The Paradox of Apartheid

Social Segregation and Cultural Collaboration in Medical Discourse

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I would first like to thank my family and friends for their patience and understanding as I researched and wrote my thesis; without their support this task would have been far more intimidating than it was enjoyable.

I also wish to thank Ambrose Kelly and the children of the Kalahari Desert, who have provided me with an opportunity to experience the desperation and desolation of the forced removals that shaped Bophuthatswana. My time with them in the desert has ultimately inspired this thesis and for that, I dedicate this thesis to them: they are not forgotten.

Of course I am also grateful for the support and camaraderie of Professor Spendelow and my fellow History Honors Students: Francis Gieringer, Sam Harris, Kristen Leung, Jenny McCarter, Keith Rafferty, Kirsten Sandgren, Caitlin Shea and Victoria Stulgis.

I also wish to thank the guidance of my advisor, Professor McKittrick, as well as the direction provided by Professor Shankar.

Finally, I would like to thank the late Mr. Evan Armstrong North, whose confidence, enthusiasm, and dedication to research greatly inspired my own work.¹

¹ I hereby authorize the public release of this thesis.
The very civilization that should have made witchdoctors a thing of the past is keeping us very much in business.

- South African Traditional Healer, address to students and staff of the Medical School of the University of the Witwatersrand, 1974

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Timeline of Significant Events and South African Medical Journal articles

1970
The South African government decides to transfer the control of health services and hospitals in the Black homelands to the Department of Bantu Administration and Development, under the executive authority of the Department of Health.  

1971
30 January: “Medical History Taking Among the Bantu Tribes of South Africa”
31 July: “Acute Renal Failure from Callilepsis lureola”

1972 – Bophuthatswana’s first year of self-rule
22 July: “Senecio Species: Toxic Plants Used as Food and Medicine in the Transkei”
5 August: “A Report of Two Rare Cases of Factitious Anemia”

Ga-Rankuwa Hospital completed.
24 February: “Do Witchdoctors Practise Clinical Pattern Recognition?”
“Observations on Medical Plants”
3 November: “Psychopathology in Bantu Culture”
22 December: “The Witch-Doctor and Tribal Scarification of the Skin and the Hepatitis B Antigen”

1974 – Medical, Dental and Supplementary Health Services Professions Act No.56 of 1974
27 April: “The African’s Concept of the Causes and Treatment of Epilepsy and Convulsions”
4 May: “Health and Disease: Some Topical Problems of Sociocultural Transition”
14 September: Editorial –“Colleagues or Opponents?”
9 November: Correspondence –“Colleagues or Opponents?”
23 November: “Clinical Observations on Toxic Effects of Xhosa Medicine”

1976 – Mounting political tension and the Soweto uprising cause White doctors to leave clinics
1 May: “Herbalists, Diviners and even Witchdoctors”
3 July: “Herb Use and Necrodegenerative Hepatitis”
10 July: “Poisoning Associated with Witchdoctor Attendance”
7 August: “A Medical Paradox: Curative versus Preventative Medicine”

1977 – University of the Witwatersrand holds symposium “to help White medical men to grasp the secrets of their Black tribal ‘colleague:’” June 25-26
South African Students’ Organization and Black Consciousness movement leader Steve Biko detained in Grahamstown on 18 August, died in custody on 12 September
8 October: “The Medical Profession and the Witchdoctor”
5 November: Correspondence - “Toxicity of Traditional Herbal Remedies”

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5 Horrell, Muriel. Race Relations as Regulated by Law. p.242
Bophuthatswana becomes independent on December 6
1978 – Year of Alma Ata (September 6-12), MEDUNSA completed in February – first class begins

4 March: Correspondence - “Traditional Healers and the Medical Profession”
25 March: Correspondence - “The Medical Profession and the Witchdoctor”
13 May: “The Impact of Renal Failure on the South African Black and his Attitude towards Haemodialysis”
24 June: “Is the Witchdoctor Medically Competent?”
2 September: Correspondence - “Witchdoctor or Which Doctor?”
11 November: Correspondence - “Witchdoctor or Which Doctor?”
16 December: Correspondence - “Witchdoctor or Which Doctor?”

1979 – Government eases restrictions on admission of Black patients to private hospitals that mainly serve Whites, still subject to some limitations. 6

21 July: Correspondence - “Witchdoctor Acupuncture”
1 December: “A Case for the Traditional Healer in South Africa”

1980 – politically motivated refusal by the secretary general of MASA to allow publication of letters concerning death of Mr. Biko; 7 “unpublished letters on Steve Biko” written, critical of MASA 8

1981

Anthropologist Harriet Ngubane notes the “habitual disposition of the Western-type health agencies to look down on practically all indigenous methods of healing – not surprising, since the training provided in medical schools disregards the existence of African methods of cure.” 9

1982 – High profile medical people resign from MASA to form NAMDA, upset that views not being represented by the South African Medical Journal, “too closely aligned with the Apartheid State.” 10

5 June: “Aspects of Stress among traditionally living people in a developing country”
25 September: “The ‘unbooked’ mother at King Edward VIII Hospital, Durban”
11 December: “The traditional healer/diviner as psychotherapist”
“Priests before healers – an appraisal of the iSangoma or iSanusi in Nguni society”

1983 – W.H.O. report Apartheid and Health Published

1984 – MEDUNSA med. student study, Self-Medication Study published

1988

2 April: “Severe invalidism – the dominant feature of Third-World psychiatry in southern Africa”

1990 – Joubert’s “Poisoning Admissions of Black South Africans” published

16 June: “Acute dichromate poisoning after use of traditional purgatives”

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6 Horrell, Muriel. Race Relations as Regulated by Law. p.162
Executive Summary

The purpose of this thesis is to understand why traditional healers were more frequently featured in *South African Medical Journal* articles during the 1970s. Ultimately, this increasing recognition of traditional healers was a pragmatic response to the ill health and inadequate biomedical healthcare system that was a product of apartheid segregation.

**Chapter One** introduces traditional healers and provides a case study from Ga-Rankuwa, a Black township in Bophuthatswana and a commuter settlement for Blacks working in Rosslyn and Pretoria. Beginning in 1981 the Medical University of Southern Africa began recording acute poisoning admissions to Ga-Rankuwa Hospital as the South African government extended health services to the Black population. This case study sets an example of mainstream medical discourse during apartheid and provides a launching point from which to discuss the multiple underlying factors that shaped its findings and conclusions. Most of the thesis is laying the groundwork for the debates surrounding collaboration with traditional healers.

**Chapter Two** describes developments in the Native Reserves and later homelands, ultimately illustrating Blacks' dependence on wage labor in White areas. It also describes briefly how this migrant labor system impacted health. Furthermore, the chapter notes the degree to which Whites were dependent on Black labor, and that economic developments in the 1970s forced a recognition for a more stable, skilled and healthy workforce. The development of the townships, which would later serve as major nexuses for the expansion of biomedical care into the homelands, is also a key point.

**Chapter Three** complements this pattern of increased 'concern' with Black health, describing the healthcare system for Blacks in South Africa and the impact of changes in the 1960s and 1970s, also noting the construction of hospitals in townships. The overall purpose of this chapter is to illustrate the inadequacy of biomedical care for the African population.

**Chapter Four** continues the theme of inadequate care, first briefly focusing on the undersupply of doctors, but quickly segueing into a discussion of "Bantu Education", which is tied to the same "tribalizing" ideology upon which the homelands were founded and consolidated. The Bophuthatswana Department of Education's annual reports revealed interesting trends regarding attendance but importantly regarding certain classes – math and science were consistently weak subjects. This affected admissions to medical schools. The chapter then provides a brief history on medical schools and admissions, leading importantly to the foundation of MEDUNSA in Ga-Rankuwa, which was the research body responsible for the research detailed in **Chapter One** and a great deal of research into Black health. The chapter subsequently outlines some of the barriers facing Black students and doctors, i.e. where and with whom they were allowed to work. Finally, the chapter introduces the concept of "modernity" which had been pushed by the Bophuthatswana government and its presence in the educational system – “modernity” was a concept that featured in the debate surrounding cooperation and collaboration with traditional healers.

The **Concluding Chapter** builds from the foundations laid by the previous body of the thesis to place developments in the context of medical discourse in the *South African Medical Journal*. Trends in the discourse suggest that the consideration and ultimate cooperation with traditional healers was a product of pragmatic necessity. South African doctors were forced to accept the existence of traditional healers not only because they persisted and continued to serve the majority of the Black population despite apartheid legislation, but because the burden of ill health was so great and the extent of biomedical care was so inadequate that traditional healers provided the most accessible forms of care.
Advent of Apartheid

The election of the National Party in 1948 ushered in a new era for the people of South Africa, an era in which the long-standing practice of racial discrimination was exaggerated and codified into a political system of “separate development.” This entailed the social, economic and political stratification of South African society based on four loosely defined categories of “race:” White, Asian, Colored and Black.¹ The National Party, which instigated the subsequent period of “separateness” or apartheid, represented the interests of the White minority population in South Africa, mainly descended from earlier Dutch and British colonists. Apartheid policies most heavily discriminated against the “Black” or native African population, which constituted approximately 70 percent of the total population of South Africa and which had long been marginalized by the relatively small population of European settlers.² Census data from 1980, when large portions of the Black population were relegated to the various “homelands” and excluded from official South African statistics, the Black population still held a clear majority in the Republic of South Africa. The estimated population of South Africa, excluding the Black homelands, at the time of the 1980 census was 23.77 million, 15.97 million or 67.2 percent of

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¹ Official statistics published by the Republic of South Africa during the Apartheid Era (1948-1994) categorized data into these four racial classifications. Figures for Blacks, alternatively labeled “Bantus,” were especially unreliable throughout most of the twentieth century: the Black population had no compulsory death registration, and many births also went unrecorded. Furthermore, inconsistency in the diagnosis of diseases such as tuberculosis skewed health data. The independence of the Transkei, Bophuthatswana, Venda and Ciskei also removed significant portions of the population affected by disease and malnutrition from the official South African register.

which were Black; in contrast only 4.45 million, or 18.7 percent of the population were “White.”

Over the course of the twentieth century, European colonists increasingly pushed this large Black population into the gradually growing ‘Native Reserves’ located in marginal rural lands. Meanwhile, the White minority dominated the most fertile agricultural lands as well as the developed urban areas. The advent of apartheid in 1948 and the Parliament’s subsequent ratification of the Bantu Authorities Act in 1951 heralded the beginning of a new era for the African Reserves, intensifying the economic and political marginalization of the Black South African population. The Nationalist government’s apartheid policies redefined earlier practices of ‘separate development’ by stressing political segregation and the autonomy of the burgeoning Black homelands. “Nationalist legislators claimed that they were doing their “utmost to save what can still be saved of the tribal life of the Bantu which embodies the whole basis of his social, political and economic structure.””

The Bantu Authorities Act of 1951 “provided for the establishment of Bantu tribal, regional, and territorial authorities in the African Reserves,” to which administrative authority would steadily be transferred. The homelands began to crystallize in earnest as ethnically-based states following the passage of the Promotion of Bantu Self-Government Act No. 46 in 1959, which identified an initial eight (later expanded to ten) Black ‘national units’ or ‘homelands’ that exemplified the ‘separateness’ at the base of virtually all apartheid policies: segregation based on cultural differences and racial inferiority of Blacks.

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4 Butler et al. The Black Homelands of South Africa. p.28

5 Horrell, Muriel. Race Relations as Regulated by Law. p.16

The homelands, or ‘bantustans,’ were ten pseudo nation-states established by the Apartheid government which delineated territories based on loosely conceived ideas of Black ethnic and tribal identity: Transkei, Ciskei, Bophuthatswana, Lebowa, Venda, Gazankulu, KwaZulu, QwaQwa, KaNgwane and later, KwaNdebele. In practice, the homelands were far from ethnically homogenous. Census data from 1985, for example, indicates that Tswana made up only about 67 percent of the population of the Tswana ‘homeland,’ Bophuthatswana. The remaining 33 percent of the population was split between thirteen other ethnicities.7

The South African government’s ultimate goal was to eliminate Black political participation at local and national levels in the Republic of South Africa.8 The result of the homeland policy was the development of an increasingly complex and dualistic economy that exacerbated preexisting social, economic and political stratification between White and Black South Africans. Apartheid segregation split the South African population between the rural, underdeveloped and economically isolated Black homelands and the White-controlled urban centers where political and economic power was concentrated.9 The growing economic disparity between the White population and the Black population was reflected in the country’s health profile, which effectively served as a paradigm for the social, economic and political dynamics of South Africa during the Apartheid Era.10

The social and economic inequality of Apartheid South Africa exacerbated ill health in the Native Reserves and subsequent Black homelands by reducing the subsistence base, which had shifted towards a focus on cash crops at the expense of subsistence crops at the turn of the

8 Butler et al. The Black Homelands of South Africa. pp.22-23
century. This in turn precipitated and perpetuated a system of migrant labor in which Black South Africans were completely dependent on income from White areas for subsistence. The migrant labor system culminated in the development of townships along the fringes of urban centers as apartheid influx controls restricted Black residency in the cities. Economic changes in the 1970s prompted Whites to recognize their economic dependence on Black labor.

Segregation and the reduction of a subsistence base in Black lands that were rapidly becoming overpopulated from forced removals and a high birth rate contributed to growing levels of malnutrition. This in turn left the population vulnerable to opportunistic diseases like tuberculosis and cholera. The townships visibly demonstrated the plight of the Blacks to White South African communities; the proximity of the townships to important urban economic centers made the dichotomy all the more striking. Meanwhile, the healthcare available to the Black South African population was grossly inadequate to mitigate the widespread malnutrition and associated diseases from which a significant portion of the Black population suffered. The inadequacy of the healthcare system itself was rooted in the same apartheid policies and ideologies as those underlying the development of the homelands: ‘Bantu identity’ as qualified by the South African government. The supply of doctors to serve the homelands, for instance, suffered from longstanding prejudices in the educational system, which was structured to direct Blacks towards wage labor, instead of more specialized professions.

The same ideologies that had shaped the South African economy, the education of the Black population, and the homelands also influenced biomedical discourse. Mainstream medical discourse throughout the Apartheid Era consistently ignored the negative impacts of apartheid policies, instead blaming the plight of the Blacks on their own incompetence and ignorance. Paradoxically, as White South Africa was forced to confront its dependence on Black labor and
the burden of illness which plagued the foundations of its economy, medical discourse demonstrated increased interest in the culture of the expanded population to whom it was their obligation to provide care. The townships – the very manifestation of the segregation and inequality at the root of the general ill-health of the Black population – provided the stage for the increased cultural interaction of the 1970s and thereafter.

Ultimately this increased interaction, spurred on to a certain extent by economic necessity, pushed biomedical doctors to reevaluate their traditionally hostile stances towards traditional healers. Traditional healers, who in the absence of adequate biomedical care provided health care to the majority of the African population, persisted and in some cases thrived during the Apartheid Era despite efforts of the Apartheid State to regulate and limit their services. This thesis proposes to demonstrate how apartheid ideologies and separate development shaped the health and economic landscape of South Africa in such a way that South African authorities were forced to accept the presence of traditional healers and recognize them as a crucial source of healthcare for the Black population out of pragmatic necessity.
Apartheid South Africa: A Profile in Disease

As apartheid divided South Africa along racial lines, it effectively created one country with two very different health profiles. The Toxicology Service at the Medical University of Southern Africa (MEDUNSA) conducted a retrospective comparative epidemiological study for the period 1970 to 1976 which discovered a pattern of acute poisonings amongst the Black South African population that closely resembled the epidemiology of acute poisoning in less economically developed countries. In contrast, the White South African population demonstrated a pattern of acute poisoning which resembled that of more economically developed countries.\textsuperscript{11} The World Health Organization (WHO) similarly noted an unequal distribution of disease and “diseases of development” in its 1983 report, Apartheid and Health.\textsuperscript{12}

The emerging White elite during the Apartheid Era suffered from increased incidents of diseases prevalent in developed countries: hypertension, cardiovascular accidents (strokes associates associated with atherosclerosis, a buildup of plaque within the blood vessels), diabetes mellitus and peptic ulcers. Such diseases were not solely confined to the social and economic elite of Apartheid South Africa; a study conducted by two South African researchers in 1976 found hypertension to be the second most common cause of heart failure among the urban Black population above age 30. The researchers associated this severe form of hypertension with stress related to life in urban areas under apartheid conditions, as it was rare among the rural Black population.\textsuperscript{13} Incidentally, Black female domestic servants had the highest rate of hypertension in South Africa as of 1988.\textsuperscript{14}

\textsuperscript{11} Joubert, Pieter H. “Toxicology units in developing countries: different priorities?” J Toxicol Clin Toxicology, 19. 509-516. 1982.
\textsuperscript{12} “Living Conditions and Patterns of Disease.” WHO. Geneva, 1983. pp.130 \textit{et seq}.
\textsuperscript{13} Seedat, Aziza. Crippling a Nation. p.11
\textsuperscript{14} Andersson, Neil and Shula Marks. “Apartheid and Health in the 1980s.”
Furthermore, the Infant Mortality Rate (IMR)\(^{15}\) and Life Expectancy (LE) among the White population during the Apartheid Era, two major health indicators of a country’s economic development and the health of a population, resembled those of developed countries such as Great Britain.\(^{16}\) Whites living in the Republic of South Africa in 1978 had an Infant Mortality Rate of 14.9 per 1,000 live births. Data for the period 1969 to 1971 demonstrate a relatively long Life Expectancy for Whites, as well: 64.5 years for males and 72.3 for females.\(^{17}\)*

Black South Africans found themselves on the opposite side of the spectrum of economic development during the Apartheid Era, and incidentally exhibited the health profile of a developing country. The segregationist nature of apartheid policies and the social and political chaos associated with the division of one country into multiple ethnically-defined nations greatly impacted the quantity and quality of health statistics available for the Black South African population. Indeed, official figures for the life expectancy of Blacks were not available following the election of the National Party in 1948. During the Apartheid Era Blacks had no compulsory birth or death registration; an estimated 50,000 deaths among Blacks, mainly in rural areas, went unregistered every year. The last official figures available were from 1945-47, immediately before the instigation of apartheid policies. At this time, the average life expectancy of Blacks was about 20 years shorter than that of Whites: a predicted lifespan of 36 years for males and 37 years for females.\(^{18}\) Dr. Aziza Seedat, a South African physician and harsh critic of apartheid writing from abroad in 1984, cited official estimates from the *Official Year Book of the Republic*

\(^{15}\) The Infant Mortality Rate, or IMR, refers to the number of infants who die before their first birthday. Figures exclude stillborn babies.


\(^{18}\) Seedat, Aziza. *Crippling a Nation*. p.9
of South Africa which placed the life expectancy of Black males at 51.2 and females at 58.9 for 1965-70. The same sources also provided a relatively high IMR of 100-110 per 1000 live births for 1974.

The concentration of the large Black population into the rural homelands also exacerbated the economic disparity between rural and urban areas of South Africa. The underdeveloped homelands rapidly became overcrowded and many of their residents were pushed to seek wage labor in White urban centers; however, due to ‘influx control’ measures which restricted the presence of Blacks in urban areas, most economic activity was in the form of labor migration, upon which the lives of the inhabitants of the homelands heavily depended.

Again, the Infant Mortality Rate illustrated the dire socioeconomic situation of Black labor migrants: the IMR among migrant and commuter families living in the homelands in the late 1970s was estimated at 227 per 1000 live births, three times the IMR among non-migrant Blacks living in urban areas: 82 per 1000 live births. Families who did not have access to employment outside the homelands, an estimated 40 percent of the population of the homelands, presented with an even higher Infant Mortality Rate of 282 per 1000 live births. At the same time, broad estimates such as these disguised regional variations. Dr. Seedat cited estimates in his book, Crippling a Nation: Health in Apartheid South Africa, that between 30 and 50 percent of children died before their fifth birthday in some rural areas, and that the IMR among Blacks in Worcester, Cape Province, was as high as 550 per 1000 live births.

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20 Seedat, Aziza. Crippling a Nation. p.9
21 Andersson, Neil and Shula Marks. “Apartheid and Health in the 1980s”. p. 671
24 Seedat, Aziza. Crippling a Nation. p.9
The majority of the Black population suffered from diseases associated with poverty, notably malnutrition, during this dichotomous period. Severe malnutrition alone was, according to Dr. Aziza Seedat, “the single biggest killer of Black children in South Africa.” Malnutrition manifested itself in several ways. The most severe forms of malnutrition evident in the Black population were marasmus and kwashiorkor. Marasmus is the childhood equivalent of starvation associated with protein deficiency but is principally caused by a deficient calorie intake. Kwashiorkor, on the other hand, is an extremely severe nutritional disease resulting from a dietary deficiency in milk and other high-protein foods. Consequently, kwashiorkor tends to develop among children following weaning who have little or no access to adequately nutritious sustenance, e.g. milk. Despite the severity of kwashiorkor and the extent to which it affected Black children, it ceased to be a notifiable disease in 1967, allegedly because notifications of kwashiorkor were ‘unreliable’ due to regional variations in diagnostic criteria. Incidentally, tuberculosis suffered from similar diagnostic uncertainties but was consistently regarded as a notifiable disease. Seedat implied that the government removed kwashiorkor from the list of notifiable diseases as a means of hiding the statistics. The final official figures published for kwashiorkor in 1967 were:

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25 Ibid. p. 24
29 Seedat, Aziza. p. 24
Malnutrition was more than the product of economic poverty: it was also the product of the physical impoverishment associated with the social, environmental and political conditions in the homelands, such as overcrowding and the heavy dependence on migrant labor in White areas. This was exacerbated by recurring droughts including a severe drought in 1983, the economic recession at the time and the expansion of White agriculture at the cost of forced resettlements of Blacks. One goal of this thesis is to demonstrate the intricate degree to which the social, environmental and political conditions during apartheid were all intertwined.

Consequently, the impact of malnutrition extended far beyond its manifestation as marasmus and kwashiorkor in children. Malnutrition weakens the immune system and increases susceptibility to bacterial infections, such as non-viral pneumonia. Medical historian Randall Packard, whose exhaustive political economic history of tuberculosis in South Africa heavily influenced this thesis, demonstrated how malnutrition also contributed to the rapid spread of tuberculosis throughout the Black South African population. In addition, a 1965 publication in the South African Medical Journal which cited gastroenteritis as the leading cause of death in non-White children aged five years or younger noted a “striking association of the disease with malnutrition,” but neglected to examine the relationship between malnutrition and

<table>
<thead>
<tr>
<th>Race</th>
<th>Number of cases of kwashiorkor</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>7</td>
</tr>
<tr>
<td>[Asian]</td>
<td>12</td>
</tr>
<tr>
<td>Colored</td>
<td>1,046</td>
</tr>
<tr>
<td>Black</td>
<td>9,765</td>
</tr>
</tbody>
</table>

33 Packard, White Plague, Black Labor.
socioeconomic status, much less the underlying reasons for the poverty plaguing Black South Africa.\textsuperscript{34} A subsequent article published in 1973 identified poverty and overpopulation as significant causes of protein calorie malnutrition – alongside ignorance and social disorganization.\textsuperscript{35}

\textit{The Burden of Sickness, the Burden of Blame}

Healthcare services in South Africa were ill-equipped to ameliorate the deteriorating health among the Black population as South African society became increasingly polarized. The homelands especially suffered from a lack of access to biomedical health services such as hospitals and clinics. Some members of the South African medical community argued in the early 1970s that the severely imbalanced health statistics of the nation were a natural product of industrialization, urbanization, and a reflection of South Africa’s dual economy.\textsuperscript{36} \textit{The Health of the People}, a propagandistic publication released by the government in 1977 which extolled the excellence of the South African healthcare system, supported by official statistics which conveniently excluded the populations of the homelands, openly noted South Africa’s “heterogeneous population in varying stages of development.”\textsuperscript{37} Such statements, common in official discourse at this time, were attempts by the government to deflect attention – and blame – away from the underlying causes of the unbalanced distribution of ill health plaguing the lower, almost exclusively Black, socioeconomic strata of South Africa: apartheid policies.

\textsuperscript{37} \textit{The Health of the People: A review of health services in the Republic of South Africa in the mid-seventies}. Johannesburg, Department of Health. 1977. p.55
The South African government and forces sympathetic to apartheid built on this practice of evading blame throughout the 1980s, instead charging rapid population growth in the Black population for the prevalence of malnutrition and disease. Writing in the late 1980s Andersson and Marks noted that the so-called “neo-Malthusian rhetoric,” which held population growth as a source of economic and social decline and disparity, had grown since the early 1970s. As a result, ‘population control’ programs received heavy funding in lieu of measures to ameliorate the political economic causes of poverty which ravaged the disenfranchised Black population. The State increased expenditure on family planning programs by a factor of thirteen between 1974 and 1984; between 1983 and 1984 alone the government spent 29 million Rand (R) on family planning programs whereby Black women received the more dangerous contraceptive devices.\(^{38}\) In November 1981 Dr. Johann de Beer, the Director-General of the Department of Health, Welfare and Pensions, threatened to make sterilization and abortion compulsory unless “certain ethnic groups” accepted family planning measures.\(^{39}\)

The result was a preponderance of contraceptive clinics at the expense of an increase in health clinics. The government estimated in 1983 that the ratio of birth control advisers to women was 1:4,000.\(^{40}\) In comparison, a total of 20,077 medical practitioners (3,290 specialists and 16,787 general practitioners) were registered with the South African Medical and Dental Council at the end of 1981, with an estimated overall doctor-to-population ratio of 1:1,540, excluding figures from the then ‘independent’ homelands of Transkei, Bophuthatswana, and Venda.\(^{41}\) The distribution of services ranged from 1:750 in urban areas to over 1:6,000 in rural areas, but the government did not publish an official breakdown of figures by racial


\(^{39}\) Seedat, Aziza. *Crippling a Nation.* pp.12-13

\(^{40}\) Andersson, Neil and Shula Marks. p.668

\(^{41}\) Seedat, Aziza. *Crippling a Nation.* p.84 citing SAIRR 1982, p.542
classification.\textsuperscript{42} One South African medical expert estimated a doctor-to-patient ratio which greatly favored the White population: 1 doctor for every 330 Whites. The same expert estimated ratios of 1:730 for the Indian or Asian population, 1:12,000 for the colored population, and 1:91,000 for the Black population.\textsuperscript{43} 1980 estimates for doctor-to-population ratios in the homelands cover a relatively broad spectrum, but none of the estimates provide an image of adequate care. The lowest ratio available for 1980 was 1:10,000 in Venda, while the KwaNdebele area had a doctor-to-population ratio of 1:156,380.\textsuperscript{44} Andersson and Marks note how the disparity between rural and urban communities was not unique to South Africa, though it had been severely exacerbated by racial controls over rural-urban mobility. These ‘influx controls,’ unique to Apartheid South Africa and keystone of separate development, inhibited Black social and economic mobility. In other words, rural populations were effectively condemned to remain rural, with the inherent disadvantages regarding employment, education, and health services.\textsuperscript{45}

Cedric de Beer, an experienced health report writer and ardent critic of apartheid, indicated that emphasizing the role of population growth in the deterioration of conditions among the Black population ultimately shifted the burden of responsibility for poverty and the proliferation of ill health onto the Black population itself, despite the clear bias in the distribution of medical manpower.\textsuperscript{46} The development of separate departments of health in various homelands only reinforced such claims while complicating the provision of health services.\textsuperscript{47}

Moreover, the educational system that had been shaped by the political economy of ‘separate

\textsuperscript{42} Andersson, Neil and Shula Marks. “Apartheid and Health in the 1980s”, p. 677
\textsuperscript{43} Seedat, Aziza. Crippling a Nation, p.84 citing SAIRR 1982, p.542
\textsuperscript{44} Andersson, Neil and Shula Marks. “Apartheid and Health in the 1980s”, p. 677
\textsuperscript{45} Ibid.
\textsuperscript{47} Andersson, Neil and Shula Marks. “Apartheid and Health in the 1980s”, p.676
development’ further limited the supply of doctors to the Black homelands and perpetuated the economic subjugation of Black South Africans.

An explosion of medical studies concerning Black health in the 1970s and 1980s followed the general trend of paternalistically apportioning blame for illness to the Blacks themselves while completely ignoring the causal relationship between apartheid policies and poverty and sickness. One study published in the *South African Medical Journal* in 1972, for example, suggested ‘ignorance’ was responsible for the preponderance of poisoning by plants of the *Senecio* genus among residents of Transkei. The author simultaneously neglected to examine a stated connection between susceptibility to this specific poisoning and malnutrition, and completely ignored the existence and extensive botanical knowledge of local traditional healers – a knowledge that was in some cases displaced as the Apartheid government forcibly resettled Black populations into the homelands.48 Another article published in the *South African Medical Journal* in 1973 emphasized ‘superstition’ and ‘ignorance’ as the cause malnutrition among Blacks.49 By 1977, “dietary teaching [was] based on the premise that “mothers [did] not know what was good for their children.”50 Packard notes the relationship between increased concern over Black health and the demands of “transformations in the nature of capitalist development;”51 the 1940s, like the 1970s, witnessed an increase of studies concerning the health of Blacks as the wartime economy “necessitated the creation of a more permanent, and therefore healthy, workforce.”52

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51 Packard, *White Plague, Black Labor*. p.21
At the same time the number of articles regarding the prevalence and significance of African traditional healers, who served about 80 percent of the Black population even in the face of repressive apartheid policies, also increased sharply.\textsuperscript{53} As of yet there appear to be no studies examining this trend in mainstream South African medical discourse, in which traditional healers and traditional medications played an increasingly large role. Ultimately, the South African government accepted traditional healers as an official form of primary health care, but the relationship between biomedical doctors and traditional healers was and continues to be somewhat tenuous. The debate surrounding collaboration between traditional healers and biomedical doctors appears to have superseded the apartheid segregation that had been exemplified by the creation of the homelands.

This thesis proposes to examine the political economy of health during ‘separate development’ as embodied by the consolidation of the Tswana homeland Bophuthatswana, whose large population, extensive forced resettlements, and heavy economic dependence on migrant labor serves as a stark paradigm for the political economic mechanisms of apartheid. In turn, apartheid ideologies and separate development shaped the health and economic landscape in such a way that the mutual economic interdependence between Blacks and Whites became undeniable, despite racial legislation socially and politically segregating the communities.

\textit{The South African Medical Journal}

This thesis proposes to explore how South African biomedical discourse reacted to and interacted with the deterioration of health in the homelands, and attempt to understand why biomedical physicians began to debate cooperation and collaboration with traditional healers, long marginalized by the biomedical community, in the 1970s and 1980s. This thesis does not

propose to represent the entire scope of interaction between doctors and sangoma. This would 
have varied region to region and doctor to doctor. Rather, this thesis looks at perceptions in 
mainstream biomedical publications, especially the *South African Medical Journal*.

The *South African Medical Journal* was the main publishing body for members of the 
Medical Association of South Africa, which had been established in Cape Town in July 1883.\textsuperscript{54} What initially began as a relatively small operation grew to become the foremost and most 
influential publishing body of medical literature in South Africa by the time the National Party 
rose to power in 1948.\textsuperscript{55} The Medical Association of South Africa was a professional association 
of between nine- and ten thousand biomedical physicians, or around 80 percent of all doctors 
practicing in South Africa, and chiefly represented the perspective of White doctors during the 
Apartheid Era.\textsuperscript{56}

The controversial death of Steven Biko, the founder of the anti-apartheid South African 
Student’s Organization and a leader of the Black Consciousness movement, precipitated a series 
of events within the *South African Medical Journal* that demonstrated its close ties to the 
Apartheid State. The secretary general of MASA refused to allow the publication of letters 
concerning the death of Biko in the *South African Medical Journal* in 1980 due to their vitriolic 
criticism of MASA and the Apartheid State.\textsuperscript{57} Two years later, a number of high profile medical 
professionals resigned from MASA to form NAMDA, upset that their views were not adequately 
represented in the *South African Medical Journal*, which they accused of being “too closely 
aligned with the Apartheid State.”

\textsuperscript{54} *SAMJ*. 1884.
\textsuperscript{55} Van Niekerk, J.P. e-mail correspondence
\textsuperscript{56} Seedat, Azia. *Crippling a Nation*. p.95
\textsuperscript{57} Van Niekerk, JP. Personal correspondence, Feb 23-28, 2011. ; Ncayiyana, Daniel J. “The unpublished 
Chapter One

Conflicting Cures: Poisoning in Ga-Rankuwa, Bophuthatswana

Over decades, if not centuries, the duel between the witchdoctor and the medical profession has been simmering wherever Western and more 'primitive' cultures meet.

In South Africa, at the moment, there seems to be a general 'buzz', heralding an explosion in this low-key confrontation of such long standing. It certainly behooves our profession to move with the utmost care and to show respect for alien cultures in this dispute, but there are principles at stake which are basic to our professional ethics, and these should not be adulterated in fruitless compromise.

- G.H. Roux, 1977

In many ways, poisoning studies provide the archetype for biomedical discourse during the Apartheid Era, when most problems of ill health, notably malnutrition, were blamed on Black “ignorance, social disorganization and overpopulation.” One study in particular provides insight into trends of how discourse shaped and was shaped by apartheid. The Department of Pharmacology and Therapeutics at the Medical University of Southern Africa (MEDUNSA) conducted a study in the 1980s examining the trends of acute poisoning among Black patients admitted to Ga-Rankuwa Hospital. Ga-Rankuwa Hospital, situated in the Black township of Ga-Rankuwa in the Odi district of eastern Bophuthatswana, provided biomedical healthcare mainly to the surrounding Black South African population of about 60,000 people. Ga-Rankuwa Hospital admitted a total of 1,306 Black South African patients suffering from acute poisoning between 1981 and 1985. Sixty of these patients, twenty-two of whom were children, died. The Department of Pharmacology and Therapeutics at MEDUNSA, which had been monitoring such cases since 1981, identified exposure to kerosene, pesticides, and the use of traditional medicines

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1 Roux, G.H. “The Medical Profession and the Witchdoctor.”
4 Seedat, Aziza. Crippling a Nation. p.70
as the leading causes of acute poisoning in the patients admitted to Ga-Rankuwa Hospital. Despite the clear dominance of kerosene-related cases, which accounted for 59 percent of all acute poisoning admissions, the 204 cases of acute poisoning by traditional medicines received special scrutiny.\(^5\)

Traditional medicines and the traditional healers who administered them had long been under the critical and somewhat paternalistic gaze of South Africa’s biomedical practitioners by the time MEDUNSA conducted its poisoning research in Ga-Rankuwa: one early study devoted to the practice and risk of traditional medicine dates to 1955, but this article appears to have been an anomaly at the time.\(^6\) The 1976 publication of “Poisoning Associated with Witchdoctor Attendance” in the *South African Medical Journal* makes a more significant connection between traditional healers and poisoning due to its place among the growing body of discourse addressing traditional medicine which began to escalate in the 1970s and 1980s.\(^7\)

Accompanying this escalation in medical discourse was a growing body of ethnographic research which delineated the ideological parameters of traditional medicine and biomedicine. The works of anthropologists such as Harriet Ngubane, John Janzen, Steven Feierman and John and Jean Comaroff established the theoretical framework in which the two disparate yet “parallel health care systems” interacted.\(^8\) The complex interactions of these two powerful and distinct systems of healing have ranged from complementary to confrontational; the admission of patients poisoned by traditional medicines to Ga-Rankuwa Hospital are a testament to the occasional clash of systems. Yet these clashes extended beyond the occasional accidental poisoning and the hospital ward; the two systems represent very different approaches to health

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5 Joubert, Pieter H. “Poisoning Admissions”


8 Kale, Rajendra. “A Parallel Health Care System.”
and healing. The distinction between the two parallel systems is crucial in understanding how they defined themselves especially as they crossed paths with one another, and how the theoretical divide between the systems shaped official South African medical discourse throughout the twentieth century.

Although biomedicine had firmly established itself as the dominant, ‘official’ form of health care in South Africa by the launch of apartheid in 1948, traditional healers continued to play a major – and in many ways more extensive – role in the provision of health care to the non-White population groups of South Africa, especially to the Black population living in the homelands. The Republic of South Africa was therefore a country of a dualistic economy complemented by parallel, distinct health care systems: bio- or ‘modern’ medicine and traditional medicine. The Western biomedical model had been introduced to South Africa during the early years of colonialism in South Africa, largely through the establishment of Christian missionary hospitals. Even before the implementation of apartheid in 1948, the biomedical understanding of disease and methods of diagnosis and treatment had become relatively well known and widely accepted throughout South Africa. Biomedicine, characterized by a scientific, empirical approach to the etiology of diseases, understands illness as a product of natural phenomena such as bacteria and viruses, and diagnoses and treats them accordingly. Biomedical practitioners’ ardent adherence to empiricism has been a major factor contributing to their cultural alienation from traditional healers.

11 Interview with Ambrose Kelly, January 3, 2011.
Traditional medicine in sub-Saharan Africa is more complex and difficult to define than biomedicine: terminology, methods of healing and the structure of rituals vary between region and culture. Nevertheless, South African articulations of traditional medicine benefit from a long history of interaction and cultural exchange. Accordingly, both Central and Southern Africa share a widespread and complex ritual institution which is commonly referred to as *ngoma*. *Ngoma*, or ‘drum,’ encompasses several concepts but ultimately refers to traditional healing practices.\(^{13}\) The main characteristic of traditional medicine which distinguishes it from the biomedical model is its emphasis on the supernatural nature and etiology of disease, as opposed to a strictly empirical model. Due to its emphasis on the spiritual realm and the ritualistic nature of its healing practices, biomedical authorities habitually dismissed traditional methods of healing as inane products of the Black ‘superstition’ or ‘ignorance,’ a mentality which surfaced in the debates of the 1970s and 1980s but which had existed since European missionaries in South Africa had introduced the derogatory term “witchdoctor” to the local lexicon.\(^ {14}\)

Ngubane’s research revealed an interesting relationship between traditional healers and biomedical doctors themselves. Despite apartheid segregation the two disparate medical systems remained in constant interaction with each other. The type of interaction varied from accidental poisonings from traditional treatments, to the referral of a patient by a traditional healer to a biomedical clinic or hospital. Patients who sought biomedical care after seeing a traditional healer, with or without a referral, often encountered difficulty at the hospital or clinic. The most significant barrier was the language barrier which separated Black patients from their generally White physicians, but cultural differences were also a factor. According to Ngubane, it was not

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uncommon for the doctor or translator to reprimand the patient for having sought traditional care before consulting biomedical professionals. Black patients were frequently treated in a condescending manner with little consideration given to the great distances or other obstacles they had to overcome to visit the often inaccessible hospitals and clinics.¹⁵

Though this may have been the general trend in interaction, biomedical doctors occasionally used traditional healers as a resource. The Medical, Dental and Supplementary Health Services Professions Act No.56 of 1974 legally prohibited biomedical doctors from collaborating with traditional healers as equally qualified healthcare professionals.¹⁶ Biomedical doctors were simultaneously pushed to recognize the prevalence and significance of traditional healers within the Black community as they increasingly used traditional healers as resources from whom they could learn how to provide culturally relevant care. By 1990, when Joubert and his associates at MEDUNSA published “Poisoning Admissions of Black South Africans,” traditional healers continued to be represented as liabilities to public health rather than providers of effective health care.¹⁷ The publication specifically drew attention to the fact that there was “no legislation controlling African traditional medicines,” which echoed the paternalistic calls for legislation that dated back at least to 1955.¹⁸

¹⁷ Joubert, Pieter H. “Poisoning Admissions”
**Poisoning Admissions at Ga-Rankuwa Hospital**

MEDUNSA’s study of acute poisoning admissions to Ga-Rankuwa Hospital in Bophuthatswana was both the product of the political economy of this dichotomous period and nearly two decades of increased interaction with the Black population in the townships. MEDUNSA’s focus on the incidence of traditional medicine-related poisonings reflected both the researchers’ recognition of the importance of traditional medicines within Black South African communities as well as a stated interest in the local poisoning pattern; this study was one of a larger body of medical research conducted as more comprehensive health services were gradually introduced to the marginalized Black population.

The study determined that accidental poisoning by traditional medicines was responsible for thirty-one of the sixty deaths, 51.7 percent of all mortalities, resulting from acute poisoning; traditional medicine poisonings also represented the highest overall associated mortality rate of 15.2 percent. Although data appear to indicate a significant incidence of traditional medicine poisonings in children below the age of ten, analysis of poisoning patterns appears to have focused on the impact of traditional medicine poisoning on the “adult” (ten years of age or older) cases of acute poisoning, 78.1 percent of which were males. Traditional medicines were responsible for 44 percent of the cases of acute poisoning in this group as well as 62.5 percent of deaths.

While MEDUNSA researchers concluded traditional medicines were responsible for the greatest proportion of acute poisoning cases among adults admitted to Ga-Rankuwa Hospital between 1981 and 1985, pesticides also posed a significant danger to public health. The study found 23.3 percent of acute poisoning cases in adults linked to pesticides. Pesticides, specifically

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19 Increased interaction in the context of a recognition of mutual economic dependence, addressed further in Chapter Two.
20 Joubert, Pieter H. “Poisoning Admissions”
organophosphates, were responsible for 12.5 percent of adult mortalities and represented the second highest associated mortality rate in MEDUNSA’s 1981-85 study, following traditional medicines (6.5 percent and 15.2 percent, respectively). On a broader scale, pesticide poisoning only accounted for 6 percent of admissions to Ga-Rankuwa Hospital during the study and 8.3 percent of all deaths. These figures were overshadowed by the sheer magnitude of kerosene-related poisonings, which were responsible for 26.7 percent of deaths.\textsuperscript{21}

Kerosene therefore also posed a threat to the general health of the Black South African population. Kerosene was responsible for 59 percent of all acute poisoning cases admitted to Ga-Rankuwa Hospital between 1981 and 1985, and accounted for 72.7 percent of all acute poisoning deaths that occurred in children below the age of ten. Despite the relative lethality of kerosene poisoning among children, only 2.1 percent of all kerosene-related acute poisoning admissions between 1981 and 1985 ended in death. Kerosene therefore represented the lowest associated mortality rate of the three categories in question. In contrast, pesticides only represented 6 percent of the etiology of all acute poisoning cases but had an associated mortality rate over three times greater than that of kerosene.\textsuperscript{22}

\textsuperscript{21} Ibid.
\textsuperscript{22} Ibid.
Following the first five years of what would become an ongoing epidemiological study, MEDUNSA’s Department of Pharmacology and Therapeutics had identified three major threats to public health: traditional medicines, pesticides, and kerosene. At the same time, MEDUNSA downplayed the significance of pharmaceutical drugs as poisoning agents, explicitly stating that drug poisoning was “relatively unimportant.” Yet drugs, like pesticides, were responsible for 12.5 percent of mortalities among adults admitted to Ga-Rankuwa Hospital for acute poisoning during the five year study period. Furthermore, drugs and pesticides shared a similar mortality rate; 6.3 percent of patients admitted to the hospital due to drug poisoning died. Acute poisoning from drugs was therefore three times more lethal than kerosene poisoning, but it apparently did not merit attention for mitigation schemes like those suggested for traditional medicines, pesticides and kerosene. Mitigation schemes, like the study itself, did not address the source of

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\[23\] Joubert, Pieter H. “Poisoning Admissions”
the poisonings – economic disparity – but instead suggested child-resistant containers for kerosene, and “modernization.”

The Department of Pharmacology and Therapeutics also conducted supplementary research to the study of acute poisoning admissions to Ga-Rankuwa Hospital. This second study, published in the *South African Medical Journal* in 1984, examined patterns of self-medication in the Black South African population of Ga-Rankuwa. Researchers from the Department of Pharmacology and Therapeutics surveyed a sample of six hundred households in Ga-Rankuwa to determine which medicines residents had in their homes and for which illnesses they would use them; traditional medicines, or *mutis*, again received special scrutiny as the counterpart of “Western” biomedical healthcare.

The study revealed that “Western medicines” represented the dominant substances in self-medication within the Ga-Rankuwa households surveyed [89.2 percent of medicines present in households]. Researchers noted how “Western medicines already [played] a major role [emphasis added]” in the population of Ga-Rankuwa. Traditional medicines played a comparatively minor role, at least in patterns of self-medication: only 9.4 percent of medications present in the study population were *mutis*. Nevertheless, researchers understood that traditional medicines “still [played] an important role [emphasis added]” within the Ga-Rankuwa population and the Black population as a whole than their survey of household medicines indicated. This language reveals a common association between the type of healthcare and the level of development – or ‘civilization’ – which extended beyond this study and permeated

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26 Ibid.

27 Ibid. p. 130

28 Ibid.
several of the articles throughout the *South African Medical Journal*. Numerous articles published within the *South African Medical Journal* also illustrated a clear association between traditional superstitions and practices with centuries-old European practices: the reinforced apartheid’s apologists’ claims that Blacks were simply at an earlier, more primitive stage of development. That this concept of underdevelopment was further reinforced by the conditions under which they lived during the Apartheid Era is but one example of how apartheid shaped medical discourse.\textsuperscript{29}

The Department of Pharmacology and Therapeutics’ awareness of the larger extent to which Black South Africans made use of traditional medicines stems from their familiarity with the traditional methods by which *mutis* were administered: not personally, but by traditional healers.\textsuperscript{30} Researchers demonstrated an increasing familiarity with the significance of traditional healers in the Black South African population throughout the larger body of medical literature surrounding poisoning cases in Ga-Rankuwa, especially as reports approach the year 1992. In this year, the Department of Pharmacology and Therapeutics at MEDUNSA published a joint study conducted with the Department of Experimental and Clinical Pharmacology at the University of the Witwatersrand entitled “Cardiac Glycoside Poisoning Involved in Deaths from Traditional Medicines.”\textsuperscript{31} Incidentally, the Department of Pharmacology and Therapeutics at this time was still under the leadership of Doctor Pieter H. Joubert, who had overseen the acute poisoning studies at Ga-Rankuwa Hospital in the 1980s.


\textsuperscript{30} Joubert, Pieter H \textit{et al.} “Self-medication in a developing community.” p. 130

In this report, researchers cited two earlier publications published in 1989 and 1990, as well as “personal communication” with a traditional healer as sources for their relatively detailed description of the traditional medical system.\(^{32}\) Researchers had noted the distinction between several categories of “traditional healer practitioners:”\(^{33}\)

(i) diviners, who receive a strong ‘calling’ from ancestors by way of dreams; (ii) inyangas, the majority of whom are men, who diagnose and prescribe medicine, but not always through visions or dreams; sangomas, predominantly women, who usually diagnose and then send the patient to an inyanga; (iii) herbalists, men or women, who usually sell or prescribe herbal remedies; (iv) members of the family, e.g. grandmothers, whose knowledge is passed down through the generations, who collect plants for medicinal purposes to administer to their children and grand-children; and (v) it is suspected that there also exist ‘traditional healers’ who practice without any formal training or ‘calling’ and have a low success rate – this appears to represent the negative aspect of traditional healing. [sic]\(^{34}\)

Although external sources suggest divisions between classes are not so clear and several of the abovementioned categories may even overlap, this extract from “Cardiac Glycoside Poisoning Involved in Deaths from Traditional Medicines” is nonetheless significant:\(^{35}\) it appears to be the first report within the body of medical literature surrounding the etiology of acute poisoning in the Ga-Rankuwa area in which traditional healers are represented as a structured and diverse body of practitioners, each with different skills. It also suggested that traditional healers were generally well-versed in the effects and dangers of their materia medica, adding to a gradually growing body of literature supporting traditional healers. This article, which noted how a relatively small body of unqualified practitioners was responsible for the bad


\(^{33}\) McVann, A. I. *et al*. “Cardiac glycoside poisoning involved in deaths from traditional medicines.”

\(^{34}\) *Ibid*. p.139

name of traditional healers, also contradicted commonly held preconceptions of Black “ignorance” which permeated apartheid literature and had generally been supported by poisoning studies. Nevertheless, this report, published during the decline of apartheid, is not the first evidence of “Western” biomedical practitioners’ familiarity with traditional healing practices within *South African Medical Journal*, though it appears to demonstrate an unprecedented knowledge of the traditional healers, at least among mainstream biomedical discourse. Reports subsequently published in the 1980s appear to have replaced the long-standing pejorative term “witchdoctor” with “traditional healer.”

Predating this increasing familiarity with traditional healing as a diverse practice in which several categories of ‘specialists’ such as the *sangoma* operated was a recognition of the extent to which Black South Africans consulted traditional healers as their means of treating an illness. This knowledge, and the knowledge that traditional medicines were rarely self-administered, but instead dispensed by traditional healers, is especially important considering MEDUNSA’s study of the etiology of acute poisoning admissions to Ga-Rankuwa throughout the first half of the 1980s. The traditional healers, who normally administered traditional medications, were indirectly tied to the health risks posed by their *mutis*, on which the initial study at Ga-Rankuwa Hospital so heavily focused. At the same time, MEDUNSA’s studies of acute poisoning in the

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38 Joubert, Pieter H. *et al.* “Self-medication in a developing community.”
1980s seem ambiguous towards the traditional healers: they at once represented a threat and a potential benefit to public health. This complex relationship was a cornerstone in the health landscape of South Africa during the Apartheid Era.

Although MEDUNSA’s 1984 survey focused on the presence of ‘Western medicines’ compared with that of traditional medicines, it also indirectly touched upon several other factors intertwined with public health at this time. Researchers noted factors such as overcrowding and a “high percentage of children present” represented a health risk as they increased the risk of misusing medications and accidental poisoning.\(^{39}\) Whether or not such possibilities directly linked to the drug poisonings in the 1981-1985 study is unclear, though it confirms that drugs were still a public health risk.

<table>
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<tr>
<th>Sources of the Medicines Found(^ {40})</th>
<th>Hospital or Clinic</th>
<th>Pharmacist</th>
<th>Private Doctor</th>
<th>General Dealer</th>
<th>Traditional Sources*</th>
<th>Other</th>
</tr>
</thead>
<tbody>
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<td>No.</td>
<td>155</td>
<td>363</td>
<td>23</td>
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<td>2.4</td>
<td>34.9</td>
<td>6.7</td>
<td>3.1</td>
</tr>
</tbody>
</table>

*Traditional Healer, African medicine shop, self-collected herbs.

MEDUNSA’s initial study at Ga-Rankuwa Hospital may not have called for screening techniques for drugs, but the supplementary study of self-medication in Ga-Rankuwa in 1984 indicated concern for the sources of personal medications. Researchers considered their findings important for the training of physicians, pharmacists and the provision of health services and education to the community of Ga-Rankuwa and presumably elsewhere.\(^ {41}\) In fact, the top priority of the researchers was to train more medical professionals, especially pharmacists, “to serve the Black community,” which had been woefully underserved by biomedical professionals.

\(^{39}\) Ibid. p. 130  
\(^{40}\) Ibid.  
\(^{41}\) Ibid. p. 131
throughout the Apartheid Era. Their findings therefore only confirmed an enduring reality: education was precious. Among Blacks, education to the levels necessary to enter medical school and be prepared to work outside the major urban centers was extraordinarily rare.

One common thread visible between the studies outlined above is the divide and perceptions of treatment in terms of development of healthcare. Traditional medications, which were largely dispensed by traditional healers, appear to represent a liability to public health: antiquated, and contrary to the curative goals of biomedicine. This division between biomedicine and traditional medicine was a common theme during the Apartheid Era; indeed, these studies are only a sample of a larger body of writings found throughout the *South African Medical Journal* discussing the both the values and perils of traditional healers, as well as debates over contesting ideologies underlying the different healing systems. At the same time, collaboration between biomedical doctors and traditional healers had also been a topic of discussion.

The debate over collaboration between biomedical doctors and traditional healers threads through all the aforementioned studies, the results and patterns of which were all ultimately shaped by the development and consolidation of the homelands; in this case, the Tswana homeland of Bophuthatswana. Similarly, MEDUNSA’s semi-paternalistic mentality towards the regulation and training of traditional healers represents a mentality which had, like the patterns of ill health and poisoning in the studies above, been shaped by the segregation embodied within the creation of the homelands. This poisoning study, published in 1990, embodies many of the dynamics permeating medical discourse which began in earnest 1970s as the South African

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42 *South African Institute of Race Relations*. 1982. p.541
44 Joubert, Pieter H. *et al.* “Self-medication in a developing community.”
government began to take an increased interest in Black health and expand healthcare into the homelands. The subsequent chapters will establish the foundations of sickness and disparity that shaped the findings of researchers working in Ga-Rankuwa.
Chapter Two

The Foundations of Sickness: Separate Development and Economic Dependency

The series of poisoning studies conducted in Ga-Rankuwa throughout the 1980s provides an excellent example of how the increasingly dualistic economy of Apartheid South Africa shaped medical discourse as it shaped the landscape of malnutrition and disease. The township of Ga-Rankuwa itself was particularly important within biomedical discourse as the Republic of South Africa was forced to recognize its economic dependence on Black laborers in the 1970s and made efforts to extend healthcare to the Black population.¹ The construction of Ga-Rankuwa Hospital in 1973 and the subsequent addition of the Medical University of Southern Africa (MEDUNSA) in 1978 provided biomedical researchers with direct access to a large and densely settled Black population; the series of poisoning studies conducted by MEDUNSA’s Department of Pharmacology and Therapeutics throughout the 1980s are a testament to the significance of Ga-Rankuwa and other townships as a locus of interaction between Blacks and the White Republic of South Africa.² Ga-Rankuwa and its sister townships, however, were especially significant as a crucial expression of the wage labor system which characterized South Africa’s dualistic – yet unified – economy.

The Black townships were more than just defined communities into which biomedical health services expanded in the 1970s; they were essentially products of the political economy of separate development under apartheid conditions.³ Blacks had become almost entirely dependent on wage labor in White areas by the 1970s, generally in the form of migrant or commuter labor. The growth of the apartheid wage labor system reinforced the dualism of the South African

¹ Packard, Randall. White Plague, Black Labor. p.21
² Retief, F.P. “The Medical University of Southern Africa after 5 years.” SAMJ. Vol. 62. 1982: 841-845
³ Packard, Randall. White Plague, Black Labor. p.21
economy and exacerbated the poverty and consequent ill health within the Black population that had been building since the beginning of the twentieth century. The South African government constructed ‘townships’ such as Ga-Rankuwa to house the rapidly growing population of Blacks accumulating on the outskirts of White urban centers to where most commuted daily as wage laborers. Of course, these commuters had little choice but to live in the townships. Apartheid policies collectively known as ‘pass laws’ or ‘influx controls’ greatly restricted the political and economic autonomy of Blacks by forbidding them from remaining in urban centers for over 72 hours, unless they met certain criteria. Few did. Bophuthatswana, the homeland in which Ga-Rankuwa is located, depended heavily on commuter labor and provides a good historical model of how segregation and separate development ultimately sculpted the poverty and health profile of the homelands.

Maize, Malnutrition and the Reproduction of Labor

The economic and physical poverty of the Black population has significant roots in the geographical location and environmental conditions of the homelands themselves; the lack of a reliable subsistence base was much of the ill health and economic disparity that plagued homeland Blacks throughout the latter twentieth century. Environmental historian Nancy Joy Jacobs provides an excellent environmental history of the Kuruman area, which fell within the boundaries of western Bophuthatswana during the Apartheid Era. Although her work does not explicitly address the topics of health and healing, her history illustrates several key factors rooted in the land itself that contributed to the foundations of the political economy of health.\(^4\) The dynamics of South Africa’s dualistic economy and the burden of illness accompanying it had long been underway before the instigation of apartheid policies following the election of the

National Party in 1948. Indeed, the Black homelands were vestiges of pre-apartheid policies of separate development and inherited the legacy of the Native Reserves which were established in 1913 by the Natives Land Act No. 27 in response to the demands of White farmers, who dominated South African politics in the early twentieth century, for a reliable source of cheap wage labor.\(^5\)

Before the Natives Land Act of 1913, Blacks in each of South Africa’s provinces had been subject to laws which set aside certain land for exclusive Black occupation.\(^6\) The size of this land varied between provinces: Blacks in the Orange Free State, for example, were limited to relatively small tracts of land; in the Transvaal and Natal, the land was more extensive but more fragmented, while in the Cape Colony Blacks were provided with a large and consolidated area of land in the Transkei region.

The Natives Land Act marked the beginning of a process that would reconcile the array of different land laws across the provinces and ultimately eliminate the longstanding favored position of Cape Blacks.\(^7\) The act effectively restricted the entire Black South African population to ‘scheduled areas’ which covered a total of 10.7 million morgen (22.5 million acres): 7.3 percent of the total area of South Africa. Furthermore, the act prohibited Blacks from purchasing land outside the reserve areas or even offering their services as sharecroppers on the White-owned farms.\(^8\) The government subsequently passed the Natives Trust and Land Act in 1936 both in recognition of the poor conditions of the Reserves and in an effort to eliminate the ‘Black spots’ scattered throughout the territory reserved for the Whites. “The 1936 Act provided that a

\(^6\) *Ibid*.  
\(^7\) *Ibid*  
\(^8\) *Ibid*, p.10
‘quota’ of 6,209,857 hectares of land gradually be added to the scheduled areas,” bringing the total amount of land allocated to the Black population to about 13 percent.\textsuperscript{10}

The restriction of a large population with a high demand on resources such as food to relatively small areas of land, with no plans for expansion, had significant ramifications in agricultural production. Blacks were traditionally accustomed to using the land extensively and therefore depended on a certain degree of mobility. Confinement in the Reserves forced Black farmers to intensify farming and herding; this was especially problematic for Black farmers dependent on maize.

The gradual integration of rural areas into expanding commodity markets from the middle of the nineteenth century had led to an increased dependence on maize as both a source of income and a source of nutrition. Packard provides an excellent demonstration of the significance of the rise of maize production in the context of the Native Land Act.\textsuperscript{11}

Although maize was an attractive prospect to farmers as a marketable good, easy to produce and one which produced a relatively high yield, it ultimately became a major liability to both the economy and to health. Maize production had increased at the expense of the less marketable millet and sorghum, which traditionally comprised the main sources of starch in rural diets. In 1963 a survey of Black school children living in the Pretoria area determined that mealie-meal, a type of porridge made from maize, formed a major component of the Black diet but was supplemented by a greater variety of foods on weekends and towards the end of the month, “when money [was] more plentiful.” The researcher did not challenge why money – and

\textsuperscript{9} Horrell, Muriel. Race Relations as Regulated by Law. p.76
\textsuperscript{10} Seedat, Aziza. Crippling a Nation.
\textsuperscript{11} Packard, Randall. White Plague, Black Labor. pp. 108-112
necessary dietary supplements – were only available at the end of every month.\textsuperscript{12} Compared to maize, sorghum is more nutritious; maize required supplementation with other vegetables to negate any disadvantages of shifting to a diet based on maize. These vegetables eventually ceased to be a regular part of the diet following the First World War, which meant Blacks were generally left with an inferior diet.\textsuperscript{13}

Maize also quickly depleted the soil of nitrogen, phosphorous and potassium, macronutrients that are not only crucial to plant life but the structure and stability of the soil. Soils depleted of these key nutrients are susceptible to desertification, in which the once-nutrient-rich topsoil becomes vulnerable to being blown away by wind.

Under normal circumstances, maize production included patterns of shifting cultivation in which the land was left fallow and allowed to restore itself naturally. The restriction of arable land by the Natives Land Act meant farmers had less land to farm while trying to maintain maximum productivity. As a result, farmers dedicated nearly all available land to maize production. Without the option of shifting cultivation, Black farmers were forced to depend heavily on fertilizer to maintain the nutrient load of the soil: cattle manure did not replace potassium and the nitrogen-fixing legumes did little to prevent the long-term deterioration of the soil under such intensive farming conditions.

Eventually, Black farmlands suffered from declining productivity as fallow periods were shortened and the land was leached of its nutrients, and a less nutritionally diverse diet as maize production was expanded at the expense of millet, sorghum and other vegetables. This left the Black population extremely vulnerable to climatic variations such as drought: maize was less resistant to drought than sorghum. Farmers were aware of this attribute of maize and generally


\textsuperscript{13} Packard, Randall. \textit{White Plague, Black Labor}. pp. 108-112
planted sorghum as a backup should drought strike, but pressure to raise commodity crops and declining soil fertility often meant desperate farmers would extend maize onto land reserved from sorghum production.\textsuperscript{14} Despite their knowledge of sustainable farming techniques, Black farmers were effectively forced to result to practices that were ultimately detrimental to productivity and health. Medical discourse throughout the Apartheid Era focused on such actions, and not the underlying causes, to reinforce claims of Black ignorance and redirect blame from apartheid policies to the activities of the Black population.

The droughts of the late 1920s, 1930s, 1960s and 1980s illustrated the social costs of maize production.\textsuperscript{15} It also revealed the degree to which Black farmers had become dependent on markets, rather than their own land, for subsistence.\textsuperscript{16} In 1932 the Native Economic Commission described the situation in the reserves as a “race against time” to prevent “the destruction of large grazing areas, the erosion and denudation of the soils and the drying up of springs.”\textsuperscript{17} Despite government efforts to regulate land use through invasive ‘betterment schemes,’ environmental conditions in the Reserves continued to deteriorate. In 1952 the Natal Agricultural Union expressed a view that would be typical of apartheid discourse by ignoring causality, instead blaming the resulting problems on Black competence: “The Native is not a farmer and never will be a farmer. He would ruin every bit of land that was placed at his disposal, and it was the height of folly and irresponsibility to hand over the district to Natives.”\textsuperscript{18}

\textsuperscript{14} Packard, Randall. \textit{White Plague, Black Labor}. pp. 108-112
\textsuperscript{16} Packard, Randall. \textit{White Plague, Black Labor}. pp. 108-112
\textsuperscript{17} Platzky, Laurine and Cherryl Walker. \textit{The Surplus People: Forced Removals in South Africa}.” Johannesburg: Ravan Press. 1985. p.93
\textsuperscript{18} Natal Agricultural Union, 5 Nov. 1954
The decline of independent food production in Black agriculture contributed towards a pattern of increased dependence on a cash economy for subsistence: a crucial concept underpinning the political economy of health during the Apartheid Era. This pattern of dependence extended beyond the realm of agriculture: overcrowding, soil erosion and declining agricultural productivity also gave way to an increasingly prevalent trend of people seeking wage labor outside the Native Reserves, both out of economic necessity and out of a desire escape the biting poverty of the overcrowded rural areas. The growing number of wage laborers seeking work outside the Reserves effectively removed the Reserves’ productive base: the Reserves, and later the homelands, lacked industry and the internal capacity to develop – they were entirely economically dependent on White South Africa.19

These dynamics of dependency have led many scholars to conceptualize the marginal rural areas to which the Black population was confined as “labor reserves” or “labor reservoirs” from which White industries could easily extract a workforce. This is a crucial concept in Packard’s political economy of tuberculosis.20 This may be an accurate and thoroughly justified perspective, but more recent scholarship has openly challenged this long-held concept of “labor reservoirs,” at least regarding the first half of the twentieth century: environmental historian Jacobs argues that “dependence on cash was mitigated by other forms of remuneration.”21 In *Environment, Power and Injustice* Jacobs demonstrates how people in Kudumane had a certain degree of flexibility in choosing labor; some of the jobs that people sought out did not pay cash at all, indicating how, “even after herding and cultivating were not able to support the population, people did not become immediately dependent on cash; they actually identified new supplements to it.” At the same time, she notes the increase of selling labor as providing

19 Butler *et al.* *The Black Homelands of South Africa*. p.141
subsistence became more difficult; after the 1948 elections supplementary forms of production dwindled as the population of Kudumane became increasingly dependent on the cash economy.22

**Apartheid and the Rise of Labor Migration**

Natives Land Act and the subsequent Natives Trust and Land Act did not immediately spell the demise of Black agriculture and the dependence on wage labor in White-owned industries, though the dynamics of production and soil erosion detailed above were extremely important to the development of economic inequality, malnutrition and disease endemic to the Black homelands throughout the Apartheid Era. Agriculture in Dinokana village, a small Black settlement located in ‘Moiloa’s Reserve’ west of Pretoria near the border with Bechuanaland,23 thrived throughout the 1920s and 1930s despite a heavy emphasis on cash crops. Historians Drummond and Manson place the downturn of agriculture in Dinokana at the rise to power of the National Party in 1948 and the implementation of apartheid policies linked to the development and consolidation of the homelands. Dinokana village fell within the boundaries of a slowly crystallizing Bophuthatswana and as such was subject to the series of forced resettlement of thousands of Blacks as the South African government expelled them from lands designated for White ownership: Dinokana was a site to which over thirteen thousand labor tenants and squatters were ‘removed’ from White farms in the western Transvaal and the urban area of Reef, under influx control laws, in 1969.24

The extremely important concept of ‘tribal identity’ which underscored apartheid policies ranging from social and economic segregation to education to the provision of health services

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23 Bechuanaland consisted of lands that currently make up northern South Africa and Botswana.
also justified and facilitated the consolidation of the homelands by means of mass forced removals. South African policymakers took advantage of traditional African systems of land tenure: communal land tenure. Indeed, most of the ethnic groups who received homelands according to the Promotion of Bantu Self-Government Act of 1959 shared similar customs of communal ownership to land. As part of the ‘tribal identity’ to which the homelands were dedicated to preserving, communal land tenure conveniently factored into the Apartheid State’s plans for consolidation: groups of thousands of people were forcibly removed from their ancestral lands and placed on land already ‘belonging’ to a certain village, for example.

In 1969 the aforementioned thirteen thousand labor tenants and squatters were removed from their homes in newly designated White areas to ‘Moiloa’s Reserve.’ The sudden influx of thirteen thousand people contributed to overcrowding and led to the erosion of pastures and a fall in crop yields. Piet Mohalelo, a local resident of Dinokana, recalled the sudden increase in population as victims of resettlement schemes poured in: “From ’65 ja, people are so moving on to the reserve that I don’t know in five years’ time how the place will be. It will be overpopulated.”

Yet the forced resettlements of ‘homeland consolidation’ did more than exacerbate population pressure on the land; resettled groups frequently came into conflict with those upon whose ancestral lands they were unwillingly impinging. In the case of Dinokana and Lehurutshe, the conflict arose not from a competition for land, but from a competition for water. Water was redirected from the Dinokana Eye to the resettlement area of Lehurutshe, which

26 Drummond, James and Andy Manson. “The Rise and Demise of African Agricultural Production”
27 Interview with Ambrose Kelly, January 3, 2011.
28 Oasis
adversely impacted irrigation and consequently year-round crop production in Dinokana.\textsuperscript{29} Aerial photographs revealed a decrease in agricultural production in Dinokana between 1957 and 1984 due to mounting population pressure and the diversion of water from irrigation to Lehurutshe: 470 hectares in 1957 to 206 hectares in 1984, a 56 percent reduction of cultivated land.\textsuperscript{30}

The case of Dinokana and Lehurutshe demonstrates how apartheid policies led to overpopulation and subsequent denigration of agriculture, causing the villages that survived the land restrictions of the early twentieth century to suffer from declining yields. Elsewhere in South Africa, the segregation and forced removals of apartheid exacerbated preexisting dynamics of overpopulation, soil erosion, and growing poverty in rural areas. The rapid urbanization and industrialization in South Africa following the Second World War greatly contributed to influx of Black workers towards urban areas as the burgeoning White-owned business attracted wage laborers from the impoverished rural areas. At the same time, these years were also laden with political and economic conflict as the 1940s bore witness to what Platzky and Walker called “an upsurge in the political consciousness of the Blacks” as the rapidly expanding manufacturing industry desired to establish a more stable and highly skilled Black workforce.\textsuperscript{31}

The South African government also exhibited an increased interest in the health of the Black South African population during this period of heightened economic interest and Black political activity. One of the first articles published within the \textit{South African Medical Journal} explicitly devoted to Black health dates to August 1945; “Impressions of the Transkei, After a Visit by a Group of Medical Students” focused on the clinic system in Transkei region. More

\textsuperscript{29} Drummond, James and Andy Manson. “The Rise and Demise of African Agricultural Production”
\textsuperscript{30} \textit{Ibid.} p.275
\textsuperscript{31} Platzky, Laurine and Cherryl Walker. \textit{The Surplus People}. p.96
importantly, researchers examined the interrelationship between medicine, agriculture and education, the same interrelationships at the heart of this thesis.\(^\text{32}\)

A second article, published later in 1945, more directly addressed Black health: “Medical research in physical education; health and efficiency; a comparative study of clinical status, standards of growth, and of physical performance of 1,495 South African Bantu school-children.”\(^\text{33}\) The focus on physical health in this early article reflected South Africa’s perception of Blacks as a major source of cheap manual labor. Mines and small manufacturers, whose profitability depended on cheap migrant labor, opposed industries’ endeavors to stabilize their workforces, which called for a degree of permanent Black urbanization. White farmers, suffering from a labor shortage in the post-war period, similarly opposed the stabilization and urbanization of a large Black workforce because they were incapable of competing with wages offered by the mines and urban industries.\(^\text{34}\) The mechanization of agriculture following the Second World War eased White farmers’ labor shortages in the early 1960s, but in the short term only increased demands for labor.\(^\text{35}\) The growing economic dichotomy between rural and urban areas continued throughout the twentieth century and was a major push-pull factor compelling Blacks to seek wage labor in urban areas.

Mounting political and economic tension as more and more Blacks moved to the higher-paying urban industries culminated with the first segregation measure enacted by the Nationalist government: the Group Areas Act of 1950, later amended in 1957 and 1966.\(^\text{36}\) The Group Areas

\(^{32}\) “Impressions of the Transkei, After a Visit by a Group of Medical Students.” *SAMJ*. Vol.19, 1945: 300. p.300


\(^{34}\) Platzky, Laurine and Cherryl Walker. *The Surplus People*. p. 97

\(^{35}\) *Ibid*. p. 97

\(^{36}\) *Ibid*. p. 99
Act consolidated White hold over the urban areas but did little to address the rapidly growing Black population squatting on the outskirts of urban centers; a situation which promised political and economic conflict between the threateningly large Black population and the significantly smaller but more privileged White population. The restriction of Black urbanization had been a cornerstone of apartheid politics since the election of 1948, and the Group Areas Act was the first piece of legislation that set precedence for the subsequent pattern of influx controls and forced removals that removed Blacks from White urban areas and farmlands to their designated homelands.

The implementation of a uniform system of influx controls in 1952 restricted Black presence in urban areas to 72 hours, unless he or she:

a) Had been born there and had resided there continuously since birth; or
b) Had worked there continuously for one employer for ten years, or had been there continuously and lawfully for fifteen years and had thereafter continued to reside there, and was not employed outside the area, and while in the area had not been sentenced to a fine exceeding R100 or to imprisonment for a period exceeding six months; or
c) Was the wife, unmarried daughter, or son under 18 years of age of an African falling into classes (a) or (b), and ordinarily resided with him, and initially entered the area lawfully; or
d) Had been granted a permit to remain, issued by a labor bureau.

Influx controls did little to stem the flow of economic refugees fleeing the poverty, joblessness and rapidly deteriorating environmental conditions of the reserves, a trend which continued past the Promotion of Bantu Self Government Act in 1959 and the establishment of the Black homelands. The Bureau for Economic Research Regarding Bantu Development’s (BENBO) 1975 *Economic Revue* of Bophuthatswana and KwaZulu, the two largest homelands, illustrated the degree to which rural homeland populations were dependent on wage labor in the White areas of South Africa:

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37 Platzky, Laurine and Cherryl Walker. *The Surplus People.* p.103
38 Horrell, Muriel. *Race Relations as Regulated by Law.* p.70

<table>
<thead>
<tr>
<th>Year</th>
<th>Income of Permanently Absent Tswana or Zulu (million rand)</th>
<th>Gross National Income (million rand)</th>
<th>Per Capita Income (rand)</th>
<th>Income Earned in Homeland</th>
<th>Commuter Income</th>
<th>Migrant Income</th>
<th>Total Gross National Income</th>
<th>Income Earned in Homeland</th>
<th>De Facto Inhabitants</th>
<th>De Facto Inhabitants and Migrants</th>
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<tbody>
<tr>
<td>1960</td>
<td></td>
<td>Bophuthatswana</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>11.8</td>
<td>--*</td>
<td>15.0</td>
<td>26.8</td>
<td>28.3</td>
<td>29.8</td>
<td>29.8</td>
<td>57.8</td>
<td>60.1</td>
</tr>
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<td></td>
<td></td>
<td>24.4</td>
<td>58.0</td>
<td>19.5</td>
<td>101.9</td>
<td>104.3</td>
<td>28.2</td>
<td>95.3</td>
<td>112.5</td>
<td>158.7</td>
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<td></td>
<td></td>
<td>38.0</td>
<td>94.5</td>
<td>30.5</td>
<td>163.4</td>
<td>--*</td>
<td>40.2</td>
<td>140.2</td>
<td>165.2</td>
<td>230.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>KwaZulu</td>
<td>34.2</td>
<td>--*</td>
<td>40.7</td>
<td>74.9</td>
<td>78.6</td>
<td>28.4</td>
<td>28.4</td>
<td>54.0</td>
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<td></td>
<td></td>
<td>54.7</td>
<td>80.0</td>
<td>94.1</td>
<td>228.8</td>
<td>234.0</td>
<td>64.1</td>
<td>64.1</td>
<td>100.9</td>
<td>254.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>79.7</td>
<td>130.5</td>
<td>149.0</td>
<td>359.2</td>
<td>365.6</td>
<td>91.5</td>
<td>91.5</td>
<td>145.0</td>
<td>368.3</td>
</tr>
</tbody>
</table>

*data not available

In other words, income from external sources, namely repatriations from labor in White areas in the form of either commuter labor or migrant labor, composed total of 77 percent of Bophuthatswana’s GNI, of which 58 percent came from commuter labor. In KwaZulu migrant labor and not commuter labor was dominant source of external income. In 1973, average income of internal sources in Bophuthatswana was approximately R 40, which was R 12 higher than in 1970, but made little difference in the face of rising prices and unemployment. Rapidly increasing unemployment and the ongoing deterioration of resources in the overpopulated homelands offset the increases of real wages for certain groups of Black workers, namely those in manufacturing, construction, and mining, in the 1970s and 80’s.

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40 Butler et al. The Black Homelands of South Africa. p.126

The Rise of the Townships

As Black South Africans continued to flock towards the cities in search of wage labor and to escape the dire conditions of the overcrowded homelands, the strict enforcement of influx controls restricted their ability to freely enter urban centers. The exclusionary legislation of the Group Areas Act and subsequent influx controls were relaxed in 1975 when it was clear to the government that separate development had become an established pattern. The result was the rapid accumulation of impoverished Blacks on the fringes of their homelands, kilometers away from the lucrative major urban centers such as Cape Town, Johannesburg, or Pretoria.42

In 1968 the South African government diverted funds from a drawn-out and largely unsuccessful family housing scheme focused on municipal townships “toward the construction of ‘homeland townships’ or barracks-like unisex hostels.”43 These townships grew almost exclusively from the need to house the rapidly growing population of laborers who were forced to commute daily from their homeland to their place of work in urban-based industries. The commute was often slow and frustrating, and many workers spent 100 minutes or more simply in transit and generally in overcrowded conditions as the commuter infrastructure struggled to keep pace with rapidly increasing magnitude of commuter laborers.44

The increase of wage laborers and the population of the townships were not simply attributed to the unidirectional flow of people escaping the rural hinterlands. Homeland townships like Ga-Rankuwa and Mabopane in Bophuthatswana, Mdantsane in the Ciskei and Mpophomeni in KwaZulu “received an estimated 670,000 Blacks removed from municipal areas

42 Horrell, Muriel. Race Relations as Regulated by Law. p.49
43 Packard, Randall. White Plague, Black Labor. p.261
between 1968 and 1980.” In these homeland townships and countless others like them, rapid population growth from the ‘removals’ outstripped the rate at which housing could be constructed – just as it overburdened the transport infrastructure – leading to severe overcrowding which was never effectively ameliorated. The MEDUNSA researchers who conducted the “Self-Medication” study detailed in Chapter One noted the factor of overcrowding in Ga-Rankuwa and the hazard it posed as a potential factor contributing to accidental poisoning.

Yet overcrowding was but one factor within a matrix of health risks in the townships. Water and sanitation in these homeland townships were grossly inadequate, at first: mounting political pressure as the townships grew led to a series of investigations and a slight improvement in conditions by the 1970s. Ironically, the much-needed raised standards of sanitation actually exacerbated the housing shortage: for example, the South African government postponed the erection of houses in Mpophomeni at the end of March 1971, pending the “pending the provision of water and other essential services.”

Water and sanitation remained inadequate as thousands of Blacks desperate for jobs and shelter migrated to the fringes of Bophuthatswana northwest of Pretoria. The stagnation of housing projects in the already overcrowded townships led to the proliferation of slums as the population continued to grow from forced removals and the dependence on wage labor in urban areas. “The Deputy Minister of Bantu Administration said, early in 1973, that there were about 20,000 [Blacks] (half non-Tswana) squatting on the outskirts of Ga-Rankuwa and about 100,000

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48 Ibid. p.156
(four-fifths non-Tswana) in the Winterveld area near Mabopane.”⁴⁹ These squatters rented land from private Black owners and constructed makeshift huts from mud, stones, packing cases and hessian.

Ga-Rankuwa, the site of the Medical University of Southern Africa and a major hospital providing service to Blacks, was located about 34 kilometers away from Pretoria, by rail. The Bantu Trust initially established it as a settlement for the families of laborers working in Rosslyn, an industrial area on the borders of Bophuthatswana. The government quickly capitalized on the nascent settlement and decided to relocate approximately 400 Tswana families residing in the Pretoria municipal townships to Ga-Rankuwa: “by mid-1973 there were about 8,000 family houses in this area, some 200 of which were used as hostels for single men.”⁵⁰

Another township of Bophuthatswana, Mabopane, had a population of 52,214 with an overall average household size of 4.84 persons; however, this average is not representative of the conditions in certain areas of Mabopane. For instance, in ‘Block R’ of Mabopane, the average household size was 6.11 persons, similar to the figures found by MEDUNSA’s researchers in Ga-Rankuwa in 1984.⁵¹ These figures may not include large numbers of illegal squatters or boarders: official estimates placed the average occupancy per dwelling of Mdantsane, for example, at six people, but estimates of the de facto population gave an average occupancy of at least twelve people per dwelling.⁵²

In contrast to Mpophomeni and Mabopane, Ga-Rankuwa more closely resembled a modern town, complete with “an Black-owned hotel, a hospital, a variety of shops and premises

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⁴⁹ Ibid.
⁵⁰ Ibid. p.155
⁵¹ Joubert, P.H., et al. “Self-Medication in a Developing Community.”
⁵² Packard, Randall. White Plague, Black Labor. p.261
for professional men, and a full range of services.” The hospital, equipped with 2,000 beds, came into operation in April of 1973 and would later serve as base for medical studies and the training center for the Medical University of Southern Africa. This somewhat idyllic representation belies the grim reality of the countless squatters, mentioned above, which could not be accommodated by the town. The proximity of these communities to White urban centers facilitated the expansion of biomedical health services, including the erection of a medical school dedicated to educating Black physicians, the Medical University of Southern Africa. MEDUNSA conducted an increasing number of studies as interest in Black health increased. Discourse within the *South African Medical Journal* at this time demonstrated not only a heightened awareness of the illnesses among the Black population, but also demonstrated efforts to understand the culture of the Black patients to whom the expanding services were oriented. A 1982 study conducted through Ga-Rankuwa Hospital and Boekenhout Clinic, for example examined “traditional [African] attitudes towards tuberculosis,” among the residents of Mabopane A and B, and the Winterveldt – all settlements that were consequences of the political economy of separate development.

**Electricity, Kerosene and Acute Poisoning**

These areas not only suffered from inadequate water and sanitation, but also lacked a decent infrastructure, including electricity. In fact, only about one third of the population of South Africa had access to the electricity grid; the remaining two thirds were dependent on wood, kerosene, coal or gas. Kerosene was especially dominant as a source of power among

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lower socio-economic groups such as the Black families living in slums and overcrowded townships. Young children in these families frequently mistook bottles of kerosene for “water or cold-drink,” especially during the summer months, and as a result were commonly poisoned; accidental ingestion of kerosene was the commonest cause of childhood poisoning among the Black community. The instigation of a series of poisoning studies at Ga-Rankuwa Hospital in the 1980s revealed this pattern of poisoning, but did not challenge why this was the case, instead explaining that the Black population was simply at a lower stage of economic development. Another study of kerosene poisoning from Ga-Rankuwa Hospital in 1994 noted the continuation and increase of this pattern, suggesting the introduction of child-resistant containers and better health education as measures to mitigate kerosene poisoning, again blaming Blacks’ lower level of economic development instead of challenging apartheid policies. The following graph illustrates the association between kerosene poisoning and what researchers had dubbed the “modernization index,” or level of economic development.

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57 Ibid.
58 Joubert. “Poisoning Admissions of Black South Africans.”
60 Ibid.
Sickness and the Wage Labor System

The incidence of kerosene poisoning may demonstrate the impact of the economic disparity reinforced by apartheid policies on the nation’s health profile, but the sickness tied to the wage labor system extended beyond the overcrowded and underprovided townships and slums to the nature of commuter labor itself. While MEDUNSA was conducting its poisoning studies among the denizens of Ga-Rankuwa, South Africa’s National Institute for Transport and Road Research (NITRR) was conducting a series of studies in Ga-Rankuwa and neighboring townships regarding travel conditions for Black daily commuters.61

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According to one NITRR survey in 1980, about 10 percent of Black commuters spent over 10.1 percent of their monthly income on transport, though the majority of those interviewed spent between 2.6 and 5 percent of their monthly income on commuting alone.\(^{62}\)

<table>
<thead>
<tr>
<th>Percentage of monthly income spent on transport</th>
<th>Respondents</th>
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<tbody>
<tr>
<td>Up to 2.5</td>
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<td>24</td>
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<tr>
<td>2.6-5.0</td>
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<tr>
<td>5.1-7.5</td>
<td>164</td>
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<tr>
<td>7.6-10.0</td>
<td>73</td>
<td>10</td>
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<td>10.1 +</td>
<td>79</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>752</td>
<td>100</td>
</tr>
</tbody>
</table>

Even percentages as low as 5 percent were significant considering the real per capita GNP in the homelands in 1980 ranged from R 120 in Gazankulu to R 314 in Bophuthatswana.\(^{63}\)

In fact, the 1982 *Survey of Race Relations in South Africa* revealed a *decline* of 12.4 percent in real terms of average Black household incomes between 1976 and 1980.\(^{64}\)

The costs of commuter labor in the context of falling wages had severe implications the families in the homelands that were dependent on remittances from commuter laborers for subsistence; migrants permanently absent from the homelands spent most of their income on housing, food and other necessities and sent very little to the homelands. Decreasing real wages and relatively high prices of daily travel meant commuters had less money to spend on food, and less to remit home. Packard, in his political economic history of TB in South Africa, describes how milling companies, e.g. Premier Group, launched major advertising campaigns which


\(^{63}\) Seedat, Aziza. *Crippling a Nation*. p.20

\(^{64}\) *Survey of Race Relations in South Africa*. South African Institute of Race Relations, Johannesburg, 1982. p.67
encouraged Black consumers to purchase super-refined maize meal in lieu of unrefined maize meal. Marketing ploys like this only served to intensify malnutrition by both deepening poverty and encouraging a diet with lower nutritional value: super-refined maize meal was both more expensive and significantly less nutritious than unrefined maize meal. As a result, diets were necessarily less nutritious with few, if any, supplements. In the context of apartheid, commuter labor therefore both paradoxically sustained the homelands and contributed to malnutrition.

The demographics of commuter labor contributed further to the incidence of malnutrition among the Black population. The population pyramid for Ga-Rankuwa provides an excellent example of how working-aged men and women flocked to the townships in search of work in urban centers while the elderly, the infirmed, and the very young remained in the homelands, dependent on remittances:

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The bulge between the age ranges of 10-14 and 25-29 represent the influx of working-age men and women to Ga-Rankuwa, in search of labor in Rosslyn or Pretoria. Parents often left children to work in White areas. The Medical Association of South Africa published multiple studies of malnutrition among Blacks between 1965 and 1977 which revealed an increased likelihood of malnutrition with a disrupted family structure; in other words, when one or both parents were missing. The disruption of family structured only exacerbated the poverty endemic to the wage labor system of Apartheid South Africa. As a result, malnutrition constantly plagued the Black population.66

**Black Illness and White Responses: A Pattern of Self-Interest?**

The manifestations of malnutrition and the association of malnutrition with the incidence of other diseases such as tuberculosis have already been discussed in the introduction; however, the rapid diffusion of cholera through the homelands in the late 1970s and early 1980s deserves attention as an example of how self-interest motivated South Africa to address the health problems of the Black population. Immune systems weakened by malnutrition are more susceptible to bacterial infections; cholera is a bacterial infection transmitted through water and, like malnutrition, is associated with poverty.

The first cases of cholera were reported in the eastern Transvaal in 1980. Between 1980 and 1982, hospitals confirmed nearly 7,000 cases of symptomatic cholera, including 70 deaths.

Nearly all cases were Black. The South African government sprang into action when cholera infiltrated the Bophuthatswana township of Temba, about 30 kilometers northeast of Ga-Rankuwa and another township housing workers who commuted to industrial areas near Pretoria, the capital of South Africa, every day. Temba itself was protected with a filtered water system, but the surrounding “semiurbanized communities” which also provided some of the industrial workforce to Pretoria, spillover from the rapid population growth and inadequate housing scheme, did not benefit from similar sanitation.67

The South African government’s earnest albeit limited response to the cholera outbreak of the early 1980s took place at a time when Bophuthatswana had already developed its own Department of Health and Social Welfare, discussed in the next chapter. Importantly, the development of the Department of Health and Social Welfare allowed the South African Department of Health to repudiate its responsibility to the Black population. Official statistics and other publications were quick to take advantage of this, yet in barely three years after Bophuthatswana’s independence the South African government was eager to attack the problem of cholera in Temba.

South Africa’s behavior in this instance reflected the historical pattern of self-interest characterizing its development of health services for the Black population. Indeed, historian Randall Packard notes the incidences of heightened interest in Black health during the 1940s and the 1970s as transformations in the South African economy required at first a more stable, then a more skilled, Black workforce in close proximity to White-owned industries.68 NITRR’s studies of travel conditions for Black commuters to Pretoria in the 1980s appear to suggest economic foundations for the increased interest in Black health in the 1970s and 1980s.

68 Packard, Randall. White Plague, Black Labor. p.21
**Mutual Economic Dependence**

The crystallization of homelands and the accumulation of people on the borders near White urban centers physically demonstrated the dependence of the sizeable Black population on the South African economy. At the same time, Blacks made up a substantial portion of the South African workforce, notably the in the mines, and almost exclusively composed the primary level of production. Not only were Blacks effectively the drivers of the South African economy, but a substantial proportion of migrant incomes recycled through the South African economy as they spent money on housing, food and other amenities.\(^{69}\) Furthermore, the growth of townships of the fringes of urban areas provided South African companies a larger population to whom it could cater: the aforementioned maize marketing scheme is one such example.

During the 1970s both agriculture and the manufacturing industry that had flourished following the Second World War stagnated as the services sector expanded. Mining remained important, but economic growth slackened in the late 1970s and early 1980s as the price of oil increased.\(^{70}\) Industrialists of the 1970s were pushed to “recognize a demand for skilled labor [especially in mining and manufacturing] and a necessity to recruit from the Black majority to meet that demand.”\(^{71}\) South Africa was therefore also pushed to recognize the need of a more permanent and healthy workforce.\(^{72}\)

**Intercultural Centers**

White and Black South Africa were bound to each other out of economic necessity, if nothing else. MEDUNSA and NITRR’s emphasis on studies in Ga-Rankuwa and other

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\(^{70}\) http://countrystudies.us/south-africa/62.htm

\(^{71}\) Susser, Mervyn and Violet Padayachi Cherry. “Health and Health Care Under Apartheid.” p.456

townships are a testament both to the townships as crucial components of the South African economy, and to the significance of Black labor as the driver of the South African economy. Just as South Africa was obliged to acknowledge the crucial role of Blacks in their economy, so too were they obliged to recognize some of the social realities Blacks faced during apartheid as expanding health services began to conduct an increasing amount of studies focused on Black health; virtually no studies conducted under the auspices of the South African government during this period impugned apartheid policies for the sickness and poverty of the Black population.

The poisoning studies conducted by MEDUNSA in Ga-Rankuwa and the commuter studies conducted between Pretoria and Bophuthatswana’s townships are excellent examples of the role townships had in exposing White South Africa more directly to the Black population and its burden of illness, while simultaneously representative of a system that displaced responsibility for sickness onto the Blacks themselves. Physical expressions of South Africa’s increasingly dualistic economy, townships such as Ga-Rankuwa provided defined Black communities into which biomedical health services could easily expand as the economic transformations of the 1970s sparked an increased awareness of Black health, which was heavily influenced by apartheid segregation and the consolidation of the homelands. As a consequence the predominantly White biomedical physicians and researchers became increasingly exposed to Black society and its traditions. Indeed, this is the period during which the ‘witchdoctor,’ became gradually more present in biomedical discourse as Western physicians tried to define their relationship with the ubiquitous traditional healers.  

But recognition of traditional healers, or at least debates surrounding the role of traditional healers in an increasingly – so doctors hoped – biomedical world, was borne from more than mere economic necessity and increased cultural contact through township hospitals.

73 SAMJ. 1884-1990
The townships and the political economic dynamics they represented set the stage, but the expansion of biomedical health services during the 1970s also played a significant role.
Chapter Three

Increasing Exposure: The Proliferation of Biomedical Healthcare in the Homelands

While the segregation of society, embodied in growth of the homelands, exaggerated Black dependence on wage labor in White areas, it also demonstrated the degree to which the White economy was dependent on Black labor. The increasing definition of this mutualistic economic dependency ultimately had significant ramifications in the realm of health and healthcare, especially as large communities of impoverished Blacks accumulated along the borders of White urban areas in search of labor. By the time Ga-Rankuwa Hospital came into operation in April 1973, South Africa’s healthcare services were woefully inadequate to mitigate the massive burden of malnutrition and disease that plagued the majority of the country’s population.¹ The high and unequal distribution of Infant Mortality Rates, covered in the introduction, was the clearest indicator of the inefficacy of South African healthcare within the Black community; a study conducted between 1989 and 1994 determined that access to health care was a statistically significant factor affecting the IMR.² The construction of the hospital in Ga-Rankuwa was part of a larger scheme of extending biomedical care to the homelands, which began in April 1965.

Health services in the homelands prior to 1965 fell under the jurisdiction of the State Department of Health as per the Public Health Act of 1919, as they did throughout South Africa as a whole. According to this act, the provision of health services was divided into three tiers with different but occasionally overlapping responsibilities. The Department of Health was

¹ Retief, F.P. “The Medical University of Southern Africa after 5 years.” SAMJ. Vol. 62. 1982: 841-845
responsible for the advisor and executive duties involved in promoting public health. The Department’s tasks generally focused on the prevention of plague and the monitoring and control of malaria, in addition to the provision of hospital services for mental, leper, and especially tuberculosis patients. The Department of Health also offered medical services to patients for whom clinics and private practitioners were inaccessible, in addition to employing inspectors to uphold the standards of health services provided by other authorities.

The four separate provincial administrations into which South Africa had been divided composed the second tier of the health hierarchy. The provincial administrations established several hospitals throughout the Reserves; however, they played a relatively minor role compared with that of the mission societies which, bolstered by the financial support of small provincial subsidies, provided and managed the majority of hospitals in Black territory. “Eventually, these societies founded 95 hospitals in the [Black] homelands and 13 in the rest of South Africa. They also [ran] several out-patient clinics.” These provincial administrations were ultimately “responsible for general hospitals for people of all racial groups, and out-patient services for outlying clinics,” and a major part of their task involved providing rural areas with district nursing and midwifery services.

The central government delegated the responsibility for environmental health services such as the handling of foodstuffs, water supplies and sanitation to the local authorities, which made up the third and final tier defined by the Public Health Act of 1919. Local municipalities, like the mission societies, were subsidized by the State. They were responsible for the

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3 *The Health of the People.* p.15
4 *Ibid.* p.38
5 Horrell, Muriel. *Race Relations as Regulated by Law.* p. 157
administration and maintenance of “infectious diseases hospitals, tuberculosis and venereal disease clinics, and ante-natal, infant welfare, and family planning clinics.”

Each tier was responsible, to a certain degree, for public health and hospitals. The consequent confusion arising from the overlapping responsibilities adversely impacted the provision of care. The president of the South African Medical Association at the time criticized the system as “a crazy patchwork of public medical services, determined not by scientific principle but by the accidents of constitutional development in South Africa.” Numerous historians and critics of the apartheid health care system have characterized this period of healthcare as one in which services focused on curative rather than preventative measures and were notably “uncoordinated.” Government programs to address the growing malnutrition among the Black population during the 1950s suffered from both this lack of coordination and from an unwillingness to recognize and ameliorate the underlying causes of the poverty from which malnutrition grew. Incidentally, additional efforts beginning in the mid- to late 1960s suffered from similar problems.

Inadequate Changes

The South African government began efforts to ameliorate the dismal situation in the homelands on April 1, 1965, following accumulation of reports from mission doctors of serious illness, malnutrition, overcrowding, understaffing and inadequacy of funds. In 1970 South African government decided to transfer the control of health services and hospitals in the homelands to the Department of Bantu Administration and Development, under the executive

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6 Horrell, Muriel. Race Relations as Regulated by Law. p. 157
8 Horrell, Race Relations as Regulated by Law; Seedat, Aziza. Crippling a Nation.
9 Packard, Randall. White Plague, Black Labor. p.266
10 Horrell, Race Relations as Regulated by Law. p.157
authority of the Department of Health in 1970, until homeland departments of health were established.\textsuperscript{11} Ga-Rankuwa Hospital, which came into operation in April 1973, was part of a larger project in which the Department of Bantu Administration and Development constructed a number of regional hospitals near urban areas in the homelands such as Mdantsane, Umlazi and near Kuruman. These hospitals were simultaneously an effort to expand the provision of healthcare to Blacks in the homelands and an effort to further segregate Blacks from Whites, as they were “designed to replace the Black sections of urban provincial hospitals that [were] sited in [White] areas.”\textsuperscript{12} Again, Ga-Rankuwa Hospital ultimately became a key research institution for health and healing among Black communities with the construction of the Medical University of Southern Africa in 1978.

In March 1973 the Deputy Minister of Bantu Development announced that the Department of Bantu Administration and Development would begin a gradual takeover of all mission hospitals on the first of April 1973 before transferring control and all associated responsibilities to homeland governments.\textsuperscript{13} The missionary-run hospitals, as mentioned above, represented the main source of primary care for Blacks throughout each of the homelands. Before the government takeovers in 1973, the missionary societies had remained autonomous in administrating their respective hospitals.\textsuperscript{14}

The transfer of administrative control to the State precipitated multiple problems. “Mission hospitals under the control of Catholic missionaries, for example, were presented with a dilemma in that, under the government’s health service scheme, hospitals receiving subsidies

\textsuperscript{11} Horrell, \textit{Race Relations as Regulated by Law}. p.158
\textsuperscript{12} Horrell, \textit{African Homelands of South Africa}. p.161; Retief, F.P. “The Medical University of Southern Africa after 5 years.” \textit{SAMJ}. Vol. 62. 1982:841-845
\textsuperscript{13} Horrell, \textit{African Homelands of South Africa}.
\textsuperscript{14} \textit{Ibid.}
are obliged to provide advice and equipment for contraception.”\textsuperscript{15} Other practitioners like Dr. Barker in KwaZulu, “objected to the concept of becoming a civil servant, subject to the control of the State, and [separation] from [their] Black colleagues by the proposed differential basis of employment.”\textsuperscript{16} Objections like that of Dr. Barker reflect the intimate degree to which apartheid policies could present a barrier to effective medical care. Most practitioners working in missionary-run hospitals and clinics resigned their posts, for the reasons discussed above, after the government took control. In their stead the Republic of South Africa was forced to appoint military doctors; a severe blow to the image of cultural sovereignty the homelands ostensibly represented.\textsuperscript{17}

Ultimately, the government takeovers and the transfer of health responsibilities to homeland governments exacerbated an already bleak situation. Logistically, the growth of homeland departments of health further complicated the health bureaucracy: Bophuthatswana’s Department of Health came into being on March 31, 1975; Ciskei’s Department of Health on November 1, 1975; Lebowa’s Department of Health on April 1, 1976; and both Gazankulu’s and Venda’s Departments of Health on September 1, 1976.\textsuperscript{18}

Gazankulu and Venda provide an interesting comparative example illustrating how the South African Government used healthcare as a political tool to push for the independence of the homelands. In 1975, Gazankulu received R 6.3 million from the Apartheid State, which controlled the health budgets of the homelands. After refusing to take independence in 1976,

\textsuperscript{15} Seedat, Aziza. \textit{Crippling a Nation}. p.69
\textsuperscript{16} Horrell, \textit{African Homelands of South Africa}. p.161
\textsuperscript{17} Seedat, Aziza. \textit{Crippling a Nation}.
\textsuperscript{18} \textit{The Health of the People}. p.53
Gazankulu received R 7 million in 1981. Venda, in contrast, accepted independent status and “received consecutive increases of 40% in 1979 and 92% in 1980.”19

By the late 1980s, there were ten different health services responsible for healthcare in the homelands, in addition to three separate departments for Whites, Asians and Coloreds – all on top of preexisting provincial-municipal authority model, outlined above.20 South Africa’s motivation to push for independent homelands was clear: independence both lent credibility to the homelands as sovereign states, though no foreign countries ever recognized them as such, and perhaps more importantly it allowed South Africa to repudiate its responsibility to the Black population. In this way South Africa was able to legitimate its claims as one of the world’s leaders in biomedical healthcare even as hundreds of thousands of people were dying of malnourishment a few kilometers away from the administrative capital, Pretoria. In its 1977 publication, *The Health of the People*, the South African government calculated the average doctor to population ratio based on the exclusion of Black South Africans from the statistics: as a result, South Africa appeared to have one of the most favorable ratios compared with ten other African countries: at the bottom of the chart, the author noted that “all figures, except for those applicable to the Republic of South Africa, were extracted from World Health Statistics Report, Vol. 29, No. 3, 1976, WHO, Genéve [emphasis added].”21

Ultimately the reforms of the 1960s and 1970s were superficial and failed to address the root causes of malnutrition and, in turn, poverty: the political and economic marginalization of Blacks in apartheid policies. Remote rural areas remained largely unaffected; even after the ostensible reforms, some remote rural areas in the homelands lacked primary care for the Black

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20 Andersson, Neil and Shula Marks. “Apartheid and Health in the 1980s”. p.676
21 *The Health of the People.* p.50
community, much less the infrastructure to support and facilitate travel to them. In these areas clinical staff may have only been present once or twice a week, and “patients [had] to travel long distances at great expense to obtain medical help.”

Traditional healers prospered in these areas, despite officially being banned from practice by the Medical, Dental and Supplementary Health Services Professions Act No. 56 of 1974.

**Incongruity in Bophuthatswana**

The rapidly growing townships provided easily accessible Black communities for studies as health services expanded: Ga-Rankuwa Hospital in Bophuthatswana served over 60,000 people and offered fourteen extension clinics in the nearby Winterveld slum. The slum was overcrowded and lacked the most basic amenities. Diseases flourished under these conditions as the clinics’ tiny staffs struggled to work without electricity and telephones.

The clinics and the sprawling slum areas they served lacked more than electricity: they also lacked water sanitation. The aforesaid study conducted between 1989 and 1994 also identified a statistically significant relationship between the source of domestic water and the IMR. In fact, results from studies in Bophuthatswana illustrated increased health risks associated with resettlement locations like Ga-Rankuwa or Lehurutshe. The lack of basic infrastructure and severe overcrowding, noted but not explored in Joubert et al.’s 1984 “Self-medication in a developing community” study, meant conditions in the townships were frequently worse than conditions in many rural areas: the cholera outbreak of 1980, discussed in

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22 Seedat, Aziza. *Crippling a Nation.* p.69-70
23 Kale, Rajendra. “A Parallel Health Care System.” p.1183
24 Seedat, Aziza. *Crippling a Nation.* p.70
the previous chapter, is one example of the risks associated with the overcrowded and unsanitary conditions of the townships.26

Annual reports from Bophuthatswana’s Department of Health remained relatively positive despite the grim realities facing most of the pseudo-nation’s population. Bophuthatswana, which received most of its funding from the South African government, was even less prepared to address burden of disease than the South African government had been: increased responsibility and the deleterious effects of the transition of administration weakened their ability to mitigate the spread of diseases such as cholera. Official statistics from the Department of Health and Social Welfare indicate a total of 10 hospitals (4,138 beds) and 288 clinics (435 beds) in 1985.27 The census report from that year, while not perfectly accurate, estimated a total population of 1,740,600 – or one bed for every 380.6 residents of Bophuthatswana.28

Indeed, healthcare system in Bophuthatswana followed trend of championing the image of ‘modernity,’ a trend also seen in the annual reports of the Department of Education.29 Stamp issues in Bophuthatswana further advocated the image of ‘modernity,’ as defined by the Republic of South Africa, in field of medicine. “Hypertension” stamps released in 1978 use imagery strongly associated with biomedicine, such as a cross-section of human kidneys with the words “avoid kidney infections” sprawled across the front. A subsequent stamp issue in 1985

more directly advocated the use of biomedical health care; traditional healers, in contrast, went completely unmentioned in both the annual reports of the Department of Health and the stamp issues.

1978 “Hypertension” Stamps:  

1985 “Health Care” Stamps:

Homeland bureaucracies were in many ways alien to the population over which they presided, and ironically tended to identify more with the cultural values of the South African government which established them as expressions of traditional Bantu tribal identity. This is especially significant considering the cultural heterogeneity of the homelands, best embodied by Bophuthatswana.

Ethnographic research conducted by John Comaroff between 1969 and 1970 revealed that several of his informants were aware that “the very concept of a homeland ignores the fact that these chiefdoms have never comprised a united body politic with a paramountcy or a council.

30 Source: <http://www.swakop.com/namibstamp/bophpics/sacc2224.jpg>
31 Source: <http://www.swakop.com/namibstamp/bophpics/sacc133136.jpg>
of chiefs.” Indeed, many of Comaroff’s informants expressed suspicion of the Bophuthatswana government, and believed that it was neither aware of nor interested in their best interests: “We cannot see it [the government of Bophuthatswana]. It does nothing for us. There are men in Mafeking, it is true. But who are they? We do not know their faces and until they show us what they are doing, we will not know them.”

This incongruity with imposed political system, which “ignored the processual dynamics of indigenous systems,” was clearly demonstrated by the process of forced removals, and their impact on traditional healers. Traditional healers’ power was rooted in their spiritualism, as conduits to the ancestors, which distinguished him from the general population, and their ability to cure certain ailments. Their ability to heal depended on both the patient’s confidence in the healer and the healer’s own specialized knowledge of local herbs with medicinal properties. Society before the implementation of invasive apartheid policies was in a delicate state of balance, wherein the traditional healer commanded a respect in his or her community that balanced the political power wielded by the chief.

The advent of the Apartheid Era and the extensive forced removals associated therewith disrupted the delicate balance of power between chiefs and traditional healers. Forced relocations pushed many communities from their ancestral lands and resettled them in new and alien environments, disrupting healers’ ties to ancestral heritage and adversely affecting their social prestige. On a more practical level, traditional healers were removed from the areas where they were familiar with the vegetation and landscape a whole; in other words, they knew where to

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33 Ibid. p.44
34 Ibid. p.46
35 Ibid.
find the correct plants for herbal remedies.\textsuperscript{36} One article published in the \textit{South African Medical Journal} in 1974 demonstrated how this understanding of the landscape and plants was crucial to the mystique underpinning the authority of traditional healers.\textsuperscript{37} Following resettlement, however, their intimate knowledge of their former landscape was no longer relevant, and their communities lost respect for them.\textsuperscript{38}

On a political level, the forced resettlements were powerful tools cementing the loyalty of local chiefs, who depended on the government for their salaries and their status. Many chiefs were bribed.\textsuperscript{39} Other chiefs, who opposed resettlement, were ‘processed’ by their superiors in the homeland. They were given the choice of either cooperating with the homeland administration or losing their status and salaries. Few resisted.\textsuperscript{40} Incidentally, the puppet chiefs, whose authority was no longer grounded in their people but in the homeland administration, clashed with traditional healers – many of whom opposed apartheid – as a result.\textsuperscript{41}

\textbf{Barriers to Care}

Discourse at this time may not have appreciated the sociocultural complexities of apartheid policies, but this incongruity was also reflected in the medical field, illustrated within doctor-patient interactions: the emphasis on the supernatural within traditional etiologies often created a chasm between the patient accustomed to traditional healing methods and the biomedical physician. Anthropologist Harriet Ngubane examined this relationship during the late 1970s and the 1980s. Traditional medicine had long been interacting with biomedicine, as the

\begin{itemize}
\item \textsuperscript{36} Interview with Ambrose Kelly, January 3, 2011
\item \textsuperscript{38} Interview with Ambrose Kelly, January 3, 2011
\item \textsuperscript{39} Platzky, Laurine and Cherryl Walker. \textit{The Surplus People}. p.168
\item \textsuperscript{40} \textit{Ibid}. p.286
\item \textsuperscript{41} Interview with Ambrose Kelly, January 3, 2011.
\end{itemize}
spiritual etiologies provided within traditional medicine did not preclude the use of Western biomedical treatments, if necessary. Ngubane demonstrated how diviners, or *isangoma*, commonly advised patients to seek care at biomedical clinics and even recommended a combination of traditional and biomedical services. 42 Biomedical physicians, on the other hand, were forbidden by law to refer their patients to traditional healers as doing so would have acknowledged their medical expertise. 43

While the majority of Blacks perceived biomedical care as a complementary component within a larger framework of healing that incorporated traditional and biomedical forms of care, biomedical doctors commonly looked down on virtually all traditional practices of healing; medical educations did not acknowledge the viability or existence of traditional African methods of cure. Doctors or nurse-interpreters – few doctors spoke local languages – in South Africa tended to “reprimand the patient at some length for wasting time with African traditional healers instead of coming straight to the Western practitioner and institutions.” Indeed, Black patients were “often shouted at, insulted or subjected to humiliating and degrading treatment. [A Black] patient’s dignity [was] seldom respected,” though the patient had to overcome the obstacles of distance and payment in search of biomedical care. 44

In addition to discrimination and a language barrier, payment and transport were two major obstacles facing the majority of Blacks during the Apartheid Era, even after the reforms of the 1960s and 1970s. Both Blacks and Whites were responsible for payment for treatments in hospitals and clinics, but prices varied and many Whites, unlike Blacks, were covered by insurance. In 1977 The Transvaal Administrator announced an 80 percent rise in hospital fees in

43 “Herbalists, Diviners and even Witchdoctors.” SAMJ. Vol. 50, No. 19. 1976: 721
1977. This increase was especially difficult for Black patients, whose fees rose from R 8 to R 15 for admitted patients and from R4 to R 6 for outpatients. In the townships, rising costs of care compounded the financial strain faced by commuter laborers, many of whom already spent over 10 percent of their monthly income on transport alone.\textsuperscript{45} When South African health services announced increased charges again in 1982, people protested against higher charges for the poor: provincial hospital fees in the Transvaal were doubled and sometimes tripled for the lowest income groups.\textsuperscript{46} In remote rural areas such as the Moshaweng River Valley, north of Kuruman, patients deliberating between traditional and biomedical care considered the cost of transport, “which was not provided,” to the nearest clinic.\textsuperscript{47}

The overall image of biomedical care for Blacks during the Apartheid Era was a negative one. The reforms of the 1960s and 1970s served more as political tools allowing South Africa to remove Blacks from health statistics while legitimizing the sovereignty of the homelands; the Apartheid State’s manipulation of funding to homeland departments of health provides evidence to this end. The same reforms effectively reduced the extent, accessibility and quality of biomedical care available to the Black population as the government takeover of mission hospitals precipitated the resignation of the mission doctors who provided care to Blacks beyond the reach of hospitals and clinics. In other words, the healthcare reforms exacerbated an already inadequate system of care, which is especially significant in the context of rampant malnutrition and disease rooted in apartheid economic development.

\begin{itemize}
\item \textsuperscript{46} Seedat, Aziza. \textit{Crippling a Nation}. p.71
\item \textsuperscript{47} Kelly, Ambrose. “Just a Couple of Questions about Bophuthatswana!” Message to Charles McElveya. February 14, 2011. E-mail.
\end{itemize}
### Hospitals and Clinics in Selected Homelands, 1981

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<th>Homeland</th>
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<th>Population per clinic</th>
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**Notes:**
1. Also takes any private and mission hospitals into account.
2. The beds available in state hospitals in Bophuthatswana in 1981 broke down into general hospital beds – 2,493, psychiatric – 1,035 – and tuberculosis – 1,000. The numbers of beds per 1,000 population were 1.8 (general hospitals), 0.8 (psychiatric) and 0.7 (tuberculosis).
3. Plus four day-hospitals with 16 beds each.
4. Also including three mission hospitals with a total of 586 beds.
5. Also including two private hospitals with a total of 500 beds.

At the same time, the ostensible extension of South African-sponsored biomedical care and the considerable number of clinics constructed during this period coincided with the gradual increase of discourse within the *South African Medical Journal* regarding Black culture and the significance of the traditional healer – the same discourse that would erupt into a debate in which South African biomedical doctors challenged longstanding prejudices and reevaluated their relationship, as healthcare providers, with traditional healers. The inadequacy of biomedical care in the face of a massive burden of illness was without a doubt a major factor prompting this debate.

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Chapter Four

Endemic Ignorance: Bantu Education and the Supply of Doctors

The statistics regarding the number of clinics and beds in relation to the population, while strikingly inadequate for the demands of the homeland population, masked a more fundamental problem regarding the provision of health services to homeland populations: the supply and distribution of qualified biomedical physicians. Furthermore, the ability of physicians to provide linguistically and culturally relevant care to the Black population was also a crucial factor in the provision of adequate care, and featured heavily in the South African Medical Journal throughout the 1970s and 1980s.

The introduction has already illustrated the imbalance in the provision of doctors to the four different racial categories, of which Blacks received the least favorable doctor to population ratio. What is not mentioned is how the supply of doctors affected the efficacy of the clinics which were so rapidly being established within the homelands. Rural medical practice had historically not been attractive to the doctors of the Medical Association of South Africa (MASA) and most medical services in these areas were provided through mission hospitals.¹ The administrative changes following the reforms in 1973 and the subsequent withdrawal of large numbers of doctors from the rural areas and mission hospitals underscored a preexisting shortage of medical personnel in these areas. For example, between 1981 and 1985 the number of clinics in Bophuthatswana increased from 119 to 288: about 34 clinics per year.² These clinics and other

¹ “Leading Article: Wednesday, December 15, 1886.” SAMJ. 1886: 93-94
clinics in rural areas were meant to provide service to 60 percent of the South African population – almost exclusively Black – but were only staffed by 5 percent of the country’s doctors.³

Homeland Administrations’ rapid extension of healthcare services by creating more clinics drastically outpaced the rate at which doctors were being trained. This meant proportionally fewer doctors were responsible for providing care in a rapidly growing number of clinics. The Department of Health and Social Welfare reported a total of 81 doctors in the homeland in 1981, supplemented by 2,839 nurses and 2,135 members of allied health professions. Overall, this meant one doctor for per 17,000 members of the population and one nurse per 500 population.⁴ This also meant there were 81 doctors to administer 119 clinics. The results of the disparity between the growth of facilities – statistics used to bolster the image of healthcare – and the training of doctors, the true sources of care, were evident in Ga-Rankuwa. Ga-Rankuwa Hospital, which provided care to the surrounding 60,000 people, provided fourteen clinics which as mentioned in a previous chapter did not have electricity, were staffed by two to six nurses. Doctors, a rare resource in the homelands, were only present for an hour at a time, two or three times a week.⁵

⁴ Republic of Bophuthatswana (South Africa). Department of Health and Social Welfare. 1981. ; Seedat, Aziza. Crippling a Nation. p.70
⁵ Seedat, Aziza. Crippling a Nation. p.70
This shortage of trained medical professionals, namely doctors and pharmacists, was featured in Joubert’s Ga-Rankuwa poisoning study. Joubert et al. were particularly concerned with the supply of pharmacists whose dispensation of medicines had profound impacts on public health; the 1984 “Self-medication” study demonstrated the significance of over-the-counter medications among the population of Ga-Rankuwa.7 As mentioned in Chapter One, the top priority of MEDUNSA’s researchers was to train more medical professionals to serve the surrounding Black population which had previously been neglected.8 This implied the training of Black doctors, since Black general practitioners were only allowed to work in their own ‘ethnic’ group, or designated homeland.9 Their priority revealed one of the most crippling impacts of apartheid policies and the “tribalizing” ideology upon which the South African government founded the homelands and justified their consolidation: Bantu Education. Educational policies serve as an excellent paradigm for the ideological dynamics underlying the collaboration debate since they were, like sickness and healthcare, a direct expression of the segregation of Apartheid

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7 Joubert et al. “Self-Medication in a Developing Community.”
9 Seedat, Aziza. Crippling a Nation. p.90
South Africa, and interacted on a practical level with public health regarding education and provision of doctors.

Much like South Africa’s dualistic economy, segregationist schooling patterns pre-date the 1948 election and the instigation of apartheid; they had already been established by the 1930s. The schooling system during the 1930s was a reflection of the dualistic economy, and was designed to reproduce certain social relations: Blacks were concentrated at lower levels of schooling and received an education conducive to life as a wage laborer. Christie and Collins provide an excellent description of the ideological orientation of Black education and how it was geared towards the reproduction of labor encapsulated within SA’s increasingly dualistic economy:

As regards skills, schooling was geared to instruction in basic communication, literacy and numeracy. Familiarity with one of the official languages, English or Afrikaans – the languages of the employers – was an important part of the curriculum. As well as this, schooling for Blacks was based overtly on religious and moral training, with values such as cleanliness, punctuality, honesty, respect, courtesy, etc. being explicitly articulated as aims of the system.

The basic principles underlying this pattern of education, in which Black students were effectively taught to be unskilled wage laborers dependent on the South African economy, were rearticulated in a propagandistic pamphlet released in February 1948 by the Instituut vir Christelik-Nasionale Onderwys (Institute for Christian-National Education, or CNO) entitled Christelik-Nasionale Onderwysbeleid (Christian-National Education Policy). Although a policy issued by a private organization three months before the election of the National Party and the rise of apartheid, the CNO policy statement provided the framework for an educational system.

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11 Ibid. p.167
greatly favoring the White minority at the expense of the much larger but already marginalized Black population. The young National government whose segregationist ideology was based on cultural differences and the racial inferiority of the Blacks was quick to adopt similar principles in its educational policies.

Despite the protests of prominent figures such as the former Rector of the University of Pretoria, Professor M.C. Botha, apartheid legislature pushed forward. The Bantu Education Act of 1953 concentrated control of Black education in the hands of the apartheid government, which subsequently restricted the operation of the mission schools that had been active since the early nineteenth century, replacing them with state schools in 1955. The educational priorities under the state-controlled system were very similar to those proposed by the CNO in February of 1948, reflecting and perpetuating the patterns of reproduction of labor wherein Blacks occupied the lowest socioeconomic strata.

In 1954 Minister of Native Affairs Verwoerd issued a statement which effectively summarized the ethos of the Bantu Education Act, which itself was rooted in the same “tribalizing” ideology used to justify the delineation and development of the Black homelands 5 years later and inextricably linked with the Native Reserves and later homelands as a place of ‘Bantu culture’:

There is no place for [the Black] in the European community above the level of certain forms of labor. Within his own community, however, all doors are open. For that reason it is of no avail for him to receive a training which has as its aim absorption in the European community, where he cannot be absorbed. Until now he has been subjected to a school system which drew him away from his own

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13 Tobias, Phillip V. “Apartheid and Medical Education: The Training of Black Doctors in South Africa.” p.396
community and misled him by showing him the green pastures of European society in which he was not allowed to graze.\textsuperscript{16}

The power of this ideology became clear when, in 1958, the Department of Bantu Education became a separate department of state responsible for the administration, funding, and syllabi for Black schools.\textsuperscript{17} The Apartheid State subsequently had more control over the education of Blacks, and acted accordingly; the policy of directing education towards life as a wage laborer had severe ramifications within the realm of training Black physicians, a concept against which several leading Whites were strongly opposed.\textsuperscript{18}

Even as homelands such as Bophuthatswana gradually progressed towards ‘independence’ and developed their own bureaucracies, they still bore the burden of the low standards of education fostered under Bantu Education policies. Indeed, the Department of Bantu Education continued to coordinate the functions of the Homeland Departments of Education for several years, and only began to phase out of Bophuthatswana following the Bophuthatswana Education Act of 1973; just as the homelands continued to bear the burden of illness fostered by separate development and inadequate care.\textsuperscript{19}

An examination of the annual reports of the Bophuthatswana Department of Education throughout the 1970s while the Republic of South Africa began to expand health services to Blacks as it recognized the need for a more skilled and healthy workforce reveals the lasting impact of Bantu Education and the political and economic marginalization of Blacks. The nature of classroom education, for instance, resembled that which characterized the segregated educational system since before apartheid: the dominant subjects listed in the 1972 Department

\begin{footnotes}
\item Verwoerd, H.F. Speech to the Senate. 7.6.1954
\item Christie, Pam and Colin Collins. “Bantu Education: Apartheid Ideology and Labour Reproduction.”
\end{footnotes}
of Education’s annual report were: “agriculture; art and crafts; cultural organizer; homecraft; homecraft (sic.); music; psychological services; religious instruction; sports organizer.” ^20 Black curricula therefore had a clear emphasis on subjects not conducive to social or economic mobility. The repetition of ‘homecraft,’ though probably accidental, emphasizes the socioeconomic position Blacks were expected to take. The annual reports also emphasized education in the “two official languages” – English and Afrikaans, the official media of instruction in post-primary levels of education – further suggests the orientation of education as a means of training wage laborers capable of understanding the orders of their White superiors. ^21

This emphasis on the wage labor economy was also reflected in the quality of education. The Department of Education’s annual reports consistently noted a shortage of qualified teachers. In 1972, 25 percent of teachers in Bophuthatswana’s primary schools were unqualified; in 1977 13.6 percent of the 7,447 Black teachers and 24.4 percent of the 160 White teachers were unqualified. Secondary schools were relatively stable, but 20 percent of teachers were still under-qualified. Remote rural areas especially had higher incidences of unqualified teachers. ^22

At the same time, the Black educational system suffered from a relatively high dropout rate which, alongside the teacher shortage, was associated with rapid population growth as large populations were forcibly relocated into Bophuthatswana in the name of ‘consolidation.’ Student enrollment increased from 21,882 to 26,590 between 1973 and 1974: an increase of 21.5 percent in one year. The population, and therefore the student body, grew at a rate with which the training of teachers could not keep pace. In 1974 the teacher-to-student ratio was 1 to 65, not

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^21 DoE 1972-79

including regional variation. Incidentally, doctors faced a similar problem in the homelands, as population growth far outstripped the rate at which Black doctors could be trained; this will be expatiated upon in a subsequent section.

The rapidly growing student body masked the high rate at which students were dropping out of schools, a pattern featured throughout the Bophuthatswana Department of Education annual reports for the 1970s:

<table>
<thead>
<tr>
<th>Class</th>
<th>Enrollment 1971</th>
<th>Form</th>
<th>Enrollment 1972</th>
<th>Decrease in Numbers</th>
<th>Percentage decrease in Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Std. 6</td>
<td>16,397</td>
<td>I</td>
<td>7,312</td>
<td>9,085</td>
<td>55.4</td>
</tr>
<tr>
<td>Form I</td>
<td>6,149</td>
<td>II</td>
<td>5,880</td>
<td>269</td>
<td>4.4</td>
</tr>
<tr>
<td>Form II</td>
<td>4,975</td>
<td>III</td>
<td>4,192</td>
<td>783</td>
<td>15.8</td>
</tr>
<tr>
<td>Form III</td>
<td>4,105</td>
<td>IV</td>
<td>1,046</td>
<td>3,059</td>
<td>74.5</td>
</tr>
<tr>
<td>Form IV</td>
<td>801</td>
<td>V</td>
<td>456</td>
<td>345</td>
<td>43.1</td>
</tr>
</tbody>
</table>

Note:
1. The drop from the 1971 Std. VI enrollment to the 1972 Form I enrollment is caused by: the large number of 3rd class passes and failures in Std. VI; a high percentage of successful candidates who failed to obtain admission to secondary schools, because of insufficient classroom and hostel accommodation.
2. The difference between the 1971 Form III enrolment and the 1972 Form IV enrollment is owing to:
   A normal number of 3rd class passes and failures;
   The high percentage of Form III candidates (1st and 2nd class) who obtained admission to teachers' training schools;
   A large number of successful Form III candidates who failed to obtain admission to senior secondary schools, because of insufficient classroom and hostel accommodation.
3. The standard of the internal examinations (Forms I and II) varies from school to school. In some schools the tendency is to fail too many candidates in Form II in order to show good results in the Junior Certificate Examination. Circuit inspectors counteract this rigidity.

The high dropout rates are somewhat paradoxically due to the same factor providing the higher number of students: rapid population growth. Like the failure of housing projects in the townships to keep up with population growth from removals, the erection of schools was vastly

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24 (all DoE reports)
outpaced by the number of young Blacks flooding the homelands throughout the Apartheid Era: only 50 percent of students had proper accommodation in 1972, and only 1 in 3 had a desk.\(^{26}\)

The shortcomings of this rapid population growth manifested themselves in a manner that directly impacted the future supply of doctors. Ga-Rankuwa High School celebrated its 10 year anniversary in 1973, when it published a short document filled with student poems, the school’s accomplishments, and the stance of its various educational departments. The science department published the following synopsis of its existence, which reveals the direct impact of rapid population growth on education and especially on education in the sciences:

> Because Ga-Rankuwa is an expanding township the High School had to grow. The student roll did, but not the buildings. As a result a serious problem of accommodation developed.

> For instance, the school had set aside a classroom to function as a laboratory but instead of one finding students performing experiments in this laboratory one is likely to find students sitting at their desks, waiting either for a language lesson, a history lesson, or a science lessen [sic]. At one corner stands a cupboard with chemicals, at the other apparatus and somewhere behind the cupboard – charts and models.

> We hope that in future the school will have a least [sic] two laboratories – one for the senior classes and another for the junior classes.\(^{27}\)

Indeed, the sciences, along with math, both of which are crucial to a biomedical education, suffered the worst under the political economy of homeland consolidation, viz. an emphasis in education on less specialized subjects, alongside rapid population growth from the forced removals that continued throughout the 1980s despite the Apartheid government’s announcement of their discontinuation in February 1985.\(^{28}\) Annual reports expose math and sciences as consistently weak subjects among students, largely due to the absence of qualified


\(^{27}\) *Anniversary [sic] 10\(^{th}\), Ga-Rankuwa High School. 1973* (Gedruk deur Lamton Drukkers / Hi Sackgebou, 3de Vloer / H/v. Mitchell en Von Wieligstr. / Pretoria)


87
teachers in such subjects. The annual report from 1972 – the first and most thorough of the Department of Education’s annual reports which introduced all the issues addressed in subsequent issues – called the demonstrated lack of ability in math and the sciences “a serious handicap.”\textsuperscript{29} The number of students qualified for admission to medical school seriously suffered as a result of said ‘handicap’ rooted in the ideologies of Bantu Education.\textsuperscript{30}

The relatively few students who managed to overcome the language and educational barriers and perform well on their exams and qualify for higher education still faced difficulty in applying to universities. The Extension of University Education Act No. 45 of 1959, the act immediately preceding the Promotion of Bantu Authorities Act No. 46 of the same year which delineated the homelands, provided for the establishment of universities for non-White students. In the case of Blacks, these universities were financed by Parliament from the Bantu Education Account. This act not only segregated education in the manner that the subsequent Promotion of Bantu Authorities Act ostensibly segregated political and economic development, but it also empowered the South African government to restrict the enrollment of Black students at universities – except the University of South Africa and the Natal Medical School – unless given written permission by the Minister. This restriction was in effect from January 1, 1960 for registered students, and January 1, 1961 for all Black students.\textsuperscript{31}

These regulations greatly impacted South Africa’s production of Black medical graduates. Dr. Phillip V. Tobias, Chairman of the Department of Anatomy and the Dean of the Faculty of Medicine at the University of the Witwatersrand in Johannesburg, divided this pattern into three distinct periods:

\textsuperscript{30} Tobias, Phillip V. “Apartheid and Medical Education: The Training of Black Doctors in South Africa.” p.397
\textsuperscript{31} Horrell. Race Relations as Regulated by Law. p.147
<table>
<thead>
<tr>
<th>Average Number of Black Doctors Graduating at Various Periods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Years</strong></td>
</tr>
<tr>
<td>1946-1956</td>
</tr>
<tr>
<td>1957-1966</td>
</tr>
<tr>
<td>1967-1975</td>
</tr>
</tbody>
</table>

Between 1946 and 1956 only the University of the Witwatersrand was graduating Black doctors with an extremely low output of 6.2 doctors per annum. The subsequent period between 1957 and 1966 had a higher output because both the University of the Witwatersrand and the University of Natal Medical School (for non-White students) were training doctors. Between 1967 and 1975 only the University of Natal produced Black doctors. Consequently, these years saw some of the lowest figures during the Apartheid Era: only nine Black doctors graduated in South Africa in 1975, and only eight graduated in 1969.\(^{33}\)

The relative proportion of Black doctors to White doctors also represented the misdistribution of medical services in addition to reflecting the social, political and economic inequities of Apartheid South Africa. Between 1968 and 1977, only 3 percent of medical graduates were Black; 85.4 percent were White. The South African Medical Students Council published a survey of fourth year White medical students at the University of Cape Town in 1978. Surveyors asked the informants a series of questions regarding how well the medical school prepared them for certain fields of medical care, as well as their preferred career paths. Only six percent of the students interviewed intended to practice community medicine, of which the large Black population was in dire need. Furthermore, students’ responses indicated that their medical school curriculum did not prepare them well for community health practice: community health came in ninth on the list of their responses, while medical care in a developing African

\(^{32}\) Tobias, Phillip V. “Apartheid and Medical Education: The Training of Black Doctors in South Africa.” p.396

\(^{33}\) Ibid, p.397
country – a category, under which South African medical discourse at the time placed the Black homelands, came tenth.\textsuperscript{34}

These results did not bode well for the Black population; Black doctors, not White doctors, were expected to provide care to their own ethnic groups. In other words, 3 percent of South Africa’s qualified biomedical physicians were expected to serve 70.4 percent of the population of South Africa. The low rate of production of biomedical doctors, outlined above, was clearly inadequate to ameliorate the medical demands of one of the most rapidly growing populations in the world.\textsuperscript{35} Furthermore, Black doctors were increasingly concerned and frustrated with the poor socioeconomic conditions of Black South Africans; conditions which gave rise to a score of conditions and diseases for which Black doctors were ill equipped. The same 1978 survey determined that over one third of Black South African medical students “felt that their medical education did not provide them with adequate training to deal with [the aforementioned problems associated with poverty].”\textsuperscript{36} The survey also revealed that a substantial proportion of Black medical students wanted a course for social and preventative medicine reintroduced into the syllabus which entirely disregarded traditional African methods of cure.\textsuperscript{37}

The Medical University of Southern Africa, which offered its first class in 1978, was to address this looming issue of community care, but the radius of its care was largely confined to Ga-Rankuwa, the Winterveld, and their environs. The completion of Ga-Rankuwa hospital in


\textsuperscript{35} Seedat, Aziza. *Crippling a Nation.* ; Tobias, Philip V. "Medical History - Apartheid and Medical Education: The Training of Black Doctors in South Africa."


\textsuperscript{37} Ngubane, Harriet. “Clinical Practice and Organization of Indigenous Healers in South Africa.” p.369
April 1973, as the South African government expanded healthcare to Blacks, provided a potential training center for Black medical students and facilitated the development of the Medical University of Southern Africa, or MEDUNSA, which was established by the Medical University of Southern Africa Act No. 78 of 1976.\(^{38}\)

MEDUNSA was affiliated with the South African Department of Health but was devoted to the training of Black doctors and the provision of medical care to the surrounding Black communities. The university’s policies were therefore geared towards the acceptance of Black students, whose academic standing, affected by the legacy of Bantu Education, tended to be weaker than their White counterparts; however, matriculation scores from secondary education remained important admissions factors, and the inherent weaknesses of the math and science education throughout Black schools was evident in the relatively small student body: 152 in 1978 and 707 in 1982 – an impressive increase in enrollment, but not nearly sufficient to match the momentum of population growth in the homelands. Nevertheless, the university took measures to accommodate its Black students, well over half of whom received bursaries from either their respective homelands or MEDUNSA. Private donors and institutions also subsidized tuitions and book fees: students repaid homeland loans by providing medical services in the homeland that sponsored them.\(^{39}\)

The Apartheid government and MASA took pride in MEDUNSA as an effective step forward in the provision of medical education and health services to Black population. From their perspective, the Medical University of Southern Africa was a method of ‘[building] bridges’ between White and Black communities.\(^{40}\) In fact, MEDUNSA, as a research institution, and Ga-Rankuwa Hospital, as a center from which medical research could be conducted, were

\(^{38}\) Retief, F.P. “The Medical University of Southern Africa after 5 years.” \textit{SAMJ}. Vol.62, 1982: 841-845
\(^{39}\) Retief, F.P. “The Medical University of Southern Africa after 5 years.” \textit{SAMJ}. Vol.62, 1982: 841-845
\(^{40}\) \textit{Ibid.}\)
instrumental in the expanding number of studies into the health of the surrounding Black population; the series of poisoning studies outlined in Chapter One are one such example. Overall, “the number of publications from MEDUNSA appearing in scientific journals increased more than threefold during 1981, and the staff made significant contributions to professional meetings.”\textsuperscript{41}

At the same time, these studies did little to criticize or expose the injustices rooted in apartheid policies themselves. MEDUNSA also faced harsh criticism from doctors such as the aforementioned Dr. Seedat and Dr. Tobias as a means of increasing apartheid segregation. Indeed, MEDUNSA was “part of a plan to phase [Black] students out of the other centers of training.”\textsuperscript{42}

\textit{Medicine, Modernity and Education}

This chapter demonstrated the ways in which education had been impacted by the apartheid ideology of ‘Bantu’ or ‘tribal’ identity, which was embodied in the Promotion of Self-Government Act of 1959 and the subsequent growth of the homelands. The pattern of segregation and concepts of racial and intellectual superiority of Whites shaped and was further reinforced by an educational system relegating Blacks to positions of menial labor almost exclusively in White-owned industries.

Apartheid ideologies shaped more than the curriculum and the future prospects of Black students: education is a powerful cultural tool, and instills and reinforces cultural values and morals. Despite the extensive discourse about “Bantu culture” and its free rein in the Reserves and homelands, the educational system under the South African Department of Bantu Education paradoxically instilled White cultural values as they defined a syllabus ostensibly representing

\textsuperscript{41} Ibid.
\textsuperscript{42} Seedat, Aziza. \textit{Crippling a Nation}, p.85
the interests of the ‘Bantu culture.’ This was true in Bophuthatswana even as it developed its own Department of Education, which like the Department of Health extolled the virtues of ‘modernity,’ defined by the dominant, Apartheid State.

Historians Christie and Collins have noted how Black children were trained to be submissive, polite, and able to understand the commands of their English or Afrikaans employers. They did not, however, address the representation of traditional African beliefs, especially traditional healers, within the educational system. Ga-Rankuwa High School’s tenth anniversary publication contained a parable which illustrated the homeland administration’s official attitude towards traditional healers and the belief system they represented.  

How Louis Came to Know About the Library

Jacob and Louis are class-mates. They are students at Ga-Rankuwa High School. This is their first year at high school. It seemed as though Louis was cleverer than Jacob, but Jacob’s performance in class was better then [sic] Louis’. His work was always up to date, and, it was as though he knew all the answers.

This was queer to Louis who has passed his Junior Certificate with distinction. How was it possible that he could be beaten by Jacob who only obtained a [sic.] second class pass? Every other day Louis saw Jacob carrying a black plastic-bag labeled “African”. Louis also observed that Jacob was no longer seen regularly at the playground.

Louis saw Jacob, and immediately followed him. Jacob was carrying the black plastic-bag. Louis saw him entering a solitary building at the corner of Schoeman and Edward streets in Pretoria. On the wall of the building there was a marble stone in which “Isaac Shepard Library” was depicted. Louis did not know this place, and he did not know its purpose. He had never taken the trouble to visit this building. What Louis did to get a distinction pass was to go to a wise witchdoctor. This witchdoctor gave him a dried locust to tie around his waist, this was how he got his distinction.

At the Library Louis waited outside for some time, still making plans to get hold of Jacob’s bag. Why was it that Jacob was always carrying that black plastic-bag? Jacob emerged from the building after an hour. Jacob was still carrying the plastic-bag. Louis hid himself behind a big hedge. He wanted to ambush Jacob and steal the black plastic-bag from him. He felt that what was in the black plastic-bag was the key to

Jacob’s success. He wanted to know that secret, and he was determined to get hold of the black plastic-bag.

When Jacob was about to go around the corner, Louis hit him on the head with a brick. Jacob fell unconscious. Thereafter Louis opened the plastic-bag, and to his amazement and dismay he found four books in the bag…

Like Modern Graded English, As You Like It, a dictionary and a memo book. Since then, Louis has also started visiting “Isaac Shepard Library” regularly.44

While essentially a parable about the merits of hard, individual work and academic diligence, this parable was laden with symbolism contrasting ideals of ‘the modern,’ represented here by the Isaac Shepherd Library and the honest pursuit of academia, and ‘the primitive,’ represented by ineffective superstitious beliefs, shortsightedness and simple-minded, barbaric hostility. This ideological conflict between conceptions of ‘the old’ and ‘the new’ extended beyond the boundaries of education and homeland administrations; indeed, this ideological dichotomy featured heavily in the series of articles published in the South African Medical Journal surrounding the role and significance of traditional healers.

A research project examining the supernatural beliefs of Black medical students at MEDUNSA in 1984 determined that “two-thirds to three-quarters of the students have strongly retained their traditional supernatural beliefs… there can be no doubt that there is a high acceptance among students that witchcraft is a very real power in the world” and that evil spirits were primarily responsible for most diseases.45 This study not only revealed the persistence of traditional beliefs even among Black biomedical students, but it also established the persistence of traditional healers as socially and culturally integral members of the Black community: traditional healers, the belief systems they represented, and their occasionally toxic treatments, persisted despite the extension of biomedical services to Black communities.

44 Ibid. p.12
At the same time, this study demonstrated South African and biomedical researchers’ increased awareness of the inevitable persistence of traditional healers and belief systems even as biomedical services increased their presence in Black townships and, to a lesser extent, more rural communities. By 1984, while Joubert conducted his toxicology and “Self-medication” studies in Ga-Rankuwa, it appeared as if biomedical health services, overwhelmed by the burden of disease rooted in the social and political economic dichotomies of apartheid, had gradually and begrudgingly accepted the existence of traditional healers.
Conclusion

Apartheid Politics and Discourse in the South African Medical Journal

The consolidation of the homelands represented a political economic dualism that economically subjugated the Black population to White industries and precipitated a cycle of poverty, malnutrition and unsanitary living conditions. Consequently, diseases such as gastroenteritis, tuberculosis and cholera flourished amid the poverty and malnourishment of the homeland populations. As large communities of Blacks seeking wage labor in the Republic of South Africa began to accumulate along the fringes of major White urban centers such as Pretoria and Johannesburg in townships, the South African government took steps to protect the economic and health interests of its own White population. The resulting expansion of health services into Black areas not only extended biomedical care to township and several rural Black communities; it also contributed towards the ‘separateness’ at the heart of apartheid politics and ultimately reduced the amount and quality of care available to homeland Blacks as mission hospital doctors refused to serve under the Apartheid regime and resigned their posts.

Yet this extension of biomedical services into the Black townships and their environs in the early 1970s coincided with an increasing trend in mainstream biomedical discourse of attempts at cultural awareness within Black communities and the necessity to provide culturally relevant health care. Swazi physician K.P. Mokhobo wrote an article published in the South African Medical Journal in January 1971. This article appears to have been the first of the burgeoning body of literature focused on interaction with traditional African health and healing systems within biomedical discourse, examining the cultural divide between traditional and biomedical systems regarding the doctor-patient relationship. Mokhobo concluded that “it [was] essential to adapt medical history taking to Bantu culture… A medical vocabulary does exist for
the indigenous peoples. It [behooves] every doctor who has to practice among Bantu to learn their culture and their language.” Indeed, communication between what apartheid maintained as two alien cultures was a fundamental theme throughout biomedical discourse as health services expanded into Black townships, and distinguished the discourse of the 1970s from the discourse of the 1940s.¹

Dr. J. W. Bodenstein, the Head of the Health Education Section of the Department of Health in Pretoria, followed a similar trend of discourse in his article, published in the South African Medical Journal in late February 1973. Like Mokhobo, Bodenstein made a plea for cross-cultural dialogue in his article ‘Observations on Medicinal Plants,’ “a dialogue,” he wrote, “which will give the Bantu a better chance of learning to adjust, of attaining new horizons.” Mokhobo, however, focused on informing biomedical doctors of Black cultural expectations that they may better serve the ‘foreign’ population to whom it was their recently recognized obligation to cater. Although Bodenstein’s suggestion embodied the paternalism common among the White biomedical community during the Apartheid Era, he also contravened the “supercilious, orthodox” biomedical attitudes towards traditional African medicines and healers by extolling the virtues of many traditional African remedies.²

Biomedical discourse throughout the Apartheid Era appeared to have forgotten its previous interest in and attempted adaptation of many traditional African medicines.³ For instance, the leading article in the South African Medical Journal for Wednesday, September 7, 1887 contained the following:

¹ Mokhobo, K.P. “Medical History Taking Among the bantu Tribes of South Africa.” SAMJ. 1971: 111-114 ; SAMJ 1940-1990
…we hear of cures talked of amongst the laity for syphilis, cancer, leprosy *as used by the natives* and such like. Well, *such remedies may be quite worthless for the diseases in which they are used by the Ignobile Vulgus*, nevertheless *they may contain some valuable properties which should entitle them eventually to a position amongst the recognize armamentaria of the physician* [emphasis added].

Despite the characteristic paternalism of the colonial European doctors who published this article – a bias that continued throughout most of the twentieth century – biomedical doctors clearly appreciated the efficacy of certain medicinal plants used in traditional African medicine. A similar article published in the *South African Medical Journal* in 1899 described a scenario in which a ‘Kafir,’ or Black, traditional healer cured a man’s fever by the administration of “some beans.” A biomedical doctor who had been involved in the healing process, Dr. Maberly, acquired several of the beans from the “Kafir doctor” and submitted them to tests in an attempt to adopt the treatment for biomedical purposes. Biomedical doctors appear to have frequently met with frustration as they attempted to adapt traditional medicines that were beyond their realm of expertise: “as a fact, the natives would not give up the secret of their most valuable drugs.”

Apartheid brought with it an explicit repudiation of all value in Black culture and methods of healing; a repudiation that was at the foundation of the policies that justified the development of the homelands as ‘Black States.’ Consequently traditional healers and their treatments became marginalized within mainstream biomedical discourse as the Black population as a whole became increasingly socially, politically and economically marginalized.

At the same time, the consolidation of the homelands and the development of homeland bureaucracies allowed South Africa to renounce its responsibility for the physical, social, economic and, to a certain extent, political well-being of their unwilling denizens. The

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Bophuthatswana Department of Health was apparently eager to take on its newfound responsibilities. South African government itself took great pride in this ostensible shifting of administrative responsibility: homeland Departments of Health were a powerful legitimating factor for the ‘sovereignty’ of the Black homelands.\(^6\) In reality the homeland governments remained heavily subsidized by the South African State, and did little more than provide leverage for the Apartheid regime’s Public Relations.\(^7\) The introduction to this thesis has already demonstrated how official discourse during the Apartheid Era placed the burden of blame for illness upon Blacks’ own over-reproduction; however, blame often extended beyond the more empirical justification of unchecked population growth – flawed as that perception may have been – to ideological concepts of racial inferiority.

These concepts were evident in articles addressing the malnutrition that plagued the Black South African population throughout the Apartheid Era. The Republic of South Africa recognized poverty as factor in malnutrition, but heavily emphasized ‘superstition,’ ‘ignorance’ and ‘social disorganization’ in addition to overpopulation as the reasons for which the Black population was malnourished.\(^8\) One study published in the *South African Medical Journal* published December 1977 indicated contemporaneous studies that determined “people generally [preferred] protein-rich foods when they are available, and that it [was] generally poverty which [prevented] their regular incorporation into the diet.” Nevertheless South African authorities continued to conduct studies based on the premise that Black “mothers [did] not know what [was] good for their children.” Furthermore, the study primarily featured within the aforementioned article concluded that “the two most important factors associated with a weight

\(^6\) Bophuthatswana Department of Health, 1981; *The Health of the People*

\(^7\) Butler *et al.* *The Black Homelands of South Africa.*

below the BTP\textsuperscript{9} were an income of less than R 30 per month, and the lack of sound dietary knowledge.”\textsuperscript{10} The average low incomes and ostensible lack of sound dietary knowledge – which was more an issue of access to a varied diet than it was of education – were direct consequences of the political economic dynamics of apartheid segregation.\textsuperscript{11} Westcott and Stott, the researchers who had composed the above report on malnutrition, gave both factors – ignorance and income – equal weight in their conclusion.

Their conclusion also indicated an awareness of the dire economic conditions within the homelands, as they believed “child welfare would certainly benefit from the existence of more employment opportunities for men in the homelands, which would ensure that a higher proportion of the income earned [was] available to the family.”\textsuperscript{12} Their clear awareness of the political economic complexities of Apartheid South Africa was matched by their unwillingness, or inability, to critique the system itself. This inability to critique the system at the root of the social and economic disparity and the associated ill health that plagued the Black population was common to virtually all official bodies of discourse during the Apartheid Era.

Within medical discourse, this bias followed the paradigm of curative medicine versus preventative medicine. The numerous poisoning and malnutrition studies conducted by research institutions such as MEDUNSA essentially focused on treating symptoms and not the underlying causes. For example, the mitigation schemes for kerosene poisoning suggested by Joubert and his research associates were incongruous with the reality that people needed kerosene as a source of power, because in many cases they had been displaced from more developed areas via forced

\textsuperscript{9} The Boston Third Percentile: a method of defining the minimum dietary requirements for adequate nutrient intake. People below the BTP qualify as ‘malnourished.’


\textsuperscript{11} Seedat, Aziza. \textit{Crippling a Nation}. p.24

removals. Furthermore, the dynamics of economic dualism outlined in chapter two hindered the homelands’ ability to develop a self-sustaining infrastructure.\textsuperscript{13}

The emphasis placed on curative medicine at the expense of the development of all but the most distorted preventative practices – namely the population control efforts outlined in the introduction – continued even after the nominal healthcare reforms of the late 1960s and 1970s. Following the reforms, official efforts to address malnutrition and disease seemed to concentrate on the maintenance and erection of more hospitals throughout the homelands instead of efforts to ameliorate the poverty at its base. Food programs such as the distribution of free milk and government subsidies for basic foods such as butter, wheat, maize and bread, but not including highly nutritious foods such as fresh fruits, meat and vegetables met with limited success as they failed to address the roots causes of malnutrition: the exploitation of Black labor through a systematic system of social, political and economic segregation.\textsuperscript{14}

Moreover, Whites, whose low IMR indicated a higher standard of living, benefitted more from curative medicine than did Blacks, whose ill health was rooted in the poverty fostered by the political economy of apartheid. Indeed, the health services of South Africa were largely geared towards serving the small White population: “98 percent of the medical budget [was] spent of curative services ‘usually supplied to an urban elite at high cost.’”\textsuperscript{15} The remaining 2 percent were estimated to go to preventative medicine, of which the large Black population was in dire need.\textsuperscript{16}

\textsuperscript{14} Packard, Randall. \textit{White Plague, Black Labor}. p.267
\textsuperscript{15} Seedat, Aziza. \textit{Crippling a Nation}. p.12, cites Seftel, H.C. “A Sick Society” \textit{Financial Mail}, Johannesburg, 2.3.79.
In a sense, this contest between curative and preventative medicine carried over into the
debate surrounding the recognition, or at least tolerance, of traditional healers. Multiple articles
published during this period noted the efficacy of traditional healers as psychologists whose
societal influence and rituals constituted a more preventative form of medicine. Even Dr. G.H.
Roux, a skeptic and ardent opponent of collaboration with traditional healers, noted how “the
inyanga (witchdoctor) [played] an important and vital role in the ‘diagnosis’ and treatment of
patients suffering from any form of psychiatric disturbance.” Indeed, the South African Medical
Research Council had conducted research in 1976 focused on the benefits of the psychosomatic
approach of witchdoctors which fell within their broader practice of preventative medicine;
quick, targeted cures were the realm of biomedicine, provided patients completed their drug
regimens, which was not frequently the case.17 Some doctors consequently found traditional
healers’ practices to complement those of biomedicine in such a manner that promoted
professional collaboration. Furthermore, traditional healers were in a better position to provide
culturally relevant care. The expression of these sentiments in the South African Medical Journal
sparked philosophical debates regarding the role and scope of biomedical care as well as
potential collaboration with traditional healers as official members of the healthcare system.18
Again, MEDUNSA’s Ga-Rankuwa poisoning studies serve as a paradigm for this debate, laden
with both pragmatic and ideological tensions which were frequently at odds with each other.
Poisoning studies represent a convergence of these two contrasting dynamics where both
pragmatic concerns for public health and ideological biases played a role.

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17 Roux, G.H. “The Medical Profession and the Witchdoctor.” SAMJ; Packard, Randall. White Plague,
Black Labor.
18 Kiernan, J.P. “Is the Witchdoctor Medically Competent?”; Hurwitz, H.S. “Witchdoctor or Which
Doctor?”; Ferguson, D.L. “Witchdoctor or Which Doctor?” SAMJ. 1978: 810; Dunston, T.
“Witchdoctor or Which Doctor?” SAMJ. 1978: 1043; Mankazana, E.M. “A Case for the
Traditional Healer in South Africa.” SAMJ. 1979: 1003-1006
Pragmatism and Prejudice

While MEDUNSA researchers were conducting studies in and around Ga-Rankuwa, traditional healers had long been the subject of debates regarding cooperation and collaboration with biomedical doctors, as the latter struggled to define its own scope practice and mores. At the same time, the predominantly White body of South African doctors faced the reality of having to treat the majority of the population, whose average income and standard of living fostered diseases instead of preventing them. Due in part to the sheer scale of the health problems plaguing the Black population, and thanks in part to the apartheid ideologies which limited the education of Blacks and therefore the supply of doctors willing and able to provide culturally and linguistically relevant care, this was a reality for which South African doctors were woefully unprepared. Articles published in the early 1970s as the South African government undertook its extension of biomedical healthcare to the homelands shared a common theme: they tended to highlight the cultural and linguistic barriers facing White South African doctors who were becoming increasingly exposed to Black culture, and who had to adapt accordingly. In fact, the entire strand of discourse in which traditional healers play an increasingly significant roll began alongside the extension of health services into the homelands.

The very real and, due in part to the growth of the townships, increasingly visible, burden of ill health under which the Black population suffered precipitated change within the South African biomedical community. Doctors became obliged to recognize not only the necessity to provide more effective care to the Black population, but also became obliged to recognize the cultural and linguistic barriers between them and the Black South African community. These barriers were reinforced by the apartheid government: In 1974 the South African Medical

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Journal published an editorial entitled “Colleagues or Opponents?” which noted “the fence erected by the Medical and Dental Council.” This editorial further exemplified the gradually transforming perspectives of traditional healers and challenged biomedicine’s own biases, claiming: “hitherto we have been only too willing to negate everything the witchdoctor does and to regard him merely as a charlatan who thrives on the gullibility of the uneducated and unsophisticated.”

This article presented a very pragmatic view of cooperation, but not professional collaboration, with witchdoctors as the ideal social figureheads from whom doctors could gain advice on cross-cultural interaction. One example of cross-cultural difficulties was the symbol of South African National Tuberculosis Association (SANTA), a red cross. According to “Colleagues or Opponents?” the red cross was a symbol of death to the Black population. Consequently, SANTA’s campaign against tuberculosis met with resistance among the Black population. The necessity of traditional healers as cross-cultural agents was a common theme throughout the majority of articles that discussed the role of traditional healers during this period.

At the same time, the article presented a pejorative image of the “mere purveyors of herbs, charms and spells” which suggested a strong bias against traditional healers’ ability as purveyors of medical care. Traditional healers appeared to be resources from which the biomedical community was able to draw in order to increase the effectiveness of its own care. In other words, co-operation – and not collaboration, which connoted equality in medical expertise and efficacy of treatments between traditional healers and biomedical doctors – was a means to

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the end of making much needed improvements to patient care. The same *South African Medical Journal* article subsequently cited the practices of Dr. Nigel Stott and his associates, who had demonstrated the principle of “if you cannot beat them, join them… with remarkable effect;” Dr. Stott and his coworkers had accepted the cultural significance and sheer prevalence of traditional healers within Black society and responded accordingly.22 Interestingly, Dr. Stott published a response to the editorial in which he had been referenced. His response effectively illustrated the general mentality of the biomedical community regarding the recognition of traditional healers at the time: “that fresh progress on the Black medical scene could come from collaborative studies with witchdoctors had been suggested23, but this is still within the context of research and cooperation, and not at the level of ‘meet my partner the witchdoctor’, as you somewhat flippantly suggested.”24

Another editorial published in May 1976, “Herbalists, Diviners and even Witchdoctors,” reinforced Stott’s rejection of traditional healers as equal medical partners. This article echoed the recognition of the importance of traditional healers in Black society stated in two articles mentioned above, reiterating the “the place of the witchdoctor in the community cannot be ignored;” however, the article specified between accepting traditional healers’ influence and recognizing them as “part of the health care team.” This opinion was expressed in the law: the Medical, Dental and Supplementary Health Services Act No. 56 of 1974 made it an “offence for any registered practitioner to practice in collaboration with a non-registered person, and for non-registered persons to perform acts pertaining to the medical or dental professions.” Biomedical doctors therefore faced the conundrum of not being able to ignore traditional healers – both out

24 Stott, Nigel C.H. “Colleagues or Opponents?” *SAMJ*. 1974: 2241
of the necessity that has been demonstrated throughout this thesis, and their persistence and prevalence throughout Black society – and not being able to practice in partnership with them.\textsuperscript{25}

This actually contributed to a lack of balance in the dynamic between traditional healers and witchdoctors regarding patient care: traditional healers, as discussed in Chapter One, frequently referred patients to biomedical doctors. In many cases traditional healers would seek treatment from biomedical physicians.\textsuperscript{26} Yet doctors were legally prohibited from referring their patients to traditional healers. Nevertheless, traditional healers continued to thrive among the social and physical malaise rooted in apartheid segregation, and were undeniably a part of life with which doctors had to come to terms as their scope of practice expanded in Black areas.\textsuperscript{27}

Stott’s pragmatic “if you cannot beat them, join them” mentality culminated in a symposium hosted by the prestigious University of the Witwatersrand on June 25 and 26, 1977. The purpose of this symposium was, according to Dr. Roux, “to help White medical men to grasp the secrets of their Black tribal ‘colleague,’” and despite the cynicism of many members of the medical community, had two important points.\textsuperscript{28} The first point was to note the inappropriateness of the term ‘witchdoctor’ as a derogatory vestige of the colonial era. The second and no less significant point was the recognition of the need to “exert some control over this group of healers through their own organization, to maintain standards and to exclude charlatans responsible for much of the adverse criticism levied at traditional healers.”\textsuperscript{29}

Ultimately this symposium illustrated, to a certain degree, the submission of the biomedical

\textsuperscript{25}“Herbalists, Diviners and even Witchdoctors.” \textit{SAMJ}.
\textsuperscript{27}“Herbalists, Diviners and even Witchdoctors.” \textit{SAMJ}.
\textsuperscript{28}Roux, G.H. “The Medical Profession and the Witchdoctor.”

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community to the larger overarching dynamics of illness that were deeply rooted in apartheid segregation.

In one sense, the Witwatersrand symposium was a turning point within biomedical discourse; the symposium was essentially an expression of the sheer necessity of biomedical practitioners to recognize traditional healers as factors influencing public health and public opinion. Whether or not they represented a benefit or a liability continued to be a topic of debate among the biomedical community throughout and beyond the remainder of the Apartheid Era. The poisoning studies introduced in the first chapter, for example, are a testament to the ambiguous standing of traditional healers in the decade following the symposium: did MEDUNSA conduct its tests as a means of assessing, accepting and adapting to the undeniable persistence of traditional healing methods, or were the poisoning studies yet another means by which the Apartheid State attempted shift the blame for the burden of ill health to the Black population itself? Both factors certainly played a role as longstanding prejudices against the vilified “witchdoctors” underscored the more pragmatic debate surrounding the incorporation of traditional healers – either as cultural informants or as primary care providers – into the medical system.

The poisoning studies at Ga-Rankuwa expressed another dynamic to which traditional healers were subjected: the burden of blame. Joubert’s focus on the impact of traditional medicines on public health at the expense of a focus on pharmaceutical drugs reflected long-standing biases against the unregulated and ‘unqualified’ traditional medicine and the healers who administered them.30 Four months after the Witwatersrand symposium, Dr. G.H. Roux published an article in the *South African Medical Journal* entitled “The Medical Profession and the Witchdoctor” in which he noted the prevalence of hypertension among Black South Africans.

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30 Joubert, P.H. “Acute Poisoning Admissions.”
Hypertension, as discussed in the introduction, was attributable to a variety of factors, including the stress from which Blacks suffered during the Apartheid Era. Roux, however, followed the common pattern of ignoring the apartheid and blamed traditional healers as “important contributing factors” from their “regime of fear and terror.” Roux used his distorted and disparaging characterization of traditional healers as a point in his argument against medical collaboration with traditional healers. Incidentally, Roux’ article was followed by a chain of responses the overwhelming number of which condemned his highly prejudicial view and extolled the virtues of traditional healers as significant members of the medical community with whom it was their obligation to cooperate; however, these sentiments were not without opposition, as doctors continued to associate traditional medicine with a primitiveness that was incongruous with Western biomedicine.31 Indeed, the prejudiced sentiments expressed by Roux persisted despite mounting efforts to reevaluate biomedical perceptions of their “Black tribal colleagues.”32

Authors like Buchanan and Cane attempted to place the debate surrounding traditional healers in perspective: in July 1976 the South African Medical Journal published Buchanan and Cane’s “Poisoning Associated with Witchdoctor Attendance.” The purpose of this article was “not to dispute the cultural and possible medical values of herbalism, but to draw attention to its ‘iatrogenic’ complications;” the same complications suffered by patients of biomedicine.33 Research of traditional healing’s iatrogenic complications was a relatively young field of study when Buchanan and Cane wrote their article in the mid-1970s, but an extremely important

32 Roux, G.H. “The Medical Profession and the Witchdoctor.”
33 Buchanan, N. and R.D. Cane. “Poisoning Associated with Witchdoctor Attendance.”
indicator of the growing recognition of traditional healers as people whose treatments had a very
real impact on public health – an impact that had to be studied and understood in accordance
with biomedical methodology.

Such a necessity for understanding the impact of the ever-present traditional healers was
spurred on by the increasingly evident significance of Black labor within the White economy in
the context of expanding health services. When the creation of the Regional Health Organization
for Southern Africa as a liaison to homeland departments of health strained South Africa’s
already struggling economy in 1979 the *South African Medical Journal* published “A Case for
the Traditional Healer in South Africa.” This article effectively concluded the aforementioned
debate following Roux’s article, but it differed in that it was a full and official article: the
responses to Roux were mainly shorter articles featured in the “correspondence” section.34 The
growth of this field of understanding the iatrogenic complications of traditional treatments was,
in part, attributable to the recent expansion of health care into Black areas.

This was a category into which the later poisoning studies would fall, albeit in a broader
sense, but some of the earliest articles were published in 1971. In July the *South African Medical
Journal* published an article written by Seedat and Hitchcock which Dr. YK Seedat and
Hitchcock discussed the signs and symptoms of acute renal failure caused by *Callilepsis
laureola*, an herb used in traditional remedies.35 The following year Dr. Rose similarly discussed
the uses and possible pitfalls of plants of the *Senecio* species which features largely in the food
and medicines of the people of the Transkei and Ciskei.36 The subsequent issue of the *South
African Medical Journal*, one month later, contained an article written by Dr. Dinner which

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34 Mankazana, E.M. “A Case for the Traditional Healer in South Africa.”
35 Seedat, Y.K. and P.J. Hitchcock. “Acute Renal Failure from *Callilepsis laureola*.”
36 Rose, E.F. “*Senecio* Species: Toxic Plants Used as Food and Medicine in the Transkei.”
discussed the etiology of two cases of factitious anemia rooted in traditional treatments. In 1974 the *South African Medical Journal* printed Solleder’s findings from a study of 50 adults and 25 infants who had taken Xhosa medicines. These articles and the broader dynamics of research they represent indicated a heavy element of pragmatism underlying the increased frequency with which traditional healers featured in mainstream biomedical discourse.

Even as doctors made inroads to understand the etiologies and treatments of traditional African healing, their research suffered from enduring biases. Dr. Rose, for example, found it “remarkable that the local inhabitants [were] unaware of the toxicity of plants like the *Senecio* species which [contributed] so much … to the ill health of the population.” Not only did this play on preconceptions of Black ignorance, but followed the general trend of displacing the blame for ill-health from apartheid onto the Black South African population itself. Meanwhile, Dinner similarly presented tribal customs as a health risk, referring to traditional administration of treatments. These treatments commonly involved the laceration of the epidermis to facilitate the absorption of topical medicines into the bloodstream. Dinner drew associated the self-infliction of lacerations with mental illness, revealing a severe lack of cultural relativism.

**Roots of Prejudice**

The same mentality that encapsulated the implementation of apartheid policies and the segregation of Black South Africans into ethnically-defined ‘homelands’ permeated medical discourse throughout the Apartheid Era. The homelands were paradoxically locations wherein “Bantu culture,” as defined by the South African government, was to be fostered; yet homeland administrations and the Apartheid government pushed for the ‘modernity’ evident

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39 Rose, E.F. “*Senecio* Species: Toxic Plants Used as Food and Medicine in the Transkei.”
40 Dinner, D.S. “A Report of Two Rare Cases of Factitious Anaemia.”
Bophuthatswana’s stamp issues, discussed in the previous chapter, and in the reports from both the Department of Education and the Department of Health.\(^4\)

This bias was similarly present in the body of Ga-Rankuwa studies detailed in Chapter One. Researchers’ tendency to overlook drugs as poisoning agents revealed a commonly-held association of traditional medicine with primitiveness and medieval Europe; this has already been discussed in the first chapter.\(^4\) An additional factor in the apparent prejudice of the poisoning studies may have been attributable to the cultural divide between Western medicine and traditional African medicine: researchers understood the composition, indications and contraindications of pharmaceutical drugs, which were strictly regulated by the South African government. Traditional medicines, on the other hand, were not within their legislative or intellectual grasp.\(^4\) This did not correspond with the arrogant pride displayed by several doctors, whose own supercilious prejudice regarding the superiority of western medicine was a barrier.\(^4\)

The *South African Medical Journal* had a long history of such prejudicial tones. It is therefore fascinating that the *South African Medical Journal*, as the voice of the apartheid-affiliated Medical Association of South Africa, would publish debates surrounding doctors’ relationships with traditional healers. This is especially interesting regarding the publication of a surprisingly large number of articles in favor of collaboration with traditional healers, who under apartheid conditions were paradigms for the ‘traditional African culture’ upon which much segregation was based and justified. The debate and apparent communication between


\(^4\) Joubert, Pieter H. “Poisoning Admissions” ; Joubert, Pieter H. *et al.* “Self-medication in a developing community.”

\(^4\) Joubert, Pieter H. “Poisoning Admissions”

\(^4\) Bodenstein, J.W. ‘Observation on Medicinal Plants.”
biomedical doctors and traditional healers within the *South African Medical Journal* appears to have superseded normally accepted perceptions of the apartheid as a system of extreme segregation.

**Conclusion**

Of course, the growing debate among South African biomedical doctors that culminated in the Witwatersrand symposium of 1977 did not operate in a vacuum: the international community had long criticized the social injustices of apartheid. In 1978 the international community held a conference at Alma Ata, wherein traditional healers were promoted as undeniable and integral components of a country’s health care system; the same points that South African doctors had been debating in the weeks, months and years preceding the international conference.\(^{45}\) The World Health Organization’s 1983 report, *Apartheid and Health*, criticized the “distorted version of the past” presented in official South African discourse, which established an historical narrative legitimating apartheid and attributing the profile of disease among the Black population simply to the Blacks’ lack of economic development.\(^{46}\) Indeed, the World Health Organization was not alone in the international community to draw attention to the underlying cause of the dichotomous nature of South African society and, in turn, the burden of disease under which the Black population suffered: apartheid policies.\(^{47}\)

Despite its refusal to address the negative impacts of apartheid on human health, medical discourse in Apartheid South Africa gradually began to overcome long-held prejudices against ‘primitive’ traditional healers. Not only did this increased cross-cultural communication occur

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during a period of apartheid segregation, but it was in fact kindled by the very forces that would see the country divided by race. Indeed, one traditional healer openly commented on this paradox at an address to the students and staff of the medical school of the University of the Witwatersrand in 1974: “The very civilization that should have made witchdoctors a thing of the past is keeping us very much in business.”48 Such was the impact of apartheid segregation on health and the manifestation of mutual economic dependency that medical discourse debating cooperation between traditional healers and biomedical doctors that it preceded both the Alma Ata conference and the 1983 WHO publication that attacked the injustices and inadequacy of the apartheid health care system. International pressure, while certainly a factor, was secondary to mounting internal social and economic pressures.

The discussion surrounding the acceptance of traditional healers as members of South Africa’s profile of health care seemed to be largely pragmatic: traditional healers were important and unalienable members of the Black community whose treatments had an undeniable impact on public health. The debate itself, though, was bolstered by prejudice and what Dr. Bodenstein called the “supercilious, orthodox” behavior of biomedical practitioners.49 The growing debate had its foundation in the political economy of apartheid. The development a mutualistic economic dependency that also fostered illness among the Black population led to an extension of health services into readily accessible and densely populated Black communities: the townships. The townships, such as Ga-Rankuwa and Mabopane in Bophuthatswana, were themselves products of the political economy of separate development as Blacks were proscribed residence in White urban centers. This expansion, bolstered by the necessity to provide medical care led not only to increased cultural awareness but an awareness of the inadequacy of the

48 “Colleagues or Opponents?” SAMJ. Vol. 48, No. 45. 1974: 1899
49 Bodenstein, J.W. ‘Observation on Medicinal Plants.”

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biomedical system to address the burden of sickness faced by the Black population – an inadequacy that was reinforced by a racist educational system. Perhaps the most accurate description of the relationship between traditional healers and biomedical doctors at this time was one of tolerance: the biomedical community was ultimately forced to recognize the inalienable cultural significance of traditional healers within Black South African society.\textsuperscript{50}

\textsuperscript{50} Stott, Nigel C.H. “Do Witchdoctors Practise Clinical Pattern Recognition?” \textit{SAMJ}. 1973: 334 - 335
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