> Hospitals' goals are largely focused on the development of specialised activities and they may become '*fortresses*' protecting those working inside their walls from responding to the needs of the community. They may also become *'prisons'* for health workers needing to undertake community-based activities. The hospital-curative approach differs in important ways from the PHC-preventative approach: traditionally, hospitals report in terms of numbers of patients served (total admissions, surgical procedures carried out, deliveries conducted, etc.), whilst PHC concentrates on the unreached. The hospital tradition is to concentrate on unusual or interesting cases, whilst primary healthcare focuses on what is afflicting the majority of the population.[541]

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[539] Witwatersrand University Historical Archives, AD, Box 1912 File 112.46, Health, 1992, *The Citizen* 20 September 1991, p. 16.
[540] Witwatersrand University Historical Archives, AD, Box 1912 File 112.46, Health, 1992, *The Citizen* 20 September 1991, p. 16.
[541] H.C.J. van Rensburg et al, *Health and Health Care in South Africa*, p. 487.

Despite the above scenario, however, some of the community based health institutions in the Northern Transvaal had to involve the hospitals in the provision of primary health care. The experience of the care groups, community health workers, and community based health care centres indicates a very close relationship with the hospitals located in the homelands.

When the Steinmefz Committee was set up by the Department of Health in September 1992 on the recommendation of the Minister of Health, it hoped to rationalise the South African health service in the homelands.[542] The Commission recommended that the six self-governing "states" should be integrated to create a single healthcare department that would provide services to all racial groups in the country. However, the Commission's efforts were overshadowed by criticism from the progressive health organisations for its narrow composition and exclusion of the major stakeholders such as the ANC, professional healthcare groups, health workers and other interested public sector stakeholders. The establishment of Health Desks by the ANC and PAC in 1992 had made way for increasing public participation and counterbalance to the National Party government. The ANC had also set up various commissions to address the restructuring of national health services during the years leading to the general elections.[543] The ANC's Health Desks, supported by the non-governmental organisations such as the South African Health and Social Services (SAHSSO) and the NPPHN, had accused the government during the early 1990s of deliberately pursuing the strategy of unilateral restructuring in an attempt to strengthen its position in the negotiations.[544] This accusation led to the establishment of a National Health Forum later in 1993, "…comprising senior representatives of government, the Patriotic Health Front and other formally represented organisations.[545]

The early 1990s continued to witness the continuation of poverty with nutrition related problems in the homelands, which were predominantly rural. The study M.S. Kgaphola entitled 'Nutrition knowledge of clinic nurses in Lebowa, south Africa: Implication for nutrition services delivery;' published in 1997 by the *Journal of Human*

[542] *Reddy, South African Health Review 1995*, p. 76.
[543] *Reddy, South African Health Review 1995*, p. 76.
[544] *Reddy, South African Health Review 1995*, p. 77.
[545] *Reddy, South African Health Review 1995*, P. 77.

Nutrition and Dietetics, revealed that Lebowa Homeland had inadequate nutrition services and qualified nutrition professionals and dieticians.[546] The nurses had incomplete or insufficient knowledge about nutrients and their toxicity if they are taken in large quantities or doses. It was also discovered that maize and beans were common diets and regularly consumed as staple foods in most of the black rural communities. In order to overcome these health challenges and related health complications like malnutrition, measles and kwashiorkor, it was recommended that efforts should be taken to implement intensive training of nurses in various rural clinics in the homelands as qualified dieticians.[547]

According to Dr Elliot Kgoadi–Molaba, the new state policy initiatives were faced with the intractable problem of the fragmentation of health services. He stated that the homelands inherited new policies which were foreign to them as the existing health policy and infrastructure were primarily tailored for blacks, who were considered to be second class citizens. The homelands were small, fragmented 'islands' within the Republic of South Africa, with inadequate hospitals and clinics while serving large populations. Furthermore, the allocation of one qualified nursing sister for each hospital made the provision of community health services difficult as they had knowledge of nursing but could not dispense medications to the patients since they were not qualified in this field. The fact that nurses at clinic levels were only specifically performing midwifery duties, meant that patients were usually referred to the hospitals.[548] In order to overcome this challenge, the state made provision for training of nurses as qualified midwives, drug dispensers, handlers of money collected from paying clients, record keepers and examiners of patients. Kgoadi–Molaba's experience at Groothoek Hospital in Zebediela included his involvement in the training of nurses who were then sent them to various clinics where the community health services were mostly needed. Kgoadi–Molaba's main contribution to the promotion of community or primary health care service was his suggestion for incentives for the rural nurses and doctors in the form of higher salaries. The then

[546] M.S. Kgaphola et al, 'Nutrition Knowledge of Clinic Nurses in Lebowa, South Africa: Implicationa for Nutrition Services Delivery', *Journal of Human Nutrition and Dietetics (1992),* 10, p 295.
[547] Kgaphola et al, 'Nutrition Knowledge of Clinic Nurses in Lebowa, South Africa: Implicationa for Nutrition Services Delivery', *Journal of Human Nutrition and Dietetics (1992),* 10, p. 296.
[548] Interviw by W. Maepa, with E. Kgoadi – Molaba, Gamphahlele, Seleteng, 04 December 2016.

Prime Minister of Lebowa, N. Ramodike overwhelmingly endorsed the proposal by Kgoadi-Molaba.[549]

8.3 The National Progressive Primary Health Care Network in the 1990s

The National Progressive Primary Health Care Network (NPPHCN), which was a community-based non-governmental organisation created in 1987, played a vital role in influencing some of the changes that were witnessed in the development and promotion of a national primary health care strategy. This organisation contributed immensely to the development of primary healthcare during the 1990s. This organisation's objectives included the promotion of collaboration, participatory research and policy formulation, the development of projects and programmes throughout the country and organising funds mainly from foreign funders to sustain primary health care. The organisation had to involve other non-governmental and governmental organisations for the success of this health strategy.[550]

In 1993, the NPPHCN realised that the involvement of political parties was crucial to the realisation of their objectives as the general election was imminent. In December 1993 it submitted a 29-Section questionnaire on primary health care issues to various political parties contesting the upcoming elections.[551] These included the ANC, the Conservative Party, the Inkatha Freedom Party, the National Party and the Pan Africanist Congress. The parties responded straight to the NPPHCN with the exception of the National Party, which did not respond to this organisation. Although the National Party did not support the filling of the questionnaire, its letter directed to the NPPHCN stated that the state of health in the country was unacceptable and needed immediate attention. The National Party also enclosed a number of documents, which were less than one year and were accepted by the NPPHCN. It was in this respect that the NPPHCN believed that all parties could work together

[549] Interviw by W. Maepa, with E. Kgoadi – Molaba, Gamphahlele, Seleteng, 04 December 2016.
[550] Witwatersrand University Historical Archives, AG, Box 3176 Reports, NPPHN, File ES 26 .5-37, "How Healthy is Our Future": An Analysis of Where the Political Parties Stand on Health Care Network. Reports, NPPHN. February 1994. p. i.
[551] Witwatersrand University Historical Archives, AG, Box 3176 Reports, NPPHN, File ES 26 .5-37, "How Healthy is Our Future": An Analysis of Where the Political Parties Stand on Health Care Network. Reports, NPPHN, February 1994. p. i.

with the elected parliament to fulfil their commitments in the improvement and strengthening of primary health care service to all South Africans.[552]

Although all parties agreed on the desirability of universal access to basic health services, they differed on the definitions of what those basic services should be, as well as on the schedules for access, and the level of detail to which they are to commit. The NPPHCN reported the following concerning the new primary health care system:

> …The ANC is unambiguous in its commitment to universality, and presents concrete time schedules for including certain services and population groups.
> …The Conservative Party envisions an Afrikaner state and extends their commitments only to those who reside in that state
> …The DP while articulating recognition of the importance of primary PHC services, does not commit unequivocally to undertaking the responsibility for assuring, within the limitations of available resources.
> …The Inkatha Freedom Party states its support for universality emphatically.
> …The National Party makes contradictory statements in recent documents. On the one hand, they state that access to health care is a basic human right while also saying it is not possible for government to ensure that right. They say that they have not defined which basic health services should be provided and that they will rely on a future process of negotiation to arrive at that definition. The present government has recently made some efforts to enhance access but the steps taken have been small when measured.
> ... PAC responses to NPPHCN's questionnaire were emphatic in their support for universality. However the responses were brief and supplied little detail and plans for implementation.[553]

[552] Witwatersrand University Historical Archives, AG, Box 3176 Reports, NPPHN, File ES 26 .5-37, "How Healthy is Our Future": An Analysis of Where the Political Parties Stand on Health Care Network. Reports, NPPHN, February 1994, p. i.
[553] Witwatersrand University Historical Archives, AG, Box 3176 Reports, NPPHN, File ES 26 .5-37, "How Healthy is Our Future": An Analysis of Where the Political Parties Stand on Health Care Network. Reports, NPPHN, February 1994, pp. ii – iii.

The NPPHCN was also instrumental in the mobilisation of other non-governmental organisations, community based organisations and community structures in the promotion of primary health care. These organisations worked in collaboration with the NPPHCN in the mobilisation of funds, mostly from foreign funders already operating in the country. When HIV/AIDS was showing dramatic increase most particularly among the blacks during the early 1990's, it was the Kagiso Trust and Independent Development, which funded the NPPHCN's Aids Programme (NAP).[554]

The northern and north eastern Transvaal areas, which were poverty-stricken areas with high disease notification, were areas which benefited most from these funders. The funds were also utilised for national expenditure between 1993 and 1994 in the production of media campaign materials. These campaigns were organised countrywide where the NAP worked with the women's groups, the ANC Youth League, the Congress of South African Students (COSAS) Unions, other civic organisations, the ANC and community care groups in the homeland areas. Primary schools in the black rural areas were mostly targeted.[555] In the Northern Transvaal, Elim Drama became popular as a result of the support from NPPHCN. According to NPPHN: "At the end of 1993 there were twenty local committees in N.Transvaal and four in E. Transvaal, N. Transvaal employed a total of twelve CWs and E. Transvaal three"[556]. Despite the shortage of resources, in 1993 the region managed to host a visit by an Australian consultant who drafted a funding application to AIDAB (Australian Government), which led to the approval of the funding by NAP and AIDAB for the Northern Transvaal scheduled to start from April 1994.[557]

The Northern Province, which comprised the former homelands of Lebowa, Venda and Gazankulu, had 91% of inhabitants living in rural areas, with high levels of unemployment and illiteracy. These undesirable conditions made the work of NPPHCN coordinator in this province difficult and challenging. Since most of the

[554] Witwatersrand University Historical Archives, AG, Box 3176, File NPPHC E6, Report from NPPHCN National Aids Programme to Kagiso Trust for the Period November 1991 to December 1993, p. 1.
[555] Witwatersrand University Historical Archives, AG, Box 3176, File NPPHC E6, Report from NPPHCN National Aids Programme to Kagiso Trust for the Period November 1991 to December 1993, p. 2.
[556] Witwatersrand University Historical Archives, AG, Box 3176, File NPPHC E6, Report from NPPHCN National Aids Programme to Kagiso Trust for the Period November 1991 to December 1993, p. 1.
[557] Witwatersrand University Historical Archives, AG, Box 3176, File NPPHC E6, Report from NPPHCN National Aids Programme to Kagiso Trust for the Period November 1991 to December 1993, p. 1.

NGOs operated without funding and appropriate skills, the NPPHCN worked very hard to see to it that Provincial Coordinators together with Provincial Committees worked with the Government of National Unity (GNU) to see to it that more employees are employed to be able to service the CBOs and NGOs in the province. It was here that the Network started to organise the women's groups with facilitation of empowerment and capacity building through workshops, courses and other training based on health themes. These community based women's organisations were drowned from rural and peri-urban areas. The Network undertook to train the women's organisations for a variety of projects for government departments where the members participated as the main role players. The women's projects which were trained on how to start a project included Batlokwa Women's Resource Project, Mashashane Development Forum Organisations, Resource Centre Houtbosdorp, Seshego/Turfloop/Lebowakgomo Women's Training, Giyani/Malamulele and other women's training projects in the province.[558]

In Mpumalanga Province, the Network also operated in Acornhoek (situated in the former Eastern Transvaal) from 1994 until it was officially launched during March 1995, with its office based in Sabie. Its significance became crucial when it received the support of the then provincial Member of Executive Committee (MEC) where several workshops and meetings were held. Like in the Northern Province, the NPPHCN worked closely with NGOs and CBOs with a focus on several issues, which included women's health programmes, sexual health programmes, vulnerable groups, and the development of District Health System.[559]

8.4 The role of research on primary health care

Besides organised groups such as the PPHCN, research groups also played a role in promoting primary health care in the poor black areas. The notion of 'building a healthy nation through research' as advocated by the Medical Research Council had

[558] Witwatersrand University Historical Archives, AG, Box 3176, File NPPHC E6, Report from NPPHCN, Interim Report on NPPHCN Core Support: Project # 93-1157 and Final Report on the Project Development Fund: Project # 90-8268 To the Witwatersrand University Historical Archives, e Henry J Kaiser Family Foundation, 1995, pp. 251-252.
[559] Witwatersrand University Historical Archives, AG, Box 3176, File NPPHC E6, Report from NPPHCN, Interim Report on NPPHCN Core Support: Project # 93-1157 and Final Report on the Project Development Fund: Project # 90-8268 To the Henry J Kaiser Family Foundation 1995, pp. 24-25.

a tremendous influence in highlighting the desirability of development of primary healthcare among blacks in the Transvaal province and the rest of South Africa. The council realised that the effective transformation of health care in South Africa could be achieved through the establishment of health projects with the mobilisation of members of the rural black communities. In 1991, the Medical Research Council (MRC) led by Nkosazana Dlamini Zuma added impetus in the desire for primary health care development in general. The significance of preventative health care was emphasised in her projects, which focused mainly on HIV/AIDS and maternal and child health. Some of the preventative measures emphasised by the projects included abstaining from sex, rights of women to refuse unprotected sex, and the careful use of abortion to end unwanted or enforced pregnancies. One of her projects regarding the investigations into the lessons learned from Pholela Health centre was significant as the model was adopted by other rural areas of the blacks in South Africa.[560] Pam Mamogobo's experience revealed that the centres like Ithuseng, Hlatlolanang, Elim hospital and other clinics in the rural black areas of the Transvaal used the Pholela model in their implementation of primary healthcre projects.[561]

Photograph 15: *Nkosazana Dlamini Zuma as a research scientist, Medical Research Council, Durban 1991-1994.*

Source: www.worldwhoswho.com. Dlamini-Zuma Nkosazana Clarice, Accessed 25 July 2020.

[560] Medical Research Council, Researcher is new Minister of Health, *Nursing RSA*, 9 (7), 1994, p. 5.
[561] Interview by W.Maepa with P. Mamogobo, Nursing Faculty, University of Limpopo, 29 January 2015.

The early 1990s could also be studied in the context of the role played by the Witwatersrand University Department of Community Health. It was the Health Systems Development Unit (HSDU) of this Department, which was involved at the research-service in the Bushbuckridge (BBR) area. The Unit had been involved in the development of primary healthcare in the Eastern Transvaal since 1980s. In order to facilitate effective primary health care services delivery in the area, the focus shifted to a district health system since 1990. This shift in focus was possible through government interaction with a Democratic Surveillance System (DSS), which functioned on health care planning and delivery. Both HSDU and DSS were aimed at the assessment of the content and values for local, regional, national and international applications. [562]

Bushbuckridge, which had a population of half a million people in 1990 lies 500km east of Johannesburg in the region of the Eastern Transvaal, with fragmented ethnic homelands: the Mhala region of Gazankulu and the Mapulaneng region of Lebowa. These two fragmented homelands were experiencing severe undesirable conditions of overcrowding, poverty semi-arid poor infrastructure and unemployment. In order to alleviate these challenges, the HSDU saw the need to work in close collaboration with district, provincial and national health service personnel to develop a District Health System in collaboration with DSS. The research carried out by the DSS played a vital role in gathering information to improve planning and primary healthcare service delivery to the needy communities. The collection of data was based on the identification of health and social problems, policy developments, general research questions, monitoring, evaluation and intervention. It soon became evident that the DSS's intended objectives would not progress unchallenged due to the existence of limited resources, limited skills, limited managerial capacity and demand for health information from a variety of constituencies in the district. [563]

A letter dated 09 January 1990 from Secretary of Mapulaneng Hospital, Mr M.P. Maacha, to Secretary for Health and Social highlighted the results as per the requested investigation regarding patients from Lebowa clinics who visited Tintswalo

[562] Impact of a Demographic Surveillance System (DSS) on Health Care Planning and Delivery and on its Consequent Impact on Health Indicators, 15 April 1996, p. 1.
[563] Impact of a Demographic Surveillance System (DSS) on Health Care Planning and delivery and on its Consequent Impact on Health Indicators, 15 April 1996, pp. 1-2.

Hospital due to its accessibility. The investigation was conducted by Maacha and the Nursing General Manager at Brooklyn clinic on 16 January 1990 to get information as to whether indeed the referred patients from this clinic located near Tintswalo were made to pay. The two investigators reported that:

> We were taken to three different families who confirmed that they were made to pay R15.00 (maternity fee) being the difference between Lebowa tariff and Gazankulu? The extra amount of R12.00 is paid should the ambulance be called out to Brooklyn clinic. When asked why Mapulaneng Hospital Ambulance is not called, they said that Tintswalo Hospital is nearer to their homes and therefore it becomes easier for their next – of – kin to pay their visits while they are hospitalized.[564]

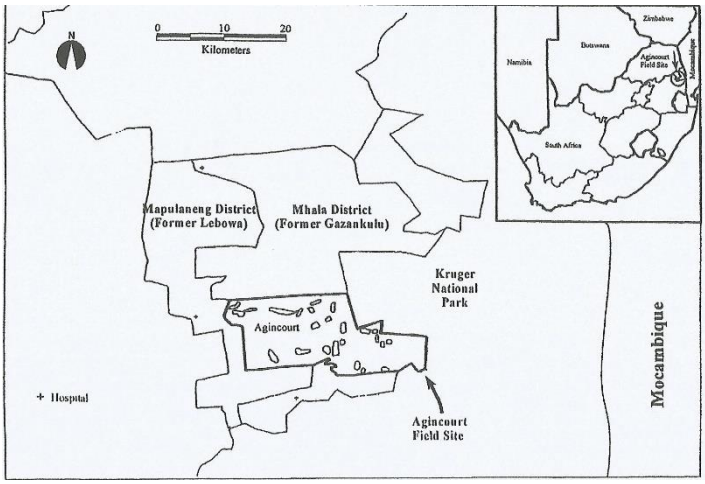
This practise by Tintswalo Hospital was an on-going pattern despite the Standing Resolution undertaken by the states' Joint Tariff Committee. The investigation also revealed that most of the clinics in Gazankulu were manned by Nursing Assistants – a practise which impacted negatively on the provision of proper preventative and curative health care services to the communities.[565]

The ever-increasing population, aggravated by the influx of refugees, had already worsened the situation in these areas. According to the population census taken in 1991,

> … the figure showed a population in Mhala of approximately 181 000, and a population in Mapulaneng of approximately 224 000, excluding migrants. A recent survey of 9700 households in the southern part of Mhala found figures over one third higher than the census figures, yielding a total population of over 500 000, if migrants are included.[566]

[564] Limpo Provincial Archives, Box 185, File 2/17/2/3, A letter from Mapulaneng Hospital to Secretary for Health and Social Welfare in Lebowa Government Services, in Lebowakgomo, 17 January 1990, p 1.
[565] Limpopo Provincial Archives, Box 185, File 2/17/2/3, A letter from Mapulaneng Hospital to Secretary for Health and Social Welfare in Lebowa Government Services, in Lebowakgomo, 17 January 1990, p 1.
[566] Witwatersrand University Historical Archives, AG, Box 3176, File ES.38 , A Situational Analysis of Health and Health Services in South Africa, NPPHCN Report, Health Policy, Johannesburg 1993, p 3.

Map 5: *Mhala District and Angincourt Field Site, Mpumalanga (Eastern Transvaal) Lowveld, South Africa.*



Source: C.G. Dolan et al., 'The Link between Legal Status and Environmental Health: A Case Study of Mozambican Refugees and Their Hosts in Mpumalanga (Eastern Transvaal) Lowveld, South Africa', *Health and Human Rights*, 2(2), 1997.

With the influx of Mozambican refugees on the south-eastern part of the Mhala District, the primary health care service was stretched to the limit. These refugees were part of large numbers of the Mozambicans who moved into this area during the middle of the 1980s due to the civil war in the former Portuguese colony. Some of the refugees settled in the Agincourt area, which was also a field site for a project established in 1992 by the Witwatersrand Health Systems Unit, as a subsidiary of district health system initiative.[567] The area was semi-arid, densely populated, deficient in basic services and infrastructure and experienced high levels of unemployment. The demographic census taken in 1992 and an environmental health survey conducted in 1993 revealed that undesirable factors such as lack of clean drinking water and sanitations, availability of waste disposals, shortage of fuel and adequate housing and shelter, and other unfavourable conditions, were common in the area.[568] It was discovered that ''…there are no communal toilets while 77 percent

[567] C.G. Dolan et al., 'The Link between Legal Status and Environmental Health: A Case Study of Mozambican Refugees and Their Hosts in Mpumalanga (Eastern Transvaal) Lowveld, South Africa, *Health and Human Rights'*, 2(2), 1997, p. 67.
[568] Dolan et al., 'The Link between Legal Status and Environmental Health: A Case Study of Mozambican Refugees and Their Hosts in Mpumalanga (Eastern Transvaal) Lowveld, South Africa, *Health and Human Rights'*, 2(2), 1997, p. 71.

of households report having to use ''the bush''.[569] This scenario posed a serious threat to the health of the refugees in the settlements as depicted in Table 5 below.

Table 5: *The Report about sanitation and water disposals at Angincourt in 1993.*

Refugees n=125 Mixed n=375	**Refugee Settlements**	**Mixed Settlements**
Toilets inside house	0%	0%
Pit toilet in yard (total)	24%	25%..
Best settlement	62%	76
Worst settlement	4%	33%
Communal toilet	19%	0.5%..
The Bush	51%	22%..
Best settlement	25%	4%
Worst settlement	77%	43%

Source: C.G. Dolan et al., 'The Link between Legal Status and Environmental Health: A Case Study of Mozambican Refugees and Their Hosts in Mpumalanga (Eastern Transvaal) Lowveld, South Africa', *Health and Human Rights*, 2(2), 1997.

Furthermore, the socio-economic profile of migrants revealed that:

> Migrants comprise about 12% to 13% of the total population, and between 40% and 70% of wage earners. In the 30 to 49 age, about 13% of women are migrant. The main destinations for migrants are Nelspruit, Phalaborwa, Johannesburg, Pretoria, the East Rand and the South Eastern Transvaal. This high migrancy rate has many implications for the health situation of the area, especially in terms of high S.T.D rates and transmission of HIV to the rural areas. Approximately 75% of male tuberculosis cases seen at Tintswalo are ex-miners.[570]

The presence of Mozambican refugees added strain on the already scarce resources in the Mhala district. The reluctance of the indunas and chiefs to assist their communities in the district worsened the situation.[571] Furthermore, cultural groups like Shangaan, Sotho and refugees also made it more difficult for the people

[569] Dolan et al., 'The Link between Legal Status and Environmental Health: A Case Study of Mozambican Refugees and Their Hosts in Mpumalanga (Eastern Transvaal) Lowveld, South Africa', *Health and Human Rights*, 2(2), 1997, P.73.
[570] Witwatersrand University Historical Archives, AG, Box 3176, File ES.38 , A Situational Analysis of Health and Health Services in South Africa, NPPHCN Report, Health Policy, Johannesburg 1993, p. 4.
[571] Witwatersrand University Historical Archives, AG, Box 3176, File ES.38 , A Situational Analysis of Health and Health Services in South Africa, NPPHCN Report, Health Policy, Johannesburg 1993, .p. 7.

to organise themselves as part of community involvement in the provision of health services and the prevention of diseases.[572] It also became evident that attempts by the National Party government to intensify health changes and the involvement of non-governmental organisations like Wits HSDU would not survive as negotiations for the establishment of democratic government was imminent.

8.5 The Post-1994 era and the new health development plans

The post 1994 era of healthcare delivery, which was associated with the building of a new health care system based on the mainstreaming of primary health care, had its roots in the unofficial efforts many decades before the democratic South Africa was established. The ideas of Comprehensive Primary Health Care, which emphasised preventative, promotive and community-based care was met with many challenges before the inception of democratic South Africa as the State was unwilling to entertain it. Efforts by various political, social, progressive health organisations, idealists and realists, and other interested groups continued to desire health reforms for equitable, accessible and free health care most particularly directed towards the rural impoverished black communities. Such efforts were considered through commissions, which to certain extent compelled the government to issue many acts, which were never implemented.[573]

The ANC realised that the transformation could also be effected through the process of developing the National Health Plan based on primary health care. Another significant initiative by the ANC immediately after the general elections was evident when it drafted and published a document called *ANC Health Plan,* which aimed at removing the past inequalities in healthcare by embarking on a new policy framework based on parity in the provision of health care services. This initiative led to the drafting of proposed health policies by the team comprised of members of the ANC, Health Department consultants appointed by the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF). The draft document was based on the documents already prepared by the ANC. The fact that the plan was

[572] Witwatersrand University Historical Archives, AG, Box 3176, File ES.38 , A Situational Analysis of Health and Health Services in South Africa, NPPHCN Report, Health Policy, Johannesburg 1993, p. 7.
[573] van Rensburg et al, *Health and Health Care in South Africa*, p. 240.

drafted with the involvement of the ANC Health Department, WHO and UNICEF, created new hopes among the black South Africans in general. The draft document was based on the health documents already prepared by the ANC's Health Policy Commissions, together with other democratic movements before the 1994 election.[574]

C. Myers argued that it was only the ANC, which released its health guidelines with its principles reflecting primary healthcare approach. The ANC's main objective in this respect was aimed at reducing inequality and promoting community health development as the rural areas of the blacks were still suffering from poverty and underdevelopment. Apart from health development, the ANC emphasised the need to improve housing, education and social welfare of the blacks in the rural area.[575] The second document was drafted after in-depth discussions during the National Workshop, which resulted in its release for public debate. The positive response from members of the public was a victory by the ANC'S long awaited Health Plan that would make provision for an equitable health system for all racial groups, with special emphasis on primary health care.[576] As noted by C. Myers,

> …the document articulated much of the popular rhetoric concerning health and established the primary health care approach as the central tenet of future health practice. Henceforth the Plan would serve as the benchmark against which all policy and planning would be measured.[577]

The areas with the least healthcare centres that were severely affected by the backlog of health care service delivery with were the former homelands of Lebowa, Venda and Gazankulu. These governments fell under the category of areas with widespread incidences of poverty, unemployment, ill health and diseases. The ANC Health Plan, which was based on the Reconstruction and Development Programme (RDP) was to see to it that the restructuring of health sector took place with immediate effect. This new effort laid a strong foundation in the establishment of the

[574] ANC, *A National Health Plan for South African*, 1994, p. 7.
[575] C. Myers, From Apartheid to Intergration: The role the Witwatersrand Medical Library in Health Care Services in Johannesburg, South Africa, *Bulletin Medical Library Association*, 83(1), January 1995, p. 74.
[576] Myers, From Apartheid to Intergration: The role the Witwatersrand Medical Library in Health Care Services in Johannesburg, South Africa, *Bulletin Medical Library Association*, 83(1), January 1995, p. 74.
[577] Reddy, *South African Health Review* 1995, p. 77.

new health information system that would provide equitable health services to all racial groups in the country.[578]

Selina Maphorogo argued that the National Health Plan of 1994 was a victory for a long-awaited desire by interested individuals within the health circles of government and non-governmental health organisations in the former homelands of Lebowa, Venda and Gazankulu. The health centres of these former homelands were inefficient as they were deliberately underdeveloped by the apartheid state. Maphorogo went further to say that this scenario created hopes that lack of funds and sufficient primary healthcare services would be a thing of the past.[579] Although the Health Plan was criticised by some individuals and groups for being dominated by WHO and UNICEF, it laid a strong foundation for the development and transformation of primary healthcare in general, and served "…as a benchmark against which all policy and planning would be measured."[580] The period was followed by the new health initiatives, of which the District Health System was the core, and will be discussed later in this chapter.

It was also at the beginning of the 1994 before the elections that the training of health personnel remained a crucial component of RDP where medical schools in the country were to carry this task. The profitable private health sector was structured in such a way that it benefited the white minority while the black majorities in the rural areas were neglected. The doctors in these schools were expected by the state to train competent doctors to overcome health challenges that prevailed in the inter-city communities, among squatters, and in the peri-urban and rural black communities. Since the South African medical schools have been modelled on medical schools in London, Edinburgh and Boston, their competency in training specialist doctors was unquestionable. The training emphasised the prevention of illness and the promotion of lifestyles. The fact that most of the nurses were reluctant

[578] J. Braa and C. Hedberg, 'The Struggle for District-Based Health Information System in South Africa', *The Information Society*, 18(2) 2002, http//www.tandfontline.com, Accessed on 30 January 2016, p. 112.
[579] Interview by W. Maepa with S. Maphorogo, Elim Care Group Centre, Waterval Louis Trichardt, 10-March-2007
[580] Reddy. J. *South African Health Review* 1995, p. 77.

to practice in the rural areas, the state implemented incentives in the form of rural allowances.[581]

The 27th of April 1994 came as a relief to those who made the effort to transform the National Health Service for the country under difficult and challenging circumstances. Although the agreement between the ANC and National Party paved way for the establishment of a Government of National Unity scheduled for five years, the resounding mandate to address the ills created by the apartheid state paved way for favourable conditions necessary for the full implementation of primary health care in the rural areas. It became evident that the newly appointed President of South Africa, Nelson Mandela, would make provision for the implementation of primary health care sector clinics throughout the country. The period signaled a dramatic shift from the old apartheid policy to a new era of comprehensive health care based on the tenets of primary health care.[582]

The new South Africa inherited a highly fragmented, biased and inequitable health system with little signs of improved or available primary health care services in the former homelands as they were purely rural in character. The challenges facing the new government included the need to come up with a new comprehensive programme that would redress the socio-economic imbalance created by the apartheid government as well as to alleviate poverty through the direct involvement of grassroots members of the communities and other interested individuals. An attempt to overcome these challenges included legislation that would ensure new commitments. The ANC stated that such goals could be achieved by:

- Ensuring that the emphasis is on health not only on medical care.
- Redressing the harmful effects of apartheid health care services.
- Encouraging and developing comprehensive health practices that are in line with international norms, ethics and standards.

[581] Witwatersrand University Historical Archives, HE, 13; Training 1994 January, Medical Care for Minority, January 7 September 1994, Unpaginated.
[582] K. Kautzky and S.M.Tollman, 'A Perspective on Primary Health Care in South Africa: Primary In Context', *South African Health Review*, 2008(1), p.18.

- Emphasising that all health workers have an equally important role to play in the health system and ensuring that team work is a central component of the health system.
- Recognising that the most important component of the health system is the community and ensuring that mechanisms are created for effective community participation, involvement and control.
- Introducing management practices that are aimed at efficient and compassionate health care deliver.
- Ensuring respect for human rights and accountability to the users of health facilities and the public at large.
- Reducing the burden and risk of disease affecting the health of all South Africans.[583]

The period from 1994 was also characterised by the government's effort to redress disparities between blacks and whites. The plight of the blacks, most particularly in the outlying and isolated rural areas remained a challenge to the newly formed democratic government. The rate of unemployment particularly in the former black homelands aggravated socio-economic problems. The RDP which had as its main objective the alleviation of poverty among blacks in the social and economic sphere, was considered a relief instrument to addressing the imbalances created during apartheid era. These developments were reflected in the field of employment, housing, health, education, communication network, electricity and other related areas of life. It was in this respect that the national system of social grants became significant in the alleviation of poverty and unemployment. According to Coovadia et al: "One of the successes of the post-apartheid years has been to unify the national state pension system and disability and to introduce new grants including child support grant."[584]

The government's attempt to create access to basic health services was also reflected in many local governments or municipalities. The merging of surrounding rural areas with the towns or urban areas was an attempt to improve the lives of the

[583] ANC, *A National Health Plan for South Africa*, May 1994, p. 7.
[584] H. Coovadia et al, 'The Health and health system of South Africa: historical roots of current public challenges, Health in South Africa', p. 824.

blacks. The government's intention to provide cheap houses and free water and electricity was rocked by lack of proper implementation. It became evident that government systems could not cope with growing challenges of financing the new initiative.[585]

The newly formed nine provincial departments had to operate at optimum levels in order to address the peoples' expectations, including improving the quality of health services for all South Africans. In order to facilitate the restructuring process, the Strategic Management Team was instituted in each province to reflect new leadership structures including members from the previously banned departments and non-governmental organisations.[586] In the Northern Province, which included large parts of the former Northern Transvaal, the integration of health departments of the previous provincial and homelands of Gazankulu, Venda and Lebowa to form a single provincial health department became a challenge. J. Reddy pointed that:

> A potentially serious shortcoming lies in the fact that many of the senior managerial positions in the new health departments are held by the same people who held such positions in the old departments. They were responsible for implementing the fragmented, centralised and discriminatory policies of the past. Only time will tell whether they will be able to rise above themselves and their history and boldly implement badly needed reforms.[587]

The new government also made notable efforts to reduce disparities by establishing the National Programme of Action. This programme made provision for the implementation of free medical services for pregnant women and children under the age of 7, with the involvement of Ministry of Welfare, a National Youth Commission and the Nelson Mandela Children's Fund. The significance of this plan became evident when it supported the expanded primary health care system.[588]

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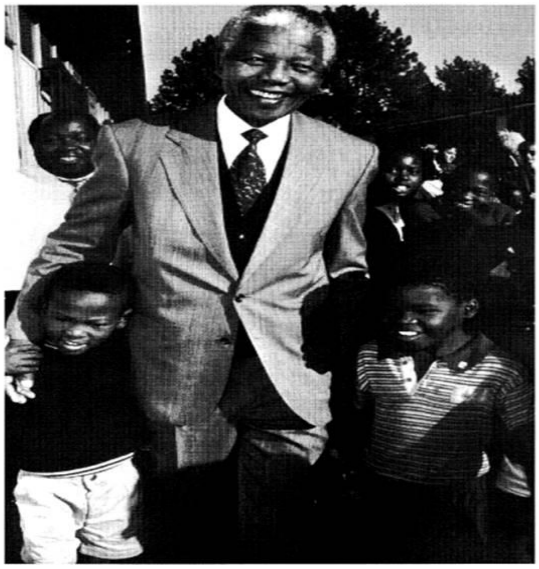
[585] Coovadia, et al, 'The Health and health system of South Africa: historical roots of current public challenges, Health in South Africa', p. 824.
[586] Reddy, *South African Health Review 1995,* p. 80.
[587] Reddy, *South African Health Review 1995*, p 80.
[588] S.A. .Burgard & D. J. Treiman, Trends and Racial Differences in Infant Mortality in South Africa, *Social Science Medicine,* 62, 2006, p. 1128.

Photograph 16: *Nelson Mandela with children, promoting a healthy nation.*



Source: ANC, *A National Health Plan for South Africa.*

Nutrition and a school feeding scheme had been one of the initiatives undertaken by the new Government of National Unity in an attempt to eradicate poverty and improve the delivery of health services to the poor. This endeavour was part of the state's policy whereby the primary school children were also educated on nutrition with particular focus on rural and peri-urban informal settlements. The National government had allocated millions of rands to all provinces through Nutrition and Social Development Programme. According to Reddy:

> The allocation of almost R1 billion in 1994/5 to food programmes through the Department of Health demonstrates the importance that the Government of National Unity attaches to the alleviation of malnutrition.[589]

While the year following the 1994 elections was marked by the rapid population increase of black children in primary schools, the proportion of white school children continued to decrease. The survey conducted by the South African Labour and Development Research on behalf of the World Bank revealed that black children, mostly from provinces which were mainly rural had high percentages of

[589] Reddy. *South African Health Review* 1995, p. 151.

undernourishment of which the new Northern Province and the Eastern Cape had the highest notification."[590]

The ANC also realised that political change was necessary for the implementation of its Health Service Policy in order to force the abandoning of the existing health care policies created in the homelands. It was only the ANC which released its health guidelines with its principles reflecting the primary health care approach as adopted by the World Health Organisation and United Nation's Children Fund at Alma Ata Conference in 1978. The ANC's main objective in this respect was to reduce the inequality and promote community health development as the rural areas of the blacks were still suffering from poverty and underdevelopment. Apart from health development, the ANC emphasised the need to improve housing, education and social welfare of the blacks in the rural areas.[591]

The new government also came up with a new health model that would create health reform based on primary health care. This new approach was motivated by the ANC's health vision of promoting health for all South Africans with the aim of securing and achieving equitable social and economic development in terms of employment, housing, clean water, sanitation reductions in the levels of violence and malnutrition and the provision of healthy lifestyle.[592] Other visions were based on the right to free health care, the creation of an integrated National Health System, coordination and decentralisation of health institutions, respect for all races and other related rights of individual South Africans to free access to health services.[593]

The democratically elected government was also faced with a task of eradicating discrimination, disempowerment and underdevelopment in the former homeland areas of which Lebowa, Gazankulu and Venda were not exceptions. The government immediately issued a Health Service Plan which became a health model. Despite the high expectations for ultimate implementation of health services to the previously disadvantaged rural blacks, the problem of the shortage of primary

[590] Reddy. *South African Health Review* 1995, p. 152.
[591] Myers, 'From Apartheid to Intergration: The role the Witwatersrand Medical Library in Health Care Services in Johannesburg, South Africa', *Bulletin Medical Library Association*, 83(1), 1995, p. 74.
[592] ANC, *A National Health Plan for South African*, 1994, p. 20.
[593] ANC, *A National Health Plan for South African*, 1994, p. 22.

health personnel and resources hampered the intended growth of primary health care services. The clinic services were provided by the local authorities and were partially subsidised by the National Public Health Budget. The densely populated rural areas or homelands were unable to afford services offered by the private health institutions. The insufficient health resources were injected into the badly planned and already financially impaired health system that placed little emphasis on primary and community health services. The consequences of this situation left even the best hospitals under pressure to cope with their health provisions. This over-utilisation and over-occupancy of hospital beds, mainly in public hospitals serving the blacks in turn affected the clinics to such an extent that deterioration of primary health care services became a norm. [594]

One of the greatest challenges facing the new government was the HIV/AIDS pandemic. The ANC predicted earlier before the general elections that between four and seven million South Africans would be infected with the disease by the year 2000.[595] Since this prediction was widely acknowledged by the South African democratic government and the international World Health Organisation, it was believed that comprehensive and localised preventative measures should be taken worldwide. The escalating incidences of HIV/AIDS related illness and deaths alarmed the governmental and non-governmental organisations to view the disease as a serious threat to the people of South Africa. Although the threat of this disease was escalating, it seemed little progress was made as most South Africansparticularly in the rural areas were in denial. This understanding was also expressed by Keegan Kautzky and Stephen Tollman when explained that the disease was never considered a priority by the newly formed democratic government under the presidency of Nelson Mandela.[596]

Further efforts to improve health services were made when the national government started to focus on the prevention of HIV/AIDS through campaigns and education projects to raise public awareness of the impact of the disease on South African

[594] A. Fourie and H.C.J. van Rensburg, 'Policy-making for real: Politics and Progress in South African Health Care', *Curations,* 16 (3), 1993, p. 13.
[595] Kautzky and Tollman, 'A Perspective on Primary Health Care in South Africa: Primary Health Care: In Context', *South African Health Review*, 2008(1), 2008 p. 25.
[596] Kautzky and Tollman, 'A Perspective on Primary Health Care in South Africa: Primary Health Care: In Context', *South African Health Review*, 2008(1), 2008 p. 25.

societies. This initiative had far-reaching implications in the history of health in South Africa in general. When Manto Tshabalala Msimang became a Minister of Health in 1999, she announced that testing for HIV/AIDS would be a national policy which made provision for all South African citizens to know their HIV status. This step was taken with the aim of reducing the spread of the disease through medical treatment. In order to encourage people to test, the following circumstances were to be considered:

a) Upon individual request, for diagnostic or treatment purposes with the informed consent of that individual;

b) On the recommendation of a medical doctor that such testing is clinically indicated with the informed consent of the individual;

c) As part of HIV testing for research purposes, with the informed consent of the individual and in accordance with statutory provisions regarding blood donations;

d) As part of unlinked and anonymous for epidemiological purposes undertaken by the national, provincial or local health authority or an agency authorities by any of these bodies, without informed consent provided that HIV testing for epidemiological purposes is carried out in accordance with national legal and ethical provisions regarding such testing.

e) Where an existing blood sample is available and emergency situation necessities testing the source patients' blood.[597]

[597] GN, Box 1479 GG20710, National Policy for Health Act, 1990 (Act No. 116 of 1990), www.enviroleg.co.za, 10 December 1999, pp 1-2

Photograph 17 : *Dr Manto Tshabalala Msimang, Minister of Health, 1999-2009.*

Source: www.google.co.za/search?q=manto+tshabalala+picture&biw, Accessed on 06-03-2014. GN, Box 1479 GG20710, National Policy for Health Act.

Although Tshabalala-Msimang made efforts to effect meaningful health promotion in the prevention of diseases, her controversial statements about the treatment of HIV/AIDS elicited severe criticism countrywide and internationally. One can also state that her service left her caught in political statements uttered by President Thabo Mbeki when he denied that HIV causes AIDS, leaving her with minimal space to apply her mind correctly in her decisions as a Minister of Health. Since many South Africans who suffered from HIV/AIDS died during her tenure, it was a severe blow to the government's health policy of promoting primary health care projects, most particularly in the rural areas as happened in the former Transvaal homeland due to high levels of poverty and diseases.

In the former homelands of Lebowa, Venda and Gazankulu, HIV/AIDS infections had been increasing since the 1980s, with many blacks losing their lives. The denial about the existence of this disease emerged from politicians and chiefs. In the Lebowa parliament, many ministers had a perception that HIV/AIDS was non-existence. Napoleon Makgoga, who was one of the primary health care team members who conducted research at the University of Venda in early 1989 revealed that many academics who were interviewed also had similar perception that the disease did not exist. Some respondents believed that the talk about the disease

was the intention of the Americans to discredit blacks and their traditional medicine.[598]

According to Makgoga, the team's message to prevent the disease and make awareness programmes was a difficult task due to the people's perception of denial and as a result, the disease continued to kill many blacks in the Transvaal.[599]

8.6 The National Health System and the District Health System

Before the 1994 general elections, the District Health System (DHS) was recommended and experimented worldwide as a way of eradicating poverty and diseases. When the homeland system came into being in South Africa, the system continued to be a priority in the provision of primary healthcare services to the poverty-stricken rural population. The system was supported by the WHO's Division of Strengthening Health Services, which produced essential categorisation to assist with the development of this system in support of primary health care. The WHO emphasised five areas such as organisational capacity, planning and management, development of human resources, financing and resource allocations and community involvement. In the Transvaal, the district health development was made possible in September 1992 when a meeting was convened with representatives from local health services for the Mhala, Mapulaneng, Hoedspruit, including the prominent members of Gazankulu and Lebowa departments of health, and senior members of Department of National Health and Population Development.[600]

At that meeting that key issues and concerns were discussed. Issues included organising the district in relation to the local community participation, district management at Mapulaneng and Tintswalo Hospitals in relation to Hospital superintendents' responsibilities at hospitals, health centres, clinics and other health posts. Relating to district and regional authority it was agreed that in the meantime the homeland head would exert excessive control over its activities, and the working

[598] Interview by W. Maepa with N. Makgoga, Limpopo Provincial Department of Health, Polokwane, 08 September 2017.
[599] Interview by W. Maepa with N. Makgoga, Limpopo Provincial Department of Health, Polokwane. 08 September 2017.
[600] S.M. Tollman et al, 'Developing district health systems in the rural Transvaal: Issues from the Tintswalo/Bushbuckridge experience', *South African Medical Journal*, 83 August 1993, p. 566.

relationship between the doctors, nurses and health teams was considered crucial. The participants finally encouraged co-equal participation and working relationships among local communities, local health services, educational and research institutions to sustain the district health system at Bushbuckridge.[601]

Each district comprised a district hospital and a number of clinics that were aiming at providing health services to the local communities with available scarce resources through the involvement of the communities themselves. For example, Angincourt fieldsite, established by the University of Witwatersrand 's Health Systems Development Unit in 1992 as a research project was intended to demonstrate the development of local and district health services. This research project was part of health reform in the country based on community-orientated primary health care.[602]

According to Dr Elliot Kgoadi-Molaba, the population, poverty and associated diseases in the homelands were increasing rapidly from the time of their inception, and available clinics and hospitals, most of which were missionary-driven, could not cope with these challenges.[603] Although the districts were established as a possible solution, underdevelopment, shortage of doctors, nurses, hospitals and clinics, as well as the remoteness and fragmentation of rural population worsened the situation.[604] According to S.M. Tollman et al,

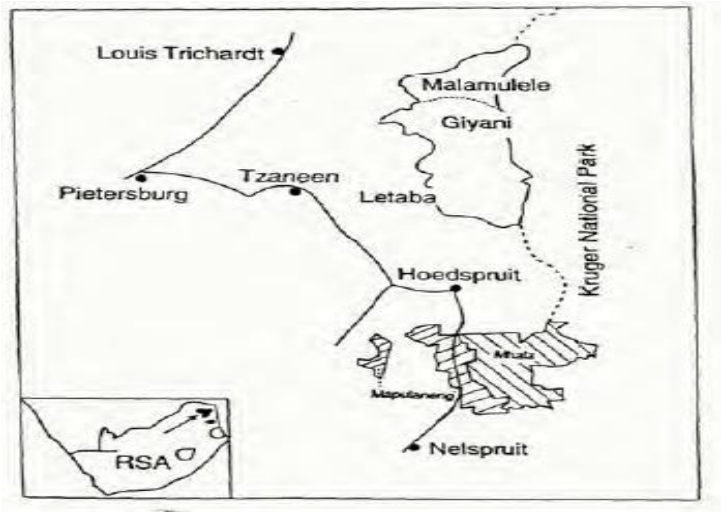
> Some results of this fragmentation include: (i) distorted patient referral patterns that result in patients having to travel long distances to reach 'their' hospital; (ii) associated increased travel costs to patients and families; (iii) extra cost toduplicate services in areas adjacent to to each other; (iv) failure to ensure that local health care development, such as the siting of clinics, is according to population distribution; (v) inability of local services to provide ambulatory care properly (in cases of, for example tuberculosis or sexually

[601]Tollman et al, 'Developing district health systems in the rural Transvaal : Issues from the Tintswalo/Bushbuckridge experience', *South African Medical Journal*, 83 August 1993, p. 567.
[602] Dolan et al, 'The Link between Legal Status and Environmental Health: A Case Study of Mozambican Refugees and Their Hosts in Mpumalanga (Eastern Transvaal) Lowveld, South Africa', *Health and Human Rights'*, 2(2), 199, p. 67.
[603] Interviw by W. Maepa, with E. Kgoadi – Molaba, Gamphahlele, Seleteng, 15 October 2017.
[604] Interviw by W. Maepa, with E. Kgoadi – Molaba, Gamphahlele, Seleteng, 15 October 2017.

transmitted disease); (vi) failure to combine duplicate community services, such as school health, psychiatric or ambulance services.[605]

These challenges prevailed in various rural areas in the former Lebowa, Venda and Gazankulu.

Map 6: *Map of the eastern Transvaal showing the Mhala and Mapulaneng health wards of the Bushbuckridge area.*



Source: S.M. Tollman et al, 'Developing district health systems in the rural Transvaal : Issues from the Tintswalo/Bushbuckridge experience. *South African Medical Journal'*, 83, August 1993.

When the New Democratic Government of National Unity came into being after the 1994 general elections it also regarded the district orientated primary health care as possible solution to the health challenges of the rural blacks in the newly formed provinces. This period witnessed serious attempts by the new government to bring about total and effective defragmentation and deracialisation of health system in the newly formed provinces.[606] The national government envisaged that the districts were to be large enough to be economically viable, but small enough to ensure effective management to accommodate the needs of the local people with the involvement of the community through training and education. The system was based on the following definition of the World Health Organisation:

[605] S.M. Tollman et al, 'Developing district health systems in the rural Transvaal : Issues from the Tintswalo/Bushbuckridge experience. *South African Medical Journal'*, 83, August 1993, p. 566.
[606] J. Reddy. *South African Health Review* 1995, p. 54.

> A District system based on Primary Health Care is a more or less self-contained segment of the National Health System. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private, or traditional. A District Health System therefore consists of a large variety of inter-related elements that contribute health in homes, schools, work places, and communities, through the health and other related sectors. It includes self-care and all health care facilities, up to and including the hospital at the first referral level, and the appropriate laboratory, and other diagnostic, and logistic support services.[607]

This new approach was considered by the government as an effective way of dealing with a variety of health challenges that prevailed in the previously disadvantaged rural areas of the blacks, of which the former Lebowa, Venda, and Gazankulu in the Transvaal were not exceptions. The ANC believed that:

> It is fundamental to primary health care principles that the communities served have significant input into decision-making process. In its plan the ANC describes local approaches and responsibility for delivery of health services. The ANC plans are detailed in their descriptions of elected community committees as vehicles for participation in decision making and are illustrative of ANC'S strong support of participation of communities and of organs of civil society.[608]

This move was also motivated by the fact that the system was successfully practiced in many countries worldwide, both in the developed and developing worlds. The newly formed government realised that the concepts 'caring' and 'wellness' could effectively be promoted through the district health system, with the aim of providing

[607] World Health Organization, *A Policy for the Development of a District Health System for South Africa*, p. 1.
[608] Witwatersrand University Historical Archives, AG, Box, 3176 Reports, NPPHN, File ES 26 .5-37, "How Healthy is Our Future": An Analysis of Where the Political Parties Stand on Health Care Network. Reports, NPPHN, February 1994. P. iii.

health services to the local communities, of which the following tasks were envisaged:

- emphasise the prevention, health education and promotion, early intervention , and rehabilitation
- be responsive to community needs by placing control and management responsibilities at a local level
- eliminate inequities and establish intersectoral developmental links
- integrate institutional, community-based and prevention programmes both within the health sector and with other sectors impacting on health
- reduce waste and eliminate duplication at all levels.[609]

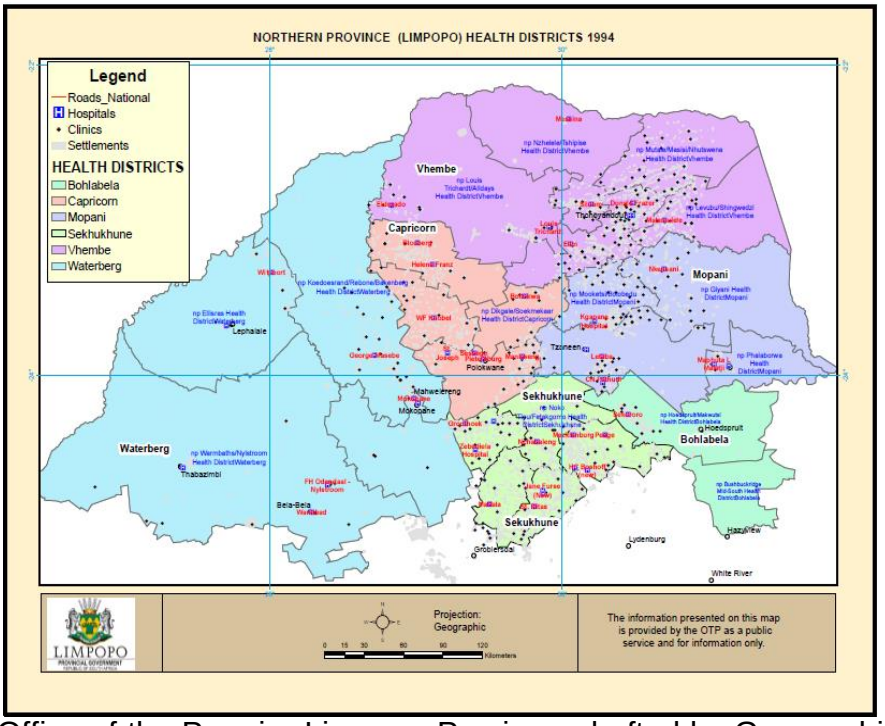
The Plan also envisaged that each district must comprise one or more district hospitals, community health centres, clinics and smaller facilities such as mobile units and visiting posts.[610] The system was to be implemented in all nine provinces where each was divided into several districts in terms of their functional and geographical coherence. The boundaries of the districts were to be determined politically to ensure that integrated and comprehensive health service delivery is effectively facilitated, with a District Health Authority (DHA) responsible for each district. The DHA, with its membership drawn from the local authorities were to be responsible for the promotion of primary healthcare and to plan, coordinate, support, supervise and evaluate services based on national and provincial norms, policies and guidelines. The DHAs received budgets for the primary health care, which made it possible for effective provision of primary health care services to the rural communities. The Health Plan also made provision for the coordination between the national, provincial and district levels for effective provision of primary health care services. [611]

The development of policy and strategy for the DHS was drafted by a team of officials from the nine newly-formed provinces led by the national Department of Health, which led to the release of policy document public comment at the end of

[609] World Health Organization, *A Policy for the Development of a District Health System for South Africa*, p. 1.
[610] P. Mclaren, A *Policy for the Development of a District Health System for South Africa,* Unpaginated.
[611] ANC. *A National Health Plan for South African*, 1994, pp. 62-63.

1995 entitled 'A Policy for the District Health System for South Africa'. Despite local government officials' displeasure with the process because of non-representation, the document was finally adopted by the Department of Health, with the inclusion of certain aspects of it into the White Paper on the Transformation of Health System. The document was formally endorsed by Parliament in 1997.[612] However, the persistent challenges pertaining to the implementation of the DHS received attention from the non-governmental organisation and the South African universities Public Health Departments, which took active interest in the country's healthcare sector.[613]

Map 7: *Northern Province (Limpopo) health districts 1994.*



Source: Office of the Premier Limpopo Province, drafted by Geographic Information System, 13 January 2017.

The above map shows that Vhembe district, which is largely located in the former Venda homeland, was overcrowded by a large number of clinics around the capital Thohoyandou because the former Venda homeland managed to build more clinics than Lebowa and Gazankulu. In Capricorn District, there was a high concentration of clinics in the surrounding rural areas. In Waterberg District, a high concentration is

[612] The District Health System in South Africa: Progress made and next step, htts:www.westerncape.gov.za/text/2003/district_health_system_sa, July 2001, pp. 7-8.
[613] The District Health System in South Africa: Progress made and next step, htts.www.westerncape.gov.za/text/2003/district_health_system_sa, July 2001, p. 10.

found around Mokopane area while Lephalale, Witpoortand, Thabazimbi show sparse distribution of clinics because commercial farming was the main activity under white farmers. The nearly even or well distribution of clinics in Sekhukhune District could possibly be due to the barren land, with poor soil fertility and low annual rainfall. On the other hand, the district of Bohlabela has low concentration of clinics due to relief barriers with sparse population distribution. The general implication in this respect is that the higher the population distribution density, the higher the distribution of clinics.

At provincial level, the Provincial Health Authority (PHA) was to be responsible for all people of the province with health specialists from the provincial health institutions being responsible for visiting and providing support to various districts in the province. These specialists were also responsible for facilitating referrals between primary, secondary and tertiary health institutions. The elected PHA was chaired by the Member of Executive Committee (MEC) for health with members including Provincial Director for health services, Heads of the Provincial Health Departments, and representatives from DHAs. This committee was responsible for the control of provincial health budget, functioning within the National guidelines.[614]

The experience of Dr M. Masipa, who was a Director of the Primary Health Care in the Limpopo Province, explained that the districts were powerful institutions in the effective provision of primary health care services in the province since the establishment of the new democratic government in 1994. The transformation of the health system was made possible by the government imposition of free health services to all hospitals, clinics and other government health institutions. Because most of the rural areas were still underdeveloped, most particularly in terms of infrastructure and communication networks, the health districts, together with the help of the Provincial Department of Health and local governments saw the need to strengthen the mobile services whereby every five kilometre was provided with these mobile health facilities. When the health problems increased, especially malaria disease and dental problems, health support was provided through referrals to the

[614] ANC. *A National Health Plan for South African*, 1994, p. 66.

hospitals as the mobile clinics could not effectively deal with these diseases. As a result, these clinics treated patients with minor ailments.[615]

The transformation of health care through DHS went through various alternative policy structures of which one of them was the Universal Health Coverage (UHC) during the post-1995 era. This occurred as a result of the growing enthusiasm at global and national levels with the aim of strengthening the health needs of the low and middle income countries. The UHC was intended at the development of the National Health Insurance as a model that will roll out community–orientated primary health care. In Ghana and Vietnam, the system worked effectively as the population depended much on local context while in South Africa the system was complicated by the history of racial inequality, the size of the private sector and political complexity.[616]

However, despite the inception of the DHS health challenges still persisted as there were no clear national norms and guidelines regarding the location of any new facilities, and there was no clarity at the national level regarding equitable and appropriate means of distributing funds to the different levels of the health system in the provision of primary health care services to the needy rural communities.[617]

Although the DHS appears to be the best policy on paper, its implementation was met with a variety of challenges that limited its success. The factors included the changing disease patterns, lack of managerial skills, migration of health professionals, poor staff commitment and motivation, and unequal distribution of personnel in public and private sectors.[618] One can therefore conclude that the process of implementing the district primary health care in the rural areas in the former Transvaal was gradual. Nevertheless, the DHS remained a crucial guide in attempts to re-engineer primary health care in the country.

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[615] Interview by W. Maepa with M. Masipa, 22 Wiehan Street Bendorpark, Polokwane, 02 October 2016
[616] A. Fusheine and J. Eyles, 'Achieving Universal Health Coverage in South Africa through a District Health System Approach: Conflicting Ideologies of Health Care Provision', *BMC Health Services Research*, 16 (558), 2016, p. 1.
[617] Reddy, *South African Health Review* 1995, p. 192.
[618] S. Dookie and S. Singh, 'Primary Health Care Servicesat District Level in South Africa: A Critique of the Primary Health Care Approach', *BMC Family Practice*, 13, 1912, Unpaginated.

As part of the new endeavour by the Government of National Unity, the National legislation was tabled in 1996, followed by the establishment of the provincial legislation. This newly formed government was to see to it that the DHS is fully implemented. This system became functional at the end of 1997. However, despite the inception of a District Health System, health challenges persisted as there were no clear national norms and guidelines regarding the siting of any new facilities, and there was no clarity at the national level regarding equitable and appropriate means of distributing funds to the different levels of the health system in the provision of primary healthcare services to the needy rural communities.[619]

8.7 The mobile clinics and primary health care

The mobile clinics, as one of the strategies used in the provision of primary health care services could be traced back to the 1970s when they were implemented in the homelands. This strategy occurred as a result of the inadequacy of health care centres which were not easily accessible, with poor roads and irregular terrain. The recollection of K.N. Khuzwayo, who became a community health nurse at Mokopane Hospital in Mahwelereng Township outside Mokopane revealed that the system of mobile clinics was considered the best way of providing primary healthcare to the rural population. These clinics were to operate in the whole rural areas of the blacks throughout the country. She indicated that the hospital vehicles, which were vans with canopies, were used by community nurses to visit the rural villages to explain the need to receive primary health care services as a way of preventing diseases. She also indicated that working with chiefs, Indunas and other members of the community was used as a convenient method to persuade the village population to understand and comply with the value of these services. In some instances, community schools or garages were used as accommodation.[620]

Khuzwayo also made reference to the shortage of nurses in the homelands as the main challenge faced by many hospitals, both of government and of the former missionaries. She indicated that as the only community nurse at Mogalakwena

[619] Reddy, *South African Health Review* 1995, p. 192.
[620] Interview by W. Maepa with K. N. Khuzwayo, 595 Madisha Drive, Mahwelereng, Mokopane, 02 April 2016.

Hospital, she was serving the three surrounding clinics like Mapela, Mahwelereng 1 and Mahwelereng 2 clinics. Prevalent diseases were Kwashiorkor, typhoid and polio. She indicated that at Mahwelereng 2 Clinic, which served Tshamahantse, a Shangaan village outside Mahwelereng, these diseases were rife due to the fact that this community was reluctant to use the clinic, with resultant massive outbreaks of polio in the early 1980s.[621] This disease, which wrecked havoc among the children, compelled the community to see the need to visit the clinic in order to receive immunisation.[622]

In the homelands of Venda, Gazankulu and Lebowa, the experience of practicing primary health care enabled them to adapt to the new health developments based on the comprehensive primary health care during the early 1990s. This experience, together with the increasing availability of sophisticated technology in the homeland health care systems, with closer coordination levels of regionalisation of services manifested in the health districts, also added advantage to the implementation of primary health care services. Other developments included the decentralisation of health services in satellite clinics and sub-clinics, with greater emphasis on primary and community-orientated care. The continuation of the use of mobile clinics in the early 1990s became a powerful and effective means for primary health care services in the homelands. In Lebowa, the replacement of vans with ambulances occurred as a way of improving the implementation and provision of primary health care services. Despite these efforts, more problems emerged with dental challenges and other diseases like malaria, as the mobile clinics were able to cater for minor ailments, while serious patients were referred to hospitals, which were remotely situated. Other important challenges included the poor gravel roads which did much to affect the condition of ambulances.[623]

The restructuring of health care paved way for the newly-formed government of National Unity to reassess the mobile health services in the whole of the Northern Province. This reassessment was based on the general investigation regarding the

[621] Interview by W. Maepa with K. N. Khuzwayo, 595 Madisha Drive, Mahwelereng, Mokopane, 02 April 2016.
[622] Interview by W. Maepa with K. N. Khuzwayo, 595 Madisha Drive, Mahwelereng, Mokopane, 02 April 2016.
[623] Interview by W. Maepa with K. N. Khuzwayo, 595 Madisha Drive, Mahwelereng, Mokopane, 02 April 2016

progress of the district health system as part of the primary health care service delivery programme in the province. It was during 1994 that the Department of Community Health in the Medical University of South Africa (MEDUNSA) in Ga-Rankuwa outside Pretoria was requested by the Northern Province government to design and evaluate a pilot study on the Southern region of this Province where the hospital-linked mobile clinics and the clinic-linked mobile services of Lebowakgomo and Phokoane were compared in terms of their extent of health services to the surrounding rural or village communities.[624]

The survey conducted by Medunsa researchers revealed that there was a significant difference between fixed and mobile clinics.[625] Despite these findings, most of the communities in the two areas regarded the mobile health services as being more convenient as the stop points appeared to be accessible to the homes of patients than the fixed clinics. The findings of the Medunsa study were echoed by the Centre for Health Policy of the Department of Community Health University of the Witwatersrand. Further investigation by this department proved that Sexually Transmitted Disease cases were lower at the mobile clinics than in the fixed clinics. Again, the Centre for Health Policy of the Department of Community Health of the University of Witwatersrand echoed these findings. Further investigation by this department found that sexually transmitted disease cases were lower in the areas served by mobile clinics than in the areas where fixed clinics were the main source of care in Lebowakgomo District. However, shortage of nursing staff and gravel roads posed a challenge in the provision of primary health care services in Lebowakgomo district and other districts throughout the province.[626]

Due to the growing health challenges in the Province, mobile health services continued to be supported by the provincial Department of Health and Welfare since most of the population were rural or village based, with fragmented health services. The system is still used in the rural areas of the successor Limpopo Province and other former homelands throughout the country.

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[624] A.J. Herbst et al, 'The Evaluation of a Primary Health Care System in the Southern Region of Northern Province of South Africa, *CHANSA Journal of Comprehensive Health'*, 8(2), April/June 1997, p. 89.
[625] Herbst et al, 'The Evaluation of a Primary Health Care System in the Southern Region of Northern Province of South Africa', *CHANSA Journal of Comprehensive Health*, 8(2), April/June 1997, p. 89.
[626] Herbst et al, 'The Evaluation of a Primary Health Care System in the Southern Region of Northern Province of South Africa', *CHANSA Journal of Comprehensive Health*, 8(2), April/June 1997, pp. 91-92.

8.8 The media and primary health care

The National Health Plan also envisaged a wide range of community-orientated health initiatives which were established throughout the country since 1994. This initiative emerged from the Public-Private Partnerships (PPPs) and Non-Governmental Organisations which worked tirelessly to see to it that HIV/AIDS pandemic is prevented at all costs. These community-orientated initiatives took the form of community-based projects like Love Life and Soul City. The contribution of Love Life, which was focusing on the needs of the young people and the implementation of health services in clinics and establishment of health centres that were to provide education and HIV prevention, remained one of the crucial project.[627]

The post-1994 era also witnessed new innovations to raise public awareness to the blacks in the townships and rural areas regarding various social and health issues. This step was taken in order to change knowledge and attitudes towards health challenges and to promote preventative measures to deal with poverty and related diseases on a wider spectrum of issues, where the involvement of the community is crucial. The use of media became part of the restructuring process of health care system based on primary health care where the previously disadvantaged black population, both in the township and rural areas were targeted. As part of the national health system policy, the government pledged its commitment in the provision of massive financial investment in an effort to achieve maximum implementation of primary health care programme based on district health care system.[628]

It was due to the contribution of Soul City that electronic media became critical in the distribution of health messages regarding the prevention of HIV/AIDS. Garth Japhet, a physician who worked for the World Health Organisation in the South African community clinics explained his experiences during the early 1990s.[629] Japhet obtained his qualification as a medical doctor from Witwatersrand University in 1987,

[627] Kautzky and Tollman, 'A Perspective on Primary Health Care in South Africa: Primary Health Care: In Context', *South African Health Review*, 2008(1), 2008 p. 25.
[628] Kautzky and Tollman, 'A Perspective on Primary Health Care in South Africa: Primary Health Care: In Context', *South African Health Review*, 2008(1), 2008 26.
[629] S. Armstrong, 'The Soul City', *World Health*, 50th Year, No 6, November-December 1997, p. 24.

with further qualifications in maternal and child health. Japhet was greatly concerned about many pregnant women who did not use antenatal health services.[630] The surveys conducted in this respect revealed that most of these women were always busy and therefore could not create time to visit the clinics. One other crucial reason discovered was that most of them were unaware of these services offered by the clinics, most particularly in the rural areas. As a result, nurses in the clinics found themselves dealing with emergencies based on health complications and diseases that could have been prevented or minimised during antenatal health services. According to Japhet, "…there was a pressing need to give people the knowledge to safeguard their own health", a notion that was in line with one of the most important principles of the primary health care. [631]

Japhet's contribution was realised when he started writing a health column for the newspapers to convey the message, but later discovered that this was ineffective as many blacks both in the rural and urban areas were less educated. He also realised that since 92% of the blacks listened to Radio and 76% to television, these media could be the most effective way to reach them as they were poor and most affected and exposed to the disease. He partnered with Aggrey Klaaste, the editor of the most popular black newspaper in South Africa, *Sowetan*, who offered to pay young doctors a salary of three months and at the same time continued to encourage more awareness campaigns and funding to keep the project in force. As time went on, Japhet realised that the multimedia approach could only be successful when used effectively. The survey ratings revealed that education programmes on television rarely reached 500 000 viewers while the prime time drama was viewed by more than 11 million audiences. As a result, Japhet came to a conclusion that an effective way of delivering health messages was through the incorporation of a drama series called Soul City. This drama series was able to get off the ground at the beginning of 1994, with funding from UNICEF, joined by Dr Shereen Usdin, who was innovative in the promotion of health awareness projects.[632]

[630] http: //za.linkedin.com/in/gareth japhet, Accessed on 23 August 2017, Unpaginated.
[631] S. Armstrong, The Soul City, *World Health*, 50th Year, No 6, November-December 1997, p. 24.
[632] Armstrong, The Soul City, *World Health*, 50th Year, No 6, November-December 1997, p. 24

Photograph 18: *The Soul City team and representatives from other African countries.*

Source: S. Armstrong, The Soul City, *World Health*, 50th Year, No 6, November-December 1997

Progress was realised when Japhet and Usdin were able to come up with one of South African's best scripts, using the relevant topics like 'Mother and Child': HIV/AIDS, TB and smoking. The researches were effectively conducted by these script writers who visited clinics in the townships for practical observations before writing. The scripts were effectively tested by experts, consultants and representatives of the target audiences who eventually approached the series to be viewed on television and other media programmes. The success of the Soul City was amazingly felt beyond many peoples' expectations when it was revealed that millions of people were watching it and discussed even in the streets by ordinary poverty-stricken population groups. The success of this project was further realised when Soul City 2 was introduced which was able to attract children under the age of 15 years. [633]

[633] Armstrong, The Soul City, *World Health*, 50th Year, No 6, November-December 1997, p. 25.

Although Soul City was initially aimed at the poor township population, through television, while the rural population were better reached through radio, it became evident that the message was spreading across as many rural populations started to accessing television from the 1990s as the Reconstruction and Development Programme started improving the lives of many previously disadvantaged blacks. The massive installations of electricity and television satellites were also significant. One could therefore state that the reach of Soul City among rural black populations increased steadily and was significant in the spread of preventative health measures and awareness through effective multimedia programmes.[634] In the former Lebowa, Venda and Gazankulu homelands, primary health care projects had been distributed through utilisation of both Primary and Secondary Schools. The non-governmental organisations, in partnership with the Department of Education became instrumental in the distribution of awareness programmes based on the prevention of diseases. This move was also evident in the Advocacy Programme of the NPPHCN which utilised the media in the province to capture all issues related to the promises made by a variety of political parties during elections as a reminder so that they can be implemented. These issues included:

> …education crisis, status of women , definition of primary health care, reproduction health, lack and/or inadequate supply of water, community participation, access to affordable health service, concerned and accountable health worker practice, rationalisation of the health department, restructuring of the health service, NPPHCN/SABC documentary on environmental health project.[635]

However, other commentators such Makgoga are of the view that Soul City activity was limited in the promotion of primary health care in the rural areas due to underdevelopment in terms of infrastructure. He is of the view that this media project was basically operating in Alexander Township in Johannesburg as part nof Witwatersrand University Medical School initiative. He reiterated that media services

[634] Armstrong, The Soul City, *World Health*, 50th Year, No 6, November-December 1997, p. 25
[635] Witwatersrand University Historical Archives, AG, Box 3176, File NPPHC E6, Report from NPPHCN, Interim Report on NPPHCN Core Support: Project # 93-1157 and Final Report on the Project Development Fund: Project # 90-8268 To the Henry J Kaiser Family Foundation 1995, p. 22.

were there in the Northern Transvaal homelands of Venda, Gazankulu and Lebowa but the activity was never documented.[636]

8.9 Conclusion

The period since 1990 brought new hopes in the minds of anti-apartheid organisations for the implementation of the unitary national health system based on the primary health care of which the previously neglected rural areas of the blacks in South Africa would be a priority. This was premised on developments such as the Health Desk 116 of 1990, the Health Service Delivery Plan of 1991, the Steinmete Committee of 1992, the ANC's Health Desk of 1992, and ANC's National Health Forum of 1993, all of which attempted to transform and integrate all previously separated health departments but with little success as the National Party government was negotiating from a position of strength. The conflict of interests and friction between the state and non-governmental organisations throughout the period of negotiations during the early 1990s was a clear indication that the state's limited health reforms did not meet the expectations of the blacks. The marches, violence and mass actions continued to pressurise the state to implement equitable and quality health services for all South Africans.

The advent of democracy and a black majority government in 1994 was followed by the implementation of the ANC's Health Plan, which paved way for meanungful transformation of the health care system, of which primary healthcare was significant. In the Northern Province, the district health system and other projects initiated by the new government of National Unity through the National Department of Health, faced many challenges of managing and providing the health care services to the former homelands of Lebowa, Venda and Gazankulu due to the existence of high notification of poverty, fragmentation, poor infrastructure, high levels of unemployment and diseases. As a result, the newly formed Northern Province, which was later renamed Limpopo Province, continued to struggle with the provision of primary health care services. As a result, the ANC-led government had

[636] Interview by W. Maepa with N. N. Makgoga, Deputy Director, Limpopo Provincial Department of Health, 08 September 2017.

to deal with the transformation of the public sector inherited from the previous health departments with different heath personnel, and managers who were to sustain and continue to deal with health challenges in the province. It became clear that the notion of creating ‘health for all by the year 2000’ would not be easily achieved.

CHAPTER NINE: CONCLUSION

In the South African context, the transformation of primary health care has been a long process, determined by social, political and economic disparities between different racial groups. This state of affairs emerged from the period of colonialism long before the 20th century. By 1930, the general state of health of the blacks in the rural areas or reserves was appalling. The rural blacks who were reduced to the level of landlessness and exposed to the vagaries of the migrant labour, remained poor, hence their vulnerability to a variety of diseases of poverty like tuberculosis, malaria, sexually transmitted diseases, kwashiorkor, malnutrition, cholera, measles, and other related diseases associated with poverty. It was during this period that that the state intervention was initiated by the Department of Public health as part of 'Natives Health' reform initiative. Although several attempts were made by the Union government, most particularly by the Department of Public Health, the intervention was minimal and in most cases determined by political motives based on the state's long-term strategy of marginalising blacks from all spheres of modern and colonial life.

These socio-economic challenges manifested themselves starkly in the Transvaal province, particularly the northern part of this province. Factors such as migrant employment, low wages, poor housing, poor infrastructure, absence of rural based clinics or health centres and other related undesirable conditions accelerated ill-health amongst the black rural population. It is also clear that the success in the provision of primary health care could only be maintained through economic redistribution and general improvement of socio-economic conditions of the rural areas of the blacks.

Tentative initiatives and limited reform from the state's health departments, and experimentation in social medicine, were clear indications that the health of the blacks needed a form of attention as it could not be entirely neglected. Individuals like Harry Gear, Dr Sydney Kark and his wife Emily Kark, and Henry Gluckman became instrumental in the early promotion of the idea of health centres as an effective way of providing community health care in black communities. The experience of the Pholela Health Centre, which pioneered social medicine, had

immense influence in the establishment of other health centres like Ithuseng in the 1940s, Hlatlolanang, Elim Hospital, missionary health institutions and other rural health centres in the former Transvaal. In the Transvaal, certain individuals like Mamphela Ramphele, Mankhuba Ramalepe, Selina Maphorogo and other health workers and practitioners both of governmental and non-governmental health organisations were significant. Apart from all these initiatives, government remained an obstacle as most of these health centres were halted and derailed as it was the case with the recommendations of the 1944 Gluckman's Report.[637]

The efforts of advocates of social medicine from the Department of Health such as that of Harry Gear, Eustace Gluver, Henry Gluckman and Emily and Sidney Kark were behing the early success of health centres and the founding of the Institute of Family and Community Health at Clairwood in Natal.[638] The relationship between the Institute and black students of the University of Natal Medical School contributed to the development of community health in the area. The doctor-students who graduated from this institution, such as Aaron Motswaledi, Elliot Kgoadi-Molaba, Lucas Monyamane, Jerry Mamabolo and Lelau Mohuba, among others, played a crucial role in the promotion of primary health care in the former Northern Transvaal rural areas.

The hopes for the establishment of a National Health Service for all South Africans were frustrated when the National Party Government introduced 'Grand Apartheid' in 1948 after winning the general elections. However, the 1948 political developments did not completely remove the idea of primary health care service delivery to the rural blacks as other non-governmental organisations and liberation movements like PAC and ANC continued to pursue the idea through various means from the 1950s to the 1980s, though under difficult repressive circumstances. One of these organisations was Wits Rural Facility projects, established in the 1980s in the Eastern Transvaal districts like Achornhoek, Bushbuckridge and other centres in the Mhala District. The Community-based Rehabilitation Workers Projects which were implemented through educational means were also vital in the general improvement

[637] S. Marks, South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics, *American Journal of Public Health*, 87(3), March 1997, p. 453.
[638] S. Marks, South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics, *American Journal of Public Health*, 87(3), March 1997, P 453.

of the peoples' lives. Missionary institutions also helped to carry the idea of community healthcare forward by establishing many clinics and hospitals in the homelands, which were eventually placed under homeland governments' control during the early 1970. However, a constant feature of rural community healthcare was the fragmentation of healthcare services between the homelands which shared boundaries as it was the case with Lebowa, Venda, Bophuthatswana and Gazankulu. The diseases like Malaria and tuberculosis were also common in the homelands. In the final analysis, Price maintains that, among other things, the National Party eventually failed to maintain apartheid as the opposition by blacks against the homeland health policies intensified in the 1980s.

The fragmentation of health services during apartheid hampered the smooth delivcery of health care services because of overlap and confusion which were serious problems for the homeland health departments. This state of affairs which occurred in Lebowa, Venda and Gazankulu Departments of Health was a practical example. Over the years the apartheid state would tinker with and reshape the system through various legislation, commissions, and political reforms such as the introduction of the tricameral parliamentary system. However, these failed to meet the expectations and the intentions of the advocates of equitable healthcare. While the establishment of Browne Commission and Tricameral Parliament weakened health services in the black rural areas through government underfunding of the homelands, on the other hand it strengthened resistance by the anti-apartheid organisations and their call for the establishment of the National Health Service for all racial groups.

The outbreak of cholera and the discovery of HIV/AIDS in the early 1980s worsened the burden of disease in the rural areas. In the Transvaal homelands the diseases escalated due to poverty and underdevelopment caused by state neglect and segregation. The political developments of the late 1980s, when F.W. de Klerk became the President of the Republic of South Africa raised new hopes for the provision of equitable health care services, with emphasis on primary health care services in the previously neglected rural areas. This new readiness to implement strategic reforms in the system was a result of the internal and external pressure for the implementation of transformation in the country. There were some notable

developments during Rina Venter‘s tenure as Minister of Health and Dr Coen Slabber’s tenure as Director-General in the Department of Health. On the broader political scale, the release of Nelson Mandela and the unbanning of previously banned political organisations in 1990 was a clear indication that health reforms were inevitable.

Attempts by the National Party government to equalise health services for all South Africans unfolded throughout the period of negotiations between the state and African National Congress during the early 1990s. The Government of National Unity that took power after the democratic elections of 1994 paved way for the African National Congress to issue its National Health Plan under the directive of the new National Department of Health, which subsequently made primary health care a priority in the provision of health services, with special emphasis on the previously disadvantaged black rural communities. The newly formed government’s programme called Reconstruction and Development Programme (RDP) focused its attention on the eradication of poverty and on working towards the improvement of health for all South Africans based on primary healthcare service provision. The Health Sector System associated with RDP paved way for the involvement of all sectors of populations like non-governmental organisations, and other members of the communities. This enabled the previously marginalised health sectors to engage in their activities with ease.

Despite the ANC-led governmental health reform initiatives, the complex legacy left by apartheid in the social, political and economic spheres proved difficult to surmount as health challenges continued to endure. Healing the ills of apartheid through rural development, with emphasis on the building of many rural based clinics and hospitals with free access to medication, was a relief to many rural populations in the former Transvaal homelands and elsewhere in the country. The ANC Health Plan, together with the new health system based on the District Health System played a major role in facilitating renewed implementation of primary health care programme, although challenges persisted.

The evolution of primary health care and its piecemeal implementation had far-reaching implications on the history of health in South Africa, and in the post-

apartheid era it became a national government policy that saw all government departments adopting it until recent times. However, the notion of achieving ‘health for all by the year 2000’ remained a challenge as the South African black population, together with increasing migrants from the African countries and abroad continued to grow exponentially, and by so doing putting more strain on the available resources. The primary health care services in the rural areas of the former Transvaal generally showed improvement even though some challenges existed, such as the increasing incidence of chronic diseases like blood pressure, HIV/AIDS, and sugar diabetes, among others, which cause high mortality and ill-health among South Africans.

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