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HEALTH AND POLITICS

An appraisal and evaluation of the provision of health, and mental health services for Blacks in South Africa.

SEAN B. O'DONOGHUE

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Perhaps even Little Red Riding Hood could understand it... for if the Blacks of South Africa ask her question to South African society and history: "Why are you wearing a racial system?" The answer is indeed not mysterious but brutally simple: "So as better to eat you with."

(Johnstone, 1979.)

ABSTRACT

The aim of this study has been to examine, in the light of recent events in the field of Health Care in South Africa, the remarks and claims made by the World Health Organization, and the American Psychiatric Association between 1976 and 1978 on Health Care services, as provided for Blacks, by the South African government.

In two reports, these organizations instituted the earliest, and arguably most significant claims against South Africa's system of Health Care. This study sketches firstly the political genesis and social context of the WHO, and APA examinations. Secondly, this study evaluates responses made by the South African State to the critical climate inspired by the above mentioned reports, through a close analysis of recent events associated with the politics, and provision of Health Care Facilities - particularly with regard to Black South Africans.

This analysis suggests that the governments' earlier tentative policy of privatisation (which was soundly condemned by WHO and the APA) has been even more enthusiastically pursued - in contradiction to it's avowed policies of Community Health Care, and to the continuing detriment of those South African communities who are in most need of adequate Health Care services. The study concludes that the criticisms raised by the WHO and APA had the effect of inspiring positive reforms in South Africa's health services, but in no way thwarted the governments', at first only tentative plans, to increasingly privatise it's psychiatric and other medical institutions.

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CHAPTER ONE

INTRODUCTION

> "It is like ... "The play within the play" wherein just as Hamlet, many of the secret and unpleasant truths of South African society ... are revealed in stark simplicity, unsoftened and unredeemed ..."
>
> (Johnstone, 1979, p. 23)

1.1 Aims and focus of study

In the report of the special Committee to Study Commitment Procedures - of the Association of the Bar of the city of New York (1962) - it is stated that: "When a person must be sent to a mental hospital ... he should not be treated like a criminal and be tried and convicted of being sick " (Leifer, 1967, p. 1). In South Africa one could reasonably add "... being **black** and sick", for if the politics of health care in this country reveal anything, it is that Apartheid (as this study will intend to reveal) places the majority of the black population at a severe disadvantage in the pursuit of mental health. The racial and socio-economic class structuring of South African society permeates the medical profession on both the ideological and structural level of health care: this study hopes to illuminate the present situation in that context.

More specifically, this study aims to evaluate the provision of mental health facilities (that is, mental institutions) for black South Africans in the light of the international reports published by the world health organization, and the American Psychiatric Association. These two reports are not merely the **only** critical articles to be published by credible international organizations (if we discount the less objective, but nevertheless damning literature published by, for instance UNESCO) but in terms of the reaction they evoked from the Nationalist government, also the most significant. The WHO Report was published in 1977, the APA Report in 1978. The former, inspired by a flurry of controversial articles in the local press on the state of Black mental hospitals, took as its basic data information that was gleaned from official government statistics , and the latter in response to an official invitation for the Association to

"investigate the accusations made by the United Nations Committee Against Apartheid in regard to psychiatric services in the country" (American Journal of Psychiatry, 136/11, 1979).

The focus then of this study is on the WHO and APA reports: both purport to describe a situation with regards to the provision of mental health services for Blacks which is devastatingly poor. The accusations made (now just over a decade ago) **need** to be addressed still : not essentially because the situation might have remained unchanged,but rather because it **has** changed,and yet, as I will argue, a critical review of the present state of affairs can, and should still be made.

My intentions in this study are therefore twofold: Firstly, I hope to contextualize recent developments in the mental health services by clearly stressing the historical links between the events of 1977/78 and of more recent years. Due to a substantial lack of critical inquiry into these events (precipitated I believe by the hostile legislative climate that surrounds all researchers of the social sciences in South Africa) it seems important to explore these historical links if only to illustrate how history becomes a 'selective appropriation of the truth' if the telling of it becomes the responsibility of those who have the most influence in shaping it.

This aspect of the study is in no small way inspired by Michel Foucault's remark that:

> "...one "fictions" history starting from a political reality that renders it true, one "fictions" a politics that does not yet exist

starting from a historical truth."
(Foucault, in Dreyfus and Rabinow, 1982, p.204)

That is, by virtue of the situation which has defined the limitation of this investigative study, my approach will essentially be to start with the political reality of the WHO and APA reports, the 'historical truth' against which contemporary developments in the field of mental health care can be compared and evaluated. If this latter process can be called a 'fiction it is only so in the sense that history, as it is being made, is at best a complex matrix of events too uncomfortably close to the horizon of objective detachment to fully explicate without exploring the disparate and contradictory elements of the main thread of events. In the case of the data most relevant to this study - namely, the information revealed in the press, in journal articles, and in government publications and debates - a certain amount of explorative 'reading between the lines' has been a necessity. In the sense that this is an active, and interpretive rendition of political truth on my part, this study engages, at least in certain respects, in the kind of fictionalizing process Foucault speaks of.

In other words, the second intention expressed in this study is to evaluate the **present** conditions of existing provisions for Black mental patients institutionalized all over the country by:

(a) Comparing recent developments in the field of mental health against the accusations made in the WHO and APA Reports. These 'recent developments' have (and intentionally so) all been referenced from events reported in the local press and in critical journals like those published by the South African Institute of Race Relations.

(b) Comparing the state's intentions (as revealed in official journals etc.) with regards to the Department of Health's Policy, and what actually appears to be happening if certain recent developments are critically interpreted.

1.2 Methodological notes

It has been noted, that without a theoretical and social content, psychology "erodes into a technique" (Jacoby, 1977, p. xxii). A study of institutionalized health care could arguably be approached from several angles. This could not be an empirical study for obvious reasons, in view of scope, prohibitive legislation and bureaucratic impossibility.

While certain mental institutions in the Eastern Cape were visited (under the guise of facilitating, government-sanctioned research under the Human Sciences Research Council), the feasibility of extrapolating the experiences gained into a relatively self-contained, objective study seemed to be minimal and highly problematic. Furthermore, a straightforward historical study would arguably fall outside the bounds of critical **psychological** research. The format decided upon therefore, reflects a desire to both objectively summarize the pivotal events in the mental health field of the last decade, and to contrapose these events against the tapestry of contemporary developments in the field of health in the present decade.

This study is not a history but a critical overview of political events in the field of health care. It is contextually both historical and

theoretical, but only in illustration of a broad thread of events that have crystallized into the present state of affairs. As an exercise in Critical Psychology this study is clearly sensitive to the more openly rhetorical aspects of political critique. That is, while the purpose of this thesis is to evaluate the claims made by the WHO and the APA a decade ago which can still be considered politically significant in spite of evidence reflecting a certain evolution in the standards of mental health services, the intended style of this study never intends to stray too far from the 'language' of political critique.

Ivey (1985) has suggested that critique is "a form of emancipatory praxis that **envisions** a more rational democratic organization of western society" (pg. 1). A critique,in this sense, is not a proof but a certain **style** of discourse in that it envisions, extrapolates, and even imagines political possibilities that would serve to better contextualize present realities. Rhetorically, it might be both polemical and fictive to achieve it's aims. It attempts in the final analysis, to transcend the accepted, the conventional, the obvious; that is, it repudiates the notion of a fixed methodology of truth and it suggests an alternative vision.

1.3 Summary

The politics of health in South Africa reached a crisis of sorts in the years between 1974 and 1978 when a significant amount of adverse publicity (both local and international) focusing on the field of mental health, resulted in a flurry of state activity. Until that time the subject had been a relatively uncontroversial one. Hard hitting legislation and subtle ideological manoeuvring subsequently aimed to get it back to that position.

To the extent that these policies have achieved some success in the fields of privatisation and "homeland health" suggests the need for renewed critical application. If this study were to fulfil any larger aim it would be to articulate the efficacy of a critical approach to psychological study, especially with regard to the South African context.

CHAPTER TWO

A Brief Early History of Health Care in South Africa.

"I am talking of millions of men who have been skilfully injected with fear, inferiority complexes, trepidation, servility, despair, abasement."
(Aime Ce'saire:Discourses sur le Colionalism)
(Fanon, 1970, p.1)

2.1 Introduction

After 1652, when the colonisation of South Africa began, hospitals were built for specific and limited purposes. The first hospital at the Cape served sailors of the Dutch East India Company. Slightly later, around 1665, the first private hospitals were established by religious denominations that not only administered to the spiritual needs of the members of their congregations and instituted charitable services for the aged and others requiring help, but also, because of the lack of private hospitals, provided hospital treatment for members of their congregations who were not in the employ of the Dutch East India Company. Later, in the Eastern Cape, military hospitals served soldiers injured in the frontier wars (RSA Blue Books, 1974, p.2).

In 1755, the Cape suffered a serious smallpox epidemic, killing 963 White settlers and 1 000 slaves. Two temporary hospitals opened to isolate the victims, one for Whites, the other for Blacks. The purpose of these institutions was apparently not to treat the sick, but isolate them; when the epidemic ended the hospitals closed (De Beer, 1984, pg.16). In 1807 (a year after British occupation of the Cape) four physicians, nine surgeons and nine apothecaries were licensed to practice in the Cape. At this time a leper colony opened at a place called "Hemel en Aarde" and by 1822 120 lepers were confined there in what apparently amounted to appalling conditions (De Beer, 1984, pg.17). 1845 saw the opening of Robben Island to a colony of lepers and lunatics before it became, at a later stage, a prison - a fact De Beer (1984) notes as a reversal of the usual sequence in South African medical history: "Wherever White settlers started jails were constructed before hospitals. The sick, poor and mentally ill were confined

in these jails" (p.17).

In Europe, much as in South Africa at this time, the mentally ill were no longer killed or persecuted as common practice. Instead they were chained and confined in jails with criminals - a practice that came to an end in Europe, according to Foucault (1973), not due to medical enlightenment alone but also at the **insistence of prisoners** who were indignant at being forced to live with madmen - an interesting distinction in more recent times considering that one of the prime differences between the mental patient and the criminal is the failure to provide the former with the same legal safeguards as the latter (Leifer, 1967).

The first asylum in South Africa was opened on Robben Island in 1836. By 1848, the inpatient population reached 78 and in 1913 the Union Government decided to close down the asylum as there were seven other asylums throughout South Africa, namely; Valkenburg in Cape Town, For England in Grahamstown, Kowie in Port Alfred, Tower in Fort Beaufort, Orange in Bloemfontein, Tower Hill in Pietermaritzburg and Weskoppies in Pretoria).

Only after the Hospitals Act was passed in the Cape in 1893 did many of the smaller towns begin to build "cottage hospitals" subsidised by the Cape government. At that time hospitals for Blacks already existed in Pietermaritzburg and King Williams Town (both named after Sir George Grey, Governor of the Cape Colony) - a development that reflected in some parts a change in policy from killing the heathen, to winning their co-operation through technological means. As the first superintendent to the King William's Town hospital stated:

> "Give me only one institution like this, give me talent and ability combined with kindness and mildness. . . let pure untainted charity have free play. . . let the heathen feel as free as his kraal. . . such an institution will draw the savage from the remotest part of South Africa and attach him forever to that government which entered in spirit into his sickness and provided a remedy."
> (Cited in De Beer, 1984, p.17)

By all accounts, this appears to be a relatively enlightened view. Evidence sugeests, as De Beer (1984) has noted, that isolation is the theme which runs through much of South Africa's medical history; where hospitals were established for Indians and Blacks, fears of immigrant-induced infection and contagious diseases from an ignorant multitude were the motivation, not goodwill. That this charge of isolation still applies - especially with regard to the hospitalization and institutionalisation of Black patients - begs the question of how such policies, if they don't reflect any longer medical or psychiatric interests, are obliged by social policies and racial ideology.

In the trekker republics of the interior of the country, provision of the health services was sparse, and as late as 1885 there were barely 30 doctors in the entire Transvaal area. The absence before the mineral discoveries of any heavy concentrations of population meant that demands for a public health system were minimal.

The relationship of political and economic power to disease patterns and the health care system in South Africa has been remarked on by several authors. Marks and Andersson (1987) have for instance noted that: "Contemporary health patterns in South Africa are rooted in the social changes which began

with the discovery of minerals in the last third of the nineteenth century: diamonds in Kimberley in 1868, vast seams of gold at very deep levels underground on the Witwatersrand in 1886" (p.178). In these territories, the hospitals built were for the rapidly expanding population around the diggings, and were not to begin with, havens for the sick or injured whatever race they were.

In 1888, a small hospital was begun in the ealy days of Johannesburg after the sick and injured were housed in the jail. In 1896 the Simmer and Jack mining company ran a hospital for its mineworkers, an example that was presently followed by other mines. In 1910 the four colonies became provinces within the Union of South Africa but there was as yet no public Health service. It took the 1918 influenza epidemic (and the dramatic fatalities that resulted) to initiate the first Union wide public health legislation - the Public Health Act of 1919 - and the creation of a ministry of public health. Prior to the outbreak of the epidemic the Department of Public Health in Pretoria was a small sub-department in the Interior Ministry: health services had received little attention since 1652. However, as conditions improved in the mine compounds, doctors in rural areas began to note the increase of tuberculosis and venereal disease among "hitherto healthy populations" on an alarming scale.

In the 1930's and 1940's it was estimated that 75% of the Transkeian population was infected by tuberculosis and in most parts of rural South Africa the disease had become endemic (Report of the Native Laws Commission, 1948, pp.36-39). The increasing exploitations and rationalization of the Black labour force had begun to take its toll. A certain Doctor Isidore

Frack noted at the time that:

> "In South Africa we have produced the most up-to-date and scientific means of producing this disease tuberculosis in natives. Raw natives. . . brimful of health and natural vitality (are) sent down the mine in skips. After a period varying from two to six years they develop silicosis and. . . contract tuberculosis. They are then withdrawn from the mines and, after a few months in a native mine hopital, are repatriated to the territories. A natural reservoir of tuberculosis is being established. . . and the native population is being tuberculised." (UNESCO, 1981, p.90)

Tuberculosis, while in principle both preventable and treatable, still affects a substantial number of South Africans. In 1985, 44 106 new cases were confirmed. Of these 1,6% were White, 1,3% were Asian, 25% were Coloured and 71% were Black (Weekly Mail, 27 March, 1986). These figures are minimum considering the fact that only those individuals in contact with the health services are recorded. The relative proportions would show figures to be far greater per capita in the Bantustans than elsewhere in the country (Marks and Andersson, 1987, p.179).

Dr George Gale, Secretary of Health in 1946 in evidence given to the Native Laws (Fagan) Commission at the time appeared to be well aware of the connections between the migrant labour system and disease in the rural areas. While less critical than Frack he nevertheless summed up the situation as follows:

> "The indivdual mine labourer recruited under the Native Labour Regulation Act is hygienically housed, well fed and medically cared for on the mine. It is sometimes claimed that an advantage of the mine compund system is that it provides the Native with good food and medical services. That is

> true, but the mine medical services protect the mine worker only so long as he is on the mine. . . **the point is that the mine medical services do not meet the really serious detrimental effects, for health, of the migratory system.**" (Report of the Native Laws Commission, 1948, pp.38-39 - emphasis mine)

Indeed, neither the mine medical services nor the migratory system should be considered out of context of the political whole - a reality relatively unchanged today.

Recently, a press report carried the opinion of the medical superindendent of the Charles Johnstone hospital in KwaZulu who believed that against a background of forced resettlement programs, poverty, malnutrition, family breakdown, migrant labour and limited labour resources there was "no possibility of a decrease in T.B" (Star, 28 January, 1978).

Gale's recommendation included plans for th development of a stabilized work force with the families of the labourers permanently settled with them in the towns of their employment. This proposal was neither accepted by the Commission in its final report, nor by subsequent South African governments. The health of the "native" continued to be of importance only insofar as his labour was needed by White industry, or his proximity to Whites threatened their carefully preserved health, a situation best maintained by a continuing policy of racial segregation and medical isolation. Much of the thinking behind health policy towards Blacks in these years is exemplified in this report of the Department of Health which stated in 1938 that:

"With a national agriculture and industrial economy based on cheap Native labour, the health conditions of the non-European have become of paramount

interest to the European. Further, the fact has been stressed that disease knows no colour bar and the European community is continually paying the penalty for tolerating reservoirs of infection among the Bantu population " (Department of Health, 1938, p.13).

Enlightened self interest thus underscored much of the development towards more appropriate health services at the time. Where progress was urged, a kind of utilitarian argument was posited; if White hygiene, or industrial profit depended on it medical resources could be extended to other population groups. An ideology of health was well on the way towards becoming firmly established. While the impact of industrialisation was significant in the evolution of most aspects of health care in the western world , part of the story of twentieth century South Africa in this regard is, as Marks and Andersson (1987) point out, "How the burden of disease has come to be differentiated according to skin colour, and the roll of the State in this outcome" (p.179).

Marks and Andersson (1987) have suggested that in the early part of the century, before migrant labour came to play such an important role in the economy of Southern Africa, the demand was for a stable and efficient labour supply, and the medical consensus at the time attributed disease among the Blacks to "inexperience with civilized life and their unsuccessful adaptation to the ways of industrial society" (Marks and Andersson, 1987, pg.180). This has, as history illustrates, continued to be a predominantly held notion, albeit in recent times for more ideological reasons, not medical ignorance.

Drawing on the recent writings of Maynard Swanson, Marks and Andersson (1987) describe how increasing Black urbanization led to White calls for racial segregation on health grounds in the 1920's (Swanson, 1977, "The Sanitation Syndrome" in Journal of African History 18/1977, pp.387-440).

In the late 1920's a committee appointed to "Inquire into the training of Natives in Medicine and Public Health" stated that:

> "It cannot be denied that at present there are hordes of natives in many centres who have little chance of medical treatment, and the untreated sick become a menace but a double menace to South Africa. Firstly, there is the immediate danger of the spread of infection and contagious diseases from areas where they may be said to be practically endemic. Secondly, there is the economic danger of the deterioration and eventual failure of the labour supply." (Cited in De Beer, 1984, p.21)

As mine-owners came to rely on the advantages of a more reliant, yet stable workforce (i.e. migrant labour) their economic interests came into direct conflict with established medical opinion concerning the susceptibility of Blacks to disease.

Gradually cultural explanations gave way to a more physiological paradigm which attributed Black vulnerability to their lack of contact with certain diseases (specifically TB) and their resulting lack of immunity. Migrant labour became usefully justified as limiting "the exposure of Blacks to the adverse conditions of industrial life" by "allowing" rest and recuperation for labourers in the reserves (Swanson cited in Marks and Andersson, 1987, p.180).

By the late 1930's, a more progressive and humanitarian influence began to

By the late 1930's, a more progressive and humanitarian influence began to prevail amongst those medical officers and public health officials who were uncomfortably aware of the deteriorating conditions of Blacks in both rural and urban areas. Despite the nearly 300% growth in the national income between 1933 and 1947, these views inspired little change in the years prior to the Second World War. These were turbulent years; the value of manufacturing grew by 140% up till 1930, between 1933 and 1939, 400 000 new African workers entered the labour force exacerbating present social conditions for an almost doubled in size African working class. It was a time of increasing Black unionization and industrial strikes (UNESCO, 1981; Marks and Andersson, 1987) and during the 1940's, the Smuts' government appointed a series of committees and commissions to detail ways of responding to these changing conditions. Two of these investigations reveal the relatively enlightened concepts of the times, the Smit Committee (1942) studied ways to improve the material welfare of the urban African population, recommending that African Trade Unions be recognized and steps be taken to abolish the pass laws. The Fagan Commission (1948) established to investigate ways of responding to the economic and social changes that had taken place during the previous 15 years, also recommended, (with only some exceptions) that migrant labour system be terminated.

2.2 The National Health Services Commission, 1942-1944

Against this background, the National Health Services Commission (also known as the Gluckman Commission) stands out as a particularly enlightened document chronicaling the impact of industrialization and urbanization on the health of the working class. The report of the Commission's findings stated that:

> "First and foremost among the causes of ill health are the economic poverty and social backwardness of the greater part of the Union's population. Vast numbers of people in this country do not earn enough to purchase the minimum of food, shelter and clothing to maintain themselves in health. . ." (Report of the National Health Services Commission 1942/44 UG.30-44 p.6)

According to the report, the Commission found that all the pre-conditions existed for a high incidence of disease and ill-health, and strongly condemns the health and welfare services of the day. The report does not however argue that a simple upgrading and extension of these services would improve the situation: "unless there are vast improvements made in the nutrition, housing and health education of the people, the mere provision of more 'doctoring' will not lead to any real improvement in the public health" (Report of the NHSC, 1942/1944, p.11). Emphasizing a re-orientation of ideas and attitudes towards a promotive understanding of community health, the report significantly states that:

> "Instead of regarding the health of the individual as purely his own private concern, it is now beginning to be realized. . . that the health of its individual members is of great importance to the community as a whole, and that when people are sick or unemployed not only must they be cared for on humanitarian grounds, but that in the process they can be transformed from liabilities into assets on the economic plane." (Report of the NHSC, 1942/1944, p.8)

The Commission's proposals - regarded as "decades ahead of its time" - although accepted in principle (Minister of Health, Harry Lawrence held apparently only two reservations) were dropped even before the Nationalist government came into power in 1948. The only memory of the Commission's

recommendations exists ironically in the revived rhetoric of the 1977 Health Act. The Commission had called for a National Health Service but the provinces at that time were arguing their right to retain control of hospital services as part of an ongoing struggle with the central government over the distribution of power within the provinces. With the Minister of Health proposing (against the Commission's recommendation) that the provincial administration were to keep control of the curative medical srvices, a national co-ordination of these services was not possible. The second reservtion concerned the mobilization of resources required to put the Commission's plans into action. With the State remaining relatively inert on the issue, the medical profession, though the Medical Association of South Africa, stepped in to oppose fundamental aspects of the plan, in particular, the suggestions that private medical practice was irrational and should be replaced by a system of state-employed medical officers. The concept of free medical services to all was also strongly resisted. As the Medical Officer of Health (for Germiston) succintly put it at the time:

> ". . . the present economic competitive and curative basis on which the profession rests does not provide for a reconicliation between curative and preventive medicine. Prevention of diseases is against the interests of the profession." (Cited in Marks and Andersson, 1987, p.184)

The Chairman of the Commission, Dr Gluckman, was made Minister of Health in 1945. By 1948 about 40 "health centres" had been built nationwide. By 1949 an "Institute of Family and Community Medicine" had opened in Durban, but fiscally impoverished and suffering the lack of a consolidated administrative back-up, the health centres could not play out the role for which they had been designed. With the Nationalist Government in power De

Beer (1984) points out, the "few small atempts to implement some of the Commission's proposals were hastened to their end. By 1960 almost all the health centres had been closed down or handed over to provincial administration where they became ordinary clinics. The plan brought into the world with such hope, was finally buried (De Beer, 1984, p.27).

Buried also became any controversy surrounding Health and Mental Health Services - at least as far as public consciousness was concerned. But things were soon to change, and this change it can be argued, essentially has its origins in the founding of the Smith, Mitchell Group of companies which in the late 1940's began to provide private accommodation for Tuberculosis patients at the Government's request. Before we turn to an examination of the history of this company, however, first a brief history of institutionalised mental health care in South Africa.

In 1923, 7 626 persons were known to be mentally disorded. By 1976 there were more than 38 000 such people (Solomon, 1978, p.6). In 1925, over 80%, in 1955, over 90%, and in 1976, less than 50% of all mentally disordered patients were resident in state mental hospitals (ibid, p.2). The reason the latter percentage represents a significant drop in the number of mentally ill patients can be attributed in part, to two factors, the rise in alternative institutions from their inception in 1963 (the first so-calld "private facility" was opened in Randfontein at this time with 700 beds, by the following year nearly 5 000 beds were available at a further two institutions for Black and Coloured and Indian patients throughout the country) and the increasing sophistication of drug technology.

In South Africa, as in other parts of the world, the discovery of psychotropic drugs transformed psychiatry from a largely custodial discipline into a marginally "therapeutic science". The use of these drugs enabled larger numbers of patients to receive therapy, and to receive it in their natural community environment.

By 1976, 36 hospitals throughout South Africa provided resident inpatient facilities to the mentally ill. Of these, 21 were state mental hospitals, ten were general provincial hospitals, four "homeland" general hospitals, and one a "homeland" state mental hopital. In addition, eight other general provincial hospitals held pyschiatric outpatient clinics. At a further 96 centres clinics were held; 28 in the Cape, eight in Natal and 60 in the Transvaal. Altogether 32 192 psychiatric beds were provided, of which 15 873 were at state hospitals, 428 at provincial hospitals, 3 398 at "homeland" hospitals and 12 345 at facilities provided for by Smith, Mitchell and Company, the private concern (Solomon, 1978, p.3).

Excluding patients resident in the ten provincial hospitals altogether 31 862 patients were resident in the institutions mentioned above. 16 851 patients were resident in state institutions, 2 538 in "homeland" hospitals, 11 037 in so-called "private" facilities, and 1 436 in "other categories of licensed institutions" (ibid, p.4).

A further 4 370 patients "were recorded as absent on leave" (that is, neither discharged from, nor resident in state hospitals) and 1 712 patients were in "single care" (that is, cared for in their home situation by parents, or guardians) bringing to 38 044 the figure for known patients being provided for by the state as in-patients in 1976 (excluding once again

the figures for the provincial hospitals).

2.3 Smith, Mitchell and Company

Although Smith, Mitchell and Company had been operating with close government ties since the inception of the Nationalist Party into power, it was only in the middle years of the 1970's that the full facts of this alliance came to light.

In 1974/75 the South African press alleged that thousands of Black mentally-handicapped and psychiatric patients were living in sub-standard conditions, without adequate medical supervision in institutions "run for profit". (W.H.O., 1977) by a private company on behalf of the South African Department of Health. These were specifically the publications in the Church of Scientology's magazine "**Peace and Freedom**" (October 1974: Sterkfontein - visit reveals sex and violence; November 1974:Wes-koppies -Shock report; et al) and **Scope** magazine (14 and 21 November, 1975). Both publications received attention in the House of Assembly (Debates, 18 February 1976, p.1521, 3 March 1976, p.2401).

At this time Smith, Mitchell and Company was registered as an accounting firm and functioned as an agent for some 89 companies. In the late 1940's the company had provided private accommodation for TB patients at the Government's request. In the early 1960's the South African government approached Smith, Mitchell once again, this time for the provision of custodial-care accommodation for so-called "non-responding" mental patients. These were patients "siphoned off" from their localized "mother" hospitals (the state-run institutions) who were either so chronically psychotic or

mentally retarded that their manageability presented few problems. Patients with a history of "behaviour problems" were not taken. (Solomon, 1978) As far as my research could ascertain, this is still the situation in these insitutions today. Those that go to the Smith, Mitchell Institutions go I surmise, to stay forever.

The Director of Smith, Mitchell, up until his resignation in 1976, was David Tabatznik. According to certain reports, Tabatznik, with a variety of associates would put up capital to lease abandoned mining compounds and "convert" them to provide accommodation at a per diem rate lower than the government would be able to achive in its own facilities (West, 1979; Seedat, 1984). This arrangement was apparently initiated when the overcrowding in the state psychiatric facilities became severe and private contractors were invited to submit bids for the care of chronic patients.

The facts surrounding this arrangement however, hardly suggest an independent and objective involvement by the Department of Health. According to the Secretary of Health the bids were solicited by a tender board in a separate department. After the intial rate was set by the tender board, the Department of the Treasury reconsidered the rate annually in the basis of audited financial statements. However, because of the manner in which nurses and medical officers - not to mention government property and ministerial directorships - were supplied by government departments, it is clear that the Department of Health has a "complex relationship" to Smith, Mitchell and Company (Solomon, 1978; Seedat, 1984).

Shortly after a series of articles on particular mental institutions were

published by the Church of Scientology's magazine **Peace and Freedom**, the London **Observer** ran an article on the Smith, Mitchell institutions alleging connections between Director David Tabatznick and Minister Connie Mulder. Mulder was accused of holding several thousand shares in various Smith, Mitchell subsidiaries and had become one of the Directors of the Rand West Sanatorium which held at that time 3 600 male, and 1 490 female patients - making it easily the largest facility operated by the company. (Debates, 2 May 1975) By the end of 1977 Mulder had resigned his directorship but apparently retained the shares he and his family held in Smith, Mitchell and Company (West, 1979).

When a second article was planned on the same subject, pressure was placed on the paper (ostensibly through the South African Embassy in London) to focus its interests elsewhere.

Shortly thereafter, a ban was imposed on the issue of entry visas to all Observor journalists. Subsequently, members of the Church of Scientology experienced "harassment" from official sources and had certain issues of its magazine banned.

These bizarre events continued with Church members "raiding" Department of Health offices, and Security Branch members responding in kind. Several sessions in the House of Assembly were devoted to the discussion of the Church's practices, and the international opinion of its philosphy and intentions (Debates, 19 February 1976, pp.1565-1607). Meanwhile, in April of 1976, the Transvaler (owned by the publishers' Perskor - of which Mulder was claimed to be a director) carried an editorial defending Smith, Mitchell and attacking the Church of Scientology (West, 1979). The saga continued with

the Information Department (under Mulder's control) sending out "information brochures" concerning Smith, Mitchell to all Information Services overseas.

CHAPTER THREE

Review of the Literature : Critical International Reports on South Africa's Mental Health Services.

3.1 The Who Report : A preliminary review by WHO Secretariat of the available information on mental health services in the Republic of South Africa, prepared by the United Nations Special Committee Against Apartheid (MNH/77.5).

At the time of the 'exposure ' of conditions apparently pertaining to to certain mental institutions by elements of the local press, WHO had already examined the implications of the doctrine of apartheid in South Africa for health in general: WHO document EB 55/39 Add. 1 (1975) prepared in response to UN General Assembly resolution 3151 (XXVIII). In response to events during 1974-1975, WHO responded to a request from the United Nations Special Committee Against Apartheid (UNSCAA) to once again review the South African situation in regard to its mental health services - particularly this time in connection with the 'Smith, Mitchell Affair' (According to resolutions WHA 16.43, WHA 7.50 and WHA 18.40 - UNESCO, 1981, p. 231).

The WHO Report on Apartheid and Mental Health Care was published the 22 March 1977 as a result, and based itself entirely on questions raised in House of Assembly debates, official government reports and credited scientific publications. The abstract of the report reads as follows:

> "Between 8000 and 9000 Africans suffering from mental disorders are detained against their will in privately owned institutions in the Republic of South Africa. These Africans are the object of a business deal between the State and profit-making White-owned companies which receive Government subsidy on a per capita basis against the provision of custodial care for mental patients referred to in a Government publication as the "sediment of mentally maladjusted persons and deviates". There is not a single Black psychiatrist in South Africa, and vital decisions about thousands of African mental patients are made by part-time physicians who do not even speak the language of the patients. While the majority of the White mental patients are receiving care in services provided by the State

> (the provision of psychiatric beds per 1000 of the White population is 3.3 times greater than for Africans), the majority of the African mental patients are certified as mentally ill by the State and transferred involuntarily to profit-making private "sanatoria". About one third of the whole mental health budget of the Republic of South Africa subsidizes this operation.
>
> The rapidly rising "demand" for institutional care of the mentally ill Africans, which is given as an explanation of these anomalous and discriminatory practices is understandable in the context of overall apartheid policies which have resulted in the uprooting of over 3 million people; in the disintegration on a mass scale of the African family, and in the breakdown of community support for the mentally ill.
>
> Recent legislative measures of the Government concerning the "rehabilitation" of African pass offenders equate in a dangerous way the non-observance of the apartheid laws with mental disorder. The Mental Health Amendment Act of 1976 virtually imposes a ban on information and free discussion of the prevailing conditions and policies, being a direct effect of apartheid in the health field, are inimical to the letter and spirit of the WHO Constitution which proclaims that the 'enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions."
> (WHO, 1977, p.1.)

Concerning itself with the reported inequalities of health care between racial groups in South Africa, WHO (1977) concluded from the evidence that "apartheid in the area of mental health services leads to gross inequalities in the availability of mental health care for the different population groups ... and that the provision ... very poor in quality ..." (p. 24) Anticipating by almost two years the visit by an investigative committee of the American Psychiatric Association (APA) the report summarizes four types of allegation against the provision of mental health care for Blacks.

(1.) Smith, Mitchell institutions were little more than "places of custody" to which the patients are admitted on a "involuntary basis through a perfunctory legal and medical procedure".

(2.) The standards of care provided (by Smith, Mitchell) were "extremely poor and degrading" not only in comparison to the standards of mental health care provided for South African whites, but also in relation to the "most elementary and essential human needs and rights".

(3.) There existed collusion of interest between the state and Smith, Mitchell; the company made a profit using government subsidies, and the government spent through this arrangement, less than it would be obliged to if it were to be completely responsible for the mental health care of the black population (p.3)

(4.) Smith, Mitchell institutions served as a "tool for human rights oppression and racial discrimination" in the field of health care under apartheid (p.25) .

The report also makes the claim that:

> "Since the private institutions for African patients are operated on a profit making basis, depending on the number of patients detained, and since patients are admitted under voluntary provisions (thereby reducing the burdening the State services), the system is technically open to abuse and is the manifestation of socially harmful policies in the area of health. Such policies are however part and parcel of the overall doctrine and practice of apartheid, and radical improvements of the present situation in the mental health services are inconceivable as long as apartheid remains in

force." (p. 25)

The report is essentially divided into an examination of four separate issues. The first considers the topic of apartheid as a 'source of psychosocial stress' and draws its facts from the following references:

1. Government Gazette, 7 April 1976
2. WHO Document EB 55/39 ADD.1 (1975)
3. Kirby, A. (1976)
   Afrique du Sud : Vers la decolonisation? Quelle independence pour le Transkei? Notes et documents sur les problemes actuels du developpement, no. 2. Centre Europe-Tiers Monde, Geneve.
4. Uprooting a nation: The study of the three million evictions in South Africa. (1974).
   The African Publications Trust, London.
5. Statement in Parliament by Mr. G.B.D McIntosh, 17 June, 1976. House of Assembly Debates (1976) Col. 9586.
6. The children of Apartheid: A study of the effects of migratory labour on family life in the Ciskei (1974). The Africa Publications trust, London.
7. Orpen, C. (1976)
   The expectancy beliefs, intrumentality beliefs and job reward relevance of Black and White workers in South Africa. British Journal of Social Clinical Psychology Vol. 15, pp. 365-368.
8. Troup, F. (1972)
   South Africa: An historical introduction. Penguin Books (pg. 320).
9. Verwoed, H.F. (1954)
   Bantu education policy for the immediate future. (in Troup, F. op.cit., pp.326-327)
10. Health and healing: Hospital and medical services for South Africa's developing nations (1969). Department of Information, Pretoria.
11. Horrel, M. & Horner, D. (1974)
    A survey of race relations in South Africa. South African Institute of Race Relations, Johannesburg.

12. House of Assembly Debates (1976) Col. 1066-1070.

13. Meer, F. (1976)
<u>Race relations in South Africa.</u>
Routledge and Kegan Paul.

This list is tabulated in order of the references cited and is indicative of the kind of references used elsewhere in the report. A further Approximately 25 separate sources of reference are quoted, and are used, in my estimation, in a balanced and fair way. As the title states, it is a review based on 'available information' - as indeed this study is also. (Most, if not all, of the references in the WHO Report that could be obtained have been either checked or cited in this study.)

The second issue considered in the report is that of mental health care in the Republic. This section simply reviews the statistics of that time related to the unequal distribution of resources as reflected in the compilations of data of (amongst the official sources) De Beer (1976), Vitus (1976) and Menning (1976).

The third issue which receives attention in the report is that of the situation in the psychiatric institutions operated by Smith, Mitchell and Co. Citing statements made by the (then) Minister of Health in reply to parliamentary questions, the report states that the Government subsidy to Smith, Mitchell was R3 404 000 for 1974-75 and R5 252 000 1975-76. The figure of between R1.22 and R4.31 per patient was quoted by the government to Smith, Mitchell. This figure fluctuates "depending upon the level of service rendered" (House of Assembly Debates, 2 May 1975, Col. 860). The report presumes that the level of service is determined by the racial group of the patient.

At the time of the report, the following private mental institutions were operated by Smith, Mitchell. (The approximate total of Asian,Coloured and Black patients then institutionalised was 11 thousand.)

Table 3.1

	Institution	Number of Patients
1.	Allanridge	400 (Black)
2.	East Rand	500 (Coloured)
3.	Ekuhlengeni (Kwamakuta)	1200 (Black)
4.	Majestic Hotel	170 (White)
5.	Poloko	1200 (Black)
6.	Randfontein	
	- Male	3600 (Black)
	- Female	1490 (Black)
7.	Simmer	255 (Black)
8.	Springfield	250 (Asian)
9.	Struisbult	100 (White)
10.	Thabamoopo	1200 (Black)
11.	Turrets	125 (Black)
12.	Waverley	755 (Black)

(House of Assembly Debates, 2 May 1975, Col 861)

This part of the report speculates also on the types of patients 'detained' in Smith, Mitchell Facilities. (No breakdown of diagnosis was then available for the approximately 9000 certified Black patients treated in private institutions - as is the case at present as far as research could establish - in spite of the fact that these patients constituted the greater part of all Black mental patients. [WHO, 1976, p. 16]) For my conclusions on this matter see Chapter Six.

The most controversial conclusion (I believe) in this section is reached in the following extract:

> "The limited evidence available on the conditions within the private mental institutions suggested that the 'sanatoria' are in fact custodial institutions with very few discharges per year, and with poor standards of patient care. It is possible that some improvements in the physical environment of the patients have been introduced after the exposure in the press and the questions raised in Parliament. This, however, cannot change the fact that in a country which is among the richest in the world, the type and quality of mental health care are determined by the colour of the patient's skin." (p. 19).

The fourth and final issue in the report considered, is the effect of certain apartheid legislation on both formative developments in health policy, and the evaluation thereof. In this regard, both the Mental Health Amendment Act, 1976, and the Bantu Homelands of 1975 are discussed. (A fuller exposition of this legislation is given in Chapter Six.)

3.2 Comments on the responses to the WHO Report

The release of the report was followed by a campaign of denials and attempts to cast doubt on its validity by both South African officials and members of the medical profession. According to these sources, not only was mental health care under apartheid above suspicion, it was exemplary. For example, the director of Information at the South African embassy in London in 1977 stated that the institutions in question were visited regularly by medical inspectors and the nursing staff of the Department of Health. Furthermore, the institutions were "regularly visited by members of parliament and of all political parties ..." (Van Der Walt, 1977). One such member, deploring the fact that the position of mental health had recently been the target of an onslaught unprecedented in the history of South Africa" stated that:

> Assembly were privileged in being able to take a personal look at various institutions for mental health in South Africa ... We were impressed by the standard which is maintained there ... "
>
> (UNESCO, 1981, p. 232)

Another member of parliament stated quite categorically that he believed the Smith, Mitchell institutions would become "show-pieces for the whole world" (House of Assembly Debates, 18 February, 1976 p. 1528).

Although the Director of Smith, Mitchell and Co., David Tabatznik denied allegations of corruption and low standards of care provided, he did confirm that the private hospitals were operated on a profit basis thought to be an amount contributing to "less than 2% of (Proteas') profits". The profits made from "occupational therapy" (including farm work, renovation of buildings, mat-weaving and the manufacture of rubber knee-guards for miners - WHO, 1977, p.19) were "placed in trust funds which are used solely for the improvement of psychiatric services to Blacks" (Dr Tabatznik; Letter to the Editor, Atlas World Press Review, 10 October 1976).

This issue was not pursued in sufficient detail by WHO but receives quite a bit of critical attention in the APA Report: Consequently, a discussion of the matter will be postponed until the next section (5.3.).

Professor L.S. Gillis, Chairman of the Executive Committee of the Society of Psychiatrists of South Africa dismissed the report as "insinuative and frankly political" because it was "based on articles and documents emanating from organisations with no established reputation". This can hardly be

considered at all accurate: one wonders if Professor Gillis took the time to note the references cited in the report. Gillis suggested that apart from the difficulty of refuting the "misleading" assertions made by the report, it was "unwarranted to tie the apartheid tin to the tail of the psychiatric cat no matter how much of a pleasing din it made" (Gillis, 1977, p. 920).

Nevertheless, if the WHO Report does emphasize one point, its that apartheid has **everything** to do with psychiatric practice in South Africa. In fact, considering the report's sources of reference and it's, by and large balanced evaluation thereof, it seems imperative that its concluding allegations be given serious critical reflection. The final page of the report sums up the position taken:

> "... by and large, the allegations made in the local press about the situation of the Black mental patients in the network of private medical institutions is supported by the known facts .... In the conditions of scarcity of community health care, and as a result of the breakdown of the extended African family ... these institutions appear to provide the predominant or only type of mental health care available to Africans in their own country." (p. 21)

3.3 The report of the Committee of the American Psychiatric Association to visit South Africa

In 1978 Melvin Sabshin MD., received a letter from South Africa's Secretary for Health, J. de Beer, inviting an APA investigative committee:

> "...to familiarise [itself] with psychiatric services in the Republic ... the prime objective of the visit would be to investigate the accusations made by the United Nations Committee Against Apartheid in regard to psychiatric services in this

country." (AJP, 136/11.1979, p. 1499)

It was with very much the same attitude that the South African Minister of Health had only months earlier extended an "open invitation" to the Director General of WHO to conduct a "free and unrestricted examination of the South African mental health services" - and invitation that was declined, apparently for the reason that WHO protested at the recent passing of Amendment to the Mental Health Act of 1973. Because this law gave South African authorities power to prosecute persons giving "false information" about any aspect concerning mental health services, WHO felt potential informants would be inhibited and the possibilities of an objective inquiry would be put in jeopardy (WHO, 1977, p. 4).

Aware of the reasons WHO refused a similar invitation, the APA asked for clarification concerning the Health Amendment Act (1976) and the implications of this law forbidding the publication of "false information". Given assurances that would " not be a problem" for them, and that they would not be denied visas to visit the "homelands", the committee arrived in South Africa in September 1978.

Not all went as promised, however. Once the committee began its detailed investigation (starting with the Smith, Mitchell institutions) they were informed by the Chief Psychiatrist for the Department of Health, Dr Henning, that they could not extend their study to the State mental facilities. The reason given was that by the Government's reckoning, an aide-memoire of the International Red Cross (who sent a delegation in late 1976 and "did not find, in any of the psychiatric institutions ... visited, any patient hospitalized for other than medical reasons") had absolved them of any

complicity in the (alleged) political abuse of psychiatry in South Africa (Attachment to letter from A. Hay, President of the International Red Cross, to S.A. van der Merwe, South African Minister of Health, May 31, 1977 - Cited in AJP, 1979, 1499).

Effectively this ban meant that the committee was unable to interview staff and patients, examine records, or, more importantly, investigate a crucial link in the mental health service system the basis on which the public facilities decide which patients to send to the private institutions. As a result the committee found they were "unable to make a potentially useful comparison between the State-operated facilities and those operated by Smith, Mitchell" (p. 1499). However, the investigation team did conclude that:

> "... there is good reason for the international concern about Black psychiatric patients in South Africa. We found unacceptable medical practices that resulted in needless deaths of black South Africans. Medical and Psychiatric care for Blacks was grossly inferior to that for Whites. We found that apartheid has a destructive impact on families, social institutions and the mental health of Black South Africans. **We believe that these findings substantiate allegations of social and political abuse of psychiatry in South Africa."**
> (p. 1498 - emphasis mine)

The APA report is unique in that it contains the most extensive and well-documented evidence collected so far with regard to the status of Black psychiatric patients in South Africa. The evidence and conclusions reached in the report categorically refute the statements made by local government officials, Members of Parliament and various medical professionals. A Unesco conference report (1981) in appraisal of the APA report states that:

> "...there is suggested evidence that mental morbidity in South Africa follows patterns created or enhanced by apartheid. While the morbidity of the White populations does not differ substantially from that of other populations with compatible age structure and under similar socio-economic conditions, the psychiatric morbidity of the Black population shows high rates of preventable conditions due to physical and psychosocial stress and avoidable chronicity due to lack of inadequate care." (UNESCO, 1981, pg. 233)

In the course of a 17 day survey, using survey protocols prepared in advance to provide a framework for the facilities visited and using as models, audits developed by the APA and the Veterans Administration hospital system, the investigation claimed to clear Smith, Mitchell of certain charges, but certainly reinstated others.

3.3.1. Summary of charges and findings

3.3.1.2. Needless deaths

The Committee judged that " at none of the facilities did we find evidence of adequate medical care during the patients' (who died) final illness".

They surmised that certain patients - especially in the geriatric facilities - were being "allowed to die". Patients diagnosed as having treatable illness such as bacterial pneumonia were in some cases, not recorded as having received antibiotics. (Staff members made no claim that treatment was given but not recorded.) Members of the committee were informed that medical care of the Black patients was "not the responsibility of Smith, Mitchell" but rather of local medical doctors arranged and paid for by the

government.

3.3.1.3 Sub-standard care

The quality of the medical care at Black facilities was rated as grossly inadequate. "Most of the patients we interviewed reported that they had never had a physical examination during their hospitalization" (p.1502).

While there is some doubt as to the status of these interviews (patients were presented with a stethoscope and a blood-pressure measuring apparatus to ascertain their reaction) and only 4 patients per hospital were approached, the APA Report claims that most patient interviews were borne out by their review of the medical records.

Psychiatric care was similarly evaluated; none of the psychiatric responsible for Black patients could speak a Black language, and more importantly, several had no knowledge of tardive dyskinesia - despite the fact that their main responsibility was the care of chronic psychiatric patients, the majority of whom were maintained on neuroleptics. Tardive dyskinesia refers to the neurological side effects associated with the prolonged use of certain types of drugs. Lambley (1984, p. 265) cites the side effects as Parkinsonism, akinesia, hypotension, drowsiness, jaundice, impotence and leukopenia. These side effects can dissipate once the patient is taken off the drug(s). Other more permanent damage (e.g. retinitis) can sometimes be caused by overdose.

Furthermore, the results of brief mental status examinations were often

"totally incompatible with the recorded diagnosis" (p. 1502).

In the facilities, patients were found to be provided with neither toilet paper nor washbasins adjacent to the toilet fixtures. The Department of Health suggested that "when toilet paper is provided ... [the patients] misuse it, causing sewerage blockages and inconvenience to their fellow patients" (p. 1502). A similar argument was extended to another enquiry concerning footwear for mental patients; "if we give them shoes, they would kick their fellow patients ..." (Reported in an article published by the Anti-Apartheid Movement, London 1983: AJP, 136/11, 1979; Seedat, 1984).

Many hospitals were "by policy" not provided with sheets (standard in White institutions) despite the common problem of incontinence. Smith, Mitchell volunteered the information that blankets, because they were difficult to clean, retained the stench caused by the problem. (The therapeutic implications of this statement were not enlarged upon). Some Black wards visited were clearly overcrowded and most patients slept on the floor. The Department of Health asserted that "Like so many other Africans ... they prefer to sleep that way" (p. 1502). Needless to say, most Black patients in Smith, Mitchell institutions had no cupboards or bedstands or personal possessions.

3.3.1.4. Abusive practices

Even more disturbing was the fact that the majority of Black patients interviewed in the Smith, Mitchell institutions claimed to have been beaten and assaulted by the staff, or had witnessed assaults on other patients staff. Smith, Mitchell officials and the companies' annual reports

suggested that assaults on patients can be attributed to "inexperienced staff". While officials also claimed that the reports of violence came from patients who were "obviously delusional", the committee felt it "strained credulity to assume that a majority would have the same delusion".

> "We did not find in Smith, Mitchell hospitals a pattern of systematic government-inspired physical violence toward Blacks. However, the violence we did find grows out of the mentality of apartheid, which treats non-Whites as inferiors and accepts the degrading of their humanity as a matter of course." (p. 1503)

3.3.1.5 Inadequate medical and psychiatric staff

Based on their own observations and data provided by Smith, Mitchell, the committee judged that the approximately 10,000 Black patients in these private facilities were not receiving adequate medical and psychiatric attention. While the committee could not by virtue of decree, obtain comparable data for the public hospitals they visited, their assessment was that:

1. The ratio of physicians and qualified nurses to patients was "woefully inadequate". No physicians were available on a full-time basis to patients at any of the Smith, Mitchell institutions visited. The part-time physicians and psychiatrists (who are not directly responsible to Smith, Mitchell) did not provide even what is necessary for basic custodial care. The size of the nursing staff was apparently set by the Department of Health.

2. The nursing staff - almost entirely Black - employed by

Smith, Mitchell were mainly inadequately trained for their responsibilities. Most of the hands-on care of the patients is provided by Black nursing assistants who have little or no formal nursing education other than six months "on-the-job" training.

The committee concluded that the needless deaths of Black patients could largely be attributed to inadequate numbers and poor professional quality of the staff at these facilities.

3.3.1.6. Exploitation of patient labour

There seemed to be some confusion over the term "occupational therapy". This term, as Seedat (1984) remarks, "seemed rather misleading in the light of the fact that, at the Springfield Sanatorium for instance (an institution for 250 Indian patients) inmates were made to work 11 hours a day. ("And what is more, they look happy in their work" we are informed by one member of Parliament.) Another agreed: "One of the great things one can do for these people is to keep them occupied. It is important to keep these people busy" (Debates, 19 February 1976, pg. 1527,1566). Patients were reportedly paid the equivalent of R2.10 a month, mainly in the form of cigarettes or sweets (Seedat, 1984, p. 52).

The Black institutions of Ekuhlengeni, Waverley, East Cape, Randfontein, and Randwest had all sought manufacturing firms willing to subcontract work to their patients. The work usually consisted of simple repetitive tasks such as making wire hangers, putting strings on price tags and making rubber leg guards for miners. The APA revealed that the collective income of just

three of these institutions from this source came to almost thirty-thousand dollars in 1977 (p. 1504).

There was a marked discrimination as well as between Black and White pay scales. Black patients reported that they were paid R1 to R4 per month; White patients reported R15 to R30 per month. Only at Randwest did there appear to be some plan to return to patients some of the funds acquired through patient labour: monthly bonuses totalling R25 to R30 were divided among "especially productive patients". According to Smith, Mitchell the remainder of Randwest's revenue from patients' industrial therapy was paid after salary and other expenses into a trust fund "to provide for the welfare, maintenance and education" of patients and staff in South African mental institutions.

An important consideration to note here is that while it is not unheard of for mental patients in other countries to do 'work' of some or other kind, because Smith, Mitchell is a private company, any work done by patients which does not result in direct remuneration to those persons leads one to conclude that this work tends either to reduce costs or boost overall profits. For example, at the Randwest institution, an innovative programme of using women patients to care for the mentally retarded takes on a different meaning if the patients are not directly rewarded for their efforts or an economization of professional care is implied (p. 1504)

3.3.1.7. Abuse of ECT and neuroleptics

The committee found no substance to charges of abuse of neuroleptic drugs and ECT. In fact, no ECT equipment was found at Smith, Mitchell facilities

visited and the dosages of neuroleptics used were " drastically lower than those customary in the United States and the United Kingdom". The only question of irregularity concerned the unavailability of prescribed medication on "rare occasions".

Once again, in appraisal of state facilities was impossible but according to information they were given concerning the "enlightened" conditions prevailing in these hospitals, the committee found time to note that: "because of apartheid, there is duplication of all ECT equipment in state facilities" (p. 1504).

3.3.1.8 Psychiatric hospitalization of political dissidents

The committee concluded that there was no evidence at the time of their visit to suggest that Smith, Mitchell facilities were used to confine Blacks because of political dissent or opposition to Apartheid. The only unusual aspect appeared to be diagnosis procedure:

> "...many Black patients are initially diagnosed as having toxic psychoses (secondary alcoholism, vitamin deficiency, infection and exhaustion syndromes.) It was our impression ... that many of these toxic psychoses are actually functional psychoses that could be diagnosed by more careful evaluation" (p. 1505).

All patients transferred to Smith, Mitchell institutions had been committed and all Black patients the Committee examined had "diagnosable mental illnesses that justified some psychiatric intervention." The only group of patients (according to the Committee a substantially large group) whose involuntary confinement raised questions of judgement, were the epileptics,

who generally had no obvious mental retardation or other psychiatric condition. The Committee concluded that there was no justification for the long-term custodial confinement of some epileptic patients whose records were reviewed (p.1505).

3.3.1.9. Apartheid and the mental health of Black South Africans

Applying what they judged to be a "minimal standard." the APA Committee concluded that they found cause for "grave concern" about Black patients in certain facilities. They emphasis that much of what they found unacceptable was the responsibility of the South African Government - not Smith, Mitchell directly.

Government policies seeking to restrict and contain the movement of Blacks in most of the country make it apparently difficult for Smith, Mitchell to return patients to their families (in the rare eventuality that this state of affairs arises) which in turn contributes to the social isolation and chronicity of Black patients and makes their rehabilitation difficult. The situation is the same for coloured patients, many of whom are sent to Smith, Mitchells' East Rand facility, far from Cape Town. The Committee learned that patients are assigned to distant Smith, Mitchell facilities only if relatives agree or cannot be contacted. In this way assignment to a Smith, Mitchell facility is, in part, based on a decision at the public hospital level that the patient is already a social isolate suitable for permanent custodial care. This seems to be only one of several measures to secure this status to patients in the care of Smith, Mitchell.

On the subject of the marked discrepancy between White and Black facilities visited, the Committee stated their belief that the inadequacies of the state and private facilities for Blacks, in striking contrast to what exists for Whites, were a direct manifestation of apartheid: "We conclude that the quality of care given Black psychiatric patients is a manifestation of apartheid and that the decision to transfer patients to Smith, Mitchell facilities is predicated in the economic constraints dictated by apartheid" (p. 1505).

The committee questioned the validity of the screening process and the "quality of effort" in contacting relatives in the context of:

(a) Overcrowding at the State hospitals.

(b) The apparent inability of staff at these facilities to perform even routine discharge examinations of patients being transferred to Smith, Mitchell facilities.

"It seems likely that to avoid overcrowding, many blacks are written off as chronic, hopeless cases and transferred to Smith, Mitchell facilities." The complicity of state health departments in these arrangements seems clear. At one point in their investigation the Committee was informed by an elected official of the government that "if there were continued objections to Smith, Mitchell facilities they would be closed and Blacks would have nothing" (p. 1505). The Committee assumed that this statement was a political one in the sense that it demonstrated the "apartheid assumption that Black South Africans and those concerned about them should be satisfied with whatever the government provides because the alternatives would be

worse" (p. 1506).

Like the WHO Report, the APA Report decided that Smith, Mitchell facilities had made 'considerable progress' in the previous few years. Nevertheless, it concluded that the 'stigma of apartheid' was pervasive:

> "The Smith, Mitchell facilities can be viewed as only a sub-system of the larger South African apartheid system, reflecting in microcosm some of its pathogenic governmental and social structures and processes. **A powerful and contrived reality has been developed in South Africa that favours and protects Whites, while excluding, neglecting, or oppressing Blacks. Smith, Mitchell functions in this context - indeed, probably would not exist without it - and must conform to it."** (p. 1506 - emphasis mine)

3.3.2. Conclusions and recommendations

In the concluding section of the report, Discussion is briefly (and rather broadly) given to the 'realities of the apartheid regime', mentioning, like the WHO Report, the issues of racial classification, apartheid legislation, Black education, the 'homelands policy' and migrant labour amongst others. The emphasis here seems to centre on the Committee's position that the "contrived reality of apartheid, based on pervasive discrimination against Blacks, undermines Blacks' mental health by proclaiming them inherently inferior and robbing them of individuality" (p. 1506).

Finally, the Report ends with two recommendations:

(1) That the Association of South African Psychiatrists and

other organizations and agencies in the mental health field take a 'fresh look' at the impact of apartheid on the mental health of all South African people.

(2) That mental-related government agencies, medical schools and medical societies accept responsibility for the failure of South African educational institutions to produce important Black personnel and extend priority to this matter in the planning and allocation of resources within each institution involved in medical and premedical education.

CHAPTER FOUR

Theoretical considerations: The Repression of the Social in Traditional Psychological Theory.

> "Our clients ask. . . the same question: is there something wrong with them, or is there something wrong with the world around them? And with few exceptions, psychologists tell them there is something wrong with them and nothing wrong with the world. We usually ignore the possibility of structural social problems. . ." (Beit-Hallahmi, 1974, pg.125)

4.1 Introduction

Psychology as Jacoby (1977) notes "is not a passing fad on the fringes of society; rather it is deeply entangled in the social reality" (pg.xvii). In its traditional pursuit of scientific fact, psychology has too often embraced the positivist schema that severs data from values, observation from theory, and leans toward the essentialist and apolitical in its theoretical dichotomy between individual and society. Obliged by its intellectual heritage or not, the short history of psychology, as it has been taught and practiced, has been overshadowed by a general approach that largely ignores the interaction of the social with the personal in the formative aspects of individuality (Jacoby, 1977; Foucault, 1970, 1973, Lasch, 1978; Hayes, 1985).

To sever the social and the historical from any study of human subjectivity is to place somehow, the study of matters appropriate to psychology apart from the contextual realities of poltics. As Holdstock (1981) has put it:

> "Since we have been unable to escape the traps of our compartmentalized approach to science we have deduced quite misguidedly that psychology and poltics are mutually exclusive. In so doing we have effectively cut ourselves off from some of the burning issues of our time." (pg.126)

If Schweiso (1979) is correct in argueing that the applied branches of psychology may raise moral concerns which arise in the context of social praxis, the pursuit of scientific psychology could imply an ideological bias. Moll (1983) for instance remarks that:

> ". . .the idea that psychology is some kind of "science" is carefully maintained and reproduced without really being considered. Each succeeding generation of "scientists" are taught to belive

> that they are doing psychological science and an othodoxy develops which can rightly be called psychology's 'dominant framework'. (pg.64)

Savage (1981) has pointed out that "social research is never conducted in a vacuum; the structures, tensions and values of a society condition, and are reflected in the type of social research that is produced within it" (pg.45). This would apply to both that research which acceptingly follows the "norm" and that which attempts to transcend or undermine it. Dawes (1985) writes that:

> "It is less common for psychologists to argue that psychology and its applied derivatives are inevitably influenced by the ideological and political contexts in which they are embedded...... those who support an a-contextual position - a psychology which is seen to operate independently of the political realm - generallly argue their case on the grounds that they are scientists and that science is value free and concerned with truth. Those who would contextualize the discipline . . . see the goal of an uncontaminated truth as a dream which **mystifies as to what constitutes the deeper practice of value-free science - namely the unwritten support of a particular socio-political order.** (Dawes, 1985, p.55 - emphasis mine)

"We do not," as Hayes (1985) states "come to a better comprehension of what the psychological is by negating the context" (pg.42). Resler and Walton have called for a jettison of the "false conceptual divisions that official psychology erects between the individual and society; one must see people and society as forming a complex unity" (Hayes, 1985, pg.41).

In development of this point, Hayes (1985) has suggested that this "complex unity" be situated against a basic materialist ontology that would posit social reality **before** consciousness without reducing the "psychological" to the "social". In other words, what is necessary is the reconstruction of a

"social" psychology which would analyze broad psychic development and individual response within an historical perspective. This approach would at least recognize that limits on behaviour are also shaped by the relations between power, politics and people. "The insistence. . . on finding humanity everywhere by underestimating the objective and social foundation of inhumanity perpetuates the latter - it humanises inhumanity" (Jacoby, 1977, pg.68).

Too often South African psychologists have pursued their studies with little genuine regard for the society-and culture of which they, and it, are part. Jacoby (1977) has well described how in the case of post-Freudian psychology, the social dimension of psychological experience has been lost, forgotten and "driven out". In the pursuit of an essentialist understanding of human personality for instance, social, material and historical issues are usually ignored as if they could have no possible bearing on the matter. In this regard, Seve (1975) writes that:

> "Almost all current concepts of the human personality are based on the belief that the individual personality is a particular example of the general personality, in other words, the concrete individual is understood as a singular example of the human genus . . . this logical monstrosity, the abstract "general individual", is the skeleton in the cupboard of the psychology of personality." (Cited in Leonard, 1984 p.12)

The continued resurrection of a "general individual" clearly too easily reduces the understanding of human behaviour to an individualist distortion on which the socio-political is denied a theoretical space. In the light of this perspective the "autonomous subject" emerges as the object and aim of psychological theory; the subject to be rescued from her incapacities and

returned as it were, adapted and intergrated back into society. But as Jacoby (1975) reminds us:

> "This psychology is the ideology of conformism and synchronisation in the era of late capitalism. The reality of violence and destruction, of psychically and physically damaged people, is not merely glossed over, but buried beneath the lingo of self, meaning, autheticity, personality. The more these cease to exist, the more they are invoked". (In Ivey, 1985, pg.10)

The very humanistic principles underlying the practice of psychology become compromised in the denial of a contextual basis to personhood; as a scientific 'object' in the one extreme, the existential subject, abstracted from the social context 'decays into a thing also' - Adorno (1973) warns that:

> ". . .the more strictly the psychological realm is conceived as autonomous, self - enclosed play of forces, the more completely the subject is drained of his subjectivity." (pg.32)

Setting these words into local ideological context is the following comment from Andre Brink: "the psychology of apartheid is a mentality which must deny the humanity of another person in order to survive oneself; **once another persons humanity is denied, he can be destroyed because he is no longer a person**" (UNESCO, 1981, pg.167 - emphasis mine). In order to make South Africans "more psychologically healthy" and to "resolve the crises of mental health", Lloyd Vogelman in his opening address to the OASSSA National Conference of May, 1986 called on fellow professionals to "engage in politics" due to the fact that answers to the above problems were becoming

increasingly difficult to find within the narrow paradigms of psychology and psychiatry (OASSSA Conference Report, pg.4). Vogelman blames the individualistic focus of these paradigms on the kind of education and training workers in the health services receive.

On this subject, Beit-Hallahmi (1974) remarks that:

> "Clinical psychologists (and one could add psychiatrist's and social workers) often discuss theories of human nature but refrain from discussing theories of society. It is assumed that we can leave the task of dealing with the nature of society to others, and the decision to do that relegates the political implications of psychology to the professional unconscious where it is destined to be repressed unless uncovered through some radical treatment or severe trauma." (pg.127)

I would argue that the task of dealing with both the nature of society and the "professional unconscious" specifically requires an examination of the relationship between ideological factors and events in the politics of health - an issue to which I now turn.

4.2 Ideology and Mental Health

Ideology has been defined by Heather (1976) as disguised self interest (on the part of the state or controlling organization) and by Carlton (1977) as a:

> ". . .pattern of beliefs and concepts both normative and factual which purport to explain complex social phenomena with a view to directing and simplifying socio-political choices." (pg.23)

In this sense, ideology would both shape and define subjective understanding

of what state or organizational policy 'actually" means with a view toward constructing a stable, naturalized political consciousness.

Thompson (1984) writes that:

> ". . .to study ideology is primarily to investigate, not as a particular type of discourse linked to a particular type of society, but rather the ways in which meaning (signification) serves to sustain relations of domination." (pg.35)

The pejorative sense in which the concept is employed usually refers to the historically specific ways in which the relations of domination are obscured. As Dawes (1985) stresses, "ideologically influenced views tell members of a group what they should do and why on the basis of a "truth" composed of both true and false components" (pg.56). The idea of "false consiousness" is that the process of ideology obscures the differences between the truth (of social conditions) and what is false, it disguises internal contradictions and prevents groups or individuals from gaining insight into their own exploitation:

> "Although the State may appear to protect us from the worst excesses of capitalism, it is in fact protecting capital from our strength by ensuring that we relate to capital and to each other in ways which divide us from ourselves, and leave basic inequalities unquestioned." (Banton et.al.,1979, pg.173)

While it could be said that in South Africa at present, government policy operates at a relatively undisguised level, political theorists have argued that the State has at its disposal, two main arsenals of repression - the

apparatuses of ideological and legislative control. The more effective the persuasive power of state ideology, the less, in principle, the more overtly repressive methods of control need to be resorted to. By this simple yardstick it is clear that ideological means of control in South Africa have not succeeded - the present, and latest in a succession of government-declared states of emergency being just one illustration towards proof of this argument. As Bundy (1986) has commented only recently: "the binding cement of South African history is coercion, not consent" (pg.84).

The effect ideological saturation has had in the mental health field is significant. When racial prejudice expresses itself in the form of attitudes and beliefs that Blacks, quite apart from socio-economic issues and cultural differences, require (or deserve) **less** in the way of mental health care, then that prejudice is often camouflaged in the words of psuedo-scientific opinion. Somehow, when we read the blatantly prejudiced words of comments expressed many decades ago, it is relatively easy to shrug off those ideas as simply perhaps part of a less enlightened age. When those words are echoed in our own decade, it gives us cause to reflect. When the Nursing Amendment Bill (which introduced apartheid to the nursing practice in the year 1955) was read in parliament for instance, a Mrs C Searle voiced the opinion that:

> "The non-european nurse in South Africa is being drawn from a social milieu and has a psychological attitude which is completely different to the generally accepted concept in the Western world. . I am not prepared to describe her as a nurse.The non-European nurse is at the moment unable to discharge, either through training or in the care of a sick person, these functions of a nurse, viz., the psychological and sociological care of the patient." (UNESCO, 1981, pg.248)

If the opinions of two South Africans seperated by approximately two decades of history can be said to illustrate a certain ideology of race relations, then the following words of Dr Lamont (voiced in a letter to the Editor of psychiatric News in 1979) can be considered with perspicuity.

Commissioner of Mental Health in this country from 1961 to 1970, Lamont suggested that :

> "... manic depressive psychoses, and especially the depressive phase, are relatively rare in the Bantu at this stage of **their social and cultural development.**" (UNESCO, 1981, pg.246 - emphasis mine)

This naive and uncritical understanding of race and culture seems to completely ignore the fact that Blacks are what they are not only by virtue of their supposed "cultural development" but certainly also because they are Blacks living in South Africa, a country with a distinct and oppressive racial history.

Recently completed research in Britain on the relationship between racial prejudice and mental health suggests implications which offer an interesting parallel to the South African situation. According to a recent press report in the Guardian of London) research soon to be published by the team headed by Dr Roland Littlewood reveals that Black people born in Britain are three times more likely to be taken into hospital and diagnosed as schizophrenic ++ than Black immigrants - and twelve times more likely than White Britons (Weekly Mail, 16-22 October, 1987). This fact could too easily afford the

racial argument that somehow Black people (in Britain) are "inherently madder" than Whites. But Littlewood argues that it is the **experience** of Blacks born and brought up in Britain which causes not just distress, but serious mental illness: "It's not just a question of poverty. it is a question of racism. A large proportion of people in any society are vulnerable to mental illness but many of them live with stresses without becoming ill. My strong feeling is that Black people are being driven psychotic by our society, that racism is indeed causing these high rates of mental illness" (ibid).

Considering the oppressive racial climate of our own country, and its concomitant stresses, it would surely be a surprising fact if South African Blacks were **not** suffering - and suffering quite significantly - in their mental health. It remains, as Vogelman (1986) has noted, "an area. . . that most professionals prefer to ignore" (pg.4). I would argue that if this is so, it is due to both simple moral and theoretical impoverishment on the part of professionals - it implies an ideology of neutrality that is successfully maintained by the faith in a theoretical paradigm that serves to **exclude** from its field of interest "problematical" areas related to social goals and values. For this reason, we need to bring into question the very process by which social goals may come to influence choices of paradigm in the social sciences.

4.3 Social Goals and Intervention Strategies

Integrating a person psychologically or socially in South Africa practically amounts to integrating him or her into an oppressive, racist society (Lambley, 1978; Marks and Andersson, 1987). The more mental health services

do this, the more they can be accused of serving the system at the expense of the community - particularly the Black community. The choice for South African psychologists is not simply whether or not making the theoretical split between individual and society is methodologically, or theoretically useful, or even appropriate; the choice might ultimately concern, as Rappaport (1977) has suggested, the values and goals that underlie the efforts which result in social praxis:

> "When we hide behind the terminology and euphemisms of social science we often sound as if we all speak a common tongue in which the logic of experimental design and empirical tests determine our actions. However, when we stop and look at ourselves nondefensively we will see that most of our differences are matters of faith." (Rappaport, 1977, pg.4)

Kuhn (1970) has made the point that paradigms of approach usually allow some problems as legitimate for study, and others as outside of their scope. Rappaport adds that when we choose a model or paradigm to guide our work, we select it on the basis of faith that it will solve the puzzles we as psychologists have selected as worthy of study:

> "It is reasonable to contend that, at least in the social sciences both our selected problem areas and our faith in different paradigms reflects our social values rather than reflecting our scientific differences." (Rappaport, 1977, pg.3)

The traditional paradigms of psychology according to Rappaport, are not relevant to many of the "puzzles" society faces us with. While existing paradigms are often found to be applicable in one context, they are not adequate for all purposes. In the search for new paradigms "what guides much of this activity, but are either implicit or forgotten in the quest to

appear 'scientific', are our values and goals" (Rappaport, 1977, p.4). In Jacoby's (1977) memory loss analogy, this loss of value, and of social conscience "is not to be explained psychologically; it is not simply childhood amnesia. Rather it is social amnesia - memory driven out of mind by the social and economic dynamic of this society" (Jacoby, 1977, pg.4).

While it is not my purpose here to assess the claims made by Marxists such as Jacoby, it does seem worthwhile to consider the distinctions that Rappaport (1977) makes between different theoretical "levels" of analysis possible (of which Jacoby's is certainly one) the values, or social goals that seem to underly these levels, and the conceptions and strategies of social intervention that are concommitant to these approaches. The following four categories have been adapted from Rappaport's analysis and titled according to their respective levels of intervention.

With regard to these categories, Rappaport does emphasize that:

(1.) The level of analysis may be **cumulative** as one goes from the first category to the last. Willingness to engage in strategies at the institutional and community level for instance does not necessarily preclude a desire to engage in others. In practice, levels of analysis and strategies of intervention are often combined.

(2.) Multiple levels of study and intervention are desirable.

4.3.1 Person Centered Intervention

Social problems are a function of the inability of some people (or an entire

sub-culture) to fit into the structures of society, or to be comfortable being different. The place of applied behavioural science is to help as many people as possible adjust to the goals and norms of the small groups and organizations of which they are a part. Individual discomfort is eased by helping persons live with their differences in a non-destructive way. The values of the institutions of a society are basically benign, and the organizations developed to accomplish these values function as well as can be expected considering human falibility and expertise.

(A) Level of Analysis

An individual level of analysis is emphasized. Understanding a human-being as a **person** is the key to changing him or her to be more **competent, adaptive,** to fit in and **be comfortable with themselves and the existing structures of society.**

(B) Conceptions

Individual conceptions ranging from behavioural through to psychodynamic and phenomenological. Depending on the specific problem this level of analysis may require helping the person to find their place in a self-maintenance, transcendental or normative ecology. Social change is implied to be a summation of individual change.

(C) Strategies and Tactics

Person-centred interventions. Community mental health oriented therapies such as brief treatment, crisis intervention etc. Training of new "person

power" which could include for instance, employment training techniques for individuals and educational programs for children and parents.

4.3.2 Inter-Personal Intervention

Defects in the group rather than the individual members are emphasized; social problems are created by interpersonal difficulties within primary groups such as the family, peer, and work groups. When these groups are not functioning well internally or are in conflict with other groups they not only have a negative impact on individual members, but also inhibit the ability of organisations to accomplish the necessary tasks of administering society's institutional values and goals.

(A) **Level of Analysis**

Small group level of analysis emphazied. Understanding the dynamics of interpersonal relations and small group interaction is stressed - the definition of the problem lying in interpersonal communication and conflict.

(B) **Conceptions**

Two primary sources of conceptions are the group dynamics literature of social psychology, and the group and family treatment literature of clinical psychology.

(C) **Strategies and Tactics**

Includes family therapy, interpersonal communications training, sensitivity

groups, group therapy and the retraining of agents of socialization to communicate more effectively with themselves and the target people.

4.3.3 Systems Centered Intervention

Social problems are created by the organizations of society that fail to implement as well as they might the desirable values and goals of our social institutions. Particular organizations are imperfectly structured (or administered) such that they often fail to accomplish the values and goals of socialization as set forward by education, health, work, and welfare institutions. The aim remains to enhance the likelihood that organizations will help individuals to "fit" into society but the problems are in the organizations themselves, not "in" the person.

(A) **Level of Analysis**

Organizational level of analysis. The key to the solution of social problems lie in the techniques for changing the social structure of organizations.

(B) **Conceptions**

Systems centred conceptions from public health, social and organizational psychology - which may include conceptions of deviant sub-cultures and norms. The concepts of power and alienation are understood as psychological rather than political variables. Principle of social systems analysis, ecological and environmental psychology are applied to adjust the functioning of the organization.

(C) **Strategies and Tactics**

Public health and organization - development strategies including "systems-centred" consultation - the development of new structures and communication channels and styles within existing organizations.

4.3.4 Institutional Intervention

Social problems are created by our institutions rather than by persons or by organizations. The real key to social change - notwithstanding problems at an organizational level of analysis - lies in the attitudes, values, goals and political-economic ideology and social policy on which the organizations and institutions are based. The distribution of power among various communities is an important variable.

(A) **Level of Analysis**

Institutional and community level of analysis is emphasized because the institutions of society are seen to support and determine relationships within and between organizations and communities. These relationships limit the alternatives and the resources available to members and, therefore, hold the key to social change.

(B) **Conceptions**

Systems-centred conceptions from various social-sciences with the concept of power as a political-economic as well as a psychological variable.

Principles of social action, social policy and community organization are emphasized along with a search for new environmental alternatives.

(C) <u>Strategies and Tactics</u>

Tactics emphasize power and control of disenfranchised groups either within existing organizations or in newly created organizations based on institutional assumptions different from those currently dominant in society. The choice between changing existing or creating new settings is a function of the specifics of the situation.

4.3.5 <u>Towards a New Understanding of Social Change</u>

The application of inappropriate, or inadequate paradigms to a particular social problem results in what Rappaport (1977) and Kuhn (1970) call an "error of logical typing", that is, trying to create change by means of solutions based on a level of analysis inappropriate to one's goals. For example, to the extent that problems of severe mental illness could seem to be a function of "social labelling" and a social policy of isolation, efforts restricted to changing only identified patterns will necessarily lead to what Watzlawick, Weckland and Fisch (1974) term "first order change" (Cited in Rappaport, 1977, pg.6).Genuine, or second order change, would require questioning the institutions of society, or the very ideas by which the mental health services operate. That is, the **processes** of social labelling and isolation would have to be questioned.

An organizational level of analysis is also quite different from the type

described in the fourth category of relationships. if one's value/goals suggest that social problems are created by social institutions rather than by persons or organizations, then by the same reasoning, an organizational level of analysis is quite inadequate. Also:

> "If one's values suggest a redistribution of power (both political and psycholgical) and of money and other resources is important for genuine social change. . . then to limit interventions to those enhancing the ability of organizations. . . would be to commit an error. . . by the criteria of one's own value system." (Rappaport, 1977, pg.7)

While Rappaport's analysis emphasizes the important relationship between social values and social research, it fails to radically question the significant relationship between social ideology and social values. Many of the most socially relevant and historically critical questions about South African society are never pursued into research because, as Savage (1981) points out: "Social scientists, like other members of this society are limited and restricted by the norms, values and socially determined perceptions of the South African social structure, with the result that such questions often do not even occur to them" (Savage, 1981, pg.45). Jacoby (1977) remarks that: "exactly **because** the past is forgotten, it rules unchallenged; to be transcended it must first be remembered" (pg.8).

One question that should be asked is this; can the social sciences, like the natural sciences, free themselves from the matrix of social practices that enframe them. Or, in reference to the levels-of-analysis concept; why are **some** strategies in the human sciences adopted at the expense of other, perhaps equally possible, alternatives?

As Foucault (1973, 1980) has often noted, the human sciences are not "normal" sciences simply in that, for one thing, there is rarely general agreement among those involved as to what counts as either appropriate theorising, or even "good" theorising. In the social sciences there are always a number of conflicting conceptual approaches - each often with its own pseudo-paradigm. (By pseudo-paradigm I mean either an approach which unsuccesfully camouflages its close or even identical ties with another more ramified theory, or one which significantly overlaps with one or several other theories. In either instance the pseudo-paradigm has no fustified claim to a seperate and valid methodology.)

Foucault has suggested that levels of analysis which become adopted by professionals in various fields cannot always be explained in terms of a generally accepted scientific paradigm or general theory of truth because in the human/social sciences this kind of consensus is largely absent. his proposal is that for this kind of discourse (as with others) there must exist quasi-structuralist rules of formation, unknown to the practitioners, which govern a particular discourse during a particular period and thus determine the **range** of possible strategies which can be taken seriously - that is, including those accepted by some schools of thought and vociferously opposed by others. In the context of this study, this "range" is perhaps illustrated in the debates between those theorists influenced by the Black-consciousness movement, and those of the more radical Marxist school: the former are more inclined to adopt certain "existential" understanding of what it means to be Black in South Africa (for example Manganyi, 1973) while the latter would reject tendencies of "individualism" and explore the economical and structural bases of experience and social

change (Johnson, 1979; Couve, 1986). Both these positions would be aligned against what could be called a "Christian Nationalist" understanding, which in this country could arguably be said to pervade most, if not all, aspects of political decision making processes.

The significance of Foucault's insight in its genealogical focus on history and its call upon the social sciences to situate their studies **within** a detailed understanding of the strategic role certain kinds of discourse have to play. Foucault is suggesting that as psychologists we cannot simply assume to detach both ourselves **and** our disciplines of understanding from the matrix of forces that enmesh and limit our constructs of meaning. At its most fundamental, this point is simply a re-assertion of the view derived from Mannheim's sociology of knowledge and recently given expression by Fouche (1985) who argues that objectivity as value-neutrality is a questionable goal for social scientists - indeed the very condition of there being knowledge at all she argues, is that knowledge is culturally and historically rooted.

It is becoming less and less popular to conceive of, and practice psychology as an "autonomous" discipline. To properly approach the discipline is to develop a sturdy historical sense that situates researcher, research and methodology in their true relationship with each other. Again, in Foucaultian terms this would represent a higher abstraction of a straightforward Marxist/historical materialist understanding of "psychology as ideology-critique" to a reformulation of the concept of ideology from a coercive force on truth to a notion that would extend to certain practices of socialization a literally **fictive force** of creation.

The practices of racial discrimination in their unique South African context amount to just such a force: Blacks become not simply oppressed and severely disadvantaged through the institutionalized practices of apartheid, but rendered **literally less than persons**. Apartheid has created perhaps two "different" Black South Africans - one unto himself, the kind of person Manganyi (1973) describes as living in society in which there is hardly any situation in which his self-esteem is nourished, in which "his subjective experience is one of being emasculated" (pg.51); and one unto the White man. Apartheid, to paraphrase a comment by Frantz Fanon, can be considered the emotional, affective and often intellectual expression of racial inferiorization. If psychology is to model itself on medicine as a curative and preventive science, how could it escape the critical need social circumstances have foisted upon it?

4.4 Criticism in the Context of Education and Health

J L Grey, the University of the Witwatersrand's first Professor of Sociology remarked in his inaugural lecture in 1937 that: "In every authoritarian country it is the worker in the social sciences who is the first to be tamed." Over half a century later one of the most striking features of research in the social sciences in South Africa is the almost **total** absence of any examination of the psycho-social implications of apartheid (Lambley, 1980; Savage, 1981; Dawes, 1985). A quick glance any any University post-graduate thesis catalogue is sufficient to confirm this claim.

It has been argued that social and psychological research in South Africa seem to be channelled mainly into two kinds of studies; analyses of "racial attitudes" in cross-cultural studies, and reports on "within-group"

differences in behavioural and cognitive functions - often related to job performance and selection in industry (Nzimande, 1985; Lambley, 1980). The history of critical reporting and study on politically sensitive issues has until relatively recently, been a short and illustrious one. Most of the reference material for this study for instance was compiled by persons and organizations outside of the country. A significant quantity of this critical (but hardly rhetorically biased) information has been, and is, restricted for use and possesion under the Internal Security Act.

The Government's attitude towards critical research has rarely been enthusiastic. In 1967, the President of SIRSA (a largely Afrikaans-speaking psychological institute) warned academics that:

> ". . .the lecturers of psychology in our Afrikaans universities have been ensnared in the net of the doctrine of racial equality and. . . are busy poising the minds of our students with it." (Dawes, 1985, pg.58)

Savage (1981) has pointed out that in the Afrikaans and Black universities "theory courses are structural - functional, consensus orientated and American in their approach." This framework:

> ". . . fits the White South African mind well, emphasising order, equilibrium, gradual evolutionary change - all watch words of White South African politics. Two consequences flow from this: theory is predominantly contemporary, but the more recent theoretical debates are also ignored." (pg.47)

Certain South African academics have been known to periodically call upon their colleagues to "discover" possibly objective differences between the

racial groups of this country (Dawes, 1985; Savage, 1981). P.M. Robbertse in 1967, for instance, made the following invitation:

> "Members of the Psychological Institute of the Republic of South Africa are encouraged to undertake research in this field on a greater scale because it concerns the **scientific basis of separate development and strikes at the very root of our continued existence**". (UNESCO, 1981, pg.246 - emphasis mine)

Although this comment dates from over two decades ago it very clearly reflects the positivist notion that science can (and ought to) be practiced in a theory-neutral or value-free way. it also illustrates (as this kind of view often does in the context of South African politics) how the **need** for objective scientific enquiry often reflects ideological bias in all its frailty. In the same paper cited earlier, Robbertse warns that:

> "The shift from general opinion in regard to innate differences between races to the concept of the quality of races by some people may possibly be attributed to the following factors:
> (1) The rise of 'modern anthropology'.
> (2) The opinions and atrocities of Hitler and the Nazis.
> (3) The rise of Nationalism in Africa.
> (4) The 1954 decision of the American Supreme Court in regard to the admission of pupils to schools.
> (5) The efficient way in which the communists spread the concept of equality for their own purposes."
> (Cited in Dawes, 1985, pg.58)

Both Savage and Dawes describe a situation where the practice of theoretical research and debate, and the pursuit of balanced, critical knowledge is severely impoverished. Another academic from the University of Cape Town suggests the problem is more deeply institutionally rooted; in a recent

lecture, Bundy (1986) has deplored the quality of in particular, one of the standardly prescribed history text books for South African school children, describing it as a kind of "anti-knowledge". "An index of the intellectual well-being of any society may well be how accurate, how self-critical, how complete is its historical consiousness" (pg.ii).

I would argue that as far as the historical events this study focusses upon are concerned, our historical consciousness is neither accurate nor complete - let alone self-critical. It is a peculiar fact about critical debate in this country that it is rarely appropriately considered by most state authorities. The following is a typical example - at a two day hospital management conference in 1981, P J Loubser, MEC for hospitals "informed" delegates that there was no doubt that criticism of the hospital services was part of the "total onslaught" against the country:

> "Some of this criticism is so negative that the impression is gained that it is calculated to create a psychosis of discord and crisis just to show the authorities in a bad light. There must be no doubt that it is all part of the total onslaught against South Africa as an important bulwark of western civilization. Anyone who does not realize this is in danger of unconsiously aiding the process." (Cape Times, 17 September, 1981)

This kind of hysterical reaction to criticism levelled against the health services is far from localized; active in the field in the last few years have been medical officers of the National Medical and Dental Association (NAMDA) who, it can be said, have incurred the wrath of certain State departments.

NAMDA officials have repeatedly stated their belief that a "pattern of harrassment" is emerging in South Africa, directed at professionals who challenge the status quo in the health services (Weekly mail, 7-13 August, 1987). The organization itself has for instance been subjected to vociferous criticism by the more conservatively aligned Medical Association of South Africa (MASA). In February, Dr Andre Fouche, President of the Soutpansberg branch of MASA, was quoted as saying: "We know for a fact that NAMDA [is] sponsored by the ANC and the SA Communist party" (Weekly Mail, 7-13 August, 1987). However, quite apart from the dubious merits of such an accusation, a more likely reason NAMDA has icurred the wrath of state-sanctioned organizations like MASA might be attributed to the overtly critical stance NAMDA has taken towards the politics of health in South Africa:

> "The underlying cause for our existence is to draw attention to our belief that apartheid is a basic reason for ill-health in our country and that it is having a detrimental effect on the health of Black people especially."(Post, 1 October 1988)

The ideological differences between NAMDA and MASA are similarly reproduced in the two associations OASSSA (Organization for Appropriate Social Services in South Africa) and PASA (Psychological Association of South Africa). While the latter affiliation includes members of all ideological persuasions it has, as yet, no formal stance with regard to the relationship between apartheid and issues concerning mental health. (This is not to say that PASA members are as a body, simply apologists for state policy - the organization has, and continues to speak out against apartheid, but usually in terms related to the deplorable conditions of violence and unrest in the country. In this instance see Diana Shmukler's letter carried in the June 1988 edition of Monitor, the Journal of the Human Rights Trust, pg.65). OASSSA on

the other hand continues to reiterate the need "of taking a critical stance towards the woefully inadequate apartheid-ridden mental health structures in South Africa" Weekly Mail, October 2-8, 1987).

'Bulwark of western civilization' or not, criticism of South Africa's health services is hardly out of place. If criticism is so negative at times, the repressive climate created by South African censorship laws certainly serves to exacerbate what might otherwise be taken to be constructive critical debate. As it is, any university catalogue will illustrate the fact that as far as the controversial subject of mental and conventional health services is concerned, there is no debate, only lists of material considered either "undesirable" or "prohibited from possession".

There are in fact two broad categories of restriction: items banned under the Publications Act [designated by the symbol Y (undesirable) or YY (prohibited from possession)] and items banned under the Internal Securities Act [designated either YX (material by banned or listed persons) or (publications of banned organisations)].

Criticism, it might be argued, is not only historically appropriate at the present time, but of absolute necessity: not only are the wider ramifications of apartheid and health a significant issue but the historical antecedents to the present ideology of health as well.

CHAPTER FIVE

Apartheid and Psychosocial Stress

"The final injustice, the ultimate injustice, is injustice of health care".
(RA Lambourne in Wells, 1974, p.23)

5.1 Introduction: The Politics of Health

It has been persuasively argued by several authors that despite popular belief, there is little or no relationship between medical care and measures of morbidity and mortality (Savage, 1978; De Beer, 1984). That is to say that however technically sophisticated medical resources might be, the important factors in determining population health levels are essentially political and economic. Savage (1978) has claimed that within South Africa "the health care system is not the only, or most important determinant of health levels in a population. . . The quality of [the] nation's health overwhelmingly is a response to the nature of the political and social environment" (p.1).

At the second national conference of the Organisation for Appropriate Social Services (OASSSA) held recently, Trudy Thomas of UCT's Community Health Department spoke of the signs of mental ill-health inflicted by apartheid: "Physical and psychic well-being rests on the social pillar of a supportive family life and adequate social services, and the economic one of enough land, a living wage, and humane pensions. To the extent that either are eroded, physical and psychic ill-being result" (Weekly Mail, 11-17 September, 1987).

The point has been even more forcefully expressed by others:

> "As long as social injustice is not reduced, no amount of medicine or medical work can stem the ever-increasing tide of illness. For no amount of drugs or antibiotics can take the place of three square meals a day, and the normal means of getting three square meals a day is a just wage. Thus we see that from this viewpoint the ultimate cause of sickness is neither germ nor bacterial, but mass

> exploitation. But mass exploitation has its repercussions, and sometimes even its roots, in a political system or atmosphere." (Montmeyer in Wells, 1974, p.24)

The purpose of this Chapter (as I shall stress in more detail later) is to explore and bring to light just this "atmosphere" of apartheid. It is intended not to be an exhaustive study of all the means by which apartheid has become institutionalised, but following the direction taken by the WHO Report, a brief exegesis of the fundamental categories of psycho-social stress which can with little fear of contradiction, be said to have a detrimental effect on the quality of life experienced by the majority of South Africa's population.

The politics of health in South Africa reveal two alarming facts: one, that state expenditure continues to further the primary and curative focus of health care, and two, that the provision of primary health services to the Black population is grossly inadequate and clearly a reflection of wider ideological issues and racial discrimination.

Evidence heard in the recent trial of a Durban doctor, Vijay Ramlakan, convicted for his part in a number of bombing incidents carried out on behalf of the African National Congress, reveals some of the harsher facts of medical care under apartheid (Weekly Mail, 8-14 May, 1987). Describing conditions of Durban's giant King Edward VIII Hospital where he worked, Ramlakan said it was a "constant nightmare" for staff and the over half-a-million patients seen in the hospital every year who have to queue up to 14 hours to be seen.

The King Edward has been prevented from expanding, apparently because of its situation in a "White" population area. Over-crowded conditions often resulted in three patients being designated to a bed, and patients seriously ill have to sleep between or under beds.

According to recent press releases this is not an isolated or exaggerated case. Patients of Ward 21, the psychiatric ward of Baragwanath Hospital, have been reported as wandering around lost (often with notices pinned to them saying "Return to Ward 21"), having to sleep on the floor fighting the cold with sleeping tablets, going without bedletters, and having to exist in hopelessly overcrowded conditions (Report by Helene Zampetakis, Rand Daily Mail, 2 August, 1983). While pervasive changes are regularly being heralded by the authorities, the hospital continues to be surrounded by controversy. In the Rand Supreme Court recently Dr Beverly Traub won back her job at Baragwanath Hospital from the Transvaal Provincial Authorities. Traub was one of 101 doctors who signed their names to a letter deploring conditions at the hospital. The letter was published in the September 1987 edition of the South African Medical Journal (Weekly Mail, 7-13 October, 1988). Although the reason for her initial dismissal is telling enough, a comment by one senior doctor at the trial reflects the weary cynicism among the staff: "As far as I know, the only change at Baragwanath since then [the date of publication] has been the acquisition of three or four toilet seats" (Weekly Mail, 7-13 October, 1988).

At King Edward VIII Hospital, Ramlakan states that because of a shortage of both staff and facilities he found himself having to watch the death of patients who "could have been saved if they had [received] proper treatment." Adding that he sometimes had to "choose" which patients he would

have to allow to die, he emphasised that "no health worker can ignore the fact that apartheid causes disease" (Weekly Mail, 8-14 May, 1987).

South Africa has developed a system of political and social control which has been condemned by the rest of the international community as oppressive and inhuman to the majority of its indigenous peoples. While Savage (1979) argues that apartheid and physical health are incompatible, Dawes (1985) goes as far as to suggest that the mental well-being of **all** the people of South Africa is jeopardised by this policy: "The events speak for themselves, the anecdotes are real, and studies conducted in other countries add credence to the fact that certain social conditions, even without apartheid, produce stress" (p.60). One such study reported to a UNESCO conference states:

> "Industrialisation and urbanisation can be a source of stress and have adverse effects on health and psycho-social well-being. These have been studied and extensively documented. Economic, political and social systems can either exacerbate or buffer these effects. In the case of South Africa the destructive psycho-social stresses are not mere accidents or the unavoidable side-effects of socio-economic processes which have escaped rational control and planning. They are generated by design, guaranteed by legislation and represent a structural characteristic of apartheid." (UNESCO, 1981, p.167)

5.2 Apartheid and Mental Health

Intrinsic to the system of apartheid is the almost total control racial legislation holds over the lives and destinies of millions of people. For the vast majority of Blacks in South Africa, the institutionalisation of

racial discrimination determines almost every aspect of life from birth to death in the psycho-social "climate" of apartheid.

The categories of psycho-social stress examined in this chapter are those considered in the WHO Report to be typical of the "stresses affecting millions and creating for the African an environment characterised by basic unpredictability and hostility" (p.5). For the purpose of better contextualising both the WHO and the APA Report, the focus on these categories of stress is given to instances more accurate of the events which occured in the last decade. Under increasing international (and local) pressure, some of the harsher realities of apartheid - like the Pass laws, and the prohibitions against "mixed" marriages - have been repealed. This is not to soften the fact, that for the most part, the face of apartheid has probably changed very little for Blacks, in the transition from the 70's to the 80's.

The study of apartheid is very often also a study of how human beings are forced, coerced and segregated into their identity as "Black" people. Whether a "Black" person equals a "White" person in any sense of the word is not at issue here; in South Africa Blacks experience discrimination directly and indirectly from birth to death, from health even to madness. Apartheid is thus a major constituting force in the determination of "Black subjectivity". While this study is not directed towards analysis of this process, it hopes to make clear that the present politics of health could only be built on a thoroughly ideological foundation - one which has arguably resulted in the Black person having "inherited" a negative sociological schema of his body, his rights, his expectations and

aspirations (Manganyi, 1978).

Apartheid consistently brings to fulfilment the representation of the Black person as being of less status, an "empty shell" who "looks with awe at the White power structure and accepts what he regards as the "inevitable position". . . his heart yearns for the comfort of White society and makes him blame himself for not having been educated enough to warrant the luxury. . ." (Biko, 1984, p.11) There appears to be an insidious pattern to much racial policy that would put the "blame" for one's condition on one's own individual aspirations - as if South African society placed no real limitations on rights and social freedom etc. This is no less true of the structure of health services in this country where the disadvantaged are treated not as they should be, but often as victims of their own individual, racial or community ignorance.

5.2.1 **Alcohol Abuse**

The sale of alcohol is regulated by laws referring to race. The Liquor Act of 1977 established "special authorities for the sale of liquor to Bantu, Coloured, or Asians". The Bantu Laws Amendment Act (No 4 of 1976), which amended the Bantu Beer Act of 1962, decreed that "in addition to general dealters, employers of more than 25 Africans over the age of 18 years who operate outside the area of jurisdiction of any local authority and who are authorised by the Minister to do so, may sell and supply packaged Bantu Beer or beer powder, provided that the beer or powder is acquired from a local authority or the Bantu Investment Corporation or the Xhosa Development Corporation" (SAIRR, Survey of Race Relations, 1976, pg.202).

In a report to a health conference in September 1978 it was estimated that alcoholism among Coloured people in the Western Cape had reached levels of 6-8%, and that in total (White and Coloured males) at least 22% of the men living in Cape Town and its environs drank excessively. Coloured farm labourers are in some areas of the Cape still paid with wine as part of their wages. Under the so-called "dop-system", workers are given a tin filled with locally made wine at various times of the day beginning at daybreak. Some farmers give out as much as eight to 12 "dops" daily per worker, plus two bottles to take home, thus ensuring their addiction and dependence (Seedat, 1984). Gillis has pointed out that "plain poverty and adverse social circumstances have a lot to do with it [alcoholism], for alcohol has a numbing and care diminishing effect which makes life more tolerable for those who have to struggle daily for the bare necessities of living." Facts suggest that this situation is actively exploited by an almost direct encouragement of alcohol abuse. According to Joyce Sikakane, the people of Soweto have:

> ". . .easy access to the incredible number of liquor stores, beerhalls and bar lounges strategically built near the railway stations and main street intersections. These liquor dens tell the sordid story of an oppressed people lulled into oblivion. To add insult to their dehumanisation, the liquor profits... are used by the Government to finance the development of the Bantustan wastelands."
> (Cited in UNESCO, 1981, pg.177)

The annual per capita consumption of alcohol among Whites themselves could be one of the highest in the western world; in 1977, total spending on liquor in South Africa amounted to R1 382 million - a figure just over that spent on the defence budget that year (Press Statement, Rand Daily Mail, 15

July, 1977). Facts like these are illustrative perhaps of the reciprocal nature of stress in the relations of domination under aparteid.

In 1978 it was estimated that as much as 14,5% of personal expenditure by urban Blacks went on alcohol. The scale of the problem was also noted by a visiting Assistant Professor at the School of Social Work at Arizona State University, who claimed that alcoholism among Blacks in South Africa was more critical than in any other place he had visited (Press Statement, Rand Daily Mail, 5 June, 1978; Seedat, 1984). More recently the Minister of Health, Dr van Niekerk claimed that the loss of productivity as a result of general alcohol abuse was reckoned at R530 million a year (Daily Dispatch, 19 April, 1988). Factors contributing to stress for Blacks under the apartheid system are the facts of job reservation or access to employment, the group areas regulations, forced removals, poor living conditions and poverty, to name just a few idignities and deprivations.

5.2.2 **Pensions**

In 1972 the average social pension for Blacks was reported to be about five Rands a month (Rand Daily Mail, 27 July, 1972). In a well publicised attempt to make visible the plight of Black pensioners at this time, the Reverend David Russell spent 5 months in Dimbaza (a "resettlement township" near King William's Town) tring to survive on the same pension amount. In a letter to the Press he wrote:

> "I wish to emphasise that these conditions of tearing hardship do not only involve the so-called 'unproductive units'. The situation is just as frustrating and harsh for the few able-bodied men 'lucky enough' to be working... for a casual labourer with a wife

> and only 4 children there is a mere R3,34 per month per person for living... the R5,00 per month I have been living on for the last 3 months leaves me significantly better off... Nevertheless I am feeling the strain. It is like serving a prison sentence - I hold on grimly, counting the days. My life revolves around my stomach! Human joy is shrivelling up: my capacity for giving out is shrinking..." (Mechanic, 1973, pg.38)

On October 14, 1972, the New York Times reported that the Reverend Russell was at the point of collapse and planning to end his ordeal. He was quoted as saying, "Trying to live of R5,00 a month has been long and dreary... I feel a great tiredness deep within me, I just do not know how Africans manage" (ibid, pp.38,39).

On the first day of October 1977, pensions were increased by R7 a month for Whites, R4 for Coloureds and Asians and R2 for Blacks. Maximum monthly pensions (and free income allowed) as of this date were as follows:

TABLE 5.2.2.

	Whites	Coloureds/Asians	Blacks
Social Pensions	R79,00	R42,50	R20,50
War Veterans	R90,20	R53,35	R23,10
Max. Free Income	R42,00	R21,00	R10,50

Number of persons in receipt of pensions in 1976 were:

Pension	Whites	Coloureds	Indians	Chinese	Blacks
Old Age	135 953	78 154	14 267	108	176 880
Blind	821	1 652	197	-	4 714
Disability	23 645	40 019	12 043	13	68 074
War Veterans	14 620	6 823	211	-	183

The average amount paid to pensioners in this year, by racial classification, were reported as follows:

Pension	Whites	Coloureds	Indians	Chinese	Blacks
Old Age	R900	R410,75	R420,24	R467	R198,54
Blind	R858	R414,06	R405,96	-	R196,86
Disability	R858	R403,70	R420,36	R466	R205,74
War Veterans	R996	R465,30	R477,48	-	R257,16

(Source: SAIRR, Survey of Race Relations in South Africa, 1977.)

5.2.3 <u>Forced Mass Uprooting</u>

The South African Institute of Race Relations (SAIRR) reported in 1983 that between 1960 and 1982 the following numbers of families had been forced to move home: Whites 2 285; Coloureds 81 958; Indians/Asians 39 485. For Black South Africans, the figure is in excess of three million (Dawes, 1985, pg.59; WHO Report, pg.7). Many continue to live under the threat of eviction (often at 24 hours notice). Dawes (1985) cites research which speaks forcibly of the stress of being uprooted and losing one's home in a land settled in for generations.

One anecdote cited by Dawes (1985) has a woman, referring to relocations and migrant status of parents stating that: ". . . children grow into vagrants respecting no place, since they have no place to respect, no identity, no history, nothing proud that hold them to anything. What kind of people can they make?" (pg.59). Despite this, Dr Koornhof (then Minister of Co-operation and Development) is on record as saying that removals are carried out with "compassion and respect for human dignity, after deep thought and careful consideration " (ibid).

5.2.4 **Forced Splitting of Families**

One of the effects of the homelands policy has been to perpetuate White political and economic supremacy through the creation of a mobile pool of destitute migratory labour. A detailed recent assessment of the effects of migrant labour on the rural periphery of South Africa has pointed out that "virtually every adult male in the Bantustans is faced with the contradiction that his absence is a condition of his family's survival. But his absence also undermines the conjugal stability from which his family derives its identity " (UNESCO, 1981, pg.169).

Rendered aliens in their own land and destined to spend most of their active lives as migrant workers in White areas, many Black men return to their families in the homelands only once or twice a year - a fact reflected in the bulge of the annual curve of births every September after the Christmas visit (Seedat, 1984; WHO, 1977).

In practically every society the family functions as a basic unit of socialization, support and stability. Anthropological literature concerning the consequences of migrant labour for family life suggests that the lengthy absence of husbands and fathers from their families generates economic insecurity, marital disharmony, material and emotional misery and problems relating to the socialization of children, sexual morality and legitimacy.

A UNESCO publication quotes the opinion of South African anthropologist H. Ngubane, who comments:

> "It is this prevailing insecurity and powerlessness, in the face of an overwhelming

> authority equipped with overwhelming force, exercising detailed control and surveillance and operating largely as a law unto itself, that makes the lot of Africans under apartheid so like that of inmates of a 'total institution'. Perhaps the most apt comparison is not so much with a mental hospital or even a prison, but with a concentration camp, for such an institution not uncommonly has the function of providing labour as well as facilitating control." (UNESCO, 1981, pg.172/3)

This description is lent graphic credibility through the words of Trudy Thomas of the University of Cape Town's community health department who has remarked that in the homelands:

> ". . .Society's norms are ab-norms. Most children grow up without their fathers, many without their mothers as well. Most are sub-optimally nurtured by stop-gap guardians seldom as competent or as motivated. Although their parents may have left them because they love them, the children experience them as absent and may misconstrue this as desertion. They grow up without a model of adults to relate to each other in a loyal, supportive and responsible way. It is predictable that the boys grow up to be deserting fathers, the girls unable to nurture their children." (Weekly Mail, 11-17 September, 1987)

Thomas (1987) has concluded that through the socio-economic conditions apartheid has foisted on the homelands (specifically migrant labour, enforced ruralisation and entrapping poverty) a very extensive psychosocial pathology has resulted to "dissolve the bonds of the community, dismember families, and deplete the physical and psychic resources of individuals." (pg.1).

5.2.5 <u>Enforced Inferior Status and De-Individuation</u>

Any list of apartheid legislation enforced since 1948 is sufficient to illustrate the oppressive climate of sustained degradation imposed upon Blacks. One example would be the abolition of Passes and Co-ordination of Documents Act of 1952 which obliged Blacks until recently to carry at all times (and produce on demand) a reference book with personal details and authorization of movements.

A more insidious implication of this Act concerns the administration of the Bantu (Urban Areas) Consolidation Act, 1945 and the Bantu Labour Act, 1964. Section 25 of the latter decrees that Blacks arrested for contraveining either the Urban Areas Act or the Abolition of Passes and Co-ordination of Documents Act may be referred to a "rehabilitation centre" - the description and purposes of which are covered by a Proclamation signed by the State President on 14 May, 1975 (Gazette, Vol 120, 6 June, 1975, no. 4735).

This Proclamation regulates the establishment and functioning of "institutions for the reception, treatment, training of persons committed thereto under the Urban Areas Consolidation Act (Act 25 of 1945), or the Bantu Labour Act (Act 67 of 1964) and of other persons transferred thereto under this Proclamation or under any other law " (ibid, pg.2).

The purposes for which persons are detained in "institutions" are defined in paragraph five:

> "The inmates of an institution shall be detained therein for the purpose of improving their

physical, mental and moral condition by:

> (a) retraining them in the habits of industry and work;
>
> (b) re-orienting them to the traditions, culture, customs and system of government of the national unit to which they belong;
>
> (c) generally cultivating them in the habits of social adaptation in the community and of good citizenship including the fostering of an awareness in regard to the observance of, and the necessity for, the laws of the country."

Furthermore, Section 29 of the Urban Areas Act states that any "authorized officer" may, without warrant, arrest a Black person outside the homelands if that officer has reason to believe that the person is an "idle or undesirable person" (WHO Report, 1977, pg.7).

For the Black person in South Africa it can be argued that many of the featuresof his social existence share the characteristics of life in "total institutions" (Ngubane, in Vogelman, 1986).

According to Goffman (1968):

> "Total institutions disrupt or defile precisely those actions which in civil society have the role of attesting to the actor and those in his world - that he is a person with adult self-determination, autonomy and freedom of action " (pg.47)

The pervasive insecurity and powerlessness in the face of a state prepared to exercise overwhelming force which defines and frames the lives of millions of Black people has been aptly described by Manganyi (1973). At every turn the individual has his view of himself as an independent agent undermined and thwarted:

> "In the life of the (urban) African, there is hardly any situation... in which his self-esteem is nourished. His wife and children may have been forced by conditions beyond his control to lose the modicum of respect which they may have for him as an effective, self-steering agent in his psycho-social environment... his subjective experience is one of being emasculated." (Manganyi, 1973, pg.5)

5.2.6 **Enforced Economic Deprivation and Poverty**

Discriminatory wage scales as well as ceilings imposed by law on occupational skills can result in frustration and lowered aspirations because of the disbelief in the possibility of personal development (WHO, 1977,pg.7). A complex network of laws sustains a hierarchical structure of discrimination, exploitation and deprivation apparent on almost every social index: wages, education and disease patterns.

The migrant labour system is based on the division of South Africa into two sectors: the so-called White areas which comprise some 87% of the land and include all the major industrial and mining centres, and the so-called Bantu homelands or Bantustans which comprise 13% of the land.

While seemingly providing the government with ideological ammunition for internationally political purposes, the homelands policy undeniably also serves the government well for the purpose of supplying a cheap labour reservoir as well as a number of handy places to hide embarrasing statistics. For instance, between 1975 and 1980, South Africa's annual rate of TB notifications fell dramatically from approximately 240 to 180 per 100 000 population - a seemingly impressive improvement that dissolves when you consider that this statistic, gleaned from the Annual Report of the Department of Health, Welfare and Pensions for 1980 (Annex 12), omits the

fact that the relevant figures for Transkei, Bophuthatswana and Venda are **all excluded from this statistic.** (This information is footnoted to the graph. In the Department's latest Report (1986) comparable figures are given but this time without footnotes concerning possible omissions (p.9). See also to this effect the article in Weekly Mail, 5-11 June, 1987, p.18).

This is a significant omission when 6% of the adult population of the Transkei alone have been said to suffer from open pulmonary TB, an extremely high percentage by any standards (Marks and Andersson, 1987, p.197).

More than 350 000 migrant Black workers were employed in South Africa in 1986, most from Lesotho and Mozambique. A further 707 807 workers from the "independent homelands" of Transkei, Bophuthatswana, Venda and Ciskei and 989 311 workers from the "non-independent homelands" worked in South Africa in the same period according to figures released by South Africa in the same period according to figures released by the National Manpower Commission and the Central Statistics Services. In all, 139 161 workers from the "independent homelands" and 367 456 workers from the "non-independent homelands" commute daily to areas within the Republic (Weekly Mail, 7-13 August, 1987).

This cycle of dependence ensures a cheap labour supply for the White areas while maintaining the ideological lie that the situation simply reflects some aspect of Black development. Through a complex system of pass laws and labour bureaux the state ensures that there is a "delicate balance in the distribution of the African population. Those who are needed stay where they are needed, those who are not stay in the reserves... "(UNESCO, 1981, p.71).

The following list of figures serve to illustrate the basic and entrenched economic distinctions between South Africa's racial groups.

Table 5.2.6

(a) Average earnings (Rand) for the year 1980 (non-agricultural sectors, excluding private services of legal practitioners and earnings in kind):

White	7 627
Coloured	2 468
Asian	3 280
African	1 831

(b) Monthly Wages (in Rands):

	Mining (1979)	**Retail**	**and Wholesale Trade** (1980)
White	880	331	732
Coloured	384	158	262
Asian	432	227	367
African	146	112	201

	Manufacturing (July 1980)	**Construction (July 1980)**
White	979	937
Coloured	273	289
Asian	307	459
African	237	192

	Public Authorities	**Central & Provincial (July 1980)**
White	664	605
Coloured	255	239
Asian	592	487
African	210	158

(Source: SAIRR, Survey of Race Relations, 1979, pg.71)

5.2.7 <u>Denial of Means of Self Expression and Coping with Stress</u>

To date, the need for research into the prevalence of stress-related illness, both psychological and physical, in people affected by apartheid

laws does not appear to have been met (Dawes, 1985). This should not mean however, that the mental well-being of South Africans cannot somehow be recognized as being severely compromised by apartheid. As Dawes (1985) remarks, to argue such is similar to suggesting that "because we do not have stress data on concentration camp victims in the Boer War this experience was not psychologically destructive. The events speak for themselves, the anecdotes are real..." (pg.58).

Blacks are deprived of most of the mechanisms normally employed to cope with situations of frustration, tension and stress. Political and social activity is severely restricted through a variety of repressive laws. One victim of Dr Koornhof's "compassion and careful consideration" commented on the feelings of powerlessness resulting from removals: "One can't fight the government we just get suffering. But we can't say anything. If you talk the truth the government will punish you" (ibid, p. 59).

Lambley (1984) recounts the experience of a middle-aged nursing sister who suffered from migraine. During the course of therapy it transpired that for years she had daily experienced a certain type and level of relationship with White people - doctors, nurses and the hospital staff with whom she came into contact. This involved adopting a certain protective mode of behaviour to help shield and cushion her from being hurt. She had got used to protecting her dignity by being cold and hard and aloof from Whites - without though, being either insubordinate or hostile. "Anyone, if they're White can order you around. Nobody cares and nobody protects you. You don't exist." Exposure to the therapeutic process though, had enlightened her to a form of interaction (i.e. "normal" interest and "normal" politeness) that she had hitherto never experienced. Having no referent, the realization had

been like a traumatic injury: "I have'nt been able to work properly. I weep all the time. My husband complains that I'm bitchy now, and hard. I can't cope. You've made me worse and I have to stop" (Lambley, 1985, pp. 69,70).

> ". . . a Black person, in dealings with Whites in general and White authorities in particular, has to deal often with persons who regard and treat him as an inferior. . . attempts by a therapist to improve a Black perons' assertiveness, sense of identity, or ego are frequently made absurd in the South African context because such behaviour leads, if acted out in the 'real world', to very definite 'negative reinforcement'". (Lambley and Cooper, 1975 in UNESCO, 1981, pg.247)

Vitus, however, dubiously informs us that "whereas there is little evidence of difference in the incidence of psychosis among different population groups, the incidence of neurosis is higher among Whites and Coloureds in South Africa than among Africans and Indians." (And with misguided understatement concludes that among Coloureds this fact can be attributed to the "insecurity and frustration experiences in trying to maintain a certain way of life without possessing the means" (Race Relations news, May 1976, p.4).

At a recent symposium on violence organized by the Institute of Clinical Psychology - the Deputy Minister of Health, Dr M H Veldman remarked (with the usual understatement) that the government now admitted that "some . . . violence in South Africa is due to frustration which a large majority of the population experiences because their expectations ere not satisfied" (Cape Times, 5 August, 1988). This point brings us to another aspect of apartheid - the so-called cultural double-bind Blacks are pre-destined to struggle against.

5.2.8 **A Cultural "Double-Bind" Situation**

Some confusion of official opinion appears to exist regarding the cultural heritage of Black South Africans. One relatively recent government publication stated with pride:

> "Gradually. . . the Bantu have been weaned away from their centuries old superstitions and belief in witch-doctors; and it can be stated that in South Africa today, the battle is all but won."

This report emanates from a Department of Information pamphlet published in 1979 (UNESCO, November 1981, p.247). The opinion is typical of many which reflect a certain paternal pride at having "dragged" the Black man reluctantly into the 20th century. Yet the homelands policy of creating social and cultural tribal divisions appears to be one of "re-orientating them [Blacks] to the traditions, culture, custom and system of government of the national unit to which they belong" (Proclamation on Rehabilitation Institutions, 1975, para.5, - Appendix B).

The influence of racist sterotypes in official mental health policy is widely evident. In a letter to the editor of Psychiatric News, (the spokespiece of the American Psychiatric Association) Dr A M Lamont, Commissioner for Mental Health in South Africa between 1961 and 1970 protested against the conclusions of the APA Committee's Report on Mental Health Services in South Africa. Denying the implication that the politics of apartheid had anything to do with the conditions for Black psychiatric patients in this country, Lamont attributed the "problems" to the fact that "social conditions in all industrial revolutions are always ugly. . ."

In the same letter, Lamont goes on to proclaim that:

> "In South Africa the entrepreneurs are White and the labour force Black. . . moving from one group to the other is difficult. In the USA, your labour force during the Industrial Revolution were White immigrants who could merge with their employers as education and opportunities came their way. The indigenous population (American Indians) did not participate in the industrialization by providing a migrant labour force with a different colour and type of hair as well as basically different cultural attitudes. The type of hair is important in determining the type of offspring coming from interbreeding. In South Africa, people of mixed ethnic origins provide special social problems and are phsycially conspicuous. They have a high alcoholism rate which makes them an unreliable labour force. . . Next one must take into account the enormously high birth rate of the Blacks. . . the problem facing the Black female is that as her male counterpart increases his earning capacity so does his polygamous propensity increase. . ."
> (Lamont, 1979)

It's not always difficult to see why South African Health Services appear to struggle sometimes with their credibility internationally. Lamont gives a good example of the kind of thing Frantz Fanon wrote about when he remarked:

> ". . .It is not possible to enslave men without logically making them inferior through and through. Racism is the emotional, affective, sometimes intellectual expression of this inferiorization."
> (UNESCO, 1981, pg.248)

The utility of racism for those with a vested political interest in its maintenance lies in the fact that, once accepted, the realities of the world become less complex; the status quo is less threatened, social inequalities

become "naturalised". History furthermore becomes "re-written" according to a perspective that least challenges the political status quo. To paraphrase the words of HG Wells: he who controls the past, controls the present.

5.9 Conclusion: The Politics of Apartheid

As mentioned at the beginning of this chapter, the categories of psycho-social stress examined here are not intended to be an exhaustive catalogue of all the social sins perpetrated in the name of racial segregation. What has been attempted here, is to briefly sketch what UNESCO is fond of referring to as the "climate" of apartheid. It is clear that for many, this has, and continues to be, a climate generally at odds with the aspirations common to most levels of the population.

Mathews (1987) believes that the vast body of security laws in South African legislation had already put this country into a state of permanent emergency before June 12, 1986, the date of the onset of the third of South Africa's enforced emergencies. (April 1960 saw the declaration of the first Emergency. It lasted approximately five months. Twenty-five years later another Emergency was proclaimed in July 1985 which lasted until 7 March, 1986. This was rapidly followed by a "new" emergency declared on 12 June, 1986. This Emergency is still in operation at time of writing.)

According to Mathews, the current Emergency serves in many respects to camouflage the fact that security laws typical to Emergency rule have become a constitutionally normal part of South African life, both political and private. Describing the "mini-emergencies" law pushed through parliament (over the heads of protesting tri-cameral participants) Mathews predicts

that the Public Service Amendment Act - Act 67 of 1986 - (which allows micro- and macro-emergencies to be initiated) will soon become "the most commonly used weapon of oppression by the state alongside the Internal Securities Act" (Act 67 of 1986: Mathews, 1987, p.195).

This because the Act, "extended and rejuvenated" effectively frees the security authorities from "almost all legal controls and public accountability." This is of direct and ominous significance for the access of psychological and psychiatric professionals to, amongst others, detainees held under the Emergency regulations.

A committee of the South African Medical Association in its investigation of the medical care of prisoners and detainees established recently that lasting psychological damage was likely to be caused by the traumas of detention (Mathews, 1987, p.91). Thus it is surprising to read the Minister of National Health and Population Development, Dr W A van Niekerk claim that during 1985, 2 378 visits had been made by state doctors to persons detained under security legislation and of all these visits only 30 cases of depression were reported by these doctors! (SAIRR, 1986, p.450). One of the reasons so few detainees were reported as being depressed is perhaps due to that peculiar species of racial diagnostics, so well articulated by Minister Le Grange when he said in April 1986 that of the 40 detainees hospitalized in the previous year, a certain (unspecified) amount suffered from "Black neurosis/hysteria" (ibid, pg.450).

The politics of apartheid have resulted in a situation whereby psychologists both in the fields of clinical practice and research find themselves

increasingly (and severely) compromised by state legislation. This decrees that any social contribution likely to be made by these people is only likely to be made under conditions of extreme duress - if at all. If this is so at present, and continues to be the case, the kinds of psychosocial stresses suffered by deprived communities in South Africa will no doubt continue relatively unabated. It is thus precisely this political situation which needs to be evaluated - not only to address the situation which members of the psychological and psychiatric services are presently facing, but also to assess the current events vis-a-viz., the state's apparent intentions as regards health policy in general. For this purpose, I now turn to an examination of the state's responses to Health Care, following the events of the 1970's.

CHAPTER SIX

Critical Evaluation: State Responses following the Reports by the World Health Organisation and the American Psychiatric Association

"Our country today, due to progress in the fields of medical technology and knowledge, is a world leader! . . . In the social welfare field, the Nationalist Party has never shirked its responsibility!"
President P W Botha, 22 May, 1988.
(Crisis News, June/July, 1988)

6.1 Introduction: The Mental Health Amendment Act

According to a report in Race Relations News (May, 1975) the Department of Health, due to the "adverse press publicity overseas" had seen that the conditions at the Smith, Mitchell institutions had "improved considerably" and Industrial therapy (unspecified) and "training" became available at these institutions on a limited scale.

It was my impression from a visit to one of these institutions, the Kirkwood Sanatorium, that therepeutic programs have now been extensively and successfully, applied. In conversation with the superintendent of the institution, it was explained that a comprehensive system of active therapy had been in use for some years whereby the majority of patients would be kept busy at various times of the day occupied with tasks ranging from simple calisthenics, to co-ordination maintaining ball games, to mat weaving. Ethnic dance was also incorporated where possible. A disarmingly pragmatic purpose seemed to underly these events - it was the superintendent's opinion that considering most of his "patients" stay in his facility was a life-long one, the better their cognitive and motor functions, the easier they were to look after. (It must be remembered that most of Smith, Mitchell's patients are either epileptic, severely brain-retarded, or chronically psychotic - Race Relations News, May 1976; Solomon, 1978.)

Parliamentary debates on the issue of mental health services took a sudden upswing in the early months of 1976 with many sensitive questions being raised. While a certain amount of racial paternalism is evident in some of these speeches, it is clear that a new significance was being attached to

the care of the mentally-ill. According to one report, patients were being taught to sew and repair clothes, recognize the value of money ("To us they may be everyday things, but to a person who has never known how to use money, it is a great step forward") and learn the addresses of their homes in case they "got lost" (Debates, 19 February, 1976, p.1566). It is fair to say perhaps, that a lot of sentiments expressed at this time were sincere, if misguided. While the repressive Amendment Act was passed despite protest in certain more liberal quarters, it appears that, in the minds of certain members of parliament at least, the "protection" of mental health patients became of paramount importance.

Assented to on the 22 March, 1976, the Amendment Act (as it is known) is directed towards anyone who:

> ". . .publishes, or causes to be published in any manner whatsoever any false information concerning the detention, treatment, behaviour or experience in an institution of any patient or any person who was a patient, or concerning the administration of any institution, knowing the same to be false, or without taking reasonable steps to verify such information (the onus of proving that reasonable steps were taken to verify such information being upon the accused), shall be guilty of an offence and liable on conviction to a fine not exceeding one thousand rand or to imprisonment for a period not exceeding one year or to such imprisonment without the option of a fine, or to both such fine and such imprisonment." (Government Gazette, 1976, no.5074)

This law, like the Prisons Act of 1959, is still actively excercised: research requiring visits to mental insititutions has to be cleared with, and permission granted by, the Director General of the Department of National Health and Population Development.

The controversy over the act centres around the reasons given for its tabulation. The Act deals, in the main, with the supposed "rights" of mental patients: one clause facilitates approach to the judge in chambers to look after a state-detained patient. The patient, through the curator **ad litem**, can be looked after and his case can be heard if an application is made for his case to be re-heard (Amendment of Section 29 of Act 18 of 1973). The second part of the Act deals with the "protection" of the mentally-ill hospital patient, or more specifically his right to non-interference. (Section 66A -Appendix A.)

This part of the Act virtually imposes a ban on information and public debate about health services in South Africa. Furthermore, it incriminates individuals divulging "false information" and denies offenders (having to prove that "reasonable steps were taken to verify such information") access to the usual methods of legal defence by prohibiting the taking of photographs and sketches of psychiatric institutions and patients. As the World Health Organisation Report points out, the unusual nature of this Act inevitably raises the question of why such a law was passed and why the need is felt by the government to conceal the workings of the mental health services from the South African public and the international community.

It is disturbing to note in the House of Assembly debates that preceded the passing of the Amendment Act, the rigid ideological thought of the Members who encouraged its acceptance. A certain Dr JJ Viljoen went as far as to ridicule those members opposing the Bill as constituting a "direct affront to decently educated, learned people who are decent Christians" (Debates, 19 February, 1976, p.1581). Mrs Helen Suzman (MP for Houghton) accurately

assessed the likely effects of the Amendment when she emphasised that:

> ". . .because the amending Bill lays a very heavy burden on the Press to try and ascertain the truth of the situation, and where it is impossible for them to get positive proof, the onus is on them to show that they have obtained the correct information. From now on no abuses are likely to be exposed by the Press." (Debates, 3 March, 1976, pg.2404)

Describing the Prisons Act of 1959 which imposes virtually identical restrictions on publications and research, Savage (1981) remarks that, "the practical effects of the Act. . . is that it is now impossible either to publish any adverse information . . . or any probing analyses of conditions within them without immediately running the risk of prosecution" (Savage, 1981, p.54). This is in fact a highly likely result considering that after the case of the **Department of Prisons vs The Rand Daily Mail** where the Newspaper suffered heavy losses as far as fighting their case was concerned, articles about conditions in Prisons and about prisoners themselves ceased virtually altogether (Debates, 3 March, 1976, p.2405). Yet members of the government continued to voice their assurances that they were "not afraid of criticism" - a controversial point considering the fact that prior to the passing of the Amendment Act, the state and individuals had at their disposal both civil and criminal remedies to prevent the publication of false and or libellous articles. In the event of the latter being taken to have occurred, the disadvantaged persons involved could sue for damages under the ordinary law of libel (Debates, 19 February, 1976, p.1603). The reasonable assumption to make then about the Amendment Act is that only the first clause (which concerns the access of mental patients to legal resources) has any application; the second (which ostensibly protects the mental patient's right to non-interference by members of the press) only

serves to act as a deterrent on the publication of any articles (or studies) concerning South Africa's mental health services.

Legal restrictions like there, are as Savage (1981) points out, a double-edged sword of censorship which obliges journalists and social science researchers to be critically self-suppressive with regards certain areas of study.

However, in 1976 there were reasons evident to suggest that the furore raised by the press (and the unwelcome atteniton it focussed on the Department of Health) already made certain questions about health policy inevitable. By 1978 it was already clear that the government was having second thoughts over the viability of continued reliance on Smith, Mitchell and Company. With Department of health plans in the pipeline to rebuid and upgrade existing Black psychiatric hospitals (Solomon, 1978), the Minister of Health was reported as stating that it was his department's policy to phase out mental institutions run by private organizations" (Survey of Race Relations, 1980, p.562). To this end the Treasury has approved additional funds to expedite the construction during the 1979 to 1984 period of the following institutions: Soweto - 100 beds; Pretoria - 600 beds (additional); Queenstown - 90 beds (additional); Bloemfontein - 700 beds; Port Elizabeth - 1 080 beds (SAIRR, 1981, p.562).

More significantly a change in the shape of Department of Health policy soon became apparent. Whether in response to the events of 1974 to 1977 or in reflection to a genuine evolvement of health policy, it is difficult to say what initiated the reform process. (I shall argue that this has been an

essentially **cosmetic** process) that began towards the end of the decade. Certainly, as has been argued by several authors, these reforms in National Health policy served to achieve little but camouflage more resilient ideological notions. The so-called "Facilities Plan" devised by the Department of National health is one such example of the "reform process" initiated towards the end of the decade.

6.2 The National Health Services Facilities Plan

In 1980, three years after the Health Act (1977) was passed, the Department of Health published the Health Services Facilities Plan. The plan consists of six levels and gives details of how certain "improvements" as specified in the Health Act - should take place. De Beer (1984) remarks that some observers predicted that these two documents promised "wide-randing change" for the better in the health services. In fact, the plan provides arguably very little in the way of constructive detail for the improvement of the health situation in South Africa, and the Health Act is little more than an attempt to streamline existing health facilities at the expense of those communities whose health needs are the greatest.

The close relationship between the material and the ideological role health care can perform was alluded to, though perhaps unwittingly, by the Superintendent of the Day Hospitals' Association in the Western Cape, J A Smith, who remarked:

> "We are here to discuss health and wealth. Health and wealth for the majority spells social peace. **Disease, discontent and poverty for the majority spells social unrest. . .** I believe the enlightened new Health Act can be

> a catlyst to bring about dramatic changes in the health of the people of this country, and to fight the enemy within, disease and discontent." (UNESCO, 1981, pg.212 - emphasis mine)

On the face of it, the health legislation prescribed in the Health Act and the Health Plan subscribes to the relatively enlighted ideas of community health programmes and preventative medicine. For instance, the Health Act establishes a National Health Policy Council, one of the task of which is taken to be "the promotion of the health of persons". Health education, curative and preventive services, and the "elimination of the causes of ill health" are specified. The Plan recognizes that: "everybody needs drinking water, food, a home and services to help with the disposal of sewage and waste to maintain a complete basic level of minimal health".

The philosophy adopted by the Plan largely echos the sentiments expressed by the members of the Commission of Inquiry into Private Hospitals appointed on the 24 October, 1972" (De Beer, 1984, p.31). Throught its investigation, the Commission was mindful of the following premises:

(1) Good health is not only a privilege but the right of each individual in society.
(2) It is the duty of the State to make provision for efficient health services.
(3) Health services should be available at a reasonable price and should not show any sign of profiteering.

However, De Beer (1984) reminds us that "health services should not be understood to be a rational response to ill-health. Their development is

governed by realities and policies that have almost nothing directly to do with the health needs of the people" (p.32).

Renaud (1978), writing on the role of the state in the provision of health services, has argued that:

> "The state cannot eliminate artificial opulence created by capitalism - it can only publicize the needs for dieting and exercising, and not for smoking or drinking alcohol. . . It cannot suppress industries because people die within them. It can only force workers to be more careful. . . In brief, the state cannot reorganize the economy and correlated life styles so as to really provide solutions to health needs".(p.115)

This is of course not the same as arguing that capitalism is the **cause**of disease and ill-health - at least not directly. Renaud considers rather the efficacy (to the State) of a certain ideology of health:

> ". . . the easiest way for the state to respond is to put the blame for bad health on the individual. And it can be done in many ways: by enforcing occupational health policies premised on the idea that most work-related problems are due to workers not being careful enough... by establishing publicity campaigns to encourage the public to diet, to exercise, to quit smoking, etc. . . . All these policies focus on individual at-risk behaviours and all have in common the **imputation of responsibility on the individual.**" (Renaud, 1978, p.115)

Referring to this process as the "germ theory of disease", Savage (1978) points out that "South Africa could purchase higher health levels for the Black population and could decide to close the gap between Black and White

health standards. However, to do this it would have to act on the recognition that the primary determinants of health and illness are social and political phenomena" (p.4). Deeply permeated by the structure of apartheid, the South African medical and mental health services serve to perpetuate the political status quo rather than challenge it, and at the same time ideologically mask the social reality of their operations by, amongst other means, placing the onus of responsibility for health on the individual and the community. This, in a country fractured by gross inequalities in the allocation of both specific medical resources and educational/employment opportunities, is blatantly unjust. Beneath the relatively enlightened rhetoric of the plan for instance, is revealed the reality of beauracratic ambiguity. On the subject of the provision of drinking water for rural communities, the Department of Health states:

> "The physical provision of clean and safe drinking water is the responsiblity of the Department of Agriculture and Fisheries".

Concerning food, the Department of Health states:

> ...the production of food is the responsibility of the of Agriculture and the private sector."

And similarly for sewage, housing and waste disposal. What then, the role of the Department of Health? In official thinking, it is **individuals** who should be responsible for their own health care. in the telling paternal words of one senior health official:

> "Health authorities must not be seen as an infinite resource of health facilities and medical care. More people should be able to make use of private health services as their economic circumstance improve. **Not only will this promote self-reliance because people will not receive free services, but these peoples' dependence on the state will also decrease.** People attach to that which costs money more than to that which is freely available."
> (De Beer, 1984, pg.40)

A Commission of Inquiry (into the provision of private hospital facilities) in 1972 while recognizing that the state "is primarily responsible for supplying efficient hospital facilities" argued that if the State's facilities were "inadequate" it was appropriate for "private enterprise. . . to attempt to supplement them" and indeed, where this occured "be entitled to a reasonable profit" (RSA Blue Books RP 80-91, 1974,p.2). Again following this line taken, the Guide to Health Act states quite clearly:

> "When referring to a comprehensive health service, it is essential to note that the role of private practitioners forms an integral part of a comprehensive health service. . . Every encouragement must be given to the private sector to contribute and expand its share in achieving a comprehensive health service. (De Beer, 1984, pg.40)

In essence, the community participation outlined by the Health Plan amounts to realistacally very little under apartheid legislation. De Beer (1984) cites the case of an attempt to establish a community health centre (the Senoane Clinic) in Soweto. The project collapsed despite official promises of support when it was found to be impossible to obtain proper co-ordination between the local authority and the provincial authority. It took apparently at one stage, a years' negotiation to get the city health and provincial

health officials to agree on so simple a matter as the sharing of dining room facilities.

One serviceable definition of Primary Health Care reads as follows:

> "Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part of the country's health system of which it is the nucleus and of the overall social and economic development of the community." (Crisis News, 22/23 July, 1988,p.4)

The third level of the Plan concerns Primary health Care (PHC) in three developments:

(1) Self-care and community responsibility (i.e. the implementation of voluntary organizations in an effective way).

(2) Community health nursing.

(3) Community Health Centres (CHC). These are to be used in preventive, promotive and rehabilative services at a rate of one examination room per two and a half to five thousand people. Facilities for TB, family planning, VD and immunisations will all be provided at the CHC's.

The guide to the Health Act carries the following carefully worded paragraph:

> "It is forseen that such a centre **could** be the venue for the meetings of health related

> voluntary organizations and there **might** be areas where a community representative advisory committee could participate in determining priorities - even assist in rendering services." (Guide to Health Act of 1977, pg.50 - emphasis added)

At the rate of one room per two and a half thousand to five thousand people, an area like Mitchell's Plain (approximate population 500 000 plus) should enjoy the facilities of well over 50 such rooms. In fact, as a recent report demonstrates, Mitchell's Plain has only 40 general pratitioners and a day hospital staffed by three doctors designed to cater for only 80 000 people (Weekend Argus, 13 June, 1987). In the same report, a general practitioner with over four years service in the community said patients requiring attention at the day hospital queued from 6 a.m.in the morning. The last patient accepted onto the daily quota was four hours later at 10 a.m. "In effect . . . primary health care in Mitchell's Plain is non-existent after 10 a.m." This in an area where 40% of the residents are unemployed and bordering it is the Black township Khayelitsha with an estimated population of at least 400 000 persons.

Department of Health plans at this stage included the building (over the following decade) of four hospitals, each providing 5 000 beds at a projected cost of R60 million. These hospitals, to be built for Black patients, were to be intended as expressly psychiatric facilities. Another psychiatric hospital, with a 2 500 bed capacity was envisaged being built at Mitchell's Plain near Cape Town for coloured patients (Rand Daily Mail, 27 June, 1977).

In 1981, the Survey of Race Relations for 1980 reported that a 2 400 bed hospital was being planned (for Coloureds only) at Mitchell's Plain (SAIRR, 1981, p.563).

Originally called the "Matroosfontein project", Department of Health plans in 1965 estimated construction costs to be R6.5 million. Solomon (1978) estimated that the final costs by completion date ±1985) would be in excess of R10 million (p.17).In fact, this facility has recently been completed - at an estimated cost of R18 million - and is not a psychiatric, but a **private** hospital.

Despite assurances by the manager of the hospital, that "some people" in Mitchell's Plain could afford to pay the necessary costs, the reality of the situation is that tuberculosis, gastroenteritis and malnutrition are rife in the area. These diseases, as the report makes clear, affect a lower social group who cannot afford private care, "let alone bus fares to the hospital".

Recent figures released reveal quite clearly that Blacks suffer both quantitatively and qualitatively from inferior health services:

TABLE 6.2

Provincial Hospitals.

REGION*	**HOSPITALS**	**BEDS**		
		White	Black	Total
Cape	89	5 743	11 407	17 150
Natal	26	2 401	9 655	12 056
Orange Free State	27	2 385	2 724	5 109
Transvaal	69	8 303	13 624	21 927
Total	211	18 832	37 410	56 242

Government Hospitals.

Leper, TB etc	31	7 939	13 702	21 641
Mental	38	2 376	6 229	8 605
Grand Total	280	29 147	57 341	86 488

* Provincial regions exclude the self governing national states and the independant homelands

Ratio of hospital beds to population

	Whites	Blacks	Total
Ratio	1:156	1:208	1:190

Private and Aided Hospitals.

	Hospitals	Beds		
		Private	Public	Total
Cape	106	2 711	3 175	5 886
Natal	32	933	3 106	4 039
Orange Free State	100	7 075	3 613	10 688
Total	251	10 961	10 348	21 309

Self-governing National states.

Region	Hospitals	Beds		
		Private	Public	Total
Gazankulu	7	-	2 260	2 260
Kangwane	3	-	1 018	1 018
Kwandebele	1	-	524	524
KwaZulu	30	1	9 612	9 613
Lebowa	15	4	4 748	4 752
Qwa Qwa	1	-	224	224
Total*	59	5	20 926	20 931

*Includes two other mental hospitals with 2 540 public beds

The 1985 census results indicate the following ratio of population to hospital beds for the self-governing national states:

Gazankulu	1:219
Kangwane	1:384
Kwandebele	1:449
KwaZulu	1:388
Lebowa	1:385
Qwa Qwa	1:807
Total	1:328

Independent States

	Hospitals	Beds		
		Private	Public	Total
Bophuthatswana	11	-	6 155	6 155
Ciskei	8	10	3 528	3 538
Transkei	33	2	7 739	7 741
Venda	5	-	1 777	1 777
Total	56	12	19 199	19 211

The last census results indicate the following ratio of population to hospital beds:

Region	Census Year	Beds:population
Bophuthatswana	1986	1:291
Ciskei	1980	1:191
Transkei	1985	1:368
Venda	1980	1:194
Total		1:295

(SA Barometer, Vol2, No.1, 29 January, 1988)

In the 1981 edition of the Survey of Race Relations, it is reported that the amount spent per patient per day in the "White" areas, is much less in hospitals for Blacks than those for Whites (p.405). For example, the figure given for Baragwanath Hospital (Soweto) is R37,24, and the figure for Johannesburg General is R101,95. A more recent report put the difference at

R46,60 (Baragwanath) and R185,50 (Johannesburg) for 1985 (Crisis News, June/July, 1988).

In the same report the Minister of Health, Welfare and Pensions is quoted as saying that a total of 17 700 beds were needed for the White population. This figure is based on a ratio of four beds per 1 000 population. he also said that a total of 51 220 beds were needed for the Coloured population (also on the basis of four beds per 1 000 population), a total of 38 415 for the Indian section of the population (three beds per 1 000), and a total of 25 610 for the Black group (two beds per 1 000).

It seems clear that the government, despite tentative reforms suggested, is not through its Department of Health, taking responsibility for providing the basic necessities of health despite talk of providing primary health care and comprehensive services continues, it seems, to orient its health care apparatus towards hospital-based curative services.

Hospital and other curative services are the most important single item of health expenditure. Of the total state expenditure on health in 1979 (approximately R1 382 million), R654 million went towards hospital services,

and R500 million towards private sector subsidy - both essentially curative services. In 1986/87, of the total state expenditure on health **and** "population development" (R1 825 million) only 3,6% is spent on family planning and "community development" (around 1% in 1979).

In a paper presented to a conference on the economics of health care in Southern Africa, Scheiner (1978) reported that state contributions to medical research in previous years, come to less than 1% of the public health expenditure and, of this proportion, less than a fifth could be related even remotely to nutrition, infectious diseases or primary curative or preventive care. This percentage lies now between 1% and 2% for 1986/87 (R26 million). Despite an emphasis of the word "community" in the Plan - **community** responsibility, **community** health nursing, CHC's etc., state expenditure over the last few years suggests that the government is committed to the maintenance of its **professional** health services, especially the hospitals for which the country has won international acclaim for their high standards of clinical expertise.

Why then, asks De Beer (1984), have a **new** Health Act and Health Plan at all? "Presumably the government and the Department of Health were not simply wasting time, money and paper. . ." (De Beer, 1984, p. 44). The reason is to be found in the essentially political nature of health and expenditure on health and resources in South Africa. The relatively minimal expenditure on primary community health programmes reflects a centralization of resources (hospitals) and effectively, a minority control over science and technology within South Africa. As Marks and Andersson (1987) have put it: "The allocation of health care resources, is a powerful legitimating tool, as much for the self-image of the rulers themselves as in their relationship to their subjects" (p.183). Health care, as one report has suggested, like the vote and numerous other privileges afforded to Whites, is "a kind of bounty offered in exchange for support" (UNESCO, 1981, p.222).

There is evidence to suggest that the state is under increasing pressure to deal appropriately (or at least more effectively) with the rapidly increasing health needs of its Black citizens. Doubt exists however, as to **whose** needs are given priority at the present time. Consider the case of a recent report to the Department of national Health by MASA (The Medical Association of Southern Africa).

In this report MASA warned that state medical services were "deteriorating rapidly" due to "unsatisfactory service conditions" - or more accurately, due to grossly inadequate doctors salaries, senior medical staff, and disparities in remuneration packages offered by various authorities. Nothing about community health needs is mentioned. Minister of National health, Dr W van Niekerk, clearly sensitive to these grievances, assured MASA that: "In spite of the current financial situation. . . [the] government is doing everything possible to create a better financial deal for doctors" (Cape Times, 18 August, 1987).

If MASA is correct in claiming that as many as 40% of posts at major hospitals are vacant (the reason given that a lack of financial and promotional incentives is failing to attract "career-oriented" doctors) then good reason exists to investigate how this state of affairs could take place in a country whose community health needs are on the increase, not vice-versa. The emphasis in attracting and training medical personnel focusses upon the "career" aspects of privatised medicine, little wonder government health policy is squeezed between (a) providing adequate services for a rapidly growing Black community; and (b) apppeasing medical professionals whose services are depended upon. That the latter group of people have a powerful say in the matter is perhaps reflected in the move made by the

government toward privatisation - an incredible situation as University of Cape Town's Dean of Medicine, Professor George Dall has observed, "...when 80% of the population can't afford it" (Argus, 11 October,1988).

6.3 Primary Health Care, or Privatisation?

One implication drawn from recent events is that the state is increasingly recognising the inadequacy of its provision of health care for Black South Africans and has resorted to the dubious efficacy of a privatisation system in the face of ideological and fiscal necessity. Two facts support this conclusion:

(1) The Department of National Health under Dr Willie van Niekerk is a bureaucratic monstrosity with Ministers of National Health and Population management, Ministers of Health in the Houses of Delegates and Representatives and Ministers of Health in KwaZulu. EAch of these ministries have their own direction, supportive staff and offices. While primary health care remains a serious priority for very many communities, the "burgeoning apartheid bureaucracy" makes this provision fiscally less and less realistic (Dr F Clarke, former MEC of Hospitals Services in Natal, Sunday Tribune, 5 April, 1987).

The present health care budget of R2,9 billion is split between a bewildering assortment of Departments despite National Health Director Coen Slabber's assurance that the government's National Health Plan (NHP) "strives towards rendering a co-ordinated, efficient and balanced health service by centralised policymaking. . ." (Financial Mail, 3 June, 1988).

The obstacles to such co-ordination are many: the National Health Policy Council has underneath it the various Regional Health Authorities (whose duties include liaison with the homelands), while the provincial authorities are overseen by the Co-ordinating Board of Provincial Administrators.(We are reminded of Michael Savage's estimation that apartheid costs the taxpayer 12 cents out of every rand.)

Clearly the government is concerned to reduce state spending on health services - the Browne Commission tabled in 1987 (apart from pointing out that in 1984 and 1985 only 12,7% of public expenditure went to the homelands where perhaps 40% of the population lives - Cape Times, 5 July, 1988), identified the main problems with state expenditure as excessive fragmentation of control over health services (Financial Mail, 3 June, 1988). Also mentioned was a lack of central policy direction, under-emphasis on preventive and primary care and over-emphasis on expensive secondary and tertiary services.

(2) The maintenance costs of South Africa's segregated "high-tech monster hospitals" are becoming increasingly enormous (Argus, 11 October, 1988). Dr JJ du Toit, Director of the Midland Medical Aid Society gave examples to the press of how, what he called a "toy-complex" escalated the cost of hospital treatment. He described how the cost of health care had increased 30 times since 1950 due to more than 60% of this expenditure being spent on procedures and medicines which have "no demonstrable health benefits."

> "Such is the monster of technology and its costs... in South Africa where we straddle First and Third world medicine... we should concentrate on the old-fashioned killing of mosquitoes and microbes, the eradication of inappropriate nutrition..." (Cape Times, 18 September, 1987)

The official attitude towards privatisation in the field of health has been ambiguous, ranging from negative (De Villiers Commission, 1974; APA Report, 1978; Financial Mail, 2 July, 1982) to more recently, relatively positive, in the latter case usually by citing the supposed virtues of a competitive, free-market approach. Andre Spier for instance, in a recent debate on the subject stated that: "If the state keeps on providing all health needs. . . then the poor stay poor forever. . . the big thing is to reverse the economic incentive. . ." (Frontline, July, 1987). For many communities who live below the breadline, this would be a big thing indeed. Too big certainly for simple fragmentary economics to turn around - while the government is busy "spreading the load" as Dr Aubrey Levin, Director of Mental Health at the Department of Health Services and Welfare claims, the status quoo is maintained and the political basis of ill-health remains unchallenged (Star, 25 March, 1987). Patricia McKay, Director of the Pinetown Child Welfare Society, stated recently: "Privatisation would be a disaster for deprived Black communities. . . apartheid would be entrenched and voluntary welfare organizations would collapse." She concludes that if basic social deprivation was remedied the privatisation of welfare serves would not be necessary (Sunday Tribune, 15 March, 1987).

The whole question of necessity is interesting (and rather ironic) in the light of evidence originally furnished by a report commisioned by the Representative Association of Private Hospitals (RAPH). Written by Professor Jan Hughes (and back by the financial analyses of two independent firms of auditors), the report concluded that the "private hospital industry operating as it does under the prevailing constraints is a dying industry"

(Financial Mail, 2 July, 1982).

This report also echoes the findings made by the report of the De Villiers Commisson of Inquiry into Private Hospitals in 1974 (RSA Blue Books, RP 80-91, 1974). By that stage, mention was already made of the desire to "ultimately phase out private hospitals from the health care scene altogether" (p.19). The report also made clear that health care is a "human right" and the primary responsibility of the State". The RAPH Report warned also that if the government "continued on its present course they will definitely achive the aims of the [De Villiers] Commission's report [and] phase out the role of private hospitals in the health care field. . ." (Financial Mail, 2 July, 1982).

While the aims of the RAPH Report were to primarily examine the cost-optimisation aspects of health-care in South Africa, the political implications of the Report's findings cannot be ignored. The RAPH Report shows that private hospital services generally operated at a loss in the three years between 1977 and 1979, the period examined. These losses were covered by profits on medicine dispensing - one factor believed by the Report to have contributed to the "profiteering" image of private hospitals.

It is all the more surprising then to read of plans for a private medical-care service to be opened presently on the border between Alexandra and Johannesburg's northern industrial area (Pretoria News, 2 October, 1987). Furthermore plans for other such clinics - an estimated number of at least six - are being developed for other areas of the country where there is a "concentration of industries and people." Perhaps not coincidentally one of

the directors of the company involved, Community Clinics, is reportedly former director of Smith, Mitchell, mr David Tabatznik.

Clearly, as the above development shows, there is a large (and marketable) gap between those people supported by medical care insurance on the one side and those who depend totally on the state on the other. Into this gap fall a predominantly large proportion of urban Blacks (industrial and domestic workers) - a population which, no less than the urban Whites who may avail themsevels of the provincial services at a subsidized rate, deserves appropriate community focus. That institutions such as Smith, Mitchell and Community Clinics actually continue to operate, and profitably at that, in spite of expectations concluded by two recent reports, suggests that the state in some sense either actively encourages their development, or at the very least passively allows them to step into the breach left by Department of Health policy.

As the government moves swiftly towards privatisation quality health care is certainly becoming beyond the reach of millions of people. Several recent editorials have argued the position that privatisation is hardly the solution to health care (both mental and otherwise) in a Third World climate (Post, 1 October, 1988; Sunday Tribune, 9 October, 1988). In the recent "wave" of new hospitals being opened, very rarely does one find evidence that might contradict the theory that the government is only paying lip-service to the ideals of community health. Where new hospitals are not found to be private, other bureaucratic problems exist - for instance the Lenasia South Provincial Hospital, completed two years ago for R7 million, stands unopened for apparent lack of funds (estimated at R3 million a year). The community has waited 30 years for such a facility. Although the hopsital is

intended for people of all races, it is a 72 bed hospital; by any account an extremely inadequate size for the Lenasia, Ennerdale and Grasmere communities (Indicator, 26-29 February, 1988; Argus, 24 March, 1988).

Where so-called Community Clinics are built they often also stand unused. The Mofolo South Clinic (one of 12 centres intended to service a community of 2 million people) completed at a cost of R4.3 million remains empty also for an apparent lack of funds. The clinic is run by the Transvaal Provincial Administration, which according to reports, has had the money to spend on very exclusive "high-tec" medical equipment. (Sunday Tribune, 9 October, 1988) Clearly, the "money-crisis" Transvaal hospitals face (Star, 22 August, 1988) is only one aspect of a multitude of problems facing the Department of health. Whether or not privatisation will provide an efficacious economic solution to present difficulties is an issue the present (and as yet unconcluded) De Villiers Commission is to report to the government on. The question of privatisation forms a key part of the Commission's brief. (Financial Mail, 13 May, 1988).

However, unless the process of privatisation follows the "normal" democratic process of a free-market economy (i.e. one unencumbered by overt state manipulation through its segregation policies), it is doubtful whether the privatisation of health services will cut down on bureaucracy and the costs that go with it.

According to one analysis, the "American experiment" provides an important insight into privatisation. Under this system, the size of the bureaucracy in the US Health Services increased by 171% in the space of 12 years between

1970 and 1983. By comparison, the number of personnel directly involved in administering health care increased by only 53%: this system of "fee-for-service" (already becoming a reality for both Whites and Blacks in South Africa) has appareently failed to make health care more accessible to those citizens trapped in a cycle of ill-health and poverty (New Nation, 25 July, 1988).

Nevertheless, the state has embarked on a wide-spreading policy of privatisation, with not only major hospitals (for "hospitals" read heachache) like Groote Schurr, Baragwanath and Johannesburg General "up for sale", but also other domains of civil service (Financial Mail, 13 May, 1988). It does seem however, that privatisation of state health will follow procedures already explored with Smith, Mitchell. Several reports suggest that the government considers the Smith, Mitchell contract to be a "great success" - large sections of health care, including care for Tb patients, geriatrics and Smith, Mitchell mental patients have already been "contracted out" by the state. This care already comprises some 16 000 beds (Financial Mail, 13 May, 1988; 3 June, 1988).

One positive aspect of privatisation (and there may be many) is that the current trend in private hospitals does appear to be towards racial integration. Of the 672 hospitals in South Africa, 250 are estimated at present to be private (Star, 12 April, 1988).

Although the government maintains segregation in state hospitals, the Verwoerdian ideal of complete racial separation is under definite siege. Yet, current statistics on health care for Blacks reveal discriminatory practices as entrenched as ever (for example: "Health Care for Blacks

Declining", **Sowetan**, 25 April, 1988; "More Mental Care Needed", Natal **Witness**, 8 July, 1988; "Psychiatric Care for Blacks condemned as 'hopelessly inadequate'" **Natal Witness**, 1 July, 1988 etc. etc.) The Minister of Health, Dr van Niekerk for one, still defends hospital segregation in general on the grounds that "patients like to be with their own kind" (Star, 12 April, 1988).

If there is even some substance of truth in press allegations of discrepancies in health care for Blacks, and mental health facilities for Black communities continue to remain inadequate, then the issue of privatisation has to be examined in a political, as well as economic light. While the government appears to be concerned about pacing its process of reform, the policy of privatisation has to be seen as a convenient means by which controversial (and costly) problems no longer become those of the state. Furthermore, it reinforces the ideology that not only are communities themselves responsible for their own health care (a preposterous notion under prevailing political conditions) but that if things go wrong, the so-called "independent" health authorities can be blamed. Real control still only lies in the hands of the government.

While the process of reform is likely to continue under increasing pressure from abroad and from South Africa's own population, and the road to privatisation is also likely to become increasingly well travelled, the present political implementation of the new constitution with its tri-cameral components is destined to be with us for some time still. De Beer's opinion on the matter is that the government has, "finally split the atom into its tiniest component parts as far as health is concerned.

Fragmentation has been taken to a point beyond which it cannot go without defying the laws of logic" (Crisis News, June/July, 1988).

Thus, as far as the field of Mental Health is concerned, (and there is little reason to argue that this aspect of health is, politically speaking, any different from the other) it could reasonably be predicted that the Smith, Mitchell prototype - especially considering developments in other fields of privatisation - is going to be extended. But extended only as far as the government is likely to regard its own responsibilities in the area. The dominant ideology continues to be one of "community focus" - or in plainer language, the impetus appears to be one of getting communities to look after their own ill. Therefore (and recent developments reported in the press bare this out) the government acts to appease its present responsibilities by sanctioning the construction of hospitals and clinics for needy communities, but decrees that large proportions of these centres be private. This process has no doubt been obviated through fiscal necessity; in 1984/85 only 12,7% of a relatively small- R3.2 billion - health budget was allocated to the 42,7% of the population living in the homelands. This mis-provision has been exacerbated by the fact that only 2,2% of the total health budget was directed to preventative programmes (Crisis News, June/July, 1988). Whichever way the situation is examined, Black communities continue to suffer; they cannot afford the fees very often of private hospitals, and a great many of those facilities built that are not private, stand unused for lack of funds (Star, 22 August, 1988; City Press, 12 June, 1988; Business Day, 19 August, 1988; Sunday Tribune, 18 August, 1988; Argus, 11 October, 1988).

The government then can either decide to allocate more of its budget to

health care in order to pump money into those facilities which require it, or it can decide to shift its emphasis of allocation and spend less on curative medicine. Considering that the latter aspect is particularly relevant to White demands on health care, the government is more likely to continue the way it is at present and look for ways in which the private sector can be obliged to shoulder some of the responsibility.

I would argue that the immediate future of health care in South Africa, is particularly tied to the political fate of the present government: the process of reform (and the closely linked financial future of the country) will determine much of the direction taken.

For the present however, it has to be argued that the government, at least as far as mental health care is concerned, has survived the earlier combined critical onslaughts of the WHO and APA. If this were not the case, privtisation in health would possibly not be as enthusiastically considered. The government apears to have concluded that the Smith, Mitchell "experiment" has, in the balance of things, endured well. This will probably mean that Black mental health care will continue to be divided between the overcrowded state facilities, the under-budgeted community clinics and the Smith, Mitchell institutions - certainly to the detriment of those in need, until such time as an appropriately budgeted and co-ordinated system of health care can be realistically envisaged.

CHAPTER SEVEN

CONCLUDING REMARKS

> The test of a free society...lies not in the independence and unplanned, unregimented freedom of its rich and powerful members, but in the scope and privilege reserved to and possessed by its weakest elements, those who are under the greatest pressure to surrender their independence.
>
> DELAFIELD SMITH, 1964.
> (Leifer, 1967, p.53)

7.1 Comments on the focus of this study.

While my own, and admittedly limited, experience of the running of Smith,Mitchell institutions has been guardedly favourable, the general status of health care provided by the company is an issue impossible to comment upon in the absence of literature, or research on the situation. Yet this lack of data (not only by virtue of it's non-availability) has not meant that a critical interpretation of where history appears to be leading the health, and mental health industry, is impossible. Social and legislative conditions being what they are, I have attempted to demonstrate the efficacy and significance of interpreting political events by means of accessing information as it comes to be relayed primarily through the press, but also though other sources such as documents produced by the government printers.

While many of my conclusions are of necessity tentative, the scope of this study has determined that they at least reflect in many ways what **kind** of conclusions are at present likely to be drawn. One additional comment though, that I could make as regards the politics of health in South Africa at present, is that if the frequency of reports in the press covering a particular theme is of any significance, then it could reliably be argued that "critical consciousness" concerning the Health Services is certainly on the increase - in recent times (from about 1986/1987) articles in the press about alledged injustices in medical and psychiatric practice appear to be increasingly common.

Apart from an obvious exercise in criticism, this study is also in part an

illumination of the short and blunted history of political critique with egard to psychology and health in South Africa. As any researcher knows, good (and accessible) criticism facilitates quality research. In most academic fields (with the exception,sometimes notable, of journalism) very few precedents have been set in contextual socio-political critique, certainly **too** few...

7.2. Limitations of this study

The constitutional tenets of the World Health Organisation with regard to general health care include the following;

1) Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

2) The enjoyment of the highest attainment of standard good health is one of the fundamental rights of every human being without distinction or race, religion, political belief, economic or social condition.

3) The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of indivudals and states.

4) The achievement of any State in the promotion and protection of health is of value to all.

5) Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

6) The exension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

7) Governments have a responsibllity for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures. (UNESCO, 1981, pp. 253 - 288)

Both the WHO and the APA reports instituted serious claims against any possiblity that the South African Health Services could be said to meet the conditions listed above. To fully evaluate both these criteria, and the extensive criticisms levelled by WHO and APA reports would require I believe, nothing less than the kind of research attempted by the APA committee - all the members of which (Allan Stone, Charles Pinderhughes, Jeanne Spurlock and Jack Weinberg) were accredited and psychiatrically exprienced spokespersons in the medical field. As this would be beyond the limitations set by both legislation and other factors pertaining to my own situation (geographical, financial and academic), an approach largely following that taken in the WHO report has been adopted here. That is, an evaluation of the standards and political vicissitudes of mental health care for Blacks has been approached in terms of the available literature on the subject. Effectively, this means not so much an examination of relevant research (very little exists) but an examination of press reports, articles in critical journals and government reports on the subject of health, and mental health policy.

While in complete sympathy with Anthony Mathews (1987) on the subject of the

nature of South African legislative history, it is not my intention to appologise for the style adopted in this study. Nevertheless, in reference to some of the historical documents referenced, the press reports and the legislation examined, the following recent words of his are particularly compelling. In his book **Freedom, State Security and the Rule of Law** he writes:

> The horrendous nature of much of the material examined has meant that critical comments have forced their way to the surface from time to time...these aberrations from the intended style seem excusable in relation to a body of laws that could be introduced to the reader with Dante's ominous words: "All hope abandon, ye who enter here."(p.190)

There is, it could realistically be argued, a great deal to be negative, even fearful about. Yet, as events have revealed, the South African government does appear to be moving toward a process of increasing reform - even if that process is linked at the present time, to privatisation. Privatisation in the field of health has only been pursued, I have argued, in contradiction to the principles of community health care, precisely because Department of Health rhetoric on this subject has very little real impact on a society defined by the political and economic ideals of racial segregation. Whether the ideals of Community Health will ever be implemented in South Africa is an issue best left perhaps, in these volatile times, to careful speculation.

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APPENDICES

APPENDIX A

ACT

To amend the Mental Health Act, 1973, so as to delete certain provisions which have lapsed; to further regulate the discharge of State President's decision patients; and to prohibit sketches and photographs and the publication of information concerning patients and institutions in certain circumstances.

(*Afrikaans text signed by the State President.*)
(*Assented to* 22 *March* 1976.)

BE IT ENACTED by the State President, the Senate and the House of Assembly of the Republic of South Africa, as follows:—

Amendment of section 29 of Act 18 of 1973.

1. Section 29 of the Mental Health Act, 1973, is hereby amended by the substitution for paragraph (*a*) of subsection (1) of the following paragraph:

"(*a*) Where any person is with reference to a charge of murder or culpable homicide or a charge involving serious violence, detained as a President's patient under the provisions of section 27, 28 or 29 of the Mental Disorders Act, 1916 (Act No. 38 of 1916), a judge in chambers may at any time after the order of detention, on written application being made to him by the official *curator ad litem* for a recommendation to the State President that such person be discharged either absolutely or conditionally or that he cease to be treated as a President's patient, make such recommendation as he may think fit.".

Insertion of section 66A in Act 18 of 1973.

2. The following section is hereby inserted in the Mental Health Act, 1973, after section 66:

"Prohibition of sketches and photographs and of publication thereof and of false information.

66A. Any person—

(*a*) not being a member of the Newspaper Press Union of South Africa, who, without the authority in writing of the Secretary—

(i) sketches or photographs or causes to be sketched or photographed any institution, portion of an institution, patient or group of patients, whether within or outside any institution; or

(ii) publishes or causes to be published in any manner whatsoever any sketch or photograph of any patient or group of patients, whether such sketch or photograph was made or taken before or after the issue of a reception order in respect of the patient or in respect of any patient of the group of patients, or of any institution or portion of an institution; or

(*b*) who publishes or causes to be published in any manner whatsoever any false information concerning the detention, treatment, behaviour or experience in an institution of any patient or any person who was a patient, or concerning the administration of any institution, knowing the same to be false, or without taking reasonable steps to verify such information (the onus of proving that reasonable steps were taken to verify such information being upon the accused),

shall be guilty of an offence and liable on conviction to a fine not exceeding one thousand rand or to imprisonment for a period not exceeding one year or to such imprisonment without the option of a fine or to both such fine and such imprisonment.".

Short title.

3. This Act shall be called the Mental Health Amendment Act, 1976.

APPENDIX B

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REPUBLIC OF SOUTH AFRICA

GOVERNMENT GAZETTE

STAATSKOERANT

VAN DIE REPUBLIEK VAN SUID-AFRIKA

REGULATION GAZETTE No. 2160

Registered at the Post Office as a Newspaper

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REGULASIEKOERANT No. 2160

As 'n Nuusblad by die Poskantoor Geregistreer

VOL. 120] PRETORIA, 6 JUNE 1975 / 6 JUNIE 1975 [No. 4735

PROCLAMATION

by the State President of the Republic of South Africa

No. R. 133, 1975

REHABILITATION INSTITUTIONS IN THE BANTU HOMELANDS

Under and by virtue of the powers vested in me by section 25 (1) of the Bantu Administration Act, 1927 (Act 38 of 1927), read with section 21 (1) of the Bantu Trust and Land Act, 1936 (Act 18 of 1936), I hereby declare that the provisions contained in the Schedule hereto shall, notwithstanding the provisions of any other law, have the force of law in the areas described therein.

Given under my Hand and the Seal of the Republic of South Africa at Cape Town this Fourteenth day of May, One thousand Nine hundred and Seventy-five.

N. DIEDERICHS, State President.

By Order of the State President-in-Council:

M. C. BOTHA.

SCHEDULE

APPLICATION OF PROCLAMATION

1. This Proclamation shall apply in the Bantu areas referred to in section 25 (1) of the Bantu Administration Act, 1927 (Act 38 of 1927), and in section 21 of the Bantu Trust and Land Act, 1936 (Act 18 of 1936).

DEFINITIONS

2. In this Proclamation, unless the context otherwise indicates—

(a) any word or expression defined in the Bantu (Urban Areas) Consolidation Act, 1945 (Act 25 of 1945), shall have the meaning assigned thereto in that Act;

(b) any word or expression defined in the Bantu Labour Act, 1964 (Act 67 of 1964), shall have the meaning assigned thereto in that Act;

(c) "Bantu authority" includes—

(i) the government of any area for which a legislative assembly has been established under the Bantu Homelands Constitution Act, 1971 (Act 21 of 1971);

(ii) a territorial authority established under the Bantu Authorities Act, 1951 (Act 68 of 1951);

(d) "board", in relation to an institution, means the board of management appointed under section 6;

PROKLAMASIE

van die Staatspresident van die Republiek van Suid-Afrika

No. R. 133, 1975

REHABILITASIE-INRIGTINGS IN DIE BANTOE-TUISLANDE

Kragtens die bevoegdheid my verleen by artikel 25 (1) van die Bantoe-administrasie Wet, 1927 (Wet 38 van 1927), gelees met artikel 21 (1) van die Bantoetrust en -grond Wet, 1936 (Wet 18 van 1936), verklaar ek hierby dat die bepalings in die Bylae hiervan vervat, ondanks die bepalings van 'n ander wet, die krag van wet het in die gebiede daarin omskryf.

Gegee onder my Hand en die Seël van die Republiek van Suid-Afrika te Kaapstad, op hede die Veertiende dag van Mei Eenduisend Negehonderd Vyf-en-sewentig.

N. DIEDERICHS, Staatspresident.

Op las van die Staatspresident-in-rade:

M. C. BOTHA.

BYLAE

TOEPASSING VAN PROKLAMASIE

1. Hierdie Proklamasie is van toepassing in die Bantoegebiede genoem in artikel 25 (1) van die Bantoe-administrasie Wet, 1927 (Wet 38 van 1927), en in artikel 21 van die Bantoetrust en -grond Wet, 1936 (Wet 18 van 1936).

WOORDOMSKRYWING

2. In hierdie Proklamasie, tensy uit die samehang anders blyk, beteken—

(a) enige woord of uitdrukking omskryf in die Bantoe (Stadsgebiede) Konsolidasiewet, 1945 (Wet 25 van 1945), dieselfde as die betekenis daaraan geheg in daardie Wet;

(b) enige woord of uitdrukking omskryf in die Wet op Bantoe-arbeid, 1964 (Wet 67 van 1964), dieselfde as die betekenis daaraan geheg in daardie Wet;

(c) "Bantoe-owerheid" ook—

(i) die regering van enige gebied waarvoor 'n wetgewende vergadering kragtens die Grondwet van die Bantoetuislande, 1971 (Wet 21 van 1971), ingestel is; en

(ii) 'n gebiedsowerheid kragtens die Wet op Bantoe-owerhede, 1951 (Wet 68 van 1951), ingestel;

(d) "inrigting" 'n inrigting kragtens artikel 3 ingestel;

(e) "institution" means an institution established under section 3;

(f) "inmate" means any person who is detained in an institution under the provisions of this Proclamation;

(g) "medical officer" means the medical practitioner designated by the Secretary for Health to perform the duties of a medical officer as required under this Proclamation;

(h) "Minister" means the Minister of Bantu Administration and Development and includes any officer in the Public Service acting on his authority;

(i) "Secretary" means the Secretary for Bantu Administration and Development and includes any officer in the Public Service acting on his authority;

(j) "superintendent" means the officer appointed under section 7 to manage an institution and includes any person on his staff and acting on his authority;

(k) "social worker" means an officer who is in the service of the Department of Bantu Administration and Development, or an officer or designated officer of the Bantu authority concerned and who, in the performance of his duties, is concerned mainly with welfare work and liaises between an inmate and his dependants.

ESTABLISHMENT OF INSTITUTIONS

3. (1) The Minister may, in any area for which a Bantu authority has been established and after consultation with such authority establish institutions for the reception, treatment and training of persons committed thereto under the Bantu (Urban Areas) Consolidation Act, 1945 (Act 25 of 1945), or the Bantu Labour Act, 1964 (Act 67 of 1964), and of other persons transferred thereto under this Proclamation or under any other law.

(2) Every institution shall, subject to the provisions of this Proclamation, be maintained and conducted by the Secretary for Bantu Administration and Development.

(3) The Minister may at any time, after consultation with the Bantu authority concerned, abolish any institution.

RECEPTION AND DETENTION OF PERSONS IN INSTITUTIONS

4. Whenever any person has been commited to any institution under the Bantu (Urban Areas) Consolidation Act, 1945 (Act 25 of 1945), or the Bantu Labour Act, 1964 (Act 67 of 1964), or has been transferred to any institution under the provisions of this Proclamation or any other law, he shall be received and detained in such institution subject to the provisions of this Proclamation.

PURPOSES FOR WHICH PERSONS ARE DETAINED IN INSTITUTIONS

5. The inmates of an institution shall be detained therein for the purpose of improving their physical, mental and moral condition by—

(a) training them in habits of industry and work;

(b) re-orientating them to the traditions, culture, custom and system of government of the national unit to which they belong;

(c) generally cultivating in them habits of social adaptation in the community and of good citizenship including the fostering of an awareness in regard to the observance of, and the necessity for, the laws of the country.

(e) "inwoner" enige persoon wat kragtens die bepalings van hierdie Proklamasie in 'n inrigting aangehou word;

(f) "maatskaplike werker" 'n beampte wat in die diens is van die Departement van Bantoe-administrasie en -ontwikkeling, of 'n beampte of aangewese beampte van die betrokke Bantoe-owerheid en wat, by die uitvoering van sy pligte, hoofsaaklik met welsynswerk te doen het en tussen die inwoner en sy afhanklikes skakel;

(g) "mediese beampte" die geneesheer deur die Sekretaris van Gesondheid aangewys om die pligte van 'n mediese beampte te vervul soos by hierdie Proklamasie vereis;

(h) "Minister" die Minister van Bantoe-administrasie en -ontwikkeling en ook enige beampte in die Staatsdiens wat op sy gesag handel;

(i) "raad", met betrekking tot 'n inrigting, die bestuursraad ingevolge artikel 6 aangestel;

(j) "Sekretaris" die Sekretaris van Bantoe-administrasie en -ontwikkeling en ook enige beampte in die Staatsdiens wat op sy gesag handel;

(k) "superintendent" die beampte kragtens artikel 7 aangestel om 'n inrigting te bestuur en ook enige persoon in sy personeel wat op sy gesag handel.

INSTELLING VAN INRIGTINGS

3. (1) Die Minister kan in enige gebied waar 'n Bantoe-owerheid ingestel is en na oorlegpleging met sodanige owerheid, inrigtings instel vir die opneming, behandeling en opleiding van persone kragtens die Bantoe (Stadsgebiede) Konsolidasiewet, 1945 (Wet 25 van 1945), of die Wet op Bantoe-arbeid, 1964 (Wet 67 van 1964), daarheen verwys en van ander persone kragtens hierdie Proklamasie of enige ander wet daarheen oorgeplaas.

(2) Elke inrigting moet, behoudens die bepalings van hierdie Proklamasie, deur die Sekretaris van Bantoe-administrasie en -ontwikkeling in stand gehou en gedryf word.

(3) Die Minister kan te eniger tyd, na oorlegpleging met die betrokke Bantoe-owerheid, 'n inrigting afskaf.

ONTVANGS EN AANHOUDING VAN PERSONE IN INRIGTINGS

4. Wanneer 'n persoon na 'n inrigting kragtens die Bantoe (Stadsgebiede) Konsolidasiewet, 1945 (Wet 25 van 1945), of die Wet op Bantoe-arbeid, 1964 (Wet 67 van 1964), verwys is of na 'n inrigting kragtens hierdie Proklamasie of enige ander Wet oorgeplaas is, moet hy, behoudens die bepalings van hierdie Proklamasie, in sodanige inrigting opgeneem en aangehou word.

DOELEINDES VAN AANHOUDING VAN PERSONE IN INRIGTINGS

5. Die inwoners van die inrigting moet daarin aangehou word met die doel om hul fisiese, geestelike en sedelike toestand te verbeter deur—

(a) hulle te leer om vlytig en arbeidsaam te wees;

(b) hulle te heroriënteer ten opsigte van die kultuur, tradisies, gebruik en regeringstelsel van die volkseenheid waartoe hulle behoort;

(c) in die algemeen hulle te leer om hulle by die gemeenskapslewe aan te pas en om goeie burgers te wees, met inbegrip van die bevordering van 'n bewustheid ten opsigte van wetsgehoorsaamheid sowel as die noodsaaklikheid van die wetgewing van die land.

BOARDS OF MANAGEMENT

6. (1) The Minister shall—

(a) in respect of each institution, appoint a board of management which shall consist of not less than five and not more than nine members, as the Minister may from time to time determine, of whom at least one member shall be a member of the Public Service of the Republic of South Africa or a member of or a designated officer in the Public Service of the Bantu authority concerned; and

(b) in respect of each board of management—

(i) designate one of its members who is a member of the Public Service of the Republic of South Africa or a designated officer in the Public Service of the Bantu authority concerned as Chairman of such board; and

(ii) designate one of its members as Deputy Chairman of such board.

(2) A member of a board shall be appointed for such period, which shall not exceed five years, as the Minister may determine: Provided that a member may at any time resign or be dismissed by the Minister.

(3) If any member of a board dies or vacates his office before the expiration of the period for which he was appointed, the Minister may appoint some other person who shall hold office for the unexpired portion of the period for which his predecessor had been appointed.

(4) A member of a board shall be deemed to have resigned his office if he shall have been absent without leave of the board from three consecutive ordinary meetings of the board.

(5) A member of a board may receive such allowances as the Minister in consultation with the Minister of Finance may determine in respect of time occupied and journeys undertaken for necessary attendance of meetings of the board and for visiting any institution in discharging his duty as a visiting member.

(6) In the event of the absence of both the Chairman and the Deputy Chairman from any meeting of a board, the members of the board concerned who are present at the meeting shall elect one of their number to preside at such meeting.

(7) The superintendent or an officer of his staff deputed by him shall be secretary to the board concerned. The superintendent or his deputy shall attend all meetings of such board, may take part in the deliberations, but shall have no vote on its resolutions.

(8) Meetings of a board shall be held as often as such board may determine. A simple majority of members of a board shall form a quorum.

(9) A board shall advise the Secretary on—

(a) general questions of policy arising out of or connected with the general administration and control of the institution;

(b) general questions relating to the treatment of inmates;

(c) any matter which the Minister, the Secretary or the Bantu authority concerned may refer to it for consideration.

(10) A board may frame rules governing its procedure at meetings and generally the conduct of its business and may from time to time alter or revoke any such rules.

STAFF OF INSTITUTION

7. The Minister or, if authorised thereto by the Minister, the Secretary shall, in respect of each institution, subject to the laws governing the Public Service, appoint a superintendent, who shall be the head of the institution, and so many other officers as may be considered necessary for the effective administration of such institution.

BESTUURSRADE

6. (1) Die Minister—

(a) stel ten opsigte van elke inrigting 'n bestuursraad aan, wat bestaan uit minstens vyf en hoogstens nege lede, soos die Minister van tyd tot tyd bepaal, van wie minstens een lid 'n lid van die Staatsdiens van die Republiek van Suid-Afrika of 'n lid van of 'n aangewese lid in die Regeringsdiens van die betrokke Bantoe-owerheid moet wees; en

(b) wys ten opsigte van elke bestuursraad—

(i) een van sy lede, wat 'n lid van die Staatsdiens van die Republiek van Suid-Afrika of 'n aangewese lid in die Regeringsdiens van die betrokke Bantoe-owerheid is, aan as voorsitter van sodanige raad; en

(ii) een van sy lede as ondervoorsitter van sodanige raad.

(2) 'n Lid van 'n raad word aangestel vir sodanige tydperk, maar hoogstens vyf jaar, as wat die Minister bepaal: Met dien verstande dat 'n lid te eniger tyd kan bedank of deur die Minister afgedank kan word.

(3) Indien 'n lid van 'n raad sterf of sy amp ontruim voor die verstryking van die tydperk waarvoor hy aangestel is, kan die Minister 'n ander persoon aanstel, wat sy amp vir die onverstreke deel van die tydperk waarvoor sy voorganger aangestel was, beklee.

(4) Indien 'n lid van 'n raad sonder verlof van die raad van drie agtereenvolgende gewone vergaderings afwesig is word hy geag te bedank het.

(5) 'n Lid van 'n raad kan sodanige toelaes as wat die Minister in oorleg met die Minister van Finansies bepaal, ontvang ten opsigte van tyd in beslag geneem en reise onderneem vir die noodsaaklike bywoning van vergaderings van die raad en besoeke aan enige inrigting by die vervulling van sy pligte as besoekende lid.

(6) Ingeval sowel die voorsitter as die ondervoorsitter van 'n vergadering van die raad afwesig is, kies die lede van die betrokke raad wat op die vergadering aanwesig is een uit hulle midde om op die vergadering voor te sit.

(7) Die superintendent of 'n beampte van sy personeel deur hom afgevaardig, is die sekretaris van die betrokke raad. Die superintendent of sy afgevaardigde woon alle vergaderings van sodanige raad by, kan aan die beraadslagings deelneem, maar het geen stem by die neem van besluite nie.

(8) Vergaderings van 'n raad word gehou so dikwels as wat sodanige raad bepaal. 'n Gewone meerderheid van lede van 'n raad vorm 'n kworum.

(9) 'n Raad adviseer die Sekretaris aangaande—

(a) algemene beleidsvrae voortspruitend uit of in verband met die algemene administrasie van en beheer oor die inrigting;

(b) algemene vrae betreffende die behandeling van inwoners;

(c) enige saak wat die Minister, die Sekretaris of die betrokke Bantoe-owerheid na hom vir oorweging verwys.

(10) 'n Raad kan reëls opstel betreffende die prosedure op vergaderings sowel as die algemene behandeling van sy sake en kan van tyd tot tyd sodanige reëls wysig of herroep.

PERSONEEL VAN INRIGTING

7. Die Minister of, indien deur die Minister daartoe gemagtig, die Sekretaris stel ten opsigte van elke inrigting, behoudens die wette betreffende die Staatsdiens, 'n superintendent aan wat die hoof van die inrigting is, en soveel ander beamptes as wat vir die doeltreffende administrasie van sodanige inrigting nodig is.

POWERS, DUTIES AND FUNCTIONS OF SUPERINTENDENT

8. The superintendent shall—

(a) be subject to the control of the board: Provided that instructions by the board shall be in the form of resolutions and conveyed to him in writing;

(b) be responsible for the proper management and control of the institution;

(c) be responsible for the control and safe custody of all property at the institution and shall see to it that all official directions and instructions are complied with in this regard;

(d) keep or cause to be kept such books and records as may be required of him administratively by the Secretary;

(e) keep or cause to be kept a personal file for each inmate and shall record such particulars and keep such documents therein as the Secretary may require;

(f) interview each inmate as soon as possible after admission and explain to him the purpose of his committal and satisfy himself that the inmate understands the rules to which he is required to conform;

(g) ensure that each inmate receives proper care in accordance with official instructions;

(h) determine the duties to be performed by each inmate;

(i) ensure that all the instructions of a medical officer regarding the health of an inmate and the prevention of the spreading of infectious or contagious diseases are being carried out;

(j) keep the board informed of all matters relating to the institution, notify it of any occurrence of importance and, in the event of any emergency not sufficiently provided for in the rules, he shall immediately communicate with the board, acting, if necessary, in the mean time to the best of his judgment;

(k) have the right to search or cause to be searched an inmate on admission or at any time thereafter: Provided that—

(i) an inmate shall be searched only by a person of the same sex as such inmate;

(ii) the search of an inmate shall be conducted in a seemly manner and without offence to his dignity;

(iii) an inmate shall as far as is practicable, not be stripped and searched in the presence and in sight of other inmates;

(l) receive and keep in his custody all money, personal effects, clothing or other articles which an inmate has in his possession on admission and which, in the opinion of the superintendent, he should not be allowed to retain or receive while in the institution, and shall cause an inventory thereof to be made and kept in a safe place, which inventory shall be certified by the inmate;

(m) administer any money which is the property of the inmate and was given into the custody of the superintendent, on behalf of the inmate at the request of the inmate;

(n) if an inmate has absconded from an institution and cannot be traced, or has died, or has failed to take receipt of or claim the clothing or other personal effects which may have been given into the custody of the superintendent, after a period of 30 days has expired from the date on which the inmate absconded or the date of his death, or his failure to take receipt of or claim such clothing or effects, dispose of such property by handing it over to the magistrate having jurisdiction.

PERIOD OF DETENTION IN INSTITUTION

9. (1) Subject to the provisions of this Proclamation and to the terms of any order by which any person has been committed or transferred to an institution, such

BEVOEGDHEDE, PLIGTE EN FUNKSIES VAN DIE SUPERINTENDENT

8. Die superintendent moet—

(a) onderworpe wees aan die beheer van die raad: Met dien verstande dat instruksies deur die raad in die vorm van besluite moet wees en skriftelik aan hom oorgedra moet word;

(b) verantwoordelik wees vir die behoorlike bestuur van en beheer oor die inrigting;

(c) verantwoordelik wees vir die beheer oor en veilige bewaring van alle eiendom by die inrigting en toesien dat alle amptelike voorskrifte en instruksies in hierdie verband uitgevoer word;

(d) sodanige boeke en rekords as wat administratief deur die Sekretaris van hom vereis word hou of laat hou;

(e) 'n persoonlike lêer vir elke inwoner hou of laat hou en moet daarin sodanige besonderhede aanteken en dokumente bewaar as wat die Sekretaris vereis;

(f) so spoedig doenlik na opneming met elke inwoner 'n onderhoud voer en die doel van sy verwysing aan hom verduidelik, en hom daarvan vergewis dat die inwoner die reëls wat hy moet nakom, verstaan;

(g) verseker dat elke inwoner behoorlike sorg ontvang in ooreenstemming met amptelike instruksies;

(h) die pligte wat deur elke inwoner vervul moet word, bepaal;

(i) verseker dat al die instruksies van 'n mediese beampte aangaande die gesondheid van 'n inwoner en die voorkoming van die verspreiding van besmetlike of aansteeklike siektes, uitgevoer word;

(j) die raad op die hoogte hou van alle sake rakende die inrigting, hom in kennis stel van enige belangrike gebeure en, in die geval van 'n noodgeval waarvoor die reëls nie voldoende voorsiening maak nie, onmiddellik met die raad in verbinding tree, onderwyl hy, indien nodig, na sy beste oordeel optree;

(k) die reg hê om 'n inwoner by opneming of te eniger tyd daarna te deursoek of te laat deursoek: Met dien verstande dat—

(i) 'n inwoner slegs deur 'n persoon van dieselfde geslag deursoek moet word;

(ii) 'n inwoner op 'n betaamlike wyse en sonder om sy waardigheid te krenk, deursoek moet word;

(iii) 'n inwoner, vir sover dit doenlik is, nie in teenwoordigheid of in sig van ander inwoners ontklee of deursoek mag word nie;

(l) alle geld, persoonlike besittings, klere of ander artikels wat 'n inwoner by opneming in sy besit het en wat hy, na die mening van die superintendent, nie tydens sy verblyf in die inrigting mag ontvang of behou nie, ontvang en in sy bewaring hou, en 'n inventaris daarvan laat opstel en op 'n veilige plek bewaar, en die inventaris moet deur die inwoner gesertifiseer word;

(m) enige geld wat die eiendom van die inwoner is en wat vir veilige bewaring aan die superintendent toevertrou is, ten behoewe van die inwoner op versoek van die inwoner administreer;

(n) indien 'n inwoner uit 'n inrigting weggeloop het en nie opgespoor kan word nie, of gesterf het, of versuim het om enige klere of ander persoonlike besittings wat hy vir veilige bewaring aan die superintendent oorhandig het, in besit te neem of op te eis, na 'n tydperk van 30 dae verstryk het na die datum waarop sodanige inwoner weggeloop het, of gesterf het, of versuim het om sodanige klere of besittings in besit te neem of op te eis, oor sodanige eiendom beskik deur dit aan die magistraat wat jurisdiksie het, te oorhandig.

TYDPERK VAN AANHOUDING IN INRIGTING

9. (1) Behoudens die bepalings van hierdie Proklamasie en die bepalings van enige bevel waarvolgens enige persoon na 'n inrigting verwys of oorgeplaas is, moet sodanige

person shall be detained in such institution for a period of three years from the date of such order.

(2) A board may discharge an inmate from an institution at any time prior to the expiration of his period of detention, subject to such conditions, if any, as it may deem fit.

TRANSFER OF INMATES

10. (1) The Secretary may at any time in his discretion by order in writing transfer any inmate from an institution to any other institution.

(2) Notwithstanding the provisions of any other law, the Commissioner of Prisons or any person acting on his authority, may, after consultation with the Secretary, issue an order for the transfer of any person who is undergoing a term of imprisonment, to an institution for the unexpired period of such term of imprisonment but not exceeding a period of three years, if in his opinion—

(a) it is desirable that such person should, before he is returned to the community, receive training or treatment in an institution;

(b) such person is a type of person who will or will probably benefit by the particular kind of training and treatment provided in an institution.

CLASSIFICATION, TREATMENT, TRAINING AND CARE OF INMATES

11. (1) Inmates shall be classified in different groups and each inmate shall, as soon as possible after his admission to an institution, be classified, with due regard to his conduct, educational qualifications and the provisions of sections 5 and 11 (4) (a).

(2) Any inmate may be transferred by the superintendent from one classified group to another, subject to confirmation by the board.

(3) The general treatment, training and care of the inmates shall be so organised as to attain the purposes set out in section 5.

(4) (a) Every inmate shall, as soon as possible after admission, be examined by the medical officer, who shall report fully on the physical and mental condition of such inmate and furnish any other medical information which may be required or prescribed.

(b) Inmates shall be provided with free medical, dental and optical services: Provided that no inmate shall, except with the approval of the Secretary, be supplied with more than one set of dentures or one pair of spectacles.

(5) Inmates shall be provided with such items of clothing as may be deemed necessary by the superintendent.

(6) The clothing issued to an inmate shall remain the property of the State: Provided that an inmate may on his release on leave or lawful discharge be issued with such items of clothing free of charge as the superintendent may consider necessary.

(7) The personal clothing of an inmate to whom leave is granted may be supplemented with the most essential items of clothing: Provided that any items of clothing so issued shall remain the property of the State.

(8) The physical fitness of inmates shall be improved in such manner as may be prescribed by the superintendent in consultation with the medical officer.

(9) Provision shall be made for such leisure activities and hobbies of inmates as may be prescribed by the superintendent.

(10) Inmates may be required or allowed by the superintendent, subject to such conditions as he may determine, and with the concurrence of the board, to participate in recreation beyond the confines of the institution.

persoon vir 'n tydperk van drie jaar vanaf die datum van sodanige bevel in sodanige inrigting aangehou word.

(2) 'n Raad kan 'n inwoner van 'n inrigting te eniger tyd voor die verstryking van die aanhoudingstydperk ontslaan behoudens sodanige voorwaardes (as daar is) as wat hy goeddink.

OORPLASING VAN INWONERS

10. (1) Die Sekretaris kan te eniger tyd na sy goeddunke enige inwoner van enige inrigting by skriftelike bevel na enige ander inrigting oorplaas.

(2) Ondanks die bepalings van enige ander wet, kan die Kommissaris van Gevangenisse of enige persoon wat op sy gesag handel, na oorlegpleging met die Sekretaris, 'n bevel uitreik vir die oorplasing van enige persoon wat 'n gevangenisstraf uitdien, na 'n inrigting vir die onverstreke tydperk van sodanige gevangenisstraf, maar vir 'n tydperk van hoogstens drie jaar, indien na sy mening—

(i) dit wenslik is dat sodanige persoon, voor sy terugkeer tot die samelewing, opleiding of behandeling in 'n inrigting ontvang;

(ii) sodanige persoon 'n tipe persoon is wat by die bepaalde soort opleiding en behandeling wat in 'n inrigting verskaf word, baat sal vind of waarskynlik sal vind.

KLASSIFIKASIE, BEHANDELING, OPLEIDING EN VERSORGING VAN INWONERS

11. (1) Inwoners moet in verskillende groepe geklassifiseer word en elke inwoner moet so gou moontlik na sy opneming in 'n inrigting, met behoorlike inagneming van sy gedrag, opvoedkundige kwalifikasies en die bepalings van artikels 5 en 11 (4) (a), geklassifiseer word.

(2) Enige inwoner kan deur die superintendent, behoudens die bevestiging van die raad, van een geklassifiseerde groep na 'n ander oorgeplaas word.

(3) Die algemene behandeling, opleiding en versorging van die inwoners moet so gereël word dat die doeleindes van artikel 5 bereik word.

(4) (a) Elke inwoner moet, so gou moontlik na opneming, ondersoek word deur 'n mediese beampte wat 'n volledige verslag oor die fisiese en verstandelike toestand van sodanige inwoner moet indien en enige ander mediese inligting wat vereis of voorgeskryf word, moet verstrek.

(b) Aan inwoners moet geneeskundige, tandheelkundige en oogheelkundige dienste kosteloos verskaf word: Met dien verstande dat geen inwoner, behalwe met die goedkeuring van die Sekretaris, van meer as een stel kunstande of een bril voorsien mag word nie.

(5) Inwoners moet voorsien word van sodanige kledingstukke as wat die superintendent nodig ag.

(6) Die klere aan 'n inwoner uitgereik, moet die eiendom van die Staat bly: Met dien verstande dat 'n inwoner by vrylating met vergunning of wettige ontslag kosteloos voorsien kan word van sodanige kledingstukke as wat die superintendent nodig ag.

(7) Persoonlike klere van 'n inwoner aan wie verlof toegestaan is kan met die noodsaaklikste kledingstukke aangevul word: Met dien verstande dat enige kledingstukke aldus uitgereik die eiendom van die Staat moet bly.

(8) Die liggaamlike fiksheid van inwoners moet verbeter word op 'n wyse wat die superintendent in oorleg met die mediese beampte voorskryf.

(9) Voorsorg moet gemaak word vir sodanige vryetydsbesteding en liefhebberye van die inwoners as wat die superintendent voorskryf.

(10) Inwoners kan deur die superintendent, behoudens sodanige voorwaardes as wat hy bepaal, en met die instemming van die raad, gelas of toegelaat word om aan ontspanning buite die grense van die inrigting deel te neem.

(11) Whenever an inmate is injured, the superintendent shall, unless such injury is negligible, see to it that a full report on the circumstances is drawn up, supported by sworn statements by the inmate himself or eye-witnesses, if any, and shall obtain as soon as possible a report from the medical officer on the nature, extent and possible effects of the injury and shall keep such reports in the inmate's personal file.

(12) If an inmate's earnings are affected as a result of an accident or injury sustained in the institution which is not due to his own negligence or fault, the Secretary may, in consultation with the Treasury, grant such inmate an ex gratia compensation in money and may determine the manner in which such compensation shall be controlled.

WORK TO BE PERFORMED BY INMATES

12. (1) Every inmate shall, unless prevented by illness, be employed in such work as the superintendent may determine.

(2) The assignment of work in an institution shall as far as practicable be so organised as to meet the particular needs and circumstances of each individuel inmate and shall constitute an integral part of the programme of treatment contemplated in section 5.

(3) The normal hours of work in each week shall not exceed 56, excluding time spent in going to or returning from work, tidying premises and/or bedrooms and on meals or other approved rest periods.

(4) Inmates may be required or allowed by the superintendent, subject to such conditions as he may determine, and with the concurence of the board, to work beyond the confines of the institution: Provided that no inmate shall be permitted to work for any other person or for any body other than the State, the Bantu authority concerned or the institution.

(5) No inmate shall under any circumstances be employed by any member of the institution staff for private or domestic purposes.

(6) The board may make such rules governing the employment of inmates as are not in conflict with the provisions of this Proclamation.

PAYMENT OF ALLOWANCES TO INMATES

13. (1) Subject to the provisions of subsection (2), the Secretary may pay allowances to inmates in respect of any work performed by them while they are being detained in an institution or in respect of any period during which they are absent therefrom on leave granted under section 14.

(2) The rates of such allowances, the classes of inmates to whom the allowances are payable, the apportionment of part of such allowances to the dependants of the inmate concerned and any other conditions attaching to the payment of such allowances, shall be as determined by the Secretary from time to time.

(3) The payment of allowances to an inmate shall be a privilege to be earned by work and the amount of such allowance shall depend upon the conduct of the inmate.

LEAVE OF ABSENCE FROM INSTITUTION

14. The superintendent may, with the approval of the board, grant an inmate leave of absence from an institution for such periods and on such conditions as he may determine and may at any time revoke such leave and direct the inmate to return to the institution.

(11) Die superintendent moet, wanneer 'n inwoner beseer word, tensy sodanige besering onbeduidend is, toesien dat 'n volledige verslag gestaaf deur beëdigde verklarings deur die inwoner self of deur ooggetuies, as daar is, oor die omstandighede opgestel word, en so gou doenlik 'n verslag deur die mediese beampte oor die aard, omvang en moontlike gevolge van die besering verkry en sodanige verslae in die inwoner se persoonlike lêer bewaar.

(12) Indien 'n inwoner se verdienste geraak word as gevolg van 'n ongeluk of 'n besering wat hy in die inrigting opgedoen het en wat nie te wyte is aan sy eie nalatigheid of toedoen nie kan die Sekretaris in oorleg met die Tesourie aan sodanige inwoner 'n ex gratia-vergoeding in geld toestaan en kan hy die wyse waarop sodanige vergoeding beheer moet word, bepaal.

WERK WAT DEUR DIE INWONERS VERRIG MOET WORD

12. (1) Elke inwoner moet, tensy deur siekte verhinder, in sodanige werk geplaas word as wat die superintendent bepaal.

(2) Die toewysing van werk in 'n inrigting moet, sover doenlik, so gereël word dat aan die bepaalde behoeftes en omstandighede van elke indiwiduele inwoner voldoen word en moet 'n integrerende deel uitmaak van die behandelingsprogram in artikel 5 beoog.

(3) Die normale werksure, met uitsluiting van tyd bestee om by die werk te kom en terug te keer, die perseel en/of slaapkamers aan die kant te maak, en aan maaltye of ander goedkeurende rustye, mag nie 56 uur per week oorskry nie.

(4) Inwoners kan deur die superintendent, behoudens sodanige voorwaardes as wat hy bepaal, en met die instemming van die raad, gelas of toegelaat word om buite die grense van die inrigting te werk: Met dien verstande dat geen inwoner toegelaat mag word om vir enige ander persoon of vir enige ander liggaam as die Staat of die betrokke Bantoe-owerheid of die inrigting te werk nie.

(5) Inwoners mag onder geen omstandighede deur enige lid van die inrigtingpersoneel vir private of huishoudelike doeleindes in diens geneem word nie.

(6) Vir sover dit nie stryding met hierdie Proklamasie is nie, kan die raad reëls maak betreffende die indiensneming van inwoners.

BETALING VAN TOELAES AAN INWONERS

13. (1) Behoudens die bepalings van subartikel 2, kan die Sekretaris toelaes aan inwoners betaal ten opsigte van enige werk deur hulle verrig terwyl hulle in 'n inrigting aangehou word of ten opsigte van enige tydperk waarin hulle met verlof kragtens artikel 14 toegestaan, daaruit afwesig is.

(2) Die skale van sodanige toelaes, die klasse inwoners aan wie die toelaes betaalbaar is, die toedeling van 'n gedeelte van sodanige toelaes aan die afhanklikes van die betrokke inwoner en enige ander voorwaardes met betrekking tot die betaling van sodanige toelaes, is soos van tyd tot tyd deur die Sekretaris bepaal.

(3) Die betaling van toelaes aan 'n inwoner moet 'n voorreg wees wat hy deur werk moet verdien en die bedrag van sodanige toelae hang van die gedrag van die inwoner af.

VERLOFREËLINGS

14. Die Superintendent kan, met die goedkeuring van die raad, aan 'n inwoner afwesigheidsverlof uit 'n inrigting toestaan vir sodanige tydperk en op sodanige voorwaardes as wat hy mag bepaal, en hy kan sodanige verlof te eniger tyd intrek en die inwoner gelas om na die inrigting terug te keer.

INMATES TO HAVE ACCESS TO BOARD AND VICE VERSA

15. The inmates of an institution shall have the right of presonal access to the board and the board shall likewise have a similar right of access to inmates, during such hours and subject to such conditions as may be determined by the board and as set out in the rules referred to in section 18 (2).

ACCESS OF VISITORS TO INMATES

16. (1) No person may enter an institution without the authority of the superintendent.

(2) Any person so authorised shall conform to such rules as may be prescribed under subsection (3).

(3) The board may prescribe rules relating to personal interviews between inmates and persons authorised under subsection (1) to have access to them and such rules shall be submitted to the Secretary for his approval.

(4) The superintendent shall keep a visitors' book wherein shall be recorded the identity number, name and address of every visitor to the institution, the object of the visit and the relationship of the visitor to the inmate.

(5) The superintendent may require any visitor suspected of smuggling or of introducing or conveying contraband to be searched in private by an officer of the same sex as such visitor and may refuse admission to any visitor without furnishing reasons. The reasons for such refusal shall be recorded in a register specially kept by him for this purpose.

(6) The superintendent may remove or cause to be removed from the institution any visitor whose conduct is improper or who refuses to obey any lawful direction and shall record the circumstances of such removal and the reasons therefor in a register specially kept by him for this purpose.

(7) The superintendent may examine and search, or cause to be examined and searched, all unauthorised persons found in the institution and also any vehicle entering or leaving the institution.

(8) No person shall communicate with any inmate save in the course of a visit to the institution which has been authorised under these regulations or save by means of a letter addressed to the inmate and sent by post.

(9) The superintendent may open and read any letter or parcel addressed to an inmate or written or sent off by an inmate and investigate the contents thereof, and may withhold any such letter or parcel, the further transmission or despatch of which is in his opinion undesirable by reason of the nature of its contents or of the personality of the writer or addressee or of any relevant circumstances. Any letter or parcel so withheld shall be laid before the board at its next meeting.

(10) No person shall solicit, induce or persuade an inmate to meet or have communication with such or any other person without the consent of the superintendent.

INTRODUCTION OF ARTICLES INTO INSTITUTION

17. (1) No person shall bring or cause to be introduced into the premises of any institution any intoxicating liquor or any drug for the consumption or use, or intended consumption or use, of any inmate, or any fire-arms or dangerous weapons.

(2) The provisions of this section shall also apply to any article, substance or thing, the introduction of which into an institution for the consumption or use of any inmate therein has by resolution of the board thereof been prohibited.

INWONERS MOET TOEGANG TOT DIE RAAD HÊ EN OMGEKEERD

15. Die inwoners van 'n inrigting het die reg van persoonlike toegang tot die raad en die raad het op sy beurt 'n dergelike reg van toegang tot die inwoners gedurende sodanige ure en behoudens sodanige voorwaardes as wat die raad bepaal en soos uiteengesit in die reëls in artikel 18 (2) bedoel.

TOEGANG VAN BESOEKERS TOT DIE INWONERS

16. (1) Niemand mag sonder die magtiging van die superintendent 'n inrigting binnegaan nie.

(2) Enige persoon aldus gemagtig, moet hom hou aan sodanige reëls as wat kragtens subartikel (3) voorgeskryf word.

(3) Die raad kan reëls voorskryf met betrekking tot persoonlike onderhoude tussen inwoners en persone gemagtig kragtens subartikel (1) om toegang tot hulle te hê, en sodanige reëls moet aan die Sekretaris vir sy goedkeuring voorgelê word.

(4) Die superintendent moet 'n besoekersboek hou, waarin die identiteitsnommer, naam en adres van elke besoeker aan die inrigting, die doel van die besoek en die verwantskap van die besoeker met die inwoner aangeteken moet word.

(5) Die superintendent kan vereis dat enige besoeker wat van smokkelary of die inbring of vervoer van kontrabande verdink word, privaat deursoek word deur 'n beampte van dieselfde geslag as sodanige besoeker en kan aan enige persoon toegang weier sonder verstrekking van redes. Die redes vir die weiering word in 'n register, uitsluitlik vir hierdie doel deur die superintendent gehou, aangeteken.

(6) Die superintendent kan 'n besoeker wat hom onbehoorlik gedra of weier om 'n wettige opdrag te gehoorsaam uit die inrigting verwyder of laat verwyder en moet die omstandighede van die verwydering en die redes daarvoor aanteken in 'n register wat hy uitsluitlik vir die doel hou.

(7) Die superintendent kan alle ongemagtigde persone wat in die inrigting gevind word ondervra en deursoek of laat ondervra en deursoek en ook enige voertuig wat die inrigting binnekom of verlaat ondersoek en deursoek of laat ondersoek en deursoek.

(8) Niemand mag met 'n inwoner kommunikeer nie, behalwe in die loop van 'n besoek, by hierdie regulasies gemagtig, aan die inrigting, of deur middel van 'n brief aan die inwoner geadresseer en per pos gestuur.

(9) Die superintendent kan enige brief of pakket aan 'n inwoner geadresseer of deur 'n inwoner geskryf of afgestuur, oopmaak en lees en die inhoud daarvan ondersoek, en kan enige sodanige brief of pakket, waarvan die deursending of afsending na sy mening ingewens is weens die aard van die inhoud daarvan of van die personlikheid van die skrywer of afsender of van enige omstandighede in verband daarmee, terughou. Enige brief of pakket aldus teruggehou moet aan die raad op sy volgende vergadering voorgelê word.

(10) Geen persoon mag 'n inwoner versoek, beweeg of oorreed om met sodanige persoon of enige ander persoon te kommunikeer of te ontmoet sonder die toestemming van die superintendent nie.

DIE INBRING VAN GOEDERE IN DIE INRIGTING

17. (1) Geen persoon mag enige bedwelmende drank, of enige dwelmmiddel vir verbruik of gebruik of vir voorgenome verbruik of gebruik van enige inwoner, of enige vuurwapens of gevaarlike wapens, op die perseel van 'n inrigting inbring of laat inbring nie.

(2) Die bepalings van hierdie artikel is ook van toepassing op enige artikels of stowe of dinge, waarvan die inbring in 'n inrigting vir verbruik of gebruik deur enige inwoner by 'n raadsbesluit verbied is.

(3) Any person bringing or causing to be introduced intoxicating liquor or any drug or any article, substance or thing referred to in subsection (2) into an institution shall be presumed, unless the contrary is proved by him, to have introduced or caused to be introduced such liquor, drug, article, substance or thing into the institution for the consumption or use, or intended consumption or use, of an inmate.

MAINTENANCE OF GOOD ORDER AND DISCIPLINE IN INSTITUTION

18. (1) A board may in consultation with the superintendent and with the approval of the Secretary, prescribe rules for the maintenance of good order and discipline in the institution.

(2) The superintendent shall cause all domestic rules directly affecting the inmate to be so typed or printed as to be clearly legible and shall have them posted up together with the regulations at a place which is accessible to the inmate.

(3) An inmate shall be guilty of an offence against the discipline of the institution if he—

(a) contravenes the rules prescribed by the board under the powers conferred upon it by subsection (1);

(b) at any time refuses to allow himself to be photographed, measured, weighed, vaccinated or medically examined or wilfully obstructs any person whose duty it is to photograph, measure, weigh, vaccinate or examine him medically;

(c) gives false replies to any question put to him regarding his antecedents or any other matter upon which information is required for record or statistical purposes, or refuses to give replies to such questions;

(d) wilfully disobeys any lawful order or instruction of the superintendent, medical officer or any other member of the institution staff;

(e) assaults or abuses any member of the institution staff or any visitor or any person employed in connection with the institution or any other inmate;

(f) is indecent in word, deed or gesture;

(g) uses any abusive, insolent, threatening or other improper language;

(h) in any manner whatsoever causes discontent, unrest or insubordination among the inmates;

(i) commits any act with the intention of endangering his life or injuring his health;

(j) wilfully or by negligence damages, destroys or unlawfully removes any part of the institution or any article which is the property of the institution, or of the staff of the institution or of some other inmate;

(k) makes false or malicious reports or complaints or spreads or makes public such reports or complaints;

(l) refuses or evades work by any means;

(m) malingers by feigning any illness whatsoever;

(n) procures or receives any article whatsoever in any unauthorised manner;

(o) refuses to allow himself to be searched;

(p) absconds from the institution or without the permission of the superintendent goes outside the confines of the institution or, if employed beyond or within the boundaries of the institution, the confines of the place of employment;

(q) conducts himself in a manner prejudicial to good order and discipline;

(r) sends out of the institution any letter, other written communication or parcel without the permission of the superintendent.

(4) (a) If the superintendent proposes to take disciplinary steps against an inmate for an offence under subsection (3), he shall cause the inmate to be brought before him as soon as possible after the report of the alleged offence has been made to him.

(3) 'n Persoon wat bedwelmende drank, of enige dwelmmiddel of enige artikels, stowwe of dinge in subartikel (2) genoem, in 'n inrigting inbring of laat inbring, word veronderstel sodanige drank, dwelmmiddel, artikels, stowwe of dinge in 'n inrigting in te gebring of te laat inbring het vir verbruik of gebruik of vir voorgenome verbruik of gebruik van 'n inwoner, tensy hy die teendeel bewys.

HANDHAWING VAN DIE GOEIE ORDE EN DISSIPLINE IN 'N INRIGTING

18. (1) 'n Raad kan in oorleg met die superintendent en met die goedkeuring van die Sekretaris reëls voorskryf vir die handhawing van goeie orde en dissipline in die inrigting.

(2) Die superintendent moet die huishoudelike reëls wat die inwoner direk raak so laat tik of druk dat dit duidelik leesbaar is en moet dit, tesame met die regulasies, op 'n plek wat vir die inwoners toeganklik is, aanbring.

(3) 'n Inwoner maak hom skuldig aan 'n oortreding van die dissipline van die inrigting indien hy—

(a) die reëls deur die raad voorgeskryf kragtens die bevoegdheid hom by subartikel (1) verleen, oortree;

(b) te eniger tyd weier om hom te laat fotografeer, meet, weeg, inent of medies te laat ondersoek of 'n persoon wie se plig dit is om hom te fotografeer, meet, weeg, inent of medies te ondersoek, opsetlik verhinder om dit te doen;

(c) valse antwoorde verstrek op vrae wat aan hom gestel word aangaande sy verlede of enige ander saak waaroor inligting vereis word vir rekord- of statistiese doeleindes, of weier om op sodanige vrae te antwoord;

(d) opsetlik 'n wettige opdrag of instruksie van die superintendent, mediese beampte of enige ander lid van die inrigting se personeel verontagsaam;

(e) 'n lid van die inrigting se personeel of 'n besoeker of 'n persoon wat diens verrig in verband met die inrigting of 'n ander inwoner, aanrand of uitskel;

(f) onfatsoenlik in woord, daad of gebaar is;

(g) beledigende, astrante, dreigende of enige ander onbehoorlike taal gebruik;

(h) op enige wyse hoegenaamd ontevredenheid, onrus of insubordinasie onder die inwoners veroorsaak;

(i) 'n daad pleeg met die bedoeling om sy lewe in gevaar te stel of om sy gesondheid te benadeel;

(j) opsetlik of deur nalatigheid enige deel van die inrigting of enige artikel wat aan die inrigting of die personeel van die inrigting of aan 'n ander inwoner behoort, beskadig, vernietig of wederregtelik verwyder;

(k) valse of kwaadwillige gerugte of klagtes versin of sodanige gerugte of klagtes versprei of openbaar maak;

(l) op enige wyse werk weier of ontduik;

(m) voorgee dat hy siek is deur enige siekte hoegenaamd voor te wend;

(n) enige artikel hoegenaamd op 'n ongemagtigde wyse bekom of ontvang;

(o) weier om hom te laat deursoek;

(p) wegloop uit die inrigting of sonder die toestemming van die superintendent buite die grense van die inrigting gaan of, indien werksaam buite of binne die grense van die inrigting, buite die grense van die werkplek gaan;

(q) hom op 'n wyse gedra wat aan die goeie orde en dissipline afbreuk doen;

(r) 'n brief of enige ander skriftelike kommunikasie of 'n pakket uit die inrigting stuur sonder die toestemming van die superintendent.

(4) (a) Indien die superintendent van voorneme is om dissiplinêre stappe weens 'n oortreding ingevolge subartikel (3) teen die inwoner te doen, moet hy die inwoner so gou doenlik nadat die verslag van die beweerde oortreding aan hom oorgedra is, voor hom laat bring.

(b) The superintendent shall appoint a member of his staff to lead the evidence, and he shall record the proceedings.

(c) The superintendent shall interrogate the inmate and witnesses, if any, and shall permit the inmate to call any witness and to put questions to any witness, and shall also permit him to make any statement or give any explanation he may desire.

(d) The hearing shall be conducted in one of the official languages chosen by the inmate.

(5) (a) Upon conviction the superintendent may impose upon the inmate any one or more of the following punishments:

(i) A reprimand;

(ii) forfeiture of one or more specified privileges for a period not exceeding three months;

(iii) forfeiture of allowances referred to in section 13, wholly or in part, for a period not exceeding two months: Provided that allowances paid to the dependants of the inmate shall continue to be paid;

(iv) forfeiture of three meals on any one day;

(v) increase in the normal hours of work by not more than three hours per day for a period not exceeding three days;

(vi) separation from the other inmates in a place set aside for the purpose at the institution for a period not exceeding six days;

(vii) an extra period of physical training for two hours per day, after work, for a period not exceeding six days.

(b) No form of punishment referred to in paragraph (a) (iv), (v), (vi) or (vii) shall be imposed unless the medical officer has certified that such punishment will not in his opinion be harmful to the health of the inmate.

METHOD OF DEALING WITH ABSCONDERS FROM INSTITUTIONS

19. (1) An inmate who has been granted leave of absence from an institution and who on the revocation or expiration of his leave of absence fails to return to the institution from which he was granted such leave, and an inmate who without permission absents himself from any hospital to which he may have been admitted, shall be deemed to have absconded from the institution from which he was granted leave of absence.

(2) An inmate who has absconded from an institution may be arrested without warrant by any member of the South African Police, social worker or member of the staff of the institution and shall be brought as soon as may be before a magistrate or Bantu Affairs Commissioner of the district or area in which he was arrested and may, until he can be brought before the said magistrate or Bantu Affairs Commissioner or pending his removal to such institution, be detained in a police cell.

(3) A magistrate or Bantu Affairs Commissioner before whom any such inmate is brought shall, after having enquired into the reasons why the inmate absconded—

(a) order that he be returned to the institution from which he absconded; and

(b) forthwith forward a copy of his enquiry to the board concerned.

(4) On consideration of the magistrate's or Bantu Affairs Commissioner's report and after any further enquiry which the board may deem necessary, the board shall—

(a) direct that the superintendent deal with the inmate under section 18 (4) and (5); or

(b) direct that the superintendent take no disciplinary steps against the inmate under section 18 (4) and (5); and

(b) Die superintendent moet 'n lid van sy personeel aanstel om die getuienis te lei, en moet aantekeninge van die verrigtinge hou.

(c) Die superintendent moet die inwoner en getuies, as daar is, ondervra en moet die inwoner toelaat om enige getuie te roep en aan enige getuie vrae te stel, en hy moet die inwoner toelaat om enige verklaring te doen of enige verduideliking te gee, wat hy verlang.

(d) Die verhoor moet gehou word in een van die amptelike tale wat die inwoner verkies.

(5) (a) By skuldigbevinding kan die superintendent enige een of meer van die volgende strawwe oplê:

(i) 'n Teregwysing;

(ii) verbeuring van een of meer gespesifiseerde voorregte vir 'n tydperk van hoogstens drie maande;

(iii) verbeuring van toelaes in artikel 13 genoem, geheel of ten dele, vir 'n tydperk van hoogstens twee maande: Met dien verstande dat die toelaes wat aan die afhanklikes van die inwoner betaal word, steeds betaal moet word;

(iv) verbeuring van drie maaltye op enige een dag;

(v) vermeerdering van die normale werksure met hoogstens drie ure per dag vir 'n tydperk van hoogstens drie dae;

(vi) afsondering van die ander inwoners op 'n plek wat vir dié doel in die inrigting bestem is, vir 'n tydperk van hoogstens ses dae;

(vii) 'n bykomende tydperk vir liggaamlike opvoeding vir twee uur per dag, na werk, vir 'n tydperk van hoogstens ses dae;

(b) Strawwe genoem in paragraaf (a) (iv), (v), (vi) en (vii) mag in geen vorm opgelê word nie tensy die mediese beampte gesertifiseer het dat sodanige straf, na sy mening, nie vir die inwoner se gesondheid nadelig is nie.

HOE MET WEGLOPERS UIT INRIGTINGS GEHANDEL WORD

19. (1) 'n Inwoner aan wie afwesigheidsverlof uit 'n inrigting toegestaan is en wat by die intrekking of verstryking van sy afwesigheidsverlof versuim om terug te keer na die inrigting waaruit sodanige verlof aan hom toegestaan is, en 'n inwoner wat sonder toestemming afwesig is uit 'n hospitaal waarin hy opgeneem is, word geag weg te geloop het uit die inrigting waaruit afwesigheidsverlof aan hom toegestaan is.

(2) 'n Inwoner wat uit 'n inrigting weggeloop het, kan deur enige lid van die Suid-Afrikaanse Polisie, 'n maatskaplike werker of deur 'n lid van die personeel van die inrigting, sonder lasbrief in hegtenis geneem word, en moet so spoedig doenlik voor 'n magistraat of Bantoesakekommissaris van die distrik of gebied waarin hy in hegtenis geneem is, gebring word, en kan, totdat hy voor bedoelde magistraat of Bantoesakekommissaris gebring kan word of, in afwagting van sy verwydering na sodanige inrigting, in 'n polisiesel aangehou word.

(3) 'n Magistraat of Bantoesakekommissaris voor wie sodanige inwoner gebring word, moet, nadat hy ondersoek ingestel het na die redes waarom die inwoner weggeloop het—

(a) beveel dat hy teruggestuur word na die inrigting waaruit hy weggeloop het; en

(b) onverwyld 'n afskrif van sy ondersoek aan die betrokke raad s uur.

(4) Na oorweging van die magistraat of Bantoesakekommissaris se verslag en na enige verdere ondersoek wat die raad nodig ag, moet die raad—

(a) beveel dat met die inwoner gehandel word ingevolge artikel 18 (4) en (5); of

(b) beveel dat die superintendent geen dissiplinêre stappe teen die inwoner ingevolge artikel 18 (4) en (5) moet doen nie; en

(c) in the event of such enquiry revealing any allegation of inefficiency or misconduct against any member of the establishment of the institution within the meaning of Chapter IV of the Public Service Act, 1957 (Act 54 of 1957), forthwith forward a copy of the report on the said enquiry to the Secretary for such further action as he may deem necessary.

DEATH OF INMATE

20. (1) Upon the death of an inmate the medical officer shall submit to the superintendent a report setting out in relation to such death—

(a) the period of the inmate's illness if his death followed upon an illness;

(b) the time and date when such illness came to the notice of the medical officer;

(c) the nature of such illness;

(d) the time and date of death;

(e) the cause of death;

(f) the findings at the post mortem examination if such examination was held;

(g) any other information in connection with such death or illness which in his opinion should be brought to the notice of the superintendent.

(2) In the event of the death being due to unnatural causes, the superintendent shall forthwith report the matter to the South African Police.

(3) The superintendent shall cause the following persons to be informed of an inmate's death:

(a) The District Registrar of Births, Marriages and Deaths;

(b) the board;

(c) the Secretary;

(d) the deceased's next-of-kin or if none can be traced, any other relative or friend.

(4) The remains of the deceased shall be buried by the authorities of the institution at a burial place in the area concerned: Provided that the magistrate having jurisdiction in that area may, in his discretion, authorise the release of such remains to the next-of-kin, other relative or friend for removal and burial at their own expense.

OFFENCES AND PENALTIES

21. (1) Any person who—

(a) induces or aids an inmate to escape or who attempts to aid or induce an inmate to escape;

(b) harbours or conceals an inmate or obstructs his detection;

(c) deliberately meddles in any manner with an inmate or groups of inmates;

(d) publishes any false information in respect of an inmate or concerning the management of an institution knowing the information to be false or without taking reasonable steps to ascertain that such information is correct (the onus of proving that reasonable steps were taken to verify such information being upon the accused);

(e) is found loitering on any premises of an institution or on any property or at any place where inmates may be for labour purposes;

(f) without the authority in writing of the Secretary—

(i) sketches or photographs any institution, portion of an institution, inmate or group of inmates, whether within or outside any institution;

(ii) publishes or causes to be published in any manner whatsoever any sketch or photograph of any inmate or group of inmates, whether such sketch or photograph was made or taken before or after the detention of the inmate or group of inmates;

(c) in die geval waar sodanige ondersoek 'n aanklag van onbekwaamheid of wangedrag teen 'n personeellid op die diensstaat van die inrigting binne die bedoeling van Hoofstuk IV van die Staatsdienswet, 1957 (Wet 54 van 1957) aan die lig bring, onverwyld 'n afskrif van die verslag oor bedoelde ondersoek aan die Sekretaris stuur vir sodanige verdere optrede as wat hy nodig ag.

DOOD VAN 'N INWONER

20. (1) By die dood van 'n inwoner moet die mediese beampte met betrekking tot sodanige sterfgeval 'n verslag aan die superintendent voorlê aangaande—

(a) die tydperk van die inwoner se siekte indien sy dood deur siekte voorafgegaan is;

(b) die tyd en datum waarop sodanige siekte onder die mediese beampte se aandag gekom het;

(c) die aard van die siekte;

(d) die tyd en datum van afsterwe;

(e) die oorsaak van die dood;

(f) die bevindings van die nadoodse ondersoek, as daar so 'n ondersoek was;

(g) enige ander inligting in verband met sodanige sterfgeval of siekte wat na sy mening onder die aandag van die superintendent gebring behoort te word.

(2) In die geval waar die dood toe te skryf is aan onnatuurlike oorsake, moet die superintendent die saak onverwyld aan die Suid-Afrikaanse Polisie rapporteer.

(3) Die superintendent moet die volgende persone van 'n inwoner se dood in kennis laat stel:

(a) Die Distriksregistrateur van Geboortes, Huwelike en Sterfgevalle;

(b) die raad;

(c) die Sekretaris;

(d) die oorledene se naasbestaandes of indien nie een van hulle opgespoor kan word nie, enige ander familiebetrekking of vriend.

(4) Die oorskot van die oorledene moet deur die owerheid van die inrigting begrawe word op 'n begraafplaas binne die betrokke gebied: Met dien verstande dat die magistraat wat jurisdiksie in die gebied het, na goeddunke, die vrystelling van sodanige oorskot aan die naasbestaandes, ander familiebetrekking of vriend vir verwydering en teraardbestelling op hul eie koste, kan magtig.

OORTREDINGS EN STRAWWE

21. (1) 'n Persoon wat—

(a) 'n inwoner aanhits of help om te ontvlug, of probeer om hom aan te hits of te help om te ontvlug;

(b) 'n inwoner herberg of versteek of sy opsporing bemoeilik;

(c) hom opsetlik op enige wyse met 'n inwoner of groep inwoners bemoei;

(d) enige valse inligting met betrekking tot 'n inwoner of die bestuur van 'n inrigting publiseer wetende dat sodanige inligting vals is of sonder om redelike stappe te doen om seker te maak dat daardie inligting juis is (die bewyslas om te bewys dat redelike stappe gedoen is om seker te maak dat daardie inligting juis is berus by die beskuldigde);

(e) op die perseel van 'n inrigting of op enige eiendom of op enige plek waar inwoners vir arbeidsdoeleindes mag wees, rondslenter;

(f) sonder die skriftelike magtiging van die Sekretaris—

(i) 'n skets maak of 'n foto neem van 'n inrigting, gedeelte van 'n inrigting, 'n inwoner of groep inwoners, hetsy binne of buite 'n inrigting;

(ii) op enige wyse hoegenaamd 'n skets of foto van 'n inwoner of groep inwoners, hetsy sodanige skets of foto voor of na die aanhouding van 'n inwoner of groep inwoners gemaak of geneem is, publiseer of laat publiseer;

(g) contravenes the provisions of section 17 (1);

shall be guilty of an offence and liable on conviction to a fine not exceeding R100 or, in default of payment, to imprisonment for a period not exceeding six months.

(2) Any fine imposed in respect of any contravention under this regulation shall accrue to the State.

SHORT TITLE

22. These provisions may, for all purposes, be called the Proclamation on Rehabilitation Institutions in the Bantu Homelands, 1975.

(g) die bepalings van artikel 17 (1) oortree;

begaan 'n misdryf en is by skuldigbevinding strafbaar met 'n boete van hoogstens R100 of, by wanbetaling, met gevangenisstraf vir 'n tydperk van hoogstens ses maande.

(2) Enige boete opgelê ten opsigte van enige oortreding ingevolge hierdie Proklamasie val aan die Staat toe.

KORT TITEL

22. Hierdie bepalings heet vir alle doeleindes die Proklamasie op Rehabilitasie-inrigtings in die Bantoetuislande, 1975.

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