

**GENDER, POLITICS AND SOCIAL MEDICINE IN SOUTH  
AFRICA, 1940 - 1959**

by

Mary Susan Caesar

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## **Abstract**

This thesis is a first step to a gender analysis of South Africa's social medicine experiment of the 1940s. The research focused on the work of the Health Centres, in particular Grassy Park and Polela, which were established in South Africa between 1940 and 1959, i.e., the date when all Health Centres were either closed down or converted into ordinary outpatient clinics for the Provincial Hospitals. It is based on an examination of archival records such as the reports of the Health Centres, in, and the official records prepared by the then Department of Public Health and the Medical Officers-in-Charge of the Health Centres. In order to undertake a gender analysis, I asked two main questions: how Health Centre Practice (HCP), i.e. discourse and work of the Health Centres, responded to gender roles and relations it encountered in the community where it operated and secondly, how HCP advocates constructed a particular discourse about black people's health that effectively depoliticized health, poverty and the role of the state in the creation and maintenance of disease and poverty. There is sufficient evidence to show that the Health Centres provided a valuable service to black women at a time when the state did not prioritize black people's health, however, the historical moment within which HCP was conceived and implemented, implies that neither the project nor its implementers could escape the dominant racist, patriarchal political values.

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## **CHAPTER ONE**

### **INTRODUCTION**

In 1940, a group of white, liberal doctors, bureaucrats and politicians launched a Health Centre program at Polela, Natal (now known as KwaZulu-Natal) to save black disenfranchised people from their poverty and diseases. The family of T.M, wife of M.M, was among the beneficiaries of this program.

M.M was born in 1910 and by 1944 he had never attended the Health Centre since it was opened in 1940.<sup>1</sup> The Health Centre report, however, described M.M as illiterate, ‘somewhat lazy, unprogressive and a heavy drinker’. He worked as a migrant worker and therefore was ‘away from home most of the time’. When he was at home, usually during the harvesting season, he still did ‘very little’.

At 28 years of age, T.M. was the first wife of M.M and she had given birth to three children. She was a ‘peasant-housewife’ meaning that she maintained the home and was also responsible for agricultural work such as weeding and reaping. T.M. first encountered the Health Centre in January 1941 when she was seven months pregnant with her second child. During this visit, she appeared healthy, ‘fairly well nourished’ and had a negative Wasserman Reaction, i.e. blood test that detects syphilis. This second child died in May 1943. By the time T.M. was pregnant with her third child, the Health Centre staff noticed that she was ‘very thin [and] looked tired’. Like her husband, M.M., T.M. was illiterate in spite of the fact that ‘she considered herself to be a progressive and a person of some importance in the community’, the Health Centre’s assessment of her differed fairly drastically. Their report states that her home was ‘usually dirty, she and the children [were] dirty, and the family’s food production [was] well below average. While T.M. complained about not being well and looked ‘tired on most occasions’, the Health Centre staff considered her as ‘a case of malnutrition’. However, ‘unlike her husband, she [was] not a

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<sup>1</sup> The case of M.M and T.M and their family can be found in the 1944 Annual Report of Polela Health Centre, GES 1917, File 46/32, Annual Report, Polela Health Centre, July 1944 – June 1945



thin and wasted, and had a well-marked classical pellagra with oedema. The diet consisted solely of mealie foods, and occasionally a 'wild' spinach dish'. The problem for the Health Centre was not that the mother attended infrequently or that she brought the child for consultations only when she was ill. The problem was that T.M. consulted several *izinyanga* or traditional healers and that she believed that the child suffered from 'Isolo' and later 'Mkhondo', according to the various *izinyanga*. According to Kark, these conditions were similar to 'Infantile pellagra, nutritional diarrhea and infectious diarrhea of infancy' and could be treated however, the traditional beliefs about the causes of 'Isolo' and 'Mkhondo' proved to be a significant barrier. Traditionally, these childhood conditions are signs that someone placed a curse on the mother while she was pregnant – the mother was either struck by lightning, or walked into a hut or over a spot that was struck by lightning and in this way the curse was directed at the mother. T.M was apparently 'fully convinced' that she had been cursed so that this 'irrational belief' could not be countered with 'any amount of reasoning'. Thus, while the Health Centre started treatment, T.M. did not 'co-operate' and eventually stopped taking her child to the Centre. The child died. According to Kark, this preventable death was brought about by a number of factors including the physical conditions of the child, but more importantly, the fact that all the adults in the family were not only illiterate, but were all superstitious. 'There was no one in the family with sufficient interest or knowledge to prevent her [T.M.] from bringing about the baby's illness and subsequent death'.

Thirdly, the family's economic status affected their poor living conditions. The family was 'very poor', but their condition was made worse because of the 'delinquency' of M.M. and his brother, i.e. the two men who were engaged in wage labor. The men 'rarely' sent money home and thus did nothing to 'alleviate the poverty at home'. Following this kind of analysis of the family of M.M, the Health Centre staff recognized that some kind of intervention was necessary in order to help this family and using the principles of social medicine, the Health Centre would save this family.

Between 1940 and 1959, forty four Health Centres provided curative health services to everyone in the communities where they operated, but they also practiced a version of social medicine through their Intensive Family Welfare Program (IFWP). According to Kark and his colleagues at the Polela Health Centre, T.M. and her family would benefit from the IFWP. Firstly the family would receive free curative health services to deal whenever someone was ill. In addition, Health

Assistants would have provided the family with health education so as to prevent future illnesses. These direct, health-related interventions would have delivered positive results for T.M and her family and for the many disenfranchised poor, black people who were burdened with poverty-related diseases. The reason for this was that HCP, as the social medicine experiment was known, acknowledged that an individual's social and geographic communities influenced his / her health status. As a result, HCP emphasized curative, preventive, promotive and rehabilitative health services.

### **The historiography of Health Centre Practice (HCP)**

The history of HCP, i.e. the work of the Health Centres and the HCP advocates, covers three main themes: it highlights the work of the white, liberal HCP advocates; it recognizes the significance of social medicine; South Africa's pioneering role in the practice of social medicine, and finally, it blames the racist, minority National Party regime for the failure of South Africa's social medicine experiment. Firstly, HCP history explains and recognizes the extra-ordinary actions of the HCP advocates, who were mainly white, liberal in their political orientation and mainly male. These HCP advocates included medical doctors, health bureaucrats and politicians. As illustrated by the case study outlined above, white medical doctors provided and advocated for the provision of health care for all irrespective of race and class. Consequently, the history of HCP documents the efforts of the Medical Officers-in-Charge of the Health Centres, in particular Polela and Grassy Park Health Centres. In addition, historians have commended these 'social medicine pioneers' for their efforts to change the course of history in South Africa because the political and economic establishments of the 1940s and 1950s are not known for prioritizing the needs, especially health status, of black people.<sup>2</sup>

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<sup>2</sup> de Beer, Cedric. *The South African Disease: Apartheid Health and Health Services*. London; Catholic Institute for International Relations, 1986. Dubow, Saul and Jeeves, Alan (eds) *South Africa's 1940s: Worlds of Possibilities* Cape Town: Double Storey, 2005. Jeeves, A.H. 'Health, Surveillance and Community: South Africa's Experiment with Medical Reform in the 1940s and 1950s.' *South African Historical Journal*, 43 (2000), pp. 244 – 66. Kark, S and E. Kark, *Promoting Community Health: From Pholela to Jerusalem*. Johannesburg' Witwatersrand University Press, 1999. Kark, S and G. Steuart (eds)

Secondly, HCP historiography recognizes the important role that social medicine could have played in preventing some of the poverty-related diseases when South Africa was reconstructing itself following the formation of the Union of South Africa in 1910. Social medicine constructed health status as a condition that could be affected by social and geographical factors with an emphasis on prevention of illness and health promotion. When the National Health Services Commission (also known as the Gluckman Commission) endorsed the Health Centres as an integral part of its proposed National Health System (NHS), it officially endorsed social medicine principles and promoted access to health care for all irrespective of class and race.<sup>3</sup> De Beer and Jeeves, among others, described the social medicine experiment, including in this experiment both the Gluckman Commission report as well as the work of the Health Centres, as ‘revolutionary’ and ‘decades ahead of its time’.<sup>4</sup>

Finally, the historiography attributes the failure of social medicine to the racist policies of the Afrikaner National Party following its first electoral victory in 1948, but especially once it consolidated its political dominance after the 1953 elections. There was no political urgency during the 1940s to change the health care system by reducing or eliminating the private health care sector and improving the public health care system. In addition, the exploitation of black people served the economic and political needs of the time and therefore, from 1950 onwards, the HCP was steadily ‘starved to death’.<sup>5</sup> One example of the Afrikaner Nationalists fundamental opposition to HCP was that the regime labeled Kark a ‘communist’ because by providing services to black people, the Health Centres ‘undermined Apartheid.’<sup>6</sup> The history of HCP asked important questions and shed light on a period of South Africa’s history that had not received much attention prior to the development of this body of work.

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*A Practice of Social Medicine: A South African Team’s Experiences in Different South African Communities.* Edinburgh; E & S Livingstone, 1962.

<sup>3</sup> 6/344, UG30 – 1944, Report of the National Health Services Commission, 1942 – 1944

<sup>4</sup> Cedric de Beer, *The South African Disease: Apartheid Health and Health Services.* London; Catholic Institute for International Relations, 1986

<sup>5</sup> *ibid.*

<sup>6</sup> Alan Jeeves, ‘Delivering Primary Health Care’ in *South Africa’s 1940s*, eds. Dubow and Jeeves, p. 103

## Research themes and objectives: Gender, politics and HCP

My research considers the role of gender and politics in the way in which Health Centres defined health, identifies which health services were prioritized and the methods employed to deliver those services. This focus is one that has not been covered in the historiography of HCP and as a result, my research expands on what we know about HCP.

The main authors that influenced my thinking about gender were Cheryl Walker's *Women and Gender in Southern Africa to 1945* and Nonboniso Gasa's *Basus/iimbokodo, bawel'imilambo/They remove boulders and cross rivers: Women in South African History*.<sup>7</sup> Both edited versions provide an array of themes that aim to uncover the place of women in South African history and struggles with the contested terrain of gender and feminism in African history. Both these texts describe black women's conditions in pre-capitalist society, in particular Jeff Guy<sup>8</sup>, and how the social position of women as well as the relationships between men and women, were significantly influenced by the introduction of unequal, capitalist development. In addition, Belinda Bozzoli's *Town and Countryside in the Transvaal, Capitalist Penetration and Popular Response* and the chapter by Luli Callinicos entitled 'Testimonies and transitions: Women negotiating the rural and urban in the mid-20<sup>th</sup> century'<sup>9</sup> influenced my understanding of women's experiences under capitalist development in particular the effects of migration for both men and women. In addition to documenting African women's history, these authors, especially Gasa<sup>10</sup>, recognize the contradictions in separating women's practical needs from their strategic needs and therefore, the challenge to historians of African women's history regarding the labels of gender and feminism.

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<sup>7</sup> Cape Town: David Philip and London: James Curry, 1990 and Cape Town: Human Sciences Research Council Press, 2007, respectively.

<sup>8</sup> Jeff Guy, 'Gender and oppression in southern Africa's precapitalist societies' in Walker's *Women and Gender*, 2005, pp. 33 – 47.

<sup>9</sup> Johannesburg: Ravan Press, 1983 and Callinicos' chapter in Gasa's *The remove boulders*, 2005, pp. 153 – 184.

<sup>10</sup> 'Introduction: *Basus/iimbokodo, bawel'imilambo*, new freedoms and new challenges, a continuing dialogue' in Gasa's *They remove boulders*, pp. xiii - xxxvii

Women and gender studies in Africa continue to face critique about gender and feminism as appropriate categories of analysis in order to understand African history and in particular, African women's history. Akosua Adomako Ampofo et al. captures the essence of this debate succinctly when they write that the essence of the 'questions regarding the relevance and application of research on women's and gender studies in Africa is how to name these concepts in ways that would "allow for a collective imagining of the concept"'<sup>11</sup>. Ampofo et al. explains that some scholars identify their work as 'feminist' and so recognizes the relationship between activism and intellectualism in the liberation of women, while many others, in particular male scholars, rejected that term. The terms 'gender' or 'women' are considered more neutral and are also in use. Oyewumi<sup>12</sup> is among the most vocal of this school of thought. Oyewumi argues how feminism and gender are Western imports, rooted in Eurocentrism, which employs, *i.a.*, the nuclear family system with the dominant father, as breadwinner and the subservient mother as oppressed. These analytical tools, according to Oyewumi do not reflect the African reality where, according to her own research, family structures are informed not by the gender identity, but by the age. Thus, this view claims that the use of gender and feminism distorts our understanding of African history.

According to Gasas, however, these debates are necessary and should continue, but they should not detract from the efforts to document African women's history for there is no time when women's practical needs were not strategic, political needs. For this reason, I set out to ask how HCP and men and women, respectively interacted with each other and also, how HCP affected the relationship between men and women. My own view is, in line with Gasas, that gender, feminism and patriarchy are all useful terms that can be used to describe the black women and black men's experiences under HCP.

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<sup>11</sup> Ampofo, Akosua; Josephine Beoku-Betts and Mary Osirim 'Women's and Gender Studies in English-Speaking Sub-Saharan Africa. A Review of Research in the Social Sciences' *Gender and Society* (18/6, December 2004), p. 688

<sup>12</sup> Oyeronke Oyewumi. 'Conceptualizing Gender in African Studies' in *The Study of Africa. Volume 1, Disciplinary and Interdisciplinary Encounters*. Paul T. Zeleza (ed), Dakar, Senegal: Council for the Development of Social Science Research in Africa, 2006

The second aspect of my research examined the politics of HCP, specifically, how HCP operated as an ‘anti-politics machine’. For this theme, I used mainly James Ferguson and to a lesser extent, Diana Wylie.<sup>13</sup> While historians investigated the connections between the closure of HCP and the Afrikaner nationalist party’s politics, I investigate the ways in which HCP were already connected to white racist, patriarchal politics and what the implications were of these political connections. Wylie’s research investigated the ways in which people who explained the existence of twentieth-century South African poverty, in particular, hunger. According to Wylie, the ‘experts struggled to frame a powerful and coherent argument linking popular nutrition, national well-being and ethics. They were using science to make moral claims that in an earlier age would have been the work of religion. Well-intentioned people, they did sometimes endorse ideas that had damaging effects on African Welfare, even while they provided the service of documenting social suffering.’<sup>14</sup> Ferguson, similarly, investigates the complex questions about development projects that profess to be apolitical yet, have serious political consequences. In many respects, Ferguson’s work does not deal with binary opposites of white racists and oppressed black people, the context of South Africa’s 1940s and also the context of Wylie’s research. For Ferguson, the ‘anti-politics machine’ is about the work of political actors whose work, and its politics for that matter, occupy a more complex space

### **HCP and Gender roles and relations**

For this enquiry, the focus was the relationship between black women and HCP; between black men and HCP; and also how HCP affected the relationship between men and women. The response to these questions covers a number of themes. Firstly, in terms of the South African race terminology, during the 1940s as well as Apartheid, the racial hierarchy consisted of white, ‘coloured’, i.e. mixed race people, Indian, and African also known as Native or Bantu. In addition, people were also referred to as European, i.e. the white population and non-European, i.e. everyone who was not white. The derogatory nature of these terms meant that during the

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<sup>13</sup> James Ferguson, *The anti-politics machine: “Development,” depoliticization, and bureaucratic power in Lesotho*. (Cambridge: Cambridge University Press, 1990) and Diana Wylie *Starving on a Full Stomach* (Charlottesville and London: University Press of Virginia, 2001)

<sup>14</sup> Wylie, *Starving*, 2001, p. 5

struggle for freedom from minority, white rule, the liberation movements such as the African National Congress (ANC), used the term ‘black people’ to include all oppressed people. The two Health Centres that I used for my research, worked with African and ‘coloured’ people, i.e. Polela and Grassy Park Health Centres respectively. However, I employ the term black people or black women throughout and use ‘coloured’ only where distinction is necessary.

Secondly, in order for my research to comment on the nature of HCP and its response to the gender roles and relations, it was important to understand the pre-Apartheid social conditions such as the consequences of male migration for rural women; the role of women in society and in the home; health and poverty, and the political activism by both black and white people.

### **HCP as ‘anti-politics machine’**

The second main theme concerns the political consequences of HCP and the main question I ask is how HCP advocates constructed a particular discourse about black people’s health that effectively depoliticized health, poverty and the role of the state. For this enquiry, I rely on the work by Ferguson in *The Anti-Politics Machine: “Development”, depoliticization, and bureaucratic power in Lesotho*. Ferguson investigated the ways in which the Thaba-Tsheka development project in Lesotho was constructed as an intervention that was not influenced by the political developments and dynamics within which the project operated. This type of construction of the development project, Ferguson argues, in fact undertook sensitive political work through its very denial of being political. Some of the political consequences of development are ‘unintended’ and were not necessarily incorporated into the plans of the implementers of the development project. Following Ferguson’s approach allows me to investigate the HCP discourse about black people’s health and accepts, as discussed in Chapter four, that HCP could not avoid being political. On the surface, white men providing health services to poor black people, in particular black women in a society constructed on racist principles automatically makes this project political. Therefore, to limit the question related to the failure of HCP to the racist, Afrikaner National Party government does not reflect the complexities of politics and HCP and it is important to ask how HCP was implicated in the dominant, racist political paradigm and, how this relationship contributed to its failure. Using Ferguson’s theory of the ‘anti-politics machine’, Chapter four considers in more detail the complicated relationship between HCP and politics, in

particular how this relationship undermined the supposed gains for black women that HCP aimed to deliver.

## **Methodology**

The above research themes are examined largely through the work conducted at Polela and Grassy Park Health Centres. The main reason for this is that most of the archival records in the Central Archives in Pretoria, South Africa, are records from these two Centres and because of my available resources and time, I only visited the Pretoria depot to conduct the research. During a brief visit to the Cape Town Depot, I found mainly records documenting the communication between the Health Centre Medical Officers, Provincial and National government officials regarding the closure of the Health Centres in the Cape Province. Additional information may well be with the Durban branch of the Archives as the main training centre, the Institute for Family and Community Health (IFCH), was located in Durban. Thus, for this research, I consulted archival records related to Health Centres, communication between Medical Officers and the Department of Public Health, newspaper coverage of, *i.a.*, the Gluckman Commission's work and interviews with Medical Officers. In addition, I consulted contemporary peer-reviewed publications by Medical Officers and other doctors who worked at various Health Centres.

There is one obvious limitation when the illustrations for my research rely heavily on only two health centres. This limitation is that there is a danger that a distorted view of HCP may emerge. However, I think that the risk of distortion is very small given that Dr. Sydney Kark, the Medical Officer-in-Charge of Polela, was one of the main drivers behind HCP. Therefore, his annual reports, letters, memos, journal articles and other publications used in this research provide a fairly accurate picture of HCP and in particular, for the kinds of questions I posed in this research. However, I acknowledge that this research can be enriched by consulting material for other Health Centres, in particular, the IFCH.

## **Organization of the thesis**

Chapter two provides a context within which to understand HCP. It sets out some of the political and economic factors that shaped the 1940s and 1950s such as the effects of labour migration on women, nature and extent of disease and levels of poverty, a history of social medicine and how this was introduced and understood in South Africa. Finally, this chapter sets out the competing political visions of the Afrikaner and African nationalists as well as the Liberals. The idea of social medicine and by implication HCP, as relevant to South African society in the 1940s is as much a result of international developments regarding the role of the state in a post-war society and the local political developments.

In Chapter three I provide a gender analysis of HCP and as stated above, pose two questions related to the ways in which the work of the Health Centres and the Medical Officers negotiated gender roles and relations. This Chapter outlines in more detail how HCP operated, i.e. it expands on the definition of health, the kinds of health services that were offered and how the Health Centres provided these services.

Chapter four examines the different ways in which HCP operated as an ‘anti-politics machine’ using, as stated above, James Ferguson’s analysis of the Thaba-Tsheka development project in Lesotho. This chapter explains firstly, the nature of the ‘anti-politics machine’ and how it operated and secondly, how HCP could be understood as an ‘anti-politics machine’. For this latter discussion, I consider the following:

- HCP discourse about black people’s health
- The unintended consequences of HCP: the expansion of state control and the bureaucracy; consolidation of the Department of Health; HCP and black women’s status as second class citizens; and how HCP reproduced the dominant patriarchal, racist politics.

The overall goal of this chapter is to determine whether HCP depoliticized health, poverty and the role of the state in addressing health and poverty; and if so, how did HCP succeed in doing that.

Chapter five is the concluding chapter and here I include, for example, questions for future research.

## **CHAPTER TWO**

### **SOUTH AFRICA'S 1940s AND 1950s: HEALTH CENTRE PRACTICE IN CONTEXT**

politics is “public health in the most profound sense”<sup>15</sup>

#### **Introduction**

During the late 1930s, a number of white liberals such as doctors, bureaucrats and intellectuals developed a health program, later termed South Africa's social medicine experiment, for poor and mainly black people. This social medicine experiment was launched in 1940 on a 'Native Reserve' situated in the rural district of Polela in the province of Natal, when the first Health Centre opened its doors with Dr. Sydney Kark as the Medical Officer-in-Charge and his wife, Dr. Emily Kark as the part-time medical officer. How and why were the Health Centres and social medicine introduced into South Africa? The answer to these two questions requires an understanding of the political and economic arrangements at the time. As a result of successive racist policies and unequal economic development, most black people lived in poor conditions that helped with the spread of disease. Then, during the Second World war, rival political actors imagined a postwar society that would not only effectively deal with the poverty and disease, but also create a more just and equitable society. A health care program based on social medicine and implemented through the Health Centres, was a component of one of these competing visions and this chapter traces the steps that facilitated the introduction of social medicine into South Africa.

The first section of this chapter provides an overview of the gendered nature of health and poverty in South Africa during the 1940s and considers some of the economic and political

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<sup>15</sup> Quoted in R. Taylor and A. Rieger. 'A Medicine as social science: Rudolph Virchow on the typhus epidemic in Upper Silesia' (*International Journal of Health Services: planning, administration, evaluation*, 15/4, (1985), pp. 547 - 59

developments that produced these specific conditions. The next section will consider some of the international and domestic events during the late 1930s and early 1940s that shaped the competing political visions of a more just and equitable society. Finally, this chapter illustrates how social medicine was introduced into South Africa and provides insight into the political connections of some of the key role players who were involved in that process.

## **Poverty, health and gender**

By the 1940s, the majority of South Africans, i.e. black people, lived in poverty and suffered the health consequences flowing from poor conditions.<sup>16</sup> Most black people in the rural areas either lived on the ‘reserves’ or on white owned farms. The 1913 Land Act created the ‘reserves’ when it allocated 13 per cent of the land to black people, which comprised more than eighty percent of the total population. The overcrowded conditions that existed since the inception of the ‘reserves’ became worse especially when the implementation of the 1936 Native Land and Trust Act was delayed. This latter Act purported to increase the land available for the ‘reserves’, but the objections of white farmers caused government to postpone the date on which the provisions of the Act would become effective. The overcrowded conditions together with overstocking and natural disasters, such as droughts, severely compromised the main form of livelihood on the ‘reserves’, i.e. subsistence agriculture. As a result, the people on the ‘reserves’, i.e. mainly women, children and older men, became more dependent on remittances.<sup>17</sup> Family members,

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<sup>16</sup> Shula Marks and Neil Andersson “Apartheid and Health in the 1980s” *Social Science Medicine*, 27/7 (1988), pp. 667 – 681. Marks and Andersson trace the nature and effect of the economic and political policies that followed the discovery of minerals during the last half of the nineteenth century.

<sup>17</sup> The history of migration in South Africa is well documented. See for example Jonathan Crush, Alan Jeeves and David Yudelman *South Africa’s labor empire: a history of black migrancy to the gold mines*. (Boulder, Colorado: Westview Press, 1991); Anne Mager “Migrancy, marriage and family in the Ciskei reserve of South Africa, 1945 – 1959” in *Women, gender, and labour migration: historical and global perspectives*, ed. Pamela Sharpe (London and New York: Routledge, 2001), pp. 259 - 274; David A. McDonald, D.A., ed. *On borders: perspectives on international migration in southern Africa*. (New York: St. Martin’s Press, 2000); William Beinart, *Twentieth-century South Africa* (Oxford and New York: Oxford University Press, 1994); Deborah Posel, *The Making of Apartheid, 1948 – 1961*. Oxford: Clarendon Press, 1991, pp. 27 – 28 and John Iliffe, *The African Poor, A History*. Cambridge: Cambridge University, 1987, p. 123 discuss the issue of remittances.

chiefly men, who worked in urban centres, on the mines or on white owned farms surrounding the 'reserves', sent cash to their families in the rural areas initially as a supplement, and later as a form of survival.

Cash became increasingly important for people on the 'reserves' and Sean Redding illustrated the factors that prompted the transition to a cash economy.<sup>18</sup> People needed cash not only to supplement food rations, but they also bought clothing and utensils, paid school fees and church membership and more importantly, paid their hut taxes to the state. The question of taxes became increasingly women's responsibility. Women were the *de facto* heads of the rural household and were thus responsible for the payment of hut taxes even though they had no legal rights to own the property. The survival of women and children on the 'reserves' depended on acquiring cash.

In spite of this dependence on cash, the women did not always receive remittances and when they did, it was not always sufficient. There were at least two reasons for this situation the first being that workers generally earned low wages even during the early part of the 1940s when there was an increase in wages as a result of a booming wartime economy. (See below). The second reason was that some men acquired a second wife or family while working away from their rural home and thus had less money to remit to their rural home. By 1940, people on the 'reserves' were particularly desperate by the time the Gluckman Commission Report officially endorsed the Health Centres

The conditions for black people and particularly black women on the white owned farms were not any better than on the 'reserves'. Before the 1913 Land Act most black people on white owned farms were either cash tenants or sharecroppers. This status afforded them some bargaining power because they could generate cash without necessarily working for the owner of the farm on which they resided. However, the 1913 Land Act largely outlawed this practice and afforded black farm workers the status of labour tenants making them totally dependent on the farm

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<sup>18</sup> Redding, S 'Witchcraft, Women, and Taxes in the Transkei, South Africa, 1930 – 1963' in C. Higgs, B. Moss and E.R. Ferguson (eds.) *Stepping Forward* and 'Legal Minors and Social Children: Rural African Women and Taxation in the Transkei, South Africa' *African Studies Review*, Vol. 36, No. 3, (December 1993), pp. 49 - 74

owners. Labour tenants worked on the farm for an extended period, up to six months according to the 1932 Native Services Contract Act, in return for the right to plant crops and graze cattle on a portion of the farm. In addition, any female or juvenile dependent could be contracted to the farmer. The fact that farm workers and their dependents, including women, could only leave the farm with the farmer's written permission, entrenched the control of the farm owners over his workers.<sup>19</sup> The extended working period did not improve the poor living conditions: farm workers received no wages; they occupied inferior plots and were allowed only one day per week to cultivate their own plots. By the 1940s, black people lived in 'semi-slave like conditions on the farms' and women were dependent on the male farm owner and their husbands or fathers.<sup>20</sup>

Against this rural background, the cities were constructed as spaces of opportunities and some freedom from poverty and disease. While the possibility of earning a higher wage was real, conditions were not much different than those that were prevalent in the rural areas. People lived in overcrowded conditions, earned wages that were too low to sustain life in the city as well as support a rural family. In the informal settlements, people had no or little access to basic services such as housing, clean water and refuse removal. For example, the 1923 Native (Urban Areas) Act mandated local municipalities to provide accommodation and basic services such as housing and clean water, to black people within their boundaries however, these provisions were never enforced. Consequently, many black people crowded into backyard shacks and according to official estimates, which Posel suggests may be an underestimate, at least 58 per cent of the urban African population were squatters who had no access to approved, serviced accommodation.<sup>21</sup>

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<sup>19</sup> Iliffe, J *The African Poor*, 1987, p. 120

<sup>20</sup> Callinicos 'Testimonies and Transitions' in Gasa (ed), *Basus/iimbokodo, bawel'imilambo/They remove boulders and cross rivers Women in South African History* (Cape Town: Human Sciences Research Council Press, 2007), p. 174

<sup>21</sup> Posel, *Making of Apartheid*, p. 33 – 34. For the 1923 Native (Urban Areas) Act. For a discussion on the pass laws and the 1923 Act that afforded black people temporary residential rights in white urban areas and only if their labour was required in that specific urban area, see Posel's *Making of Apartheid* and Nicoli Natrass, 'Economic growth and Transformation in the 1940s' in *South Africa's 1940: A world of Possibilities*, eds. Saul Dubow and Alan Jeeves (Cape Town: Double Storey, 2005), p. 26. Ellen Hellmann's *Rooiyard, a sociological survey of an urban native slum yard* (Cape Town Cape Town: Oxford

Numerous surveys and government commissions confirmed that low wages was the main cause of the widespread poverty.<sup>22</sup> For example, a 1938-9 survey conducted by Dr. Edward Batson on behalf of the Department of Health, found that 53 per cent of the 'colored' people and 48 per cent of 'Africans' in the city of Cape Town lived below the poverty datum line largely as a result of low wages.<sup>23</sup> The 1944 Commission of Inquiry into the Operation of Bus Services for Non-Europeans found, *inter alia*, that many black workers in 1940 were unable to 'meet minimum requirements of subsistence, health and decency'<sup>24</sup>. The social conditions of black people as outlined above affected all black people, but particularly black women because they were socially and economically marginalized.

The situation was vastly different for white women, who faced poverty-related hardships about a decade earlier and had, by the 1940s, recovered. By this time, white poverty was largely eradicated as white men moved into professional jobs and white women shunned the factory jobs that they occupied before and during the war. About a decade earlier the *Carnegie Commission of Investigation on the Poor White Question* recorded the extent of white poverty.<sup>25</sup> This situation

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University Press for Rhodes Livingstone Institute, Livingstone, Northern Rhodesia, 1948) discusses, in minute detail, a slum area that existed during the 1930s, about two kilometers from central Johannesburg.

<sup>22</sup> See for example Iliffe, *The African Poor*, pp. 114 – 142 and Adam Ashforth, *The Politics of Official Discourse in Twentieth Century* (Oxford and New York: Oxford University Press, 1990). Ashforth examines in great detail the role of Government Commissions in relation to the 'Native Question'.

<sup>23</sup> Iliffe, J, *The African Poor*, 1987, p. 139. Dr. Batson's survey was part of a national survey, i.e. the South African Bantu (African) Schoolchildren Nutrition and Health Survey conducted between September 1938 and September 1939. It included 7 000 children from across the country and Drs. Sydney Kark and Harding le Rich were also part of the survey. Both Kark and Harding became Medical Officers-in-Charge of Health Centre with Kark as the founding Medical Officer-in-Charge of Polela Health Centre.

<sup>24</sup> Cited in Posel *The Making of Apartheid*. 1991, p. 32. See also Iliffe, *The African Poor*, 1987 and Hellman, *Rooiyard*, 1948.

<sup>25</sup> Interestingly, the Carnegie Commission found that the main source of white poverty was that poor whites earned a wage that was too low to maintain a white standard of living. See Iliffe, J, *The African Poor* and Susanne Klausen, *Race, maternity, and the politics of birth control in South Africa, 1910 – 1939*. London: Palgrave Macmillan, 2005

further deteriorated once the full effects of the Great Depression set in. Many white women left the farms to find employment in the cities so as to support their families<sup>26</sup>. The dramatic increase in the membership of the Garment Workers' Union during the 1920s and 1930s is but one illustration of this phenomenon.<sup>27</sup> The decline however, of white poverty came as a result of a number of factors, but mainly because of the state's interventionist role. For example, following the findings of the Carnegie Commission and the Cape Town General Board of Aid surveys<sup>28</sup>, the state formed the Department of Welfare as a division of the Department of Labour in 1933. Its overall function was to coordinate and provide welfare services mainly to whites. This Department expanded and by 1937 became an autonomous government department. The state also adopted racially based economic policies in order to advance white people, for instance, skilled positions were reserved for whites only and while position was suspended during the war, it was reinstated when white men were demobilized. Finally, the fact that white people had the vote was an important motivating factor for state intervention to reduce white poverty. This white voter base was significantly expanded when in 1930; white women and previously excluded white men received the right to vote.<sup>29</sup> The potential power of their vote forced the state to rescue white people from their poverty.

### **The mixed blessings of a wartime economy**

The wartime economy played a critical role in challenging race and gender relations. From an economic perspective, the war produced both positive and negative results. One of the positive consequences for black people, and in particular black women, was an increase in jobs. Black men had access to skilled and semi-skilled jobs from which they were barred prior to the war. This opportunity for black men arose when approximately 200 000 out of 790 000 white men

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<sup>26</sup> Not all white Afrikaners owned farms and some worked and lived as labourers on farms owned by white farmers. It is these white farm labourers who, together with black people, experienced the worst effects of the Depression.

<sup>27</sup> Brink, *Garment workers*, in Bozzoli, pp. 177 - 208

<sup>28</sup> One of the findings of this survey was that many poor whites in the cities were dependent on charity.

<sup>29</sup> See for example, Walker, C. (ed.) *Women and Gender in Southern Africa to 1945*. Cape Town: David Philip, 2005, Posel, D., *The Making of Apartheid 1948 – 1961*. Oxford: Clarendon Press, 1991 and Beinart, *W Twentieth Century South Africa* Oxford and New York: Oxford University Press, 1994.

vacated their jobs in order to join the army.<sup>30</sup> The movement of both black and white men opened new job opportunities for women in particular, black women. For the first time in South African history, employment opportunities in the mainstream economy became available for black women. Most of these women were employed in the fast-growing manufacturing sector. The employment of black people in this sector grew at just under 8 per cent per annum between 1939 and 1945.<sup>31</sup> According to Posel, not all the jobs for black women were unskilled as the Wage Board's records for the 1930s and 1940s indicated that a number of black women were employed in skilled positions.<sup>32</sup>

Another positive result of the war was the relaxation of some of the repressive laws. The need for jobs caused an increase in migration of black people from the rural areas into towns and also migration between towns. Wartime emergency regulations not only permitted black workers to take up skilled employment, but it also allowed black people unrestricted movement into and between towns. Between 1936 and 1946 the presence of African women in the towns increased by 79.95 per cent as opposed to the 46.80 per cent of African men.<sup>33</sup> Thus, a combination of rural-urban migration and the economy's need for workers resulted in a relaxation of the legislative measures that were introduced as early as 1923 and restricted the movement of black people into urban areas.<sup>34</sup> Thus, during the Second World War, more black people received jobs and they were free to move into the urban centres from the rural areas as well as between urban centres.

There were also a number of adverse consequences for black people that affected their relationship with the state. Firstly, as a result of food scarcity the state introduced food rations. People, who already experienced problems accessing food prior to the war, had a much harder

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<sup>30</sup> Natrass, *Economic Growth*, p. 24 – 26

<sup>31</sup> Natrass, *Economic growth*, p. 25

<sup>32</sup>. See Posel, *The Making of Apartheid. 1991*. Unfortunately, Posel did not provide any details such as the definition of 'skilled' employment or examples of the kind of work these women performed.

<sup>33</sup> Posel, *The Making of Apartheid*, 1991, p. 24

<sup>34</sup> According to Natrass, the 1923 Native (Urban Areas) Act afforded black people temporary residential rights in white urban areas and only if their labour was required in that specific urban area. See also Posel's *Making of Apartheid*, for a review of the pass laws, also referred to as influx control measures.

time securing food during the war. For example, the Cape Times reported long queues of women waiting for food rations.<sup>35</sup> Secondly, the state used their authority to adopt emergency regulations and introduced restrictions on workers' rights. One of these emergency regulations was War Measure 1425, which expressly prohibited black workers from organizing. In response, however, over 70,000 black mineworkers went on strike and they demanded an increase in wages and an end to restrictions on their rights. The state responded with force and a number of strikers died. In fact, a total of 304 strikes took place between 1939 and 1946. These included workers' strikes, but also comprised local community protests such as the bus boycotts in Alexandra, outside Johannesburg, initiated because of an increase in bus fares; and squatter movements who protested, *i.a.*, overcrowded living conditions.<sup>36</sup> As a result of the war, the state relaxed some of its pre-war race-based restrictions, but at the same time, it enforced others to the extent that black people found the space to demonstrate their opposition to state policies and neglect, severely limited.

The positive changes introduced as a result of the war also posed a challenge, for example, the incorporation of women into the formal economy created anxieties about women's roles in society and the relationships between men and women. Prior to the war, employment for women was generally organized in and around their homes where they continued to fulfill their role as mothers and wives. In the rural areas, women engaged in subsistence farming and in the towns, both black and white women had more employment opportunities in the informal sector. Black women generally brewed beer or took in laundry while white women took in borders and sewed. A number of women, however, worked as domestic workers or as prostitutes.<sup>37</sup> During the war, however, manufacturing jobs took women into public spaces. As discussed above, more black women migrated to the large cities as opposed to smaller country towns. While women were no

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<sup>35</sup> DATE

<sup>36</sup> Posel, *Making of Apartheid*, p. 35. See also, Davenport and Saunders, *South Africa: A modern history*, 5<sup>th</sup> edition, 2000, pp. 355 – 361

<sup>37</sup> Bradford, H., 'We are now the men' in Bozzoli *Class, Community and Conflict*, 292- 322 and Jochelson, K., *The Colour of Disease* 2001, pp. 93 – 110. Catherine Coquery-Vidrovitch, *African Women: A Modern History*, trans. Beth Gillian Raps (Boulder, Colorado: Westview Press, 1997) pp. 119 - 120

longer bound to the home and thus, confined to the role of mother, wife or daughter, the choices were not as straightforward for the women or the men.<sup>38</sup>

The story of Mpelilape Martha Masina, documented by Callinicos,<sup>39</sup> is illustrative of the challenges women faced and how they were forced to react to or escape the rigours of patriarchy. Masina and the rest of her family members were labour tenants and the parents depended on the children, including Masina, to provide labour to the white farm owner in order to remain on the farm. Masina's brothers worked as farm labourers and she and her sister were domestic workers. The family barely survived. Masina recalled how she and her sister 'protested that they were missing school, and even though they worked every day (even on Sundays when they worked in the family field) they had no clothes. They were dressed in sacks, which their mother had hand-stitched for them.'<sup>40</sup> Masina, like many black women in a similar position decided to disobey her father and the white male farmer in order to give her family a fighting chance. She left secretly at three o'clock in the morning without the farmer's permission and did not inform her parents of her plans even though she was aware of the fact that she was placing her family's livelihood at risk.

Essentially, the wartime economy yielded mixed blessings for black people. It opened up new opportunities, but it also exposed the dual nature of the state. From an economic perspective, the war did not result in any fundamental change in the social and economic positions of black women. In fact, most of the wartime economic gains such as relaxation of repressive laws and decrease in the wage gap were reversed from 1946 onwards. In addition, the influx into towns by more black people to seek employment did not lead to improvement in housing or other basic services. What is significant for the question explored by this research is the fact that the health consequences of poor living conditions that existed before the war were merely exacerbated.

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<sup>38</sup> See for example Jochelson, Walker

<sup>39</sup> Callinicos 'Testimonies and Transitions' in Gasa (ed) *They remove boulders and cross rivers*, 2007, pp. 154 – 156. Sean Redding 'South African Women and Migration in Umtata, Transkei, 1880 – 1935' in *Courtyards, Markets, City Streets. Urban Women in Africa*, ed. Kathleen Sheldon. Boulder, Colorado: Westview Press, 1996, pp. 31 - 46

<sup>40</sup> Callinicos 'Testimonies and Transitions' in Gasa (ed), 2007, pp. 154 – 158. Masina's testimony describes how they work long hours and have health workloads and yet, the entire family barely survives.

## **Disease and a dysfunctional health care system**

A combination of overcrowding and poor living conditions as well as the migrant labour system was the cause of widespread diseases with tuberculosis (TB) and malnutrition-related diseases as the most common. TB was rife among mineworkers and both the mining companies and the state implemented various steps to control it.<sup>41</sup> The strategy of choice was to send miners back to the 'reserves' on the basis that this was their natural environment and that the conditions on the 'reserves' would help the miners recover. According to Packard, this misconception of the 'healthy reserve' continued even when conditions on the 'reserves' had already deteriorated and could no longer be considered healthy.<sup>42</sup> One of the adverse results of the repatriation of male mineworkers with TB was that many women and children, who were on the periphery of capitalist expansion, became directly affected by one of the most serious consequences of that expansion. Others, who were exposed to TB and did not work on the mines, were those in the urban slums and squatter areas – also experiencing over crowded and unhygienic conditions.

Labour migration also affected the relationship between men and women in ways that had significant health consequences. Firstly, the men and women acquired new roles in relation to the family and the maintenance of the household as a result of extended absences by men. Women became the *de facto* heads of the household. They raised children; gathered wood; cooked; cleaned the house; did the laundry; plowed the land; cultivated and harvested the crops as well as took care of the animals, if they owned any. Women also became the primary decision-makers. For men, this change challenged their position as the final authority in relation to family matters and the household and caused a strain in their relationship with their wives and their children.

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<sup>41</sup> Coovadia, H.M and Benatar, S. R. *A Century of Tuberculosis: South African Perspectives*. Cape Town: Oxford University Press, 1991. Crush et al, *South Africa's labor empire*. Marks, S. 'The Silent Scourge? Silicosis, Respiratory Disease and Gold-Mining in South Africa', *Journal of Ethnic and Migration Studies*, Vol. 32, No. 4, May 2006, pp. 569 – 589. Packard, R. *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa*. Berkeley and Los Angeles: University of California Press, 1989.

<sup>42</sup> Packard, *White Plague, Black Labour*, PAGE

Secondly, the long periods of separation disrupted a couple's sexual relationship and men entered new relationships in the towns, or got married as part of a polygynous relationship. Many men also engaged in sexual relationships with prostitutes. As discussed in Chapter three, women on the 'reserves' also entered sexual relationships when their husbands were away.<sup>43</sup>

The health consequences of these changes included depression, anxiety and feelings of bewitchment and alcoholism, which often resulted in physical violence between husbands and wives.<sup>44</sup> Common physical and mental complaints in women were generalized body pains, headache, abdominal pains, diarrhea and marked fatigue, acute and chronic gynaecological disorders, stillbirths, depression and health complications following unsuccessful abortions.<sup>45</sup> In addition, women experienced high rates of maternal deaths and stillbirths. Both men and women became infected with sexually transmitted diseases such as syphilis and gonorrhoea.<sup>46</sup>

Signs of malnutrition were obvious in infants and young school children such as stunting growth, pellagra and kwashiorkor. Other diseases linked to poor diet and unhygienic conditions that were prevalent included high infant mortality rates, typhoid, malaria, small pox, typhus, leprosy and impetigo.<sup>47</sup>

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<sup>43</sup> See Jochelson, op cit. note 20. Catherine Coquery-Vidrovitch, *African Women*. (Boulder, Colorado: Westview Press, 1997) and Sean Redding

<sup>44</sup> Sidney Kark and Emily Kark, *Promoting Community Health: From Pholela to Jerusalem*. Johannesburg: Witwatersrand University Press, 1999, pp. 31, 64, 101 and 61. See also Helen Bradford, 'Herbes, Knives and Plastic: 150 Years of Abortion in South Africa' in *Science, Medicine and Cultural Imperialism*, eds. Teresa Meade and Mark Walker, New York: St. Martin Press, 1991, pp. 120 – 147; Klausen, *Race, maternity*, 2005; Sydney Kark and Guy Steuart (eds), *A Practice of Social Medicine: A South African Team's Experience in Different South African Communities*. Edinburgh: E & S Livingstone, 1962, p. 298 and Jonathan Crush and C. Amber, eds. *Liquor and labor in Southern Africa*, Athens, Ohio: Ohio University Press, 1992.

<sup>45</sup>. See also

<sup>46</sup> Op cit. note 20

<sup>47</sup> Kark et al, *Promoting Community Health*, p. 21 Bozzoli, *Class, Community and Conflict*, pp. 117 and 305

The health system was unable to respond effectively to all the health problems listed above and the National Health Services Commission, hereafter the Gluckman Commission, the first to conduct an extensive evaluation of the entire system, officially exposed the weaknesses in the system. In his parliamentary motivation for the establishment of a commission of enquiry, Liberal Party Member of Parliament (MP) Dr. Henry Gluckman said that ‘the majority of people are deprived of the advantages of modern medical services. The services rendered [were] determined not by the individual’s susceptibility to disease, but by his ability to pay. Members of the medical profession are compelled, under present system to practice for gain and are said to have a vested interest in disease. In the reserves... the existing medical and health services are entirely inadequate for the needs of the 3 000 000 people living there. The majority of the 3 000 000 people in the urban areas are unable to make adequate provision for medical services during times of illness and have to bear the full brunt of medical, surgical and hospital expense’.<sup>48</sup> Based on this motion, the South African Parliament agreed to an enquiry and in 1942 the Gluckman Commission was officially launched. The Gluckman Commission conducted its work between 1942 and 1944, during which time the Commission traveled across country and received both written and oral submissions. In brief, this commission was mandated to ‘investigate and recommend the best measures to be adopted for ensuring adequate health services for all sections of the population of the Union of South Africa’. It found that there were unacceptably high levels of disease largely as a result of social and economic conditions, and that health services were generally inadequate, fragmented and misdirected.

A major weakness of the health system was its disorganization and how the state failed to improve its management of health services. Different spheres of government were responsible for various components of the public health system. Local Authorities were responsible for environmental health and together with the Union Department of Health, dealt with the spread of infectious diseases. The Provincial Administrations controlled hospitals, school health programs and medical assistance to the poor. Private institutions such as mine hospitals, mission hospitals and charity organizations were also involved in the provision of health care. Doctors in private

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<sup>48</sup>The National Health Services Commission (also known as the Gluckman Commission), 1944 quoted in de Beer, Cedric, *The South African Disease: Apartheid Health and Health Services*. London: Catholic Institute for International Relations, London: Catholic Institute for International Relations, 1986, p. 15

practice were responsible for the greatest share of health care delivery.<sup>49</sup> While the Gluckman Commission did not discuss this aspect in detail, many black people continued to use traditional healers, or *izinyangas*, either as their primary health care provider or where available, they consulted both traditional healers and western-trained medical doctors.<sup>50</sup> The uneven access to health services no doubt, contributed to the spread of disease. Black people, because of their lack of citizenship and disenfranchisement, had no effective voice to demand that the state provide them with basic services including health care.

### **Political visions of a just, post-war society**

The ‘liberal interregnum’ of the early 1940s is considered a time when, according to the contributors in *South Africa’s 1940s: A world of possibilities*, radical social transformation, or at least the idea thereof, was possible.<sup>51</sup> During this time period, there was a pronounced need to find lasting political solutions for a ‘society in crisis’,<sup>52</sup> of which the health care system was but one crisis. Thus, between 1937 and 1945 a number of international and domestic developments inspired various sections of the South African society to articulate their version of that more

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<sup>49</sup> The work of mission hospitals is well documented. In his paper on a health program for the ‘Native Reserves’, Dr. Harry Gear, the Deputy Chief Health Officer for the Union during the late 1930s, recognized the success of the mission hospitals as they were the only services that were consistently available and accessible to black people, particularly in the rural areas. See Gear, H.S. ‘The South African native Health and Medical Services’, *South African Medical Journal*, 1943, Vol. 17, pp. 107 - 168

<sup>50</sup> Report of the National Health Services Commission, 1942 – 1944, UG30 – 1944. Gluckman did not recognize that the Traditional Healers could contribute positively to a new health care system as this form of health care was ‘backwards’ and contrary to modernity, or the ‘modern concept of health’.

<sup>51</sup> Dubow, S and Jeeves, A. (eds.) *South Africa’s 1940s: Worlds of Possibilities* Cape Town: Double Storey, 2005. Natrass’ chapter entitled ‘Economic Growth and Transformation in the 1940s’ in this edition, employs the term “liberal interregnum” (p. 36)

<sup>52</sup> De Beer, *The South African Disease*, p. 25. For example, the 1923 Native (Urban Areas) Act mandated municipalities to provide basic services to black people, services that would have gone along way to prevent disease. However, the municipalities were too overwhelmed by the demand for services and in some instances, actively neglected their responsibilities. See for example, Callinicos ‘Testimonies and Transitions’ in Gasa (ed), *They remove boulders and cross rivers*, 2007

equitable and just postwar society. On the international front there were two public policy developments in New Zealand and Britain, respectively, which influenced debates in South Africa. The domestic developments that proved significant were the consequences of South Africa's participation in the war and the Gluckman Commission report (referred to above).

While SA was no longer a British colony, it was very much aware of and inspired by developments in the British Empire.<sup>53</sup> In 1938 the Labour government in New Zealand adopted far-reaching social welfare reforms when it introduced universal old age pension.<sup>54</sup> This nascent welfare regime, officially implemented through the 1939 Social Security Act, was later extended to include state assistance to widows without children, deserted wives, invalids, the sick and the unemployed. The notion of social welfare appealed to some of the Members of Parliament (MP) in South Africa, who visited New Zealand and on their return, a Labour Party MP urged the South African government to follow the New Zealand example.<sup>55</sup>

Another important international public policy development was the publication of the Beveridge Report, i.e. the *Report on Social Insurance and Allied Services*, in Britain in 1942. The mandate of the Beveridge Commission was to investigate and make recommendations in relation to the 'five great evils'<sup>56</sup> of society, i.e. physical want (or poverty), disease, ignorance, squalor (or inadequate shelter) and idleness'. The South Africans found the findings of the Beveridge Commission appealing as it came in the wake of the Great Depression and while the devastation of the Second World War was unfolding.

Thus, in South Africa, the Beveridge Report influenced the work of the Committee on Social Security and, much like the public policy developments in New Zealand; MPs cited this Report in

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<sup>53</sup> Klausen, S. *Race, maternity, and the politics of birth control in South Africa, 1910 – 1939*. London: Palgrave Macmillan, 2005. Klausen deals with the influence of British thought and developments on the Department of Health in South Africa. Seekings, J considers the British influence on welfare in 'Visions, Hopes and Views about the Future: The Radical Moment of South African Welfare Reform' in Dubow, S and Jeeves, A. (eds.) *South Africa's 1940*, 2005, pp. 44 – 63.

<sup>54</sup> Seekings 'Visions, Hopes and Views' in Dubow and Jeeves (eds.), 2005, p. 51

<sup>55</sup> Ibid. (pp. 50 – 51)

<sup>56</sup> Op cit, note 41

public debates. For example, D.F. Malan<sup>57</sup>, a staunch Afrikaner nationalist who founded the *Gesuiwerde* (purified) National Party, introduced a motion in parliament calling for a ‘speedy and radical reconstruction’ of South Africa’s social security system. His motion further requested state – sponsored social security benefits for every individual and called for the equal distribution of the country’s wealth<sup>58</sup>. However, because of his political interests, Malan’s motion was rather a ‘Beveridge for the Boers’ according to Dubow and Jeeves.<sup>59</sup> In addition, the Beveridge Report influenced the findings of the Industrial and Agricultural Commission (IARC) of 1940 and the Social and Economic Planning Council (SEPC), launched in 1942. According to Natrass, both of these bodies advocated for an improvement of social welfare through improved and sub-economic housing, free medical services and subsidies of food.<sup>60</sup> Unlike Malan, however, the IARC and the SEPC were particularly broad in their conception and included black people in their recommendations. This significant influence of the Beveridge Report illustrates that the idea for a welfare state was not unique to South Africa. Furthermore, there were individuals in South Africa, and specifically individuals with some political authority, who were in favor of social welfare reform and relied on international developments to inform their notion that a welfare state would bring about greater equality and deal with the consequences of poverty including disease.

On the domestic front, there were two important political consequences of the Second World War that inspired the political visions for an equitable and just South Africa. Both the African and Afrikaner nationalists used these events to formulate what was essentially opposing visions of a society based on the principles of, *i.a.*, justice and equality. A number of white liberals presented an alternative to the two nationalist perspectives. While all of these competing visions were chiefly inspired by the same economic and political developments during the war, each these constituencies advanced their own ideology and cause.

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<sup>57</sup> Beinart, *Twentieth-century South Africa*, 1994. p. 114

<sup>58</sup> Dubow and Jeeves, ‘Introduction’ in Dubow and Jeeves (eds.), 2005, pp. 6 - 7

<sup>59</sup> Ibid.

<sup>60</sup> Natrass ‘Economic Growth’ in Dubow and Jeeves (eds.), 2005, pp. 20 – 43.

African nationalists, led mainly by the African National Congress (ANC)<sup>61</sup>, envisioned a society where black people enjoyed full political citizenship as a right and not a privilege. Interestingly enough, some Africanists, such as Herbert Dhlomo called for freedom from both white domination and paternalism.<sup>62</sup> Internally, the ANC Youth League, revived during the 1940s, was instrumental in setting this new African nationalist agenda within the ANC and thus caused a change in the way in which the ANC practice politics.<sup>63</sup> The relaxation of some of the repressive regulations during the war and the state's violent retaliation to black protests, were two domestic developments that inspired the Africanists. From an international perspective, the 1941 Atlantic Charter, an agreement, which contained principles for a post-war democratic world, also inspired the Africanists to advocate for democracy in South Africa. They drafted the African Claims in 1943, which contained a rights-based, social vision and included concrete demands such as economic reform, land redistribution, health and education services to all based on need not race or class.<sup>64</sup> The Communist Party contributed to the vision of the Africanists' agenda through their demands for better housing and living conditions.<sup>65</sup>

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<sup>61</sup> The ANC was the main liberation movement in South Africa and considered itself as an umbrella organization for all those opposing white minority rule. See, among other: Dubow, S *The African National Congress* Stroud: Sutton, 2000 and McKinley, D. T., *The ANC and the liberation struggle: a critical political biography*. London and Chicago, Ill.: Pluto Press, 1997

<sup>62</sup> Dubow and Jeeves "Introduction" in *World of Possibilities*, p. 5. See also Paul Rich. *White power and the liberal conscience: Racial Segregation and South African liberalism 1921 – 1960*. Manchester: Manchester University Press, 1984. Rich deals, *i.a.*, with the role of white liberals in African nationalist politics and how the latter responded to white liberalism from 1921 until 1960.

<sup>63</sup> Edgar, P. 'Changing of the Old Guard: A.P. Mda and the ANC Youth League, 1944 – 1949' in Dubow and Jeeves, *World of Possibilities*, 2005, pp. 149 – 169. See also Gish, S. *Alfred B. Xuma: African, American, South African*. New York: New York University Press, 2000. Prior to this, the ANC under the leadership of Dr. Xuma adopted a more cautious approach often working for change with an agenda set by white liberals.

<sup>64</sup> van Niekerk, R, 'The Evolution of Health and Welfare Policies in South Africa: Inherited Institutions, Fiscal Restraint, and the Deracialization of Social Policy in the Post-Apartheid Era' *Journal of African American history*, 2003, Vol. 88, Issue 4, pp. 361 - 376

<sup>65</sup> Iliffe, J *The African Poor*, 1987, p.

The Afrikaner nationalists constructed a very different vision of an equitable society, specifically, one based on race and separate development. The war highlighted the sharp divisions within the white community. Beinart and others note that the decision to go to war specifically on the side of the British was particularly controversial. The Afrikaner nationalist opposed an alliance with Britain. A significant number of Afrikaners fostered fascist sentiments and identified with the white supremacist nationalist sentiments within Germany, versions of which they practiced at home. This constituency would have preferred to support Nazi Germany in the war. In addition, this same constituency disapproved of British liberalism, the effects of which they saw in the ex-British colonies of the Cape and Natal. While the British governed these colonies, there was considerable 'tolerance' for black people the most evident of which was the qualified voting rights afforded to black men. While the effects of this liberal British rule were only brought to an acceptable conclusion for the Afrikaner nationalist in 1936 when, all black people were removed from the common voters' roll, they feared an alliance with the British may reintroduce legislative recognition of black people.<sup>66</sup> The wartime concessions, discussed above, did not do much to allay Afrikaner concerns. The lawyer Ellison Kahn's contemporaneous observation provides insight into the way in which Afrikaners could have arrived at this conclusion. Kahn wrote, 'it may be imagined that the old Cape liberal spirit is in the process of re-birth [and] that a war-time neo-liberalism is waxing.'<sup>67</sup> Thus, wartime economic changes created political anxieties for white Afrikaner nationalists and they used this situation to consolidate Afrikaner nationalism as a mandate around which to organize.

Alongside these opposing visions of a more just and equitable South Africa was a third option promoted largely by white liberals and can, according to Dubow and Jeeves, be labeled social democratic in nature. A central theme that permeated liberal politics during the early part of the twentieth century was the notion of respect for black people as human beings and recognition of co-existence between black and white people. They applied these principles in South Africa through the promotion of separate, but equal development, of race groups.<sup>68</sup> A central political

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<sup>66</sup> The 1936: the Representation of Natives Act

<sup>67</sup> Natrass in Dubow and Jeeves (2005), p. 37.

<sup>68</sup> Rich, *White power*, 1984 and Saul Dubow. *Racial Segregation and the Origins of Apartheid in South Africa, 1919 – 36* London: Macmillan Press in association with St. Anthony's College Oxford, 1989

figure in liberal politics during the 1940s was Dr. Jan Hofmeyr, initially Minister of Social Welfare and later during the war, Minister of Finance. Hofmeyr used his political position and diverted public funds to social services for black people. For example, he inspired and funded the 1938 - 9 National Nutrition Survey that measured the health status of black people.<sup>69</sup> Liberal politics about race was, however ambiguous about the status of black people and in particular, the extent to which the latter should enjoy political rights. For example, during debates regarding the Native Representative Bill, which eventually disenfranchised all black people by removing those black men from the common voters' role, some liberals concluded that black people were not ready for full democracy and promoted a compromise position whereby white people would represent black people in parliament.<sup>70</sup> In addition, a number of liberals supported the Native Trust and Land Act and considered it as an opportunity to introduce economic development on the 'reserves'.<sup>71</sup>

In general, the social democratic nature of the liberal vision was shaped by in the dominant racial ideology and so favored social upliftment of black people as opposed to full citizenship with political rights.<sup>72</sup> This kind of vision was in line with a long liberal tradition of 'paternal concern and rescue and welfare work to alleviate hardships of city life'. It also draws on the missionary idea of 'social upliftment through values of hard work and self help'.<sup>73</sup>

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<sup>69</sup> Kark et al, 2005. p.

<sup>70</sup> Catherine Higgs, *The Ghost of Equality: The Public Lives of D.D.T. Jabavu of South Africa, 1885 – 1995*, Athens, Ohio: Ohio University Press, 1997. Rich, P *White power*. 1984

<sup>71</sup> Rich, P. *White power*, 1984, p. 51. Rich and Catherine Higgs 'African women's Self-help Organizations in South Africa' *African Studies Review*, 47:3 (December 2004), pp. 119 – 141 discusses the role white liberal scholars like social anthropologist Alfred Radcliffe-Brown, educators Charles T. Loram and J.D Rheinallt Jones and the historian Edgar Brookes.

<sup>72</sup> Deborah Gaitskell, 'Housewives, Maids or Mothers: Some Contradictions of Domesticity for Christian Women in Johannesburg, 1903 – 1939' *Journal of African History*, 24 (1983), pp. 241 – 256. Shula Marks, ed. *Not Either an Experimental Doll: The Separate Worlds of Three South African Women*. Bloomington: Indiana University Press, 1991.

<sup>73</sup> Ibid. p. 1. Berger, Iris. 'An African American 'Mother of the Nation': Madie Hall Xuma in South Africa, 1940 – 1963' *Journal of Southern African Studies*, 27:3 (September 2001), pp. 547 – 566 and 'Zenzele:

The three competing visions of a more just and equitable South Africa also had views about women and their role in the new South Africa. For the African nationalists, there are three important aspects to note. Firstly, the ANC admitted women as full members into the organization only in 1944 and the ANC Women's League was founded in 1948.<sup>74</sup> However, and this is the second issue, long before 1944, women were active in what can be termed political activism. Black women in the urban areas were active in local protests in relation to issues such as housing, food prices and permits. In the rural areas, women largely lived under pre-capitalist conditions, but this did not prevent them from collective action.<sup>75</sup> Finally, black women were active in the Zenzele clubs, also known as the Bantu Women's Home Improvement Clubs and the African Women's Self-Improvement Associations.<sup>76</sup> While the main objective of the clubs was not overtly political because they aimed to improve women's domestic skill; the clubs served as a reflection of women's complex contemporary social roles. For example, Catherine Higgs

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African Women's Self-Help Organizations in South Africa, 1927 – 1998' *African Studies Review*, 47:3 (December 2004), pp. 119 - 141

<sup>74</sup> Shireen Hassim, *Women's organization and democracy in South Africa: contesting authority* Madison, WI: University of Wisconsin Press, 2006. Peter Magubane, *Women of South Africa: their fight for freedom* (1<sup>st</sup> edition), Boston: Little Brown, 1993. Myakayaka-Manzini, Mavivi 'Political Party Quotas in South Africa' paper presented at the conference *The Implementation of Quotas: African Experiences* in Pretoria, South Africa, 11 – 12 November 2003 hosted by the International Institute for Democracy and Electoral Assistance (IDEA), Electoral Institute of Southern Africa (EISA) and the Southern African Development Community (SADC) Parliamentary Forum.

<sup>75</sup> Belinda Bozzoli, ed. *Town and Countryside in the Transvaal. Capitalist Penetration and Popular Response* Johannesburg: Ravan Press, 1983. Bozzoli, ed. *Class, Community and Conflict: South African Perspectives*. Johannesburg: Ravan Press, 1987. Hassim, S 'Motherhood and Zulu Nationalism: The Politics of the Inkatha Women's Brigade' *Feminist Review*, Spring 1993, No. 43, pp. 1 – 25 and Anne Kelk Mager., *Gender and the Making of a South African Bantustan: A Social History of the Ciskei, 1945 – 1959*, Cape Town, David Philip, 1999

<sup>76</sup> Catherine Higgs, 'Helping Ourselves: Black Women and Grassroots Activism in Segregated South Africa, 1922 – 1952' in *Stepping Forward: Black Women in Africa and the Americas*, eds. Higgs, Catherine; Barbara Moss and Earline Rae Ferguson. Athens, Ohio: Ohio University Press, 2002, pp. 59 – 72 as well as 'Zenzele: African Women's Self-Help Organizations in South Africa, 1927 – 1998' *African Studies Review*, 47 (December 2004), pp. 119 - 141

comments on the tension between class and ethnicity in these clubs and how these struggles manifested in the dress code, traditional African values as well as colonial ideas of modernity. In addition, Hassim notes that women's self-help groups allowed them to seek 'safety in their own survival skills.'<sup>77</sup> Thus, irrespective of the women's political activism and whether their demands were framed as political rights; women's traditional role as mother and defender of the home occupied a central role.<sup>78</sup> Similarly for motherhood, it was 'women's role as mothers, for example, that was mobilized in defence of maintaining the sphere of the family as 'private', i.e. not subject to legislation.' In their opposition to the extension of pass laws to women, the ANC argued that 'women occupied a unique position in society [and they] stressed their physical and sexual vulnerability: arrest of women by strange male policemen, they argued, undermined the virtue of women and left them vulnerable to sexual abuse. If women were jailed families would suffer, and children would be abandoned.'<sup>79</sup> Thus, the patriarchal discourse employed by the African nationalists provides us with some insight into how women featured in their vision for a more just South Africa.

The Afrikaner Nationalist discourse on women and the future society is less ambiguous. In spite of the fact that women entered the public domain as workers in large numbers during the 1920s and 1930s, and despite the fact that these women workers were organized by the Garment Workers' Union to create a class consciousness; the construction of women as *volksmoeder*, i.e. the mother of the nation, was always present. Women's economic independence was symbolically understood, according to Brink and Jochelson, as signifying the disintegration of the family and hence the nation. Thus, the Afrikaner nationalist vision of a more just and equitable

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<sup>77</sup> Hassim, 'Family, Motherhood and Zulu Nationalism: The Politics of the Inkatha Women's Brigade' *Feminist Review*, 43 (Spring 1993), p. 13.

<sup>78</sup> Walker, ed. *Women and gender*, 1990; Walker, *Women and Resistance*, 1991; Gasa, ed. *They remove boulders*, 2007 See Walker's *Women and Resistance* (pp. 181 – 188) for the Federation of South African Women's *What Women Demand*, drafted during the 1950s that is considered as one of the first documents to explicitly connect political rights to women's demands.

<sup>79</sup> Hasim, 'Family, Motherhood and Zulu Nationalism', 1993, p. 14

society not only confirmed separate development of races, it also constructed a limited role for women.<sup>80</sup>

Thus, in the midst of wartime developments, some South Africans envisioned their place in the postwar society as well as the nature of a more just and equitable South Africa. All three competing visions included belonging and citizenship, but each of these visions had different ideas about the nature and content of that citizenship. These constructions of citizenship would determine who belonged to the nation and what kind of rights and responsibilities would flow from that membership. The African nationalists demanded full political citizenship; and the Afrikaner nationalists and the social democrats proposed different levels of co-existence. The difference between the Afrikaner nationalists and the social democrats was that the latter proposed limited rights be enjoyed to black people. During much of the 1940s, these three political forces struggled to gain dominance, but the only two with a real chance of gaining political power were the Afrikaners and the liberals. In 1948, the Afrikaner nationalist won the election and by 1950, according to Rich, the liberals had lost all influence partly because of greater polarization between themselves and the Afrikaners as well as stronger and more independent African nationalist movements. However, before their loss of political power, the liberals believed that the Gluckman Commission would provide their social democratic cause an official support it required.

### **Social Medicine as an ideal health care system for a new South Africa**

The final question explored in this chapter is how and why did Health Centre Practice (HCP) become part of the competing visions for a more equitable and just South Africa? A brief examination of the history of social medicine provides some insight into social medicine as the basis for a health system that would address South Africa's poverty and poverty related diseases. In addition, this history will also show why South African liberal intellectuals, politicians and doctors were attracted to social medicine and thus, inspired them to launch HCP.

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<sup>80</sup> Brink, E 'Man-made women: Gender, class and the ideology of the volksmoeder' in Cheryl Walker (ed.) *Women and Gender in Southern Africa to 1945* Cape Town: David Phillip, 1990. pp. 273 – 292 and Jochelson, Jochelson, K *The Colour of Disease* 2001, p. 62

HCP advocates managed to establish the Polela Health Centre in 1940 as a pilot health centre on a rural 'Native Reserve' in the then Natal Province.<sup>81</sup> This was the official introduction of social medicine into South Africa. When the Gluckman Commission recommended that the community health centres form the basic unit of the NHS, it officially endorsed the Polela model and HCP advocates interpreted this endorsement as permission to roll out their program. However, social medicine and the notion that the state should take responsibility for the welfare of its citizens not only predate the developments in South Africa during 1940; it also predates the welfare initiatives inspired by the Great Depression and the public policy developments in New Zealand and Britain. The history of social medicine is intricately linked to the history of medicine in general.

The early ecological view of health recognized that disease was not randomly dispersed throughout communities, but that there were strong associations between poverty and disease as well as death; and the association of poverty and disease with 'filth'.<sup>82</sup> Smith traces the history of social medicine directly to the 'father of medicine', Hippocrates, 460 – 370BCE, whose work displayed aspects of objective investigation of disease in populations. Galen, 130 – 210 CE, is considered the next important contributor for he believed that atmospheric factors, susceptibilities of individuals and factors related to the way of live influenced community sickness.<sup>83</sup> According to Smith, ideas about disease and society remained largely undeveloped since Galen except for the introduction of 'disease communicability'. In the seventeenth century, Sydenham (1624 – 1689 CE) 'resurrected the ideas of Hippocrates in framing the concept of disease and entities' and thus confirmed that disease as 'distinct entities [that occurred] in numbers of the population within circumscribed periods and places, but also that they varied from generation to generation in their importance'.<sup>84</sup> The fourth and final major contributor of early social medicine was John Graunt, a London Draper and part-time epidemiologist who collated data from the London Bills of Mortality and applied a numerical analysis. This proved to be a significant moment, i.e., the development of quantitative data that informed<sup>85</sup> community health. These early thinkers in social

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<sup>81</sup> Kark *et al*, *Promoting Community Health*, 1999.

<sup>82</sup> Alwyn Smith, *The science of social medicine*, London: Staples Press, 1968, p. 17

<sup>83</sup> Smith, *Social medicine*, 1968, p.15

<sup>84</sup> *Ibid*.

<sup>85</sup> Smith, A. *Social medicine*, p. 16

medicine developed the basic building blocks of social medicine and what followed was the application of these early methods.

In the nineteenth century, however, Rudolf Virchow used the existing ideas about the causes of disease and social inequalities and constructed what we know today as social medicine.<sup>86</sup>

Virchow developed the theory that physical and social forces cause disease and human suffering. He used specific illnesses, such as typhus to illustrate the ‘concrete historical and material circumstances in which disease appeared; the contradictory social forces that impeded prevention and the role of researchers in advocating reform’.<sup>87</sup> Thus, science and health cannot be detached from the socio-political reality and that researchers and scientists should strive to link their findings to the political work suggested by their research. In this way, Virchow relied on Engels and in his construction of a dialectic materialist approach in biology; in particular, Virchow cited *The Conditions of the Working Class in England* to demonstrate the relationship between poverty and ill health. Thus Virchow traced the link between poverty and disease, and provided a social critique of society and of the structure of the health system.

Virchow’s construction of social medicine thus went far beyond the early development in this field. He recognized the role of unhygienic conditions in disease, but that these conditions are the immediate causes of disease and not the root causes. The latter were located in the oppressive and the class structures of society as well as within the health system. In respect of the former, the working class areas experience higher levels of infant mortality than their wealthier counterparts. In respect of the latter, oppression in medicine or the health system was manifested by, for example, the fact that the poor had to pay for health services.<sup>88</sup> As a result of his analysis, Virchow recommended a public health service that would be publicly owned and operated by health workers who are employed by the state. In addition, such a health service would focus on prevention and thus, address the unhygienic conditions, i.e. immediate causes of disease. Finally,

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<sup>86</sup> Howard Waitzkin, ‘One and a Half Centuries of Forgetting and Rediscovering: Virchow’s lasting contributions to Social Medicine’ *Social Medicine*, 1:1 (February 2006), pp. 5 – 10. Vincente Navarro and Leiyu Shi ‘The Politics of Policy: The Political Context of Social Inequalities and Health’ *International Journal of Health Services*, 31:1 (2001), pp. 1 – 21.

<sup>87</sup> Waitzkin, H. *Virchow’s lasting contributions*, p. 6

<sup>88</sup> *Ibid.*

the public health system would be supported by state-sponsored measures that guarantee the material security of each individual, either through guaranteed employment or welfare benefits.<sup>89</sup>

Virchow, however, recognized the limitations of working outside of the sphere of political power and entered politics essentially, to bring about the changes he advocated for as a medical doctor. It was his 'commitment to 'the protection of the public' [that] led him to seek public office and become a politician in the literal sense'.<sup>90</sup> He had a very active political career as an elected representative: the Berlin Town Council, from 1859 until his death; the Prussian Landtag from 1862; and following unification of the German State, the Reichstag, from 1880 to 1893.<sup>91</sup> Eisenberg notes that Virchow was known as a trouble-making legislator for Virchow vigorously opposed Bismarck's policies to the extent that, fitting with the time, challenged Bismarck to a duel. Virchow supported a constitutional democracy so as to undermine the ruling elites and to give the working class a stronger voice in governance. In addition, Virchow supported the principles of socialism in particular, the public ownership and rational organization of health and welfare facilities.<sup>92</sup>

## **White liberals, black health**

It is not surprising that South African liberal politicians and intellectuals considered social medicine as a solution for the poverty and health related problems experienced by South Africa's poor. As noted above, the Gluckman Commission was the first official enquiry into the health system and as a result, the Commission was mandated to recommend the best measures that could be adopted in order to deliver affordable and accessible health services to everyone regardless of race. The Commission took two years to complete its work during which it traveled across the country. Many people, who could not attend the Commission's hearings, sent written submissions that included their analysis of the health status and system and appropriate recommendations.<sup>93</sup> The Commission also paid a visit to the Polela Health Centre (hereafter referred to as Polela) and

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<sup>89</sup> Op cit. p.7

<sup>90</sup> Leon Eisenberg, 'Rudolf Virchow: The Physician as Politician' *Medicine And War*, 2 (1986), p. 247

<sup>91</sup> Ibid.

<sup>92</sup> Waitzkin, H. *Virchow's lasting contributions*, p.9

<sup>93</sup> Government of South Africa, *Report of the national Health Services Commission*, UB 30/1944

so was impressed by the Centre's work that it used Polela as a model for 'community health centres'. In 1944, the Gluckman Commission released its report and proposed far-reaching recommendations that, if implemented, would replace a defective health system and transform society.

The Gluckman Commission recommended that South Africa establish a National Health System (NHS), one that was more effective, widely accessible and provided free health care to every person. The idea of a NHS was informed mainly by the Commission's view that it was the state's responsibility to provide health care.<sup>94</sup> Thus, the NHS would be established as follows:<sup>95</sup>

- All personal health services would be free of charge.
- The state would provide all personal and preventive personal health services.
- 400 community health centres would form the basic unit of health care delivery and each centre would services between 10 000 - 30 000 people. A multidisciplinary health team would work from each community health centre and include doctors, dentist, hygiene officers, radiographers and health visitors. The latter would conduct health education and act as the link between the community and the health centre.
- Each community health centre would be connected to specialist and teaching hospitals.
- The state would have to train additional health personnel as well as several thousand health visitors. Prevention would be a central theme in the new construction of health and thus, the state would establish an Institute of Hygiene to provide training to health personnel.

The Gluckman Commission's call for an overhaul of the health system is considered revolutionary and progressive. The NHS would do away with the fragmented health system and therefore, the Union Department of Health would take responsibility for all health services and actively oversee the work of the other spheres of government. In respect of race, the Gluckman Commission constructed a new form of race relations under the NHS. It recommended that the NHS would be a universal system and provide services to everyone, irrespective of race. The

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<sup>94</sup> Ibid. and De Beer, *The South African Disease*, p. 15

<sup>95</sup> De Beer, *The South African Disease*, p. 25

Commission also explicitly stated that there should be no discrimination based on race for the selection and training of health personnel.<sup>96</sup>

This principle of equality was extended to gender relations. The Gluckman Commission recommended that ‘in the NHS there shall be equal opportunity and equal pay for men and women performing work of the same nature [and] there shall be no bar to the employment of married women’.<sup>97</sup>

The recommendations of the Gluckman Commission contained the blueprint for equality and thus, a vision for a new, more just and equitable postwar society. It aimed to deal effectively with the range of diseases that were causing devastation across the country, as well as the underlying causes of disease, i.e. poor living conditions. For this reason, it included a list of non-personal / environmental factors that impact on disease and should therefore, be eradicated. These non-personal health services included housing, town planning, water supply, drainage, sanitary measures and food handling.<sup>98</sup> The failure of the state to implement all of the Gluckman Commission’s recommendations was, according to De Beer, because of its progressive nature. South Africa’s history of colonialism and racial oppression, the nature of the economic system and a lack of political power of the oppressed people united to ensure that the Commission’s recommendations ‘could not be anything more than a noble but impossible dream’.<sup>99</sup> At the time though, the Gluckman Commission was part of the developments that informed vision of a more just and equitable postwar society, one in which the root causes of poverty and disease would be absent.

Gluckman was not alone or an isolated voice for the introduction of social medicine into South Africa. A number of other white liberal, mainly male, intellectuals, medical doctors, bureaucrats and politicians were already working on these ideas prior to the Gluckman Commission. The

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<sup>96</sup> De Beer, *The South African Disease*, p. 26

<sup>97</sup> Ibid. [De Beer, *The South African Disease*, p. 26]

<sup>98</sup> Op cit. note 50

<sup>99</sup> De Beer, *The South African Disease*, p. 16

political persuasions of these individuals tell a fascinating story of white liberals concerned with black people's health at a time when the foundation of society was constructed as white solidarity at the expense of black people.

Sidney Kark and his wife, Emily, both medical doctors, were the first medical team to head Polela: he as Medical Officer-in-Charge and she as part-time medical officer. Both Karks studied at the Medical School at the University of the Witwatersrand (also known as Wits University) and said that they were 'influenced by the liberal [politics] and active interest in social justice of many Wits University faculty members'.<sup>100</sup> Through the South African Institute of Race Relations (SAIRR) the Karks were exposed to life in 'black townships and attended interracial meetings'.<sup>101</sup> Sidney Kark and Dr. Harding le Riche, a physical anthropologist and later Health Centre physician, were part of a team of doctors who conducted the first nutrition survey of black schoolchildren on behalf of the Department of Health in 1938.<sup>102</sup> Kark's involvement in the nutrition survey was instrumental in stimulating his interest in community health and facilitated his appointment as the first Medical Officer-in-Charge of the first Health Centre. For it was through this survey that the Karks met the Chief Health Officers of the Union Department of Health who initiated the Health Centres.

Prof. Eustice Cluver was the Chief Health Officer for the Union during the late 1930s and Dr. Harry Gear, his Deputy. Before he occupied this position, Cluver was a lecturer at Wits University and, according to Dr. E Kark, was 'one of [a] few teachers who critically referred to the neglect of the African people in medicine and public health [and his] non-racist approach was quite unusual for the time'.<sup>103</sup> As for Gear, he studied public health in Britain and then went to China working for the Department of Preventive Medicine and Medical Statistics at the Henry Lester Institute of Medical Research of Shanghai.<sup>104</sup> When Gear returned to South Africa 'he had many innovative ideas about the provision of health services for the South African populations,

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<sup>100</sup> Kark *et al*, *Promoting Community Health*, 1999, pp. 6 - 8

<sup>101</sup> Ibid.

<sup>102</sup> Kark *et al*, *Promoting Community Health*, 1999, p.12. See also note no. 9.

<sup>103</sup> Kark *et al*, *Promoting Community Health*, 1999, p.9

<sup>104</sup> Ibid.

more especially the Africans living in the 'Native Reserves'<sup>105</sup> These two men initiated the nutrition survey and later the establishment of Polela as both men shared an interest in the health status of black people.

Dr. George Gale was a liberal<sup>106</sup> served on the Health Centre Advisory Committee in 1944 until he was appointed Chief Medical Officer and Secretary for Health in 1945 and on his watch; more than forty Health Centres were established. Dr. Gale was born in Natal and following his medical studies in Scotland, he returned to Natal to serve as a 'medical missionary'<sup>107</sup> in Msinga, North Natal. He was fluent in Zulu and gained experience in health problems of black people in rural areas. His 1938 publication entitled *A Suggested Approach to the Health Needs of the Native Rural Areas of South Africa* was described by Kark et al as indicative of a notable social conscience and a conviction that a new approach to health care was required. Gale was also instrumental in securing the survival of the Institute of Family and Community Health (IFCH), the HCP training centre, when he secured foreign funding from the Rockefeller Foundation during the 1950s.<sup>108</sup>

Dr. Henry Gluckman was an MP representing Yeoville who proposed the establishment of the National Health Services Commission. He became chair of that Commission and thus, the Gluckman Commission. Gluckman was appointed Minister of Health in 1945 and served until 1948 when the National Party won the general elections that ousted the Smuts government and Gluckman had to vacate his post. During his period as Minister, he appointed Dr. Gale (above) and together they spearheaded the establishment of forty Health Centres.

Finally, Jan Hofmeyr was the Minister of Education, Interior and Public Health during the 1930s and during the 1940s, Minister of Finance and Deputy Prime Minister. His commitment to liberalism was manifested in a number of ways: he diverted state funds to education for black

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<sup>105</sup> Kark *et al*, *Promoting Community Health*, 1999, p.10

<sup>106</sup> Kark *et al*, *Promoting Community Health*, 1999, p.14

<sup>107</sup> Kark *et al*, *Promoting Community Health*, 1999, p. 84

<sup>108</sup> Kark *et al*, *Promoting Community Health*, 1999, pp. 178 – 9 and 194

people<sup>109</sup>, opposed the 1936 Hertzog bills<sup>110</sup>, and rejected the term ‘Native Problem’<sup>111</sup>. The Karks are of the opinion that it was a combination of Hofmeyr’s powerful political position and his liberal views that facilitated the 1938 Nutrition Survey of black school children. In fact, they note that it was the results of this survey that gave birth to the idea of the Health Unit, which later in the Gluckman Commission report became the Health Centre. The pioneers of social medicine in South Africa thus shared a certain perspective about the solutions to the pervasive poverty and ill health in South Africa, particularly among black people. Thus, supporters of an environmental approach to health, who were all in fairly influential political and bureaucratic positions, facilitated the introduction of HCP into South Africa.

## Conclusion

By 1940, most black people lived in poverty and unhygienic conditions and as a result, suffered from numerous poverty-related diseases. (See detailed discussion in Chapter Three) The war years were promising with, *i.a.*, the relaxation of some of the repressive regulations. At the same time, though, the state also repressed black people’s efforts to assert their political rights, for example, the 1945 mineworkers’ strike as well as other grassroots protests. In addition, the health conditions did not improve and was one of many signs that the society was in crisis. Women, because of an already marginalized social status, suffered both gender discrimination as well as the generalized burdens of poverty and disease. Their health conditions were indicative of a life under stress.

In response to the domestic crises and inspired by international public policy developments, three main political groupings, *i.e.* African and Afrikaner nationalism and the liberal imagined a more just and equitable society. These visions, not surprisingly, contained competing scenarios of a postwar society. One of these visions proposed social medicine as the solution to the disease and poverty experienced by the majority of the population. This proposal, in operation, became HCP and a number of white, mainly male, liberals were at the forefront of HCP. The visions were

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<sup>109</sup> Beinart, *Twentieth-century South Africa*, 1994, pp. 124-125

<sup>110</sup> The bills, introduced in 1926, finally became law in 1936: the Representation of Natives Act and the Native Land and Trust Act.

<sup>111</sup> Kark *et al*, *Promoting Community Health*, 1999, p. 11

revolutionary in particular the social medicine proposal. The question, however, is whether it was also revolutionary in respect of gender roles and relations. This is the question that Chapter three explores.

## CHAPTER THREE

### GENDER AND HEALTH CENTRE PRACTICE

#### **Introduction**

Health Centre Practice (HCP), through its network of Health Centres, provided curative and preventive health services mainly to poor, black people with a view to ‘mitigate the results of social injustice’.<sup>112</sup> By 1940 when the first Health Centre was launched, most black people lived in conditions of poverty and experienced the burden of poverty-related diseases. Historians on HCP have highlighted mainly the ‘pioneering’ work of the doctors that were involved in HCP, i.e. providing health care to poor, black people when that was not the norm and implementing a social medicine experiment when the rest of the world, at least that part of the world dominated by the British, was only theorizing about it. However, reading the Health Centre reports and related publications through a gender lens reveal a particular history about HCP, one that has not been told. The relationship between patriarchy and the construction and delivery of health through HCP is one of the main themes that emerge when one considers the gendered nature of HCP.

This chapter asks how HCP responded to gender roles and relations it encountered in the community where it operated and whether HCP reflected the dominant gender roles and relations in its construction of health and health services. By way of answering these questions, the chapter commences with two case studies, i.e. *Families that ‘chose to live in overcrowded conditions’* and *The problem of syphilis and the rehabilitation of a women with a ‘loose character’* from Grassy Park Health Centre (hereafter Grassy Park) and the Polela Health Centre (hereafter Polela), respectively. Following these case studies, this chapter explains the notion of a ‘modern concept of health’ as employed by the National Health Service Commission (hereafter the

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<sup>112</sup> Sidney Kark and Emily Kark. *Promoting Community Health: From Pholela to Jerusalem*. (Johannesburg: Witwatersrand University Press, 1999), p. 151

Gluckman Commission) Report. This section also comments on the extent to which this concept was in fact modern. In the next section, this chapter outlines the nature of Health Centre services and some of the methods employed to deliver those services. The final section aims to analyze some of the key aspects of HCP in order to find out how HCP approached and dealt with existing gender roles and relations in the communities where the Health Centres operated.

### **Families that ‘chose to live in overcrowded conditions’**

In the 1947 Annual Report of the Grassy Park Health Centre, a Health Assistant offered the following evaluation of a family in their ‘care’, i.e. the Hess Family: ‘I like this family. They are poor but well knit and decent. Given the chance they would try to be self-supporting. Mrs. Hess is the dominant character and a real mother to her children. They will benefit by health education.’<sup>113</sup> The Health Assistant made these comments during a Health Centre staff meeting convened to discuss the welfare and progress of the families, in the Intensive Family Welfare program (IFWP). The Health Centre thought that the Hess Family was an exemplary family<sup>114</sup> and that assessment was largely due to Mrs. Hess’ role as wife and mother. Mr. and Mrs. Hess had five children and even though two the children were from Mr. Hess’ previous marriage, Mrs. Hess was a ‘real mother’ to her stepchildren. In addition, the Health Centre staff concluded that Mrs. Hess was responsible and a stabilizing influence on her family. For example, Mrs. Hess controlled the family income and in spite of Mr. Hess’ low wages, the family was not on welfare. She also cultivated a vegetable garden; kept their 3-roomed house ‘neat and tidy’ in spite of the mice and fleas, and the children were always clean and attended school regularly. The family was ‘well integrated’ for they were friendly and obliging, and attended church and social clubs.<sup>115</sup>

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<sup>113</sup> CAD, GES 1919 File 54/32 - Grassy Park Health Centre, Annual Report for the Year Ending June 30<sup>th</sup>, 1947. p. 46

<sup>114</sup> The opinion of families expressed in Health Centre reports were usually linked to ways in which families utilized Health Centre services. Thus, according to Kark, an exemplary family would be one that was ‘health conscious’ and attended Health Centre activities on a regular basis. (Sidney Kark, ‘A Health Unit as Family Doctor and Health Advisor’ *South African Medical Journal*, 18 (1944), p.44)

<sup>115</sup> Grassy Park Health Centre, Annual Report for the Year Ending June 30<sup>th</sup>, 1947 (CAD, GES 1919 File 54/32)

In spite of the 'potential for improvement', the members of the Hess Family were about to be separated. Mrs. Hess' health was deteriorating to the extent that she needed institutionalization and ironically, her 'goodwill' triggered the deterioration of her condition. Early in 1947, the Campbell Family was evicted from their sub-economic house because they could not pay the rent. Mrs. Hess took pity on the Campbells and the two families 'elected to stay under one roof' with the Hess Family sleeping in the bedroom and the Campbells in the lounge. Mrs. Hess also shared her family's food with the Campbells. The strain was taking its toll on Mrs. Hess and the Health Centre staff decided to send Mrs. Hess to a TB hospital and during her absence, the younger children went to a children's home; an adult woman cleaned and cared for the older children. The Campbell Family would be asked to move into a shack in the yard.

### **The problem of syphilis and the rehabilitation of a woman with a 'loose character'**

A 50-year-old man returned to Polela, his rural home, from the Witwatersrand where he worked. He approached the Medical Officer, Dr. Sydney Kark, requesting an examination that would declare him 'well enough to have intercourse with his wives', i.e. syphilis free. The man informed Kark that his first wife would not have intercourse with him unless the doctor considered him 'fit'. Once his own medical examination was completed, however, the man asked Kark if 'it was safe for him to have intercourse with his third wife'. This question alerted the Medical Officer of the 'true nature of the man's visit'. Kark reported that the man, on his arrival back home, heard rumors of his third wife's 'latest adulterous relationship' and he thus attempted to get confirmation of this from the Health Centre. According to Kark, the Health Centre 'was fortunate' that they had information on the woman because she attended the Health Centre regularly during the preceding seven months. During this time she was diagnosed with and successfully treated for syphilis. As a result, the Medical Officer could inform the man that he faced no danger if he had intercourse with his third wife.<sup>116</sup>

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<sup>116</sup> GES 1917, File 46/32, Annual Report, Polela Health Centre, July 1944 – June 1945

In his 1944 Annual Report, Kark described the woman as a 36-year-old wife and mother of two children aged 7 and 9, who was 'known in the local community as a loose character'. The Health Centre records also contained a 'record of adultery' for the woman which read as follows: 1941, committed adultery with a married man of the area and the latter was found guilty and fined; 1942 or early 1943, she is believed to have had intercourse with a young man, but the case never came to the notice of her husband; February 1943, the woman committed adultery with an elderly man in the area, who infected her with syphilis; and March and May of 1943, she allegedly committed adultery with another married man in the area, who contracted syphilis from her and passed it on to his wife.

The man's visit to the Health Centre prompted the staff to intervene more actively in this case. They acknowledged that the problem would be solved if the husband remained home, but 'economic necessity demanded that the man return to the Witwatersrand'. The Health Centre records indicated that the woman's extra-marital affairs coincided with her husband's absences. In spite of the fact that the Health Centre staff recognized that the women's affairs were symptoms of much broader economic and political conditions; they decided that the most appropriate intervention was the rehabilitation of the woman. This rehabilitation plan included 'endless discussion between the Medical Office, Nurse, Health Visitor and the patient'.

The above two case studies from Grassy Park and Polela form a central of this chapter. These case studies illustrate HCP's construction of health and, in light of that definition, how HCP advocates conceived the kinds of services that Health Centres delivered. They also draw attention to the complex relationship between Health Centres, on the one hand, and the men and women, on the other, in the communities where Health Centres operated. Therefore, using these two case studies as well as other examples from the Health Centre reports, this chapter will conduct a gender analysis of HCP by asking firstly, how HCP responded to gender roles and relations it encountered in the community where Health Centres were established, and secondly, whether different aspects of HCP reflected or challenged the dominant gender roles and relations. The chapter will however, commence with an overview of HCP including the definition of health and an exposition of how HCP was implemented.

For the most part, this chapter relies on the perspective of HCP as understood and practiced by the Medical Officers-in-Charge of the Health Centres and other HCP advocates, such as Department of Health bureaucrats and politicians. There is thus a danger that, by using these kinds of documents, the experiences and views of individuals and communities who participated in Health Centre programs might be ignored. The official records such as Health Department records, print media and Health Centre reports contain some evidence of people's views and how they decided to interact with the Health Centres. For example, the case of the woman with a 'loose character' mentioned above, illustrates how her husband used, or perhaps more appropriately, abused, the Health Centre.

While about forty-four Health Centres were established between 1944 and 1950, this chapter draws heavily on the work conducted at Grassy Park and Polela. According to the Gluckman Commission, a total of 400 Health Centres were to form the core of the NHS, but because the latter was never fully established, HCP managed to launch just over ten percent of the anticipated 400. This development meant that for the most part, HCP was experimental during the latter half of the 1940s. Health Centre records indicated that Medical Officers were asked to 'try out the new techniques against as many different kinds of background as possible, and a fairly free hand [was] given to the whole-time medical officers in charge to experiment with different techniques.'<sup>117</sup> Thus, because of their experimental nature, some of the Medical Officers wrote copious notes and lengthy reports about their experiences, observations and ideas about HCP in the making. Kark and Dr. Jacob Henson, Medical Officers for Polela and Grassy Park Health Centres, respectively, were two of the Medical Officers whose reports provide a rich tapestry of information and it is these two Health Centres that informs the research for this chapter. As a result, most of the secondary literature focuses on these two Health Centres and thus, my research also uses these two Health Centres to inform a gender analysis of HCP.<sup>118</sup>

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<sup>117</sup> Howard Phillips, 'The Grassy Park Health Centre', in *South Africa's 1940s: A World of Possibilities*, Saul Dubow and Alan Jeeves, eds. (Cape Town: Double Storey, 2005), p. 109

<sup>118</sup> It is far from ideal to use information from only two health centres and therefore the work of only two Medical Officers. However, as noted in the introduction, due to time constraints and resources available, I

In spite of the fact that most of the HCP information available relates to Grassy Park and Polela, these two Health Centres remain interesting case studies. An important distinction between these two Centres was the geographic location, and perhaps because of that, their relationship with other state and non-state institutions. The community of Grassy Park benefited from their urban location because they could access a wide range of services that the Health Centre could not directly provide, but whose access the Medical Officer-in-Charge, Henson, facilitated. Grassy Park was, as Philips noted, a ‘model peri-urban Health Centre in the Western Cape, a region with a social and cultural population composition and economic circumstances vastly different from that of rural Zululand or the Eastern Transvaal’.<sup>119</sup> Grassy Park was connected by road and a regular train service to the city of Cape Town and Wynberg, both major commercial centres. In addition to and perhaps because of its urban location, Henson was aware of this advantage and he accessed many of those resources on behalf of the residents of Grassy Park. For instance, he successfully lobbied the Cape Divisional Council, Department of Post and Telegraphs and the Transportation Board to deliver a range of services. As a result, Grassy Park’s residents received communal amenities such as a sanitation services to deal with vermins, a subsidized milk depot, better roads, municipal water, Post Office and dedicated bus service between Grassy Park and Wynberg.<sup>120</sup> In addition, a number of voluntary agencies such as: the Legal Aid Bureau of Cape Town, the Cape Flats Distress Association (CAFDA) provided a range of services including ‘poor relief’ following a recommendation from the Health Centre.<sup>121</sup> Henson managed to successfully exploit Grassy Park’s geographic location and thus secure a wide range of state and non-state services for the Grassy Park community, something that the residents would not easily have achieved on their own.<sup>122</sup>

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decided to focus only these two Health Centres. See also my comments on p.113 (Conclusion) regarding future research.

<sup>119</sup> Ibid. and Grassy Park Health Centre Annual Report, 1947 (CAD, GES 1919 File 54/32)

<sup>120</sup> Grassy Park Health Centre Annual Report, 1947, p.33; (CAD, GES 1919 File 54/32)

<sup>121</sup> Grassy Park Health Centre Annual Report, 1950, p.14, (CAD, GES 1919 File 58/32)

<sup>122</sup> See the discussion in Chapter Two regarding the local Authorities’ neglect of government services to black people within their boundaries. This discussion relies on N. Gasa, ed., *Basus/iimbokodo, bawel’imilambo/They remove boulders and cross rivers Women in South African History* (Cape Town:

Polela, on the other hand, was located on a farm on a 'native reserve' and regulated in terms of the Native Land and Trust Acts. It was approximately 153 kilometers from Durban and part of the Bulwer District, the main government administrative centre for the region. Next to the 'native reserve' were white owned farms. An apt description of the social and economic conditions of Polela was given by Kark when he wrote that 'the contrast between the two sides of the valley is the first introduction one has to the economic state of the people of the River Valley Area [i.e. a section of Polela where the Health Centre operated]. The brown, treeless, eroded, in parts desert River Valley Area appears a dismal contrast to the wooded, relatively green slopes of the Impendhle side of the river [i.e. the area where the white farmers lived].'<sup>123</sup> One of the 'outstanding features' of the organization of social life of Polela was that 'outsiders' provided and controlled most of the services.<sup>124</sup> Government officials, missionaries and traders, among others, provided services such as justice, social welfare, agriculture, health, education, churches and shops. The result was a Health Unit that, in many ways, acted as the state. For example, the Polela Health Unit applied for and was given permission to run a 'maternity hospital', i.e. constructed a number of huts and provided women with a physical space to give birth and unprecedented access to medical experts while at the maternity ward.<sup>125</sup> Thus, while the social conditions in Polela were, as described in Chapter Two, very much like other reserves in South Africa at the time, it had very little access to state and non-state resources.

## **A modern concept of health for South Africa**

The Gluckman Commission report employed the term 'modern concept of health' when it outlined the proposed health system for a future, more equitable South Africa.<sup>126</sup> The report was critical of the health care system in place at the time and proposed, as discussed in Chapter Two,

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Human Sciences Research Council Pres, 2007) and Deborah Posel, *Making of Apartheid, 1948 – 1961*. (Oxford: Clarendon Press, 1991)

<sup>123</sup> Sidney Kark. 'A Health Unit as Family Doctor', *SAMJ*, (February 12, 1944), p.39

<sup>124</sup> Ibid.

<sup>125</sup> Polela Annual Report for the Year Ending 30 June 1950, pp. 4 - 5.

<sup>126</sup> Report of the National Health Services Commission (Gluckman Commission), UG 30/1944, Chapter II

a system that would prioritize prevention and health promotion as well as give all people equal access to health services. Of course, this concept of health was not at all ‘modern’ and the Gluckman Report acknowledged this. The history of social medicine outlined in Chapter Two traces this kind of health care back to the origins of medicine, but more specifically to Rudolf Virchow in nineteenth century Germany. The Gluckman Report does not specifically mention Virchow, however, it uses the 1871 Royal Sanitary Commission and the 1926 ‘Provisional Articles of National Policy in Preventive Medicine’ prepared by Sir George Newman, Chief Medical Officer (1919 – 1935) in the British Ministry of Health. Based on these documents, the Gluckman Commission produced their own ‘*desiderata* [that contained] the essential phases of a comprehensive health service’; a set of definitions and list of services necessary in order to achieve its goals. It was these definitions and services that both confirmed HCP as implemented by the pilot Health Centre and then became the basis for the ‘modern concept of health’ – a broad understanding of health and the factors that influenced health status, and consequently, recommended a vast range of services.

According to the ‘modern concept of health’ and HCP, health status was the result of group living, which essentially meant that an individual’s health status was intricately linked to the health status of his / her social and geographical communities, such as families, friendship groups, co-workers and neighborhood.<sup>127</sup> Three principles informed this broad construction of health and a health system, based on such a broad definition of health. The first principle was that health status was no longer an individual matter, but rather a matter of public concern. Accordingly, an ill person not only posed a risk to others, but was also considered an economic burden on the community and society. The Gluckman Commission concluded that ‘when people are sick or unemployed not only must they be cared for on humanitarian grounds, but that in the process they be transformed from liabilities into assets on the economic plane’<sup>128</sup>.

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<sup>127</sup> Alwyn Smith, *The science of social medicine*, (London: Staples Press, 1968); Sydney Kark and Guy Steuart (eds), *A Practice of Social Medicine: A South African Team’s Experience in Different South African Communities*. (Edinburgh: E & S Livingstone, 1962),

<sup>128</sup> Union of South Africa, National Health Services Commission, 1944, p.5

The second principle related to the role of the doctors, i.e. he/she should be a community doctor based on the concept of the 'Family Doctor'. The medical practitioner could only be effective in treating an individual by taking into account the health status of the household and the various communities to whom the patient belongs. Kark envisioned that the multidisciplinary health team at the Health Centres would perfect its teamwork to such an extent that the entire team would eventually operate as 'family doctor and health advisor. Each member of the staff (Medical Officer, Nurses, Medical Aid and Health Assistants) played a part in bringing health and medical advice to the family. The school medical and health services, maternal and infant welfare clinics, nutrition classes and therapeutic clinics, are all co-ordinated with the continuous visits to homes. The field worker is informed of the state of health of various members of the family seen by the medical office and his findings regarding the family's standard of living are related to the medical problems of the home.'<sup>129</sup> Thus, as the Health team took care of each family in the community, they could keep track of the health status of the community.

A third and final principle was that health was no longer limited to the physiological aspects and the treatment of symptoms manifested by an individual. One's health status was also affected by a range of non-personal or environmental and social factors. For instance, cleanliness and overcrowded conditions in the house, inappropriate disposal of human and household waste and the availability nutritious of nutritious food were all thought of as factors that affected an individual's health. In addition to the environmental factors, health status was also affected by social factors, for example, the nature of the relationship between a husband and wife. The case study above illustrates that labour migration forced many husbands to be away from their homes for long periods and this facilitated extra-marital sexual relationships. One of the major health consequences of this way of life was that individuals became infected with sexually transmitted diseases such as syphilis. In this regard, an epidemiological study by Polela in 1944 found that the majority of adult women (i.e. 27 out of 32 that were tested) contracted syphilis or gonorrhoea at their homes, i.e. in the rural areas, from their husbands or men to whom they were engaged. In all cases, the men had returned to their rural homes from areas where they worked. Conversely, the majority of the men were infected away from their homes, i.e. in the towns, on the farms or in the

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<sup>129</sup> Sidney Kark et al., *A Practice of Social Medicine*, 1962, p. 3 and Kark, 'A Health Unit as Family Doctor', *SAMJ*, (February 12, 1944), p.39 and p. 42.

villages where they worked.<sup>130</sup> The historiography therefore, noted the revolutionary nature of this modern concept of health in respect of race and class, however, it may be a long stretch to extent that particular understanding to gender.

## **HCP: Health services**

The health services were designed to give effect to the broad definition of health and as defined above, covered a wide range of personal and non-personal health-related aspects. This next section will provide an overview of these services and how they were implemented.

HCP categorized health services as personal and non-personal health services and for each of these categories, there were sub-categories. Non-personal health services included those services that dealt with ‘*things* and do not require medical, dental, nursing or similar personnel for their execution’ and included housing and town planning, water supplies, drainage, sanitary measures, food handling, nuisances and regulation of offensive trades.<sup>131</sup> Personal health services were services that could only be executed with the assistance of medical, dental, nursing and ancillary personnel. The sub-categories of personal health services were defined as follows:

- Personal promotive health services entailed the maintenance of the health of individuals through, for example, adequate wages, nutrition; general education; physical exercise and recreation; and industrial welfare and hygiene.
- Personal preventive health services are those ‘based on the *family* as the unit and on *periodic medical and dental examinations* (emphasis in original text) as the main method, and [included] the following: ante-natal and post-natal clinics; infant welfare clinics and immunization services; crèches; pre-school child clinics (nursery schools); child guidance clinics; school health services – physical and health education; medical examination of apprentices, etc. by physical and aptitude tests; workers’ health services – mines, factories,

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<sup>130</sup> Polela Annual Report, 30 June 1944, p. 17

<sup>131</sup> Report of the National Health Services Commission (Gluckman Commission), UG 30/1944

etc, periodic medical examinations, nutritional; and physical and health education; and routine medical examination of all other adult groups at prescribed intervals'.<sup>132</sup>

- Personal curative health services include 'domiciliary, clinic and hospital services, and [were] carried out at the homes of patients, at health centres and in institutions, including dental institutions'.<sup>133</sup>
- Personal rehabilitative health services comprise two aspects, i.e. health and educational services including re-employment.

The initial health plan proposed by the Gluckman Commission which incorporated these services listed above, had to be scaled down, firstly, because of the immense need for curative health services in the communities where the Health Centres were established. As discussed in Chapter Two, the communities targeted by HCP, i.e., mainly black, experienced high levels of poverty and poverty-related diseases. Henson reported frankly that Grassy Park would not concentrate in any great degree on promotive and rehabilitative health services because of the impossibility of achieving all four areas of health.<sup>134</sup> Secondly, there were not enough Medical Officers to establish Health Centres and neither was there sufficient medical personnel trained in HCP. Finally, by 1944 when the Gluckman Commission Report was released, there was little political commitment to endorse a health program that would largely benefit poor, black people. As a result, the HCP advocates amended their original plan and launched HCP that incorporated the Intensive Family Welfare Program.

The IFWP was a way of implementing social medicine, i.e. it emphasized health prevention and health promotion. In terms of the IFWP, the Medical Officer-in-Charge divided the entire community served by the Health Centre into two areas. In the one area, a relatively small section, they implemented the IFWP, which in theory included the full range of health services and consisted predominantly of fieldwork, i.e. in and around people's homes and in communal

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<sup>132</sup> Ibid.

<sup>133</sup> Ibid.

<sup>134</sup> Dr. Henson, Grassy Park Health Centre, Annual Report 1947, p. 4

spaces. The rest of the community received only curative health services at the Health Centre and home visits during emergencies. By implementing a smaller IFWP as well as a general curative health program, the HCP advocates made a critical compromise, i.e. provide much needed curative services while beginning the practice of social medicine.

### **HCP: Collection of data**

The foundation of the IFWP was the collection of vast amounts of data. All the Health Centre reports are filled with evidence of the extensive collection of a wide range of information. For example one of the first activities of the Medical Officers-in-Charge did was prepare a map the area and allocate numbers to the huts and houses. Health Centre staff then collected, on an ongoing basis, general census data; vital statistics; family structures and the movement of people. Households were expected to provide the names, ages and sex of each member of the family; their relationship to each other and to the head of the household; occupation and religion as well as their relationship to each other. Specific data collected included:<sup>135</sup>

- Births: live births, stillbirths, infant mortality, neonatal mortality and abortions.
- Care of mothers who had live births: attended to by Health Unit, other doctors and *Izinyanga*.<sup>136</sup>
- Legitimacy of babies born: A child was considered illegitimate if the parents of the child were engaged but not married at the time of the child's birth, no engagement at all, or the child was conceived as a result of casual sexual relationship, i.e. no relationship at all between the parents.
- Level of education of adults in the community.

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<sup>135</sup> Kark, 'A Health Unit as Family Doctor', *SAMJ* 1944

<sup>136</sup> The former two categories, i.e. Health Unit and other Doctors were grouped together as 'skilled attention' indicating that for the most part, HCP advocates did not consider traditional healers or *Izinyangas*, as individuals who had skills and could contribute to the improving the health of the communities where Health Centres operated. See further discussion below.

- Communicable diseases, recorded by age and sex. In the case of syphilis, Polela also recorded information such as source and place of infection and whether the source was a local or from another place.
- Food production: frequency and kinds of vegetables produced including number of vegetable gardens.
- Livestock: kinds of livestock and use of products, for example, milk and eggs.
- Housing: structural details of all houses such as the nature of the walls, roofs, floors and doors; pieces of furniture in each room and sleeping arrangements.

The information regarding the movement of people was especially significant in the rural areas where it indicated how often the men involved in migrant labour were away from home and the length of each period of absence.

There seems to have been a number of related reasons for the collection of statistics, including determining of health status, improving service delivery and tracking the progress of HCP. In order to meet its overall objective, Health Centre staff used the data to identify individuals and households that demonstrated ‘unhealthy behaviors’ or ‘unhealthy relationships’ and thus in need of Health Centre services. The two case studies outlined above illustrate this process of identification and intervention took place. Thus, HCP relied on statistics to understand the health status of individual communities, plan their interventions and monitor their successes.

### **HCP: Environmental Health Services**

The environmental health services were another type of health intervention and here, HCP constructed health status as the result of the interaction between an individual and his/her physical environments. Health Centre staff reported that they found the ‘general state of the [homes] and personal cleanliness was of a very low order’ and that the ‘condition of the homes as regards disposal of feces, urine, cattle manure, slops and garbage was, generally speaking, very

poor'.<sup>137</sup> This kind of environment was ideal for the spread of disease and common infectious and poverty-related diseases included leprosy, small pox, tuberculosis, scarlet fever, typhus, enteric fever, poliomyelitis, dysentery, cholera, scabies, impetigo and chickenpox.<sup>138</sup> Kark ended his 1942 Annual Report for Polela with a list of four issues that constituted the main factors affecting health, i.e. food, sanitation and poverty and ignorance.<sup>139</sup>

In response to these conditions, Health Assistants conducted extensive demonstrations in order to teach people how to dispose of human and household waste in a manner that does not spread disease. For example, they provided instruction on the construction and use of pit latrines, compost pits and water purification methods. Health Assistants also encouraged people to construct their huts in ways that would improve ventilation. In Polela, the majority of homes had three huts and most of the huts, 405 out of the 492 that were included in the 1944 survey, were oval or circular or round. In addition, most people used wattle covered in clay or mud to construct their huts, i.e. 361 of the 492 huts. Most of the huts had no foundations, earth floors and at least one window, which was really shutters made of wooden planks. For the Health Centre staff, the main problem was that the way in which the huts were constructed, meant that it facilitated the spread of disease and that there were too few huts per home resulting in overcrowded conditions. Health Centre staff recommended higher walls and larger windows.<sup>140</sup>

In an effort to improve nutrition and thus, improve people's resistance to disease, Female Health Assistants taught the women how to prepare nutritious meals using the 'little food that they had'.<sup>141</sup> Households were also encouraged to cultivate their own vegetable gardens and Mrs.

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<sup>137</sup> Polela Annual Report, 1941, p.3,

<sup>138</sup> The list of diseases provided here are the ones that featured regularly in all Health Centre reports that I accessed.

<sup>139</sup> CAD GES 1889, File 2/32H, Polela Annual Report for the Year July 1943 – June 1942

<sup>140</sup> P. 44 - 5, Polela Report ending June 30<sup>th</sup>, 1944

<sup>141</sup> Kark confirmed the lack of access to food in Polela when he noted that in 'no single respect do the people as a whole produce sufficient food for the most elementary requirements of health. The position of the poorer 50 – 75% of the population is little short of pitiable...'. Polela, Annual Report ending June 1944, p.32

Hess' garden, above, is one example of the apparent success of this kind of intervention in the urban areas. As for rural areas, Polela initiated a 'Grow and Eat more Vegetables' program through the distribution of seeds. People either received seeds, for free, from the Health Centre's garden or they joined the Vegetable Seed Co-operative Buying Plan. The Co-operative collected money from its members and bought seeds for them.<sup>142</sup> Polela considered the 'Grow and Eat more Vegetables' program a success merely by comparing the number of vegetable gardens and the range of vegetables cultivated over a period of time.

**Table: Example of the number of Vegetable Gardens and Types of Vegetables in Polela from 1941 to 1944<sup>143</sup>**

Types of Vegetables	January 1941 113 Homes	January 1942 127 Homes	January 1943 128 Homes	January 1944 188 Homes
Potatoes	69	83	91	118
Tomatoes	7	18	33	59
Chinese Cabbage	-	-	27	53
Spinach	-	43	15	24
Soy Beans	-	2	26	52
Ground Nut	-	2	2	2
Cauliflower	-	6	1	1

While the Vegetable Garden program succeeded in the introduction of new types of vegetables as well as an increase in household vegetable gardens; the overall success in respect of improving people's diet was not met. In 1950, Kark reported that local vegetable production remained too low to support the community's nutritional needs.<sup>144</sup> The environmental health services, as a form of health promotion and prevention, aimed to improve the food and water supplies, encourage appropriate waste disposal methods and construction of better huts.

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<sup>142</sup> I found no information clarifying the difference between and the need for these two programs. However, one possible reason may have been that the Health Centre did not have had enough seeds for everyone or it did not have the seeds for all the vegetables that people were encouraged to grow.

<sup>143</sup> Polela Health Centre Report, 30 June 1944, p. 27

<sup>144</sup> Polela Health Centre Annual Report, 1950, p.7

### **HCP: Personal Health Services**

Personal health services comprised activities such as education and literacy, infant and pre-school child health, maternal health, health of the school child, nutrition and growth, recreation, communicable diseases and general disorders. Some of the core activities in this group of health services are:

- Provide advice, for example, to mothers and children about the importance of attending school and about immunization against, *i.a.*, smallpox, chicken pox and measles.
- Conduct examinations and provide treatment for ill health at specialist clinics such as infant and pre-school children, and pre- and post-natal clinics for mothers.
- Conduct surveys, for example, of educational standards in the schools in the area.
- Conduct health propaganda with regard to school attendance, periodic medical examinations (discussed in detail below) and maximum use of limited resources for the production nutritious of food and a balanced diet
- Identify pregnant women and the chronically or disabled persons and encourage them to attend the Health Centre.

### **HCP: General Activities & Recreation**

In addition to environmental and personal health services, the Health Centre provided a number of other health services termed as general services, but were still understood as efforts to ‘uplift the community’. For example, the collection of meteorological records, interventions aimed at the prevention communicable diseases and the organization of weekly vegetable markets in the rural areas. In respect of the meteorological records, the Health Centres recorded weather patterns for the area including droughts and rainfalls and how these impacted on soil conditions and the community’s ability to cultivate vegetable gardens. Specific activities related to communicable diseases included recording incidents of diseases and providing requisite treatment. From time to time, Health Centre staff would also undertake vaccination tours. The rural Polela Health Centre

ran a regular market where locals could exchange, sell or buy home made products or buy vegetables cultivated in the Health Centre's garden.<sup>145</sup>

Recreational and social clubs were part of the HPC general activities. In 1945 recreational activities for adults in Polela included concerts, dances, debates and discussion. These recreational activities were important as another forum to undertake health promotion and disease prevention interventions. However, they were also constructed as interventions to change the way in which people spent leisure time and this is particularly important given Kark's observation that the 'main form of recreation of the adult community' was beer feasts.<sup>146</sup> As for Grassy Park, the Centre launched two clubs, the first, a charity, the Helping Hand Fund with a view of assisting the poorer members of the community; and the second, a Women's Club, i.e. a club formed by women staff members and wives of male staff members to teach women how to knit, mend and cook as well as some adults to read and write.<sup>147</sup> In Polela, people were also encouraged to read when the Health Centre opened a library. A Mothers' Society was also established in Grassy Park with Henson as its Chairperson. Some of the themes covered at the meetings of the Mothers' Society include:

- The Body and its functions, physical education, feminine hygiene.
- Crafts and skills such as dressmaking, making Christmas toys, preparation of meat, knitting, attractive homes;
- Health topics included TB, principles of health education and co-operation of Mothers' Society, infant feeding, domestic hygiene and how a baby grows in the womb.
- Other: Old Wives' Tales<sup>148</sup> and child development.
- Ways to health in the home; the importance of cleanliness; children's illnesses; feminine hygiene; budgeting, and sex education.<sup>149</sup>

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<sup>145</sup> This was considered foremost as a demonstration garden where people could learn how to cultivate vegetables. It was maintained by the Health Centre staff.

<sup>146</sup> Op Cit. note 36.

<sup>147</sup> Polela, Annual Report, 1945, p. 24

<sup>148</sup> Henson taught this topic and it refers to superstitious beliefs.

In respect of this list of topics, the issue of sex education should be noted. The actual Health Centre records do not provide any specific insight into how sex education was conceived and carried out. However, the publication in the *South African Medical Journal* by Dr. Louis F. Freed provides some insight into how HCP may have viewed this topic. Freed noted that sex education should comprise more than just the ‘knowledge of the medico-biological aspects of the sexual life of men and women’. The reason for this was because sex ‘represents only one aspect of the wider field of human relationship, and the purity of its expression is dependent upon what other factors enter into that relationship, such as psycho-spiritual and socio-economic values’. As a result, sex education could, according to Freed, be classified as ‘social – hygiene education’ instead of sex education. Such a classification would result in sex education that connected sexual life with ‘a moral standard, which will have reference to the highest interests of the family, the community and the race’. Freed proceeds to explain, as part of the educational measures, which agency should undertake sex education, the qualifications of such an agency and what methods of social hygiene education should be undertaken. In addition, he outlines the legislative measures that could be adopted in order to ensure a high standard of social hygiene can be achieved and other ‘social protective-preventive measures’ required in order to remove the ‘factors that contribute to the development of sexual delinquency in a community’. Although Freed makes reference to the socio-economic factors that may influence the nature of one’s sexual life, he proceeds to emphasize factors such as family life, prevention of delinquency, over which most black people had very little control at the time.

This contradiction is also found in Kark’s opinion about the ‘social pathology of syphilis’. He recognized the role of unequal and unjust economic development in the creation of a ‘social pathology’ that inspired and continued to drive the problem of syphilis.<sup>150</sup> For instance, Kark notes that ‘without an understanding of the economic factors involved and the historical development of the vast social pathological changes brought about during the last 70 years, no treatment will save the spread of syphilis in South Africa’. Thus, the most effective way of dealing with syphilis is to ensure healthy rural and urban family relationships and therefore, where necessary, ‘ordered urbanization’.

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<sup>149</sup> Grassy Park, 1950 Annual Report, p.18

## HCP Methodology: Health Assistants

In summary, the Health Centres tried to implement that broad definition of health as conceived initially by the Native and Health and Medical Service program and later, the Gluckman Commission. They faced many barriers in the process but, without a doubt, the Health Centres provided much-needed curative health services and began to demonstrate the possible benefits that may flow from a sustained program of preventive health services both in the personal and non-personal spheres. Internally, the Health Centres relied on their multidisciplinary team to provide the health services and on this team, the Health Assistants<sup>151</sup> were considered central to the success of Health Centre services.

Henson referred to the Health Assistants as the ‘eyes and ears’ or the ‘right-hand man’ of the Medical Officer.<sup>152</sup> He wrote that the success of HCP ‘depends entirely on the knowledge, ability, perseverance and zeal of the field worker’.<sup>153</sup> Their main function was health education and propaganda in the field, i.e. in and around people’s homes and in the community. Historically, the professional category of Health Assistants was known as the ‘Native Health Assistants’ and worked, for example, on malaria prevention campaigns as well as efforts to control of bilharzias, general health propaganda, typhus and venereal diseases.<sup>154</sup> HCP took over this category of health workers and developed their health promotion and prevention skills in order to prepare them for their new role as part of HCP. The course outline for a proposed training course for Health Assistants stipulated that they be trained in the following areas:<sup>155</sup>

- Physical science: including physics and geology and its relation to health, for example, nutrition, soil fertility, water supplies, ventilation and an explanation of natural phenomena such as thunder, lightening, disease and good health.
- Biology: the ‘ecological approach to health including the story of evolution’.

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<sup>150</sup> Kark, ‘The social pathology of syphilis’, *South African Medical Journal*, 1939: 23, pp. 77 - 84

<sup>151</sup> All Health Assistants were paid employees of the Department of Public Health and

<sup>152</sup> Dr. Henson, Grassy Park Health Centre, 1946 Annual Report, p. 4

<sup>153</sup> Ibid.

<sup>154</sup> Gear, S, ‘The South African Native Health and Medical Service’ (*SAMJ*, Vol. XVII, No. II), p. 167

- Physiology: the anatomy of the body including reproduction, growth and natural functions of the body
- Sociology: history of society including the ‘changing modes of life of various peoples as related to changing social structure e.g. industrial revolution; changed ways of living; health problems arising [from these changes]. Detailed course on South African conditions with influence on health of various sections of the community.’ In addition, the course in sociology included ‘common beliefs of various communities regarding natural events, e.g. life, death, physiological illness, the ‘medicine man’, herbalist, ‘quack’, magic and witchcraft’
- Other courses included first aid; nutrition; personal hygiene including mental hygiene and family relationships; environmental hygiene; ‘health book-keeping’ and family welfare.
- While both female and male Health Assistants received the same training, there were aspects of their training that were gender-specific given their gender-determined job descriptions. Female Health Assistants would focus on personal hygiene such as maternal and infant welfare; pre-school child centre work and ‘housewifery, for example, clothing, cleanliness (e.g. washing and laundering, repair of clothing, knitting) [and] this would be done in conjunction with their cookery classes, and cleanliness of home and environs’.<sup>156</sup> Male Health Assistants focused on environmental hygiene such as ‘protection of water supplies, the construction of latrines, i.e. making floor slabs, foundations, etc. and hut building’<sup>157</sup>

Therefore, the Health Assistants retained their core function, i.e. community health education; however, they were now an integral part of the multi-disciplinary health team. The language in both Kark and Henson’s reports recognize the central role of the Health Assistants. It is however, the detailed description of their work in these reports that confirms the importance of Health Assistants in HCP. It would be correct to assume that the Health Assistants were permanent fixtures in people’s homes and in the community.

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<sup>155</sup> GES 1917, File 46/32, Annual Report, Polela Health Centre, July 1944 – June 1945

<sup>156</sup> Ibid. ‘Additional Notes on Practical Work’

<sup>157</sup> Ibid.

**Table: Frequency Distribution of Home Visits to 435 Homes during 1943**

<b>No. of Homes</b>	9	32	115	156	74	33	6
<b>No. of Visits</b>	0-4	5-9	10-14	15-19	20-24	25-29	30-34

**Note:** For this period, the Health Assistants completed 6905 home visits with the mean visit per home as 16.25. In addition, the mean number of visits by each Health Assistant was 1,381, i.e. 26.5 homes per week.<sup>158</sup>

This ‘constant surveillance’<sup>159</sup> of the social relationships and living conditions of people was necessary, according to Kark, in order to use undertake effective health education. The overall goal was that the ‘unfelt needs’ of a community should become more apparent and members of the community would then be interested to ‘change aspects of their way of life to meet these needs themselves.’<sup>160</sup> For example, the observation of behaviors and practices before anyone in a home felt sick, allowed Health Centre staff to intervene and encourage changes.<sup>161</sup> According to Kark, in one home the immoral behavior of a woman might be the outstanding social defect and in another it could be alcoholism.<sup>162</sup> Thus, if the immoral woman changed her ways, such as the case study referred to at the beginning of this Chapter, then future health consequences would be prevented. The idea was for communities and individuals to adopt the HCP model of analysis of disease and health so that they identified the causal factors of ill health and intervened prior to the onset of disease. This is why health education and propaganda was so central to HCP.

Much of HCP was based on effective health education. As noted above, curative health services were important, but in terms of the IFCW program, health promotion and prevention of disease should have received equal priority. These two interventions could only be effective if health education was successful. One of the main goals of health education, both at the Health Centre during routine clinics and in the community or people’s homes, was to encourage people to

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<sup>158</sup> The Health Centre reports suggest that a six-day working week was in operation at the time.

<sup>159</sup> Kark, Polela Annual Report, 1941, p.1

<sup>160</sup> J. Cassel. ‘Social and Cultural Implications of Food and Food Habits’ *American Journal of Public Health*, (June 1957), p. 734 and Kark et al, *Promoting Community Health* 1999, p. 36

<sup>161</sup> Kark, Polela Annual Report, 1944, p. 1

<sup>162</sup> *ibid.* (Kark, Polela Annual Report, 1944, p. 1)

change their way of life and their beliefs about health, the causal factors of various health conditions and appropriate remedies.<sup>163</sup> Henson was of the view that people would never be in a position to help themselves in the prevention of ill health and the maintenance and promotion of good health if they were not subjected to intensive health education.<sup>164</sup> For this reason all of the health services discussed above contained health education or propaganda as one of its strategies.

The nature of the problem determined the nature of the health education. For example, propaganda was ‘an intensive effort to put over special effects so as to get an immediate response in a particular situation’<sup>165</sup> such as the containment of epidemics immunization programs, construction of pit privies, maintenance of compost posts and care of babies. On the other hand, health education was more comprehensive in nature and the results only noticeable after a much longer campaign. Intervention strategies that qualified as health education included assistance with preparation of meals, construction of huts and gardens and the work, i.e. lectures and films, in the social clubs such as the Mother’s Society in Grassy Park. While this distinction existed, both these strategies had similar objectives, i.e. to ‘uplift the community, ensure self-help and foster self-reliance’.<sup>166</sup> Thus, given the importance of health education and propaganda, it is important to recognize those factors that, according to the Health Centre staff, acted as a barrier to effective health education.

This section outlined the nature of health services and how these services were implemented. It looked at the personal and non-personal health services as well as the curative, preventive and health promotion aspects of health services. A critical aspect regarding the implementation of health services was health education and thus, the role of the Health Assistants. The next section considers the gendered nature of HCP.

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<sup>163</sup> *ibid.* p.5. (Kark, Polela Annual Report, 1941,)

<sup>164</sup> *Ibid.* p.6 (Grassy Park Health Centre, Annual Report 1947)

<sup>165</sup> Grassy Park, 1947 Annual Report, p. 32

<sup>166</sup> *ibid.*

## **Health Centre Services and Gender Roles and Relations**

The main question that this chapter set out to explore is to determine the ways in which HCP, in its definition of health and health services as well as methods, interacted with the gender roles and relations. This section will first consider the definition of health and its gender implications because the conceptualization of health influenced the nature of the health services rendered and methods used. By using some of the information outlined above, the next section will examine how the definition of health, health services and methods were gendered, i.e., HCP and its relationship to women; to men; and HCP and the relationship between men and women. In addition, the Chapter asked whether there were instances where the manifestation of gender roles and relationships caused any change in way HCP operated. This sub section is organized in the following way: how HCP excluded women's experience and their cultural practices; how HCP became aligned with maternal feminists and different public and private ways in which men, who were supposedly on the periphery of HCP, stepped up and negotiated the terms and nature of HCP.

### **HCP and the exclusion women's experience and cultural practices**

HCP took control of women's lives, their knowledge and experiences by imposing the philosophy and methods of HCP. There were at least two ways in which HCP not only ignored the local knowledge and contribution of black women, but it also turned access to health into an issue that brought women into conflict with their tradition and culture. Firstly, HCP created no space for the Zenzele clubs and secondly, it actively discouraged women from relying on their traditional sources of knowledge and support systems.

The Zenzele movement consisted of women's associations or clubs and was spaces where black women learnt how to improve themselves and learn domestic skills. The African Women's Self-Improvement Association and the Bantu Women's Home Improvement Association, collectively known as the Zenzele movement after the two associations merged, were founded in the 1920s by 'Christian mission – educated, black women who sought to improve the lives of rural African

women'. The main goal of these clubs was 'self-help', as suggested by its name, Zenzele, and their activities included teaching women how to improve their lives by 'enhancing their subsistence farming and cooking skills and educating them about household cleanliness, basic child care, and health care'. Both associations gave less attention to cultural differences and did not take part in activities that were overtly political. By the 1940s, 'African women took the lead in the club movement and came to see the clubs as a way to participate in community and later national development'<sup>167</sup> According to Higgs, the Zenzele movement 'sought to unite African women across class and ethnic lines and focused their efforts on community development'.<sup>168</sup>

It seems that HCP made no provision in their program for the contribution of local, black women for the Zenzele clubs are conspicuously absent from all Health Centre reports that I reviewed. The historiography of the Zenzele clubs describes active participation of women where these clubs existed and according to Higgs, both educated and illiterate women attest to benefiting from their membership to these clubs. However, while the Zenzele movement and HCP may share similar goals, I have found no evidence of either of these two programs referring to each other. However, because of HCP's focus on black women, it may have been in their interest to co-operate with the Zenzele clubs and thus, HCP seemed to implemented their program without drawing on the knowledge and experience of local black women.

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<sup>167</sup> Catherine Higgs, 'Zenzele: African Women's Self-Help Organizations in South Africa, 1927 – 1998', (*African Studies Review*, 47(3), December 2004), pp. 119 - 14. Higgs, p. 120, quotes Susan Grieger's work that concluded that 'despite colonial administrators' efforts "to counter women's politicization" by diverting their attention to domestic concerns like "homecraft, child care and home hygiene," club women nevertheless became increasingly active in the [political organizations]'. Higgs also refers to Tripp's research about the use of the clubs in the 1940s by black women.

<sup>168</sup> Higgs, 2004, p. 119. See also, Higgs 'Helping Ourselves: Black Women and Grassroots Activism in Segregated South Africa, 1922 – 1952' in *Stepping Forward: Black Women in Africa and the America's*, eds., Higgs, Catherine, Barbara Moss and Earline Rae Ferguson. (Athens, Ohio: Ohio University Press, 2002), pp. 59 – 72 and Higgs' *The Ghost of Equality: The Public Lives of D.D.T. Jabavu of South Africa, 1885 – 1995*. (Athens: Ohio University Press, 1997)

Another way in which HCP ignored local knowledge and cultural practices was in relation to traditional healers. HCP advocates actively discouraged women from relying on advice from the *izinyanga* and in fact concluded that women's use of traditional healers in conjunction with the 'false beliefs' that women held, were two of the biggest obstacles to effective health education. The concern about these issues for the Medical Officers can be found in a number of examples. Firstly, the Health Assistants' training course, outlined above, specifically included a component on 'common beliefs of various communities regarding natural events, e.g. life, death, physiological illness, the 'medicine man', herbalist, 'quack', magic and witchcraft'.

Secondly, Kark and Henson also deal extensively in their annual reports with what they considered as problems related to superstitions and the fact that people consulted *izinyanga*. The case of T.M. outlined in Chapter One, illustrates Kark's attitude towards these issues. In this case, he concluded that the death of one of T.M.'s child was as a result of a number of factors including the actual illness. One of the main factors, however, was the fact that all the adults in that family were superstitious and was not in a position to persuade T.M. to continue the Health Centre treatment plan and thus abandon the advice from the traditional healer. In this case, the 'irrational beliefs included T.M.'s conviction that someone placed a curse on her while she was pregnant and as a result, she did not believe in the Kark's diagnosis and his proposed treatment. In Grassy Park, Henson reportedly also came across false beliefs and superstitions, which he termed 'old wives tales'.<sup>169</sup> The initial social survey included questions regarding people's beliefs about remedies for wounds and cuts, food and diseases as well as doctors, hospitals and medicine.<sup>170</sup> Henson compiled an interesting list of these 'false beliefs' that he came across in Grassy Park:<sup>171</sup>

- Too much bread and meat in children causes worms
- The main meal is at night and most children consume bread and coffee during the day
- Fear of hospitals because of unsympathetic doctors and nurses
- Any chest condition can be cured with oily medicine as the latter 'oils the lungs'

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<sup>169</sup> Grassy Park, 1951 Annual Report, p. 6

<sup>170</sup> Grassy Park Health Centre Annual Report, 1947, pp. 74 and 77 - 79

<sup>171</sup> Grassy Park Annual Report, 1946 - 1947, pp. 77 - 78

- One visits a doctor only when sick
- Some men believed that intercourse with a virgin will cure them of gonorrhoea
- Babies wear amulets around their necks to ward off disease
- Holding the arms above the head would stop coughing

The fact that these items listed above were included in Henson's list of false beliefs perhaps says more about HCP advocates and their views about the communities with whom they worked than about the community itself. Several of the items on Henson's list could have alternative explanations. It is difficult to evaluate Henson's motivation for including these items on the list of 'false beliefs' as he did not include any rationale. In any event, Medical Officers encouraged all Health Centre staff to take cognizance of the nature and role of the supposed false beliefs so as to recognize the signs when dealing with patients. In Polela, the 'Bantu staff' was commended for doing much to overcome this problem and was expected to play an important role in 'the eradication of false beliefs and superstitions'<sup>172</sup>

HCP advocates, therefore, made a concerted effort to persuade the women to reject traditional healers and to change the way in which they thought about health and healing. I found no evidence in the Health Centre reports or related publications of any efforts to incorporate into HCP elements of the local, cultural practices that may assist the work of the Health Centres. Instead 'false beliefs' as well as the use of *izinyanga* and other Bantu medicine-men' were considered a special problem. For example, in 1944 sixteen women used only *izinyanga* for pre-natal care and during the birth of their child; however, this may have been one opportunity to incorporate the work of traditional healers into the HCP team.<sup>173</sup> One advantage of such co-operation could have been improved maternal care considering the fact that HCP advocates disapproved of the nature of care provided by traditional healers. In stead, one of the things that the Medical officers decided to do was to expand the Health Centre services and thus 'spearhead of the necessary process of enlightenment'<sup>174</sup> because only people's 'experience would help them

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<sup>172</sup> Polela Health Centre Annual Report, 1950, p.34

<sup>173</sup> Polela Annual Report, 1944, p. 10

<sup>174</sup> Ibid. (Polela Health Centre Annual Report, 1942, p.1)

change their beliefs'. HCP was constructed as a project that delivered health services; however, it also undermined local knowledge generated by black women and put women in a position where they were asked to reject their traditional systems of health and healing.<sup>175</sup>

### **HCP and the maternal feminist**

HCP was largely constructed as women's health and in particular, as maternal health and therefore, reinforced the 'maternal feminist' views of women and women's health.<sup>176</sup> The health services to black women were mainly ante – and post – natal services and most notably, curative services for women and in particular, their children. The kinds of services to children that benefited women, as mothers, included routine immunization, health education and a nutrition or school-feeding program.<sup>177</sup> For women who worked, the Health Centres provided day care services. HCP offered a much-needed service given that before the Health Centres were established, the black section of the population had limited or no access to modern health services. Every Annual report of the Health Centres that were accessed for this research emphasized women and children. It was not uncommon for Medical Officers to write that 'the main emphasis of our work this year has once again been directed towards the care of the mother and child' or once again it can be seen that the people who make the most use of the Health Centre are the women and children'.<sup>178</sup> While this kind of service quite clearly reflected the demand in the community, it also promoted an essentialist view of women and women's social roles and this is evident in HCP and its birth control services.

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<sup>175</sup> In part, this approach to discourage the use of traditional healers was very different from other, Western-trained health professionals who worked with traditional healers. One such professional was Wulf Sachs who wrote about his relationship with a 'witch doctor' named John Chavafambira. W. Sachs, *Black Hamlet* (Johannesburg: Witwatersrand University Press, 1996).

<sup>176</sup> This section relies on the work by Susanne Klausen and includes specifically the following: 'For the Sake of Race': Eugenic Discourses in the South African Medical Record, 1903 – 26' *Journal of Southern African Studies*. 23 (1997), pp. 27 – 50 and *Race, maternity, and the politics of birth control in South Africa, 1910 – 1939*. (London: Palgrave Macmillan, 2005)

<sup>177</sup> See also CAD NGR 4, File 53, School Feeding (general) and CAD NGR 4, File 53 Government plans regarding school feeding of African Children in the Rural Areas.

<sup>178</sup> Annual Reports for Grassy Park and Polela, 1948 and 1950, respectively.

Grassy Park's 'family spacing clinic' was considered as one of HCP's great successes even though it was, like all birth control interventions, highly controversial. During the second half of 1950, Grassy Park<sup>179</sup> reported a 50% increase in attendance at their Family Spacing clinic compared to their 1949 records.<sup>180</sup> Forty-three (43) mothers attended 47 times and this was largely because the Health Centre staff undertook a number of steps to increase access to birth control services.<sup>181</sup> In 1947, Dr. Barlow, the Medical Officer, underwent training in the provision of family spacing services, which enabled the Health Centre to provide this service on a regular basis. Previously, the Mother's Clinic<sup>182</sup> was given space at the Health Centre to offer this service on a weekly basis. Grassy Park's rationale for the use of some form of fertility control was based on the belief that well-spaced families, not necessarily small families, made socio-economic sense. The most common reasons, thus, for promoting family spacing services were the low income and overcrowded conditions, as well as the characters of the mother and father. For example, the mother's alleged ignorance and negligence of her children were both considered legitimate reasons for the promotion of family spacing services. Of course, the fact that the mother worked in order to supplement the family income was also cited as a reason to provide birth control services. As for the father, his 'unwillingness to work or chronic alcoholism' would

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<sup>179</sup> Grassy Park is the only Health Centre for which I was able to access Family Planning services. This seems to be an anomaly. Klausen documented that by the 1940s, birth control services were already a public health issue endorsed and supported by the Department of Health. During the 1930s when Dr. Thornton, the then Secretary of Public Health and Chief Health Officer for the Union publicly endorsed birth control. According to Klausen, his rationale was partly the expansion of the mandate of the Department (see Chapter Four) and partly, the promotion of a medico-social approach to disease. Inherent in his approach was a neo-Malthusian notion that smaller families would advance rehabilitation of the poor. While Thornton referred to the 'poor white' problem, at Grassy Park, this same ideology was applied to black people. See Klausen, S. 2004 *Race, maternity* for a detailed history of the politics of birth control in South Africa during the first half of the twentieth century.

<sup>180</sup> Throughout the Health Centre reports, contraceptive services were referred to, as Family Spacing clinics whereas Klausen found that originally these centres were know as Mother's Clinics.

<sup>181</sup> Grassy Park Annual Report for the period 1 July 1950 – 31 December 1951 (CAD, GES 1919 58/32)

<sup>182</sup> See Klausen's *Race, maternity* (2004) for a history of birth control in South Africa during the first half of the twentieth century.

be sufficient for the women to access family spacing services. The birth control services at Grassy Park affected the relationships between the Health Centre's female clients and their male partners or husbands.

For the women, this service could be understood as an intervention that gave them control over their own fertility and their lives and therefore, allowed them to re-negotiate their social roles. It is clear from the Health Centre reports read together with Klausen's account of women's experiences that multiple pregnancies endangered women's lives, large families prevented them from taking up employment to supplement family income and closely spaced children affected their economic status. Most users of the Mothers' Clinics, according to Klausen, 'experienced numerous pregnancies [and] for some, childbirth was an annual occurrence. One woman was noted as having had thirteen pregnancies, all of whom survived into childhood. Another woman had '12 Pregnancies in 11 years'.<sup>183</sup> Family spacing services, as a general rule, afforded women with an opportunity to gain control over their fertility and their lives and in a complex way, HCP operated as women's ally in offering them this opportunity for control.

Birth control services in Grassy Park also became an issue of power and control for which both the husbands and Health Centre competed. Firstly, some of the men objected to family spacing service because, according to the Henson, they exercised enormous power in the home and that they opposed any new ideas introduced by the Health Centre.<sup>184</sup> It is therefore not surprising that the Health Centre considered the husbands as the main obstacle to effective family spacing services and that the husbands considered these services as 'subtle blows to their status'. The

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<sup>183</sup> Ibid. (p. 118)

<sup>184</sup> CAD, GES 1919 58/32. Grassy Park Annual Report for the period 01 July 1950 – 31 December 1951. Bradford, 1991; Kaler, 2003; and Klausen, 2004. While Kaler's research is set in Zimbabwe, she provides firstly, examples of ways in which women's fertility in Africa were linked to the psychopolitical and spiritual well-being of communities and how sex and reproduction have been invested with power and symbolism far beyond the biological mechanics of the acts. (pp. 2-3) Secondly, the struggle for control manifested through the family spacing services confirm much of Kaler's analysis of power, gender and fertility control. (pp. 1-2 and 225 – 235)

problematic relationship that men had with the Health Centres was discussed below including the possible reasons why men avoided the Centres. In light of this, Henson may have understated the extent of the 'blow to their status' when he considered it to be subtle. What is interesting though, is how this blow to men's status was constructed. It is not clear from the reports whether the husbands considered the women, the Health Centre, or both of these as undermining their status. In all likelihood the men understood that both the women and the Health Centres worked, in different ways, to undermine their status.<sup>185</sup>

Secondly, the Health Centre also tried to exercise their control over women's bodies, albeit in different ways than the husbands of the women. Through its Family Spacing Clinic, HCP reinforced the role of women as mothers. Klausen provides a detailed analysis of the birth control movement in South Africa including the Mothers' Clinic Committee (MCC). It is the MCC that first provided birth control services to women in Grassy Park at Henson's invitation. According to Klausen, the founders of the MCC were maternal feminist, 'middle class, mostly Anglophone women [who] also advocated birth control as a solution to the nation's crises'. The MCC recognized that 'the main threat to the nation was the tremendous suffering to which mothers were subjected to' including maternal deaths from abortion or during childbirth. The MCC was 'firmly committed to the notion that mothering was a women's primary social role', therefore, they reflected a 'prominent strand of international feminism in the 1920s and 1930s. As a 'liberal organization' the MCC served both 'poor white and black women, albeit in segregated sessions' and thus, the MCC shared 'elements of white supremacist thought'.<sup>186</sup> While Klausen's research compared the maternal feminist with the Race Welfare Society and their eugenicist philosophy, from a HCP perspective, the philosophy of the MCC also seem to have suited the HCP advocates. The politics of HCP and its birth control services were aligned with the maternal feminists and HCP, through the presentation of birth control, exercised control over women's bodies.

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<sup>185</sup> Ibid. (CAD, GES 1919 58/32. Grassy Park Annual Report for the period 01 July 1950 – 31 December 1951)

<sup>186</sup> Klausen, *Race, maternity*, 2005, p. 7

## **HCP: men negotiating the terms and nature of HCP**

Men also interacted directly with HCP advocates on various aspects related to the nature and terms of HCP. The first example included here relates to men as clients; the second illustrates how men shaped the nature of HCP, a service mainly used by women.

The Medical Officers were concerned about the fact that not as many men as women used Health Centre services and both Grassy Park and Polela undertook steps to correct this. In Grassy Park, the Health Centre provided a medical and dental clinic especially for men on a Sunday morning. This specific time was decided upon because Henson concluded that the men worked during the week and that they were not in Grassy Park during the Centre's normal operating hours. The special male clinic commenced during 1947 and in his 1948 report, Henson noted that the men were not making the best use of the Sunday morning sessions. In addition, he wrote that they are conservative and suspicious of social medicine and Health Centre services, as they, i.e. the men, are more familiar with curative health services.<sup>187</sup> Henson may have misunderstood the men's response to the Health Centre, as there may be at least three other possible reasons for their non-attendance.

While the men's conservatism and their levels of suspicion should not be underestimated, Henson's report does not sufficiently explore the reasons why the men avoided the Health Centre. Firstly, as discussed below, some of the men took exception to Henson's analysis of Grassy Park's problems and could have avoided the Centre on political grounds. Secondly, some of the people of Grassy Park considered themselves 'too grand' to make use of the Centre because they considered it as a service for poor people.<sup>188</sup> Thirdly, my own analysis found that HCP constructed health service largely as women's health and this may also have played a role in the men's perception of the Health Centre, i.e., the HCP was for women and children. I also found no evidence of deliberate efforts to attract male patients in Grassy Park, other than the Sunday morning sessions. Polela reported similar problems regarding male attendance: 24% and 32.4% of the male population attended the Health Centre in 1948 and 1949, respectively. Thus, it seems

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<sup>187</sup> Grassy Park Health Centre, Annual Report for the Year Ending June 30<sup>th</sup>, 1947. pp. 1 and 38

<sup>188</sup> Phillips, 'The Grassy Park Health Centre', in Dubow and Jeeves, 2005, p. 115

that the Health Centres struggled to get men ‘interested in their health and the health of their families.’<sup>189</sup> Finally, the men may have objected to some of the Health Centre’s services and express their protest by avoiding the Centre. For instance, Henson noted in his reports, and discussed above, some of the men objected to the family planning services offered to the women and that the men interpreted this as undermining their authority in their homes and their control over their wives. The non- or low attendance by the men in the communities where Health Centres operated cannot be dismissed merely as conservatism and suspicion.

A second illustration about HCP and its relationship with men concerns HCP, and in particular, Henson’s narrative about health and poverty and how some men from Grassy Park challenged that narrative in such a way that Henson was forced to engage the community with regard to the terms of HCP. In 1947, about a year after the Health Centre opened its doors, a reporter from a local newspaper, the Cape Argus, interviewed Henson during which he gave an overview of the work of the Health Centre. Henson explained the extent of disease and unhygienic conditions in the area. He was further quoted as saying that every third person died of TB and one in five of venereal disease and that the ‘ravages of malnutrition, caries and infestation with worms and vermin are clearly marked on the population. The overcrowded houses, badly ventilated and poorly lighted, are the breeding ground of infectious disease and immorality’.<sup>190</sup>

In addition to this interview, Henson further angered the men of Grassy Park when he opposed a liquor license application for the area on the basis that the ‘over-indulgence in alcohol’ was partly responsible for some of the social and physical ills in Grassy Park.<sup>191</sup> Henson said that ‘these people are not ashamed to drink, and to have babies while in a single state’ and that people’s social conditions have resulted in a loss of self-respect. He further suggested that the solution was to prevent the men from accessing alcohol; reduce the number of hours of service; and that the government should provide recreation facilities such as halls, parks, swimming pools, physical culture facilities and libraries. Both the interview and Henson’s views regarding the liquor license

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<sup>189</sup> Polela Annual Report, 1950, p. 10

<sup>190</sup> NAD, GES 2757, 141/70; [Cape Argus, 25 June 1947]

<sup>191</sup> Phillips, ‘The Grassy Park Health Centre’, in Dubow and Jeeves, 2005, p. 117

presented a narrative about Grassy Park, its people and the role of HCP that were contested by some of the men in the area.

The response by the men who challenged Henson's narrative of health and poverty in Grassy Park illustrates how men, who were supposedly on the periphery of HCP, could step out and engage with the man running the Health Centre and contest the nature and parameters of HCP. A group of them objected to Henson's assessment of the problems, especially his omission both in the interview and in his opposition to the liquor license, of the state's role in the creation and maintenance of poor health. The protestors publicly contested Henson's views and demanded an apology. They sent their letters of protest to the Minister of Public Health, the Department of Public Health and the Cape Argus, i.e. the newspaper in which the original interview appeared. They argued that Henson blamed the people for the appalling conditions, i.e. that they 'chose to live in overcrowded conditions'. In addition, they alleged that Henson overstated his case while he ignored the economic conditions of the people. Thus, their central argument was that Henson failed to mention that the Municipality neglected its responsibility with regard to the provision of basic services. Grassy Park, they continued, could not be considered an exception when it came to overcrowded homes as this was 'the root of bad health in different parts of the country, and [was] no fault of the people. Dr. Henson does not regard re-housing to fall in his scope of work. Neither does he give a solution to this vital problem. Instead, he suggests that it is the choice of the people to overcrowd for the purpose of breeding disease and immorality.'<sup>192</sup> With regard to the liquor license, the men raised arguments about their dignity for they wrote that they knew 'hundreds of families with good homes' and therefore, Henson had insulted 'every respectable member of the community'. The men particularly disputed Henson's view that the alcohol resulted in illegitimate children and that there was no evidence of overindulgence in alcohol.<sup>193</sup> The

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<sup>192</sup> Ibid. Letter to Minister of Health, Dr. Gluckman, 11 June 1947.

<sup>193</sup> Henson alluded to the abuse of alcohol in his reports, but did not go into any significant detail about this problem and it is therefore not possible to provide an opinion either way in respect of these counter arguments. What can be assumed is that each side may have overstated their case in order to win the sympathies of the authorities and make themselves look better than their accuser. It is interesting that Henson, in his communication to the Department of Public Health regarding the protestors, made a point of stating that Mr. Smith, the main author of the letter, may have an axe to grind because Smith 'applied for

protesters were emphatic that the poor conditions were allowed to persist by the State because of a lack of state services and active neglect of black people's health.

This altercation between the men of Grassy Park and Henson, as Medical officer shows that men were not really on the periphery of HCP. They could engage with HCP whenever it suited them and force a renegotiation of the terms and nature of HCP. In fact, as a result of this interaction, Henson was required to set up an Advisory Committee for the Health Centre. One of the main goals of such a Committee was to act as a community consultation forum where the work of the Health Centre was discussed. The women's voices are largely silent in this altercation and yet, as noted above, they were the main users of the health services. In a complex way, men emerged as the main, public negotiators of HCP, a service largely used by women.

## **Conclusion**

This chapter aimed to shed new light on HCP, in particular, what the history that is revealed when one applies a gender analysis to HCP. It therefore, aimed to show that programs, such as HCP, that may seem gender-neutral, are unable to escape the gender roles and relations. In addition, this kind of analysis illustrates that the limited recognition given to women in HCP historiography, does not recognize how deeply gendered HCP actually was. All the elements of HCP, i.e., the definition of health, types of health services and methods of delivering those health services, were informed by a specific worldview about black men and women. In return, when HCP was implemented, it interacted with those black men and women in ways that either reinforced or challenged their social identities.

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the post as Health Assistant but declined to accept the position when it was offered to him because he did not like the pay'. See Letter from Henson to the Department of Public Health, dated 26.6. 47, GES 2757, File 141/70.

## CHAPTER FOUR

### HEALTH CENTRE PRACTICE AS AN ‘ANTI-POLITICS MACHINE’

The suspension of politics from even the most sensitive political operations is the trick so that the project can form a strategically coherent or intelligible whole, i.e. the anti-politics machine.<sup>194</sup>

#### **Introduction**

*‘Visitors to the Health Centre have asked us whether our efforts were not after all in vain unless we could improve the economic status of the people, e.g. cause an increase in wages, etc. We have always replied that although this may be true, it is nevertheless our contention, that the residents of Grassy Park do not use even their present meagre incomes to the best advantage. We have therefore a tremendous amount of work to do even before we come to discuss an increase in wages, better housing and more effective educational measures.*

*We want to teach the people in the meantime to spend their money wisely on the best food at the cheapest prices; to save whatever they can for a rainy day; to cultivate their plots and grow their own vegetables; to clean out their houses and backyards; and to bring up their children in the best way possible. We have to make them racially conscious and proud; we have to foster social strata to awaken a desire for better things in life. In other words we must strive to improve the welfare not only of the individual and the family but also of the community as a whole, and help the people to regain their self-respect. Then and then only will our*

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<sup>194</sup> James Ferguson, *The anti-politics machine: “Development”, depoliticization, and bureaucratic power in Lesotho*. Cambridge: Cambridge University Press, 1990, p. 256

*work become worthwhile, as people will be able to help themselves and our work will become easier and less expensive to the tax-payer.*<sup>195</sup>

These are Dr. Jacob Henson's views about the people of Grassy Park, HCP and the broader political and economic context within which HCP operated during the 1940s. He recognized that perhaps an increase in wages might alleviate the poverty and poverty-related diseases that were so prevalent. However, Henson maintained that the HCP approach was still the most appropriate way for people to improve themselves. The causes of disease were, according to the HCP methods, largely attributed to the fact that the people were not using their financial and other resources effectively; they lived in unhygienic conditions and suffered numerous social ills. This kind of construction of the health problem led Henson and other HCP advocates to conclude that, i.e., intense and long-term health education would help people to change their ways. Poor black people and especially women, who did not have the vote and thus, were not fully recognized as citizens; had to learn to be racially proud, develop 'class-consciousness' and thus develop a desire to improve themselves as a community, and will then regain their self-respect. Once this was achieved, Henson opined, the real fruits of HCP will become visible.

We now know that HCP was never institutionalized and thus did not become the preferred method of health care delivery in South Africa.<sup>196</sup> During the 1950s no new Health Centres were opened and vacancies at existing Centres were not filled. Eventually, these existing Health Centres were either closed or handed over to the Provincial Administrations, which converted the Centres to ordinary clinics offering only curative services. Grassy Park officially lost its Health

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<sup>195</sup> GES 1919, File 54/32, Annual Report, Grassy Park Health Centre, 1947, p.7

<sup>196</sup> Alan Jeeves, 'Delivering Primary Care in Impoverished Urban and Rural Communities: The Institute of Family and Community Health in the 1940s' in *South Africa's 1940: Worlds of Possibilities*, eds. Saul Dubow & Alan Jeeves, Cape Town: Double Storey, 2005, pp. 87 – 107. Howard Phillips, 'The Grassy Park Health Centre: A Peri-Urban Poholela?' in *South Africa's 1940*, eds. Saul Dubow & Alan Jeeves, 2005, pp. 108 – 128. Shula Marks, 'South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics', *American Journal of Public Health*, 87 (1997), pp. 452 – 59 and 'Doctors and the state: George Gale and South Africa's experiment in social medicine' in *Science and Society in southern Africa*, ed. Saul Dubow, Manchester and New York: Manchester University Press, 2000, pp. 188 - 211

Centre status in October 1957 and most other Health Centres in the Cape Province during 1957 and 1958.<sup>197</sup> The Institute for Family and Community Health (IFCH), of which Polela became the rural Centre at the end of the 1940s, was officially closed in 1957.<sup>198</sup> Historians attributed the failure of HCP to Apartheid policies implemented by the National Party initially following their 1948 electoral victory, but more aggressively, following the 1953 election that they also won. The closing of the Health Centres was the most visible sign that HCP, and by implication the social medicine experiment, had failed and that the Afrikaner Nationalist state was instrumental in that failure.

This chapter engages with that particular aspect of the historiography about HCP that attributes the failure of HCP and by implication South Africa's social medicine experiment to the rise of Afrikaner Nationalism. While asking why HCP failed is an important question, I suggest that asking what was achieved in spite of the failure of HCP will shed new light on this aspect of South Africa's history. Both this research question and the conceptual framework used in this chapter are based on the approach developed by James Ferguson in *The Anti-Politics Machine: "Development", depoliticization, and bureaucratic power in Lesotho*. In brief, Ferguson concluded that a development project that aimed to be apolitical, in fact did highly political work. In addition, he argued that development projects may have 'unintended consequences', i.e. results that may not have been planned or even intended by its implementers. Ferguson's conceptual framework allows me to consider HCP as a development project that failed to achieve its overall objectives, and yet had significant consequences. This kind of analysis of HCP is useful for a number of reasons. Firstly, the discourse around HCP constructed health and health services in a very specific manner that had an impact on the way in which black people's health was perceived. Secondly, HCP acted as a conduit that produced certain unintended consequences that require investigation, something that has not yet been done. Finally, HCP was connected to the

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<sup>197</sup> GES 2754, File 106/70C Vol. 1, Department of Public Health Memorandum re: Closure of Health Centres

<sup>198</sup> Sidney Kark and Emily Kark, *Promoting Community Health: From Pholela to Jerusalem*, Johannesburg: Witwatersrand University Press, 1999. Alan Jeeves, 'Delivering Primary Care in Impoverished Urban and Rural Communities: The Institute of Family and Community Health in the 1940s' in *South Africa's 1940s: Worlds of Possibilities*, eds. Saul Dubow and Alan Jeeves, Cape Town: Double Storey, 2005, pp. 87 - 107

broader political and economic context in complex ways that partly determined the way in which HCP failed.

With respect to the layout of this chapter, the first section describes the nature of the *anti-politics machine* and the second, an analysis of HCP as an ‘anti-politics machine’, i.e. HCP discourse about black people’s health and also the unintended consequences of HCP. There are four specific consequences that will be covered: the expansion of state control and the bureaucracy; the consolidation of the Department of Public Health at the expense of the people it served; ways in which HCP reinforced black women’s status as second class citizens and how HCP not only reproduced the political ideologies through its own practices, but was implicated in the patriarchal, racist politics of the time.

### **The ‘anti-politics machine’**

A development institution<sup>199</sup> becomes an ‘anti-politics machine’ when it ‘depoliticizes everything it touches, everywhere whisking political realities out of sight, all the while performing, almost unnoticed, its own pre-eminently political operation of expanding state power’.<sup>200</sup> This is how Ferguson described the political work of the Thaba-Tsheka Project that operated in Lesotho from 1975 until 1984. The project was co-sponsored by the World Bank and the Canadian International Development Agency (CIDA) and the overall goal of the project was the development of a fairly isolated Thaba-Tsheka mountain region. The Thaba-Tsheka project aimed to ‘open up and develop the rangeland in the interior of the country for increased commercial livestock production’.<sup>201</sup>

The Thaba-Tsheka project consisted of a number of components, two of which will be mentioned here. Firstly, the project planned the construction of a regional Administrative Centre to establish a government presence. It was assumed that economic development could only take place with

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<sup>199</sup> The ‘development institute’ is understood as a combination of a very specific kind discourse, ways of thinking and interventions and for this reason, argues Ferguson, the ‘development model’ can be transplanted without consideration of local particularities or even historical factors.

<sup>200</sup> Ferguson, *The anti-politics machine*, 1990, p. viii

<sup>201</sup> *Ibid*, p. 75

state assistance and the actual presence of the state bureaucracy. Secondly, the project planned to improve the road link between Maseru and the Thaba-Tsheka region by constructing a new road. According to the project implementers, the road reduced the transport costs<sup>202</sup> and provided the farmers easier access to markets in Maseru where they sold their surplus agricultural production. These two interventions, i.e. the administrative centre and the new road, were meant to stimulate and develop economic growth in the region. It is important to note that in order for the project to succeed, the project implementers encouraged the farmers to change their agricultural practices. Prior to the commencement of the project, the farmers concentrated on subsistence maize production and the Thaba-Tsheka project implementers convinced the farmers to switch to wheat, as the latter would do better on the market. Clearly the Thaba-Tsheka development project planned a radical transformation of the region.

Unfortunately, the project did not unfold as planned and by 1979, the CIDA spokesperson concluded that the project was ‘considered a very large and costly mistake’.<sup>203</sup> In addition, a CIDA evaluation found that ‘neither the households nor the area [were] better off [and] the quality of village life as perceived by the people and as measured by people’s perceptions of well-being did not improve and in fact, declined’<sup>204</sup> While Ferguson’s research does not ignore the fact that the Thaba-Tsheka project did not meet its goals, rather he asked what was achieved in spite of the failure of the project? He developed the analogy of the ‘anti-politics machine’ to illustrate the ways in which the Thaba-Tsheka development project may have failed, but during its lifetime carried out sensitive political work, the effects of which remained long after the project was terminated. Essentially, the nature of the political work was two-fold; one, the construction of a conceptual framework that depoliticized poverty, the state and oppression and, two, the expansion of state control and the state bureaucracy in ways that were non-existent prior to the commencement of the development project.

Firstly, the conceptual framework and discourse of the development project served as vehicles through which poverty, the state and oppression, all highly political issues, were depoliticized.

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<sup>202</sup> Ibid. p. 78

<sup>203</sup> Ibid. p. 256

<sup>204</sup> Ibid. p. 251

The Thaba-Tsheka development project produced the depoliticization effect in the way in which it analyzed the causes of poverty, the nature of oppression and the role of the state in both poverty and oppression. In addition, the development discourse prescribed ways in which these issues can be addressed. Thus, in Lesotho, the Thaba-Tsheka project constructed Lesotho as a particular kind of object of knowledge, and created a structure of knowledge around that object. The World Bank, for example, constructed Lesotho as a less developed country and its people were poor largely because of government inaction. With respect to Thaba-Tsheka, the mountainous region was constructed as being inaccessible and that the farmers were not engaging in agricultural activities that could improve the economy of the region. This information informed the project planners to include in its plans, i.a., new road and switch from maize to wheat production. Thaba-Tsheka's description of the government and the causes of poverty omitted, for instance, the effect of Lesotho's colonial past as well as the effect of the unequal and racist economic development in South Africa, to which Lesotho was intricately bound.<sup>205</sup>

Thaba-Tsheka's particular construction of the people, the Lesotho government and causes of poverty was, however, necessary for the development project to operate. It was true that the mountainous region was difficult to access and that there was no effective road link between Thaba-Tsheka and Maseru. It was also true that there were no direct state presence in the region however, these facts constituted part of a much more nuanced reality. As noted above, this kind of discourse omitted important political and economic information and Ferguson found that the construction of Lesotho by the Thaba-Tsheka development project provided a distorted version of the reality. Contrary to the World Bank and CIDA project documents, Lesotho entered the twentieth century, not as a 'subsistence' economy or a 'traditional peasant society' and neither was it 'untouched by modern economic development'.<sup>206</sup>

The importance of the production of ideas and knowledge in this instance was, according to Ferguson, not merely about ideas. Thaba-Tsheka's discourse about poverty, the state and oppression were used to design and implement interventions and as a result, had real effects, i.e.

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<sup>205</sup> Ibid. p. 37. Lesotho was, for example, also affected by the consequences of unequal economic development in South Africa following the discovery of minerals on the Witwatersrand.

<sup>206</sup> Ibid.

the construction of a new road link between Maseru and Thaba-Tsheka as well as an Administrative Centre. In addition, certain strategies were implemented to improve agricultural production and to cultivate produce that would sell on the market. What the Thaba-Tsheka project did, however, was affect the social organization of the community and these changes were considered legitimate because the knowledge that facilitated these changes in the community was itself afforded legitimacy because of its association with the development institution.

Central to the conceptual framework and discourse of the Thaba-Tsheka project was that the implementers of the project did not view it as political in nature or considered development work as political work. The project did not address the economic and political causes of poverty and it did not consider the role of politics, contemporary or historical, in the creation and maintenance of poverty and oppression. Therefore, the effect of this development discourse was that it presented poverty, oppression and the state in neutral terms precisely because the development institution insisted that development work was about technical problems with technical solutions. This construction effectively depoliticized conditions of poverty, the nature of oppression and the role of the state.

Secondly, the expansion and control of state power constituted a different way by which the Thaba-Tsheka project conducted political work and therefore operated as an ‘anti-politics machine’.<sup>207</sup> The Administrative Centre, referred to above, allowed the state to establish itself physically in an area where, prior to the development project, it was only marginally present. Towards the end of the project, a range of government agencies occupied the Administrative Centre and delivered services to the people. Historically, the opposition controlled the Thaba-Tsheka region and the government had no real influence over the people. Once the state bureaucracy established itself in the Administrative Centre, it exercised political control over the region through the provision of state services. As an ‘anti-politics machine’, the development project was not a machine that eliminated poverty that was incidentally involved with the state bureaucracy, as was intended, but it was a machine that reinforced and expanded bureaucratic state power, which incidentally took poverty as its point of entry.<sup>208</sup>

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<sup>207</sup> Ibid. p. 255

<sup>208</sup> Ibid. p. 256

Based on Ferguson's analysis of the Thaba-Tsheka project above, I propose that HCP, similar to the Thaba-Tsheka development project, was an 'anti-politics machine'. In addition, HCP knowledge was used to design a range of health services and therefore, HCP discourse had real consequences. The second issue is that HCP, through the implementation of its health services, facilitated an expansion of state control and bureaucracy using disease and poverty and health as its entry points.

### **HCP discourse about black people's health**

The particular discourse about black people's health effectively omitted the role of the economic and political factors in the creation and maintenance of the poor living conditions of black people. As discussed in Chapter three, HCP constructed health in a broad manner, i.e. that health status was the result of group living and therefore an individual's health status was intricately linked to the health status of his / her social and geographical communities, such as families, friendship groups, co-workers and neighborhoods.<sup>209</sup> This definition of health could easily include the political and economic causes of poverty as significant determinants of health status. While HCP acknowledged the consequences of both unequal economic development and labour migration, it chose not only to accept the political and economic conditions as a *fait accompli*, but went much further by blaming black people. The next section provides three illustrations of the HCP conceptual framework and discourse in respect of black people's health.

Firstly, HCP constructed the problem of overcrowding as one of choice without any reference to the unfair land policies and the local municipality's dereliction of its obligation to provide black people, within its boundaries, with basic services. The most common diseases listed in the Health Centre reports were tuberculosis (TB), venereal diseases such as gonorrhoea and syphilis, small pox, typhus, leprosy and impetigo. These conditions were directly related to poverty and unhygienic living conditions. Henson pointed out: the people failed to clean their homes and backyards, to cultivate their own vegetable gardens and to bring up their children in a proper way.

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<sup>209</sup> Alwyn Smith, *The science of social medicine*, London: Staples Press, 1968. Sidney Kark and Guy Steuart, eds. *A Practice of Social Medicine: A South African Team's Experiences in Different South African Communities*, Edinburgh: E & S Livingstone, 1962

He also concluded that people chose to live in overcrowded conditions, for example, the case study of the Hess Family referred to in Chapter three. According to the Grassy Park records, the Hess family was one of the families that could benefit from health education and Mrs. Hess was reportedly a proper mother and wife. According the Health Centre records, she managed the family's small income; the children were always clean and attended school regularly. In addition, the house was always tidy and Mrs. Hess also cultivated a vegetable garden. However, early in 1947 when the Campbell Family was evicted, Mrs. Hess took them in. As a result, two families shared a three-roomed house. Mrs. Hess, her husband and their five children slept in the bedroom and the Campbell family slept in the living room. In Henson's view, the families 'elected to stay under one roof'.<sup>210</sup> Thus, Henson personalized the overcrowded conditions and in his assessment made no reference to the shortage of housing, the reasons why the Campbell family was evicted or should not have been evicted. In addition, Henson does not mention the role of the local municipality in the Campbell eviction, even though he did this in great detail when he outlined the services he managed to secure for Grassy Park as a result of his own advocacy.

Another illustration of HCP discourse and how it constructed black people's health relates to women and their role in the prevention of ill health. Some women were considered ignorant and backward by HCP advocates, when these women failed to act as good mothers. In his evaluation of the 'Home and Family of H NZ' in Polela, Dr. Sydney Kark, the Medical Officer-in-Charge of Polela Health Centre, wrote that while the family was very poor, the 'head of the home is keen to progress, but spends 11 hours a day away from home [and his] present wife is an extremely backward person, lazy and unkempt, and the home, unfortunately, reflects her personality. It is kept in an untidy and filthy condition.' In addition, 'there has been a marked decline, e.g. the state of repair of the huts is very poor – leaking roofs, cracking walls and closing in with daub of the few windows in the huts.'<sup>211</sup>

While Kark's reports recognizes that the family was 'very poor' he did not provide details about the woman's mental health status, whether she could physically undertake the tasks required in

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<sup>210</sup> GES 1919, File 54/32, Annual Report, Grassy Park Health Centre, 1947

<sup>211</sup> Sidney Kark, 'A Health Unit as Family Doctor and Health Advisor' *South African Medical Journal*, (February 12, 1944), pp. 39 - 46

order to maintain the hut or whether the family access to building materials in order to repair the hut. Instead, Kark's assessment blamed the family's conditions on the woman and her laziness as well as her backwardness. In addition, his report did not include any reference to the political and economic systems that allowed a man to be away at work for eleven hours. Yet, Kark's basis for intervention was the fact that the man 'was keen' to improve his family's conditions and therefore, the Health Centre would not withdraw their services from the family.

A third and final example of HCP discourse and black people's health relates to the anti-soil erosion measures that the Health Centres implemented particularly in the rural areas. HCP encouraged the cultivation of vegetable gardens and alongside that program, taught people soil conservation strategies. In respect of the latter, Kark recognized the role of weather patterns such as drought, but emphasized the fact that people conducted poor agricultural practices.<sup>212</sup> Kark's reports omitted that a combination of land shortage, overcrowding and poverty meant that the 'reserves' were no longer economically viable. As discussed in Chapter two, the reserves did not expand in any significant way since the adoption of the 1913 Land Act, which allocated only 13 per cent of the land to black people, who comprised more than 80 per cent of the population.<sup>213</sup>

The construction of soil erosion and the reserves, for instance by Kark, was not very different from the dominant view about black people and soil conservation. Dodson describes how politically divisive soil conservation was. The 1923 Draught Investigation Commission's Report essentially institutionalized the view that black people were not managing the land on the reserves.<sup>214</sup> The actual goal of this Commission was to find a suitable response to white poverty and to help white farmers, but it also commented on land use by black people. For example, the findings in respect of the reserves and black people's agricultural practices, led to the adoption of a number of legislative measures that were enacted and effectively punished black people if they did not abide by the law, despite the fact that it was almost impossible to do so. For example, the Department of Native Affairs launched its postwar reclamation program in December 1944. According to the program, the 'primary measures' included 'scientific demarcation of residential,

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<sup>212</sup> See various Annual Reports for the Polela Health Centre.

<sup>213</sup> For example, Deborah Posel, *The Making of Apartheid: 1948 – 1961*. Oxford: Clarendon Press, 1991

<sup>214</sup> Dodson, B. 'Above Politics? Soil Conservation in 1940s South Africa' *South African Historical Journal*, 50 (2004), pp. 49 - 64

arable and grazing land, limitation of stock numbers, the establishment of rural villages to provide suitable houses for the families of Natives regularly employed in industry and other services'.<sup>215</sup> This particular health service was another way in which HCP attempted to construct black people's health and their role in prevention of disease in an apolitical manner. The problem of soil was framed as technical interventions whereby people were taught certain strategies that would their agricultural practices and consequently, avoid malnutrition by improving their diet. These anti-soil erosion interventions omitted the role of the state, in particular, its land policy and constructed a discourse about malnutrition that blamed people's inability to, for example, follow effective subsistence agricultural practices.

In various ways, HCP discourse constructed a particular kind of knowledge about black people's health and their role in prevention of disease. This discourse created a set of facts about black people's health that identified the immediate causes of disease as more important than the underlying causes. In fact, in most instances, HCP discourse failed to mention the underlying causes of black people's health and thus, presented a distorted view of the true nature of black people's health. Henson's quotation at the beginning of this chapter illustrates this point for he recognized the potential contribution of an increase in wages yet, he immediately writes it off as a significant factor. HCP, similar to the Thaba-Tsheka development project, operated as an 'anti-politics machine' and depoliticized the state, disease and the role of the state.

## **Unintended consequences of HCP**

As stated above, this section examines some of the unintended consequences of HCP, specifically the:

- expansion of state control and the bureaucracy
- consolidation of the Department of Public Health at the expense of the interests of the people it served
- reinforcement of black women's status as second class citizens
- reproduction of patriarchal, racist political ideologies through its own practices

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<sup>215</sup> Ibid. p. 57

## **Expansion of state control and the bureaucracy**

The most obvious example of the ways in which HCP expanded the control of the state was, like Thaba-Tsheka, through the establishment of a physical presence representing the state and providing access to state services. When the Polela Health Unit was established, Kark noted the absence of communal services organized from within Polela. Everything, he noted, was organized by ‘outsiders’, such as government officials and thus, there were no or limited government services available in Polela other than those organized from outside of Polela. The Health Centre was physically and symbolically, at the ‘centre of the community’.<sup>216</sup> For example, the physical absence of the state meant that the Health Centre had to offer an extensive list of services, including those normally delivered by other government departments. Polela established a maternity ward close to the Health Centre. The purpose of the maternity ward was twofold. Firstly, the Centre provided medical assistance to women who experienced difficulties during childbirth and secondly, the ward also acted as a training centre where mothers were taught how to take better care of their babies. Polela ran the School Feeding Scheme that provided daily meals to the school in the area on behalf of the Department of Education.<sup>217</sup> In addition, in the absence of any direct government presence, Polela collected all the census data and at one stage applied to become the official ‘office’ to house a registration of all births and deaths. Even though this application was turned down, Polela continued to collect health data and vital statistics. In a number of ways, Polela became representative of the State.

Grassy Park acted as a proxy for the state in less obvious ways and largely because it took on the role of an intermediary. Henson facilitated access to services provided by other government agencies, in particular the local municipality and the social welfare department. As discussed in Chapter three, Henson exploited the peri-urban location of Grassy Park as well as the state’s practice of a racial hierarchy, i.e. a practice that allowed ‘colored’ people to access more services than ‘African’ and Asians. Some of the successes of Henson’s exploits were the establishment of

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<sup>216</sup> Kark, ‘A Health Unit’, *SAMJ* (1944), pp. 39 - 46

<sup>217</sup> See various Annual Reports for the Polela Health Centre including GES 1917, File 46/32, Annual Reports, Polela Health Centre, June 1945 and June 1950; NGR 4, File 53, School Feeding: General and NGR 4, File 53: School Feeding – communication regarding School Feeding of African Children in Rural Areas.

communal amenities, for example, a subsidized milk depot, better roads and supply the area with municipal water supply<sup>218</sup>, a post office as well as a regular bus service between Grassy Park and Wynberg.<sup>219</sup> Henson and the Grassy Park Health Centre did not only act as an intermediary between the people and the state, it also facilitated the extension of government services.

HCP, through Polela and Grassy Park, assisted the state bureaucracy to extend its reach and thus, transformed HCP into an 'anti-politics machine'. HCP, like Thaba-Tsheka, had positive consequences, for example, more people benefited from state services than before Health Centres were established.<sup>220</sup> In addition, HCP also neutralized the neglect, harassment and violence that people experienced at the hands of the very same state. Thus, the way in which HCP operated was to depoliticize the role of the state in the creation and maintenance of disease and poverty. In the case of Polela, the Health Centre created a physical presence for the state where no official office existed prior to the establishment of Polela. Both Polela and Grassy Park can be understood as using the apparent enjoyment of health services to appease people who were at the receiving end of the injustice and violence of the state. Kark stated that the social goals of the Health Centres were to 'mitigate the effects of social injustice'<sup>221</sup>.

The social injustice that Kark referred to was widespread, often violent and extended far beyond a lack of health services, which was a form of institutional violence in and of itself. The context within which Health Centres were established was described in Chapter two and includes the experiences of black labour tenants on white owned farms<sup>222</sup>, harassment as well as physical and

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<sup>218</sup> CAD, GES 1919 File 54/32 (Grassy Park Health Centre Annual Report, 1947, p.33)

<sup>219</sup> CAD, GES 1919 File 58/32 (Grassy Park Health Centre Annual Report, 1950, p.14)

<sup>220</sup> The initial reports of both these Health Centres documented people's access to health services prior to the establishment of the Health Centres.

<sup>221</sup> Kark et al, *Promoting Community Health*, 1999

<sup>222</sup> See Callinicos' description of Mpelilape Masina's family in Chapter two and reported in Luli Callinicos, 'Testimonies and transitions: Women negotiating the rural and urban in the mid-20th century' in *Basus/iimbokodo, bawel'imilambo/They remove boulders and cross rivers Women in South African History*, ed. Nombonisa Gasa, Cape Town; Human Sciences Research Council Press, 2007, pp. 153 – 184.

emotional violence when police implemented the pass laws.<sup>223</sup> In addition, in 1946 several workers died during the mineworkers' strike that aimed to address low wages and the right to organize that was prohibited by War Measure 1425.<sup>224</sup> There were also indications that people were suspicious of the *bona fides* of the HCP advocates who arrived to rescue them from poverty, but may act on behalf of the repressive state. The interaction between Health Assistants and members of the community in Polela reflected the people's suspicion of HCP. When a Health Assistant advocated the use of the pit privy to one individual, the latter reportedly replied that the privy appeared to be 'a very good thing, provided your doctor is not starting a campaign to open more gates for Government taxations.' Both the colonial and the settler governments used taxes to undermine people's livelihoods and drew them closer to the state. In this instance, the individual wondered whether the Health Centre aimed to provide them with services that would seemingly improve their lives and at the same time, attempt to enforce a repressive state practice.

In a different incident, another individual said to the Health Assistant, 'my son, you have been to school and you know that this was once our land and we had one supreme chief. Today we are beggars for land. The man who has sent you to us (i.e. Government or white man generally) is one of those who took our land by giving friendly advice which made it appear as though they were quite prepared to help us.' Again, this individual reminded the Health Assistant about the loss of their land at the hands of the white colonizers implicating the missionaries who also arrived at an earlier time to rescue black people from their poverty.<sup>225</sup> Thus, the establishment of

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<sup>223</sup> Gasa, ed. *They remove boulders and cross rivers*, 2007. Deborah Posel, *The Making of Apartheid, 1948 – 1961*, Oxford: Clarendon Press, 1991

<sup>224</sup> T.R.H Davenport and Christopher Saunders, *South Africa, a modern History*, eds. 5<sup>th</sup> edition, New York: St. Martin's Press, 2000, pp. 356 - 361

<sup>225</sup> GES 1889, File 2/32H, Annual Report of Polela Health Centre, June 1941, p.5 and Davenport *et al*, *South Africa*, 2000. Similar sentiments were expressed in the urban centres when black people had to engage with Health Assistants and white University researchers. In certain instances, the people of Rooiyard linked increased police harassment directly with the visits and work of the anthropologist, Ellen Hellman. See *Rooiyard, a sociological survey of an urban native slum yard*. Cape Town: Oxford University Press for Rhodes Livingstone Institute, Livingstone, Northern Rhodesia, 1948. Also, there is a discussion about people's perceptions about Hellmann's work, for example, that black people were only

the Health Centres cannot be considered apolitical for, as in Lesotho; HCP was invariably an extension of the state, but it was also an intervention that omitted to recognize the institutional and actual physical violence perpetrated by the state.

### **Consolidation of the Department of Health**

HCP became the vehicle through which the Department of Public Health could spearhead its struggle for the expansion of its mandate. This view does not negate the fact that there was a need for an expanded health care system, but rather requires an examination of the institutional context within which HCP was established and developed. The struggle for greater control over health and related services was already underway and the Department of Public Health bureaucrats used this opportunity to advance their position.

The division of powers related to health care was a contentious issue since the formation of the Union.<sup>226</sup> The 1909 conference convened to discuss the nature and structure of the Union, determined the health-related functions of the three spheres of government. The Provincial Administrations retained control of the hospitals and were thus responsible for expensive and highly technical, curative medicine. The local authorities were granted control over environmental and all non-personal health services such as provision of water, electricity, waste removal and housing. 1918 was the first time that the Health bureaucrats could really challenge the organization of the health care system with a view of expanding their mandate. The Influenza Epidemic of that year resulted in the drafting of the Public Health Act, formally adopted in 1919, and the establishment of a Union Department of Public Health (DPH). The latter department was formed under the authority of the Ministry of Welfare and Demobilization, which was renamed the Ministry of Health, Welfare and Demobilization. Thus, since the formation of the Union, the

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useful to white people as research subjects. See Sachs Wulf, *Black Hamlet*, Johannesburg: Witwatersrand University Press, 1996.

<sup>226</sup> Rich, *White power and the liberal conscience*, 1984. During the conference convened to discuss the formation of the Union, the question of health was also discussed and the outcome of these discussions informed the 1911 Constitution. See also Hon. Robert Henry Brand *The Union of South Africa*, (Oxford: The Clarendon Press, 1909) and Davenport et al, *South Africa*, 2000.

Health bureaucrats sought opportunities to extend their mandate and between 1918 and 1940, there were at least two opportunities to do this.

The Department of Public Health extended its mandate when it incorporated birth control services during the 1930s. The Mother's Clinic and the Race Welfare Society provided birth control services to poor black and white women, respectively. Klausen documented how these private institutions approached government for funding to operate the birth control clinics and by 1935, the then Secretary for Health, Dr. Thornton, approved their requests for public funds.<sup>227</sup> This approval on the part of Thornton was surprising, argued Klausen, given the political divisions related to birth control, motherhood and the role of women. However, Thornton convinced his political superiors of the need to support the birth control clinics when he advocated for a medico-social approach to public health. Thornton could also advocate for financial support for the birth control clinics because of the anxiety related to the poor white problem, the notions of a strong white nation and consequently, the significance of healthy women and their reproductive role.<sup>228</sup>

Further impetus for an expanded mandate came via the welfare work of the Union government. Following the Carnegie Commission of Investigation on the Poor White Question<sup>229</sup> and the Cape Town General Board of Aid survey of white poverty in Cape Town, Union Government set up a Department of Welfare. The latter was launched as an autonomous department in 1937 when the state expanded its welfare work.<sup>230</sup> 'The Union Government's welfare role was at first limited. Its

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<sup>227</sup> The following publications by Susanne Klausen traces this history: 'The Race Welfare Society: Eugenics and Birth Control in Johannesburg, 1930 – 1939' in *Science and Society in Southern Africa* ed. Saul Dubow, Manchester: Manchester University Press, 2000; ' 'Poor Whiteism', White Maternal Mortality, and the Promotion of Public Health in South Africa: The Department of Public Health's Endorsement of Contraceptive Services, 1930 – 1938' *South African Historical Journal*, 45 (2001), 53 – 78; and *Race, maternity, and the politics of birth control in South Africa, 1910 – 1939*, (London: Palgrave Macmillan, 2005), p. 132

<sup>228</sup> See Klausen, note 34. See also, Cherryl Walker, ed. *Women and Gender in Southern Africa to 1945* Cape town: David Philip and London: James Currey, 1990

<sup>229</sup> John Iliffe, *The African Poor: A History*, Cambridge: Cambridge University Press, 1987

<sup>230</sup> Op cit, note 36, especially pp. 117- 123 for the construction of white poverty and the expansion of the state through the establishment of the Department of Welfare.

most important service (in conjunction with the provinces) was medicine, which was in effect free to the poor, although often difficult of access. The Union Government was also responsible for miners' phthisis and workmen's compensation. Under the Children's Protection Act of 1913 it made maintenance grants to white and Coloured destitute children, orphanages and children's home, and eventually needy mothers and grandmothers. Old age pensions for indigent whites and Coloureds were introduced in 1928, making the Union Government for the first time a larger contributor to social welfare than the provinces.'<sup>231</sup> In addition to the Union Government's efforts, there were many private welfare agencies providing services to the poor. It was this 'uncoordinated welfare' regime that, according to Iliffe, the Union Government aimed to manage with its new Department of Welfare. The increase in staff members is the most obvious indication that this latter Department was expanding in its scope: between 1939 and 1949, the staff complement increased from 257 to 1,278.<sup>232</sup> The expansion of the Welfare Department illustrated the possibility for expansion.

HCP was introduced into this context outlined above, i.e. a history of bureaucratic efforts to expand the mandate of the Department of Public Health. HCP thus came as another opportunity to extend the reach of this Department and by 1940, social medicine, as an underlying philosophy for health services, was not foreign to the Department. During the 1920 and 1930s, Thornton promoted the idea that an improvement of public health services for all races and particularly for rural inhabitants was urgent. His predecessor, J.A Mitchell, also recognized the importance of a medico-social approach to disease and thus, the connection between social and biomedical dimensions of health. It was this institutional tradition that Dr. H.S. Gear, the Assistant Health Officer in the Department of Public Health relied upon when he wrote in 1936 that the 'defects and ill health arise in large part from the play of social and economic factors, the study and treatment of which thus becomes a health function' and therefore, effective responses must include the prevention of mortality and morbidity.<sup>233</sup>

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<sup>231</sup> Ibid.

<sup>232</sup> Ibid.

<sup>233</sup> Klausen, *Race, maternity*, 2004, p.132

What, however, about the consolidation of the Department of Public Health can be considered as transforming HCP into an ‘anti-politics machine’? How did the internal, institutional dynamics of the Department depoliticize the state, poverty and health? The expansion of government services, in particular HCP is in and of itself not problematic, however, returning to Ferguson’s analysis of the development project, it is the political effects of that consolidation that is more important. The Departments’ ambitions for expansion were hugely curtailed when the State adopted only certain aspects of the Gluckman Commission’s report.<sup>234</sup> However, by relying upon the individual and politically less controversial aspects of HCP, Department bureaucrats continued their expansionist agenda.<sup>235</sup> The construction of nutrition serves as an example and via its new Division of Nutrition; the Department perpetuated the idea of health and poverty as apolitical and thus, omitting to deal with or discuss the critical role of the state.

HCP emphasized nutrition and implemented a number of services, including health education, in order to improve the nutritional state of poor black people. As a result of the importance of nutrition, the Department established a Division of Nutrition in 1952 with Dr. C. H. Spamer as its head. Spamer explained the role of this division and its construction of nutrition in a paper that he presented at the 10th Annual Congress of the Health Officers’ Association of Southern Africa.<sup>236</sup> The main thrust of Spamer’s views about nutrition, and therefore the Department, was that nutritional status was an individual responsibility and the extent to which one exercised that responsibility, effectively determined the nature of one’s citizenship. Spamer identified food,

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<sup>234</sup> The State, represented by the then Minister of Health, Harry Lawrence, announced that it would accept the recommendations of the Gluckman Commission’s report with two reservations: the provincial administrations would retain control over curative medical services, i.e. the hospitals, and that there would be a phased approach with regard to the implementation of the services. De Beer, *South African disease*, pp. 26 - 7

<sup>235</sup> One of the reasons for the partial adoption of the Gluckman Commission’s Report, according to De Beer, was that poverty was largely a black problem by 1944 and thus, the political imperatives for a National Health Service (NHS), as envisioned by Gluckman as well as Department bureaucrats, were no longer present. Also, the political leaders and white minority were not interested in amending an entire system in order to accommodate black people.

<sup>236</sup> NVR 13, File 128, Presentation by Mr. C. Spamer: ‘The Role which the New Union Department of Nutrition will play in the Health of Europeans and Non-Europeans in our Country’

clothing and housing as the three basic needs of all humans and noted that by the 1950s, 'only a small percentage of the population [was] in an optimum nutritional condition'. According to Spamer, the causes of poor nutrition were poverty, lack of food and ignorance and solutions to this problem were constructed as follows:

- The 'lack of purchasing power', i.e. poverty, could be addressed by enriching basic food items such as brown bread and maize meal.
- The lack of access to protective food could be resolved by extending food subsidies.
- 'Ignorance, indifference and wrong eating habits', ironically, in Spamer's view as the 'most important' causes of poor nutrition, could be addressed through education. While Spamer recognized the 'diversity of the population and their eating habits', he believed that 'housewives' had to be educated so that they would understand the 'basic principles of food preparation'. In the tradition of HCP, Spamer was of the opinion that 'it [was] useless to waste good food and poor preparation'.

Similar to HCP, Spamer and therefore, the Department of Public Health, recommended strategies that would essentially effect cosmetic changes and omit dealing with the underlying political and economic causes of under nutrition. In fact, Spamer clearly stated that an individual who is undernourished would be a 'useless citizen'. The construction of nutrition not only blames poor people for their own poor nutritional status, it also defines the nature of people's citizenship by the way in which they take responsibility for their own nutritional status. Nowhere in Spamer's construction of nutrition and the solutions to poor nutritional status of people does he reflect critically on the political and economic conditions that created poverty and lack of access to, for example, protective food. Consequently, Spamer succeeds in depoliticizing poverty, health status and the role of the state. The consolidation of the Department of Health, which could be seen as an internal, institutional matter, however contained elements of an 'anti-politics machine', as illustrated by the construction of nutrition by Spamer and his vision for the Division of Nutrition within the Department of Health.

## **HCP and black women's status as second class citizens**

More women than men used Health Centre services and this was as much influenced by the conditions on the ground as well as the way in which HCP structured its services. Before the Health Centres were established, black women who used Health Centre services had limited access to the benefits of western-based health care. HCP, as discussed in Chapter three, allowed women to access curative health services, for themselves and their children. However, black women's engagement with HCP reinforced their status as second-class citizens.

HCP engaged with black women through the delivery of health services and on the one level constructed this relationship as a technical intervention, i.e. the provision of curative and preventive health services. Through its environmental health services, Health Assistants taught people how to dispose of human and household waste in a manner that does not spread disease. Health Assistants also encouraged people to construct their huts in ways that would improve ventilation and thus, prevent the spread of infectious diseases. HCP also included personal preventive and curative health services with a focus on, for example, infant and pre-school child health, maternal health, health of the school child, nutrition and growth, education, literacy and recreation. Specific interventions that Health personnel undertook were:

- Mass immunization programs in communities and at schools.
- Advised mothers about the importance of attending school and about immunization.
- Conducted examinations and provided treatment at specialist clinics such as infant and pre-school children, and pre- and post-natal clinics for mothers.
- Conducted health propaganda with regard to periodic medical examinations and maximum use of limited resources for the production nutritious of food and a balanced diet.
- Identified pregnant women and chronically or disabled persons and encourage them to attend the Health Centre.

While this relationship between black women and the Health Centres had advantages for women, it also had serious political consequences such as HCP's construction of black women's status as second class citizens. In 1929, white women were granted the vote and gained full political citizenship. While this form of citizenship was not understood as radical or feminist, it afforded

white women the opportunity to engage with the state on their terms.<sup>237</sup> In addition, and probably far more important, this opened the door for future negotiation about women's roles and status in ways that would not have been possible if they were not recognized as full citizens. For example, Iliffe argued that one of the factors that influenced the eradication of white poverty was the fact that white people could use the power of their vote in order to demand change. On the contrary, black women were denied the vote and political citizenship, and HCP, perhaps unintentionally, reinforced the difference in status by the way in which it responded to women based on their racial identity.

Firstly, the Health Centres that operated in mixed-race areas maintained separate entrances for black and white women. The floor plan (Annexure A) of Grassy Park clearly indicates separate entrances. It also indicates how, in non-verbal ways, white women were privileged over black women. The building had a 'general waiting area' presumably for white women as the 'European Entrance' leads directly into that general waiting area. On the other hand, the 'Coloured Entrance' leads into a 'Waiting Room' located behind the 'General Waiting Room'. In addition, the waiting room for white women provided direct access to the consultation and treatment rooms as well as the dispensary. The black women, however, had to walk through the waiting room for white women in order to reach the rest of the facilities in the Centre. The separation of races in public spaces was not new or unusual; however, the official Apartheid legislation was enacted until the mid 1950s and thus, the Health Centres were not forced to impose racial separation.<sup>238</sup>

Secondly, problem of malnutrition was constructed differently for black and white women thus questioning the former's ability to be proper mothers. The strategy to deal with malnutrition in black children consisted largely of subjecting black women to intense health education in order to combat the women's alleged ignorance and backwardness. However, in the Hilltops community<sup>239</sup> where the Health Centre served middle class white women, the problem of malnutrition was constructed as a consequence of the relationship problems between the parents.

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<sup>237</sup> Walker, *Women and gender until 1945*, 1990

<sup>238</sup> Davenport et al, *South Africa*, 2000, pp. 396 - 398

<sup>239</sup> in *A Practice of Social Medicine: A South African Team's Experiences in Different South African Communities*, eds. Sidney Kark and Guy W. Steuart, Edinburgh: E & S Livingstone, 1962.

In this community, most of the men were ex-Servicemen who had fought in the Second World War and upon their return; the parents had problems adjusting to each other. The manifestation of malnutrition in children was considered a consequence of the dysfunctional relationship between the parents. In addition, white women's economic status meant that their children's diet contained too much refined sugar, however there is no evidence that the problem was constructed as the ignorance of white women in relation to food preparation.<sup>240</sup> This construction of black women as different from white women occurred in a broader political context, i.e. one where white women were considered worthy of the vote and therefore, full political citizenship and not merely participants in state welfare programs. By drawing a distinction between white and black women, HCP reinforced the notion that black and white women were different and that the former could only expect any form of state intervention at the behest of the state or its intermediaries, i.e. white liberals.

This interpretation of HCP and black women's status as welfare recipients and also their need for intermediaries were well established and framed the HCP response to black women and their social status. Firstly, black women were already recipients of various forms of state welfare benefits even though these were 'benefit levels were racially discriminatory'.<sup>241</sup> Secondly, the practice of white liberals acting on behalf of and representing black people was also common at this time especially in the political arena where white liberals represented black people in parliament.<sup>242</sup> HCP and its construction of black women's status drew inspiration from the

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<sup>240</sup> Ibid.

<sup>241</sup> Jeremy Seekings 'The Origins of Social Citizenship in Pre-Apartheid South Africa' in *South African Journal of Philosophy*, 19:4 (2000), pp. 386 – 405. According to Seekings, these 'multi-racial welfare system' was implemented by the state during the early and mid 1940s, but these reforms did not last long as they were abolished by the National Party following their 1948 electoral victory – at the same time when the National Party began to close the Health Centres and thus, dismantle HCP.

<sup>242</sup> This kind of political representation was strongly favored by some white liberals during the debates on the native representation bill, i.e. one of the 1926 Hertzog Bills. This bill proposed that black men should be removed from the common voters' roll and according to, for example, Higgs *The Ghost of Equality* and Rich *White power and the liberal conscience*, some of the white liberals were of the view that black people were not ready for full political citizenship and a compromise position was that liberal whites represent blacks in parliament.

broader political context that defined that status as non-political and second-class and by doing so, HCP reinforced the notion that black women could not achieve full citizenship.

These consequences of HCP, perhaps not intended and planned for by HCP advocates, illustrate ways in which HCP operated as an ‘anti-politics machine’. Again, using Ferguson’s analogy<sup>243</sup>, HCP was able to expand the state bureaucracy under the guise that it responded to a technical problem with technical solutions, but in the course of that response, it facilitated an expansion of the state. HCP was instrumental in establishing a physical presence for government in Polela. HCP also redefined the relationship between the state and communities so that the latter became more dependent on state-services in a way that delivered those services only as a privilege not as a right, i.e. conferring social welfare status on black people generally and on black women specifically. This method of operation allowed HCP to perform extremely sensitive political operations under the cover of neutral, technical interventions. Through the construction of an apolitical health service, HCP effectively operated as an effective ‘anti-politics machine’.

### **HCP reproduced the dominant patriarchal, racist politics**

HCP was both a product of and a response to the economic and political conditions of South Africa in the 1940s and as a result, HCP did not operate independent from the state, or formal politics. In fact, HCP was intricately connected to and implicated in the dominant racist, patriarchal political paradigm. This proposition does not aim to label the HCP advocates as racist as I did not specifically investigate that question and it is also not a negative critique of what the white, male liberal Doctors, involved in HCP, achieved. However, what this section aims to achieve is to show that HCP could not escape the political dynamics within which it operated for in its conception and in practice, HCP could not escape being implicated in the dominant patriarchal, racist politics.

As for the conception of HCP, discussed in Chapter two, this program has its roots in the Native Health and Medical Service. HCP was a health program designed to respond to health and

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<sup>243</sup> Ferguson, *The anti-politics machine*, 1990, pp. 255 – 256

poverty on the 'reserves', a responsibility that the state not only neglected, but also actively perpetuated through its policies. Gear, one of the pioneers of HCP, noted that there were individuals who were concerned about the health consequences of the state's discriminatory policies and the final step that inspired these individuals to act was the land policy contained in the 1936 Native Land and Trust Act.<sup>244</sup> The white, male liberal HCP advocates saw in the 1936 Act an opportunity for the introduction of economic and health interventions, i.e. the Health Centres, that would help the people on the 'reserves', whom were mainly women, children and older men. Through this action, white, male liberal HCP advocates intervened so as to alleviate the consequences of 'social injustice'<sup>245</sup> instead of challenging the nature of this Act. Thus, right from the start, HCP was political and implicated in patriarchal, racial politics.

According to the historiography, if the Gluckman Commission's recommendations were implemented, in particular, the National Health System (NHS), it would have secured quality, western-based health services for all, including black women.<sup>246</sup> For this reason, historians have labeled the Commission revolutionary and ahead of its time in respect of an accessible health system, particularly because the Commission Report advocates for a health system that ignores race and class.<sup>247</sup> This interpretation of the Report was challenged by, among others, Randall Packard, who asserts that in fact the reformist language of the Gluckman Commission report is part of a rise in environmentalism not very different from an earlier discourse on African health and urbanization.<sup>248</sup> The Gluckman Commission report can also not be considered as

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<sup>244</sup> Gear, 'The South African Native Health and Medical Service' *SAMJ* Vol, XVII, No. II, pp. 167 - 172

<sup>245</sup> Kark et al, *Promoting Community Health*, 1999

<sup>246</sup> Cedric De Beer, *The South African Disease: Apartheid Health and Health Services*. London: Catholic Institute for International Relations, 1986 and Sydney Kark and Emily Kark *Promoting Community Health: From Pholela to Jerusalem*. Johannesburg: Witwatersrand University Press, 1999. See also Phillips 'The Grassy Park Health Centre' in *South Africa's 1940s*. eds. Dubow and Jeeves, 2005, pp. 108 – 128; Marks, 'South Africa's Early Experiment', *AJPH*, 87 (1997), pp. 452 – 59.

<sup>247</sup> Ibid.

<sup>248</sup> See for example, De Beer, *The South African Disease*, p. 16. See also Alan Jeeves, 'Delivering Primary Care in Impoverished Urban and Rural Communities: The Institute of Family and Community Health in the *South Africa's 1940s: Worlds of Possibilities*, eds. Saul Dubow and Alan Jeeves, Cape Town: Double Storey, 2005, pp. 87 – 107, for the construction of the Gluckman Commission's report as revolutionary.

revolutionary in respect of women's health generally and more specifically, black women's health. The Commission's detailed analysis of South African society and health determinants did not comment on the gendered nature of health and poverty.<sup>249</sup> There were only two references to women and these confirmed the right of married women to work for the proposed NHS. This recommendation was really more applicable to professional women such as doctors and nurses and thus, would have included a small minority of professional black female nurses.<sup>250</sup> The specific reference to women would have had very little or no real effect of the lives of many black women. The conclusion, therefore, by some historians that the Gluckman Commission's recommendations were revolutionary can only be extended to race and class, but certainly does not extend to gender. From its inception, HCP did not deviate from the dominant racist, patriarchal framework of the time.

Similar to its inception, the implementation of HCP was also implicated in the dominant patriarchal, racist values for it operated in ways that also characterized HCP as an 'anti-politics machine'. The African and the Afrikaner nationalists' approaches to disease and poverty experienced by black people illustrate that the interventions designed by the white Liberals could not escape the political label. As discussed in Chapters two and three, HCP was a project

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Randall Packard's *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa*. Berkeley, University of California Press, 1989, challenges this view (p.236). Packard contends that the HCP advocates could rather be described as realist, i.e. white people who recognized the need for co-existence between black and white people and that appropriate political and economic policies were required to reflect that reality. In this regard, the Gluckman Commission is much similar to the Native Laws (Fagan) Commission of 1946 – 1948 or the Inter-Departmental Committee on the Social, Health and Economic Condition of the Urban Areas (Smit) Committee of 1942. See also Adam Ashforth, *The Politics of Official Discourse in Twentieth-Century South Africa* Oxford, Clarendon Press; 1990

<sup>249</sup> This does not mean that the Commission should have had a kind of feminist analysis of health; however, the Commission does not make any reference to the nature and effects of disease and poverty and how these affected, for example, women differently from men.

<sup>250</sup> Shula Marks, *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession*. Great Britain: Macmillan Press, 1994 – specifically p. 78 where Marks notes that during the 'first half of the twentieth century, the majority of professionally trained nurses in South Africa were white'.

developed and implemented by white, liberal male doctors, bureaucrats and politicians.<sup>251</sup> The absence of black doctors in Health Centre reports is very noticeable. Health Centre reports list numerous black men and women as Health Assistants, nurses, midwives, drivers and cleaners. The highest position for a black man is a Medical Assistant who had five years of medical training, but was not a medical doctor. As for white women, they were either Assistant Medical Officers, part-time Medical Officers and in a few instances, in charge of Health Centres.<sup>252</sup> I have found no evidence of black doctors, male or female, in charge of a Health Centre or involved in HCP and this absence could be interpreted as a rejection of this kind of intervention given these doctors' construction of black people's health and poverty.

The black doctors and the white, liberal doctors disagreed on the causes of black people's poverty and disease and as a result, they followed different paths when they responded to these issues. During the 1940s and 1950s a number of black doctors aligned themselves with the political goals of the African nationalists, in particular the African National Congress (ANC). Digby's study of black doctors concluded that their awareness of patients' deprivation led black Doctors to political activism. She writes that between '1948 and 1954, increasing government intimidation along with an intensification of protest politics resulted in older, moderate medical leaders withdrawing from the political frontline. Younger doctors were more radical and their continued political activism led to vigorous repression by the apartheid state.'<sup>253</sup> For example, Dr. Motala revived a branch of the Natal Indian Congress and developed links with the ANC; Dr. Ralph Hendrickse organized the Natal 'coloured' population in response to the Separate Representation of Voters Bill<sup>254</sup>; Dr. Margaret Chuene Mncadi was active in the women's campaign against the

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<sup>251</sup> Chapter two outlines some of the social identities and political associations of the HCP advocates. See also Kark et al, *Promoting Community Health*, 1999 for a personal history of some of the HCP pioneers and Ashforth, *The Politics of Official Discourse*, 1990 as well as Catherine Higgs, *The Ghost of Equality: The Public Lives of D.D.T. Jabavu of South Africa, 1885 – 1995*, Athens: Ohio University Press, 1997 for a discussion of liberal politics during the first half of the twentieth century.

<sup>252</sup> See various Health Centre Reports, which all provide details of staff members.

<sup>253</sup> Anne Digby, 'Some early black doctors – a very politically active cohort, 1941 – 1954' in *South African Medical Journal*, August 2007, Vol. 97, No.8, p. 577

<sup>254</sup> This was one of the 1926 Hertzog Bills that aimed to, and eventually succeeded in 1936 to remove black men from the common voters' roll.

pass laws and later became vice president of the ANC Women's League in Natal.<sup>255</sup> Thus, black doctors considered the solutions to disease and poverty suffered by black people as part of political and economic reform and in line with the ANC demands for popular democracy, economic reform, land redistribution and the provision of education and health services based on need. Black doctors, in line with the ANC demands, believed that only full political citizenship for black people would improve the social conditions of black people, including health status. Therefore, when black doctors linked poverty and disease to political and economic policies, they exposed a major weakness in the technical approach to disease and poverty.

The Liberal approach to black health and poverty also came under attack from the Afrikaner nationalists. The latter were deeply suspicious of the Health Centres and according to Jeeves, 'were offended by the multiracialism' to the extent that they referred to the IFCH, as a subversive organization, claiming that it was promoting 'colour blindness'.<sup>256</sup> In addition, the Apartheid state considered Kark a 'closet communist' for his use of public funds in order to service black people and thus undermined Apartheid.<sup>257</sup> One would think that these allegations meant that HCP advocates were closer to the African nationalists, or that African nationalists would embrace the work of the HCP advocates. However, as illustrated above, this was not the case.<sup>258</sup> On a broader political stage, the nature of political engagement was being reframed and with the rise of Afrikaner and African nationalism, the white, liberal politics were under attack and as a result, the Health Centre approach to black poverty and disease came under scrutiny and was found wanting.

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<sup>255</sup> Op cit. not 55, pp. 578 –9

<sup>256</sup> Jeeves, 'Delivering Primary Health Care' in *South Africa's 1940s*, eds. Dubow and Jeeves, p. 103

<sup>257</sup> *ibid.*

<sup>258</sup> This rejection of white paternalism in the form of the rejection of HCP was part of a broader rejection of white paternalism at a political level. See, for example, Robert Edgar, 'Changing of the Old Guard: A. P. Mda and the ANC Youth League, 1944 – 1949' in *South Africa's 1940s: Worlds of Possibilities*, eds. Saul Dubow and Alan Jeeves, Cape Town: Double Storey, 2005, pp. 149 – 169. Other sources include Higgs' *Ghost of Equality* and Nelson Mandela, *A Long Walk to Freedom*.

## **Conclusion**

Suspending politics is never easy and suspending politics in South Africa's 1940s and 1950s was almost impossible. The evidence is unambiguous that black people were poor and lacked access to appropriate health care not because they were 'lazy' or 'backward'. In addition, black people and in particular black women were not free to develop 'racial pride' by merely improving the unhygienic living conditions or cultivating their own food so as to eradicate malnutrition. While these steps would have helped to alleviate some of the consequences of their poor living conditions, it could not be sufficient because black people were up against powerful economic and political forces during the 1940s. The tide was changing and even though the National Party victory was not predictable, the stage was set for a political backlash against the 'liberal interregnum' of the early and mid-1940s. HCP advocates were allowed to flourish during liberal moment however, their failure to fully recognize and deal with the political roots of poverty and ill health meant that they could not withstand the political consequences of their work. As a result, HCP was transformed from a technical, health intervention to an 'anti-politics machine.

## CHAPTER FIVE

### CONCLUSION

This research was an attempt to begin a gender analysis of Health Centre Practice (HCP) and thus, expand the historiography for this particular development in South Africa during the 1940s. South Africa's 1940s was, in line with international developments, a time when progressive thoughts and projects could be entertained and implemented. The unequal economic development that followed the discovery of minerals made South Africa an ideal place for the practice of social medicine and according to the contributions by, *i.a.*, Alan Jeeves, Howard Philips, Cedric de Beer and Shula Marks, South Africa's social medicine experiment had a lot of potential. It was certainly 'ahead of its time' and largely because of that, according to de Beer, the project was terminated.<sup>259</sup> However, as I have illustrated, this particular historiography fails to take into account that HCP was informed by and implicated in a racist, patriarchal paradigm, a not too insignificant fact that, I propose, contributed significantly to the termination of the project. In an attempt to find out how HCP reinforced or challenged the gender roles and relations of the time, I found that HCP was not quite as 'revolutionary' as we first thought it was. Gender cannot be dissociated from race and class, certainly not in South Africa during the 1940s and the 1950s. In addition, by looking at HCP as an 'anti-politics machine',<sup>260</sup> I concluded that HCP, seemingly apolitical, actively depoliticized health, poverty and the role of the state in the maintenance of both health and poverty. This depoliticization did not advance the interest of black women. With

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<sup>259</sup> de Beer, Cedric. *The South African Disease: Apartheid Health and Health Services*. London; Catholic Institute for International Relations, 1986. Dubow, Saul and Jeeves, Alan (eds) *South Africa's 1940s: Worlds of Possibilities* Cape Town: Double Storey, 2005. Jeeves, A.H. 'Health, Surveillance and Community: South Africa's Experiment with Medical Reform in the 1940s and 1950s.' *South African Historical Journal*, 43 (2000), pp. 244 – 66. Kark, S and E. Kark, *Promoting Community Health: From Pholela to Jerusalem*. Johannesburg' Witwatersrand University Press, 1999. Kark, S and G. Steuart (eds) *A Practice of Social Medicine: A South African Team's Experiences in Different South African Communities*. Edinburgh; E & S Livingstone, 1962.

<sup>260</sup> James Ferguson, *The anti-politics machine: "Development," depoliticization, and bureaucratic power in Lesotho*. (Cambridge: Cambridge University Press, 1990)

these two themes of gender and politics, therefore, I aimed to expand and hopefully, began a process of reviewing the historiography of HCP.

In general terms, this research also aimed to contribute to the history of women in South Africa. It was however, not a project that aimed to highlight the stories and their direct experiences of women who participated in HCP. That important project is far more ambitious than what I attempted here, but it is certainly an aspect of this history that needs to be told. However, in respect of the history of women in South Africa, I attempted to show that gender, and even feminism, are important and useful concepts for research in South Africa and therefore, in Africa. According to Ann Oakley, 'feminist research' means research that relates to an understanding of women's position as that of an oppressed social group and knowledge that 'omits women's perspectives and experiences are embedded with masculinist values'.<sup>261</sup> This is exactly what Nombonisa Gasas says that she does not remember when there was ever a time when women's practical needs were not considered strategic, political needs. Black women may not have used the words 'political', gender or feminism, but in different ways black women aimed to achieve liberation.<sup>262</sup> Therefore, my research hopefully contributed to South African history, but more importantly to the history of South African women.

## **What should they have done?**

What should the HCP advocates have done? Were the white liberal doctors not doing what they could do best, i.e. practice a form of health care that not only provides curative health services, but also 'mitigates the results of social injustice'.<sup>263</sup> This research was never an attempt to

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<sup>261</sup> Ann Oakley. *Essays on Women, Medicine and Health*. (Edinburgh: Edinburgh University Press, 1993), p. 245

<sup>262</sup> Nombonisa Gasas, 'Introduction: *Basus/iimbokodo, bawel'imilambo*, new freedoms and new challenges, a continuing dialogue' in *Basus/iimbokodo, bawel'imilambo/They remove boulders and cross river. Women in South African History*. Gasas (ed) (Cape Town: Human Sciences Research Council Press, 2007, pp. xiii – xxxvii)

<sup>263</sup> Sidney Kark and Emily Kark. *Promoting Community Health: From Pholela to Jerusalem*. (Johannesburg: Witwatersrand University Press, 1999), p. 151

critique directly the actions and motives of HCP advocates, in particular the doctors who were at the forefront of this initiative. In fact, there is sufficient evidence in the historiography to illustrate that while the Health Centres were operational, it provided much needed health services, particularly for black women. However, the question that should be asked is whether the nature of the intervention responded to the best available option, i.e. were the compromises that were made following the release of the National Health Services Commission (i.e. Gluckman Commission) Report<sup>264</sup> the best compromises? From my research, I conclude that HCP, and therefore South Africa's brand of social medicine, was intricately linked to the racist, patriarchal paradigm from its inception. All of the HCP advocates adhered to a liberal, progressive political school of thought and at the time, that kind of politics did not envisage the independence of black people. It certainly did not envisage that black women should be allowed to vote. In addition, HCP had its roots in the Native Medical and Health Program of 1938 and that in it, validated the existence of the 'reserves', i.e. separate geographic and therefore, social spaces, for blacks and whites. At no time did the HCP advocates challenge the dominant racist, patriarchal paradigm within which they operated. Their main achievement was to show us that it is possible to conceive of a social medicine project and that sufficient political will can ensure the implementation of such a project.

## **Future research questions on HCP research**

This research raises more questions than answers and a number of issues, both new and related to what has been discussed here, can be identified:

- A document of the experiences and views of the women and men who used the services of the Health Centres. Howard Philips' research on Grassy Park is the only research that interviewed people who lived in Grassy Park at the time that HCP operated. Thus, many of the interviewees had indirect or direct experience of the Health Centre.<sup>265</sup>

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<sup>264</sup> 6/344, UG30 – 1944, Report of the National Health Services Commission, 1942 – 1944. See also de Beer, *The South African Disease*: (London; Catholic Institute for International Relations, 1986)

<sup>265</sup> 'The Grassy Park Health Centre: A Peri-Urban Pholela?' in *South Africa's 1940s*, 2005, pp. 108 - 128

- HCP and local, traditional methods of healing as well as traditional healers. From my research, I found that HCP advocates encouraged people to stop using traditional healers and the Health Centre reports imply that traditional healing practices were not only harmful, but were obstructing the success of HCP. Further research into the actual interaction between traditional healers and HCP advocates is required, for example, ways in which traditional healers responded to HCP and its advocates; how this competition for dominance affected the people and their relationship with both of these institutions, i.e. Health Centres and traditional healers.
- The relationship, if any, between the Zenzele Clubs and HCP. A rich history of the Zenzele Clubs exist however, during the course of my research, I did not find any reference to HCP or any Health Centre in the literature on the Clubs and *vice versa*. The Health Centres and the Clubs had similar objectives, but as an institution, the Clubs had a longer history than the Health Centres. However, it is not clear whether women made use of both Health Centres and the Clubs or if there were any competition. In addition, the culture, race, gender and class dynamics of these two institutions cannot be ignored: the Clubs were run largely by educated black women and black women of all classes were members. On the other hand, the Health Centres were run by white men and both of these institutions aimed to, *i.a.*, teach women how to be proper wives and mothers.
- The question of abortion looms large in the Health Centre reports and mainly because of a complete absence of analysis of this issue. As I discussed above, the Grassy Park reports go into detail with the way in which birth control, or ‘family spacing’ services were provided. The Polela reports only mentions that the number of abortions must be under-reported. This is an under-researched topic in South Africa and historical research would certainly, according to Klausen shed light on how black women deal with abortion in a democratic, post – 1994 South Africa. In an unpublished article, Klausen comments on contemporary research that suggests that black women are not using their right to an abortion and argues that a look at the historical relationship between black women and the health services and specifically, the

- A final research area that could be explored relates to trans - / cross - racial solidarity, in particular, the relationship between black people and white liberals. This group of people cannot easily be classified as racist whites, i.e., the way in which Afrikaner nationalists are classified. HCP indicates that some white people sought to work for and on behalf of black people's liberation, however, what requires further examination is how that solidarity should be expressed.
- Finally, South Africa came very close to implementing a national, social medicine program. In the post-Apartheid South Africa, the delivery of health care to all South Africans remains a challenge. South Africans flirted with the social medicine model during the early 1990s when Emily and Sydney Kark visited South Africa and met with members of the African National Congress (ANC) and Health advocates. There would be some value in revisiting the relevance of the Gluckman Commission, albeit in a revised form as my research suggests, and HCP for a post-Apartheid South Africa.<sup>267</sup>

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<sup>266</sup> Klausen, “‘Reclaiming the White Daughter’s Purity’ Racism, Heteropatriarchy, and the 1975 Abortion and Sterilization Act in Apartheid South Africa.” (unpublished)

<sup>267</sup> Kark et al, *Promoting Community Health*, 1999 and Van Niekerk, ‘The evolution of health and welfare policies in South Africa’, *The Journal of African American History*, pp. 361 – 377.

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