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Piecing Together Health
in the Homelands

by

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PIECING TOGETHER HEALTH IN THE "HOMELANDS"

WHAT ARE THE "HOMELANDS"?

The apartheid system has developed as a refinement of earlier policies aimed at ensuring a cheap labour supply for industry and agriculture in South Africa. The underdevelopment of rural areas which took place during the development of the South African economy provided the origins of the cheap labour system. The apartheid system itself is a method of institutionalising the system. Furthermore, it represents an attempt by the South African state to gain acceptance and credibility for a system which sets aside 87% of the land for 20% of the population. The apartheid policy was formulated by the Nationalist Party, the political party which is still the present government in South Africa, after it came to power in 1948.

The main architect of the system was Dr H F Verwoerd. His intentions were to legitimate racial distinctions by changing them into ethnic distinctions and then granting each ethnic group certain authority. By dividing the black population of South Africa into ten ethnic groups, the state could rationalise its programme by claiming to be granting land and authority to each of these separate groups.

A number of black tribal reserves were thus established. Over the years the policy has been modified and refined and the terminology has changed from regarding these tribal reserves as "bantustans", "tribal homelands", "self-governing states", "emerging states" and now "independent states" and "black national states". However, as Saul and Gelb show, there was never any doubt about the underlying purpose and nature of this development. (Saul and Gelb, 1981). Verwoerd stated at the outset that the Bantu homelands may be areas which to a large extent, although the people live within their own areas and are governed there, are dependent on basic incomes earned in the adjoining white territory. (Saul and Gelb). The basic intention of the policy of separate development has not been concealed. According to Gerrit Viljoen, chairman of the Broederbond,
an Afrikaans right-wing cultural and political organisation which exerts considerable influence in South Africa, it is to form the basis of the maintenance of political power by whites in the so-called white country. (Saul and Gelb, 1981).

A further development has been the granting of "independence" to certain of these tribal reserves. All Africans, urban and rural, are defined as belonging to one of these tribal "homelands". With the granting of "independence" to many of these areas, those "belonging" to it are automatically made citizens of it, thereby losing their right to South African citizenship. In 1978 when the Bantu Homelands Citizenship Amendment Bill was read in parliament, Dr Connie Mulder, the then Minister of Plural Relations and concerned with all matters affecting blacks in South Africa, stated that "if our policy is taken to its logical conclusion as far as the black people are concerned, there will not be one black man with South African citizenship".

The success of the "homeland" policy has been extremely limited. None of the "independent" states has been recognised by the international community. The black population generally has not been co-opted by the "homelands", and have little belief that the "homelands" provide a solution to the political problems in South Africa. For example, the Quail Commission, appointed to investigate the wisdom of the Ciskei, one of the "homelands", seeking "independence", found that 90% of all Xhosa-speaking blacks desired one-man one-vote in a unitary South Africa. According to another poll, conducted in Soweto, the biggest black urban township in South Africa, 92% of Zulu speakers had the same aim. (Saul and Gelb, 1981).

Those "homelands" that have opted for "independence" are unviable in many respects, for example, they receive, on average, 75% of their revenue from South Africa. In the Transkei, only 15.2% of the labour force is internally employed. More than 70% of the economically active population is involved in the migrant labour system, while the rate of job-creation in the "homelands" fails to absorb more than 10% of those who come onto the job-market every year. (Saul and Gelb, 1981)
The "homelands" are provided with the "option" of seeking "independence" from South Africa. This is the present political aim of the South African state - to have ten "independent homelands". Both the pressures to opt for "independence" and the effects of the "homeland" policy itself are mirrored in an examination of the health sector in the "homelands". The next section of this paper will attempt to demonstrate these issues more fully. It will be shown that the "homeland" health services play a part in the political and ideological forces at work in the "homelands". Before proceeding with this discussion, it is necessary to look at the history of the "homeland" health services in order to demonstrate the changes that have occurred with changing political incentives.

HISTORY OF "HOMELAND" HEALTH SERVICES:

Health services in rural areas were originally provided by traditional practitioners. These herbalists and diviners provided for the health needs in traditional African society. To this day, even in urban areas, traditional practitioners play a valuable role in the provision of health services.

Mission doctors from Europe first started coming to Southern Africa in the early nineteenth century. (Wells, 1980). Initially, health services were set up to cater for the needs of the missionaries and their families, who were exposed to new "tropical" illnesses and they required hospital services for this purpose. Later, mission health services were set up to provide medical care for the African population, and also to play a part in the "educational and religious uplift of the Bantu". (O'Reagain, 1970). Wells, writing about mission hospitals in South Africa, states that there "was confusion in many places between the medical and evangelical function of the mission; the hospital might become a place for drawing people together, curing their illnesses, and making them feel grateful as a first step towards conversion". (Wells, 1980).

Elsewhere in Africa, the success of western medical techniques in preparing the way for imperialist penetration was noted by a missionary in 1899 when he stated that "the usefulness of
the medical arm of the missionary service is indisputable. It breaks down opposition, dissipates prejudice, and wins its way to the hearts and homes of the high and low, rich and poor". (Dennis, 1899).

The role of the Christian missions in paving the way for other forms of western domination has been well described elsewhere. (Doyal, 1979). Health services could be used to win the hearts and minds of the people. This paper will go on to show that this concept has been used more recently with other objectives in mind.

After the Second World War there was a sudden growth of mission stations in South Africa. By 1962, as many as 77,2% of the total of 14 976 hospital beds in "homeland" areas were administered by over 100 mission hospitals, while a mere 10,7% were controlled by the Department of Health. Private organisations, provincial administrations, and industry provided the remaining 12% of the beds. (Roux, 1974).

In many rural areas the mission hospitals provided the only health care services in the vicinity.

Initially the state supported the activities of the mission hospitals as they clearly provided a valuable service at little direct cost to the state. Furthermore, both the state and the missions had an interest in weaning africans away from their indigenous culture and institutions and socialising them into European modes of behaviour. (Doyal, 1979).

In the late 1960s, a combination of factors led to the initiation of a policy by the South African state to take over rural mission hospital services. The state began this process of take-over by providing subsidies to these hospitals, initially on a 50-50 basis. This entailed a certain degree of control being handed to the state by enabling the hospitals to be inspected by the provincial administrations. (van Rensburg and Mans, 1982). "Most of the missions certainly needed the financial assistance although many saw it as a first step towards complete government control - as in fact it turned out to be". (Wells, 1980).
The missions were independently run and controlled, and mission hospitals were "frequently planned and erected without due consideration for existing health services and specific needs". (Wells, 1980). According to Roux, it therefore became imperative to institute proper planning and co-ordination to attain control over the hospitals of the missionary societies. (Roux, 1974).

A previous "homeland" health service employee claims that the state was also concerned about the liberalising influence of the missionary and expatriate doctors in the mission hospitals. "Of main political concern in 1968 amongst the Nationalists was the extensive influence the 126 mission hospitals and their followers could exert on the mind of the black man in the rural areas. As local leadership began to develop, the republican (South African) government found it difficult to keep a close watch and grip on the developments in the rural areas. So, mission hospitals had to be taken over and the influence of foreign staff reduced". (Kok, 1981).

The government was also proceeding with its plans for "separate development" and the provision of health services by future "homeland" authorities was an important consideration. It was intended that the mission hospitals taken over by the central state would ultimately be handed over to the "homeland" administrations.

The policy of the state to take over the mission hospitals may have had other reasons too. "A government hospital is a tangible sign of government activity which is understood by every native, but it is doubtful whether a subsidised mission hospital is in any way connected in the minds of the majority of the patients, as being anything more than a token of benevolence of the missionaries who therefore reap the credit and resulting influence. It is a fact which cannot be gainsaid, that the provision of medical attendance, even of the crudest and most primitive description, is the best form of advertisement for any form of activity among the natives". (Beck, 1970).
Towards the end of the 1960s and the early 1970s, the government offered to supply any reasonable request from the mission hospitals, for staff, equipment, and buildings. The churches, being short of money, made use of this offer, and diverted additional funds into other church projects. Many of these projects required a commitment for long-term funding, but hospitals were willing to make this commitment as money was guaranteed by the state for recurring hospital costs.

Then, in the mid-70s came an ultimatum from the state, threatening to withdraw its financial assistance if the churches insisted on maintaining control. The churches had no choice in the matter; they had already committed their funds to other ongoing projects, and could not possibly finance the hospitals as well.

In 1970, in terms of Proclamation R96 of 26 March 1970, all responsibility for health services for africans in rural areas was handed over to the Department of Bantu Administration, with the Department of Health acting as the executive authority. (Hammond, 1983). The Deputy Minister of Bantu Development announced that his Department would begin a gradual take-over of all mission hospitals as from 1 April 1983. This step would precede the transfer of control and financing to the "homeland" governments. The process began in the Transkei, the first "homeland" to become "independent", where a department of health had already been created. (South African Institute of Race Relations, 1973). According to the Deputy Minister, the churches would be compensated for their previous actual capital expenditure. Black employees would become officials of the "homeland" government concerned, while white staff would become officials of the central government seconded to the "homelands" until "suitable" replacements could be found. (South African Institute of Race Relations, 1973). To date, the vast majority of doctors working in these "homeland" areas are still seconded by the central government in Pretoria, which therefore exerts considerable control over them.

Teams of state officials were responsible for setting up the required infrastructure at each hospital. All vehicles were
registered with government numberplates, stationery was
printed with state letter-heads, new record systems were
introduced and other changes were made to administrative
structures.

At the time of the announcement of the take-over by the state,
64,6% of the total number of hospital beds in the "homeland"
areas were administered by the mission societies. (Roux, 1974).
Approximately 90% of all the hospitals in "homeland" areas were
run by the missions, who employed 59,2% of the doctors and 81%
of the nurses in "homeland" areas. (Malan and Hattingh, 1975).

In the early stages of state control over the mission hospitals,
the hospitals continued to function in much the same way as they
had previously. Conflicting reports about the financial position
of the mission hospitals at this time exist with some reports
claiming that some of the churches withdrew that financial support
that they were still providing because they felt that the state
should then assume responsibility for all the hospital finances
and not just certain aspects of them.

There was opposition to the state control of mission hospitals
by some of the mission doctors. They stated that it was an
event "causing grave concern to many who are involved in the
work of the mission hospitals". Amongst their reasons were that
"nationalisation appears to have been decided upon without due
consideration of other alternatives. Consultation between the
mission hospital bodies and the State Health Department has been
permitted only on the mechanism of nationalisation and never on
whether it is the only alternative". Other stated reasons were
that a "large proportion of these doctors, who would be prepared
to work under the banner of a mission society, will not, for
various reasons, work under that of the republican government".
(Larsen, 1975).

Furthermore, it was stated that nationalisation of the hospitals
would mean that the staff of the hospitals would be responsible
to three separate authorities.
According to Circular 517/3 from the Department of Health, the black staff would be under the authority of the "homeland" departments of health, the white medical and paramedical personnel would be under the central Department of Health, and the white administrators would be under the Department of Bantu Administration and Development (BAD). The doctors concerned anticipated "extraordinary administrative difficulties" with the proposed splitting up of hospital staff under separate administrative authorities, and finally expressed "grave doubt" as to the wisdom of the proposed changes. (Larsen, 1975).

Some doctors resigned because they were reluctant to work for the central state rather than a missionary organisation, others because of bureaucratic hold-ups which occurred. However, "within ten years of its inception, the Nationalist Government plan to get rid of foreign liberal elements within the health services in the "homelands" had become a reality. The methods used were simple and straightforward. No advertisements were allowed to be placed by the hospital itself, recruitment from outside the country was obstructed and endlessly delayed by the administrative machinery, the promotion of foreign doctors was virtually impossible unless you returned to the other side of the white wall". (Kok, 1981).

The passage of the Bantu Homelands Constitution Act (No. 21 of 1971) provided for the various designated "homelands" to pass through several phases before becoming "national states" and ultimately "independent states". These stages are briefly outlined below:

1. Regional authorities - these take responsibility for some aspects of schooling, road maintenance, etc.

2. Territorial authorities - these have a greater degree of responsibility in the same areas as the Regional Authorities.

A legislative assembly is set up and a Chief Minister is elected. "Self-governing states" are not permitted to form departments of foreign affairs or defence, but they are able to request "autonomy" from South Africa in other areas, for example, health.

4. "Independence" - the "state" takes over responsibility for foreign affairs and defence, and is responsible for government in all areas including health. Gazankulu, for example, became a "self-governing state" in 1972, but only requested to organise its own health services in 1976. On 1 September 1976, a separate Department of Health and Welfare for Gazankulu signed agreements with the Pretoria capital, whereby co-operation would continue between the two authorities. Infectious diseases would be controlled, and Gazankulu would continue to collect health statistics. From that date onwards, all legislation dealing with health passed in the South African Parliament was invalid in Gazankulu unless the legislative assembly chose to adopt it. All previous legislation passed before that date would apply unless specifically revoked. (Hammond, 1983).

The old mission hospitals, which had been taken over by the state, were handed over to the Gazankulu authorities, and work began on drafting a Health Act for Gazankulu as well as a Health Policy for the area. Finances for the health services continued to derive from Pretoria to a large extent, and local sources such as patient fees to a lesser extent. (Hammond, 1983).

HOMELAND HEALTH SERVICES.

The establishment of "homeland" health departments was a step along the road to "independence" for the various "homeland" authorities. Both prior to "independence" and following "independence" changes in the political structures have had major effects on the structure and function of the "homeland" health services.
What have been the effects of fragmenting health in the "homelands"?

The first point to note is that there are no longer just three tiers of health authority (state, province, and local authorities) but there are also an additional eight health authorities - the "homeland" health authorities. All of the "homelands" except for Kangwane and Kwandebele had their own departments of health and welfare by 1982.

The immediate spin-off for the South African State is that it can concern itself chiefly with the health problems of white South Africa, and shrug off responsibility for the health of most of the rural black population. This effect has become apparent in the last few years.

A newspaper editorial published soon after the Transkei opted for "independence" pointed out the high rate of malnutrition in that area. The editorial pointed out that previously the problem of malnutrition had been the problem of the South African government, but it was now the responsibility of the Transkei authorities. "The Tsolo malnutrition and death-rate are now the worry of Transkei's government. 'White' South Africa has shrugged off the problem. This is being done in the guise of giving freedom to blacks. Could anything be more cynical?". (Rand Daily Mail, 30 December 1977).

A further function of the "homeland" health services is their use in regulating the movements of people. Pensions, disability grants, and unemployment insurance can often only be collected in the "homelands". These economically unproductive people are therefore forced to move out of the urban areas and into "homeland" areas in order to claim their benefits. The South African State is thus able to relocate some of the less productive population in the rural "homeland" areas where it claims it is no longer responsible for providing services. (Cooper, 1982).
The National Health Facilities Plan was released by the South African Department of Health in 1980 and states that a "complicating factor" in the provision of health care in South Africa is the continuous "flux of patients from the self-governing and independent black states to the white RSA (Republic of South Africa) areas for health services". (Department of Health, Welfare and Pensions, Annual Report, 1980). The report claimed that in Natal an estimated 60% of black patients came from the "homelands", mainly from Kwazulu. Kwazulu in fact consists of numerous fragments of land all geographically separated from one another and interspersed within Natal which is regarded as part of white South Africa.

Dr Fred Clarke, the member of the Natal Executive Committee, and in charge of hospitals, spoke of the "untold strain on our doctors and nurses" caused by having to serve Transkei and Kwazulu. (Sunday Tribune, 12 September 1982). He claimed that "Natal's biggest health problem is that every one of our hospitals is burgeoning with foreign blacks for which we get paid only a nominal fee".

One doctor pointed out that many blacks from the Transkei and Kwazulu shopped in Natal and said that the provision of hospital services to Transkeians was a "bit like the price we have to pay for having them shop here. Our wholesale and retail trade depends on them". (Sunday Tribune, 12 September 1982). This comment is particularly interesting because it demonstrates to some extent the motives for the "homeland" system. The South African State would have it that Transkeians work and shop in white South Africa, but that the burden of providing health services should fall on the Transkei.

A farmer living in the area bordering on the Transkei said "it shows the homelands are just not coping with matters like health and that their problems are spilling over the border". "Before Transkei became independent Pretoria could send in teams to innoculate in those areas. Now they can't. Our hospitals are having to cope with the overload", he explained. (Sunday Tribune, 12 September 1982).
Dr Rob Mears, part-time superintendent at the hospital in Matatiele said "these people are doing what they've always done. Just because someone has drawn a line between us that represents a border doesn't stop them from going to their doctor" - but the South African authorities would have it otherwise. (Sunday Tribune, 12 September 1982).

The take-over by "homeland" authorities led to a deterioration in health services. Lebowa, for example, according to the Secretary for Health there, had no anti-tuberculosis vaccine for more than a year because of a "communication breakdown". (Star, 9 August 1982). It was also stated that in the same area only 34.2% of the full-time posts for doctors in the Lebowa Hospital Services were filled. (Mphahlele, 1981). Details of the health services and health status of people in "homeland" areas are presented elsewhere. (See Patel and Zwarenstein papers).

When Kwazulu took over the administration of 15 hospitals in 1978, it was forced to reduce its financial allocations to hospitals by about 7%, according to Dr Madide, the Minister of Health for Kwazulu. (Rand Daily Mail, 20 May 1978).

An ambulance crisis developed in 1979 when Kwazulu took over the Edendale Hospital near Pietermaritzburg. There were 20 ambulances at the hospital when it was taken over by Kwazulu in October 1977. (Star, 20 May 1979). Two years later there were only 13 vehicles present of which only two were road-worthy. The superintendent at Edendale Hospital, Dr Adnams, explained that "when Kwazulu took over the hospital, it quite rightly said that it was not its responsibility to serve the white areas of the province any longer, but we are still expected to provide a service for what really amounts to a foreign country". (Sunday Tribune, 3 June 1979). The Kwazulu government claimed that with its limited allocation from the South African government it was impossible to provide this essential service. Thus, the fragmentation of services has led to squabbling over whose responsibility it is to provide various services. This in turn has led to a deterioration of health services, particularly in rural "homeland" areas.
The multitude of authorities responsible for health care in any area, as well as the uncertainty as to whom is responsible for providing any particular service, was made apparent during the cholera epidemic which first struck South Africa in 1980. There was a tremendous degree of duplication of administrative responsibility at the beginning of the epidemic. Even the Department of Health acknowledged this when it stated: "Co-ordinated action requires co-ordinated authority. This was not always easy to ensure in the face of at least five health authorities in the afflicted area".

Amongst those services causing unnecessary duplication were the South African Department of Health, Welfare and Pensions, the Kangwane (another of the "homelands") Department of Health and Welfare, and the Transvaal Provincial Administration. (Department of Health, October 1980).

A major report into conditions in Natal and Kwazulu had the following to say about duplication of services: "If we look at the existing position in regard to the provision of welfare and health services in Kwazulu/Natal, we find, broadly speaking, that the position is one of overlap, duplication, gaps, and wastage of scarce resources through the division of the geographical area occupied by Kwazulu and Natal into separate politico-administrative units, and through the segregation of services on a racial basis, thereby involving the multiplication of departments and organisations concerned with health and welfare needs in the region of Kwazulu/Natal. Often several departments or authorities are involved in the same area, whereas other areas are virtually a kind of 'no man's land' where no one in particular seems to be responsible and consequently little if anything is done". (Buthelezi Commission, 1981).

How are the "Homeland" health services used to bolster the "Homeland" system itself?

There are a number of ways in which "homeland" health services and policies regarding these services reflect broader policies regarding the "Homelands" and their relationship with white South Africa generally.
These manifestations of South African State policy can be shown to be apparent in the following ways: enforcing the dependency of the "homelands" on Pretoria; attempting to give credibility to the "homelands"; stimulating ethnicity and tribal separateness; focusing attention away from Pretoria and onto the "homeland" authorities when issues might be embarrassing for the State; diverting attention away from Pretoria by manipulating statistics; excluding "homeland" personnel from organisations in South Africa; establishing a rural petit bourgeoisie which has a stake in preserving the "homeland" system; and exerting pressures on the "homeland" authorities to opt for "independence".

Each of these issues is discussed briefly below with the use of one or two examples. As individual examples they provide some illustrations of the nature of the health services in South Africa: together they provide some insight into the political and ideological use of the "homeland" health services in order that the "homeland" policy itself be furthered.

1. ENFORCING DEPENDENCY ON PRETORIA.

There are a number of ways in which the "homeland" health services can be shown to be dependent on Pretoria.

In the first place, the majority of the budgets for all of the "homelands", including the "independent" ones, derive from Pretoria. In fact, funding for "homeland" health services is a complex matter. Funding for the Ciskei health services, for example, derive from the Department of Co-operation and Development, the South African Development Trust, the South African Department of Foreign Affairs, and Treasury Grants from Pretoria. (Community Health Research Project, 1983). Most of the funding thus derives from South Africa.

Another way in which dependency is created is the use of seconded South African staff in the "homeland" health services. While on the one hand this may be seen as a benevolent gesture, on the other hand it enables Pretoria to have control over much
of the staffing of "homeland" health services, and can determine who is appointed or not appointed at any "homeland" hospital. At one hospital in Kwazulu, every doctor applying from overseas to work there had to complete a security clearance form ((81/97244 (Z 204)) before being accepted to work in the hospital. The form asks whether the applicant has ever belonged to the Communist Party, and also if the applicant has at any time belonged to any organisation with political aims other than a political party. The security checks on doctors wishing to work in "homeland" areas may take a long time and cause delays, which often results in committed doctors deciding to work elsewhere. (Goetze, 1983).

A further way in which the staffing situation is controlled is by the seconding of South African Defence Force personnel to rural "homeland" hospitals. These doctors in some cases provide the only medical care available in an area. In 1982 the superintendent of Nongoma Hospital in Kwazulu stated that it was very short of doctors, facilities, and funds. (Star, 16 April 1982). He continued to say that "at the moment if it was not for the (South African) Defence Force doctors in Kwazulu, the health system would probably collapse". Another doctor said he was sure the Kwazulu Health Department was doing everything it could, but it was "basically a money problem originating in Pretoria". (Star, 16 April 1982).

So, clearly, the "homeland" health departments have experienced a budgetary squeeze since they took over the mission hospitals. This crisis in hospital staffing has in turn led to the appearance of South African army doctors serving in the old mission hospitals.

The fact that the South African army provides the only medical care in some areas enables considerable leverage to be exerted on the "homeland" authorities. Not only does the threat exist of withdrawing doctors if the "homelands" do not tow the line, but the doctors themselves can exert considerable ideological influences on the local "homeland" population.
All army doctors are instructed to wear military uniforms at all times and along with teachers seconded by the army to "homeland" areas, are expected to play their part in winning the hearts and minds of the local population.

The army was called in to "save the people" in cholera epidemics in both Bophuthatswana and Kwazulu. The army set up chlorination points for water and provided water in high profile army tankers. Even in the "independent homelands", the South African Defence Force plays an ideological role. For example, nine military vehicles carried about 1,5 million litres of water per week to the Ciskei. (Die Burger, 29 March 1983). In this way the army hopes to gain credibility for the South African State, as an assister of the "homelands".

Evidence that these activities have been used for ideological propaganda was provided when the South African army chief, General Geldenhuys, apologised publicly to Chief Buthelezi of Kwazulu, for incidents involving the intimidation of Inkatha (the Zulu ethnic political organisation) by army members. White soldiers had apparently asked villagers what Inkatha had done for them, and reminded them that it was the army personnel who had helped to supply water during the drought in Kwazulu in 1980 and during the cholera outbreak in 1981. (Rand Daily Mail, 12 January 1983).

2. GIVING CREDIBILITY TO HOMELAND AUTHORITIES.

The health services are used to show that the "homelands" are separate authorities and responsible for their own affairs. The fact that the "homelands" provide medical care for the local population disguises the fact that the entire "homeland" structure is still dependent on Pretoria for funding and other forms of support.

The Department of Health keeps separate statistics on the state of health in the various "homelands" and states that the collection of statistics from the "independent homelands" are the responsibility of those authorities. A statement released by the Department of Health in Pretoria stated that there had
been 201 cases of polio, including 19 deaths, in Gazankulu (one of the "homelands"), 18 in Lebowa (another of the "homelands"), and only 7 in South Africa! (Rand Daily Mail, 17 July 1982).

A more recent example is also useful to demonstrate the effect that the separation of authorities has on the collection of statistics. A recent report of a severe measles outbreak in the Eastern Cape was presented in a Department of Health publication. The report demonstrated a very high case fatality rate of 11.8% and showed that most of the cases occurred along the coastal belt between Port Elizabeth and East London. (Department of Health, May 1983). The study, remarkably, excludes any mention of the Ciskei, part of which lies between Port Elizabeth and East London along the coast! (See map, Figure 1). No reason was given for excluding this area of the Ciskei - presumably it was because the Ciskei is now "independent" and South Africa need no longer study these areas, nor be particularly concerned about the state of health there. It also serves to attempt to project the image of the "homeland" as a separate authority.

3. ENCOURAGING ETHNICITY.

The "homeland" policy depends on fostering a tribal identity rather than a national identity in the minds of South African blacks. The policy thus is an attempt to "re-tribalise" and fragment African nationalism. (Patel, 1983). A modified form of tribal authorities andchieftain structures was introduced in the "homelands", (Patel, 1983), and this served to stimulate an ethnic identity.

The harm resulting from establishing this form of ethnic identity in the "homeland" health services is well demonstrated in the following case.

Shiluvane Hospital is situated in an area claimed by both the Lebowa and the Gazankulu "homelands". In 1976 the State took over this hospital but was undecided as to whom should administer
the hospital until such time as the Department of Health made a final decision on the matter. It was subsequently decided that the hospital should be awarded to Gazankulu, and this was duly published in the Government Gazette. Up to that time, the hospital had been used by the many Tsongas, Sothos and Pedis (ethnic groupings) in the area, and there was no friction between these groups. In July 1982 Gazankulu authorities arrived at the hospital and declared that they had been authorised to take over the hospital. The administrative staff, seconded by Lebowa, had not been informed of this decision and resisted by withdrawing all staff and patients with Sotho backgrounds from the hospital. Of 38 staff members, only 14 remained. Over 30 patients and numerous hospital records were also removed to Meths Hospital over 30 kilometers away. (Zwi, 1982).

The incident created considerable tensions between the two major ethnic groupings in the area. Sotho-speaking people near the Shiluvane Hospital, about 60% of the local population, had been unwilling to use the hospital after it had been transferred to Gazankulu. "After the Lebowa government removed all their Sotho-speaking patients, the Sotho-speaking people in the area believed that they were no longer welcome at the hospital. They believed that if they went there, the Shangaans would kill them" said Sister Ramalepe who works in the area. (Rand Daily Mail, 17 July 1982).

Some people even blamed a number of polio cases which occurred in children in the area on the fact that Sotho mothers were unwilling to take their children to Shiluvane Hospital for their polio-vaccine, and were unable to make the 30 kilometer journey to Meths Hospital for the vaccine. (Rand Daily Mail, 17 July 1982). A senior State Health official played down the theory, but certainly the tribalization of hospital services has had adverse effects on health care in the area.

Another example of the effects of separating "homeland" health services is presented below. Tintswalo Hospital in Gazankulu is responsible for providing health care in the Mhala District of Gazankulu, in which live approximately 150 000 population
in about 60 villages. The south-western part of the district (see map - Figure 2.) is closer to Masana Hospital. However, Masana Hospital cannot officially provide any services nor can it supervise the clinics in the area, because Masana Hospital belongs to the Sotho "homeland" of Lebowa. (Hammond, 1983).

4. **FOCUSING ADVERSE PUBLICITY ON "HOMELANDS" AND AWAY FROM PRETORIA.**

Another important feature of the "homeland" policy is to focus adverse publicity on the "homeland" authorities and away from Pretoria. This serves to direct dissent away from South Africa and onto the "homelands". There was the hope that africans in the reserves might be encouraged to focus their aspirations and their discontents locally, at the "homeland" level, rather than directing them toward the overall system of capitalist exploitation and racial oppression. (Saul and Gelb, 1981).

An interesting demonstration of this occurred during the cholera epidemic in the Eastern Transvaal in 1980. The cholera epidemic began in the Swazi "homeland" known as Kangwane. Prior to the epidemic, the Chief Minister there had commented on the large number of people who had been forcibly relocated into the area as part of the apartheid policy. "As far as we are concerned resettlement is a political bomb", he said. He claimed that Kangwane had absorbed 150 000 people in the last few years, adding that "some resettlement areas have no amenities whatsoever, no running water, no sewage system, no schools, and no clinics. Many of the people have no jobs. Some people have to drink dirty water. They think we (the Kangwane authorities) are responsible". In this way, blame for inadequate conditions is directed away from Pretoria and onto the "homeland" authorities.

Professor de Klerk of the Medical Association of South Africa stated that while South African health services compared with the best in the world, the health services of neighbouring states and the "independent homelands" were either in a state
of collapse or totally inadequate. (Sunday Express, 20 June 1982). This comment directs attention away from health problems in South African rural areas by calling these areas "independent states".

This strategy is reinforced by the keeping of separate statistics for "homeland" areas. This is discussed in the next section.

5. MANIPULATING HEALTH STATISTICS.

The manipulation of health statistics is one of the more sophisticated examples of attempting to separate the responsibility for "homeland" health care away from Pretoria. The separation of rural health services according to "homelands" has allowed for the statistical manipulation of health-related data. For example, South Africa's annual rate of notifications for tuberculosis fell dramatically from about 240 per 100 000 population in 1975, to 180 per 100 000 population in 1980. On closer examination it becomes clear that this "improvement" took place with the exclusion of statistics from the Transkei, Bophuthatswana, and Venda. (Stern, 1981). (See Figure 3.)

A similar process is apparent in a scientific publication dealing with poliomyelitis in South Africa. The paper, written by epidemiologists in the Department of Health, excludes discussion of poliomyelitis in the Transkei, Ciskei, Venda, and Bophuthatswana, the four "independent homelands" in South Africa. (Carmichael, 1981). Clearly, by considering certain "homeland" areas as outside of South Africa, the State can divest itself of providing adequate health care or even accurate statistics for these areas. It is notable that more than 20% of the reported cases of polio in South Africa in 1980 were from the Transkei (Department of Health, January 1981). The recording of statistics separately according to the various authorities can be seen as an attempt to define the "homeland" health authorities as independent.
6. **ENFORCING MEMBERSHIP OF ETHNIC ORGANISATIONS.**

The Nursing Amendment Act No. 70 of 1982 had the effect of forcing nurses in the "homelands" to become members of "homeland" nursing associations and prevented them from joining the South African Nursing Association. According to the legislation which was passed, it is stated that membership of the South African Nursing Association is confined to persons participating in the profession "within the Republic". (South African Institute of Race Relations, 1983). According to the Minister of Health in the Republic, for the purposes of this legislation, excludes the "self-governing states which exercise control over health matters". (South African Institute of Race Relations, 1983).

Dr Munnik, the Minister of Health, added that since the South African Nursing Association was a statutory body, its continued existence in "homeland" areas would give rise to an untenable situation where its affairs would be regulated by authorities of both the South African government and those of the self-governing "homelands". Dr Munnik said that nurses in a territory with an authority with legislative powers over health should establish their own nursing associations. He also said that representatives from the Ciskei, Transkei, Venda, Gazankulu, and Qwa Qwa, as well as South Africa and Namibia, had met earlier that year and formed the League of Nursing Associations of South Africa (LONASA). Lebowa had sent an observer, while Kwazulu had not been represented. (South African Institute of Race Relations, 1983).

The Minister of Health and Welfare of Kwazulu, Dr D Madide, said that although the issue appeared to be a minor one, the principle embodied in the measure could be far-reaching. He said general acceptance of this principle could lead to a strategy of giving african areas de facto "independence" by "legislating them out of South Africa piecemeal". Representatives of Kwazulu and South Africa had met in an attempt by the Kwazulu authorities to ensure that their nurses would retain membership of the South African Nursing Association.
The executive director of the South African Nursing Association said that the legislation would clarify the situation and that SANA's responsibility was to look after the interests of nurses in South Africa, and thus it could not interfere with the "homelands" with their own health departments.

Mr Swart, a member of the Progressive Federal Party, the official parliamentary opposition, said the measure was clearly designed to deprive nurses in self-governing "homelands" of their right to belong to the South African Nursing Association, and to compel them to form their own ethnic nursing associations. He pointed out that this was the first time that a parliamentary bill had stated that self-governing "homelands" were outside of South Africa. (South African Institute of Race Relations, 1983).

In June 1982, the Transkei Minister of Health, Dr Bikitsha, said that the Transkei Nursing Council was no longer allowed to write examinations under the South African Nursing Council. Appeals to have this decision reversed were unsuccessful. It was very worrying to the Transkei that their nurses may not be able to work in South Africa if nurses wrote a special Transkei examination. (South African Institute of Race Relations, 1983).

Dr Madide, the Transkei Minister of Health, was also concerned that eventually all professional people such as doctors and social workers might be similarly excluded from registering or working in white South Africa. (Daily News, 3 May 1981).

Legislation such as that described above can be seen as an attempt to enforce the separation of ethnic authorities and to legitimise those authorities by claiming that they have control over health services in their respective areas.

Another organisation, the Regional Health Association of South Africa (RHOSA) has also been established to promote communication on health matters between the "homeland" authorities. These organisations seek to give the impression that each of these areas is totally independent and really has control over health services in their areas.
7. ESTABLISHMENT OF RURAL PETIT BOURGEOISIE.

The establishment of "homeland" health services has led to the creation of many jobs within the civil service in "homeland" areas, and this has had the effect of "buying off", with jobs or status, people in rural areas who might otherwise have been critical of the "homeland" system. (Critical Health, 1983). This policy has been aimed at establishing a rural petit bourgeoisie comprising of shopowners, farmers, professionals, teachers, and health workers. It is hoped that these people will have a stake in supporting their positions in the "homelands" and not criticising the "homeland" authorities or the "homeland" system itself.

8. PRESSURISING "HOMELANDS" TO OPT FOR INDEPENDENCE.

The State take-over of "homeland" hospitals has enabled a number of pressures to be exerted on the "homelands" to opt for independence. The number of doctors in many rural "homeland" areas decreased substantially following the take-over by the State. (van Rensburg and Mans, 1982). A number of different accounts relate this decrease in the number of doctors to State bureaucracy. Dr Madide, the Kwazulu Minister for Health and Welfare, believes that obstructionism from Pretoria is aggravating the staffing problems in the "homelands". Foreign doctors who apply to work in Kwazulu have to wait up to a year for their application to be processed, and by then many doctors are no longer interested. (Financial Mail, 29 May 1981). At least one of the contributory factors to the delay is the elaborate security clearance required, as alluded to earlier.

At the same time as problems are placed in the way of applicants to work in "homeland" areas, many hospitals are totally understaffed. At the time that Dr Madide complained about obstructionism in Pretoria at least three hospitals in Kwazulu had no doctors at all, while others were staffed only with South African Defence Force doctors who could be withdrawn at a moment's notice. (Financial Mail, 29 May 1981).
Another form of exerting pressure on "homeland" authorities is through the annual budget granted to the "homeland" by Pretoria. In 1977 Gazankulu produced a five year health services plan which included proposals for the establishment of numerous health centres and would provide a comprehensive health service in reach of everyone. It was certainly a progressive health policy by South African standards. The Gazankulu health budget has however been plagued with problems in receiving sufficient funds in order to put the plan into action. In 1976 the South African government contributed 6,3 million rands to the health budget of Gazankulu, but the following year only 5,7 million rands was made available. The 1981 health budget was 7 million rands, of which 68% was earmarked for existing hospital services and another 10% for existing health centres and clinics. Very little money remained with which to reorientate the health service. (de Beer, 1983).

Another example makes clear the sorts of financial pressures to which the non-independent "homelands" are subjected. Venda, one of the "independent homelands" received 40% more money in 1979/80 than in the previous year. The following year it increased again by 92% to 70 million rands. All but 15 million rands came directly from Pretoria. On the other hand, the Tsonga/Shangaan Development Corporation of Gazankulu had its budget slashed from 12 million rands in 1980 to 5,5 million rands in 1982. The difference between the two territories is that Venda has accepted independence while Gazankulu has not. (de Beer, 1983).
CONCLUSION

This paper has attempted to focus on the health services in the "homelands" of South Africa, and to draw attention to the political and ideological roles that these health services play. It has been shown that events in the "homeland" health services mirror those taking place in the relationship between the "homelands" and white South Africa generally.

The take-over of church-run mission hospitals in the early seventies led the way for various pressures and constraints to be placed on those hospitals. In some instances health services have deteriorated apparently because health service incentives were regarded as less important than the political and ideological imperatives of the South African State.

Ultimately, it must be recognised that the health care system reflects the nature of the society in which it is located. This is particularly apparent in the South African context.

A truly democratic health system, free and available to all and controlled by the people, will only exist in a democratic society. We must, however, look at the past and the present in order to develop our ideas of what sorts of alternatives we must work for in the future.

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The present version is entirely my responsibility.
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FIGURE 1. EASTERN CAPE HEALTH REGION (FROM EPIDEMIOLOGICAL COMMENTS, MAY 1983, DEPARTMENT OF HEALTH).
NOTE THE GAP BETWEEN GRAHAMSTOWN AND EAST LONDON.
THE AREA CONCERNED WAS NOT COVERED IN A DETAILED STUDY OF MEASLES IN THE AREA.

NOTE THAT THE AREA ON THE PREVIOUS MAP WHICH WAS EXCLUDED FROM A STUDY IN THE AREA, IS SHOWN TO BE PART OF THE CISKEI, AN "INDEPENDENT HOMELAND".
FIGURE 2.

MHALA DISTRICT OF GAZANKULU

+ 60 Villages; + 150 000 Population

TINTSWALO

GAZANKULU

MASANA

KEY

Railway

* Clinics

○ Hospitals

NOTE THAT TINTSWALO HOSPITAL IS RESPONSIBLE FOR HEALTH CARE IN THE ENTIRE REGION WHICH HAS BEEN DEMARCATED, AND THAT MASANA HOSPITAL IS NOT SUPPOSED TO PROVIDE ASSISTANCE TO THE CLINICS IN THE MHALA DISTRICT NEARBY BECAUSE MASANA HOSPITAL IS IN LEBOWA AND THE MHALA DISTRICT IS IN GAZANKULU.
FIGURE 3.

LONG-TERM TRENDS (1921-1978) IN THE NOTIFICATION OF TUBERCULOSIS IN SOUTH AFRICA (RATES PER 100 000 OF THE TOTAL POPULATION) AND THE ROLE OF SPECIFIC RELEVANT EVENTS AND FACTORS

Annual notification rate per 100 000 of the population

A. Introduction of streptomycin; B. Introduction of para-aminosalicylic acid; C. Introduction of isonizide hydrochloride; D. Intensification of case detection; E. Compulsory notification of positive PPD reactors under 5 years of age; F. Compulsory BCG vaccination of all newborn infants; G. Transkei not included; H. Transkei and Bophuthatswana not included.


NOTE THE EFFECT THAT EXCLUDING TRANSKEI AND BOPHUTHATSWANA, TWO "INDEPENDENT HOMELANDS" HAS ON THE GRAPH OF TUBERCULOSIS IN SOUTH AFRICA.
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