
Research Article

The Politics of Primary Health Care of the Blacks in the Former Northern Transvaal Province of South Africa During the 1990s: A Historical Perspective

William Maepa¹ and Pamela Mamogobo¹

¹University of Limpopo, South Africa

***Corresponding Author:** William Maepa, University of Limpopo, South Africa

Abstract

The development of 'primary health care' which is also referred to as 'community-based care or healthcare at clinic level' has been a challenge for the state over many decades in South African health system. In South Africa, the rural black population have long experienced racial disparity and marginalisation. The turn of political events towards gradual democratisation in the early 1990s created a situation conducive to the total transformation in the country's health system as new hopes for the attainment of a long-anticipated 'equal health for all' seemed to be fast approaching from the horizon. The new political dispensation by the National party government under the leadership of F.W De Klerk created auspicious domain for full implementation of primary health care. This article will seek to explore the circumstances or developments throughout the 1990s and determined the speed at which the health system based on primary health care featured in the new democratic dispensations under the leadership of the African National Congress. The article argues that attempts to achieve the implementation of primary health care faced a variety of political and socio-economic challenges which had a serious impact on the intended efforts dealing with healthcare issues. The article also argues that the period since the inception of democracy left the newly formed government with problem of closing the health disparity gap created by the apartheid government. It became evident that attempts to implement the envisaged universal healthcare based on 'equal health for all' would be a mammoth task faced by the new government. The invigoration of the country's health system through the District Health System was considered as the best model to achieve primary health care goals. The article will also touch the efforts taken by the new government, with the involvement of non-governmental organisations and other interested health professionals to support transformation process. Greater focus will be on the former homeland areas of Lebowa, Venda and Gazankulu, which occupied a large part of the former Northern Transvaal.

Keywords: Primary health care, democracy, universal healthcare, transformation, governmental and non-governmental organisations, district health system, African National Congress,

Introduction

The period of the 1990s was a turning point in the history of health care system in South Africa. The situation created new hopes for the attainment of a long-awaited equal health services to all racial groups in the country. Immediately after de Klerk's appointment as a President in 1989, he saw the need to speed up the process of transformation by engaging the previously banned political organization into meaningful negotiations. The new leadership and its preparedness to enact serious and meaningful reforms initiated by De Klerk's predecessor, P. W. Botha and his cabinet, paved a new path that is in line with the popular notion of 'health for all by the year 2000' as envisaged by the Alma Ata conference in 1978. To all intents and purposes, de Klerk's initiatives turned out to be limited and did not fully meet the high expectations of the majority of the blacks who were 'smelling' freedom. Needless to say, this led to the continuation of conflict and friction that accompanied the negotiation process for the implementation of democratic government. It was after the 27 April 1994 general democratic elections that the restructuring process of South Africa's health system by the newly formed Government of National Unity (GNU) was prioritised. The new government embarked on a new comprehensive health policy programme that aimed at addressing the imbalances of the past apartheid era, most particularly in the homelands where poverty and related diseases were common. The former homeland areas of Lebowa, Venda and Gazankulu, which occupied a large rural part of the former Northern Transvaal were also severely affected by high notification of these anomalies.

The politics of the early 1990s and health legislation

The election of the new reformist president F.W de Klerk in 1989 and his willingness to accept the mass democratic movement's demands for the new political, social and economic reforms, was a significant development in the history of the country. During his opening address to parliament on 2 February 1990, he announced the major reforms which included the unbanning of the African National Congress (ANC), the South African Communist Party and other political organisations. Although uncertainties regarding the possibilities of effective implementation of these reforms were flooding the minds of many black South Africans, high hopes and expectations were predominant. These new expectations were also felt in the healthcare fraternity, most particularly from the progressive organisations, which struggled for years to persuade the government to transform the national health policies. [1]

The first step taken by de Klerk and his government was aimed at redirecting the healthcare system from curative hospital-based to a preventative primary health care system that would accommodate all racial groups. The different health authorities of the central health departments and homelands redirected their efforts towards the provision of comprehensive health care services in the previously disadvantaged black communities, both in the rural and township areas. The pressure felt by the government to do away with apartheid related policies which were obstacles for many years, forced the state's hand to act decisively. This effort by the government was largely influenced by the principles of the World Health Organisation and Alma Ata Declaration of 1978, which considered primary health care (PHC) as a priority in solving many socio-economic problems in the rural areas of the blacks [2].

The state's willingness to implement meaningful reforms based on preventative and primary health care services was part of the negotiation process during the 'road to democracy'. These efforts put specific emphasis on health education, environmental and community health and family planning, as the cornerstones of a comprehensive primary health care system. Other issues included health budget and community health centres. These new developments were strengthened by the Health Act No. 116 of 1990, which empowered the Minister of Health to transform and improve health delivery services and financing the non-independent homelands by the National government. The Act also made provision for the Local Authorities to develop PHC model that would be vital for effective health service delivery in the former homelands. Although the recommendations of this Act were not

implemented, it reflected signs of meaningful intention by the government to equalise health services to all racial groups in the country [3].

Dr Elliot Kgoadi-Molaba, an employee of the former Lebowa homeland appreciated the Act for attempting to equalise salaries of both whites and blacks working in healthcare sector. The work of funding the former homelands was carried forward by the National Health Service Delivery Plan of 1991, which introduced a series of national forums that dealt with themes related to the development of PHC, including training of health personnel and research projects. These projects paved a way for drawing diverse and opposing groups to engage in dialogue for the transformation of health care services [4].

The new health dispensation was strengthened by the announcement made by Minister of Finance, Rina Venter in parliament on 13 May 1991. She emphasised the need for the implementation of the new management style with community involvement and the removal of the past rigid bureaucratic decision-making process. PHC clinics were expanded by granting academic hospitals and National Policy Advisory Council a management autonomy to advise the Minister on health policy matters [5]. Moreover, it was during the South African Nursing Centenary Conference held in Bloemfontein on 19 September 1991 that de Klerk emphasised the need for the health profession in the country to adapt to the new pattern suitable to the Third World realities where health related economic challenges in the country needed immediate attention. Nurses were encouraged to have background knowledge of family circumstances for the effective and appropriate treatment of common diseases and injuries affecting the communities [6].

The early 1990s also witnessed the continuation of poverty with nutrition related problems in the homelands, most of which were predominantly rural. Related challenges were highlighted by Dr M.S. Kgaphola who singled out insufficient nutrition services and qualified dieticians prevailed in Lebowa homeland. The insufficient knowledge among nurses who were on the frontline of health services in relation to nutrients and their toxicity if they are taken in large quantities or doses, added health challenges and the vulnerability of the rural blacks to a variety of health related complications. In addition, efforts were made to implement intensive training of community nurses in various rural clinics in the homelands to upgrade their ability to provide nutrition-related health services in the absence of qualified dieticians within rural hospitals and clinics [7].

Further attempt to rationalise the South African health service in the homelands was reflected in the Steinmezf Committee in 1993. The Commission recommended the integration of six self-governing states to create a single healthcare department that would provide services to all racial groups in the country. However, the Commission's efforts were overshadowed by criticism from the progressive health organisations for its narrow composition and exclusion of the major stakeholders such as the ANC, professional healthcare groups, health workers and other interested public sector stakeholders. The ANC's Health Desks, supported by the non-governmental organisations such as the South African Health and Social Services (SAHSSO) and the National Progressive Primary Health Care Network (NPPHCN), had accused the government during the early 1990s of deliberately pursuing the strategy of unilateral restructuring in an attempt to strengthen its position in the negotiations. This accusation led to the establishment of a National Health Forum later in 1993, comprising of senior representatives of government, Patriotic Health Front and other formally represented organisations [3].

According to Dr Elliot Kgoadi-Molaba, the new state policy initiatives were confronted with the intractable problem of the fragmentation of health services. He claimed that the homelands inherited new rules that were unfamiliar to them because the prior health policy and infrastructure were primarily designed for blacks, who were seen as second class citizens. The homelands were small, fragmented 'islands' within the Republic of South Africa, with insufficient hospitals and clinic serving large population. Furthermore, there was a scarcity of qualified nurses, with instances where allocation of one qualified nursing sister for each hospital made the provision of community health services

difficult. The fact that nurses at the rural clinic level were specifically performing midwifery duties, patients were usually referred to the hospitals where curative services are provided [4]. To overcome this challenge, the state made provision for training of nurses to supplement and upgrade the role of midwives in providing competent curative services in the absence of visiting doctors, drug dispensers, handlers of money collected from paying clients, record keepers and examiners of patients. Kgoadi-Molaba's experience at Groothoek Hospital in Zebediela involved training nurses, who were subsequently assigned to the local clinics where community health services were mostly needed. Kgoadi-Molaba's proposal for improvement of salaries for nurses serving in the rural communities was overwhelmingly supported and endorsed by the then Prime Minister of Lebowa, Nelson Ramodike [4].

The impact of National Progressive Primary Health Care Network

The National Progressive Primary Health Care Network (NPPHCN), which was a community-based non-governmental organisation created in 1987, also contributed immensely to the development of PHC strategy during the 1990s. This organisation's objectives included the promotion of collaboration, participatory research and policy formulation, the development of projects and programmes throughout the country and organising funds mainly from foreign funders to sustain the organisation. The organisation involves other non-governmental and governmental organisations to facilitate the success of the strategy [8].

In December 1993, the NPPHCN submitted list of questionnaires on primary health care issues to various political parties contesting the upcoming 1994 elections. These included the ANC, the Conservative Party, the Inkatha Freedom Party, the National Party and the Pan Africanist Congress. The parties responded straight to the NPPHCN with the exception of the National Party. Although the National Party did not support the filling of the questionnaire, its letter directed to the NPPHCN supported the view that the state of health in the country was unacceptable and needed immediate attention. The National Party also enclosed several documents that were accepted by the NPPHCN. It was in this respect that the NPPHCN believed that all parties could work together with the elected parliament to fulfil their commitments in the improvement and strengthening of PHC service to all South Africans [8].

The northern and north-eastern Transvaal areas, which were poverty-stricken areas with high disease notification, also benefited from NPPHCN funders. The funds were also utilised for national expenditure between 1993 and 1994 in the production of media campaign materials. These campaigns were organised countrywide where the NPPHCN operated with cooperation of the women's groups, the ANC Youth League, the Congress of South African Students, workers unions, civic organisations, the ANC and community care groups in the homelands where primary schools were mostly targeted. In the Northern Transvaal, Elim Drama became popular as a result of the support from NPPHCN. Despite the shortage of resources, the region managed to host a visit by an Australian consultant who drafted a funding application to AIDAB (Australian Government), which led to the approval of the funding scheduled to start from April 1994 [9].

The Northern Province created after the 1994 democratic elections, comprised of the former homelands of Lebowa, Venda and Gazankulu, had 91% of population with high level of unemployment, poverty and illiteracy. These undesirable conditions made the work of NPPHCN coordinators in this province difficult and challenging. Since most of the NGOs operated without funding and appropriate skills, the NPPHCN worked very hard to see to it that Provincial Coordinators together with Provincial Committees worked with the Government of National Unity (GNU) to hire additional employees. The Network started to organise the women's groups with facilitation of empowerment and capacity building through workshops, courses and other trainings based on health themes. These community-based women's organisations were drawn from rural and peri-urban areas. The Network undertook to train the women's organisations in a variety of projects for government departments where members

participated as the main role players. The women's projects that were trained on how to start a project included Batlokwa Women's Resource Project, Mashashane Development Forum Organisations, Resource Centre Houtbosdorp, Seshego/Turfloop/Lebowakgomo Women's Training, Giyani/Malamulele and other women's training projects in the province [10].

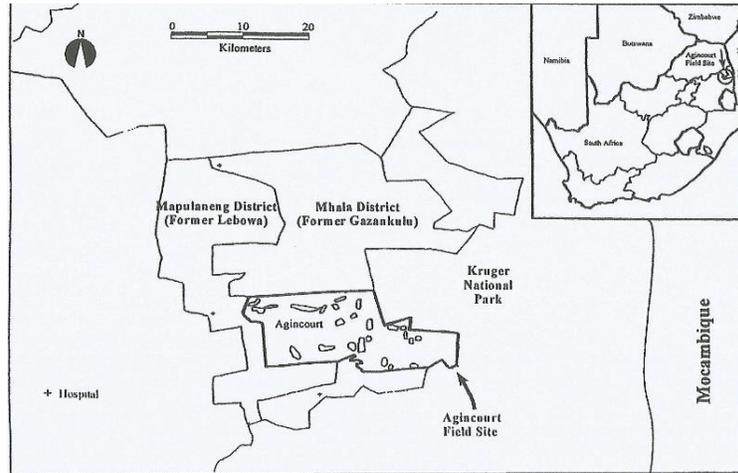
In Mpumalanga Province, the Network operated in Acornhoek (situated in the former Eastern Transvaal) from 1994 until it was officially launched in March 1995, with its office based in Sabie. The Network received significant support from the then provincial Member of Executive Council (MEC) where several workshops and meetings were held. Like in the Northern Province, the NPPHCN worked closely with NGOs and Community Based Organisations (CBOs) with a focus on several issues, which included women's health programmes, sexual health programmes, vulnerable groups, and the development of District Health System [10].

The role of research on primary health care

Besides organised groups such as the PPHCN, research groups also played a significant role in the promotion of PHC care in the poor black areas. The notion of 'building a healthy nation through research' as advocated by the Medical Research Council had a tremendous impact on the establishment of health projects through mobilisation of members from the rural black communities. In 1991, the Medical Research Council (MRC) led by Nkosazana Dlamini Zuma added impetus in the desire for PHC development in general. The significance of preventative health care was emphasised in her projects, which focused mainly on HIV/AIDS, maternal and child health. Some of the preventative measures emphasised included abstaining from sex, rights of women to refuse unprotected sex, and the careful use of abortion to end unwanted or enforced pregnancies. One of her projects regarding the investigations into the lessons learned from Pholela Health Centre was significant as the model was adopted by other rural areas of the blacks in South Africa [11].

The early 1990s could also be studied in the context of the role played by the Witwatersrand University Department of Community Health. It was the Health Systems Development Unit (HSDU) of this Department, which was involved at the research-service in Bushbuckridge (BBR) area. The Unit had been involved in the development of primary healthcare in the Eastern Transvaal since 1980s. To facilitate effective PHC services delivery in the area, the focus shifted to a District Health System (DHS) since 1990. This shift in focus was possible through government interaction with a Democratic Surveillance System (DSS), which functioned on health care planning and delivery. Both HSDU and DSS were aimed at the assessment of the content and values for local, regional, national and international applications. The challenge of fragmentation of health services in Mhala region of Gazankulu and the neighbouring Mapulaneng region of Lebowa homeland compelled the HSDU to develop District Health System where research by DSS played a significant role in gathering information to improve planning and PHC services to the needy rural communities [12].

With the influx of Mozambican refugees in the south-eastern part of the Mhala District, the PHC service was stretched to the limit. These refugees were part of large numbers of the Mozambicans who moved into this area during the middle of the 1980s due to the civil war in the former Portuguese colony. Some of the refugees settled in the Agincourt area, which was also a field site for a project established in 1992 by the Witwatersrand Health Systems Unit, as a subsidiary of DHS initiative [13].



Map showing the Mhala and Mapulaneng health wards of the Bushbuckridge and Angincourt Field Site

The area was semi-arid, densely populated, deficient in basic services and infrastructure with high levels of unemployment. The demographic census taken in 1992 and an environmental health survey conducted in 1993 revealed that undesirable factors such as lack of clean drinking water and sanitation, threat of waste disposals, shortage of fuel and adequate housing and shelter, and other unfavourable conditions, were common in the area [13].

The presence of Mozambican refugees added strain on the already scarce resources in the Mhala district. The reluctance of the indunas and chiefs to assist their communities in the district worsened the situation. Furthermore, cultural groups like Shangaan, Sotho and refugees also made it more difficult for the people to organise themselves as part of community involvement in the provision of health services and the prevention of diseases [14]. It also became evident that attempts by the National Party government to intensify health changes and the involvement of NGOs like Wits HSDU would not survive as negotiations for the establishment of democratic government were imminent.

The Post-1994 era and the new health development plans

The post 1994 era of healthcare delivery, which was associated with the building of a new health care system based on the mainstreaming of PHC, had its roots in the unofficial efforts many decades before the democratic South Africa was established. The idea of Comprehensive Primary Health Care, which emphasised preventative, promotive and community-based care was met with many challenges before the inception of democratic South Africa as the state was unwilling to entertain it. Efforts by various political, social, progressive health organisations, idealists and realists, and other interested groups continued to desire health reforms for equitable, accessible and free health care most particularly directed towards the rural impoverished black communities. Such efforts were considered through commissions, which to certain extent compelled the government to issue many acts, which were never implemented [2].

The 27th of April 1994 came as a relief to those who made the effort to transform the National Health Service for the country under difficult and challenging circumstances. Although the agreement between the ANC and National Party paved the way for the establishment of a Government of National Unity (GNU) scheduled for five years, the resounding mandate to address the ills created by the apartheid state

paved way for favourable conditions necessary for the full implementation of PHC in the rural areas. It became evident that the newly appointed President of South Africa, Nelson Mandela, would make provision for the implementation of PHC sector clinics throughout the country. The period signaled a dramatic shift from the old apartheid policy to a new era of comprehensive health care based on the tenets of PHC [15].

The ANC realised that the transition could also be accomplished through the recorded National Health Plan, a policy document drafted by the ANC to guide the transformation of health system based on the primary health care approach and principles. Another noteworthy attempt by the ANC right after the general elections was realised when it wrote and issued a statement titled ANC Health Plan, which aimed at removing the past inequalities in healthcare by embarking on a new policy framework based on parity in the provision of healthcare services. This initiative led to the drafting of proposed health policies by the team comprised of members of the ANC, Health Department consultants appointed by the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF). The draft document was based on the health documents already prepared by the ANC's Health Policy Commissions, together with other democratic movements before the 1994 elections. The fact that the plan was drafted with the involvement of the ANC Health Department, WHO and UNICEF, created new hopes among the black South Africans. [16].

The areas covering the former homelands of Lebowa, Venda and Gazankulu were also affected by these new developments. Apart from health development, the ANC emphasised the need to improve housing, education and social welfare of the blacks in the entire rural areas. The second document was drafted after in-depth discussions during the National Workshop, which resulted in its release for public debate. The positive response from members of the public was a victory by the ANC's long awaited Health Plan that would make provision for an equitable health system for all racial groups, with special emphasis on PHC [17]. Despite the high expectations through the Health Plan, challenges related to shortage of PHC personnel, and resources hampered the intended growth of PHC model. Attempts to engage local authorities to provide clinic services through partial subsidies were also hampered by the badly planned health system, high population density and financial constraints inherited from the previous homelands. The consequences of this situation left even the best hospitals under pressure to cope with services. This over-utilisation and over- occupancy of hospital beds, mainly in public hospitals serving blacks also affected the clinics, leaving the PHC services in the state of deterioration [18].

The plight of the blacks, most particularly in the outlying and isolated rural areas compelled the government to resort to the Reconstruction and Development Programme (RDP) remained a challenge to the newly formed democratic government. The rate of unemployment particularly in the former black homelands aggravated socio-economic problems. The RDP's main objective was the alleviation of poverty among blacks in the social and economic spheres to address the imbalances created during apartheid era. These developments were reflected in the field of employment, housing, health, education, communication network, electricity and other related areas of life. It was in this respect that the national system of social grants including child support and disability grants, and national state pension system, became significant in the alleviation of poverty and unemployment [19]. These efforts were bolstered by the establishment of National Program of Action which made provision for the implementation of free medical services for pregnant women and children under the age of seven. The plan was overwhelmingly supported by the Ministry of Welfare, a National Youth Commission and the Nelson Mandela Children's Fund [20].

The newly formed nine provincial departments had to operate at optimum level to address the peoples' expectations, including improving the quality of health services for all South Africans. To facilitate the restructuring process, the Strategic Management Team was instituted in each province to reflect new leadership structures including members from the previously banned departments and NGOs. The provision of Nutrition and School Feeding Programme became a meaningful initiative to eradicate

poverty and related disease burden among the rural communities Millions of rands were allocated to schools to sustain nutrition programme with particular focus on the rural and peri-urban informal settlements [3].

One of the greatest challenges facing the new government was the HIV/AIDS pandemic. The ANC predicted earlier before the general elections that between four and seven million South Africans would be infected with the disease by the year 2000. Since this prediction was widely acknowledged by the South African democratic government and the International World Health Organisation, it was believed that comprehensive and localised preventative measures should be taken worldwide. The escalating incidences of HIV/AIDS related illness and deaths alarmed the governmental and NGOs to view the disease as a serious threat to the people of South Africa. Keegan Kautzky and Stephen Tollman argued that the disease was never considered a priority by the newly formed democratic government under the presidency of Nelson Mandela [15].

In the former homelands of Lebowa, Venda and Gazankulu, HIV/AIDS infections had been increasing since the 1980s, with many blacks losing their lives. The denial about the existence of this disease emerged from politicians and chiefs. In the Lebowa parliament, many ministers had a perception that HIV/AIDS was non-existence. Napoleon Makgoga, who was one of the PHC team member who conducted research at the University of Venda in the early 1989 revealed that many academics who were interviewed also had similar perception that the disease did not exist. Some respondents believed that the talk about the disease was the intention of the Americans to discredit blacks and their traditional medicine [21].

While the threat of this disease was escalating, it seemed little progress was made as most South Africans, particularly in the rural areas were increasingly becoming infected possibly due to ignorance or denial. Further attempts by the national government to prevent the escalation were carried out through campaigns and education projects to raise public awareness of the impact of the disease on the society. This initiative had far-reaching implications in the history of health in South Africa in general. When MantoTshabalala-Msimang became a Minister of Health in 1999, she announced that testing for HIV/AIDS would be a national policy for all South African citizens to know their HIV status. This step was taken with the aim of reducing the spread of the disease through diagnostic or clinical testing and medical treatment [11].

Although Tshabalala-Msimang made efforts to effect meaningful health promotion in the prevention of diseases, her controversial statements about the treatment of HIV/AIDS elicited severe criticism countrywide and internationally. One can also state that her service left her caught in political statement uttered by President Thabo Mbeki when he denied that HIV causes AIDS, leaving her with minimal space to apply her mind correctly in her decision as a Minister of Health. Since many South Africans who suffered from HIV/AIDS died during her tenure, it was a severe blow to the government's health policy of promoting PHC projects, most particularly in the rural areas as the burden of diseases was also rife in the former Transvaal homeland areas.

The District Health System and Primary Health Care

The District Health System (DHS) has been one of the health priorities practiced and recommended by many countries of the world to overcome poverty and disease burden. The World Health Organisation (WHO) division also supported the system by involving its Division of Strengthening Health Service, which produced essential categorisation to enhance the development of PHC. In South Africa the homelands created by apartheid government resorted to similar district system in the provision of primary or preventative health care. The WHO Stressed essential areas for the effective functioning of District Health System which included organisational capacity, planning and management, development of human resources, financing and resource allocations with community involvement. In the Transvaal

province the district health model development was emphasised during September 1992 meeting, supported by the representatives from Mhala, Mapulaneng, Hoedspruit, including the prominent members of Gazankulu and Lebowa departments of health, and senior members of Gazankulu and Lebowa Departments of Health and senior members of the Department of National Health and Population Development [22].

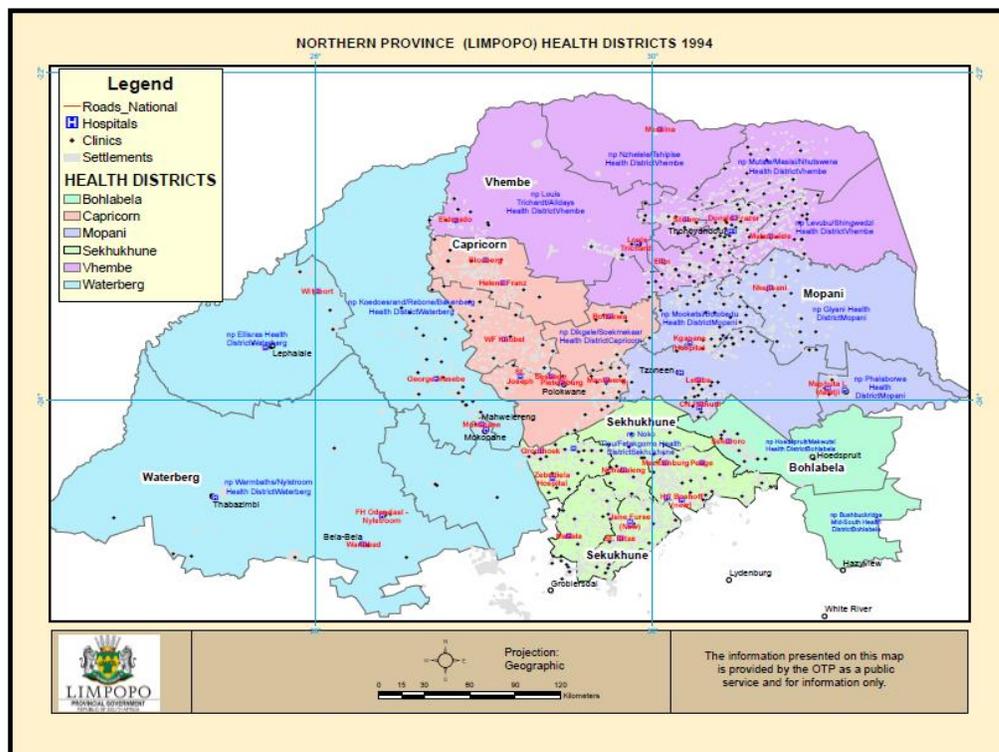
The experience of other countries of the world where the system was successfully practiced, motivated the government to support the initiative. The newly formed government realised that the concepts of 'caring' and 'wellness' could be effectively promoted through the utilisation of DHS to enhance health services to the local communities, with particular emphasis on prevention, education, promotion, early intervention and rehabilitation [23].

After the 1994 general elections the GNU regarded the district orientated primary health care as a possible solution to the health challenges of the rural blacks in the newly formed provinces. This period witnessed serious attempts by the new government to bring about total and effective defragmentation, decentralisation and deracialisation of health system. The concept was aimed to overcome health inequality and inefficiency, with greater involvement of the local communities. The decentralization of health services was supported by World Bank as critical in the improvement of efficiency and responding to the local conditions and demands [24]. The inception of DHS was considered essential for the overall functioning and delivery of PHC. The naming of the districts was considered with reference to municipal demarcations [25]. The national government envisaged that the districts were to be large enough to be economically viable, but small enough to ensure effective management to accommodate the needs of the local people with the involvement of the community through training and education [3].

The Plan also envisaged that each district must comprise of one or more district hospitals, community health centres, clinics and smaller facilities such as mobile units and visiting posts [26]. The system was to be implemented in all nine provinces where each was divided into several districts in terms of their functional and geographical coherence. The boundaries of the districts were to be determined politically to ensure that integrated and comprehensive health service delivery is effectively facilitated, with a District Health Authority (DHA) responsible for each district. The DHA, with its membership drawn from the local authorities were to be responsible for the promotion of PHC and to plan, coordinate, support, supervise and evaluate services based on national and provincial norms, and policy guidelines. The DHAs received budgets for the PHC, which made it possible for effective provision of health services to the rural communities. The Health Plan also made provision for the coordination between the national, provincial and district levels for effective provision of health care services [16].

Although the DHS appeared to be the best policy on paper, its implementation was met with a variety of challenges that limited its success. The factors included the changing disease patterns, lack of managerial skills, migration of health professionals, poor staff commitment and motivation, and unequal distribution of personnel in public and private sectors [27]. One can therefore conclude that the process of implementing the district PHC in the rural areas of the blacks countrywide including the former Transvaal, was gradual. Nevertheless, the DHS remained a crucial guide in an attempt to re-engineer PHC in the country.

The draft document on district health policy was finally adopted by the Department of Health, with the inclusion of certain aspects of it into the White Paper on the transformation of the country's health system. Despite criticism against some of the contents of the document, the parliament formally endorsed it at the end of 1997 [28].



Map showing health Districts of Northern Province(Limpopo) in 1994

The above map shows that Vhembe district, which is largely located in the former Venda homeland, was overcrowded by a large number of clinics around the capital Thohoyandou because the homeland managed to build more clinics than Lebowa and Gazankulu. In Capricorn District, there was a high concentration of clinics in the surrounding rural areas. In Waterberg District, a high concentration is found around Mokopane area, while Lephalale, Witpoort and Thabazimbi with sparse distribution of clinics because commercial farming was the main activity under white farmers. The nearly even or well distribution of clinics in Sekhukhune District could possibly be due to the barren land, with poor soil fertility and low annual rainfall. On the other hand, the district of Bohlabela has low concentration of clinics due to relief barriers with sparse population distribution.

At provincial level, the Provincial Health Authority (PHA) was responsible for all people of the province with health specialists from the provincial health institutions being responsible for visiting and providing support to various districts. These specialists were also responsible for facilitating referrals between primary, secondary and tertiary health institutions. The elected PHA was chaired by the MEC members for health, including Provincial Directors for health services, Heads of the Provincial Health Departments, and representatives from DHAs. This committee was responsible for the control of provincial health budget, functioning within the National guidelines [16].

Dr M. Masipa, who was a Director of the PHC in the Limpopo Province, stated that the districts were powerful institutions in the effective provision of PHC services in the province since the inception of the new democratic government in 1994. The transformation of the health system was made possible by the government imposition of free health services to all public hospitals, clinics and other government health institutions. Because most of the rural areas were still underdeveloped, most particularly in terms of infrastructure and communication networks, the health districts, together with the help of the Provincial Department of Health and local governments saw the need to strengthen the mobile services whereby every five kilometres were provided with mobile health facilities. When the health problems increased, especially malaria disease and dental problems, health support was provided through

referrals to the hospitals as the mobile clinics could not effectively deal with these diseases. As a result, these clinics treated patients with minor ailments [29].

The transformation of health care services through DHS went through various alternative policy structures including the Universal Health Coverage (UHC) during the post-1995 era. This occurred as a result of the growing enthusiasm at global and national levels with the aim of strengthening the access of health needs of the vulnerable communities within the low- and middle-income population. The UHC was intended at the development of the National Health Insurance (NHI) as a model that will roll out community-orientated primary health care. In Ghana and Vietnam, the system worked effectively as the population depended much on local context while in South Africa the system was complicated by the history of racial inequality, the size of the private sector and political complexity [30].

It was despite inception of the DHS that health challenges still persisted as there were no clear national norms and guidelines regarding the location of any new facilities. In addition, there was no clarity at the national level regarding equitable and appropriate means of distributing funds to the different levels of the health system in the provision of PHC services to the needy rural communities [3]

The mobile clinics and primary health care

The mobile clinics, as one of the strategies used in the provision of PHC services could be traced back to the 1970s when they were implemented in the homelands. This strategy occurred as a result of the inadequacy of health care centres which were not easily accessible, with poor roads and irregular terrains. The recollection from K.N. Khuzwayo, who became a community health nurse at Mokopane Hospital in Mahwelereng Township revealed that the system of mobile clinics was considered the best way of providing PHC to the rural population. These clinics were to operate in the areas where black people reside throughout the country. She indicated that the hospital vehicles, which were vans with canopies, were used by community nurses to visit the rural villages to explain the need to receive PHC services as a way of preventing diseases. She also indicated that working with chiefs, Indunas and other members of the community was used as a convenient method to persuade the village population to understand and comply with the value of these services. In some instances, community schools or garages were used as accommodation [31].

Khuzwayo also made reference to the shortage of nurses in the homelands as the main challenge faced by many hospitals, both of government and of the former missionaries. She indicated that as the only community nurse at Mogalakwena Hospital, she was serving the three surrounding clinics like Mapela, Mahwelereng 1 and Mahwelereng 2 clinics. Common diseases were Kwashiorkor, typhoid and polio. She indicated that at Mahwelereng 2 Clinic, which served Tshamahantse, a Shangaan village outside Mahwelereng, these diseases were rife due to the fact that this community was reluctant to use the clinic, with resultant massive outbreaks of polio in the early 1980s. This disease, which wreaked havoc among the children, compelled the community to see the need to visit the clinic in order to receive immunisation [31]

The survey conducted by Medunsa researchers revealed that there was a significant difference in health services between fixed and mobile clinics. Despite these findings, most of the communities in the two areas regarded the mobile health services as being more convenient as the stop points appeared to be accessible to the homes of patients than the fixed clinics. The findings of the Medunsa study were echoed by the Centre for Health Policy of the Department of Community Health of the Witwatersrand University. Further investigation by this department found that sexually transmitted disease cases were lower in the areas served by mobile clinics than in the areas where fixed clinics were the main source of care. In Lebowakgomo District. However, shortage of nursing staff and gravel roads posed a challenge in the provision of primary health care services in Lebowakgomo district and other districts throughout the province [32].

The media and primary health care

The media coverage was considered a powerful platform in the promotion and dissemination of evidence-based PHC to the needs of the communities. The coverage was effected through the newspapers, published research articles and books, newspapers, radios and televisions and other related media platforms that could be readily accessible to the local communities. It was through media that issues related to the understanding of diseases, role of nurses doctors and health workers, clinics and hospitals can be easily accessed by the communities.

The National Health Plan also envisaged a wide range of community-orientated health initiatives which were established throughout the country since 1994. These initiatives emerged from the Public-Private Partnerships (PPPs) and NGOs which worked tirelessly to prevent the HIV/AIDS pandemic. These community-orientated initiatives took the form of community-based projects like Love Life and Soul City. The Love Life, that was focusing mainly on the needs of young people and the implementation of health services in clinics, and health centres and HIV/AIDS education, had significantly benefited the local communities. [32]. The initiative started to receive support in the late 1990s through funding of NGOs to strengthen home and community based care [33].

In the former Lebowa, Venda and Gazankulu homelands, PHC projects had been distributed through utilisation of both Primary and Secondary Schools. The NGOs, in partnership with the Department of Education became instrumental in the distribution of awareness programmes based on the prevention of diseases. This effort was also evident in the Advocacy Programme of the NPPHCN which utilised the media in the province to capture all issues related to the promises made by a variety of political parties during elections as a reminder for the implementation of the project [10].

The post-1994 era also witnessed new innovations to raise public awareness to the blacks in the townships and rural areas regarding various social and health issues. This effort was taken with the aim of changing knowledge and attitudes towards health challenges and to promote preventative measures on a wider spectrum of issues. The use of media became part of the restructuring process of health care system to improve health services to the previously disadvantaged black population, both in the townships and rural areas. As part of the national health system policy, the government pledged its commitment to provide massive financial investment in an effort to achieve maximum implementation of PHC. It was due to the contribution of Soul City that electronic media became critical in the distribution of health messages regarding the prevention of HIV/AIDS and other related diseases. Gareth Japhet, a physician who worked for the World Health Organisation in the South African community clinics explained his health care programme based on district health care system [32].

Japhet findings revealed that most of women were unaware of a variety of health services offered by the clinics, most particularly in the rural areas. As a result, nurses in the clinics found themselves dealing with emergencies based on health complications and diseases that could have been prevented or minimised during antenatal health services. The empowerment of people with informed knowledge to safeguard their own health was considered a priority in the prevention of diseases. Although Soul City was initially aimed at the poor township population, through television, while the rural population were better reached through radio, the message was spreading across many rural populations as many started to access television from the 1990s. It was through the RDP that the massive installations of electricity and television satellites improved the lives of many previously disadvantaged black communities. One could therefore state that the accessibility of Soul City platform to rural black populations increased significantly in spreading preventative health measures and awareness through effective multimedia programmes [34].

Conclusion

The struggle for the total transformation of apartheid health system produced fresh hopes towards the end of 1989 when F.W de Klerk announced meaningful changes by unbanning of political organisations and followed by the unconditional release of political prisoners including the famous leader of ANC, Nelson Mandela in February 1990. These new developments created 'fertile terrain' for invigoration of PHC system to the disadvantaged rural black population. The political instabilities accompanied the road to democracy became a thing of the past when de Klerk announced the 27 April 1994 as the scheduled date for the general elections. The post- 1994 government's initiatives were based on the restructuring and integration of different health departments created by apartheid. The new government embarked on a new comprehensive health policy programme which aimed at addressing the imbalances of the past apartheid era, in order to eradicate poverty and related diseases. The GNU also considered the district health system, mobile clinics and media as the best approach suitable for PHC system and other health challenges, most particularly in the areas of the blacks. It was despite these efforts that the intension to the full implementation of PHC faced challenges related funding, ANC-linked cadre deployment, unethical leadership and administration, influx of illegal migrants, declining employment opportunities, increasing rate of corruption, shortage of sufficient medical resources and threats of new emerging pandemics. The recent areas of Limpopo province continued to rely on primary preventative healthcare system as a convenient and affordable system suitable for the rural population. The system continued to be used against pandemics like HIV-AIDS, Tuberculosis, Malaria, COVID-19, sugar diabetes, high blood pressure and other related diseases which are constantly notifiable in the country, including Limpopo Province. Until recent times, the Department of Health is still grappling with ways and means for the full implementation of National Health Insurance, which is also facing some evidence of public concern and criticism.

References

1. Liebenberg, B.J. & S B Spies, South Africa in the 20th century. Van Schaik, Pretoria, 1993.
2. Van Rensburg, H.C.J et al., Health and Health Care in South Africa. Van Schaik, Pretoria, 2004.
3. Reddy, J. South African Health Review. Health Systems Trust, South Africa & Henry I. Kaiser Family Foundation, USA, September 1995.
4. Kgoadi-Molaba E, Seleteng GaMphahlele, 04 December 2016.
5. Witwatersrand University Historical Archives, AD Box 1912, File 112.46, Health 1992. New management Style in health services, RSA Policy Review, August 1991.
6. Witwatersrand University Historical Archives, Box 1912, Health, 1992, The Citizen, 20 September 1991.
7. Kgaphola et al. Nutrition Knowledge of Clinic Nurses in Lebowa, South Africa: Implications for Nutrition Services Delivery', Journal of Human Nutrition and Dietetics, 10(5), 1997.
8. Witwatersrand University Historical Archives, AG, Box 3176 Reports, NPPHN, File ES 26 .5-37, "How Healthy is Our Future": An Analysis of Where the Political Parties Stand on Health Care Network. Reports, NPPHN. February 1994.
9. Witwatersrand University Historical Archives, AG, Box 3176, File NPPHC E6, Report from NPPHCN National Aids Programme to Kagiso Trust for the Period November 1991 to December 1993.
10. Makgoga N, Deputy Director, Limpopo Provincial Department of Health, 08 September 2017.
11. Witwatersrand University Historical Archives, AG, Box 3176, File NPPHC E6, Report from NPPHCN, Interim Report on NPPHCN Core Support: Project # 93-1157 and Final Report on the Project Development Fund: Project # 90-8268, Henry J. Kaizer Family Foundation, 1995.
12. Medical Research Council, Researcher is new Minister of Health, Nursing RSA, 9 (7), 1994.
13. Impact of a Demographic Surveillance System (DSS) on Health Care Planning and Delivery and on Consequent Impact on Health Indicators, 15 April 1996.
14. Dolan C.G et al. The Link between Legal Status and Environmental Health: A Case Study of Mozambican Refugees and Their Hosts in Mpumalanga (Eastern Transvaal) Lowveld, South Africa, Health and Human Rights, 2(2), 1997.
15. Witwatersrand University Historical Archives, AG, Box 3176, File ES.38, A Situational Analysis of Health and Health Services in South Africa, NPPHCN Report, Health Policy, Johannesburg 1993.
16. Kautzky K and Tollman S.. 'A Perspective on Primary Health Care in South Africa: Primary In Context', South African Health Review, 2008(1).
17. ANC, A National Health Plan for South African, 1994.
18. Myers C. From Apartheid to Integration: The role the Witwatersrand Medical Library in Health Care Services in Johannesburg, South Africa, Bulletin Medical Library Association, 83(1), January 1995.
19. Fourie A and Van Rensburg H.C.J. Policy-making for real: Political and Progress in South African Health Care. Curations, 16(3), 1993.
20. Coovadia H et al, The Health and Health System of South Africa: Historical Roots Current Challenges.

21. Burgard S.A and Treiman D.J. Trends and Racial Differences in Infant Mortality in South Africa. *Social Medicine*, 62, 2006.
22. Tollman S.M et al, 'Developing district health systems in the rural Transvaal: Issues from the Tintswalo/Bushbuckridge experience', *South African Medical Journal*, 83 August 1993.
23. World Health Organization. Global and Regional Review Based on Experience in Various Countries. 1995. <https://journal.co.za>. Accessed on 27 May 2025.
24. <https://7.westerncape.gov.za>, The District Health System in South Africa: Progress made and next steps. July 2001.
25. Barron P and Asia B. Initiative for Sub-District Support, Health System Trust. *South African Health Review*, 2001(1), <https://journals.com.za>. Accessed on 23 March 2025.
26. McLaren P. A Policy for the Development of a District Health System for South Africa. *South African Health Review*, 1997. <https://www.hst.org.za>. Accessed on 20 May 2025.
27. Dookie S and Singh S. Primary Health Care Services at District Level in South Africa: A Critique of the Primary Health Care Approach. *BMC Family Practice*, 13, 1912.
28. The District Health System in South Africa: Progress made and next steps. July 2001. <https://d7.westerncape.gov.za>. Accessed on 27 May 2024.
29. Masipa M, 22 Wiehan Street Bendorpark, Polokwane, 02 October 2016.
30. Fusheini A and Eyles J. 'Achieving Universal Health Coverage in South Africa through a District Health Health System Approach: Conflicting Ideologies of Health Care Provision. *Health Services Research*, 16(558), 2016.
31. Khuzwayo K.N, 595 Madisha Drive, Mahwelereng, Mokopane, 02 April 2016.
32. Herbst et al, 'The Evaluation of a Primary Health Care System in the Southern Region of Northern Province of South Africa', *CHANSA Journal of Comprehensive Health*, 8(2), April/June 1997.
33. Akintola O et al. Print media coverage of primary healthcare and research evidence in South Africa. *Health Research policy and Systems*, 13(68), 2015.
34. Armstrong S. The Soul City, *World Health*, 50th Year, No 6, November-December 1997.

Citation: William Maepa and Pamela Mamogobo, *Adv Clin Med Sci*, "The Politics of Primary Health Care of The Blacks in the Former Northern Transvaal Province of South Africa During The 1990s: A Historical Perspective". 2025; 4(1): 115

Received Date: June 05, 2025; Published Date: June 19, 2025

Copyright: © 2025 William Maepa. This is an open-access article distributed under the terms of the Creative Commons Attribution License.