Health and Health Care under Apartheid

Simonne Horwitz
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The exhibition opened at the Adler Museum of Medicine, Medical School, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, on 18 March 2009. It was opened by Deputy Chief Justice Dikgang Moseneke, Chancellor of the University of the Witwatersrand, Johannesburg, as part of the programme: Ethics alive: yesterday, today and tomorrow, co-hosted with the Steve Biko Centre for Bioethics, 16 to 20 March 2009.
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The health sector, through apathy, acceptance of the status quo and acts of omission, allowed the creation of an environment in which the health of millions of South Africans was neglected, even at times actively compromised, and in which violations of moral and ethical codes of practice were frequent, facilitating violations of human rights.

Final report of the Truth and Reconciliation Commission, Volume V, p 250

The state of a country’s health care system is reflected in its infant mortality and life expectancy rates. These statistics tell a story of two distinct patterns of health in apartheid South Africa. For example, in the 1950s:

**Amongst white South Africans:** Infant mortality was low (less than 15 deaths per 1 000 live births) and life expectancies were high (about 65 for men and 72 for women).

**Amongst black South Africans:** In rural areas, 30-50% of live births died before they turned five. During the early years of apartheid, the life expectancy of a male was 36 and a female 37. By the late 1960s, life expectancy was marginally better: 51 for men and 59 for women.

Apartheid policies had a very damaging effect on the health of the majority of South Africans.

**Implementing Inequity**

Some features of the apartheid health care system were:

- The health needs of the majority of South Africans were ignored.
- Most resources benefited whites in whites-only facilities.
- Some health services were developed in the 10 ‘homelands’ but they were inadequate.
- Services for the black population were extremely under-funded, and health workers battled to deal with the overwhelming need for health care. Patients, including young children and the elderly, commonly queued for hours to receive care.
- Hospitals serving the black population were notoriously overcrowded with patients often sleeping on mattresses on the floor.
- By the 1980s, there were 14 health departments, each serving a specific area or racial group.
- Altruism on the part of private individuals and missionary societies went some way towards improving the plight of the black population.
- Urban services were far better funded than underdeveloped rural services.
- The private health sector consumed 60% of health care resources, and employed the majority of doctors, dentists and pharmacists, whilst serving only 20% of the population.

- In urban areas, there were separate hospitals for blacks and whites, often in close proximity. In the few hospitals which served both blacks and whites, there were separate hospital entrances for each race group. Many hospitals also had separate entrances for black and white medical staff.
An example of hospital apartheid
Hospital apartheid manifested as separate hospitals or separate hospital sections for black and white patients. The JG Strijdom Hospital (for whites) and Coronation Hospital (for ‘non-Europeans’) situated in close proximity, reflected an unnecessary and uneconomical duplication of resources.

The 1988/1989 statistics show:

<table>
<thead>
<tr>
<th></th>
<th>Coronation</th>
<th>JG Strijdom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved number of beds</td>
<td>588</td>
<td>495</td>
</tr>
<tr>
<td>Daily occupancy %</td>
<td>86.7</td>
<td>48.3</td>
</tr>
<tr>
<td>Admissions</td>
<td>30,029</td>
<td>15,019</td>
</tr>
<tr>
<td>Outpatients and casualty</td>
<td>393,662</td>
<td>390,300</td>
</tr>
</tbody>
</table>

When the JG Strijdom Hospital fell administratively under the White Own Affairs Health Ministry, the University of the Witwatersrand withdrew the academic status of the hospital. This resulted in a collapse of clinical services there. The Department of Health requested the doctors at Coronation Hospital to assist with the provision of clinical services at the JG Strijdom Hospital. The doctors at Coronation Hospital refused to do so unless clinical services at the two hospitals were amalgamated for the benefit of all patients irrespective of ethnicity. The Minister of Health in the White Own Affairs Health Department instructed the Director of Hospital Services in the Province (Transvaal) to accede to the request of the Coronation doctors.
Segregationist health policies were already in place before the National Party came to power in 1948. Outbreaks of diseases like the bubonic plague (1901), smallpox (1912) and Spanish influenza (1918) were used as justifications for racial segregation.

1919  **Public Health Act**  
This was the first attempt to coordinate South Africa's health care system on a national level under a Department of Health.

1923  **Native (Urban Areas) Act**  
This Act attempted to deal with urban slums, which the Smuts government saw as places of racial mixing and disease. The Act also allowed for curative health services in black areas.

1923  **Group Areas Act**  
This Act made it impossible for white doctors to practice in black areas and for black patients to seek health care in white areas. Black wards in certain white hospitals were the exception.

1928  **Loram Committee**  
The recommendations of the Loram Committee to train black doctors to deal with the health crisis in black communities were not taken up.

1942  **Smit Committee**  
The Smit Committee reported high incidences of ill health among urban blacks and recommended the expansion of health care services ‘for urban natives’.

1942-4  **National Health Services Commission (Gluckman Commission)**  
The creation of a national health care service was recommended to provide primary health care for all South Africans.

1944  **Nursing Act**  
This Act made the registration of nurses of all races compulsory within the South African Nursing Council. The South African Nursing Association was also established as a professional body.

1948  **Fagan Commission**  
The Commission predicted the inevitability of black urbanisation and called on the government to provide adequate services, including health care.

1948  **The National Party came to power**

1946-52  **Legislation suppressed the Gluckman Commission’s developments**

1952  **Public Health Amendment Act**  
Some of the local authorities’ rights were withdrawn, indicating a more centralised health policy.

1957  **Nursing Amendment Act**  
Racial segregation was introduced into nursing legislation for the first time. The Act allowed for different training programmes and separate nursing registers based on race.

**Early 1970s**  
Mission hospitals were taken over by the State in its attempt to exercise increasing control over the health care system.

1977  **Health Act**  
The roles of national, provincial and local authorities within the health care system were redefined.

1977  **National Health Facilities Plan and the Health Act**  
These set out racial admissions policy at State hospitals.

1978  **Nursing Act**  
Separate nursing councils were created in the ‘homelands’.

1980-6  **Browne Commission**  
The Commission advocated a national health policy which would prioritise preventive and primary health services. It also advocated the privatisation of health services which the State could no longer afford.

1986  **National Health Plan**  
The main function of this was to define six levels of health care:

1. Environment and basic subsistence
2. Health education
3. Primary health care
4. Community hospitals
5. Regional hospitals
6. Academic hospitals

1990  **De-segregation of Hospitals**  
In keeping with the general climate of social and political reform between 1990 and 1994, a number of changes to the health care system were made. These required no legislation.

Slums were a feature of Johannesburg from its earliest days. Seen as sites of disease and moral degeneration, authorities believed that the slums posed a threat. In 1904 bubonic plague broke out in the ‘Coolie’ location which was located to the west of the city. To curb further outbreaks, the authorities burnt the location to the ground. Museum Africa
Medical missionaries
It has often been said that the medical work of missionaries was a means of converting people to Christianity. However, for much of the 19th century, the missionaries brought the only bio-medical care to remote rural areas in South Africa.

Dr Rt Rev Henry Callaway, Bishop of Kaffraria later St Johns, was the father of the South African medical hospital movement. Callaway left a prosperous practice in London to work with the Society for the Propagation of the Gospel in Foreign Parts (SPG) mission. He eventually built a hospital in Umtata (Mthata).

Another prominent early medical missionary was Dr Neil Macvicar who came to the Victoria Hospital at Lovedale in 1902. This was the only missionary hospital which was placed on the same funding scale as public provincial hospitals and was therefore well equipped. It also took the lead in training black nurses.

Early missionary medical care was generally basic, consisting of essential surgery for the removal of tumours and cataracts and the treatment of sepsis. Many mission hospitals were short staffed and could not cope with the number of patients requiring treatment.

From the 1930s, there was a growing professionalism among the medical missionaries. This, together with the powerful drugs available after World War II, led to major developments in missionary medicine and revolutionised inpatient or hospital care.

Funding of mission hospitals
During the late 18th and early 19th centuries, mission hospitals relied on limited philanthropic assistance from Britain and foreign associations. Many were short staffed and could not cope with the number of patients requiring treatment. In some parts of southern Africa, the colonial administration and the missionaries formally became partners in creating a cohesive health care system.

In South Africa, the government's neglect of the rural population meant that for much of the 20th century, mission hospitals struggled to fill the gaps in health care provision. During the 1940s, there were about 62 mission hospitals in South Africa and one out of every five hospital beds in the country were in mission hospitals.

During the 1960s, one-third of the non-specialist hospitals for black patients was provided by the missionaries. The 81 mission hospitals offered a limited number of positions to black doctors who had trained in South Africa, but were unable to practise at segregated state hospitals.

By 1970, the apartheid government was funding the 117 mission hospitals in the country but did not have overall control of these institutions. Three years later, the State took control of them, leading to the end of the recruitment of missionary doctors.

The example of All Saints Hospital
Dr Ronald Ingle, former Senior Lecturer, Department of Family Medicine, MEDUNSA

All Saints Hospital was started in 1929 as part of the missionary work of the Anglican Church of the Province of South Africa. The hospital lies at the foothills of the southern Drakensberg mountain range, some 80km west of Mthata in the heart of rural Transkei.

The themes outlined below reflect the challenges of rural health care during the apartheid years at hospitals such as All Saints. Doctors who were almost entirely trained in academic hospitals aimed to replicate the methods and standards of care that they had been taught. However, the dramatic realities of working within a rural environment prevented these aims from becoming a reality.

Health education
The prevalence of infant malnutrition saw Nutrition Rehabilitation Units (NRUs) replacing the treatment of kwashiorkor in wards. NRUs focused on the mother’s capacity to nurture her child and to spread messages to her neighbours at home. Problems like ‘Transkei silicosis’ caused by the inhalation of dust from grinding stones, led to innovations in teaching about health, such as participative singing and acting out health messages.
District Clinics were staffed by resident nurses as community outreach increased with the dawning of community-based primary care.

**Issues then – and now!**

**Clinical Assistants.** Doctors could not manage the situation without dedicated nursing, domestic and maintenance staff. Much of a doctor’s manual work began to be effectively practised by clinical assistants, a role now officially recognised.

**Traditional Healers Conference, 1971**

As part of the hospital’s health education outreach programme, a conference in 1971 initiated a monthly workshop for a period of six months combining six hospital doctors and local GPs and six traditional healers. This created an invaluable experience for both groups with great co-operative potential.

And the work grew as these figures show:*  

<table>
<thead>
<tr>
<th>Year</th>
<th>Beds</th>
<th>Inpatients</th>
<th>Outpatients</th>
<th>Total Births</th>
<th>Sections</th>
<th>Caesarean</th>
<th>Maternal Mortality Rate **</th>
</tr>
</thead>
<tbody>
<tr>
<td>1954</td>
<td>91</td>
<td>925</td>
<td>53</td>
<td>118</td>
<td>3</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>1975</td>
<td>300</td>
<td>4,042</td>
<td>9,883</td>
<td>1,754</td>
<td>327</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

* Figures per annum ** per 1,000 total hospital births
As South African-born medical students at the University of the Witwatersrand (Wits), Johannesburg, Sidney and Emily Kark became acutely aware that the response of the state health care system to the severe health needs of the general population was inadequate. They recognised that ill health is often determined by social factors, a fact which was often overlooked.

Both were inspired by Medical School teachers such as Raymond Dart, Joseph Gillman, Eustace Cluver and WH Craib as well as by a group of liberal teachers in the humanities at Wits, including Professors RFA Hoernlé (philosopher), Winifred Hoernlé, Max Gluckman, Ellen and JD Krige (all anthropologists), WM MacMillan (historian) and JD and Edith Rheinhold Jones, the latter being the founders of the Institute of Race Relations. Contact with these now-famous teachers sharpened the Karks’ social awareness.

During this period they became health activists; aware that the hospital-based clinical teaching was often inappropriate to the diseases and conditions that afflicted black patients. As a result, they helped found the Society for the Study of Medical Conditions among the Bantu. As concerned medical professionals, they arrived at the concept of ‘promotive health’. Their approach included establishing individual medical care and public health routines but further developed community-based programmes to deal with high-priority conditions such as massive infant mortality and rampant congenital syphilis.

The Pholela Experiment
In 1940, the Karks were recruited by the South African Health Department to establish the Pholela Health Centre in rural KwaZulu-Natal. Their mission was to develop a model service to deliver primary health care to the local population. With the support of the Health Department, which at that time was headed by two exceptional men, Eustace Cluver and his deputy, Harry Gear, they implemented a range of innovative activities.

The services at Pholela were based on a thorough understanding of the root causes of disease. By engaging intensely with the community and conducting community-based research their integrative approach, even unusual today, laid the basis for what later became known as Community-Oriented Primary Health Care (COPC). It included:

- Prioritising health problems in the community in terms of the need for intervention.
- Preventive care and health promotion.
- Inter-sectoral action, for example, by improving agricultural techniques, soil erosion is prevented leading to improved food production which in turn combats malnutrition.
- Training community health workers.
- Formal evaluations of interventions directed at altering the health status of the community to establish the effectiveness of and guide future programmes.

During the first decade at the Pholela Health Centre, the infant mortality rate declined from an estimated 270 to just under 100 per 1 000 live births.

By the time the Karks left the Centre they had, together with a multi-disciplinary health team, implemented a comprehensive health care programme.

The Gluckman Commission and the South African legacy of the Karks
The Smuts government, in the wake of enthusiasm for reform that followed World War II, set up the National Health Services Commission. As a response to the rapid effects of urbanisation, the Commission was seen as a way to protect the white elite from the ‘menace’ posed by the black population, which had very limited access to bio-medical health care.

Dr Henry Gluckman, a Yeoville MP, was elected chair of the National Health Services Commission in 1942. Sidney Kark was an advisor to the Commission.

In 1945, the National Health Services Commission, also known as the Gluckman Commission, released a radical and visionary report. It found an unacceptable level of ill health and associated this largely with socio-economic conditions. It criticised services for being disease-oriented, centred on hospital care, urban and essentially tailored to meet the needs of the white elite. Private practice was criticised as

Located deep in the rural southern Drakensberg region of KwaZulu-Natal, Pholela Health Centre is acknowledged internationally as the site where the Community-Oriented Primary Health Care concept was successfully initiated. Professor Jeremy Kark
It proposed a national health service for South Africa, along the lines of the National Health Service in Britain, which would have a strong preventive emphasis and community health centres based on the Pholela model.

Neither the Smuts government nor the subsequent National Party government made a serious effort to implement the egalitarian plan. Nonetheless, once Henry Gluckman became Minister of Health and George Gale his Chief Health Officer, they set up over 40 health centres based on the Pholela model. As part of this effort, a training programme was established in Durban in 1945 under the directorship of Sidney Kark: its mission was to provide personnel as well as research in support of the new clinics. In 1954, it became integrally linked with the newly-founded Department of Social, Preventive and Family Medicine at the Natal Medical School, headed again by Sidney Kark.

State funding was limited and over time the clinics dissolved or reverted to the old-style model of provincial services. Both the Institute and university department were closed in 1960, but a body of knowledge about the effectiveness of the COPC approach had been accumulated.

Some 50 years after the Karks’ experiment in Pholela and the radical Gluckman Commission, these experiences informed and inspired academic and non-governmental organisations in the policy-making process in the run-up to the first democratic elections in 1994.

The International Legacy of the Karks

As the National Party implemented its apartheid policy, it became increasingly difficult for the Karks to implement their ideas. In 1958, the Karks left South Africa, taking the lessons of their Pholela experience to the United States. Sidney Kark served as the founding chairman of the Department of Epidemiology at the School of Public Health of the University of North Carolina in Chapel Hill.

The Karks then left for Israel at the invitation of the Hadassah Medical Organisation and the Hebrew University Faculty of Medicine to establish a social medicine project supported by the World Health Organisation. In Jerusalem, Sidney Kark headed and developed an academic Department of Social Medicine, which included a demonstration and teaching community health centre where COPC was practiced.

The Karks’ approach was carried into sub-Saharan Africa, in particular Uganda and Tanganyika, and South-East Asia. Over time, their influence spread further: through an international Master of Public Health training programme based in Jerusalem, and through their writings. These helped to inform the deliberations at the famous World Health Organisation Primary Health Care Conference at Alma Ata in 1978.
The conditions of black migrant workers

Black migrant workers who came to the cities were often in poor health when they arrived, as conditions in rural areas and in the homelands were harsh and many were impoverished. Faced with infections and diseases to which they had not previously been exposed, they had little or no immunity. Appalling living conditions increased susceptibility to alcoholism, violence and sexually transmitted infections. Many suffered from malnutrition and others from kwashiorcor and marasmus, both diseases related to inadequate diets. Overcrowded conditions led to the spread of meningitis and gastroenteritis.

At work, they were exposed to harmful chemicals, heat, dust and noise. In these conditions, the greatest risk to a worker’s health was the work itself.

The approach of the authorities

During the apartheid period, the National Party government established a system of labour control to protect white workers and to ensure a flow of cheap black labour for farms, mines and other industries. Because the capitalist bosses saw it as cheaper to replace sick black workers than to treat them, little attention was paid to their health or to their living and working conditions.

Some safety laws were put in place by the State but they were seldom enforced. In 1974, 32 state-employed inspectors had to oversee some 30,000 factories around the country. During the decade following the Soweto Uprising of 1976, it was estimated that 250,000 workers were injured in industrial accidents and about 800 workers died each year from occupational lung disorders, including tuberculosis.

The Workers Compensation Act of 1941 and the Occupational Disease in Mines and Works Act contained no overt racial discrimination, but black workers were often excluded from the compensation they deserved for injury or work-related illness.
The appalling living conditions of the migrants encouraged the spread of disease because they:

- Lived in hostels which were badly ventilated, damp and overcrowded and worked in underground tunnels which were also overcrowded and dusty.
- Were subject to stress, heat, hard physical labour, and many were malnourished.
- Were apart from their families for up to 11 months of the year which created an environment in which there were high rates of alcoholism, violence and other stress-related disorders.
- Were separated from their wives and men took on other partners, thereby increasing the risk of spreading sexually transmitted infections and other diseases when they went home.

**TB and mining**

The developing mining industry in South Africa in the late 19th century resulted in new labour patterns and socio-economic conditions which fundamentally affected disease patterns in southern Africa.

**Skilled labour and the spread of TB**

In the 19th century, skilled miners recruited from Britain and Europe carried TB in a non-active form. However, the stress they experienced, as well as their exposure to silica dust which causes silicosis, encouraged the progression of the disease to active TB.

The disease was easily passed on to black miners who worked alongside them in poorly ventilated underground tunnels. As these workers became sick, they were sent back to their families in rural areas, thus spreading the disease further.

**Unskilled mineworkers and the spread of disease**

Both the 19th century colonialists and the apartheid government forced hundreds of thousands of rural blacks off their land to seek work in the cities by imposing taxes that had to be paid in cash, and by expropriating their land. In this way, the apartheid government, in collusion with the mine bosses, ensured a flow of cheap labour to the urban areas.

By 1910, there were about 200 000 migrant miners on the highveld; by 1940, this number had increased to 300 000 and by the mid-1980s, it had peaked at about 500 000.

The appalling living conditions of the migrants encouraged the spread of disease because they:

- Lived in hostels which were badly ventilated, damp and overcrowded and worked in underground tunnels which were also overcrowded and dusty.
- Were subject to stress, heat, hard physical labour, and many were malnourished.
- Were apart from their families for up to 11 months of the year which created an environment in which there were high rates of alcoholism, violence and other stress-related disorders.
- Were separated from their wives and men took on other partners, thereby increasing the risk of spreading sexually transmitted infections and other diseases when they went home.

**TB and apartheid**

Official apartheid-era figures show a decrease in incidences of TB from the mid-1960s. One reason for the alleged decrease may have been the introduction of effective antitubercular drugs in 1952.
among all population groups. The knowledge that a successful treatment was available might have encouraged people to come forward, especially at a time when the black population was increasingly engaging bio-medical options. Also, the mining industry expanded its use of x-rays to diagnose cases of TB in the 1950s and 60s, which would have increased the number of cases recorded and treated.

However, there are reasons to believe that the incidence of TB did not actually decrease. More cases of TB among the black population might have been reported during the apartheid era than official records show.

Drugs to treat and cure TB were introduced but, despite a declining death rate, the broader control of the disease was not achieved. Treatment for TB requires a prolonged period of consistently taking the prescribed medicines and sometimes a period of hospitalisation but, for example, in 1957 there were only 14,410 beds for blacks at TB institutions and there were about 40,000 new cases in that year alone. There were nearly three times more black cases per available bed than white cases.

As the apartheid government tightened its grip on the country, the social and economic conditions of black people deteriorated, making them more susceptible to TB. Economic factors often mitigated against individuals completing courses of treatment, thus making them vulnerable to a recurrence of active TB and heightening the risk of the virus becoming resistant to drugs.

Black mine workers found to have TB would have been admitted to a mine hospital for treatment for between two weeks and two months. When they were fit to travel, although not necessarily cured, they were repatriated with limited or no compensation. This created a risk that the disease would spread to their home communities and accessing treatment in the rural areas was far more difficult. Often individuals would not have the money to complete treatment or to travel to clinics where this was available.

In the 1970s and early 1980s, the focus on the development of independent health services in the ‘homelands’ further fragmented and complicated treatment. Throughout the apartheid era, the focus on separate development above public health led to a failure of treatment and prevented the creation of an efficient system of health care.

Economic pressure meant that individuals were likely to seek new jobs once they were feeling better but before they were cured. Being in a new job might make them fearful of taking their medicine or requesting time off to attend the clinic. In case their home communities and accessing treatment in the rural areas was far more difficult. Often individuals would not have the money to complete treatment or to travel to clinics where this was available.

In the second extract, the singer refers to the conditions on the mines.

DB Coplan: In the Time of Cannibals:

Extracts from Songs of a Mosotho Migrant
Majara Majara (Ngoana Rakhal) Recorded by David Coplan

Ho tsella, pele ke reng ho lona
Bana ba Molimo?
Oa tebela Fereginia, V.A. Tikoe Maokeng
Thaba-Mashai, ea helelela batho.
Ke moo ho sholepg lekholo la batho.
Ho setse ‘na, lelimo la motho.
Ke setse ke le monetseana ke le mong.
Ke ne ke hula lito tola malika.
Bana ba batho be bolie; ba nkh."a.
Ba se bile le ba nyenea litshenane.
Ore, Itsaba tsaa mokotil, le mpe le li tsehole.

Likomponeng tsena, khale ke li sebetsa...
... Ke reng ho lona, likempolara?
Ke qati ea n'tja; ha ke butsoe.
Ke leboko le lintja; ha ke aparua.
Ke sebore sa botsikoane; ha ke ke kenoe.
Ke ka holo le setseseg sekoereeng -

Bona, e hanne mochini-boi o chaise.
Mochini-boi, ke o pomme hiloooh;
Sepaneree, ke se pomme letsoho.
Ke moo sepanere se neng se
gala ho omana: “Uena, pekenene; uena, thimba-boi,
Koala metsi, u koale limoko.
Thapo tsena li se li re chesitse;
Mali a batho a kopane le majoe”

Furthermore, I say what to you,
Children of G-d?
You know Virginia, Tikoe-among-the-Whitethorns
Montain-Mashai, it fell on people [miners].
It’s there a hundred men died.
It’s me who survived, a cannibal of a man.
I alone survived among that tribe [of corpses].
I was pulling corpses from under rocks.
People’s children have rotted; they smell
They already swarm with maggots.
No, but these mine affairs, you can leave them.

These mine compounds, I’ve long worked them...
... What do I say to you, gamblers?
I am a dog’s stomach; I don’t get cooked.
I am skin with lice; I am not worn.
I am a nest of mites; I am not entered.
I’m like a charge that remained in the ore-face [unexploded] -
Look, that stopped the drill boy from working.
Drill boy, I slashed his head;
Drill guide, I slashed his hand.
It’s then the drill guide
started to scold:
“You, charge-setter; you timber boy,
Shut off the water, so you stop the stream.
These cables have burned us;
Men’s blood is mixed with the stones.”
**Before apartheid**

From the mid-19th century, the mentally ‘disordered’ in South Africa were confined to permanent institutions to minimise their impact on society and to prevent them from procreating and passing on ‘undesirable’ characteristics.

In 1910, South Africa had eight mental institutions that could accommodate approximately 1,692 white and 1,932 black, coloured and Indian patients. Based on the British model, these institutions were prison-like, overcrowded and mostly housed the underprivileged and the deviant. White patients received superior treatment to black patients but in neither case was there much therapeutic treatment.

Mental health care facilities were extended in the early 20th century to accommodate:
- Poor whites whom the State viewed as ‘feebleminded’ and whose procreation they wanted to restrict.
- Soldiers returning from World War 1 who were suffering from a variety of psychiatric problems.

One of the main institutions for ‘lunatics’, lepers and the chronically ill was the General Infirmary on Robben Island. In 1890, the supposedly less dangerous and more curable patients were removed from the island. By 1913, only lepers and black ‘lunatics’ remained there. By the following decade it was considered too expensive to keep the ‘lunatics’ on the island and they were moved to institutions on the mainland. However, services at these institutions remained limited. In 1940, only 26 of the 50 medical practitioners working in mental hospitals were registered psychiatrists.

**Mental health during apartheid**

Apartheid South Africa was one of the most psychologically ill societies in the world, characterised by repression, human rights abuse, violence, alcohol-related problems, malnutrition and poverty. These factors had serious detrimental effects on the mental health of South Africans, especially the black populace. They were systematically denied their dignity and made to believe they were worthless. Black people with mental illness and retardation were stigmatised on the basis of both race and disability and were often denied professional services.

**Race and diagnosis**

Treatment for black people consisted largely of institutionalisation in inadequate facilities and was based on inaccurate notions, such as:
- Black people did not get depressed.
- Black people displaying symptoms of severe stress or trauma suffered from ‘Bantu Hysteria’ and should be treated with sedatives.
- Black people were subject to permanent and untreatable disorders such as schizophrenia, paranoia and epileptic psychosis, while white people were more inclined to manic-depressive psychosis, neurosis and defective mental development which were considered to be less severe.

Black people were often misdiagnosed and denied professional services because:
- The bio-medical concepts of the formal medical sector were often in conflict with the culture of the majority of patients in need of treatment. For example, while communication with the ancestors was an important part of healing for many black people, it was not a treatment that bio-medical health professionals understood.
- Bio-medical practitioners did not acknowledge the psychological effects of apartheid.
- Diagnostic criteria were deliberately abused and used to silence activists by condemning them to institutions where they were under State control.
Provision of services during apartheid

‘Conditions in mental institutions were appalling and did nothing to foster mental health. Inmates were used as sources of income-producing labour and there are (unproved) allegations that black patients were used as “guinea pigs” in research. Mental health professionals remained silent about the situation.’


The following statistics attest to this:

1977  There was one psychiatric hospital bed for every 392 white patients and one for every 1 316 black, Indian and coloured patients. (World Health Report)

1978  Black patients were made to sleep on grass mats on the floor. They received a government subsidy of R1.70 per day, whereas whites received R7 per day.

1980s  At Baragwanath Hospital, there were only two consultant psychiatrists who each consulted one day a week. Psychiatric patients were distributed between the wards and were often tied to beds or sedated as there were no proper facilities for their care.

1986  At least 25 000 people were detained under emergency regulations, of which an estimated 40% were between the ages of 8 and 18. In 1989, the ratio of counsellors to black youth, who were subject to extreme brutality, was in the region of 1:30 000 compared to 1:3 000 for whites.

The Smith, Mitchell scandal

In 1974, the South African press exposed the existence of a chain of privately-owned institutions where thousands of black psychiatric patients were detained involuntarily. Smith, Mitchell and Co. Ltd was running the venture in collaboration with the South African Department of Health, for profit. By the late 1970s, it was estimated that between 10 and 15 black patients were being sent to the various Smith, Mitchell institutions every day.

The Society of Psychiatrists of South Africa

In 1985, the Society of Psychiatrists of South Africa stated that it would strive for the elimination of all forms of discrimination that harm mental health, but it fell short of drawing attention to the destructive effects of apartheid or calling for its end.

For example, in 1986, in a statement on the effects of criminal detention on mental health, it noted vaguely that ‘detention in isolation’ and ‘immoderate interrogation’ may be damaging to mental health but added that ‘justice must be done and security maintained’ and advised that ‘this should not be done in a manner that diminishes the dignity of the individual or the integrity of his or her mind and body’. It did not call for any specific actions to release political prisoners, stop torture, or otherwise protect human rights.

A former SAP [South African Police] psychologist admitted in an interview that work associated with the use of psychology in torture and interrogation was ‘contracted out’ to outside psychologists, so that the SAP could deny the involvement of their own staff in this type of unethical behaviour.


As in other professional societies, it was left to courageous individuals to speak up strongly against apartheid and its policies.
The pre-apartheid years
As early as 1878, black men were being trained as medical auxiliaries or aides at Lovedale, the famous missionary school, and at Victoria Hospital in the Cape. The already segregationist government supported the training of medical aides over fully-fledged doctors.

Black South Africans wanting to become doctors were forced to train abroad. In 1885, John Nembula qualified as a medical doctor in the United States of America. Although a handful of black South Africans followed his example, by the 1930s the number of black doctors had hardly increased. With the outbreak of World War 11, it became impossible for students to train abroad. Pressure was placed on local institutions to offer medical training to black students to ease the growing health crisis among the black population.

In 1941, the University of the Witwatersrand, Johannesburg (Wits) became the first university to open its doors to black medical students. Shortly afterwards the University of Cape Town (UCT) began accepting ‘coloured’ and Indian students, but not black students – allegedly because of a lack of clinical facilities for them at Groote Schuur Hospital.

In 1951, the Natal Medical School opened with an intake of about 40 black students. Training was segregated. Black students followed a seven-year curriculum rather than the six years undertaken by white students. This was one of several attempts to create segregated training for a segregated health system.

Black students at ‘white’ universities
During apartheid, black people who wanted to become doctors faced many obstacles.

- Bantu Education ensured that the majority of South African children received inferior education. This limited their ability to get into medical schools.
- Between 1959 and 1984, the Extension of Universities Education Act was in place. This made it compulsory for anyone of colour wanting to attend university to apply for consent from the relevant ministry. This consent was not readily given.
- Black students at ‘white’ universities generally faced an extraordinary degree of discrimination and humiliation. Although there was academic integration there was social segregation. Facilities at training hospitals were segregated and were vastly unequal.
- Black students were barred from attending post-mortems conducted on white bodies. They would have to wait outside until the organs were removed, as they were allowed to view the organs but not the body of a white person.
- In many cases when black students were allowed into ‘European’ hospitals, they were not allowed to wear their white coats or stethoscopes and had to enter the hospital through a separate back entrance.
- Students who had been given government scholarships, as many black students had, were obliged to work among their ‘own people’ in the rural areas for a number of years.

The training of black medical students at Wits University and Baragwanath Hospital
Even at Wits, considered to be the most liberal of the ‘white’ universities, there was resistance to black students.

During the early 1940s, a rule was introduced preventing black students from entering Medical School until they completed a first degree at the South African Native College, Fort Hare. This increased the cost, time and difficulty of medical training.

From the mid 1940s to 1980s, the number of black medical students at Wits and the number of black doctors at Baragwanath Hospital remained remarkably low.

Until the 1980s, medical specialisation was almost entirely limited to white doctors. Black doctors could only treat black patients in wards with black nurses at black hospitals. They therefore saw limited pathologies and did not have access to the leading specialists who worked and taught mainly at white hospitals.

Timeline and statistics

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>1941</td>
<td>The University of the Witwatersrand (Wits) opened its doors to black medical students.</td>
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<tr>
<td>1945</td>
<td>82 black medical students were enrolled at Wits: 46 Indians, 33 blacks, 3 coloureds</td>
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<tr>
<td>1947</td>
<td>Mary Malafehe, the first black female medical student, graduated from Wits.</td>
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<tr>
<td>1949</td>
<td>Two black women, Olivia B Bikitsha and HL Mahabane, graduated as medical doctors from Wits.</td>
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<tr>
<td>1952</td>
<td>Baragwanath Hospital appointed the first black interns: Drs Ntatho Motlana and Diliza Mji. They were restricted to working inwards where there were only black sisters.</td>
</tr>
<tr>
<td>1959</td>
<td>Changes to the system of admissions to Wits Medical School produced a sharp rise in the number of black enrolments. This was short-lived; soon after a quota system was introduced which limited admission to eight black students in the first year and twelve in the second. 84 black medical students graduated from Wits. By then, only one out of five black graduates was female.</td>
</tr>
<tr>
<td>1960s and 1970s</td>
<td>On average, black medical students constituted less than 10% of Wits classes. 3% of South Africa’s medical graduates were black.</td>
</tr>
<tr>
<td>1969</td>
<td>Transvaal Provincial Administration structures employed over 1 000 white doctors but only 30 black doctors.</td>
</tr>
<tr>
<td>Late 1970s</td>
<td>Ministerial permission was granted to increase the number of black medical students at ‘white’ universities.</td>
</tr>
<tr>
<td>1976</td>
<td>The Medical University of South Africa (MEDUNSA) was opened. It was linked to the University of Pretoria but in effect it was a segregated medical school for black students. Few blacks held leadership posts there and most faculty members were white.</td>
</tr>
<tr>
<td>1977-1988</td>
<td>The percentage of black medical students at Wits rose from 8.9% to 28.9%.</td>
</tr>
<tr>
<td>1985</td>
<td>Black students no longer had to obtain ministerial approval to attend ‘white’ universities.</td>
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</table>
These newspaper clippings span almost three decades and show how challenging it was for black students to become doctors. They are from the Adler Museum of Medicine Archives and the personal archive of Professor Phillip V Tobias.
To lighten the darkness of ill health over Africa is the wide vision which Baragwanath Hospital has for its nurses. This is depicted in its badge which shows a radiant lamp, the symbol of nursing, casting light over the whole continent. This can be true if all service given in this great hospital springs from real desire to serve the sick with kindness and gentleness, as well as with efficiency and good organisation.

Wendy Petersen, Principal, Baragwanath Nursing College, 1954 -1963

**Early training of black nurses**

The education and training of black nurses in South Africa began in the early 1900s, but the process was slow. There were few women who had suitable educational qualifications and there were limited places where they could train. These training institutions were also expensive. Therefore, many women chose to enter teaching rather than nursing.

**The training of black nurses in the 1940s**

By the 1940s, there were only about 800 registered black nurses in South Africa. The dominant white nursing establishment did not view this small group as a threat to their identity or professional status. When the South African Nursing Association (SANA) was created it was, in theory, open to nurses of all races.

The government, under increasing pressure, and aware of the growing demand for health care for black people, opened new nursing schools at a number of government hospitals. Their aim was to replace white nurses serving in black hospitals with black nurses. Black women could only train at, and until the late 1970s only work at, black hospitals.

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**Dr John Patrick Fitzgerald became the first superintendent of the Native Hospital of King William’s Town in 1856. It was the first of its kind in South Africa to train black personnel (mostly male) in basic nursing. Amathole Museum, King Williams Town**

**In the pre-apartheid period, nurses were trained mostly by missionaries. In 1903, Mina Colani and Cecilia Makiwane were the first black women to be enrolled for a three-year nursing course. In 1907, Cecilia Makiwane became South Africa’s first black professional nurse. Adler Museum of Medicine Archives**

**A copy of the Nurses Pledge of Service from the Johannesburg Hospital c 1950s. The Florence Nightingale Pledge was drawn up by a committee headed by Mrs LE Gretter in 1893. Adler Museum of Medicine Archives**

**A nursing sister from Orlando Clinic, late 1950s. Museum Africa**
I wanted to be a teacher. But conditions wouldn’t allow me to be a teacher. So I had to take up nursing, where when you are training you are being paid. So my hope was that at least if I am being paid, I will be able to help my brothers and sister.

Albertina Sisulu www.anc.org.za/people/alberta.html

Baragwanath Hospital

The Baragwanath Nursing College, established in 1948, became one of the largest and most renowned training colleges for black nurses in South Africa, and probably in the whole of Africa.

When the hospital opened as a civilian institution to treat black patients in the late 1940s, there were three white matrons, 33 white sisters, two black sisters and 118 black nurses. By the 1950s, the hospital was receiving between 2 000 and 3 000 applications for the limited number of positions available.

The new Baragwanath College of Nursing opened in 1982. It could accommodate up to 1 500 students a year, but by the 1980s there were between 20 000 and 30 000 annual applications.

Why black women became nurses during apartheid

During apartheid, nursing was one of the most important avenues for black women to have an independent career and to be employed. Nursing provided status, respect and employment in a world in which black people, particularly women, faced incredible oppression.
For some, nursing was almost like a religious calling. Others took up nursing for altruistic reasons:

I grew up with this thing in me that said I wanted to help other people, especially the sick and the helpless, and maybe make a difference in their lives.

Edith Ngema, Baragwanath Hospital, 14 September 2004

Many were attracted by professional prestige:

In high school we used to visit our friends’ sisters at Baragwanath Hospital. We would see them walking in those wards, very, very straight, bright and shaking the thermometers. We used to visit the nurses’ home. We found them busy. Some were reading, others were doing handwork and crocheting. I said this is the profession for me.

Mpho Tsoku, Baragwanath Hospital, 5 October 2004

The nursing profession was viewed as ‘ladylike’, bringing dignity and sophistication together with training and proficiency.

For nurses during the apartheid period, the white uniform was an important symbol of belonging to a profession. It also said much about class and status.

When you walked in your white uniform even the children knew that there is a nurse passing. Anything the community wanted to know they knew they would get it from a nurse. It was the passion and respect that made nursing what it was.

Florence Mudzuli, 14 September 2004

**Being a black nurse during apartheid**

In 1958, Harriet Rita Shezi took charge of the black hospital in KwaThema, becoming the first black matron in charge of a hospital in South Africa.

As the number of black nurses increased, so too did white attempts to gain control over the profession. The Nursing Amendment Act of 1957 introduced racial segregation into nursing. Meetings called by the SANA to explain the Act to black nurses were boycotted, and South Africa was expelled from the International Council of Nurses in 1973 as a result of segregated nursing practices.

The daily experiences of nurses working in black and white hospitals in South Africa were fundamentally different. For example, although black and white nurses wrote the same examinations, they were forced to sit in segregated rooms. Nurses of different races earned different salaries.

Everything was not the same! So you can imagine, you train with a white nurse and you complete at the same time, but once you become a registered nurse then the discrepancy is so much. You remain black with your black salary and she remains white with her white salary.

Florence Mudzuli, Baragwanath Hospital, 14 September 2004

Many black nurses found the training environment restrictive and paternalistic. They had to get permission to leave the nurses’ residence and all visitors, especially males, were monitored.

The sisters were too militarist! As a junior you had to dance to the music of that power, not for the patients. Once at Bara I was doing a bed-pan when the matron called me to do something else but I finished with the patient, and the sister said to me: “Who is more important, me or the patient?” and I said: “The patient”. AWH! I got a bad report!

Anastasia Zungu, Retired Staff Nurse, 4 October 2004

Author’s note: The names of the nurses quoted above have been changed to protect their identities.
THE CASE OF STEVE BIKO

Who was Steve Biko?
The name Steve Biko is synonymous with Black Consciousness in South Africa.

In the mid 1960s, while a medical student at the University of Natal (non-European section), he founded and later became president of the South African Students’ Organisation (SASO). His aim was to address the negative self image that he saw among black students.

In 1972, Biko gave up his medical studies and dedicated himself to various projects rooted in Black Consciousness. Although he was banned and restricted to King William’s Town in 1973, he established the Zanempilo Community Health Clinic in Zinyoka near King William’s Town to show the community how they themselves could provide health services for their people, and was instrumental in founding the Zimele Trust Fund which assisted political prisoners and their families.

The State feared this enigmatic, strong leader who was black and proud and, as a result, he was frequently harassed. In August 1977, Biko was arrested and detained under Section 6 of the Terrorism Act.

The ‘Biko doctors’
In 1977, Steve Biko died in prison from injuries sustained during his detention and torture.

Two district surgeons, Dr Ivor Lang and Dr Benjamin Tucker, a physician in private practice, Dr Colin Hersch, and a neurosurgeon, Dr R Keely, attended to Steve Biko. At the inquest into his death, it emerged that the attendant doctors had found symptoms and signs of serious trauma, which included an intracranial injury.

Although these signs and symptoms were consistent with brain damage, the district surgeons ignored them. They accepted the

Steve Biko was born in King William’s Town in 1946. He died on 12 September 1977 in prison in Pretoria from brain damage sustained during torture in Port Elizabeth security police headquarters.

UWC Robben Island Mayibuye Archives - IDAF Collection

Selected works from Colin Richards’ Biko Series II, 2008.

Colin Richards (born 1954) first encountered the post-mortem photographs of Steve Biko while working as a medical illustrator at Wits in late 1977.

Almost twenty years later Richards participated in the Faultlines exhibition, curated by Professor Jane Taylor which as held at the Castle in Cape Town. The exhibition sought to articulate a ‘cultural response to the Truth and Reconciliation Commission’.

The University of the Western Cape’s archive was opened to all the artists who participated in the exhibition. The archive contained hidden, obscure or forbidden histories which few has seen. It was there that Richards came upon some post-mortem photographs that he recognised, and others he did not. Working with these images and other photographs of cells, passages and diagrams telling of the fate of detainees at the hands of the security police, Richards produced two bodies of work. The original installation is in the collection of the South African National Gallery (SANG) and Biko Series II forms part of the Adler Museum of Medicine Art Collection.
explanation of the warders who argued that, since Biko had been a medical student, he had the knowledge to fake the symptoms of brain damage. They also claimed that Biko was dangerous and had sustained his injuries in a scuffle.

Shortly before he died, Biko was transported 1 100km to Pretoria, semi-conscious and half naked, on a mat on the floor of a Land Rover. Despite his condition, no medical attendant travelled with him and his medical records were not sent to Pretoria. He died in a prison cell on 12 September 1977, alone and unattended.

The inquest

Shortly after Biko's death, the routine inquest into unnatural deaths began.

The Biko inquest lasted two weeks. Police witnesses were unable to explain the physical and mental deterioration of Biko during his 24-hour interrogation. The doctors admitted to clinical errors and the falsification of medical reports. Ultimately, it was found that no-one could be blamed for Biko's death and that the severe head injury from which he died was sustained during a scuffle with police. However, the magistrate found some evidence of improper conduct by the doctors and referred the matter to the South African Medical and Dental Council (SAMDC).

Since the SAMDC was made up primarily of government appointees, it was hardly surprising that after three years of procrastination, and in spite of the glaring medical negligence of the doctors, the SAMDC found no evidence of improper conduct on the part of the doctors. It did not institute any disciplinary action against them.

The Medical Association of South Africa (MASA), a voluntary organisation which included two-thirds of South African doctors, reached the same conclusion. The medical fraternity had closed ranks in spite of local and international protests.

The second enquiry

The SAMDC's failure to provide ethical guidance on the treatment of detainees, particularly Steve Biko, led to an outcry both at home and abroad. However, the SAMDC did not change its position on the Biko doctors until two independent groups of doctors took the matter to the Supreme Court in 1984. These doctors were Phillip Tobias, Frances Ames, Trefor Jenkins, Yosuf Veriava, Tim Wilson and Dumisani Mzamane. Tobias was Head of the Department of Anatomy and Human Biology and Dean of Medicine at Wits; Ames was Professor of Neurology at the University of Cape Town; Jenkins was Professor and Head of the Department of Human Genetics at the South African Institute for Medical Research and Wits; Veriava was a specialist physician at Coronation Hospital; Wilson was Director of the Alexandra Clinic in the 1980s. The clinic, which was established by Wits medical students, remained an important site for medical care during the apartheid era. Mzamane became Head of the Nephrology Department at Wits and also was the first black physician to be appointed head of a medical unit at Baragwanath Hospital. The pressure that these individuals brought to bear through their court action led to an enquiry.

The Court decided to hear the two appeals at the same time. Eight years after Biko's death, in an historic ruling in the case of Veniava and others vs SAMDC, the Court ordered the SAMDC to hold a disciplinary hearing into the conduct of the doctors. The judges ruled that not only did the doctors have the right to claim that some colleagues had been negligent, but that it was the duty of doctors to do so.

Lang and Tucker were both found guilty of improper conduct. Lang received only a caution and reprimand and continued to practice for a further five years before he retired. Tucker was struck off the role but he applied to be reinstated, successfully. He issued a public apology.

The effect of Biko's death on MASA members

A number of resignations from MASA followed its silence in relation to the Biko doctors. MASA responded by setting up ad hoc committees to consider the ethical issues raised by the treatment of detainees. It was only after the death of the detainee, Dr Neil Aggett, that MASA spoke out more strongly against detention without trial, but never pushed for its abolition.
Truth and Reconciliation Commission health sector hearings

The Truth and Reconciliation Commission (TRC) was intended to investigate human rights abuses as experienced by victims, and to encourage perpetrators to disclose their actions in full. The special hearings on the health sector covered issues such as medical complicity in gross human rights violations, the ways in which health professionals relate to human rights generally, neglect in rural health and the degrading treatment of mine workers.

Organised by Dr Wendy Orr, the hearings were perceived as more self-reflective and more practical in their contribution to further transformation than some of the other hearings.

It was only at the TRC that MASA acknowledged its role in sustaining apartheid and apologised to ‘persons within and outside the medical profession, who might in the past have been hurt or offended by any acts of omission or commission on MASA’s part’.

MASA was so wrapped up in its white, elitist, educated, professional world as individuals and as a collective organisation and as part of a broader society from which doctors were drawn, that it failed to see the need to treat all people as equal human beings … MASA allowed black and white people to be treated differently, and this is the form of human rights violations for which it stands disgraced. Dr Hendrik Hanekom, former Secretary-General of MASA and then of SAMA.


(It) was quite comfortable with the status quo, and its public reaction to any criticism of the inequities and iniquities in society, and particularly in health care delivery, was to dismiss such criticism as the work of subversive enemies of the State.

ibid.

After the special hearings on the health sector, the TRC concluded that it was not only detainees whose human rights were infringed by health professionals but also civilians.

The charge sheet

1. Reporting injured people to the security forces. This meant that people who were involved in civil unrest and sought medical care from health facilities were often arrested. Such facilities became associated with the tyranny of the State.

2. Allowing medical records of patients to be seized by the security forces. This breached patient confidentiality, and could lead to detention and interrogation.
3. Permitting security forces to compromise the clinical care of patients. This included treating patients in the presence of security personnel, and early discharge of patients into police custody.
4. Interfering in the clinical decision-making of colleagues, to the detriment of the patient. This happened particularly when district surgeons prevented doctors from protecting the mental health of detainee patients in their care.
5. Improper treatment of hunger strikers.
6. Shackling detainees and prisoners. Detainees and prisoners were often shackled to hospital beds, as they were regarded primarily as prisoners rather than patients.
7. Failing to record injuries or to adequately document the patient’s condition. On occasion, not all injuries were reported. This was problematic for clinical care, as well as for medico-legal reasons.
8. Preventing family access to patients. Relatives were often not informed, or prevented from seeing family members who had been admitted to hospital. It is probable that many child detainees were treated without parental consent.
9. Participating directly in security force action. Some health professionals actively participated in security force activities as reservists.
10. Participating in structures of state security. Some health professionals participated in Joint Management Centres which formed a large security network that interfaced with community, business and defence committees, especially in black townships.

The Wits Faculty of Health Sciences’ Internal Reconciliation Commission

Arising out of discussions which occurred during the Wits Faculty’s preparation for its submission to the TRC’s Health Sector Hearings, it was decided that the Faculty should undertake an Internal Reconciliation Commission.

The commission aimed to investigate and report on the role of the Faculty and its teaching hospitals during the apartheid era. It sought to record the history of racial discrimination in the Faculty as well as the history of resistance to apartheid by Faculty members and students. The process began in 1997 and the commission was set up under Advocate Jules Browde and Drs Essop Jassat and Patrick Mokhoba. Oral and written evidence was collected. The report was submitted to the then Dean of the Faculty, Professor Max Price, in late 1998.

Although there were criticisms of the report, including challenges to the limited number of submissions the commission gathered – especially from black Faculty members and doctors – the commission made notable conclusions. These included that:

- there was a general lack of sensitivity to black students;
- the Faculty as a whole colluded with, or at least capitulated without a unified opposition to, apartheid and enforced racial discrimination which led to unfair treatment of black students, postgraduates and staff;
- teaching at the University-affiliated teaching hospitals was racially structured and the fact that black students could not rotate through all hospitals was a serious handicap to them;
- the majority of Faculty members, with a few notable exceptions, did not interact with black students or participate to any great extent in their teaching, and
- there were some notable individuals who did stand up to the apartheid regime but they were in the minority.

The process was subsequently followed by other South African universities.

The Wits Faculty of Health Sciences, University of the Witwatersrand, it commemorates the Internal Reconciliation Commission undertaken by the Faculty in 1997. The plaque below the sculpture reads:

Sculptor Lawrence Chait (b 1943) produced this work for the Faculty of Health Sciences, University of the Witwatersrand. It commemorates the Internal Reconciliation Commission undertaken by the Faculty in 1997. The plaque below the sculpture reads:

The Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, commits itself to the ideals of non-discrimination in its teaching, the constitution of its student body, the selection and promotion of its staff and in its administration. It reaffirms its rejection of racism and other violations of human rights in whatever form they make their challenge. In committing itself to these ideals the Faculty acknowledges that these values have not been honoured and it apologises for the hurt and suffering caused to students, staff and patients by past racial and other discriminatory practices.

The Faculty recognises the respect that staff and students have in preserving these ideals and pays tribute to the efforts of those who strove to bring about change for the benefit of future generations.

2 February 2000
Steve Biko was the 46th political prisoner to die under interrogation by the South African security police. This is a list of those who died in detention between 1963 and 1990.
Steve Biko was the 46th political prisoner to die under interrogation by the South African security police. This is a list of those who died in detention between 1963 and 1990.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>NO</th>
<th>NAME</th>
<th>DETHED</th>
<th>AGE</th>
<th>PLACE</th>
<th>CAUSE</th>
<th>OATHSHELD</th>
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<td>MAHLANGANE, Anthony</td>
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<td>20</td>
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<td>1964</td>
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<td>MOKGONGANE, Toti</td>
<td>11/06/63</td>
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<td>11</td>
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Sources: South African Democracy Education Trust, Centre for the Study of Violence and Reconciliation; and Human Rights Commission of South Africa.
Detention without trial

Detention without trial was introduced in the late 1950s. From the 1960s onwards, as opposition to apartheid grew, the government put increasingly harsh security measures in place. By 1976, the year of the Soweto Uprisings, modifications to the law meant that detainees could be held for unlimited periods at the whim of the security forces.

By the late 1980s, there had been over 73,000 arrests, mostly detentions without trial. Many detainees were children under the age of eighteen. Some were as young as 10 years old.

While in detention, the civil liberties of detainees were suspended. They had no contact with the outside world. The security police meted out brutal treatment to political detainees, which had serious long-term consequences on their physical and mental health as well as that of their families and communities.

The rate of detentions strained the prison health services and challenged the medical profession to provide ethical and responsible care. Only a minority of health care professionals condemned apartheid and fought to bring appropriate health care to those who needed it most.

Hunger strikes

During the 1980s, the hunger strike (a voluntary fast) became a tool for detainees to protest against their detention or the conditions they were forced to endure.

One of the largest hunger strikes began in the Johannesburg Prison in January 1989. It eventually involved 652 people and drew considerable attention from the media and the medical profession. By August, many activists were released: however, the numbers of deaths due to the strike are unknown.

What is known is that the prison guards and security police often physically abused the strikers, withheld prescribed medicines and moved them so that their lawyers struggled to access them. In most cases, when the strikers’ conditions deteriorated, they were hospitalised, often shackled to the bed with a guard present at all times.

People from different walks of life, including medical doctors, formed organisations to oppose the detentions and to spread information about the hunger strike and its consequences. The University of the Witwatersrand called for the release of all those detained without trial, as their detention was not only unjust and an abuse of their human rights, but was also detrimental to their health.

In an article published in the South African Medical Journal in 1989, the Wits Faculty of Medicine discussed the difficult medical and ethical issues that health care workers faced when treating people on a hunger strike. Respecting the individual’s right to choose to die voluntarily for their beliefs is in sharp contrast with health professionals’ training which aims at preserving life.

A protocol for hunger strikes

In 1991, a protocol, developed and endorsed by a wide range of political, medical and human rights bodies, was presented to the Department of National Health and Population Development. Key points of the protocol were that:

- No medical personnel may apply pressure on the hunger striker to suspend the strike, although the striker must be informed about the medical consequences of a hunger strike.
- Unconditional treatment must be rendered to hunger strikers.
- Hunger strikers have the right to choose their doctor and/or a second professional opinion.
- The hunger striker will not be force-fed.
- The hunger striker should be encouraged to make a living will stating his/her wishes with regard to treatment once he/she is unable to make such decisions.

MASA urged its members to follow the Tokyo Declaration, which approached hunger strikes similarly.

Deaths in detention

In Detention

He fell from the ninth floor
He hanged himself
He slipped on a piece of soap while washing
He hanged himself
He slipped on a piece of soap while washing
He fell from the ninth floor
He hanged himself while washing
He slipped from the ninth floor
He hung from the ninth floor
He slipped on the ninth floor while washing
He fell from a piece of soap while slipping
He hung from the ninth floor
He was washed from the ninth floor while slipping
He hung from a piece of soap while washing

Chris van Wyk

It is estimated that about 70 deaths in detention occurred between 1963 and 1989. However, it is unlikely that the full list of people who died in detention will ever be known.

One of the last detainees to die in detention was Clayton Sizwe Sithole. He died 12 days before Nelson Mandela was released in 1990. At the time, he was Zinzi Mandela’s partner and the father of one of Nelson Mandela’s grandsons.

The security police tended to claim that the deaths of political detainees were due to accidents or suicide. All unnatural deaths had to be investigated by an inquest. The post-mortems were conducted in government mortuaries and government pathologists gave the testimonies. The courts generally ruled in favour of the police claims.

In some cases, medical negligence was an important contributing factor to deaths in detention. Detainees had limited access to doctors. Those they did have access to were state-paid district surgeons who were accountable only to the State, specially selected “for security
Ahmed Timol.

Timol died during his detention in 1971. Police said that he ‘fell from the 10th floor window at police headquarters in Johannesburg while being interrogated’.

The official verdict was that ‘no-one was to blame’ for his death. The inquest ruled it suicide and stated that he had not been tortured or assaulted before his death. While giving evidence at the inquest, Dr Gluckman noted that there was possible complicity by the state pathologists and that the pathology was inconsistent with the simple explanations given by the officials.

The Death of Ahmed Timol
The inquest ruled it suicide and stated that he had not been tortured or assaulted before his death.

As a result of her actions, Orr was victimised and isolated. She was removed from any contact with detainees. She was provided little support by MASA, even once she had become a member. Many years later, Dr Orr convened the health sector hearings of the Truth and Reconciliation Commission.

Jonathan Gluckman and the exposing of falsified medical and autopsy reports
Dr Jonathan Gluckman, a pathologist in private practice from 1978 to 1991, collected the most comprehensive record of the medical community’s collusion with the security forces. In 1991, he made public his dossier covering over 200 cases. Using these cases, on which he had acted as an independent forensic pathologist, he showed that the State forensic pathologists had falsified medical reports in order to protect the security police. His papers are now housed in the Wits Archives. The death of Ahmed Timol was one of his cases.

101 doctors protest at Baragwanath Hospital
By the 1980s, the number of patients at Baragwanath Hospital far exceeded the number of beds. Doctors at the hospital launched campaigns to force the authorities, including Wits University, which was responsible for the hospital, into action. When these were

Dr Wendy Orr and the treatment of detainees
In 1985, during the first State of Emergency, 25-year-old Dr Wendy Orr worked in the building where Biko had been assaulted. As Orr was not politically active before she entered the medical service, she was given police clearance to act as a district surgeon. What she witnessed once she entered the service led to her taking action. The torture of detainees and the seeming indifference and medical neglect by her superiors resulted in her applying to the Supreme Court for an urgent interdict to prevent police from assaulting detainees.

The interdict had the immediate effect of stopping the assaults on the detainees at St Alban’s where Orr worked, but elsewhere the systematic use of violence against detainees and complicity of medical personnel continued.

Doctors who took a stand against apartheid
For the most part, the medical community failed to oppose the human rights abuses inherent in the apartheid system. Many actually colluded with the security police. But there were those who took a stand.

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Medical practitioners did not identify solitary confinement as torture and many did not expose or fight other forms of punishment.

Yosuf Veriava, in his article titled ‘Torture and the medical profession in South Africa – complicity or concern?’ which appeared in the journal Critical Health in 1989, shows how the medical community was guilty of both ‘medical acquiescence in, or tolerance of torture’.

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unsuccessful, a group of senior Baragwanath Hospital physicians, David Blumsohn, Kenneth Huddle, Leib Krut and George Marinopoulos, wrote a letter of protest against the deplorable conditions at the hospital. The letter was signed by 101 doctors, almost the entire Baragwanath Hospital Department of Medicine. It was submitted for publication to the South African Medical Journal (SAMJ) in September 1987.

Letters of support, comment and reproach flowed into the SAMJ. The media picked up the story and reports and exposés appeared in the newspapers. Baragwanath Hospital was in the public eye.

The Transvaal Provincial Administration (TPA) denied its callous lack of action and doctors were threatened with disciplinary action if they did not sign a grovelling apology, drafted by the TPA.

This was signed by 49 doctors but they made alterations and did not apologise for statements made about the overcrowding itself.

The majority of senior doctors emerged from the affair with little more than an official reprimand. However, a number of junior doctors faced punitive action.

Beverly Traub and Hubert Hon were both refused reappointment as Senior House Officers, while Linda Jivhuho, Zolela Ngcwabe, Gideon Frame and Mark Friedman, who were all completing periods of internship, were not appointed as House Officers as was the usual practice. All had signed the original letter - none had signed the apology. They approached the courts to have the administrator’s decision reversed. Justice Richard Goldstone demanded that the six were given a hearing in December 1987, but it was claimed that they were ‘not suitable’ for appointment. Feeling that they had no other option, five doctors apologised. However, Beverly Traub did not.

Traub again instituted legal action against the Administrator of Transvaal, the Director of Hospital Services, the Superintendent of Baragwanath Hospital and the Director of Personnel of the TPA. In August 1989, the Court upheld the earlier judgment of the Witwatersrand Local Division that the doctors should be given a fair hearing and should be hired because they fulfilled all the stated criteria. Traub had not only questioned a decision taken by four top officials, including the Administrator of the Transvaal, she had won.

WITS and the 101 doctors’ letter

In direct response to the 101 doctors’ letter, Wits University set up a commission of inquiry into conditions at the hospital under the leadership of Professor DJ du Plessis, former Wits Vice-Chancellor and former head of the Department of Surgery at Baragwanath Hospital.

The commission’s report, issued in late 1988, confirmed many of the claims made in the original letter about inadequate facilities at the hospital, and also stated that although many doctors and nurses tried to provide optimum care amidst appalling conditions, these conditions negatively affected staff morale. It concluded that the heavy workload and congestion in the wards made teaching and research almost impossible. It also disputed the TPA’s claim that patients were admitted unnecessarily.

Wits’ engagement brought some material benefits to the hospital. The University raised R3.9 million from private sources to provide an extra 325 beds at Baragwanath and to erect ward extensions to accommodate the overflow.

While the TPA had not undertaken any such initiatives itself, it seemed happy to support those of the University and to take advantage of the opportunities this created not only to ease the overcrowding in the wards, but to provide some positive publicity.
The Gluckman Commission Report of 1944 was an early attempt to reconstruct South Africa’s health care system. This brief experiment with social medicine, which had a number of primary health care centres at its core, was short-lived. Some of the ideas inherent in this commission were resurrected almost five decades later.

The Maputo Conference
In 1990, after the African National Congress (ANC) was unbanned and Nelson Mandela was released from prison, the ANC began putting structures in place for when it came to power. One area of increasing concern was health.

In April 1990, a conference was held in Maputo, which brought together exiled health leaders and the ANC Health Secretariat for the first time. Developing an HIV & AIDS policy was high on the agenda: exiles had seen the devastating effects of the disease in neighbouring countries.

The National Progressive Primary Health Care Network was appointed to lead and coordinate work in HIV & AIDS in South Africa.

The conference emphasised the need to address the wider social factors which promoted ill health such as poverty, the migrant labour system, forced removals, the lack of education and inadequate health care for most of the country’s people.

The evolution of the ANC health plan
The ANC’s 1994 National Health Plan, drawn up with the assistance of consultants appointed by the World Health Organisation and UNICEF, outlined post-apartheid health policy.

The plan aimed to address the fragmented health service which was biased towards the private sector and curative care, rather than prevention. It called for a comprehensive National Health Service based on a multidisciplinary and intersectional approach to ill health. It highlighted the integral role of primary health care and the need to focus on improving the social and economic environments in which people lived.

The plan was, however, criticised by the National Treasury and health professionals for being too expensive and too rigid.

Post-apartheid changes
In the wake of the 1994 election, the new health ministry introduced an Act providing free maternity services and free health care for children under the age of five, as promised by the ANC during the elections.

Various activist health worker organisations were formed in the 1970s onwards opposing the apartheid policies. These included the Transvaal Medical Society, which later became the Health Workers’ Association (HWA). Dr Dumisani Mzamane was the President and Dr Yusuf Veriava its Vice-President. The HWA spearheaded the movement among progressive groups across the country to have the Medical Association of South Africa (MASA) expelled from the World Medical Association. The HWA then became the South African Health Workers’ Congress, open to all health professionals.

A new association of progressive doctors and dentists, NAMDA, was formed in 1982 in opposition to the South African Medical Association (SAMA). A number of doctors who were disenchanted with MASA broke away and joined NAMDA.

NAMDA held a major conference in 1985: Towards Health care for all, mobilising the profession for social change, which stimulated debate on key issues of concern to health workers in South Africa.

Adler Museum of Medicine Archives
The Act strained the already stretched health care services. The focus on primary health care also increased the pressure on hospitals and specialist care. By significantly increasing health services in under-serviced areas, it allowed for more people to seek care.

The next major piece of legislation to guide the transformation of the health service was the 1997 White Paper for the Transformation of the Health System in South Africa. This strove to create a comprehensive plan that would promote equality, accessibility and community participation in demarcated health districts.

While these documents suggested holistic, integrated plans for transformation, the immense problems in the health care system were heightened by the emigration of large numbers of health-care professionals.

Two major strategies were initiated to deal with this problem:

- The government began importing Cuban doctors, many of whom worked in rural areas.
- Two years of community service for all new medical graduates became compulsory.

Lack of skills was not the only major challenge facing the health care structures – the devastating HIV & AIDS epidemic fundamentally reshaped and continued to challenge health and health care needs in South Africa.

The apartheid legacy

Fifteen years into democracy, many features of apartheid still plague the health system. Health-related resources are still concentrated in the private sector and in urban areas. Whilst the fourteen health departments of the apartheid era were problematic, the sharing and co-ordination of responsibilities between the present national, provincial and local levels of government remains a complex process. And although the new health system is based on the concepts of primary health care, the health status of much of the black population remains poor, reflecting the level of poverty and other factors, both social and educational, which impact negatively on the health of communities.

Despite these obstacles, progress has been made. Apartheid health care systems have been eradicated. All South Africans have constitutional protection of the right to health care and there is a commitment among the medical fraternity to provide high-quality health services for all. The professional bodies: the Health Professions Council of South Africa and the Medical Association of South Africa have been transformed. There is improved access to health care and greater attention to health care priorities including the present AIDS epidemic.
Primary sources

**CENTRAL ARCHIVE DEPOT, PRETORIA NATIONAL ARCHIVE (SAB)**
- Archives of the Department of Health (GES)
- Archives of the Department of Public Works (PWD)
- Archives of the Johannesburg General Hospital (JHM)
- Archives of the Secretary of Native Affairs (NTS)

**UNOFFICIAL ARCHIVAL SOURCES**
- Adler Museum of Medicine (Adler Museum), Wits Faculty of Health Sciences, Johannesburg, South Africa
- Archives of the Secretary of Native Affairs (NTS)
- Archives of the Department of Public Works (PWD)

**UNIVERSITY OF THE WITWATERSRAND COLLECTIONS**
- University of the Witwatersrand, Central Archives and Registry (Wits Archives), Johannesburg, South Africa
- University of the Witwatersrand, Faculty of Health Sciences Library (WHSL), Johannesburg, South Africa
- University of the Witwatersrand, Faculty of Health Sciences Registry (WHSR), Johannesburg, South Africa
- University of the Witwatersrand, Historical Papers Collection (HPW), William Cullen Library, Johannesburg, South Africa

**PRINTED PRIMARY SOURCES**
- Johannesburg Municipal Publications
- Union of South Africa Government Publications

**Books and Journal Articles**

- Deacon, H., P. Howard and E. van Heyningen (eds.), The Cape Doctor in the Nineteenth Century: A Social History (Amsterdam, 2004).
- Digby, A., Diversity and Division in Medicine: Health Care in South Africa from the 1800s (Peter Lang, 2006).
- Dubow, S., Scientific Racism in Modern South Africa (Cambridge, 1995).
- Marks, S., Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession (London, 1994).
- Murray, B., Wits, the Open Years: A History of the University of the Witwatersrand, Johannesburg, 1939–1959 (Johannesburg, 1997).
- Orr, W., From Biko to Basson: Wendy Orr’s Search for the Soul of South Africa as a Commissioner of the TRC (Johannesburg, 2000).

**UNPUBLISHED THESIS**
