

**Perceptions and Constructions of Cholera in the *Eastern Province Herald* and  
*Daily Dispatch*, 1980-2003**

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**ABSTRACT**

While the growing literature on South Africa's healthcare and epidemics has often mentioned cholera in passing, there is as yet little academic work dedicated to it. This thesis addresses that deficit by examining the causes, spread and extent of cholera in South Africa between 1980 and 2003. Furthermore, it examines cholera-related coverage in two newspapers, the *Daily Dispatch* and the *Eastern Province Herald* to determine how cholera and people with cholera were represented, and show how changes in the coverage of two major epidemics between 1980 and 2003 exemplify the political transition in South Africa, reflect changing political ideologies and reveal the shifting role of media within this period.

The thesis argues three main points. Firstly, that representations of cholera and those who were sick with cholera were based on long-standing tropes connecting disease, class and 'race'. Secondly, that policy-making based on these tropes influenced the unfair distribution and quality of health resources along racial lines, resulting in cholera outbreaks during the apartheid era. Failure to address these inequities post-apartheid, and the replacement of racial bias with discrimination on the grounds of socioeconomic development, resulted in further cholera outbreaks. Thirdly, using Alan Bell's newspaper-discourse analysis framework to examine cholera-related articles the thesis compares and contrasts apartheid and post-apartheid coverage in the two newspapers.

This analysis reveals that during the 1980s the coverage was uncritical of the government's handling of the epidemic or of its racially-discriminatory healthcare

system. The newspapers uncritically accepted government-employed medical professionals as the final authorities on the epidemic, excluding alternative viewpoints. The coverage also “blamed the victim”, constructing affected “black” groups as potential threats to healthy “white” communities.

Conversely, post-1994 coverage was criticised the government’s handling of the epidemic and the state of the public healthcare system. Government-employed medical professionals or spokespeople were not accepted as incontestable authorities and a range of sources were included. The coverage also shifted blame for the outbreaks to the government and its failure to address public health service delivery and rural development problems. The thesis shows the historical threat to the health of communities posed by uncaring governments.

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## PREFACE

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## INTRODUCTION

The study of epidemics is a more unusual field of historical study than it ought to be. Humankind's difficulty with eliminating existing diseases and dealing with emerging ones makes it clear that one of the only remaining options in terms of overcoming the challenges posed to society by disease is improving our understanding of past epidemics. In this way, historical examination of disease could make a great contribution. This is because, as the historian Joseph Strayer has noted:

History has the ability to help in meeting new situations, not because it provides a basis for prediction, but because a full understanding of human behaviour in the past makes it possible to find familiar elements in present problems, and thus makes it possible to solve them more intelligently.<sup>1</sup>

This is especially significant in terms of the historical study of disease. The study of history necessarily involves examination of the ways in which humans perceive, explain and react to events happening to and around them. It may not be unreasonable to suggest that only about two thirds of any given event is happening where everyone can see it: the remaining third takes place in the minds of the people affected.

In the particular case of epidemics, the actual infection of hosts by a pathogen is only the first event of the epidemic. Understanding the mechanisms of infection and cure may be important in terms of restoring individual health, but to understand an epidemic in its entirety it is necessary to examine the uneasiness it may cause. That is, to look into the ways in which affected communities react towards infected individuals, regions or groups; how they explain the appearance of the disease in their midst, and to whom the responsibility of containing the epidemic is given.

This study of how the *Daily Dispatch* and *Eastern Province Herald* newspapers constructed the South African cholera epidemics within their pages is intended in some way to answer these questions for the outbreaks of 1980-1982 and 2000-2003.

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<sup>1</sup> Joseph Strayer, quoted in Arthur Marwick, *The Nature of History* (London, 1970), pg. 18

The body of writing on the history of disease and dis-ease in South Africa is not particularly comprehensive, and has tended to focus more on epizootics such as rinderpest and lung sickness<sup>2</sup> rather than on human disease. The work done on any particular human disease has either focused on South Africa as a whole without much regional detail,<sup>3</sup> or has confined itself to the large urban areas of the Cape and Witwatersrand.<sup>4</sup> The Eastern Cape region tends to enter this work only tangentially, usually because the region has, since the late 19<sup>th</sup> century, functioned as a labour reserve for urban industries and mining. A much larger body of work exists on the broader health trends existing in South Africa, particularly on the health implications of the racial discrimination during the apartheid era, and the healthcare shortfalls of the South African government both pre- and post-1994.<sup>5</sup> Also increasing is a body of work on the HIV and AIDS pandemic, probably the most severe health challenge South Africa (or indeed the world) has ever faced. While cholera has been a recurring medical challenge in South Africa, no academic work dedicated exclusively to cholera has yet appeared (although texts with broader focuses occasionally make mention of it).<sup>6</sup> There is likewise a gap in South African media historiography, particularly regarding the print media of the Eastern Cape. No texts dedicated to news coverage produced by the *Daily Dispatch* or the *Eastern Province Herald* exist,

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<sup>2</sup> Howard Phillips, "AIDS in the Context of South Africa's Epidemic History: Preliminary Historical Thoughts", *South African Historical Journal*, 45, 2001, pg. 11.

<sup>3</sup> Karen Jochelson, *The Colour of Disease: Syphilis and Racism in South Africa, 1880 – 1950* (Basingstoke, 2001).

<sup>4</sup> Randall M. Packard, *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Pitersmaritzburg, 1990).

<sup>5</sup> See, for example: H.C.J. van Rensburg, A. Fourie and E. Pretorius, *Health Care in South Africa: Structure and Dynamics* (Pretoria, 1992); Merle de Haan, *The Health of Southern Africa* (Kenwyn, 1991); The Henry J. Kaiser Family Foundation, *Changing Health in South Africa: Towards New Perspectives in Research* (Menlo Park, 1991); Shula Marks and Neils Andersson, "The Health Implications of Racial Discrimination and Social Inequality: An Analytical Report to the Conference" in World Health Organisation, *Report of an International Conference Held at Brazzaville, People's Republic of the Congo, 19 – 20 November 1981* (Geneva, 1982); Neils Andersson and Shula Marks, "The State, Class and the Allocation of Health Resources in Southern Africa", in *Social Science and Medicine*, 28, 5, 1989; Cedric de Beer, *The South African Disease: Apartheid Health and Health Services* (Johannesburg, 1984); Shula Marks and Neill Andersson, "Apartheid and Health in the 1980s", in *Social Science and Medicine*, 27, 7, 1989; Shula Marks and Neill Andersson, "Issues in the Political Economy of Health in Southern Africa", in *Journal of Southern African Studies*, 13, 2, 1987.

<sup>6</sup> An exception to this is Mandisa Mbali, "A Bit of Soap and Water and Some Jik': Historical and Feminist Critiques of an Exclusively Individualising of Cholera Prevention in Discourse Around Neoliberal Water Policy", a paper prepared for the Health Equity and Municipal Sources section of the Municipal Services Project Conference, 17 May, 2002, accessed online at [http://www.ukzn.ac.za/ccs/files/cholera\\_msp3.pdf](http://www.ukzn.ac.za/ccs/files/cholera_msp3.pdf).

although they are occasionally mentioned in passing by texts dealing more broadly with the South African media, particularly pre-1994.<sup>7</sup>

The research undertaken for this thesis hopes to fill in some of these gaps, firstly, by providing an extended study of cholera in the Eastern Cape and secondly, by examining how the disease was presented in a particular segment of the Eastern Cape press. This examination is intended to provide an understanding of how the relationship between the South African government and the South African press, in particular the English-language daily newspapers of the Eastern Cape, changed over the long period of transition between 1980 and 2003.

Researching two topics under-represented in the existing academic canon presented some methodological challenges. Newspaper reports of cholera carried in the *Eastern Province Herald* and *Daily Dispatch* between 1980 and 1983 were accessed via bound hard-copy volumes of the publications kept in the Cory Library at Rhodes University. Coverage from 2000-2003 was accessed from the online archive of South African newspapers (at [www.sabinet.co.za](http://www.sabinet.co.za)). The articles included for publication in the newspapers were intended to be easily read and understood by a variety of readers and are thus neither very long nor particularly complex. Articles excluded from publication, and earlier drafts of published articles, were unavailable because of the high turnover of information and newspaper editions, and also because of the amount of time that elapsed between the publication of cholera-related coverage and the beginning of this research.

Once the newspaper articles had been accessed, they were divided into four sets: the *Daily Dispatch* 1980-1983, the *Eastern Province Herald* 1980-1983, the *Daily Dispatch* 2000-2003, and the *Eastern Province Herald*, 2000-2003. Once thus arranged, they were examined using the 'lens' for print media analysis developed by

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<sup>7</sup> See, for example: Richard Pollak, *Up Against Apartheid: the Role and Plight of the Press in South Africa* (New York, 1981); Keyan Tomaselli, Ruth Tomaselli and Johan Muller (eds.), *Narrating the Crisis: Hegemony and the South African Press* (Johannesburg, 1987); Herman Wasserman and Arnold de Beer, "Which Public? Whose Interest? The South African Media and Its Role During the First Ten Years of Democracy", in *Critical Arts*, 19, 1 and 2, 2005; Gordon S. Jackson, *Breaking Story: The South African Press* (Boulder, 1993).

Allan Bell in the seminal *The Language of News Media*, first published in 1991.<sup>8</sup> Bell's methods of analysing news sources, news values, and article structure were applied to the articles – that is, the articles were examined in terms of word choice, subject matter, salient points and information sources to determine the nature of the attitudes underlying the reportage. Also examined in each set of articles was the level of geographical and numerical precision with which they mapped the epidemic. Although Bell did not provide guidelines for doing this in particular, the method with which the analysis was carried out was derived from what appeared to be his “rule of thumb” for examining place in news articles: that is, determine which places are given the most prominence and why they are made significant. In this way the articles were examined on an individual basis. The trends that became visible formed the basis of the analysis chapters of this thesis.

The first part of the thesis provides the first comprehensive chronology and explanation of cholera in South Africa during the 20<sup>th</sup> and 21<sup>st</sup> centuries. It first contextualises cholera in South Africa in relation to existing tropes around the health of Africa; the relation between “race” and health; and, the relationship between “status” and health. It goes on to look at the relationship between the forms of healthcare provision in South Africa, both before and after the advent of democracy in the country. This context serves to explain in detail why South Africa was, and remains, extremely vulnerable to the kind of poverty-related diseases which are typified by cholera. The chronology that follows, therefore, demonstrates the damage done by long-standing social stereotypes and the political failings of the various South African governments in power between 1980 and 2003.

The second half of the thesis examines the changing relationship between the press and the government in terms of how the disease's advent was explained and who was said to be responsible for dealing with it. To set the stage for this, a brief history of South African print media, particularly English-language print media in the Eastern Cape, is given, accompanied by a brief examination of the changing focus of news reports between 1980 and 2003. The periods 1980-1983 and 2000-2003 exhibit deep differences resulting from their different political and social contexts and are

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<sup>8</sup> Allan Bell, *The Language of News Media* (Oxford, 1991).

therefore presented separately. An analysis of power relations and assumptions of culpability evident in the cholera-related coverage of each period is provided.

Cholera in South Africa - in the apartheid-ridden 1980s as well as in the democratic 2000s - was not the result of any innate quality on the part of the communities affected, but rather resulted from government negligence and accompanying failure to admit the extent of infrastructural underdevelopment in the country. In both epidemics, the people affected were resident in areas cut off from urban infrastructure, socially and politically disempowered and effectively at the mercy of governmental caprice. They were opposed – in the sense of being opposite, rather than of being an opponent – to the groups controlling their lives and wellbeing.

In the 1980s, this opposition was between the numerically dominant “black” and politically and financially dominant “white” population. The newspapers constructed these groups as binaries, ascribing artificial properties to each – especially “sickness” in the case of the “black” population, which was then placed opposite the “white” population’s inherent “wellness”. In the 2000s, with the race-based binaries of apartheid officially banished, the binary became “developed” versus “underdeveloped”, a class-based rather than race-based division.

### **Explanation of Terms**

The population group designated as “white” by the Population Registration Act of 1950 (repealed 1991) was made up of those South Africans considered to be of European origin or descent. To be designated as “white”, an individual had to have parents likewise designated; to be assigned to the “white” population group, an individual’s language, deportment, demeanour, speech and education were also evaluated.<sup>9</sup> In this thesis, the term “white” is used rather than “European” because – as with “black” – it expresses the grouping’s artificiality. “White”, therefore, indicates not only the population group designated under the Population Registration Act, but also the characteristics they claimed for themselves. Though not particularly subtle, these terms do express the stereotypes active in the apartheid-era mindset, and are hopefully indicative of the lack of subtlety inherent in the artificial division of races.

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<sup>9</sup> SA History, “Apartheid Legislation”, accessed at [http://www.sahistory.org.za/pages/governance-projects/liberation-struggle/legislation\\_1950s.htm](http://www.sahistory.org.za/pages/governance-projects/liberation-struggle/legislation_1950s.htm), on 2 July 2009, and again 17 November 2009.

According to the Population Registration Act, “blacks” were defined as members of any African race or “tribe”.<sup>10</sup> This restricted the definition of “black” to people who were considered to be ethnically and phenotypically African. For the purposes of this thesis, the term “black” refers to that sector of the South African population designated as “black” under the Population Registration Act of 1950, as well as to the concept of “black”, described more fully in Chapter One. In brief, this concept of “blackness” was constructed by Western Europeans, and adopted by the “white”-dominated pre-apartheid government. It grew from distinctions made by Western Europeans between themselves and the Africans they encountered in the process of invading and colonising the African continent.<sup>11</sup> These artificial divisions led to Africans being constructed as the “other”, the antitheses of Europeans.

The term “black” is used instead of “African” because of its more flexible application. “African” is a narrow term which is arguably geographical rather than cultural, ethnic, or historical. The term “black”, on the other hand, expresses the artificiality of the racially-based labels used by the apartheid government, especially when encapsulated in quotation marks. For the purposes of this thesis, the term “black” indicates not only the population group as designated under the Registration of Population Act, but also the characteristics ascribed to that group by the “white” inhabitants of South Africa. These characteristics are explained more fully in Chapter One.

While the racial divisions defined above act as binaries, the definition of “developed” is necessarily twinned with “underdeveloped” for the purposes of this thesis. That is, they are often defined in relation to each other, there being no concrete means of measuring a group or region’s level of “development” or “underdevelopment”. A region or group described as “developed” is more economically, educationally and infrastructurally advanced than a region or group described as “underdeveloped”. Factors influencing the status of a group or region as “developed” or “underdeveloped” include its access to civil infrastructure, its economic strength, and its political power. It is not a given that a rural settlement - that is, one that is small in

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<sup>10</sup> SA History, “Apartheid Legislation”.

<sup>11</sup> Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Cambridge, 1991), pg. 2

size, reliant on one source of income and situated in the countryside<sup>12</sup> – is “underdeveloped”, although this is often the case. Nor is it a given that an urban area - that is, a built-up area supporting industries such as manufacturing, mining, and tertiary-sector services including finance and legal services<sup>13</sup> – would be “developed”, although this, too, is often the case.

It is because of this lack of total congruence that “developed” and “underdeveloped” are used to designate the two regions described here. For the purposes of this thesis, “developed” designates an area and group that has access to good infrastructure, capital and power, while “underdeveloped” indicates a group and region that do not have access to these things. It should be noted that these groups are discrete, if not necessarily geographically separate – one geographical region may be inhabited by both “developed” groups and “underdeveloped” groups.

Furthermore, “underdeveloped” can also indicate that the area under discussion is inhabited by members of an underclass, which is defined as a group made up of the chronically unemployed,<sup>14</sup> many of whom subsist on government welfare payments or charity.<sup>15</sup> The underclass is typified by female-headed households and low literacy and education levels. Members of the underclass do not, obviously, have much status in society at large. Note that status differs from class in that it is determined by the power and prestige a group or individual possesses, rather than economic worth, and is a measure of their social standing in a community. Status is affected by origin, ethnicity, age and level of recognition. Although status and class are often contingent on one another, particularly in capitalist societies, they are not the same thing.<sup>16</sup>

While an individual belonging to the underclass may have status within the underclass, it is unlikely that they would have status in society at large. Conversely, residents or members of a “developed” area or group may have considerable status

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<sup>12</sup> ITS Tutorial School, “Geography Dictionary and Glossary”, accessed online at <http://www.tuition.com.hk/geography/>, on 17 November 2009

<sup>13</sup> *Ibid.*

<sup>14</sup> Athabasca University and the International Consortium for the Advancement of Academic Publication, “Online Dictionary of Social Sciences”, accessed at <http://bitbucket.icaap.org/dict/pl>, on 17 November 2009.

<sup>15</sup> Craig Calhoun, *Oxford Dictionary of the Social Sciences* (Oxford, 2002), accessed online at <http://www.encyclopaedia.com> on 17 November 2009.

<sup>16</sup> Athabasca and ICAAP, “Social Sciences”.

in society, often commensurate with their class, and may therefore be members of an elite group – that is, a minority possessing resources or power disproportionate to its size.<sup>17</sup>

For the purposes of this thesis, it is reasonable to state that the people constructed as “developed” belonged, for the most part, to an elite group. In the period before the installation of democracy in 1994, it is reasonable to say that all “white” South Africans, and a small privileged class of “black” South Africans, made up the “elite”. After 1994, government employees, particularly those in high-powered posts, joined this “elite”. In both eras, the “elite” was made up of groups and individuals with high societal status. The most profound difference between the two eras lies in the post-1994 primacy of “class” as grounds for discrimination, while discrimination pre-1994 was “race”-based. The group designated as “underdeveloped”, conversely, belonged (and belongs) to the underclass. That the Eastern Cape was (and remains) “underdeveloped” is plentifully documented, and results from the region’s historical deprivation at the hands of the apartheid-era government. The province is badly lacking in civil infrastructure, educational facilities and healthcare provision. The bulk of its population lives in conditions of poverty and is economically and politically disempowered. One set of discriminatory governmental policies has been replaced by another, equally exclusive but based on different criteria.

This thesis aims to investigate and elucidate the conditions which allowed for the appearance and spread of cholera within South Africa in the pre-democratic era as well as the so-called “new South Africa”, despite their nominal social and political differences. In doing this, it questions the truth of the construction of cholera as a disease for which infected groups themselves are to blame. Furthermore, it examines the changing relationship between the South African government and the country’s press by investigating the form and content of cholera-related coverage carried in the *Eastern Province Herald* and the *Daily Dispatch* between 1980-1983 and 2000-2003. This investigation focuses on the change from the largely unquestioning concord between newspaper and government viewpoints in the 1980s

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<sup>17</sup> Calhoun, *Social Sciences*

to the split between the “official” and “unofficial” narratives surrounding the 2000-2003 epidemic.

The cholera epidemics of 1980-1983 and 2000-2003 brought into the foreground a myriad of issues around the complicity of South African citizens – including the press - in maintaining apartheid and contributing to the misery it caused. The epidemics also revealed, however, a number of problems affecting post-apartheid South Africa. Disease is inherently political, extending beyond individual illness caused by pathogens into societal changes, moral judgements, and inter-personal and inter-group tension.<sup>18</sup> By improving our historical understanding of how disease operates within communities on a social and political level, we increase our understanding of how disease affects society and of how society deals with disease and with itself.

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<sup>18</sup> For example: the English phrase for someone who has fallen ill is “he/she got sick”, as opposed to “sick got him/her”, implying the ill individual is culpable for his/her own illness.

## Chapter 1: CONTEXTUALISING CHOLERA IN SOUTH AFRICA: RACE, CLASS, HEALTH AND CHOLERA GLOBALLY

Cholera is not unique to Africa as a disease, and nor is Africa's experience of cholera as an epidemic particularly unusual. In fact, the perceptions of and reactions to cholera in South Africa in the late 20<sup>th</sup> and early 21<sup>st</sup> centuries largely adhered to existing understandings of sickness and patterns of reaction. As the historian Howard Phillips has noted, epidemics pose an "elemental" threat to the societies in which they appear.<sup>1</sup> This threat is not only to individual wellbeing, but also to the power relations and stability of the affected society; thus epidemics attract numerous attempts to explain, distribute blame and in some way or other understand why or how the epidemic came into being.<sup>2</sup> When cholera appeared in South Africa in 1980, and throughout the sporadic outbreaks that occurred until 2003,<sup>3</sup> a number of attempts to explain it were made. Most of these were consistent with the images of the "sick other" that had been in play since the beginning of the colonial era.

### Africa as a "Sick" Continent

The socio-politically dominant "white" population believed that affected communities or groups brought cholera upon themselves due to some inchoate deficiency and that those unaffected owed their health to their innate superiority. Nevertheless, "whites" felt threatened by the affected groups. It should be said that cholera in South Africa did not originate the "othering" of affected groups; it merely reinforced it by appearing to support existing ideas around racial inferiority and the contamination of one group by another. The same can be said for the Venezuelan epidemic chronicled by Charles L. Briggs and Clara Mantini-Briggs.<sup>4</sup>

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<sup>1</sup> Howard Phillips, "AIDS in the Context of South Africa's Epidemic History: Preliminary Historical Thoughts", *South African Historical Journal*, 45, 2001, pg. 17.

<sup>2</sup> *Ibid.*

<sup>3</sup> Most recently, cholera reappeared in late 2008.

<sup>4</sup> Charles L. Briggs and Clara Mantini-Briggs, *Stories in a Time of Cholera: Racial Profiling During a Medical Nightmare* (Los Angeles, 2004).

North-western European society, particularly since the Renaissance, had long taken its physical appearance and lifestyle to be the epitome of what it meant to be human.<sup>5</sup> By the 19<sup>th</sup> century, western Europe was firmly convinced of the superiority of its culture and its science, an important part of which was its medical system.<sup>6</sup> Western medical discourse on Africa, supported by the anthropological beliefs of the time (as well as by military reports on colonisation efforts), constructed Africa and Africans as the antithesis of the European self image: that is, Africans were constructed as diseased and degenerate<sup>7</sup> and placed in opposition to Europeans as models of health and civilisation. The same oversimplified division was applied to Africa and Europe, with the continents being constructed as “black”/“white”, “bad”/“good” and “sick”/“well” respectively.<sup>8</sup>

These artificial binaries influenced the shape of colonial rule, particularly the style of indirect rule practised by the British: assimilation was discarded in favour of subjugation, which relied on maintaining and reinforcing the divisions between the rulers and the ruled.<sup>9</sup> This constant reiteration of “otherness” led to an obsession in European medical discourse on Africa with delineating and explaining the difference between the two groups.<sup>10</sup> Most of these differences were forcibly located in the African body, which was said to be significantly different to the European body. Because the European body was believed to be the pinnacle of human evolution, the supposed differences in the African body became pathologised: distance from the established European norm was seen as deeply negative and possibly damaging.<sup>11</sup> Who was believed to be at risk of being “damaged” by the “difference” of the African body is not clear.

Dividing the human body into “good” European and “bad” African bodies led to the entrenchment of stereotypes of “Africans” as universally inferior to

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<sup>5</sup> Gustav Jahoda, *Images of Savages: Ancient Roots of Modern Prejudice in Western Culture* (London, 1999), pg. 7.

<sup>6</sup> David Arnold, “Introduction: Disease, Medicine and Empire” in David Arnold (ed.), *Imperial Medicine and Indigenous Societies* (Manchester, 1988), pg. 12.

<sup>7</sup> Vaughan, *Curing Their Ills*: pg. 2.

<sup>8</sup> *Ibid.*

<sup>9</sup> *Ibid.*, pg. 10.

<sup>10</sup> *Ibid.*, pg. 12.

<sup>11</sup> *Ibid.*, pg. 13.

“Europeans”, possessed of pathological bodies and therefore inherently sick and threatening. This stereotyping, once established in the European consciousness, elided the European need to perceive and thus treat Africans as equals<sup>12</sup> or indeed even individuals.

The extreme “othering” of Africans did, however, lead to anxiety among European colonising powers: Europe, in believing itself to be the epitome of modernity and order, constructed Africa as its polar opposite with Africa therefore epitomising primitiveness and disorder.<sup>13</sup> The resulting European anxiety was completely of Europe’s own making: they had invested Africa with the very qualities they now felt threatened by, qualities which had no real bearing on actual realities.<sup>14</sup>

Stereotypes may have little basis in reality but do translate into consequences for real, living individuals. The idea of Africa as a savage and diseased continent justified imperialism because it could be seen as a civilising and healing mission rather than an economic enterprise.<sup>15</sup> The great human misery arising from imperial conquest could be elided by stereotyping Africans as inferior, inhuman and therefore to blame for their own living conditions. African living conditions resulting from colonial rule led to high levels of poverty-related disease among Africans; this in turn led to African bodies becoming associated with sickness, reinforcing the existing perception of Africa as a diseased, primitive continent.<sup>16</sup> It should be noted that this perception was based on reality; the stereotype of a diseased continent, however, exceeded the reality.

Disease was seen as an integral – though unwanted – part of the tropical and subtropical African regions colonised in the 19<sup>th</sup> century.<sup>17</sup> Much of the disease found in new colonies, however, was the result of the process of colonisation:

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<sup>12</sup> Sander L. Gilman, *Difference and Pathology: Stereotypes of Sexuality, Race and Madness* (Ithaca, 1985), pg. 18.

<sup>13</sup> *Ibid.*, pg. 21.

<sup>14</sup> *Ibid.*, pg. 20.

<sup>15</sup> John Comaroff and Jean Comaroff, *Ethnography and the Historical Imagination* (Boulder, 1992), pg. 222.

<sup>16</sup> *Ibid.*, pg., 225.

<sup>17</sup> Arnold, “Empire”, pg. 3.

newly-arrived colonists imported diseases from Europe into populations with little or no previous experience of those diseases. Military operations and trade likewise carried diseases between groups which had previously had no contact with each other.<sup>18</sup> Forced migration of populations, forcible villagisation policies and migrant labour also contributed to the spread of disease. Increased speed of travel, the result of road, river and railway networks constructed by colonists, increased the likelihood of an infected person reaching their destination and infecting others before becoming too sick to travel. Furthermore, colonial rule usually imposed by force certain changes in settlement and agriculture patterns, leading to problems such as overcrowding and malnutrition among displaced communities as well as opening up new habitats for insect and rodent disease vectors.<sup>19</sup>

The resulting high levels of sickness among colonised Africans confirmed existing stereotypes among colonial Europeans who, fearing contagion, removed themselves to small enclaves situated some distance from African settlements.<sup>20</sup> The apparent inability of Africans to avoid disease led to colonial public health bodies becoming concerned with the construction of barriers and boundaries between “diseased natives” and “vulnerable Europeans”.<sup>21</sup> This segregation, enacted on grounds of hygiene and disease-prevention (for Europeans rather than African populations who were believed to be beyond help), was also *de facto* racial segregation.

The African body itself was perceived by Europeans to be the greatest threat to the hygiene of its surroundings.<sup>22</sup> That these surroundings might be the cause rather than the effect of the perceived “sickness” of the African body was not widely believed by Europeans. Hence, segregation to preserve the health of colonial European communities hinged on keeping the African body as far away as possible from the European body, lest European surroundings become

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<sup>18</sup> Arnold, *Empire*, pg. 5.

<sup>19</sup> *Ibid.*, pg. 6.

<sup>20</sup> *Ibid.*, pg. 8.

<sup>21</sup> Warwick Anderson, “The Third-World Body” in Roger Cooter and John Pickstone (eds.), *Companion to Medicine in the Twentieth Century* (London, 2000), pg. 240.

<sup>22</sup> Alexander Butchart, *The Anatomy of Power: European Constructions of the African Body* (London, 1998), pg. 129.

contaminated. Segregation was therefore a conscious effort to maintain a “safe” distance between Europeans and a group they considered inferior but nevertheless dangerous.<sup>23</sup> These measures were justified by fears around disease combined with European conceptions of African inhumanity.<sup>24</sup> Furthermore, blaming a particular group for its own illness and then restricting it to a certain area clearly established who was in control, and, in the case of African segregation, reinforced the self-image of the dominant, usually European, group.<sup>25</sup> This assisted in entrenching segregation between Africans and European populations and also emphasized European dominance in the area.

In South Africa in the early 20<sup>th</sup> century, as in other British colonies, segregation resulted from fear that cholera, bubonic plague and smallpox present among the African and “Indian” populations might infect the European population.<sup>26</sup> The appearance of bubonic plague in the port cities of Durban and Cape Town was put down to the “scattered nests of filth”<sup>27</sup> in which African dockworkers lived. This is interesting because it evidences exactly how automatic it was to blame Africans for disease – the mode of transmission for bubonic plague was well-known by 1900. It was exponentially more likely that the outbreak had been caused by ill sailors or infected rats on recently-arrived ships from Asia (where plague was endemic) than by African dockworkers. It is undeniable that African dockworkers *were* affected by the epidemic, being quite likely to come into contact with an infected rat-flea or sailor. However, they were *unlikely* to spread the disease to the white population of professionals, merchants, artisans, labourers and servants<sup>28</sup> due to the fact that there was not much close contact

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<sup>23</sup> John W Cell, “Anglo-Indian Medical Theory and the Origins of Segregation in West Africa”, in *The American Historical Review*, 91, 2, 1986, pg. 307.

<sup>24</sup> Maynard W Swanson, “The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909”, in *Journal of African History*, 18, 3, 1977, pg. 388.

<sup>25</sup> Harriet Deacon, “Racial Segregation and Medical Discourse in Nineteenth-Century Cape Town”, in *Journal of Southern African Studies*, 22, 2, 1996, pg. 295.

<sup>26</sup> Swanson, “Sanitation Syndrome”, pg. 391. Many Indians in South Africa at the beginning of the 20<sup>th</sup> century had been imported as indentured workers from India, which was of course at that time still a British colony. Many of the qualities Europeans ascribed to Africans were also ascribed to Indians. While Indians were evidently seen to be slightly higher in the non-white hierarchy of colonial and apartheid South Africa, they were still perceived as health threats in the same way as Africans.

<sup>27</sup> *Ibid.*, pg. 393.

<sup>28</sup> Professionals include lawyers, doctors, teachers, etc.

between the two groups. Furthermore, African dockworkers had a relatively low rate of infection.<sup>29</sup>

Despite this, the African population of Cape Town was forcibly removed to a location some distance outside the town's limits. The subsequent end of the epidemic was believed to be the result of this segregation, with the contingent belief that ending segregation would re-start the epidemic.<sup>30</sup> The Locations Act of 1903 was a direct result of this, and mandated that African populations of all cities and town in the Cape Colony be moved into designated locations situated well outside the "white"-dominated areas.<sup>31</sup> By removing Africans, it was believed, Europeans would be protected from disease as well as benefit from a newly purified environment. Likewise the belief that squalor was an innate African quality, combined with the removal of that squalor to some place out of sight, allowed Europeans to ignore the possibility that the conditions they associated with "race" were in fact the result of discriminatory socio-economic practices.<sup>32</sup> Although these segregationist measures were certainly intended to prevent "sick" Africans from infecting "well" Europeans, they had the convenient secondary effect of also removing a population believed to be a threat to European safety as well as health.<sup>33</sup>

Segregation in South Africa, though initially only in the Cape, involved compressing populations that were formerly somewhat scattered into one space, and usually not the most suitable space at that. Overcrowding and associated infrastructural problems arose (assuming that infrastructure existed in the first place). The resulting high rates of poverty-related diseases such as malnutrition, tuberculosis, diarrhoeal diseases, and pneumonia<sup>34</sup> among

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<sup>29</sup> Swanson, "Sanitation Syndrome", pg. 393

<sup>30</sup> *Ibid.*, pg. 397

<sup>31</sup> *Ibid.*, pg. 401

<sup>32</sup> Maynard W Swanson, "'The Asiatic Menace': Creating Segregation in Durban, 1870-1900", in *International Journal of African Historical Studies*, 16, 3, 1983, pg. 408

<sup>33</sup> *Ibid.*, pg. 402

<sup>34</sup> Some of the leading causes of death in South Africa today in 2006 were HIV/AIDS (52% of all deaths), tuberculosis (2% of all deaths), lower respiratory infections (4% of all deaths) and diarrhoeal diseases (2% of all deaths). To put this in perspective, cerebrovascular disease, the leading cause of death after HIV/AIDS, accounts for 5% of all deaths. (World Health Organisation, "Mortality Country Fact Sheet 2006: South Africa", accessed at [http://www.who.int/whosis/mort/profiles/mort\\_afro\\_zaf\\_southafrica.pdf](http://www.who.int/whosis/mort/profiles/mort_afro_zaf_southafrica.pdf) on 26 October 2009.

segregated Africans merely acted to reinforce existing ideas of African susceptibility to disease.

The entrenchment of perceptions of Africans as diseased *no matter what* further intensified the European intention to keep Africans as far away from Europeans as possible. In South Africa, this segregation on health grounds coincided neatly with the labour needs of the growing mining-based economy, and as a result segregationist laws were developed, namely the Land Act of 1913 and the Group Areas Act of 1950. These laws had the effect of making it almost impossible for the African population to improve its living conditions by ensuring that economic and educational development in that population was blocked. A cycle developed, as health conditions worsened because of increasingly repressive segregationist laws.

The perceived African susceptibility to disease tied into the idea that Africa and Africans were pathological in nature, which suggested that there was something innate in Africans that made them sick. This led to the idea that Africans were to blame for their own sickness and therefore their own deaths. Unjust as this was, it is hardly an unusual response to sickness which has always had a moral dimension attached to it.

### **Cholera, Africa and the Social Perception of Disease**

Epidemics almost always give rise to fear among the infected and uninfected. Infectious diseases (that is, those passed from person to person, such as HIV and AIDS, cholera and influenza)<sup>35</sup> are perceived as much more of a threat to individual and societal survival than chronic, non-infectious diseases (those affecting only one individual at a time, such as ischaemic heart disease or cancer).<sup>36</sup> People affected by infectious diseases<sup>37</sup> are often seen to be carriers of contagion, threats to the health and security of unaffected people and thus

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<sup>35</sup> Note: this includes water-borne diseases.

<sup>36</sup> William A Rushing, *The AIDS Epidemic: Social Dimensions of an Infectious Disease* (Boulder, 1995), pg. 130

<sup>37</sup> Such as HIV/AIDS, cholera and influenza, typhoid, poliomyelitis and bubonic plague.

come to be feared and quite often hated.<sup>38</sup> The same does not apply to individuals affected by non-infectious diseases.<sup>39</sup>

The degree of threat is related to the extent of the infection: the more obvious a disease, the more negativity is likely to be attached to it. Likewise, the more people are infected, the more likely it is that a disease will be seen as a threat to society as a whole rather than just a few “risk groups”.<sup>40</sup> The severity of negative reactions increases if a disease is lethal, appears suddenly and is of unknown origin.<sup>41</sup> Negative reactions are also much more likely to occur when an outbreak affects a group already considered to be on the margins of “mainstream” society: groups on which outbreaks are blamed are almost certain to be groups *already* believed to cause or harbour disease.<sup>42</sup>

Societal explanations of an outbreak often influence how it is handled much more significantly than scientific explanations. An epidemic, it can be said, exists partly in the pathogen and partly in the society that pathogen enters. Cholera in Europe, as is well documented, was explained as a judgement on the moral failings of the urban poor.<sup>43</sup> In Africa, it is explained as the result of the inherent inferiority of the African. Attaching a moral judgement to an epidemic can severely hinder its treatment, as the perceptions surrounding those affected by the disease influence how they are treated.

The schema put forward in Susan Sontag's 1978 *Illness as Metaphor*, and developed further in her 1989 *AIDS and Its Metaphors*, suggests that any disease without a clear origin – which is to say practically any disease at all – will attract moral judgements because it is surrounded by fear and uncertainty. Affected individuals of such diseases will be thought to have brought the

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<sup>38</sup> Rushing, *Social Dimensions*, pg. 130.

<sup>39</sup> For example, heart disease, cancer, nephritis or chronic fatigue syndrome.

<sup>40</sup> Rushing, *Social Dimensions*, pg. 130. The fact that dividing society into “risk groups” both ineffective and inaccurate does not seem to stop the division from happening. An alternative would be to identify “risk behaviours”, although this would also be problematic.

<sup>41</sup> *Ibid.*, pg. 141.

<sup>42</sup> *Ibid.*, pg. 172.

<sup>43</sup> Charles E. Rosenberg, *Explaining Epidemics and Other Studies in the History of Medicine* (Cambridge, 1992), pg. 114.

sickness upon themselves.<sup>44</sup> Furthermore, certain illnesses are more obviously negative and damaging than others, particularly “degrading” diseases such as terminal AIDS-related complexes, cholera and cancer, and often attract stigmas.<sup>45</sup> Their sufferers, by extension, become stigmatised. This is partly a function of the visible effects of the disease on the body. The physical symptoms of cholera, for example, make the distinction between the affected and unaffected quite obvious.<sup>46</sup> The amount of stigma attached to a disease appears to be directly related to how “obvious” that sickness is. The “corruption, weakness and decay”<sup>47</sup> which the illness makes visible alarms observers to the degree to which the affected person ceases to be an individual. That is, the host becomes merely an extension of the disease, having been entirely overwhelmed by it.<sup>48</sup>

Cholera is a bacterial disease caused by *vibrio cholerae*, an organism thought to be endemic to the Ganges Delta.<sup>49</sup> It affects only humans and has no animal reservoir. The bacterium thrives in water<sup>50</sup> and can thus contaminate fish, shellfish, and vegetables (as well as clothes washed in infected water, as long as they remain wet).<sup>51</sup> Most infections result from the consumption of infected water or contact with the excreta of an infected person. Once ingested, cholera multiplies rapidly in the intestine, releasing a strong toxin which prevents the intestinal wall from absorbing water, resulting in severe diarrhoea and vomiting. If left untreated, severe dehydration results, causing muscle spasms, shock, and heart failure.<sup>52</sup>

The fatality rate among untreated cholera victims varies according to which strain of the bacterium caused the infection, but it is usually between 20% and

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<sup>44</sup> Susan Sontag, *Illness as Metaphor* (New York, 1979), pg 60.

<sup>45</sup> Susan Sontag, *AIDS and Its Metaphors* (New York, 1989), pg. 98.

<sup>46</sup> Sontag, *Illness*, pg. 33.

<sup>47</sup> *Ibid.*, pg. 59.

<sup>48</sup> Sontag, *Metaphors*, pg. 134.

<sup>49</sup> Arno Karlen, *Man and Microbes: Disease and Plagues in History and Modern Times* (New York, 1995), pg. 131

<sup>50</sup> Richard J. Evans, “Epidemics and Revolutions: Cholera in Nineteenth-Century Europe”, in Terence Ranger and Paul Slack (eds.), *Epidemics and Ideas: Essays on the Historical Perception of Pestilence* (Cambridge, 1992), pg. 153.

<sup>51</sup> Karlen, *Microbes*, pg.132.

<sup>52</sup> *Ibid.*, pg 132.

50%, with death occurring in as little as six hours.<sup>53</sup> While treatment is relatively simple, involving rehydration and antibiotics,<sup>54</sup> sick and convalescing cholera patients excrete huge numbers of bacteria which may spread the infection to others.<sup>55</sup> Furthermore, many cholera victims are asymptomatic and therefore unknowingly spread the disease.<sup>56</sup> Quarantine is thus immensely difficult and usually futile.

The most efficient way to prevent cholera is to ensure that water supplies are uncontaminated by the bacterium, necessitating water-treatment and sanitation facilities. Installing such facilities is costly and time-consuming and so they are often restricted to areas which can afford the large outlays of capital this requires. As a result, cholera is usually restricted to areas *without* adequate water purification and sanitation infrastructure. Although *vibrio cholerae* may be an equal-opportunity pathogen, as it were, cholera is not an equal-opportunity disease. Although proximity to an infected water supply is not limited to communities with less access to resources, it is certainly more likely.<sup>57</sup>

Cholera is known to have spread outwards from India in the early 19<sup>th</sup> century as a result of trade and military movements in Asia and Europe.<sup>58</sup> The expansion and consolidation of British rule in India in the 1810s involved the expansion of trade and transport routes inside India, with the result that population movement spread cholera from outlying areas to Calcutta, where an epidemic occurred in 1817. From Calcutta, an important trade port, cholera spread to China and Japan, as well as the Middle East and East Africa.<sup>59</sup> Military operations spread it to Russia via Afghanistan and Iran in the 1820s.<sup>60</sup> The Moscow epidemic of 1830 caused such panic that the Russian Army was

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<sup>53</sup> Charles L Briggs, "Modernity, Cultural Reasoning, and the Institutionalisation of Social Inequality: Racialising Death in a Venezuelan Cholera Epidemic", *Comparative Studies in Society and History*, 43, 4, 2001, pg. 666.

<sup>54</sup> *Ibid.*

<sup>55</sup> Karlen, *Microbes*, pg.132.

<sup>56</sup> *Ibid.*, pg 133.

<sup>57</sup> Evans, "Epidemics and Revolutions", pg. 155.

<sup>58</sup> World Health Organisation, "Global Epidemics and the Impact of Cholera", accessed at <http://www.who.int/topics/cholera/impact/en/index.html>, on 26 October 2009.

<sup>59</sup> Karlen, *Microbes*, pg. 133.

<sup>60</sup> Mark Harrison, *Disease and the Modern World: 1500 to the Present Day* (Cambridge, 2004), pg.101.

ordered to lay siege to cholera-infected towns and shoot any person trying to escape them.<sup>61</sup> These quarantine measures were unsuccessful as cholera continued to spread to Poland and Germany, carried by waves of refugees.<sup>62</sup>

Although Britain enforced a 15-day quarantine on trade ships coming from infected ports in Russia, Germany or the Baltic, cholera entered England at Sunderland in 1831.<sup>63</sup> From there it spread quickly to Newcastle and thence to London, where the epidemic killed at least 8 500 people (although some estimates are as high as 18 000)<sup>64</sup> before petering out in late 1832.<sup>65</sup> The disease returned to England in 1839.<sup>66</sup> Given that trade with Africa, Asia and the Middle East fuelled the Industrial Revolution, which was then beginning to gather speed, England, specifically London, was at risk of further cholera outbreaks.

In the 1830s and early-to-mid 1840s, cholera spread from India, through Afghanistan, Iraq and the Near East as far north as Germany. It re-entered England at London via a ship from Hamburg in 1848.<sup>67</sup> As in the 1830-1833 outbreak, cholera bacteria infected the River Thames, the city's main water supply, sewer, and transport route.<sup>68</sup> Between January and August 1849, 24 000 people died of cholera.<sup>69</sup> By November 1849, however, the epidemic had abated.

To date, there have been seven global cholera pandemics, with an eighth beginning in 2007.<sup>70</sup> Cholera was at its most prevalent in the 19<sup>th</sup> century, with six of the eight global pandemics occurring during that century.<sup>71</sup>

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<sup>61</sup> Robert D Morris, *The Blue Death: Disease, Disaster and the Water We Drink*, (New York, 2007), pg. 11.

<sup>62</sup> Karlen, *Microbes*, pg. 132.

<sup>63</sup> Morris, *Blue Death*, pg. 12.

<sup>64</sup> Liza Picard, *Victorian London: the Life of a City 1840-1870* (London, 2005), pg. 192.

<sup>65</sup> Morris, *Blue Death*, pg. 30.

<sup>66</sup> Picard, *Victorian London*, pg. 193.

<sup>67</sup> Morris, *Blue Death*, pg. 32.

<sup>68</sup> *Ibid.*, pg. 39.

<sup>69</sup> Picard, *Victorian London*, pg. 193.

<sup>70</sup> WHO, "Global Epidemics".

<sup>71</sup> J.N. Hays, *Epidemics and Pandemics: Their Impacts on Human History* (London, 2006), pg. 193-194.

19<sup>th</sup>-century cholera outside of India was restricted to the working-class poor of Europe, Britain and North America. Reasons for this include inferior living conditions; *de facto* (if not actively legislated) segregation between the rich and poor; and, lack of access to purified water. In 19<sup>th</sup>-century London, where massive discrepancies in quality of life existed between the emerging middle class and the city's poor, cholera spread easily among the poor but did not affect the rich.<sup>72</sup> This was because those groups did not make use of the same water sources. Economic growth had led to a sizeable increase in population in the early 19<sup>th</sup> century, particularly in the city's southern and eastern precincts, which were consequently badly overcrowded, and where the population lived in insanitary conditions.<sup>73</sup> Population increase strained the city's already inadequate sanitation systems,<sup>74</sup> putting clean drinking water at a premium. Water companies provided clean water but at a price generally out of reach of the city's poorer residents.<sup>75</sup> Consequently, the death rate from cholera in relatively poor South London was three times that of the wealthier North London<sup>76</sup> as poorer residents, unable to access clean water, made use of the highly contaminated Thames.

The epidemic was consequently seen by the city's wealthier residents to be a judgement on the poor,<sup>77</sup> who were viewed as moral and physical degenerates who had brought the disease upon themselves.<sup>78</sup> Similarly, the rich took their apparent immunity to be the result of inherent moral and physical superiority, rather than of their physical and social distance from the poor. (Conversely, the affected poor often saw cholera as a deliberate plot by the rich to wipe them out).<sup>79</sup> Similar perceptions can be seen in the Venezuelan epidemic of 1992-1993.

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<sup>72</sup> Picard, *Victorian London*, pg. 61

<sup>73</sup> Evans, "Epidemics and Revolutions", pg.155

<sup>74</sup> Picard, *Victorian London*, pg. 64

<sup>75</sup> *Ibid.*, pg. 64.

<sup>76</sup> *Ibid.*

<sup>77</sup> Harrison, *Disease and the Modern World*, pg. 106

<sup>78</sup> *Ibid.*, pg. 107; Rosenberg, *Explaining Epidemics*, pg. 114

<sup>79</sup> Harrison, *Disease and the Modern World*, pg. 108

Technological and medical advances in Europe and North America in the early part of the 20<sup>th</sup> century, along with improved living conditions, caused cholera to decline sharply in those regions. The spread of these advances resulted in only scattered cases occurring in India, the Middle East, South-East Asia and northern Africa in the early to mid-20<sup>th</sup> century.

The seventh pandemic originated in 1961 in Indonesia, rather than India, and progressed slowly westward, reaching Africa in 1971 and South America in 1991,<sup>80</sup> where a severe epidemic affected Peru and eastern Venezuela in 1992 and 1993.<sup>81</sup> Although cholera was recorded as present in sub-Saharan Africa from 1971 onwards, it did not enter South Africa until late 1980. Subsequent South African epidemics occurred in 1999, 2000-2003, and 2008-2009. The most severe African outbreak of the 20<sup>th</sup> century occurred in 1994, in Goma Refugee Camp in the Congo, where an unspecified number of Rwandan refugees died. The death toll is thought to be in the tens of thousands.<sup>82</sup> Zimbabwe and north-eastern South Africa experienced an epidemic in late 2008, which is still ongoing although significantly abated. Unrelated outbreaks of cholera occurred in Kenya, Tanzania, Nigeria, and Cameroon<sup>83</sup> throughout late 2009.

Obviously the cholera bacterium cannot itself tell one human being from another; it is merely a parasitic organism seeking a host. That some individuals rather than others become hosts is a result of differences in living conditions experienced by those individuals rather than any intrinsic biological differences. The cholera bacterium thrives in warm water; it is most likely to survive in open water sources which are situated in tropical or subtropical regions. Furthermore, cholera is easily killed by basic water-purification measures such as chlorination

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<sup>80</sup> WHO, "Global Epidemics".

<sup>81</sup> Briggs, "Racialising Death", pg. 671

<sup>82</sup> Morris, *Blue Death*, pg. 264

<sup>83</sup> "Cameroon Cholera Toll Rises", accessed at [http://www.news24.com/Content/Africa/News/965/30-10-2009-08-35/Cameroon\\_cholera\\_toll\\_rises](http://www.news24.com/Content/Africa/News/965/30-10-2009-08-35/Cameroon_cholera_toll_rises), 30 October 2009. "Cholera Outbreak in Kenya", accessed at [http://www.news24.com/Content/Africa/News/965/22-11-2009-11-13/Cholera\\_outbreak\\_in\\_Kenya](http://www.news24.com/Content/Africa/News/965/22-11-2009-11-13/Cholera_outbreak_in_Kenya), 22 November 2009; "Cholera Kills 59 in Tanzania", accessed at [http://www.news24.com/Content/Africa/News/965/Cholera\\_kills\\_59\\_in\\_Tanzania](http://www.news24.com/Content/Africa/News/965/Cholera_kills_59_in_Tanzania), 23 October 2009.

or boiling. Therefore it is more likely to strike a community without water-purification systems than it is one with such facilities. This at least partially explains why the most severe 20<sup>th</sup> and 21<sup>st</sup> century outbreaks have occurred in Asia, Africa and South America.

The Venezuelan epidemic of 1992-1993 need not have been as severe as it was. Charles L. Briggs argues that inadequacies in the country's public health services combined with institutionalised racism created a sluggish and insufficiently effective approach to the outbreak.<sup>84</sup> The group most affected were the Warao people, a Native American group marginalised by mainstream Venezuelan society and resident in a remote and underdeveloped area on the country's east coast.<sup>85</sup>

The Warao people were believed to be backward and unhygienic in lifestyle, and, like the poor of London, were therefore believed to have brought cholera upon themselves.<sup>86</sup> This allowed mainstream and “elite” Venezuelan society to ignore the possibility that their societal structure could be held accountable for the Warao outbreak. By placing the blame for the disease squarely on the affected community's ethnicity and culture, they removed the obligation to admit that socio-economic marginalisation and underdevelopment in the region was to blame. Briggs argues that on the scale of the Americas as a whole, blame took on the form of concentric rings: Venezuelans were wary of the Warao; South America as a whole became wary of Venezuela; and, North America became wary of South America.<sup>87</sup>

It is clear that poorer communities are more in danger of cholera outbreaks than wealthier ones. This is common to almost every cholera outbreak. The conditions giving rise to the outbreaks are universally similar. Affected communities everywhere share certain characteristics, the major one being lack of access to water and sanitation as a result of socioeconomic marginalisation

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<sup>84</sup> Briggs, “Racialising Death”, pg. 666.

<sup>85</sup> *Ibid.*, pg. 671.

<sup>86</sup> *Ibid.*, pg. 671.

<sup>87</sup> *Ibid.*, pg. 680.

or systematic denial of such access. Cholera is a disease that never strikes anywhere it would not be expected to strike. Historically, reactions to cholera are all broadly alike – in 19<sup>th</sup>-century England, 20<sup>th</sup>-century Venezuela, and 20<sup>th</sup>- and 21<sup>st</sup>-century South Africa, “elite” populations came to perceive the infected “non-elite” populations as both threatening to the health of “elite” populations and to blame for their own infection.

In any given epidemic, the groups affected are by and large poorer and more alienated from their society's power-structures than groups that remain unaffected. Perceptions of cholera that become dominant among economic and political elites (in the 19<sup>th</sup>, 20<sup>th</sup> and 21<sup>st</sup> centuries), therefore, tend to be those developed by unaffected groups, giving rise to narratives designed to entrench the differences between affected and unaffected groups. As a result, communities affected by cholera are “othered” by the society of which they are part, if indeed they were not already considered to be the “other” because of race, ethnicity, economic status, class or religion.

## Chapter 2: KEEPING OUT THE WELCOME MAT - CHOLERA-CONDUCTIVE CONDITIONS IN SOUTH AFRICA, 1942-2003

A cholera bacterium does not know anything about its host. It cannot determine that host's economic status, state of mind, religion, location, race or gender. There is furthermore no way for it to choose between hosts: one host is much like another insofar as providing a comfortable environment for the bacterium. That one individual rather than another should be infected must consequently be the result of differences in the circumstances in which those individuals live rather than of any inherent physical differences between them.

In the South African cholera outbreaks of the 1980s and 2000s, only rural<sup>1</sup> and peri-urban<sup>2</sup> "black" communities were affected. The bulk of these communities were resident in areas lacking in health and civil infrastructure,<sup>3</sup> leading to high child and infant mortality, low life expectancy and a high prevalence of poverty-related diseases. These dire health circumstances were not the result of any inchoate predisposition to illness on the part of the populations living in these parts, but rather of governmentally-sanctioned racial discrimination that from the late 19<sup>th</sup> century onwards systematically deprived particularly "black" populations of adequate facilities. These populations were also deprived of the economic and political wherewithal to achieve or maintain adequate health. Put bluntly, institutionalised physical and economic segregation made it nearly impossible for the bulk of the "black" population of South Africa to maintain good basic health. In addition to this, the South African and "homeland" public sector health services for the period 1919 to 1994 (and beyond) were not comprehensive, efficient or coherent enough to ensure the implementation of adequate health measures.

It is not overstating the case to say that for much of the history of South Africa, the bulk of the population was denied the resources necessary for the creation and maintenance of health. Among the most basic of these necessities was adequate

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<sup>1</sup> That is, those situated some distance from the infrastructure, civil authorities, and industries of urban areas.

<sup>2</sup> Situated on the periphery of urban areas, but separated from their infrastructure.

<sup>3</sup> Civil infrastructure includes water and sanitation-related infrastructure, as well as refuse removal, road and building maintenance, and often also electricity.

nutrition, sanitation and clean water<sup>4</sup> – the absence of which was tantamount to putting out a welcome mat for water-borne disease. Other prerequisites for maintaining health are facilities at which individuals can be immunised against disease or, once infected, access treatment.<sup>5</sup> Furthermore, the government has a responsibility towards its citizens; the creation and maintenance of health relies, in part, on governmental action and particularly on co-operation between local, provincial and national levels of administration. Local authorities should, in a tiered governmental structure, be concerned with the supply and maintenance of a safe water supply, sanitation, refuse removal and the implementation of disease-prevention projects in the area for which they are responsible.<sup>6</sup> Provincial administrations should likewise provide healthcare facilities (hospitals and community clinics, for example) as well as community-based primary healthcare and facilities for the treatment of disease.<sup>7</sup> National governments should liaise with subsidiaries to devise and implement policy.

For most of its history South African health services were divided along racial lines, leading to extreme fragmentation and unequal distribution of services. Today, this fragmentation continues in the shape of lack of accountability, ineptitude and problematic interdepartmental communication. All of these factors hinder the establishment of an efficient and effective set of health services. In both cases, the provision of resources necessary to maintain good health – such as water and sanitation, healthcare facilities and appropriate policies has been sporadic and, when supplied, has usually been inadequate. The net result is that for over a century the bulk of the South African population has been forced to make use of inadequate health services which exacerbates the health challenges caused by social and economic inequalities. In the face of this, outbreak of cholera in South Africa was, and remains, inevitable.

Historically, South African health services were developed haphazardly, beginning with the first Contagious Diseases Act of 1868<sup>8</sup> and urban segregation of the late

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<sup>4</sup> De Haan, *Southern Africa*, pg. 3.

<sup>5</sup> *Ibid.*, pg. 1.

<sup>6</sup> *Ibid.*, pg. 3.

<sup>7</sup> *Ibid.*, pg. 3.

<sup>8</sup> Three other Contagious Diseases Acts were passed, in 1864, 1866, and 1869; they were

19<sup>th</sup> century<sup>9</sup> and continuing until concerted efforts at creating a unified health service were made in the 1980s. The South African Health Act of 1909 instead of imposing coherence on the fragmented colonial health system, merely transferred the responsibilities of the dissolved colonial health authorities onto the newly-appointed provincial authorities.<sup>10</sup>

The 1909 Health Act did not establish a Department of Health, but shifted disease-prevention responsibilities, formerly administered by the local authorities, to the Department of Internal Affairs.<sup>11</sup> The Spanish Flu epidemic of 1918, however, made it clear that some kind of unified effort was necessary, which led to the 1919 Public Health Act.<sup>12</sup> This Act established a National Department of Health, intended to provide public health services alongside those provided by the local authorities. Local authorities were charged with supervising environmental health in communities under their jurisdiction, while provincial authorities were mainly concerned with hospitals.<sup>13</sup> The local authorities' environmental health programs were nominally supervised by the Department of Public Health; however, the Department had no real power to control the actions of local authorities. As a result, the changes were mainly administrative and did not improve the quality of care available.

Unsurprisingly, the Gluckman Commission of 1942, appointed by the South African National Department of Health to review health services in the country, criticised the health services of the pre-apartheid era as being inadequate, misdirected and uncoordinated.<sup>14</sup> The Commission's recommendation was that curative medicine be replaced by preventive medicine as a priority. Although this recommendation was applauded, it was not implemented.<sup>15</sup> Supporters of the Gluckman commission blamed this failure to implement what seemed to be a reasonable plan on the

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concerned with controlling the spread of venereal disease by introducing a system of registration and periodic medical examination of prostitutes (Elizabeth van Heyningen, "The Social Evil in the Cape Colony, 1868-1902: Prostitution and the Contagious Disease Acts", in *Journal of Southern African Studies*, 10, 2, 1984, pg. 172).

<sup>9</sup> Swanson, "Sanitation Syndrome", pg. 401; Van Heyningen, "Social Evil", pg. 171.

<sup>10</sup> HCJ van Rensburg, A. Fourie and E. Pretorius, *Health Care Needs in South Africa*, (Johannesburg, 1992) pg. 59.

<sup>11</sup> *Ibid.* pg. 59.

<sup>12</sup> *Ibid.*; Susan Parnell, "Creating Racial Privilege: The Origins of South African Public Health and Town Planning Legislation", *Journal of Southern African Studies*, 19, 3, 1993, pg. 472.

<sup>13</sup> de Beer, *South African Disease*, pg. 19.

<sup>14</sup> *Ibid.*, pg. 15.

<sup>15</sup> *Ibid.*, pg. 16.

ascension to power of the National Party in 1948, and the subsequent wholesale development and implementation of apartheid.<sup>16</sup> It should be noted, however, that racial segregation existed in medical and health-provision services long before the formal advent of apartheid.<sup>17</sup>

The major complication that apartheid introduced to the already somewhat byzantine South African health system was the creation of “homelands”, which necessitated the formation of 10 new Departments of Health separate from the South African National Department of Health.<sup>18</sup> All “black” South Africans had to be affiliated with the “homeland” designated by the government as the one related to their apparently specific ethnic group. When assigned citizenship of a “homeland”, “blacks” were forcibly deprived of their South African citizenship. This neatly divested South African authorities of the responsibility of maintaining the health of “black” communities. At the same time it was believed to have removed the threat “black” communities posed to “white” communities by placing those “black” communities at physically distant locations (much like the urban segregation implemented by the 1919 Public Health Act but on a larger scale).<sup>19</sup>

The creation of “homelands” divided the “black” population into a small, relatively well-resourced urban working class (which nevertheless had no South African citizenship) and a much larger, poorer and almost entirely disenfranchised rural population.<sup>20</sup> For example, KaNgwane, the Swazi “homeland” where cholera first broke out in 1981, lacked schools, clinics and even running water when it was established in 1980.<sup>21</sup> Although “homelands” were intended to be agriculture-based economies, massive population densities (around four times the South African average of 25 people/km<sup>2</sup>) made agriculture impossible: QwaQwa, barely 655km<sup>2</sup>, suffered a population increase from 24 000 in 1975 (a tightly packed 36.7 people/km<sup>2</sup>) to approximately 250 000 in 1980, leading to a population density of

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<sup>16</sup> *Ibid.* The United Party under the leadership of Jan Smuts had not moved towards an integrated public health system during its term either.

<sup>17</sup> Van Rensburg et al, *Health Care Needs*, pg. 64

<sup>18</sup> *Ibid.*, pg. 65

<sup>19</sup> Parnell, “Creating Racial Privilege”, pg. 479

<sup>20</sup> Marks and Andersson “Apartheid and Health in the 1980s”, pg. 49. Relative, that is, to *rural* “black” communities.

<sup>21</sup> De Beer, *South African Disease*, pg. 48.

381.7 people/km<sup>2</sup>.<sup>22</sup> This population density was very similar to that of the Netherlands, which was 341 people/km<sup>2</sup> in 1980 and higher than that of Japan in 1980 (309 people/km<sup>2</sup>).<sup>23</sup> The Netherlands and Japan, however, were relatively wealthy, well-resourced countries with viable infrastructure. Neither QwaQwa nor any of the other “homelands” were any of these things. Obviously, regions with adequate infrastructure can support much higher populations than regions without, and present better opportunities for subsistence and employment.<sup>24</sup>

As a result of this reshuffling of the South African population, “homeland” areas became vast sinks of ill health, owing to the high population density and the strain it placed on areas already severely lacking in infrastructure. Furthermore most “homeland” residents were economically inactive, being “blacks” that were not employed elsewhere (i.e., not migrant workers). Homelands were usually made up of the elderly, disabled or underage.<sup>25</sup> Furthermore, as technological advances reduced the amount of labour needed in the industrial and mining industries, fewer and fewer “homeland” residents were able to find jobs which reduced the “homelands” already minimal income.<sup>26</sup>

The lack of economic opportunity for “homeland” residents, combined with the environmental degradation that resulted from overcrowding, led to widespread rural poverty.<sup>27</sup> The creation of “homelands” transferred the costs of supporting these people to non-viable “homeland” governments.<sup>28</sup> This had the doubly damaging effect of placing high strain on “homeland” finances and pushed ever more people into a migrant labour system, which sustained the South African economy at the expense of the “homelands”.<sup>29</sup> As a result, the “homelands” were severely affected by poverty-related diseases, as well as malnutrition and low life expectancy.

<sup>22</sup> De Beer, *South African Disease*, pg. 48

<sup>23</sup> United Nations Data, Population Density, accessed at <http://data.un.org/Data.aspx?d=PopDiv&f=variableID%3A14> on 30 June 2009. The population density figures given are those from 1980.

<sup>24</sup> E.H Cluver, *Public Health in South Africa*, (Johannesburg, 1958), pg. 130.

<sup>25</sup> Van Rensburg et al, *Health Care Needs*, pg. 65.

<sup>26</sup> De Beer, *South African Disease*, pg. 53.

<sup>27</sup> HJKFF, *Changing Health*, pg. 11.

<sup>28</sup> *Ibid.*

<sup>29</sup> Marks and Andersson, “Health Implications”, pg. 81.

However, according to Shula Marks and Neils Andersson, these health problems were blamed not on the extreme impoverishment of the “homeland” populations, but rather on their inability or unwillingness to adhere to “white” medicine and standards of “hygiene”.<sup>30</sup> The “white” population was affected mainly by degenerative diseases (which were mostly untreatable) and conditions that could be treated with surgery, differences which only reinforced the idea among “whites” that high “black” mortality was the result of innate backwardness and sickness on the part of “black” populations. Poverty-related vulnerability to disease combined with apartheid-era segregation made disease a highly racialised concept. As a result, outbreaks of communicable diseases in rural areas and “homelands” were usually first ignored as inevitable manifestations of the inherent “sickness” of “black” populations. If the infection showed signs of spreading, fears arose that “whites” might be infected by “blacks”.<sup>31</sup>

In 1977, the Health Act was passed. It did not, unsurprisingly, deal with the health problems faced by the “homelands” – they were not considered to be part of South Africa and were therefore outside the Act’s ambit. Instead, the 1977 Act focused on alleviating problems relating to the provision of comprehensive preventive care within “white” South Africa.<sup>32</sup> Furthermore, it established foundations for a National Department of Health that would co-ordinate local and provincial health authorities and provide whichever services were not already supplied by its subsidiaries (for example medico-legal and research facilities).<sup>33</sup> The Act did not, however, address the South African healthcare services’ most severe problem, fragmentation, which had bedevilled the provision of adequate health services since the 19<sup>th</sup> century.

The Browne Commission of 1980 was a government-appointed body charged with identifying problems in the South African health services and recommending improvements.<sup>34</sup> Like the Gluckman Report of the 1940s, the Browne Commission identified fragmentation as the major stumbling-block affecting the provision of adequate health services. Furthermore, it suggested that the lack of a central policy-

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<sup>30</sup> Marks and Andersson, “Health Implications”, pg. 85.

<sup>31</sup> Marks and Andersson, “Issues in the Political Economy of Health”, pg. 180.

<sup>32</sup> Van Rensburg et al, *Health Care Needs*, pg. 72.

<sup>33</sup> *Ibid.*, pg. 73

<sup>34</sup> De Beer, *South African Disease*, pg. 75

making body to co-ordinate the 13 health departments operating within South African borders caused excessive duplication and misallocation of resources, as well as slowing down effective interdepartmental co-ordination. It recommended that a national health policy be formulated, with priority granted to preventive medicine and primary healthcare services, environmental health, and community health services.<sup>35</sup> These recommendations were not new. Unfortunately, they were, once again, not effectively implemented.

The late 1980s, however, brought about significant changes in the social and political climate of South Africa.<sup>36</sup> A new Health Act passed in 1990 was concerned mainly with changes in policy-making rather than changes in practice. It emphasized individual responsibility for health (although what this entailed was not elucidated) and the provision of a comprehensive health service by national and local authorities. At the same time, however, the 1990 Health Act encouraged the growth of the private healthcare sector and the recovery of state medical costs by taxation.<sup>37</sup> Furthermore, it established three main policy-making bodies, namely the Health Matters Council, the Administrator's Health Council (responsible for healthcare and hospital services in each province), and the Health Policy Council.<sup>38</sup>

In 1991, the National Health Service Delivery Plan was devised; it was intended to establish a comprehensive health service and ensure that this was put in place between 1990 and 1995.<sup>39</sup> This meant that it would take place at the same time as South Africa's transition from apartheid to democracy. Accordingly, the Plan was intended to make all South African health services accessible to the whole population by rendering them accessible, effective, affordable and equitable. Most of these changes were, however, cosmetic: the fragmentation that hampered the creation of a usable health service in the past remained unchanged. Furthermore, the plan encouraged the development of privatised healthcare, which diverted medical professionals - as well as income in the shape of potential clients - away

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<sup>35</sup> De Beer, *South African Disease*, pg. 76

<sup>36</sup> *Ibid.*

<sup>37</sup> Van Rensburg, *Health Care Needs*, pg. 85

<sup>38</sup> *Ibid.*

<sup>39</sup> *Ibid.*, pg. 86.

from the comparatively underpaid and under-resourced public sector.<sup>40</sup> It also favoured high-technology healthcare over more basic, and more necessary, primary healthcare.

Although the Plan had been intended to improve the healthcare delivery in South Africa, it involved the introduction of yet more administrative bodies while simultaneously significantly restructuring on a national scale. Moreover, the Act's encouragement of high-technology healthcare and the development of the private sector did not foster the development of accessible, affordable and effective healthcare services.

Changes to this ineffective system became possible with the introduction of the Reconstruction and Development Plan (RDP) by the newly-elected African National Congress (ANC) government in 1994. This plan was intended to harness South African resources in order to create sustainable systems of governance that included and empowered the South African people as a whole, rather than just a "white" elite.<sup>41</sup> However, when the RDP's effectiveness in transforming the health system was reviewed by the Health Systems Trust several years later, it was discovered that the RDP had set unrealistic goals and was therefore failing. This failure was a symptom of the ANC's wider inability to deliver on election promises as an ANC-led government.

The replacement of the RDP by the Growth, Employment and Redistribution programme (GEAR) in 1996 resulted in decreased health expenditure. These decreases are typical of changes to market-driven economic policies, which shift emphasis from democratising state facilities and services to allowing the state to become more powerful by creating a "leaner and meaner", more money-oriented state.<sup>42</sup> By shifting the expense of providing services to the profit-driven private sector, services are made even less accessible to those unable to pay for private-

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<sup>40</sup> Van Rensburg, *Health Care Needs*, pg. 87.

<sup>41</sup> Ntombenhle Torkington, *Community Health Needs in South Africa*. (Aldershot, 2000), pg. 16; Philip Wenzel, "Public Sector Transformation in South Africa: Getting the Basics Right", in *Progress in Development Studies*, 1, 7, 2001, pg. 47.

<sup>42</sup> Wenzel, "Public Sector Transformation", pg. 47.

sector healthcare.<sup>43</sup> This occurred despite the provision of health and educational services being enshrined as constitutional rights.<sup>44</sup> The effect of GEAR and its successor, Accelerated Shared Growth Initiative for South Africa (ASGISA),<sup>45</sup> on South African healthcare was negative. For example, infant mortality increased from 45.4 per 1000 births in 1996 to 59.0 per 1000 in 2002.<sup>46</sup> At the same time, the promised inclusion of the South African people in decision-making and policy formation failed to materialise.<sup>47</sup>

South African health policies post-1994 were intended to provide universal access to health services, especially the poor, the aged and children.<sup>48</sup> This was to be achieved by implementing simultaneous devolution (the strengthening of sub-national governmental levels) and deconcentration (giving administrative but not political power to sub-national departments). This was intended to give provincial governments considerable autonomy while retaining the national government's responsibility for overall co-ordination and the formulation of policy.<sup>49</sup> Local governments became responsible for the provision of primary healthcare, while provincial governments became responsible for hospital services and broader primary health care.<sup>50</sup> Furthermore, local and provincial treasuries were given the power to make most decisions regarding the allocation of funds within their regions.<sup>51</sup>

However, despite the handing over of much administrative and financial responsibility to sub-national organs, most major decisions in health services remained the responsibility of the National Department of Health. Although local and provincial levels were meant to be involved in decision-making and be consulted about policy changes (thereby fostering greater co-operation between the various

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<sup>43</sup> Fatima Pandy and Elroy Paulus, "Basic Services for All – If Only You Can Pay for It!", in *Agenda*, 45, 2000, pg. 66.

<sup>44</sup> Constitution of the Republic of South Africa, 1996, Chapter 2 Bill of Rights, Sections 27 and 29. Accessed at <http://www.info.gov.za/documents/constitution/1996/96cons2.htm>, on 12 January 2010.

<sup>45</sup> As ASGISA was only implemented in 2006, it is outside the scope of this discussion.

<sup>46</sup> Leslie London, "Health and Human Rights: What Can Ten Years of Democracy Tell Us?", *Health and Human Rights*, 8, 1, 2004, pg. 1.

<sup>47</sup> Torkington, "*Community Health Needs*", pg. 17; London, "Health and Human Rights", pg. 8.

<sup>48</sup> Di McIntyre and Barbara Klugman, "The Human Face of Decentralisation and Integration of Health Services: Experience from South Africa", in *Republic Health Matters*, 11, 21, 2003, pg. 108

<sup>49</sup> McIntyre and Klugman, "Decentralisation", pg. 109

<sup>50</sup> *Ibid.*, pg. 109

<sup>51</sup> *Ibid.*, pg. 110

levels of government), their recommendations were not always taken into consideration on a national level.<sup>52</sup> This led to confusion among staff across the various levels, as they did not always share an idea of what was necessary or unnecessary in any given context, leading to inappropriate distribution of funds and a deeply problematic lack of accountability.<sup>53</sup>

Although the structural changes made to the South African health services may have theoretically increased efficiency and thus boosted service delivery, the focus on restructuring, in practice, detracted from the quality of service delivery.<sup>54</sup> It is difficult, and inadvisable, to attempt to make major changes at the same time as maintaining service delivery – it is rather like attempting to hold a dinner party at the same time as moving house. The confusion that resulted from implementing changes before the basic framework was established led to considerable confusion and low staff morale. To exacerbate this problem, most new civil servants, in health as in other departments, lacked experience.<sup>55</sup>

That the enormity of the challenges facing South African healthcare after 1994 was well-understood by the new National Health Department is clear. The 1996 *White Paper for the Transformation of the Health System in South Africa*, published by the National Health Department, notes that 55% of South Africans lived in poverty, with 75% of the poor living in rural areas.<sup>56</sup> It is tacitly understood in the *White Paper* that the majority of impoverished South Africans were “blacks” resident in former “homelands”. Consequently, one of the Department’s major goals was to increase access to comprehensive healthcare services with a special focus on the rural and peri-urban poor, a goal which was to be accomplished, according to the *White Paper*, by promoting equitable distribution of health professionals and resources.<sup>57</sup> This equitable distribution of health facilities and resources was to accompany the re-organisation of South African healthcare into a primary healthcare based system.

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<sup>52</sup> McIntyre and Klugman, “Decentralisation”, pg. 113

<sup>53</sup> *Ibid.*

<sup>54</sup> *Ibid.*, pg. 113

<sup>55</sup> Wenzel, “Public Sector Transformation”, pg. 49

<sup>56</sup> South African Department of Health, *White Paper for the Transformation of the Health System in South Africa*, accessed at [www.info.gov.za/whitepapers/1997/health.htm](http://www.info.gov.za/whitepapers/1997/health.htm) on 10/10/2008 on 4 March 2009, pg. 1

<sup>57</sup> SADOH, *White Paper*, pg. 1.

The reconfiguration aimed to increase available resources and facilities and promote environmental health, the prevention of communicable diseases and the development of appropriate human resources for healthcare.<sup>58</sup> As with the 1980s and early 1990s, all of these areas were to prove highly problematic in the late 1990s and early 2000s, especially once the economic strictures of GEAR and ASGISA came into play. In 1996 when the *White Paper* was composed, however, the RDP programme was still nominally informed by national policy. Consequently, the modifications suggested by the *White Paper* were centred on replacing the curative-care focus of pre-1994 with a primary healthcare-based system.

The post-1994 South African Health Department was divided into three tiers: the National Department of Health, provincial Departments of Health, and health districts within provinces (which after 2000 became coterminous with municipal boundaries).<sup>59</sup> The National Health Department was to be concerned with the formulation of health policy, legislation, norms and standards, the creation and maintenance of equitable resource allocation, and the increasing of provincial and municipal capacity.<sup>60</sup> As mentioned above, the main responsibility for providing healthcare fell to health districts, with the provincial authorities monitoring them, rather than being in control. The major problem with this system, which otherwise seemed most sensible, is that given the vast variations in South African conditions, it was impossible to enforce any standardised system of staff and resource distribution.<sup>61</sup>

This was especially problematic in former “homeland” areas, which experienced massive problems in acquiring and retaining staff and resources.<sup>62</sup> The health district system was intended to make healthcare efficient and effective as well as accessible, sustainable and comprehensive.<sup>63</sup> The priorities of health districts were

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<sup>58</sup> SADOH, *White Paper*, pg. 1.

<sup>59</sup> *Ibid.*, pg. 14; South African Department of Health, *Annual Report 2000-2001*, accessed at [www.dog.gov.za/docs/reports/annual/2000-1](http://www.dog.gov.za/docs/reports/annual/2000-1) on 10/10/2008 on 4 March 2009, pg. 39.

<sup>60</sup> SADOH, *White Paper*, pg. 8.

<sup>61</sup> *Ibid.*, pg. 14.

<sup>62</sup> *Ibid.*, pg. 15.

<sup>63</sup> *Ibid.*, pg. 14.

to promote health awareness and community involvement.<sup>64</sup> At the same time, they were responsible for the environmental health of their district – specifically, the provision of safe sanitation and water – as well as the prevention and control of communicable diseases within it.<sup>65</sup>

The Health Department in handing these responsibilities over to local authorities ensured that it was in fact the communities under the care of those authorities that would carry most of the disease-prevention burden. The *White Paper* states that “communities should be involved in communicable disease-control activities”<sup>66</sup> and that “ultimately communities are responsible for their own maintenance of a healthy environment”.<sup>67</sup>

With this in mind, following the death of the RDP, the National Department of Health devised a five-year strategic plan to be implemented between 1999 and 2004, the purpose of which was to “consolidate and build on achievements relating to care access and inequality reduction [and to] give special attention to preventive and promotive health programmes”.<sup>68</sup> The National Department of Health’s *Annual Report 2000-1* admits, however, that the provision of equitable healthcare was as yet unsatisfactory. Nevertheless, it stated its objectives for 2001-2002 as decreasing mortality, improving quality of care and resource management and strengthening international co-operation.<sup>69</sup>

In the same *Annual Report*, however, the Health Department admitted that while 58% of South Africans believed that South African healthcare was satisfactory, 34% believed that it had worsened since 1994, and only 47% of “black” South Africans could easily access care. It should be added that the bulk of the “white” population was thought to be accessing healthcare in the private sector through membership of medical aid schemes.<sup>70</sup> Notably, this survey was done while KwaZulu Natal and the

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<sup>64</sup> SADOH, *White Paper*, pg. 14

<sup>65</sup> *Ibid.*, pg. 40.

<sup>66</sup> *Ibid.*, pg. 68.

<sup>67</sup> *Ibid.*, pg. 72.

<sup>68</sup> SADOH, *Annual Report 2000-2001*, pg. 2.

<sup>69</sup> *Ibid.* pg. 21.

<sup>70</sup> *Ibid.*, pg. 37

Eastern Cape were experiencing outbreaks of cholera that the Department of Health in all its forms seemed unable to stop.

Although 47% of the “black” populace was now within reach of healthcare - an improvement given pre-1994 percentages - it still amounted to less than half of that population. Furthermore the quality of care was often diminished by inadequate diagnosis, treatment, drug stocks and record-keeping.<sup>71</sup> An independent Health Systems Trust survey confirmed what the *Annual Report* suggested: while healthcare had improved in terms of outward appearances (especially in staff-to-patient ratios and the physical condition of facilities) the *quality* of the care provided had decreased. They pointed out that clinics often lacked basic equipment, reliable water and electricity, telephones and adequate referral systems.<sup>72</sup> The *South African Health Review 2001*, moreover, notes that care quality was further diminished by structural problems within the Health Department, particularly inadequate management skills, difficulties in setting priorities, huge demands and lack of rewards or sanctions for performance.<sup>73</sup> These inadequacies lay mostly within the local healthcare authorities, many of which lacked the capacity to provide adequate services,<sup>74</sup> especially in areas which incorporated former “homelands”.

In a country with a large rural population and low resource density, as well as many differences in local conditions, it is most sensible to have responsibility devolve to the level of authority closest to the people it is intended to serve. However, the massive social, political and economic changes occurring between 1994 and 2004 caused problems, only some of which were the result of weaknesses in the primary healthcare-based approach outlined in the 1996 *White Paper*.

Alongside problems of human resource allocation, funding and resource distribution, there were problems in understanding the extent of challenges, personality clashes between the authorities and their communities, and simply getting the new system to

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<sup>71</sup> SADOH, *Annual Report 2000-2001*, pg. 37.

<sup>72</sup> *Ibid.*, pg. 40.

<sup>73</sup> Antoinette Ntuli, “Preface”, in Health Systems Trust, *The South African Health Review 2001* (Durban, 2001), pg. 1.

<sup>74</sup> Di McIntyre and Sandi Mbatsha, “Financing Local Government Health Services” in Health Systems Trust, *The South African Health Review 2001* (Durban, 2001), pg. 50.

work. These problems were mostly to do with consolidating and implementing the processes and policies of the post-1994 Department of Health. However, these problems hampered the ability of the Department and its subsidiaries to deliver adequate healthcare.

This was apparent in the Eastern Cape, a large province which incorporated the former “homelands” of Transkei and Ciskei as well as “white” areas formerly controlled by the Cape Provincial Administration.<sup>75</sup> In addition to widespread poverty and inequalities of distribution of resources and services, the Eastern Cape had infrastructural problems from its inception. For example, in 2003 only 62.4% of Eastern Cape residents, most of whom reside in rural areas, had access to piped water in 2003; at the time the national average was 84.5%.<sup>76</sup> Furthermore, on a national level, in 2003, only 13.6% of South Africans were without access to adequate sanitation facilities; in the Eastern Cape this figure was 30%. Infant mortality in the region was 72 per 1000 births, while the rate for mortality for children under the age of five was 112 per 1000 births.<sup>77</sup> Life expectancy in the province is 54 years of age. The province has extremely high rates of HIV infection, tuberculosis (TB), malnutrition and diarrhoea-related deaths.<sup>78</sup>

The Eastern Cape provincial Department of Health (ECDOH) and its subsidiary districts would, even if they had started out with optimal staffing and resources, have had great difficulty in bringing the health status of that province up to an acceptable level. Given that they in fact began with a massive deficit in staffing, funding and management skills, it is unsurprising that the province’s health status should have remained generally poor.

Between 1994 and 1999, primary healthcare was made available to over one million Eastern Cape residents who did not previously have any access to it.<sup>79</sup> The

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<sup>75</sup> Colm Allan, Robert Mattes and Unathi Millie, *Government Corruption Seen from the Inside: A Survey of Public Officials Perceptions of Corruption in the Eastern Cape* (Grahamstown, 2002), pg. i.

<sup>76</sup> Debbie Bradshaw and Nadine Nannan, “Health Status” in Health Systems Trust, *The South African Health Review 2003/4* (Durban 2004), pg. 1.

<sup>77</sup> Bradshaw and Nannan, “Health Status” pg. 1.

<sup>78</sup> *Ibid.*

<sup>79</sup> Patrick Cull, “Health Services Improving”, *Eastern Province Herald*, 3 March 1999, pg. 2.

percentage of the health budget spent on the province's most impoverished region, the former Transkei, increased from 35% to 54%, but healthcare in the province remained in a state of collapse; the money was spent without any visible changes being apparent.<sup>80</sup> Furthermore, the quality of care made available was dubious: serious problems with drug supplies to clinics existed, with only 75% of clinics having supplies of even three-quarters of the drugs deemed essential. The province's tuberculosis rate of 556 infections per 10 000 was not a significant improvement on pre-1994 levels, and evidenced some failure to adequately address the region's health challenges.<sup>81</sup> In a province with over 80% of its residents depending on the public sector for healthcare,<sup>82</sup> this indicates some failure on the part of the ECDOH and its subsidiaries to adequately treat individuals already infected with TB, as well as to deal with new infections. At the same time, water-borne diseases posed a vast (and avoidable) threat to the province, where 70% of the residents of rural areas were without even basic sanitation.<sup>83</sup>

By late 2000, the situation had not greatly improved. In addition to the general complaints listed in the 2001 *South African Health Review*, it was noted that in late 2000, 226 of the province's 710 clinics had no adequate water supply, 167 were not electrified and 194 were inaccessible except on foot.<sup>84</sup> Although 107 of the unelectrified clinics were connected to a reliable power supply by mid-2001,<sup>85</sup> more clinics had meanwhile been constructed that were not adequately equipped. Furthermore, some clinics were constructed before it was ensured that staff would be available to operate them.<sup>86</sup> Staffing problems and budgetary problems bedevilled the ECDOH constantly throughout the first decade of the ANC government's rule, leading to persistent problems with both staff morale which only further eroded the ECDOH's ability to provide adequate healthcare for the province's population.

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<sup>80</sup> "Third World Conditions Can Improve", *Eastern Province Herald*, 18 August 2000, pg. 7.

<sup>81</sup> Cull, "Health Services Improving".

<sup>82</sup> "Third World."

<sup>83</sup> "Third World."; the rate for the province as a whole, including the major urban areas of Port Elizabeth, East London, King Williams Town, Queenstown and Umtata, is 30%.

<sup>84</sup> "Upgrading of Clinics a Priority", *Eastern Province Herald*, 18 October 2000, pg. 8.

<sup>85</sup> "Rural Health Care Going Mobile with New Policy", *Eastern Province Herald*, 20 July 2001, pg. 14.

<sup>86</sup> *Ibid.*

This is made clear in a February 2002 newspaper article in which acting MEC for Health, Max Mamase, is quoted calling his departmental managers “weak supervisors...with moral-fibre decay”.<sup>87</sup> Compounding these issues was what can most kindly be called ineptitude on the part of the department, which resulted in problems such as delays in budget allocations,<sup>88</sup> underspending and most worryingly, complete failure to budget adequately.<sup>89</sup> In a system where much of the onus to provide healthcare rests on local authorities funded by provincial authorities, the failure of provincial authorities to competently handle finances clearly has serious ramifications. This is especially so in areas where local authorities are still in the process of building their capacity to provide sufficient services, as was and remains the case in the Eastern Cape.

Cholera occurs only in communities where safe water supply and adequate sanitation are not in evidence – and in most cases they are not in evidence because they have not been supplied in the first place. This lack of supply arises from a number of factors, primary among which is the fact that the communities so affected do not appear to be important enough in the eyes of the authorities.<sup>90</sup> In pre-1994 South Africa, this was a fairly straightforward supposition: “black” communities were systematically and deliberately deprived, via actual legislations and government policies, of the conditions necessary for health (as outlined at the beginning of this chapter). Of these conditions required for health, it is environmental health – encompassing the provision and maintenance of sanitation and clean water – that has the most wide-reaching effect, as it is its absence which gives rise to the bulk of

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<sup>87</sup> Phumlani Mdolomba, “Go Out and Serve People, MEC Tells Officials”, *Daily Dispatch*, 6 February 2002, pg. 3

<sup>88</sup> Mphumzi Zuzile, Trevor Neethling and Heidi Bantam, “Cash-strapped Hospitals Will Wait a Week for Vital Funds”, *Eastern Province Herald*, 26 April 2002, pg.2

<sup>89</sup> Xundu, “Premier Admits”

<sup>90</sup> Personal gain is taken to be at least as important as the greater good. In a study by the Rhodes University-based Public Service Accountability Monitor, it was discovered that of all Eastern Cape governmental officials based at the provincial capital, Bisho, 58% believed that it was either “not wrong” or “wrong but understandable” for citizens to offer ‘gifts’ to public officials (Allan et al, *Government Corruption*, pg. xi). The trial of former EC Health MEC Dr Bevan Goqwana on more than 1500 counts of medical-aid fraud in 2002 (Lucas Mati, “Goqwana Goes on Trial This Week”, *Daily Dispatch*, 19 February 2002, pg. 3), and the recent furore around newly-appointed government ministers accepting cars (see, for example, “Zuma’s Cabinet Big of Flashy Cars”, accessed at [www.iol.co.za](http://www.iol.co.za) on 8 October 2009, “DA Slams Pule for Flashy Vehicles”, accessed at [www.iol.co.za](http://www.iol.co.za), on 23 September 2009, and “Transport Minister Accepts ‘Thank You’ Merc”, accessed at *Mail and Guardian Online*, [www.mg.co.za](http://www.mg.co.za), on 18 May 2009) are examples of this.

communicable diseases and other long-term health problems, especially water-borne infections such as typhoid and cholera.

Given that this deprivation was systematic, it is reasonable to suppose that when apartheid was dismantled in the early 1990s and removed entirely in 1994 these conditions would improve. In practice they did not. In fact, the situation remained so obviously unchanged that as late as 2003, Dr Daniel Ncayinana, editor of the *South African Medical Journal*, was moved to remark that,

...almost immediately [after the first democratic elections in 1994, the former Transkei] was catapulted into a wilderness of political misgovernance of such magnitude that its citizens might be forgiven for looking back to the bad old days with longing and nostalgia.<sup>91</sup>

While this is a rather emotive stating of the case, it is not an overstatement.

Management of funding is perhaps the ECDOH's most persistent woe, particularly in the forms of under-spending and the making of incorrect payments. From its establishment onward, the ECDOH seemed unable to correctly calculate its expenditures. In 1995, Eastern Cape Health MEC Trudy Thomas admitted that the health system in the province was "chaotic".<sup>92</sup> Consistent under-funding from 1997 onward led to overspending by R255 million in the 1999/2000 financial year, and the MEC suggested that vital services might have to be curtailed if more funding was not secured.<sup>93</sup> At the same time, the MEC stated that a further R22 million would be needed between October 1999 and June 2000 to fill critical supervisory, management and administrative posts within the department.<sup>94</sup>

Making provision for staff posts was, and remains, a major drain on the departmental budget, with over 33% of the R3,3 billion Eastern Cape health budget (in 2000) being taken up with staffing costs. At the same time, R1,8 billion was allocated to primary health care services at clinics and district hospitals. The fact that the same amount

<sup>91</sup> Daniel J Ncayinana, "Longing for Egypt – The Transkei Dilemma", *South African Medical Journal*, 93, 2, 2003, pg. 1.

<sup>92</sup> "Eastern Cape Health Service Chaos", *Eastern Province Herald*, 3 June 1995, pg. 2.

<sup>93</sup> "Health Services in Crisis – MEC", *Eastern Province Herald*, 14 October 1999, pg. 3.

<sup>94</sup> *Ibid.*

was being spent on staff as on the facilities for which the staff were needed is telling: service delivery was clearly struggling for parity with skills development and deployment. In October 2000, Health MEC Bevan Goqwana admitted that “our department considers all financial savings to be a priority”.<sup>95</sup> This cast doubt on the status of health as a human right;<sup>96</sup> most of the time the ECDOH seemed to treat it as a financial issue, concentrating more on saving money than on providing adequate healthcare to the residents of the province.

In April 2002, many hospital patients went without treatment or food due to delays in payments to hospitals from the ECDOH.<sup>97</sup> This was the result of delays in loading the new budget into the Department’s new financial software;<sup>98</sup> further delays were caused by the Provincial Department of Health’s sluggishness in releasing the 2002/2003 funds, which were in any case R500 million less than those budgeted for for 2001/2002.<sup>99</sup> Another problem with the 2002/2003 budget was that it made no provision for hospital maintenance, which was desperately needed in a province in which hospital and clinic buildings were either old or poorly constructed.<sup>100</sup>

This was especially alarming in light of the Department’s underspending by R700 000 in 2000/2001. In 2003, the Department claimed that it had budgeted R29 billion for rural incentives and R80 million in Mount Frere and Tsolo (both of which were areas at risk for cholera),<sup>101</sup> as well as R150 million to fill “critical health posts”.<sup>102</sup> Nevertheless, Departmental expenditures in 2003 left over R121 million unspent, most of which was intended for medical equipment for new clinics, as well as

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<sup>95</sup> “New Care Strategies”, *Eastern Province Herald*, 18 October 2000, pg. 7.

<sup>96</sup> As enshrined in the Constitution of South Africa, Chapter 2, Section 27: “1. Everyone has the right to have access to A. health care services, including reproductive care, B. Sufficient food and water, C. Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance. 2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. 3. No-one may be refused emergency medical treatment. (Republic of South Africa, Constitution of the Republic of South Africa, 1996; accessed at <http://www.info.gov.za/documents/constitution/1996>, on 28 October 2009.)

<sup>97</sup> Zuzile et al, “Cash-Strapped”.

<sup>98</sup> *Ibid.*

<sup>99</sup> *Ibid.*

<sup>100</sup> Xundu, “Premier Admits”.

<sup>101</sup> Sizwe Kupelo, “Health Department Points Out Its Successes”, *Daily Dispatch*, 23 January 2003, pg. 4.

<sup>102</sup> “More Money to Fill Health Posts”, *Daily Dispatch*, 7 March 2003, pg. 5

renovations for existing clinics.<sup>103</sup> This was alarming because there was a cholera epidemic in progress, which was placed strain on resources; the equipment for which the money was allocated was sorely needed. The cholera epidemic of 2000-2003 was made all the more severe by the ECDOH's lack of equipment and facilities for treatment. All that is needed to treat cholera is rehydration solution, purified water, intravenous drip feeds, and beds; long-term treatment and prevention consists only of supplying purified water that is not in contact with the sanitation system. It was in the latter respect that the most severe problems occurred in the Eastern Cape.

Another exacerbating factor in the 2000-2003 cholera epidemic was the lack of staff, particularly nursing staff, in the province. The majority of cholera victims were resident in rural areas serviced by clinics and, in some cases, district hospitals. These were the very facilities most unlikely to be adequately staffed. Because many of them were under-equipped, lacked electricity and water and were situated very far from major population centres, nursing staff were understandably unwilling to volunteer for work at rural clinics.<sup>104</sup> This reluctance was only made worse by the ECDOH's seeming inability to improve working conditions. As a result, "incentives" were offered to nurses in the early 2000s to encourage them to move to and remain at rural clinics. These did not seem to have a noticeable effect, as the problem persisted between 1995 and 2003.

The 2000-2003 epidemic was not inevitable in its advent; although all the conditions were present, the epidemic nevertheless required the presence of the bacterium to begin. That the bacterium would at some point arrive was likely; that it would spread once it arrived was inevitable given the woeful state of rural sanitation and water infrastructure, a holdover from the apartheid era that was not adequately dealt with by the ANC-led government.<sup>105</sup> The persistence of the epidemic, however, was arguably the sole result of the failure of the ECDOH to get to grips with budgeting

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<sup>103</sup> Mphumzi Zuzile, "DA Blames Underspensing on Lack of Checks, Balances", *Daily Dispatch*, 20 March 2003, pg. 7

<sup>104</sup> "Upgrading of Clinics."

<sup>105</sup> During the 1999-2000 cholera epidemic in KwaZulu-Natal (KZN), a spokesperson for the KZN Department of Health noted that a cholera outbreak in the Eastern Cape could make the Natal outbreak "look like a Sunday school picnic", and further commented that Eastern Cape healthcare workers were worried because the province's lack of water and sanitation infrastructure made it a "red zone" for cholera. (Chris Bateman, "Sharp Eyes on Cholera Flashpoints", in *South African Medical Journal*, 2001, 91, 4, pg. 278-9).

correctly, providing services, and correcting staffing problems, all of which hobbled the *delivery* of the few services provided. A well-organised and well-supplied healthcare authority may have been able to deal with a cholera epidemic even in the face of problematic water supplies. A “limping”<sup>106</sup> health department, understaffed, under-equipped and under-skilled, proved unable to deal with the epidemic.

As argued earlier, in the 1980s, the institutionalised racism of the apartheid regime deprived all “black” communities, particularly rural “black” communities, of the wherewithal to create the conditions necessary for them to maintain health. This deprivation made these communities extremely vulnerable to cholera, which was furthermore left untreated when it struck – at least until it threatened to affect “white” communities. The fragmentation of the health system of that era also had a role in that it obviated any attempts to provide adequate healthcare to rural areas by diffusing monetary, human and medical resources in such a way that “black” healthcare facilities were left floundering. The apartheid regime created conditions conducive to the outbreak of cholera and furthermore made its treatment nigh on impossible.

One would not expect such a statement to remain true of the post-1994 healthcare authorities in South Africa. In fairness, the conditions that made rural South African communities vulnerable to cholera were mostly holdovers from the systematic deprivation of the apartheid era. It should be said, however, that that new regime did not excel itself in combating these conditions. Furthermore, the new healthcare authorities’ focus was divided as it attempted to simultaneously improve skills and facilitate delivery, as well as overcome the problems of fragmentation. It attempted to deal with fragmentation through devolution of authority to local bodies, but because of their lack of co-ordination this tended to increase rather than decrease fragmentation. This did not decrease the risk of cholera to the country, and certainly did not visibly improve on the ability of the ECDOH to deal with the province’s myriad health challenges, let alone a widespread epidemic.

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<sup>106</sup> “DP Warns of Health Disaster”, *Eastern Province Herald*, 2 February 2002, pg. 2

It is undeniable that the ECDOH was, and continues to be, faced with a myriad of problems including resourcing, the province's health backlog, and newly-arising health problems. Rather than making a concerted attempt to organise itself sufficiently to deal with these problems, however, the ECDOH, tended to dissolve into a welter of ineffective actions and excuses. In dealing with the cholera epidemic, which required the co-operation and skill of a vast number of Health Department employees as well as representatives of the various municipalities involved, this approach was potentially damaging. Apart from this, internal disagreements obviously lowered the Department's ability to adequately combat the cholera outbreak that began in 2000.

Beginning as early as 1995, very soon after the ascension of the ANC-led first democratic government, the provincial Health Department began to experience difficulty in, firstly, attracting staff to the region and, secondly, paying those staff adequately and correctly. These problems would persist throughout the late 1990s and into the early 2000s. In July 2000, the Department's main problems were said to be "suspicion, mistrust, corruption and a lack of middle-management capacity".<sup>107</sup> While the MEC, Dr Bevan Goqwana, and the Chief of Human Resources, Mr Chauke Ngoma, cited "resistance to transformation" and "malicious compliance by hospital managers",<sup>108</sup> hospital managers countered that the provincial health authority was "incompetent and idle".<sup>109</sup>

More concretely, investigation carried out by a *South African Medical Journal* team discovered that severe operational problems also existed, in particular shortages of basic equipment, including stethoscopes and blood-pressure cuffs; a transport system so dysfunctional as to be non-existent,<sup>110</sup> and, a falling staff complement. However, "nuts and bolts" issues such as these did not receive as much attention as the problems around staff relationships. This focus was not unreasonable: while procuring new equipment would be fairly straightforward (if budgeting is done appropriately), it was far more difficult to improve staff morale and performance and

<sup>107</sup> Chris Bateman, "The Eastern Cape – Still Untangling our Homeland Legacy", *South African Medical Journal*, 90, 7, 2000, pg. 672

<sup>108</sup> *Ibid.*; the article does not define 'malicious compliance'.

<sup>109</sup> *Ibid.*

<sup>110</sup> Particularly in the north-eastern reaches of the province.

accordingly to reverse the damage it did to the quality of healthcare provision in the province. Furthermore, internal conflict within the Health Department, especially in its satellite facilities, became a problem hindering the provision of adequate healthcare.

That Goqwana had a unique view of the causes for the problems the ECDOH faced is undeniable. One focussed article in the *Eastern Province Herald* made this clear by quoting at length his views on what would constitute a “caring society”, although the occasion at which these views were expressed is not known.<sup>111</sup> Lamenting the lack of caring in South African society, Goqwana wished for

...a situation where the district nurse is not only qualified to assist a mother with a child who has colic and educate people on basic health requirements, but also is able to tell people what they can do on their ground and what can be grown.

And [I want] local taxi owners to become part of the caring society and help if a child gets ill and the clinic wants it taken to hospital urgently....

....I would like a society where you feel so free wherever you are and you feel that people will actually help you when you are in a predicament.

That is the type of society that I am looking for – but I know that it is unachievable.<sup>112</sup>

The rampant underdevelopment of the Eastern Cape was hardly unknown to its citizens. Throughout 2001, Goqwana continued to attribute many Departmental problems to lack of “transformation” among employees within the ECDOH<sup>113</sup> who displayed a pessimistic attitude that had to be “managed” to prevent them sabotaging “certain things that are actually happening”.<sup>114</sup> His apparent reaction to these detractors was a “carry-on-regardless” leadership style, as exhibited by the following quote from a 2001 newspaper article:

If something is good for the community it will happen whether people like it or not...it just depends on the vision of the person in authority and how determined he is that it is going to happen. [People do not understand democracy]: [t]hey think that if something is going to favour them then let it be done

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<sup>111</sup> “Goqwana’s Vision: a Caring Society”, *Eastern Province Herald*, 18 August 2000., pg. 8

<sup>112</sup> *Ibid.*

<sup>113</sup> “Hospital System Revamp”, *Eastern Province Herald*, 5 March 2001, pg. 6

<sup>114</sup> “Revamp”.

irrespective....You cannot get 100% but if you can get more than 50% you can go ahead.<sup>115</sup>

From the attitude exhibited in this quote – one not vastly different from the carry-on-regardless mindsets of pre-1994 leaders – it is unclear whether Goqwana saw pessimists as threatening to the ECDOH or himself. That Goqwana was widely seen as in fact helping to destroy the health service he headed was apparently unclear to him. The Member of the Provincial Legislature (MPL) for the Democratic Party (DP), Athol Trollip called him “an inept political appointee”,<sup>116</sup> while former MEC Trudy Thomas credited him with causing “a mindless, rudderless decaying and a ridiculous scenario”<sup>117</sup> and suggested that “the real agenda of the present political bosses...was the advancement of their individual political careers”.<sup>118</sup>

At this point it becomes possible to see a clear split between the Health Department's version of the Eastern Cape healthcare situation and the apparent reality. While Thomas pointed out the multiple failures of the ECDOH in its attempts to improve the Eastern Cape's health situation, an ANC health spokesperson, Phakamisa Hobongwana, responded by saying that “her logic is very naïve. You spend money for things that are budgeted for. There are no reasons for her to resign [from the ANC].We are developing the Transkei.”<sup>119</sup>

On the subject of hospital cutbacks (seemingly designed to save money without much reference to the realities of patient care)<sup>120</sup> Goqwana admitted that “[t]here had been a lot of resistance from previously advantaged people...But it has to happen. I am definitely going to do it”.<sup>121</sup> While on the subject of increasing the rural incentives paid to nurses, Goqwana stated that all he had to do to have such payments put into the budget is “discuss it with Enoch Godongwana [then-MEC for Finance] to see if

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<sup>115</sup> “Revamp”.

<sup>116</sup> Patrick Cull, “DP Slams Goqwana for Mismanagement”, *Eastern Province Herald*, 25 April 2001, pg. 10

<sup>117</sup> Pula Mabe, “Health MEC Gives Up the Struggle”,

<sup>118</sup> *Ibid.*

<sup>119</sup> Mabe, “Health MEC”.

<sup>120</sup> Hospital rationalisation involved dividing existing facilities between all the hospitals in a region to avoid duplication of services; while this saved money in some areas, the costs of patient transport increased. For people seeking care, ease-of-access would decrease sharply while bureaucratic procedures multiplied.

<sup>121</sup> Patrick Cull, “Hospital Cutbacks Have Begun”, *Eastern Province Herald*, 2 July 2001, pg. 3

we can afford it, and then it put it in the budget".<sup>122</sup> Neither of these statements suggest a great deal of democratic process inbetween Goqwana making the decision and its implementation, and give a worrying picture of the budgeting process. Shortly after this, in early 2002, Goqwana was suspended (with full pay) while under investigation on over a thousand counts of fraud.<sup>123</sup>

In February 2002, a case of maladministration was brought against the Eastern Cape Permanent Secretary for Health, Simphiwe Stamper, when a National Standing Committee on Health rejected an ECDOH annual report on the grounds that it had not provided proper answers to the committee's questions.<sup>124</sup> The Eastern Cape Department of Health's Acting Head, Mamisa Chabula, contradicted many of the report's conclusions and admitted that she did not know who had written the report.<sup>125</sup>

Funding proved the major problem of 2002-2003. Max Mamase, Goqwana's temporary replacement,<sup>126</sup> at a budget hearing in April 2002, admitted that the ECDOH would have to achieve substantially more on a smaller budget, in which inadequate provision had been made for food and maintenance.<sup>127</sup> Budget cuts in 2002 led to some hospitals being unable to purchase supplies.<sup>128</sup> The failure to pay suppliers ascribed to a changeover in accounting programmes was rejected by the Public Service Accountability Monitor as no excuse (the same body called on Mamase to "stop evading responsibility" for the ineffective planning in the ECDOH).<sup>129</sup> In May 2002, Max Mamase, when asked to account for the problems in his Department, stated that they were the result of "an element of sabotage by people who are destroying the hard work",<sup>130</sup> and furthermore blamed Trudy Thomas for the problems, for which he was called to order.<sup>131</sup>

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<sup>122</sup> "Awards for Rural Nurses", *Eastern Province Herald*, 20 July 2001, pg. 14

<sup>123</sup> Mati, "Goqwana Goes on Trial this Week".

<sup>124</sup> Mphumzi Zuzile, "Acting Head Rejects Health Report", *Daily Dispatch*, 21 February 2002, pg. 9.

<sup>125</sup> *Ibid.*

<sup>126</sup> He was MEC for Agriculture in the province before being brought in as Acting MEC for Health.

<sup>127</sup> Adrienne Carlisle, "Greater Demands, Less Cash for Health", *Daily Dispatch*, 16 April 2002., pg. 1

<sup>128</sup> Adrienne Carlisle, "EC Health Care in 'Epic' Crisis", *Daily Dispatch*, 25 April 2002, pg. 1

<sup>129</sup> Adrienne Carlisle, "Monitor Tells Mamase to Accept Responsibility", *Daily Dispatch*, 6 May 2002, pg. 3

<sup>130</sup> Mphumzi Zuzile, "Health 40% Understaffed, 43% Underspent", *Daily Dispatch*, 9 May 2002, pg. 4

<sup>131</sup> *Ibid.*

The then National Minister of Health, Manto Tshabalala-Msimang, openly criticised the Eastern Cape Department of Health's lack of performance, though she also admitted that “to appreciate progress we need to take a long-range view”.<sup>132</sup> The Eastern Cape Premier, Makhenkesi Stofile, however, was less inclined to believe that the ECDOH was its own victim, criticising the press for exaggerating the problems and claiming that: “[t]here [would] be little point basing critique purely on that source”.<sup>133</sup>

A full page open letter from the United Democratic Movement printed in the *Daily Dispatch* in September 2002, imputed the Eastern Cape's failures to the ANC's own ineptitude, arguing “[t]he law of agency prescribes that the act of an agent is imputable to the principle. Any failures that have taken place are thus ANC policy failures.”<sup>134</sup> Likewise, Costa Gazi, Head of Public Health at East London's Cecilia Makiwane Hospital, questioned the commitment of the ECDOH to anything but itself.<sup>135</sup> He called for more intensive investigations against wrongdoers inside the Department, citing the murder of an Alice doctor who threatened to expose corruption;<sup>136</sup> the Eastern ECDOH's failure to take action against a nurse caught pilfering drugs and the reinstatement of Goqwana and Stamper after they were tried for fraud. Stating that “inertia [is] a typical example of protection by corrupt syndicates”,<sup>137</sup> Gazi concluded that corruption, rather than solely poor management (or, presumably, sabotage) was to blame for the Department's poor performance. Following yet another year of under-spending (with the usual lament about underfunding), Athol Trollip remarked that all complaints about deteriorating services had “fallen on deaf ears”.<sup>138</sup>

Throughout the 20<sup>th</sup> century, South Africa has failed to provide adequate healthcare for the bulk of its population, which is reliant on publicly-provided clinics, hospitals, and public-health initiatives. During the apartheid era, this failure to provide was both

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<sup>132</sup> Patrick Cull, “Minister Critical of Eastern Cape”, *Eastern Province Herald*, 13 June 2002, pg. 1

<sup>133</sup> Patrick Cull, “Inefficiency of EC Health Service”, *Eastern Province Herald*, 17 June 2002, pg. 4

<sup>134</sup> United Democratic Movement, “Stofile and ANC Must Go”, *Daily Dispatch*, 11 September 2002, pg. 7

<sup>135</sup> Costa Gazi, “Health Service Feeling the Sting”, *Daily Dispatch*, 7 March 2003. Pg. 5

<sup>136</sup> *Ibid.*

<sup>137</sup> *Ibid.*

<sup>138</sup> Zuzile, “DA Blames Underspending”

the result of “homeland” policies and the under-resourcing of “homeland” health-services departments,<sup>139</sup> as well as an overly complicated governmental health system that battled to co-ordinate itself. In these circumstances, it is not surprising that cholera broke out and spread throughout the eastern half of the country; poor “homeland” infrastructure ensured that the disease spread fast, while the existence of a number of separate health authorities hampered its containment. The spread of cholera drew the newspapers’ attention and held it. The post-apartheid provision of healthcare services was marginally better, in that it acknowledged the existence of problems and made an effort to address the gaps left by apartheid healthcare. However, difficulties in implementing measures to address these gaps, combined with transformational issues and intra-regional disagreements that had political rather than medical roots, hindered the effective delivery of adequate healthcare in the region, leaving it as vulnerable to cholera as it ever was.

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<sup>139</sup> Ncayinana, “Longing for Egypt”, pg. i

### Chapter 3: THE SPREAD AND EXTENT OF TWO CHOLERA OUTBREAKS IN SOUTH AFRICA

#### The South African Cholera Outbreak of 1980-1982

Cholera was made a notifiable condition in South Africa in 1965,<sup>1</sup> although at that time there was no evidence of cholera in South Africa or in any neighbouring countries. The disease reappeared in Sub-Saharan Africa in 1971, affecting several countries in West Africa.<sup>2</sup> By June 1971, the disease had spread eastward into Chad's southeastern Hajder-Lamis region (formerly Massakory Province),<sup>3</sup> where it caused 1 500 deaths, before it spread to Kenya's Turkana region.<sup>4</sup> Angola experienced several outbreaks throughout 1972. Travel between Angola and Mozambique, both Portuguese colonies, led to anti-cholera surveillance being implemented at Mozambican harbours, hospitals and airports.<sup>5</sup> After 1972, the incidence of cholera in Southern and Central Africa declined sharply, only rising again in 1979 when a small outbreak occurred in Zaire (now the Democratic Republic of Congo).<sup>6</sup> Despite this decline, however, five cases of cholera were reported in South Africa between 1971 and 1980, although all of these were subsequently proven to have been contracted outside South Africa.<sup>7</sup>

Early 1980 saw cholera occurring nearer to South Africa, in Zambia<sup>8</sup> and south-west Mozambique.<sup>9</sup> It is likely that the disease entered South Africa from Mozambique at this time. The first South African cases were confirmed at Shongwe Hospital in the "homeland" of KaNgwane on 2 October 1980.<sup>10</sup> By 12 October, 23 clinically-diagnosed cases of cholera had been recorded;<sup>11</sup> an irrigation canal connected to the Crocodile River, from which all the ill

<sup>1</sup> Department of Health, Welfare and Pensions, "Cholera in the Transvaal Lowveld: a Preliminary Report", in *Epidemiological Comments*, 7, 12, 1980, pg. 1.

<sup>2</sup> "Doctor Warns of Cholera Risk", *Eastern Province Herald*, 11 January 1971, pg. 17.

<sup>3</sup> "Cholera in Chad Kills 1500", *Eastern Province Herald*, 15 June 1971, pg. 7.

<sup>4</sup> "16 Kenya Deaths from Cholera", *Eastern Province Herald*, 19 June 1971, pg. 11.

<sup>5</sup> "New Cholera Cases", *Eastern Province Herald*, 31 January 1972, pg 9.

<sup>6</sup> "Cholera on River Boat", *Eastern Province Herald*, 18 August 1979, pg. 11.

<sup>7</sup> DHWP, "Transvaal Lowveld", pg. 3.

<sup>8</sup> "Cholera Kills 16 in Zambia", 12 January 1980, pg. 7.

<sup>9</sup> "Four Die Of Cholera", 17 May 1980, pg. 3.

<sup>10</sup> DHWP, "Transvaal Lowveld", pg. 1.

<sup>11</sup> *Ibid.*

individuals had taken water, was discovered to be contaminated with cholera bacteria. Further victims were found in Malelane, twenty-six kilometres east of Matsulu, also in KaNgwane (see Appendix B, Map 1, locations 1 and 2).<sup>12</sup> The national Department of Health launched a “full-scale plan of action” on 13 October.<sup>13</sup> This was not reported in the *Daily Dispatch* or the *Eastern Province Herald*.

The outbreak of cholera in South Africa in 1980 did not find the country completely unprepared. The Superintendent of Themba Hospital (near Matsulu), quoted in the *Eastern Province Herald*, said that cholera-surveillance had been in place in the region since 1979,<sup>14</sup> while contingency plans had been devised by the Department of Health.<sup>15</sup> Putting the contingency plans into place, however, was made complicated by the number of local authorities involved, which sometimes made it difficult to establish exactly who was responsible for what.<sup>16</sup>

By the end of November 1980, 390 proven<sup>17</sup> cases of cholera had been recorded in South Africa, including six deaths.<sup>18</sup> During that month, cholera had been found west of its original epicentre at KaNgwane, infecting 25 people at Eikenhof on the east Witwatersrand.<sup>19</sup> Although the Department of Health’s *Epidemiological Comments* for that for that month do not mention it, the coverage contained in the *Eastern Province Herald* stated that 14 of the people infected with cholera were “whites”.<sup>20</sup> This is the first and only time the specific

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<sup>12</sup> “New Cases of Cholera Reported”, *Eastern Province Herald*, 13 October 1980, pg. 1

<sup>13</sup> DHWP, “Transvaal Lowveld”, pg. 1

<sup>14</sup> “Cholera Claims Four, 31 Others in Hospital”, *Eastern Province Herald*, 11 October 1980, pg 1

<sup>15</sup> DHWP, “Transvaal Lowveld”, pg. 14

<sup>16</sup> *Ibid.*, pg. 15

<sup>17</sup> The Department of Health, Welfare and Pensions *Epidemiological Comments* use “proven” to designate cases of cholera which have been ascertained, through laboratory tests, to be cholera as opposed to seasonal diarrhoea *resembling* cholera.

<sup>18</sup> Department of Health, Welfare and Pensions, “Further Notes on the 1980 Outbreak of Cholera in South Africa”, in *Epidemiological Comments*, November 1980, pg. 2

<sup>19</sup> Cholera Outbreak: Nine Now Isolated in Johannesburg”, *Eastern Province Herald*, 17 November 1980, pg. 1; “14 Whites Display Cholera Symptoms”, *Eastern Province Herald*, 20 November 1980, pg. 1; Department of Health, Welfare and Pensions, “A Brief Evaluation of the Cholera Containment Strategy Four Months after its Introduction to South Africa”, *Epidemiological Comments*, 8, 1, 1981, pg. 4

<sup>20</sup> “14 Whites”. That is, people designated as “White” under the Registration of Population Act

racial grouping of infected individuals is mentioned in the newspaper coverage of the epidemic.

Cholera also spread north of KaNgwane to Allandale, in the “homeland” of Gazankulu,<sup>21</sup> and from Gazankulu north to the Maandagshoek in the “homeland” Lebowa (see Appendix A, Figure 3, for a map of South African “homelands” *circa* 1982).<sup>22</sup> At this point, the Department of Health suggested in its monthly *Epidemiological Comments* that between 40 000 and 80 000 people may have been infected, many of these cases were ‘mild’ (where people did not seek medical attention) or asymptomatic cases.<sup>23</sup> The Department stated that spread was likely. This statement was repeated in a November radio broadcast by Dr Margaretha Isaacson, head of Tropical Pathology at the South African Institute of Medical Research, who further stated that a vaccine-based anti-cholera programme would not stop the epidemic.<sup>24</sup>

The Department of Health released a revised anti-cholera policy on 2 December 1980, aimed at containing the epidemic to as small an area as possible by supplying adequate amounts of clean water, providing large-scale health education in affected communities (particularly around matters of personal hygiene and the improvement of sanitary conditions) and treating the infected individual and any “contacts”<sup>25</sup> they may have had.<sup>26</sup> No mention of this was made in the *Daily Dispatch* or the *Eastern Province Herald*.

By the end of May 1981, 3 561 proven cases of cholera had occurred in South Africa, mainly in KaNgwane, the Northern Transvaal, and Lebowa.<sup>27</sup> The mid-February 1981 total was 1 592,<sup>28</sup> indicating that the number of infections had

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of 1950.

<sup>21</sup> DHWP, “A Brief Evaluation”, pg. 9.

<sup>22</sup> *Ibid.*, pg. 10.

<sup>23</sup> *Ibid.*, pg. 12.

<sup>24</sup> “Cholera Has Not Yet Reached ‘Crisis Stage’”, *Eastern Province Herald*, 3 November 1980, pg. 3.

<sup>25</sup> Fairly obviously, this term designates individuals who come into contact with the infected individual, and who are thus at risk of becoming ill themselves.

<sup>26</sup> DHWP, “A Brief Evaluation”, pg. 16.

<sup>27</sup> Department of Health, Welfare and Pensions, “Analysis of Cholera Data”, *Epidemiological Comments*, 8, 6, 1981, pg. 2.

<sup>28</sup> “Cholera Deaths”, *Eastern Province Herald*, 17 February 1981, pg. 4.

more than doubled since February. It was discovered that twice as many males than females had died and that death was more likely to occur if the infected individual was over 40 years of age.<sup>29</sup> Because of the correlation between maximum temperature, rainfall and the incidence of cholera, it was believed that cholera would decline in the winter season between June and August 1981.<sup>30</sup> The most severely affected regions in June 1981 were KaNgwane, the Northern Transvaal and Lebowa.<sup>31</sup> Natal had shown only three infections thus far, which was described as a “very low” incidence rate.<sup>32</sup> Males over the age of 40 were still the group most likely to become affected,<sup>33</sup> although no explanation for this was put forward.

In September 1981, the Department of Health declared the 1980-1981 cholera outbreak to have ended, with a total of 3 786 proven cases of cholera, including 42 deaths.<sup>34</sup> However, in October 1981, the *Star* newspaper reported cases in Bophuthatswana; considered to be “independent” from South Africa the region was therefore not within the Department of Health’s jurisdiction.<sup>35</sup> At the same time seven cases were reported at Hammanskraal in the Northern Transvaal, and one was reported in Lebowa.<sup>36</sup> By November 1981, over 220 cases of cholera had been confirmed in Lebowa, KwaZulu and Bophuthatswana.<sup>37</sup> By December, the disease had spread in the “homeland” of KwaZulu and Natal, with 321 and 13 infections in each of those regions respectively.<sup>38</sup>

KwaZulu reported 1 357 proven cases of cholera by January 1982, while Natal reported 847.<sup>39</sup> At this time, the Department of Health stated in the

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<sup>29</sup> DHWP, “Analysis”, pg. 2

<sup>30</sup> *Ibid.*

<sup>31</sup> *Ibid.* pg. 5

<sup>32</sup> *Ibid.* pg. 6

<sup>33</sup> *Ibid.* pg. 11

<sup>34</sup> Department of Health, Welfare and Pensions, “Up-Date: Cholera”, in *Epidemiological Comments*, 8, 9, 1981, pg. 2

<sup>35</sup> Department of Health, Welfare and Pensions, “Cholera up-date”, in *Epidemiological Comments*, 8, 10, 1981, pg. 1

<sup>36</sup> *Ibid.*, pg. 20.

<sup>37</sup> Department of Health, Welfare and Pensions, “Cholera Up-date”, in *Epidemiological Comments*, 8, 11, 1981, pg. 19

<sup>38</sup> Department of Health, Welfare and Pensions, “Cholera Up-date”, in *Epidemiological Comments*, 8, 12, 1981, pg. 10

<sup>39</sup> Department of Health, Welfare and Pensions, “Cholera Up-date”, in *Epidemiological*

*Epidemiological Comments* that it had identified the mode of transmission of the newest cholera outbreaks: the consumption of untreated water from open water sources such as rivers, dams and canals.<sup>40</sup> Anti-cholera efforts accordingly began to focus on the provision of health education on the importance of clean water.

Most cholera cases diagnosed in Natal originated in Stanger (see Appendix B, Map 2, location 3), with 591 of the province's 847 cases occurring there.<sup>41</sup> It was admitted, however, that it was not always possible to differentiate between cases originating in Natal and cases originating in KwaZulu because of the "intimate geographic relationship" between the two regions (see Appendix B, Figure 3).<sup>42</sup> Perhaps because Stanger's proximity to Durban made it likely that reports of cholera would start a panic, the infection was at first said to be something very like cholera but not cholera itself.<sup>43</sup> This statement was made by the South African Department of Health, based in Pretoria, despite the protests of the Stanger Medical Officer of Health, Dr E.C. Bhorat.<sup>44</sup> Bhorat, an Indian-trained medical doctor who had dealt with cholera in India and Pakistan, blamed the outbreak on the slum conditions in which the affected population lived. The Pretoria-based Department of Health, represented by Head Epidemiologist Dr H.G. Küstner, persisted in denying that the infection was cholera. Nevertheless, Küstner noted that the strain of cholera in South Africa was extremely difficult to contain,<sup>45</sup> thereby neatly denying the existence of an epidemic while simultaneously excusing his department's inability to contain it. However, shortly after this pronouncement, it was admitted that cholera – rather than a mysterious unidentified infection closely resembling cholera – had reached "epidemic proportions" in Maphumulo, an area of the so-called homeland of KwaZulu, 42 kilometres west of Stanger (Appendix B, Map 2, location 4).<sup>46</sup> The

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*Comments*, 9, 1, 1982, pg. 2

<sup>40</sup> Department of Health, Welfare and Pensions, "The Mode of Transmission of Cholera in Lebowa, 1981," *Epidemiological Comments*, 9, 1, 1982, pg. 11

<sup>41</sup> DHWP, "Cholera Up-Date", 9, 1, 1982, pg. 17-18

<sup>42</sup> *Ibid.* pg 17

<sup>43</sup> "Stanger Gastric Infection Not Cholera, Says Health Official," *Eastern Province Herald*, 7 December 1981, pg. 3

<sup>44</sup> "Stanger Gastric Infection".

<sup>45</sup> *Ibid.*

<sup>46</sup> "Cholera at Epidemic Stage in KwaZulu", *Eastern Province Herald*, 24 December 1981, pg.

infected people were believed to have been drawing water from the Mboti River (Stanger lies on the same river),<sup>47</sup> leading to on average 55 new cases a day.<sup>48</sup> Health Department officials brought chlorine tablets into the area, along with warnings to local residents to boil water before use.<sup>49</sup> This was the first time any physical countermeasures against cholera have been mentioned in the *Dispatch* or the *Herald*. Until then, anti-cholera measures in the press had been limited to injunctions to observe hygiene and to boil drinking water.

In January 1982, the *Eastern Province Herald* reported that the Cape regional Department of Health, Welfare and Pensions was taking precautions against serious outbreaks. The Port Elizabeth Medical Officer of Health reported that a cholera outbreak in the area was quite possible but could be easily controlled.<sup>50</sup> At this point, the epidemic was still more than 800km east of East London, the easternmost of the two major Eastern Cape cities. However, the speed at which the epidemic had spread, and the difficulty Natal authorities were having in containing it, caused the Cape authorities to begin to make contingency plans, including increasing activity at long-established monitoring points within Port Elizabeth.<sup>51</sup>

In February 1982, a “slight decline” in cases was reported for Natal and KwaZulu, although the “cholera activity” in KwaZulu and Natal was still severe.<sup>52</sup> The total number of proven cases in South Africa at that time was 5809, including 73 deaths.<sup>53</sup> The actual number of cases treated, but not clinically diagnosed, as cholera was estimated to be closer to 30 000. Also in February, cholera entered the Transkei, with 40 proven cases and three deaths reported in the Department of Health’s *Epidemiological Comments*.<sup>54</sup> It should be noted, however, that Transkei was considered by South Africa to be an independent

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<sup>47</sup> Automobile Association of South Africa, *2009 Road Atlas of South Africa*, pg 17.

<sup>48</sup> “Epidemic Stage in KwaZulu”

<sup>49</sup> *Ibid.*

<sup>50</sup> “E Cape Check for Cholera”, *Eastern Province Herald*, 5 January 1982., pg. 3

<sup>51</sup> “Natal Cholera Still Not Contained”, *Eastern Province Herald*, 8 January 1982, pg. 7

<sup>52</sup> Department of Health, Welfare and Pensions, “Cholera Up-Date”, *Epidemiological Comments*, 9, 2, 1982, pg. 2

<sup>53</sup> DHWP, “Cholera Up-Date”, pg. 2

<sup>54</sup> *Ibid.*, pg. 17

state, and therefore its cholera-related statistics were not automatically included in the *Epidemiological Comments*.

In late January 1982, the *Eastern Province Herald* reported the first fatality in the “homeland” of Transkei: a young man that had contracted the disease while working in Natal died at Mount Ayliff hospital, 20 kilometres from the Natal border (see Appendix B, Map 3, location 10).<sup>55</sup> To prevent an outbreak, 20 000 people in the Mount Ayliff area were given emergency preventive treatment.<sup>56</sup> Transkei Health Department officials were expected to work in tandem with the State Health Department in Durban to distribute information on anti-cholera measures, while all people entering the region were required to pass through medical checkpoints.<sup>57</sup> At the same time, chlorinated water was stockpiled for distribution.

Ten cholera-related deaths occurred in the Transkei between the end of January and 10 February.<sup>58</sup> On the 12<sup>th</sup> of that month the Transkei Deputy Secretary of Health, Dr R.F. Ingle stated that cholera had spread from Mount Ayliff to Port St Johns (see Appendix B, Map 4, location 8), some distance to the south-west, as well as towards Nqeleni, to the south-east (Appendix B, Map 4, location 9).<sup>59</sup> Another death occurred at Mqanduli, thirty kilometres east of Umtata, near Nqeleni (see Appendix B, Map 4, location 11).<sup>60</sup> A week later, 22 cholera cases were confirmed in the Transkei, with two deaths.<sup>61</sup> By late February 1982, 48 suspected cholera cases had been recorded in the Mount Ayliff and Port St Johns areas of the north-eastern Transkei,<sup>62</sup> although the disease had not yet spread further west or south towards East London, Port Elizabeth and Ciskei. The fourth and last reported cholera-related death in Transkei occurred in late

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<sup>55</sup> “T’Kei Hospitals Get Set for Fight Against Cholera”, *Eastern Province Herald*, 30 January 1982

<sup>56</sup> “Transkei Hospitals”.

<sup>57</sup> *Ibid.*

<sup>58</sup> “Cholera: Crash Course in PE”, *Eastern Province Herald*, 10 February 1982, pg. 3

<sup>59</sup> “Transkei Cholera ‘in Control’”, *Eastern Province Herald*, 12 February 1982, pg. 1

<sup>60</sup> “Third Cholera Death”, *Daily Dispatch*, 23 February 1982, pg. 1

<sup>61</sup> “Man Dies of Cholera”, *Eastern Province Herald*, 19 February 1982; , “Seven Cholera Cases Proved”, *Daily Dispatch*, 17 February 1982, pg. 1.

<sup>62</sup> “‘Healing Water’ Doctored Against Cholera”, *Eastern Province Herald*, 24 February 1982, pg. 3

April 1982, in the Transkei capital of Umtata (see Appendix B, Map 4, location 12).

The Department of Health stated that the 1981-1983 phase of the cholera outbreak had been halted by July 1982.<sup>63</sup> Although the epidemic continued until 1987, it was never again as severe or as widespread as in the period October 1980-July 1982.

*Table 2: Chronology of 1980-1993 South African Cholera Outbreak.*

| DATE                           | LOCATION                                  | INCIDENT  |
|--------------------------------|---|---|
| <b>PRE-1980</b>                |   |   |
| January 1971                   | Sub-Saharan Africa                        | Unspecified number ill  |
| June 1971                      | Massokory, Chad                           | Unspecified number ill  |
| June 1971                      | Turkana, Kenya                            | Unspecified number ill  |
| January 1972                   | Angola                                    | Unspecified number ill  |
| 1973                           | East London, Port Elizabeth, Eastern Cape | Surveillance of water supplies implemented.                                   |
| August 1979                    | Zaire                                     | Unspecified number ill  |
| <b>1980</b>                    |   |   |
| January 1980                   | North-East Zambia                         | Unspecified number ill  |
| May 1980                       | South-west Mozambique                     | Unspecified number ill  |
| 30 September to 6 October 1980 | KaNgwane and Eastern Transvaal            | Two dead, six ill   |
| 1 October 1980-31 May 1981     | Unspecified Location                      | 3561 proven cases of cholera in South Africa, 36 deaths                       |
| 2 October                      | Shongwe, KaNgwane                         | First Clinical Diagnosis of Cholera in South Africa                           |
| 7 to 13 October                | KaNgwane                                  | 23 asymptomatic cases, 33 ill, 2 dead   |
| 7 October                      | KaNgwane                                  | 6 confirmed cases at Shongwe Hospital, 16 suspected cases at Themba Hospital. |
| 11 October                     | Matsulu, Malelane, KaNgwane               | 4 dead, 31 ill – according to Eastern Province Herald                         |
| 12 October                     | KaNgwane                                  | 23 instances of cholera in South Africa                                       |
| 13 October                     | South Africa                              | Full-scale anti-cholera plan of action launched by DHWP                       |
| 14 – 20 October                | KaNgwane and Eastern Transvaal            | 50 asymptomatic cases, 39 ill   |

<sup>63</sup> Department of Health, Welfare and Pensions, "Cholera Up-Date", *Epidemiological Comments*, 9, 7, 1982, pg. 2

| DATE                              | LOCATION                         | INCIDENT   |
|-----------------------------------|----------------------------------|--|
| 21-27 October                     | KaNgwane and Eastern Transvaal   | 55 asymptomatic, 37 ill  |
| 28 October to 3 November          | KaNgwane and Eastern Transvaal   | 1 asymptomatic, 30 ill   |
| 30 October                        | KaNgwane and Eastern Transvaal   | 250 confirmed cholera infections, of which 127 were asymptomatic carriers. |
| 4-10 November                     | KaNgwane and Eastern Transvaal   | 15 ill   |
| 11-17 November                    | Unspecified Location             | 18 asymptomatic, 36 ill, 2 dead  |
| 11 November                       | Eikenhof (Transvaal)             | First of eventual 32 infections reported                                   |
| 17 November                       | Eikenhof (Transvaal)             | 9 ill  |
| 18-24 November                    | Unspecified Location             | 5 ill  |
| 19 November                       | Katlehong, Germiston (Transvaal) | First of 7 eventual infections reported                                    |
| 20 November                       | Eikenhof (Transvaal)             | 1 dead, 14 ill   |
| 21 November                       | South Africa                     | 6 dead, 390 ill  |
| 24-30 November                    | Unspecified Location             | 117 cases confirmed  |
| 26 November                       | Maandagshoek (Lebowa)            | Cases reported   |
| 28 November                       | Eastern Transvaal                | 47 ill   |
| 1-7 December                      | Unspecified Location             | 52 cases confirmed   |
| 1 December                        | Lebowa                           | 4 ill  |
| 1 December                        | Eastern Transvaal                | 11 ill   |
| 8-14 December                     | Unspecified Location             | 58 cases confirmed   |
| 15-21 December                    | Unspecified Location             | 100 cases confirmed  |
| 22-28 December                    | South Africa                     | 161 cases confirmed  |
| 29 December 1980 - 4 January 1981 | Unspecified Location             | 206 cases confirmed  |
| 30 December                       | Bergville (Natal)                | Cases reported   |
| <b>1981</b>                       |                                  |  |
| 5-11 January                      | Unspecified Location             | 193 confirmed cases  |
| 7 January                         | Edenville (Orange Free State)    | Case reported  |
| 9 January                         | South Africa                     | Reported that 125 ill, nationwide  |
| 12-18 January                     | Unspecified Location             | 270 cases confirmed  |
| 15 January                        | KaNgwane                         | Unspecified number ill   |
| 15 January                        | Northern Transvaal               | Unspecified number ill   |
| 15 January                        | South Transvaal                  | Unspecified number ill   |
| 21 January                        | Unspecified Location             | 1600 proven cases of cholera in South Africa                               |
| End September 1981                | South Africa                     | Cholera epidemic declared closed, with 3590 proven cases of cholera.       |
| October - December 1981           | Johannesburg (Transvaal)         | Cholera bacteria found in city's water supply.                             |

| DATE            | LOCATION   | INCIDENT  |
|-----------------|--|---|
| 13 October 1981 | Hammanskraal (Transvaal)   | DHWP Epidemiological Comments reports that The Star newspaper reports 100+ new cases of cholera.                                    |
| End November    | Odi (Bophutatswana);<br>Ingwavuma (KwaZulu);<br>Thabamoopo (Lebowa). | "New upsurge" in cholera reported in these places, with 220 proven cholera cases, 10 deaths.  |
| 7 December      | South Africa   | 616 proven cases of cholera – 216 in Lebowa, 321 in KwaZulu, 13 in Natal, 1 in QwaQwa, 62 in South Transvaal, 3 in North Transvaal. |
| 7 December      | Stanger (Natal)  | 8 dead; unspecified number ill.   |
| 29 December     | Maphumulo, Ndwedwe (KwaZulu)   | Rehydration stations set up   |
| End 1981        | South Africa   | Reported 1199 confirmed cases   |
| <b>1982</b>     |  |   |
| 2 January       | South Africa   | 3675 confirmed cases nationwide   |
| 4 January       | Empangeni, Melmoth (Natal)   | Disease said to be "approaching" here   |
| 16 January      | Bloemfontein (Orange Free State)                                     | "black" resident of PE diagnosed with cholera   |
| 19 January      | South Africa   | 2872 proven cases of cholera in SA  |
| 19 January      | Stanger (Natal)  | 591 proven cases; Osindisweni, 119; Clairwood, 70; Eshowe, 18; KwaDabeka, 14; Mariaanhill, 8.                                       |
| 19 January      | Maphumulo (KwaZulu)  | 1235 cases from Ingwavuma, Ubombo, Hlabisa. Lower Umfolozi in KwaZulu; 122 from Maphumulo in adjacent Natal                         |
| 30 January      | Mount Ayliff (Transkei)  | 1 dead  |
| 25 February     | South Africa   | 5809 proven cases of cholera; 73 deaths   |
| 25 February     | Lusikisiki, Ngqeleni, Port St Johns (Transkei)                       | 40 proven cases, 3 deaths   |
| 12 February     | Port St Johns Ngqeleni,  | Unspecified number ill  |
| 23 February     | Mqanduli (Transkei)  | 1 dead  |
| 24 February     | Port St Johns, Ngqeleni, (Transkei)                                  | 48 suspected cases  |
| 1 March         | Natal  | Collection of shellfish banned  |
| 6 March         | Umtata, (Transkei)   | 1 dead  |
| 8 March         | Estcourt Weenen (Natal)  | Unspecified number ill  |

| DATE     | LOCATION  | INCIDENT               |
|----------|---|------------------------|
| 1 June   | Groutville (KwaZulu)  | 80 possible infections |
| End July | DHWP states that “the second major cholera outbreak has ended.” |                        |

### Underdevelopment and Cholera Risk: The Eastern Cape after 1994

In the case of the Eastern Cape, a new province comprised partly of the “homelands” of Ciskei and Transkei, the provincial government faced massive problems in dealing with the backlog of service delivery and infrastructure. The region was – and remains – one of the most underdeveloped<sup>64</sup> provinces in the country. The Eastern Cape, with a total population of 8 323 786,<sup>65</sup> makes up 13,6% of South Africa’s total surface area, is the second largest province and has the third-largest population.<sup>66</sup> The former “homelands” of Ciskei and Transkei make up 4,7% and 25,6% of the Eastern Cape’s area respectively.<sup>67</sup> In 1996, the province’s population was 89,1% “black”, 4,9% “white”, 5,8% “Coloured” and 0,2% “Asian”.<sup>68</sup> Women make up 53,1% of the population, and outnumber men in rural areas – that is, where economic prospects are poorest.<sup>69</sup> This is a result of the migrant labour system that formerly predominated in the region, and which to a lesser extent still does; the result was a high proportion of female-headed households.<sup>70</sup> Only 43,3% of the population is officially urbanised – that is, was resident in a town controlled by some kind of local authority.<sup>71</sup> 84,7% of the “white” and 98,8% of the “Asian” population was officially urbanised; in contrast, only 37,8% of the “black” population was urbanised.<sup>72</sup> This imbalance is the result of the predominantly rural nature of the former Transkei and Ciskei.

<sup>64</sup> Please see the Introduction for an extended definition of this term.

<sup>65</sup> HR Lloyd and M Levin, *Research Report no. 64: A Population Analysis of the Eastern Cape Province 1996* (Port Elizabeth, 1996), pg. 1

<sup>66</sup> *Ibid.*, pg. 4

<sup>67</sup> *Ibid.*

<sup>68</sup> *Ibid.* The original source does not place racial designations in quotation marks.

<sup>69</sup> *Ibid.*, pg. 6

<sup>70</sup> Increasingly, as the HIV and AIDS epidemic worsens, it results in child-headed households, which have even less economic and political wherewithal than female-headed households.

<sup>71</sup> Lloyd and Levin, pg. 7

<sup>72</sup> *Ibid.*, pg. 8; the main urban areas are Port Elizabeth, East London, Port Alfred, Grahamstown, King Williams Town-Bhisho, Mthatha, and Queenstown.

The province's most heavily-populated rural regions in 1998 were Mthatha (total population 294 473), Ngqeleni (117 940) and Mqanduli.<sup>73</sup> Population density in these regions was, in 1998, 164/km<sup>2</sup> in Umtata district, 84/km<sup>2</sup> in Ngqeleni and 113/km<sup>2</sup> in Mqanduli.<sup>74</sup> Informal housing predominates in these areas: in Umtata 70% of the population lived in housing described as "traditional houses and shacks",<sup>75</sup> while the number was higher in Mqanduli and Ngqeleni (both 99,6%).<sup>76</sup>

Access to sanitation and purified water is consequently equally dire. In 1998, in Umtata, only 21,4% of households had access to water-borne sewerage or septic tanks; 78,6% of the population made use of bucket or pit latrines, and only 22% had access to on-site water.<sup>77</sup> Mqanduli (1,3%; 98,7%; 2,8%),<sup>78</sup> and Ngqeleni (3,1%; 96,9%; 5,5%) trailed behind in this area.<sup>79</sup> Access to electricity in formal housing was much higher: in Umtata, 59.3% of houses were electrified, while the figures in Ngqeleni (58,8%) and Mqanduli (58,7%) were similar. In informal housing (the predominant housing in these areas) access is much lower: in Umtata, only 1,6% of informal houses were electrified and in Ngqeleni, this dropped to just 1%, and to 0,5% in Mqanduli.<sup>80</sup> Unemployment in those regions averaged 70%.<sup>81</sup>

The high population densities outlined above, combined with the predominance of informal housing and the extremely low access to adequate water and sanitation, indicate extreme lack of access to infrastructure, as well as extensive

<sup>73</sup> B.M. O'Leary, V. Govind, C.A. Shwabe and J.M. Taylor (eds.), *Service Needs and Provision in the Eastern Cape* (Pretoria, 1998), pg. 15

<sup>74</sup> O'Leary et al, *Service Needs*, pg. 39-40.

<sup>75</sup> *Ibid.*, pg. 84. The editors of that volume admit that the grouping of traditional housing and shacks is unfortunate. In rural areas, traditional housing predominates over shacks. For the purposes of this analysis, however, the grouping of the two is, though unsubtle, suitable, as neither are likely to have indoor plumbing, running water, or particularly sophisticated outdoor sanitation facilities.

<sup>76</sup> *Ibid.*, pg. 87-88.

<sup>77</sup> *Ibid.*, pg. 107-108, 104-105, 112-133.

<sup>78</sup> The first percentage is that for houses with access to waterborne sewerage in the area, the second is for houses with bucket or pit latrines, and the third is that for houses with access to on-site water.

<sup>79</sup> *Ibid.*; note that the figures given in brackets are (access to waterborne sewerage/septic tanks; use of bucket/pit latrine; access to on-site water.)

<sup>80</sup> *Ibid.*, pg. 126-7.

<sup>81</sup> *Ibid.*, pg. 20-21. The individual unemployment figures are Umtata 57%, Ngqeleni 67%, and Mqanduli 77%.

economic disempowerment in the Eastern Cape. In addition, the high levels of unemployment meant that it would be extremely difficult for the bulk of those regions' populations to remove themselves from those conditions without extensive and intensive governmental assistance. It is reasonable to state that the inhabitants of the eastern half of the Eastern Cape, and particularly of those regions described in detail above, belong to the underclass as defined above, and consequently were "underdeveloped". Conversely, the governmental bodies charged with controlling the region, particularly in the case of the cholera epidemic that struck between 2000 and 2003, belonged to an elite, "developed" group. That "elite", however, was conspicuously failing to deliver services or improve the region's infrastructure by 2000.

#### The 2000-2003 Eastern Cape Cholera Outbreak

The 2000-2003 Eastern Cape cholera outbreak was an offshoot of the cholera epidemic in KwaZulu-Natal in 2000. By December 2000, there had been 71 deaths and 24 090 infections in KwaZulu-Natal.<sup>82</sup> Cholera entered the Eastern Cape in March 2001, with one person becoming infected at Mzimkulu (see Map 5, page 78, location 1). By May 2001, cholera had spread as far as Bizana (see Map 5, Page 78, location 2), some distance south-southwest of Mzimkulu.<sup>83</sup> Vetebese George, the superintendent of Bizana hospital, blamed the outbreak on inadequate sanitation and unprotected water sources in the region.<sup>84</sup> At this stage, early in the Eastern Cape outbreak, Costa Gazi, the Cecilia Makiwane Hospital Head of Public Health, advised that the government should construct a large-scale treatment and prevention campaign if it wished to prevent a serious epidemic.<sup>85</sup>

On the 16<sup>th</sup> of May<sup>86</sup>, the Department of Water Affairs and Forestry announced plans to install 59 water-and-sanitation programmes in cholera-prone areas of the Eastern Cape. Minister Ronnie Kasrils, Head of the Department of Water

<sup>82</sup> "Anti-Cholera Alert: SANDF on Standby in East Cape", *Eastern Province Herald*, 1 December 2000, pg. 5

<sup>83</sup> "Cholera Strikes in Eastern Cape", *Eastern Province Herald*, 1 May 2001, pg. 3

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

<sup>85</sup> "E Cape Cholera Worries Increase", *Eastern Province Herald*, 4 May 2001, pg. 4

<sup>86</sup> Patrick Cull, "R300m for Sanitation in Cholera Areas", *Eastern Province Herald*, 16 May 2001, pg. 2

Affairs and Forestry, stated that of the 18 million people in South Africa who did not have access to adequate sanitation, 80% had “some sort of rudimentary do-it-yourself toilets”, which could be improved rather than replaced wholesale.<sup>87</sup>

Cholera infections in the Eastern Cape all but disappeared until January 2002, when ten people died and 41 fell ill at Qinqqolo in the Mqanduli district near Mthatha (see Map 6, page 79, location 3).<sup>88</sup> According to Department of Health statistics, these infections must have occurred after 9 January, as there were no recorded infections until that date.<sup>89</sup> Although the cause of death of the Qinqqolo victims was initially unknown, it was soon confirmed as cholera.<sup>90</sup> There was no consensus as to the number of infections, with figures ranging from eight to 16 given by various members of the Health Department, local residents, and local hospital staff.<sup>91</sup>

A “joint operation committee”<sup>92</sup> was set up in late January to oversee the Qinqqolo/Mqanduli outbreak. It resolved to provide the area with more clean water and portable toilets in the short-term, with the provision of a permanent purified water supply as in the long-term. In spite of this, the disease spread to the village of Orange Grove, also in the Mqanduli area.<sup>93</sup> The residents of this village were supplied with tanked water in a effort to contain the epidemic. By 23 January 2002, 66 proven cases of cholera had occurred in the Eastern Cape, including five deaths.<sup>94</sup>

Between 8 January and 1 February 2002, 162 proven cases and eight deaths had been recorded. During February, the outbreak spread from Qinqqolo and Orange Grove to Nqanda, bringing the death toll to 174 since early 2001.<sup>95</sup>

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<sup>87</sup> Cull, “R300m for Sanitation.”

<sup>88</sup> “Mystery Disease in Transkei Kills Ten”, *Eastern Province Herald*, 21 January 2002, pg. 1

<sup>89</sup> South African Department of Health, “Cholera in South Africa as of 09.01.2002”, accessed at [www.doh.gov.za/issues/cholera/updates02/0109.html](http://www.doh.gov.za/issues/cholera/updates02/0109.html), 01 October 2009.

<sup>90</sup> Mayibongwe Maqhina, “Tests Confirm Cholera Cause of Deaths”, *Daily Dispatch*, 22 January 2002, pg. 1

<sup>91</sup> *Ibid.*

<sup>92</sup> Mayibongwe Maqhina, “Cholera Committee Set Up”, *Daily Dispatch*, 23 January 2002, pg. 1

<sup>93</sup> Mayibongwe Maqhina, “Cholera Hits Second Village”, *Daily Dispatch*, 31 January 2002, pg. 1

<sup>94</sup> Department of Health, “Cholera in South Africa as on 23.01.2002”, accessed at [www.doh.gov.za/issues/cholera/updates02/0123.htm](http://www.doh.gov.za/issues/cholera/updates02/0123.htm) on 1 October 2009.

<sup>95</sup> Mphumzi Zuzile and Phumlani Mdolomba, “Umtata Sewage Cause of Cholera Says

Acting Health MEC Max Mamase blamed this on sewage leaking from the Mthatha sewage works. The Eastern Cape government was reported to be applying for a R10 million grant from the national government to help combat the disease in the region, which stated to be the result of “historical factors like poor sanitation, lack of water supply, and lack of infrastructure”.<sup>96</sup>

The number of proven cholera cases stood at 845 on 21 March 2002 and included 22 deaths. The epidemic spread to Ngcansini near Qingqolo;<sup>97</sup> shortly thereafter several cases were recorded at Coffee Bay.<sup>98</sup> The spread of the outbreak slowed in the winter of 2002, allowing time for government bodies to re-assess both their rhetoric and future plans of action. In October 2002, the Oliver Tambo District Municipality's inter-sectoral task team met to “find proactive measures and to outline a co-ordinated approach when dealing with the spread of diseases in the region”.<sup>99</sup> They identified the following factors hampering progress: lack of access to clean water or sanitation, poor roads, and, rather vaguely, ‘cultural beliefs’.<sup>100</sup>

Despite a decline in the latter half of 2002, in January 2003 the outbreak spread to the Qumbu (see Appendix B, Map 5, Appendix B, location 4) and Port St Johns (see Appendix B, Map 6, location 5) districts, with seven deaths and 33 infections in Buziya, Buhlungwana, Gxulu and Mampabe.<sup>101</sup> Between 1 and 24 January 2003, 483 cases of cholera had been proven, including three deaths.<sup>102</sup> In February 2003, cholera spread to the Tina Falls region, where 267 people were treated for cholera, bringing the total number of infections in the Oliver

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Mamase”, *Daily Dispatch*, 7 February 2002, pg. 3

<sup>96</sup> *Ibid.*

<sup>97</sup> Stan Mzimba, “Youth Dies in Transkei's Cholera Outbreak”, *Daily Dispatch*, 22 March 2002, pg. 2

<sup>98</sup> Mayibongwe Maqhina, “Transkei Cholera Toll Up to 39”, *Daily Dispatch*, 10 May 2002, pg. 7

<sup>99</sup> Madoda Dyonana, “OR Tambo Plans to Fight Disease”, *Daily Dispatch*, 11 October 2002, pg. 5

<sup>100</sup> *Ibid.*

<sup>101</sup> Madoda Dyonana, “New Cholera Outbreak in Transkei Claims Seven Lives”, *Eastern Province Herald*, 6 January 2003, pg 2

<sup>102</sup> Department of Health, “Cholera in South Africa as on 23.01.2003”, accessed at [www.doh.gov.za/issues/cholera/updates03/0124.html](http://www.doh.gov.za/issues/cholera/updates03/0124.html), 01 October 2009.

Tambo District Municipality to 650 since December 2002.<sup>103</sup> Shortly thereafter, the disease spread to Cofimvaba;<sup>104</sup> where a further nine deaths and 147 infections occurred (see Appendix B, Map 6, location 6).

In March 2003, the disease spread to the Majola district, on the Mzimvubu River.<sup>105</sup> The cholera epidemic declined sharply in the second half of 2003 and did not resurface in any strength thereafter. In January 2004 the Eastern Cape Department of Health noted that it had successfully kept cholera in check during the summer of 2003-2004, with only six deaths and 500 infections, compared to 13 deaths and 600 infections over the summer of 2002-2003.<sup>106</sup>

*Table 3: Chronology of the 2000-2003 Eastern Cape Cholera Epidemic*

| DATE                | LOCATION                        | INCIDENT  |
|---------------------|---------------------------------|---|
| <b>2000</b>         |                                 |   |
| 2 March             | Umzimkulu                       | 1 ill   |
| 1 May               | Bizana                          | Unspecified number ill  |
| <b>2001</b>         |                                 |   |
| 22-Jan              | Qingqolo, Mqanduli District     | Unspecified no. ill   |
| 23-Jan              | OR Tambo DM and KSD LM          | Joint Operation Committee set up to combat cholera                              |
| 31-Jan              | Orange Grove, Mqanduli District | Unspecified no. ill   |
| 07-Feb              | Nqanda, Mqanduli District       | Health MEC Max Mamase blames Umtata sewage leak for outbreak; 174 confirmed ill |
| <b>2002</b>         |                                 |   |
| 06-Jan              | Qumbu                           | 7 deaths, 33 ill  |
| 06-Jan              | Port St Johns                   | Unspecified number ill  |
| 13-Feb              | Tina Falls                      | 267 ill   |
| Dec 2002 – Feb 2003 | Oliver Tambo DM                 | 650 infected  |
| <b>2003</b>         |                                 |   |
| 17-Feb              | Cofimvaba                       | 9 dead, 143 ill   |
| 31-Mar              | Majola district                 | Unspecified number ill  |

<sup>103</sup> Madoda Dyonana, "Cholera Under Control Says Health Department", *Daily Dispatch*, 13 February 2003, pg. 3

<sup>104</sup> "Medical Service on Cholera Alert", *Daily Dispatch*, 17 February 2003, pg. 1

<sup>105</sup> Ncedo Kumbaca, "Another Cholera Outbreak", *Daily Dispatch*, 31 March 2003, pg. 1

<sup>106</sup> "EC Health Department Keeping Cholera in Check", *Daily Dispatch*, 13 January 2004, pg. 7.

## Chapter 4: THE SOUTH AFRICAN PRESS, PRE- AND POST-APARTHEID

It is not possible to divorce the coverage of cholera in the *Daily Dispatch* and *Eastern Province Herald* from the socio-political contexts in which both newspapers grew and operated. In particular, the attitudes these publications displayed towards cholera and those affected by it have to be seen in the context of the press climate of the time. The relationship between the English-language South African press and the South African government has, from the mid-20<sup>th</sup> century onwards, has been characterised by mutual suspicion and sometimes outright hostility. This antagonism was particularly intense during the mid to late apartheid era (1960-1994) and remained a factor in post-apartheid South Africa. Obviously, this uneasy co-existence had, and still has, wide-ranging effects on the news as presented by South African newspapers.

### The Apartheid-Era Press

The National Party (NP) came to power in South Africa in 1948, and set about implementing 'apartheid', which cemented the existence of a deeply divided state. The most obvious division was the legislatively-enforced segregation of "black", "Indian" and "coloured" populations from the economically and politically dominant "white" population.<sup>1</sup> Further divisions existed within the "white" population as well, between English-speaking and Afrikaans-speaking populations.<sup>2</sup>

This division, though grounded in difference of language, extended beyond it in such a way that "white" South Africa was nearly as divided within itself as South Africa in general. "White" Afrikaans-speaking South Africans, the larger of the two groups, predominated in the political sphere despite being on average generally poorer and less literate.<sup>3</sup> English-speaking "white" South Africans

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<sup>1</sup> The categories of "white" and "black" are more fully discussed in the Introduction.

<sup>2</sup> Carolyn Hamilton, Bernard Mbenga, and Robert Ross (eds.), *The Cambridge History of South Africa* (Cambridge, 2008), John D. Omer-Cooper, *History of Southern Africa* (Cape Town, 1994), Aran S McKinnon, *The Making of South Africa: Culture and Politics* (Upper Saddle River, 2004)., TRH Daveport, *South Africa: A Modern History* (Basingstoke, 2000).

<sup>3</sup> Pollak, *Up Against Apartheid*, pg. 9

dominated the country's economic sphere, largely due to heavy investment in the country's mining sector, but were significantly fewer in number.<sup>4</sup>

The South African press was rigidly divided into English and Afrikaans publications. Although these two arms of the press seldom saw themselves as being in direct competition with each other, the difference in their language (and thus in their societal alliances) meant that they had greatly differing relationships with the apartheid-era government.

The Afrikaans-speaking press (that is, the segment of the press that was published in Afrikaans and aimed at "white" Afrikaans-speaking audience) tended to support the NP government, which was seen as working in the interests of the "white" Afrikaans-speaking population. In return, the NP government supported the Afrikaans press, leading to a symbiotic relationship without which, Richard Pollack argues, it is doubtful that the Afrikaans press could have survived.<sup>5</sup> As mentioned above, although the Afrikaans-speaking population was larger than the English-speaking population it was *on average* less wealthy and less literate. As a result, the Afrikaans press could not rival the English press in terms of advertising revenue and circulation, and consequently was rather poorer than its rival, the English press.<sup>6</sup> To combat this, the National Party government unofficially subsidised the Afrikaans press, although obviously not all publications or news-groups were equally subsidised. In this way, large sections of the Afrikaans press were kept financially viable, and the National Party government secured their co-operation.<sup>7</sup>

The English-language press (that is, the segment of the press that was published in English and aimed at a "white" English-speaking audience) was largely self-supporting: many major shareholders in the English press were also deeply involved in the financial and investment bodies connected to the

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<sup>4</sup> Pollak, *Up Against Apartheid*, pg. 9

<sup>5</sup> *Ibid.*, pg. 13

<sup>6</sup> *Ibid.*

<sup>7</sup> *Ibid.*

country's mining industry.<sup>8</sup> From the 1950s onward the English-language press became extremely critical of the NP government's actions.<sup>9</sup>

It is, however, oversimplifying things to state that the English press during the apartheid era was wholly and completely opposed to apartheid's systematic programme of segregation and deprivation on racial grounds. Most English newspapers were owned by either the Argus Group or South African Associated Newspapers,<sup>10</sup> both of which were owned by companies already heavily invested in the mining industry. The mining industry, of course, relied heavily on the racial discrimination of the apartheid industry for access to cheap labour and thus for continued profitability.

As the mining industry's income relied on the very system of "black" deprivation fostered by apartheid, it was unlikely that its shareholders would have been in favour of doing away with apartheid. As a result, the English press had a 'vested interest' in discouraging anything that would lead to its shareholders losing income.<sup>11</sup> The bulk of the English press, therefore, tended to object to apartheid only within the parameters set by the NP<sup>12</sup> - that is, they did not print anything likely provoke governmental repression. This led to rather more dissembling than outright decrying of apartheid.<sup>13</sup> The symbiosis between apartheid and the mining industry resulted in the English press effectively filing its own teeth blunt, thus limiting their usefulness as an anti-apartheid organ.

That said, the extremely close and mutually complimentary relationship<sup>14</sup> between the NP government and the Afrikaans-language press meant that, as far as the South African press went, the role of criticising apartheid fell squarely on the shoulders of the English press. This was particularly so once the "black",

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<sup>8</sup> Keyan Tomaselli and Ruth Tomaselli, "The Political Economy of the South African Press" in Keyan Tomaselli, Ruth Tomaselli and Johan Muller (eds.), *Narrating the Crisis: Hegemony and the South African Press* (Johannesburg, 1987), pg. 57; Jackson, *Breaking Story*, pg. 38

<sup>9</sup> Jackson, *Breaking Story*, pg. 18

<sup>10</sup> Tomaselli and Tomaselli, "Political Economy", pg. 57. Note that even this division was artificial: according to Tomaselli and Tomaselli, Argus owned 40% of SAAN in the late 1980s.

<sup>11</sup> *Ibid.*, pg. 61; Jackson, *Breaking Story*, pg. 38

<sup>12</sup> Jackson, *Breaking Story*, pg. 18

<sup>13</sup> Pollak, *Up Against Apartheid*, pg. 9

<sup>14</sup> Jackson, *Breaking Story*, pg. 33

“Indian” and “coloured” press, printed in various languages, was legislated out of existence by the early 1960s,<sup>15</sup> leaving the “white” English press as the only possible outlet for anti-apartheid journalism. “Black”, “Indian” and “coloured” readers began to read the English press and by 1977, 45% of readers of English newspapers and magazines were what was then called “non-white”.<sup>16</sup>

This increasing “non-white” readership, combined with the English press’s more critical approach, led the Afrikaner-dominated NP government to see the English press as a hostile voice.<sup>17</sup> The limited resistance that it offered was therefore met with repression of a severity disproportionate to the rather mild threat it posed to the South African status quo.<sup>18</sup> Many journalists were arrested, intimidated or banned; many more were harassed in a more diffuse way by government security forces.

The antipathy between the English-language press and the NP government intensified from the 1970s onward.<sup>19</sup> The 1970s and 1980s saw the first major cracks begin to appear in the apartheid regime. The “Muldergate” scandal of the mid-1970s revealed many NP leaders to be dishonest, pointing to a side of the National Party regime of which many of its supporters had hitherto been unaware.<sup>20</sup> The “black” rejection of the Tricameral Parliament, which included “whites”, “coloureds” and “Indians” but excluded “blacks caused more unrest than the apartheid government, with its falling morale, could adequately handle.<sup>21</sup> Simultaneously, international and internal opposition to apartheid was becoming too widespread to contain and although it was nevertheless met with the usual “deaf ear and heavy hand”,<sup>22</sup> this constant abrasion began to lessen governmental commitment to apartheid.

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<sup>15</sup> Pollak, *Up Against Apartheid*, pg. 16; Jackson, *Breaking Story*, pg. 18

<sup>16</sup> Pollak, *Up Against Apartheid*, pg. 17.

<sup>17</sup> Jackson, *Breaking Story*, pg. 40.

<sup>18</sup> Tomaselli and Tomaselli, “Political Economy”, pg. 70-71

<sup>19</sup> Pollak, *Up Against Apartheid*, pg. 1

<sup>20</sup> Jackson, *Breaking Story*, pg. 21

<sup>21</sup> *Ibid*, pg. 22

<sup>22</sup> *Ibid.*, pg. 21

The Apartheid Era Eastern Cape English-Language Press: the *Daily Dispatch* and *Eastern Province Herald*

The *Daily Dispatch* and the *Eastern Province Herald* were long-established English-language daily newspapers in the Eastern Cape and Border regions, both having been established in the late 19<sup>th</sup> century. The *Dispatch*, an independently owned newspaper, focused on the region from Port Alfred, as its westernmost point, to Aliwal North on the Northern Cape border and, in the east, the Natal border.<sup>23</sup> This geographical area included the “homelands” of Ciskei and Transkei.<sup>24</sup> It had a larger circulation than the *Eastern Province Herald*, averaging 32 000 copies per day in 1980 and 1982<sup>25</sup> and between 33 000 and 37 000 copies a day between 1983 and 1994.

The *Eastern Province Herald* concentrated on the smaller geographical area of Port Elizabeth and the western half of the Eastern Cape (as is still the case).<sup>26</sup> It was owned by the English media conglomerate Times Media Limited.<sup>27</sup> The *Eastern Province Herald* averaged a circulation of approximately 27 000 a day between 1980 and 1982, increasing to between 28 000 and 30 000 between 1983 and 1994.<sup>28</sup> Readership figures can be many times larger than circulation figures due to the likelihood that more than one person will read any individual copy.<sup>29</sup> The rather discrete geographical focus of each of these newspapers meant that not many readers read both the *Dispatch* and the *Herald*, largely because there were not many towns in which both were available.<sup>30</sup>

<sup>23</sup> Specifically, Matatiele and Mzimkulu.

<sup>24</sup> Avusa Brand Information, accessed at <http://www.avusa.co.za/aboutus/brands/default.aspx?pageid=302511>, accessed 01 November 2009. Note that this geographical area remained unchanged between 1980 and 2003, except for the brief hiatus in Transkei circulation outlined in the chapter.

<sup>25</sup> Audit Bureau of Circulation of South Africa, *Audited Average Circulation Data*, supplied to the researcher by Mr Charles Beiles, Managing Director of the Audit Bureau of Circulation of South Africa, on 5 November 2009. (See Appendix A)

<sup>26</sup> Avusa Brand Information.

<sup>27</sup> Formerly South African Associated Newspapers, and as such tied up with the mining interests outlined above.

<sup>28</sup> Audit Bureau of Circulation of South Africa, *Audited Average Circulation Data*.

<sup>29</sup> In 2009, for example, the circulation of the *Daily Dispatch* is 33 535 a day but its readership is 226 000, more than six times the circulation figure. The *Herald*, likewise, circulates 27 557, but its readership is estimated at 194 000, approximately seven times the circulation (Avusa Brand Information).

<sup>30</sup> According to a 1967 study by the Rhodes University Institute of Social and Economic Research, only 4% of *Daily Dispatch* readers also read the *Eastern Province Herald* (James Irving and FY St Leger, “Report on an Investigation into the Attitudes of a Sample of Male

The *Eastern Province Herald* conformed to the abovementioned characteristics of English-language newspapers in that it was nominally anti-apartheid but was not particularly outspoken. A detailed section of the online history of the newspaper<sup>31</sup> ends in 1950, with the article being concluded with the words “For the next 50 years, until the fall of apartheid and beyond, the *Herald* kept the community informed about happenings in Port Elizabeth,” effectively condensing the entire apartheid period as well as the first decade of democracy into a single, undetailed sentence.<sup>32</sup> Even taking into account that this is but a synopsis, the omission of any mention of anti-apartheid actions is curious – especially given that the pre-apartheid era is described in some detail. This omission suggests that no particular anti-apartheid tradition existed at the *Eastern Province Herald* beyond the assumption that it automatically opposed apartheid because it was an English newspaper rather than an Afrikaans one.

The independently-owned *Daily Dispatch*, on the other hand, saw itself as a “crusading” newspaper.<sup>33</sup> As it did not belong to any of the national English press conglomerates, it exercised a freedom of expression that many other newspapers did not. This was particularly the case after the appointment of Donald Woods as editor in 1965.<sup>34</sup> Described as “staunchly anti-apartheid”,<sup>35</sup> Woods is perhaps best known for his friendship with Black Consciousness Movement founder Bantu Steven Biko.

The *Dispatch's* anti-apartheid content in the 1960s and 1970s increased considerably under Woods' editorship, largely due to his involvement with various anti-apartheid movements and activists. Following his arrest and

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Residents of the City of East London, Cape Province, Towards the *Daily Dispatch* and Other Newspapers in the Area” (Grahamstown, 1967).

<sup>31</sup> See [www.epherold.co.za](http://www.epherold.co.za)

<sup>32</sup> The Eastern Province Herald, “About Us”, accessed at <http://www.theherald.co.za/aboutus/default.aspx>, accessed 04 November 2009.

<sup>33</sup> Tomaselli and Tomaselli, “Political Economy”, pg. 71

<sup>34</sup> Glyn Williams, *The Daily Dispatch: 125 Years Delivering the News* (East London, 1997), pg. 11. Kindly supplied to the researcher by G. Smith of the *Daily Dispatch*, on the 12<sup>th</sup> of October 2009.

<sup>35</sup> *Ibid.*, pg. 12

banning in October 1977,<sup>36</sup> the editorship passed on to George Farr. Between 1977 and 1986, the *Dispatch* continued to operate under extreme pressure from the NP government, which was introduced severe restrictions on the reporting of disturbances within the country.<sup>37</sup> At this time, the *Dispatch* toned down its anti-apartheid coverage to avoid being banned, which was a real possibility for a time following Woods' arrest, banning and subsequent exile.<sup>38</sup>

The late 1970s and 1980s saw a sharp increase in opposition to the government both within and beyond the borders of the country, in "homelands", townships and neighbouring countries. Increasing dissent in the 'homelands' lead to increased attention being paid to those areas by "whites" and consequently to greater coverage in the English-language press, which had until then paid little attention to conditions in the "homelands".<sup>39</sup> The outbreak of cholera in 1980 and its spread throughout 1981 and 1982 drew the eyes of the press to the affected regions. For many newspapers, both English and Afrikaans, the outbreak of cholera caused strong responses among "white" readers and journalists.<sup>40</sup> In the case of the *Eastern Province Herald*, which was based in a city some distance from any "homelands", the outbreak of cholera also led to increased wariness of the threat posed by these areas to its own region.

The *Daily Dispatch* was particularly vexed by the difficulties in reporting on "homelands". This was partly because there was intense discouragement on such reporting from the NP government, and partly because the governments of the Transkei and Ciskei, did not often co-operate with journalists.<sup>41</sup> Lack of co-operation from Transkei and Ciskei authorities effectively prevented the *Daily Dispatch* from gathering material, at a time when the editor, Glyn Williams, emphasized the importance of regional news. The Transkei authorities, in particular, blocked any negative reporting on incidents in the Transkei, with

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<sup>36</sup> Williams, *The Daily Dispatch*, pg. 12

<sup>37</sup> *Ibid.*, pg. 16

<sup>38</sup> Tomaselli and Tomaselli, "Political Economy", pg. 72

<sup>39</sup> *Ibid.*, pg. 64.

<sup>40</sup> *Ibid.*

<sup>41</sup> *Ibid.*, pg. 67-68

several journalists either being ‘escorted out’ of the region, or jailed within it.<sup>42</sup> The newspaper was furthermore banned for several weeks in the region, causing *Daily Dispatch* sales to plummet for that period. While the Ciskei never banned the *Daily Dispatch* outright, the region’s government employees were not allowed to read it, which caused the newspaper’s circulation in the region to decline.<sup>43</sup>

These difficulties persisted throughout the 1980s and into the 1990s, with the *Daily Dispatch* remaining as unpopular with the crumbling National Party government as it was with the fragmenting “homeland” governments.<sup>44</sup> Despite this, the *Daily Dispatch* became the most widely read newspaper in the Eastern Cape, reaching 172 000 readers a day by 1993.<sup>45</sup> In 1995, the retirement of several long-standing shareholders and a subsequent reshuffling of shares led to the *Daily Dispatch* being sold to Times Media Limited, the same company which had long owned the *Eastern Province Herald*.<sup>46</sup> This ended more than a century of independent ownership of the *Daily Dispatch*.

### **The Post-Apartheid Press**

The period 1995 to 2000 did not see any decline in the distribution of newspapers in the Eastern Cape, with both the *Dispatch* and the *Herald* experiencing increases in circulation.<sup>47</sup> Times Media Limited was purchased by the Black Empowerment Group Johnnic, and became its publishing arm, renamed Johnnic Publishing.<sup>48</sup> The fact that both newspaper fell under the same corporate umbrella did not have many significant effects on the type of

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<sup>42</sup> Williams, *The Daily Dispatch*, pg. 17

<sup>43</sup> *Ibid.* pg. 18; unfortunately this source does not elaborate on exactly how the Ciskei government managed to ensure that its employees did not read the *Dispatch*.

<sup>44</sup> *Ibid.*

<sup>45</sup> *Ibid.* The daily circulation figures between 34 184 between January and June 1992, and 35 381 between July and December 1992 (Audit Bureau of Circulations, *Audited Average Circulation Data*).

<sup>46</sup> Williams, *The Daily Dispatch*, pg. 21

<sup>47</sup> Audit Bureau of Circulation, *Audited Average Circulation Data*. Circulation of the *Daily Dispatch* increased from 37 500 a day in 1995 from 35 000 a day in 1993, while the *Herald* increased from 29 000 (1993) to 34 000 (2000).

<sup>48</sup> “Johnnic Tells CEO of Turnaround”, *Daily Dispatch*, 12 April 2001. Page unknown. Wasserman and De Beer, “Which Public? Whose Interest?”, pg. 37

coverage each newspaper carried although it did apparently lead to more overlap in coverage.<sup>49</sup>

After 1994, however, the print media operated on a free-market basis<sup>50</sup> and the previously almost predetermined political and language-based loyalties of the apartheid era became less apparent. The “new” print-media market did however segment along the same lines as the pre-apartheid market did, presumably because the ‘societal polarisations’ created by that area had not yet dissolved.<sup>51</sup> At the same time, the market at which news-based newspapers were aimed remained the same: they targeted predominantly urban communities formerly made up exclusively of “whites”, which included large numbers of affluent “blacks”. Tabloid-form newspapers arose in force after 1994 but were aimed at the poorer, less literate end of the market.<sup>52</sup> In many ways, the more things had changed the more they had stayed the same.

The transition from a minority-led NP-dominated apartheid government to an ANC-led democratically-elected government in 1994 did have some wide-ranging effects on the media. Primary among these were changes in ownership, such as the purchased of Times Media Limited by Johnnic and the accompanying name-change.<sup>53</sup> What did not change was the uneasy relationship between the print media and the government.

In the early post-apartheid era, this dislike may have arisen from mutual suspicion between the new government and the print media. The media, according to Herman Wasserman and Arnold De Beer, was uneasy about the possibility of the imposition of authoritarian anti-media laws, a move common to new governments.<sup>54</sup> Conversely, the new government resented the media’s

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<sup>49</sup> The cholera-related articles by *Daily Dispatch* reporter Mayibongwe Maqhina are a case in point: as is described more fully in a later chapter, Maqhina’s articles in the *Dispatch* were reproduced, in shortened form, in the *Eastern Province Herald* on the same day as they appeared in the *Daily Dispatch*.

<sup>50</sup> Wasserman and De Beer, “Which Public”, pg. 37

<sup>51</sup> *Ibid.*

<sup>52</sup> *Ibid.*

<sup>53</sup> *Ibid.*, pg. 37.

<sup>54</sup> *Ibid.*, pg. 43.

expectation that it would be authoritarian.<sup>55</sup> Mutual expectation of bad behaviour on both sides marred the development of a good relationship.

This early ambivalence has continued, particularly in terms of media's reaction to government actions. Merrett argues that some high-level government employees did not feel that South Africa needed a dissenting media, particularly since that media tended to point out government mistakes at the expense of the popular rhetoric of "nation-building".<sup>56</sup> Furthermore, the print media assumed the role of defender of public interests, concerning itself with protecting the public from the possible abuses of government power.<sup>57</sup> This assumed the existence of - and possibly created, given the influence of the news media on public attitude - a public that was distinct from the government.<sup>58</sup>

Anti-apartheid stances, however weak, were succeeded in the press by articles decrying the corruption and mistakes of the new ANC-led government, particularly as they affected "the public". "The public" assumed by the press, furthermore, is not homogenous – each newspaper divides "the public" into the "vocal" public (that sector which consumed and engaged with the news, including their readership) and the "voiceless" public (which did not consume or engage with the news).<sup>59</sup> The role of 'crusader against evil' adopted by many newspapers, such as the *Mail and Guardian* or *Daily Dispatch* consequently often clashed with the government's self-image, which was that of "crusader for good". This often leads to conflict.

A major factor in the ambivalent relationship between the press and the ANC-led government was the media's construction of a threat posed to the public by the government, namely, that it might become an elite group distanced from the people it was meant to represent.<sup>60</sup> This fear is common to media systems that

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<sup>55</sup> Wasserman and De Beer, "Which Public?", pg. 43.

<sup>56</sup> Christopher Merrett, "A Tale of Two Paradoxes: Media Censorship in South Africa, Pre-Liberation and Post-Apartheid", *Critical Arts*, 15, 1&2, 2001, pg. 62.

<sup>57</sup> Wasserman and De Beer, "Which Public?", pg. 45

<sup>58</sup> *Ibid.*

<sup>59</sup> *Ibid.*

<sup>60</sup> Alexander Johnston, "The African National Congress, the Print Media, and the Development of Mediated Politics in South Africa", *Critical Arts*, 19, 1&2, 2005, pg. 29.

do not have major ideological differences with the governments they comment on; the media 'watchdogs' the government to ensure that it is behaving in accordance with its stated values. To provide checks and balances, as well as to provide forums for expression of dissatisfaction is an important part of the media function. Hence, energetic examination of mismanagement, corruption and other problems is often carried out.<sup>61</sup> It hardly needs mentioning that this constant highlighting of failures and problems does not endear the press to the government, which sees them as lacking due deference to the democratically-elected government, as well as being out-of-step with the majority of the population.

For example, the Eastern Cape press – particularly the *Daily Dispatch*, which is the larger of the region's two major English newspapers - carried extensive and detailed coverage of the provincial government's difficulties in carrying out its mandate. It focussed on corruption, lack of service delivery and financial ineptitude. It is evident from quotes included in this coverage that the criticised government felt that the newspaper did not give credit when credit was due, and that it consistently underplayed the government's successes. On the other hand, the newspaper felt that the government was not adequately carrying out its stated goals. This is particularly evident in the *Daily Dispatch* and *Eastern Province Herald's* coverage of Eastern Cape Health Department actions and issues.

The post-apartheid media, then, remained (and remains) uneasy in their relationship with the South African government, despite the fact that both the media and the government underwent significant changes. During the apartheid era, the media was divided into NP-supporting Afrikaans media, which was closely allied with the government and tended support rather than criticise its actions, and the English media. English media was further divided into independent publications, which could become vociferously anti-apartheid, albeit at the risk of banning, and conglomerate-owned publications whose ties

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<sup>61</sup> Johnston, "The African National Congress", pg. 29

to the apartheid-reliant mining industry caused them to self-censor their anti-apartheid content.

In the post-apartheid period, the withdrawal of government legislation controlling newspaper content, and the replacement of “white”-owned conglomerates with more racially diverse news corporations, led to a media with no particular alliance or opposition to government. The continued criticism of government actions is especially evident in the deeply antagonistic coverage of ECDOH actions by the *Daily Dispatch* and the *Eastern Province Herald* in the post-apartheid era. Like the cholera-related coverage of 2000-2003, the newspapers’ coverage of the ECDOH’s cholera-related actions in the first decade of democracy evidence a deep distrust of the motivations of the Department’s employees, and consequently of the Department’s actions.

### **The Shape of the News, 1980-2003: The Changing Relationship between the South African Print Media and the South African Government**

The study of cholera provides a lens through which to examine the relationship between the South African media, particularly English daily newspapers in the Eastern Cape, and the South African government, particularly those sections of it charged with healthcare in the region. Through the examination of cholera-related articles published in the *Daily Dispatch* and the *Eastern Province Herald* in 1980-1982 and 2000-2003, it is possible to gain an understanding of the shifting relationship between the media and the government over a long period of transition, from the oppressive climate of an increasingly fragile late-stage apartheid to the end of the first decade of democracy, which proved to be a mixed blessing. Cholera as a disease did not change in any way between 1980 and 2003, but the ways in which it was presented in the coverage underwent substantial changes over the twenty-year period covered by this thesis.

The major shift visible over the period 1980 to 2003 concerns changes in the content of the articles, particularly in terms of the sources from which information was collected and the ways in which the relationship between

cholera and South African society was constructed. Inseparable from changes in content are changes in what made the cholera epidemic a newsworthy event besides for the health threat it posed. Examining both of these changes reveals that the newspapers' coverage of cholera was influenced by the level of tension that existed between the newspaper and the government of the time. As the government changed, so did cholera-related coverage as the role newspapers believed they played *vis-à-vis* governmental actions changed.

### Selecting the News

The majority of readers of newspapers are not necessarily aware that the news they are consuming has been selectively compiled;<sup>62</sup> that is, they have no way of knowing what has been left out of the news articles included in their daily newspapers, and in turn may not be aware that the excluded information even exists.<sup>63</sup> Furthermore, because newspapers are representations of the dominant culture's norms and values,<sup>64</sup> the strategies used in constructing a newspaper text - particularly selective inclusion and exclusion of information - leads to the presentation of a specific worldview being presented in newspapers, and this worldview which may, in turn, influence the attitudes and opinions of the readership.<sup>65</sup> The news is determined by the values of the actors producing it; those values are reflected in the news as it is presented to the public.<sup>66</sup> In keeping with this, newspapers are nominally aimed at a particular readership,<sup>67</sup> which, although it may not coincide with the newspaper's *actual* readership,<sup>68</sup> nevertheless addresses them as though they exist. In addressing the often-imaginary "typical reader", newspapers aim to address and influence their interests, attitudes and beliefs.

Therefore, examining newspaper articles concerning the 1980-1983 and 2000-2003 cholera epidemics reveals, at least partly, how the disease's appearances were perceived in each society. What is more easily discerned, however, is how

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<sup>62</sup> Danuta Reah, *The Language of Newspapers* (London, 1998), pg. 5

<sup>63</sup> *Ibid.*, pg. 4

<sup>64</sup> *Ibid.*, pg. 62

<sup>65</sup> *Ibid.*, pg. 55

<sup>66</sup> Allan Bell, *The Language of News Media* (Oxford, 1991), pg. 2

<sup>67</sup> Reah, *Newspapers*, pg. 36

<sup>68</sup> *Ibid.*

the newspapers constructed the disease outbreaks for their readers – of primary interest is where newspaper located the disease within South African borders and South African society and whose responsibility it was to contain it; these issues will be discussed in the following two chapters. Of secondary interest are the occasional disjunctions between headlines, lead paragraphs and bodies of articles. Another interesting aspect of changes in coverage is how the nature of newsworthiness shifted over time; that is, shifts occurred in the “news values” evident in the articles making up the coverage.

No information is included in a newspaper unless it is in some way newsworthy<sup>69</sup> – that is, of interest to the newspaper’s readership.<sup>70</sup> The aim of a newspaper is to inform, but it is also to turn a profit by selling newspapers and therefore the process of excluding information which is uninteresting or not worthy of notice is fairly ruthless. Newspapers aim to avoid evoking a “who cares?” or “so what?” response on the part of their readership.<sup>71</sup>

#### News Values: Proximity, Recency, Relevance and Negativity

There are a number of so-called “news values” which may qualify a story for inclusion as an article in a newspaper. These “news values” make any given information interesting. The concept is not particularly complex, which is in keeping with the general purpose of newspapers, which is to inform readers without confusing them.<sup>72</sup> Primary among “news values” are negativity (why negative events unfailingly interest news consumers is not known, but is certainly the case);<sup>73</sup> recency (how recently an event occurred; that is, how “fresh” it is, with accompanying implications for how new the information will be to readers);<sup>74</sup> proximity (how physically near to the readership it is);<sup>75</sup> and, relevance (the effect the information has on the lives and/or experiences of the readership).<sup>76</sup> Almost all news stories contain at least two of these “news

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<sup>69</sup> Obviously, this statement includes only “news articles”, not features or advertisements.

<sup>70</sup> Bell, *News Media*, pg. 155

<sup>71</sup> *Ibid.*, pg. 148.

<sup>72</sup> *Ibid.*, pg. 155.

<sup>73</sup> *Ibid.*, pg. 156

<sup>74</sup> *Ibid.*

<sup>75</sup> *Ibid.*, pg. 157

<sup>76</sup> *Ibid.*

values”, in addition to lesser ones such as unexpectedness (how surprising the information is), and eliteness (determined by whether the information is *about* elite members of society, or originates with them). Examining the news values implicit in the coverage of cholera in the *Dispatch* and *Herald* between 1980-1983 and 2000-2003 reveals changes in what, exactly, made the coverage relevant enough for inclusion in the newspapers concerned.

#### The *Daily Dispatch*, 1980-1983

Of the 20 articles that constitute *Daily Dispatch* coverage of the 1980-1983 epidemic, 15 have “proximity” as a central news value. An examination of Figure 1 (see Appendix C, Table 3, for data table) reveals that most of these articles were concerned with anti-cholera measures “at home” and in the Transkei. Of the 10 with “negativity” as a news value, five deal with cholera in the Transkei, with the remaining five distributed between cholera in Bophuthatswana (1), the probability of cholera entering the Eastern Cape (3), and the threat posed to East London by the cholera-prone peri-urban area of Duncan Village (1). 13 articles have “relevance” as a news value, most of which deal with the Transkei outbreak and East London’s anti-cholera measures. Ten include “recency”; all ten deal with cholera’s spread in the Transkei.

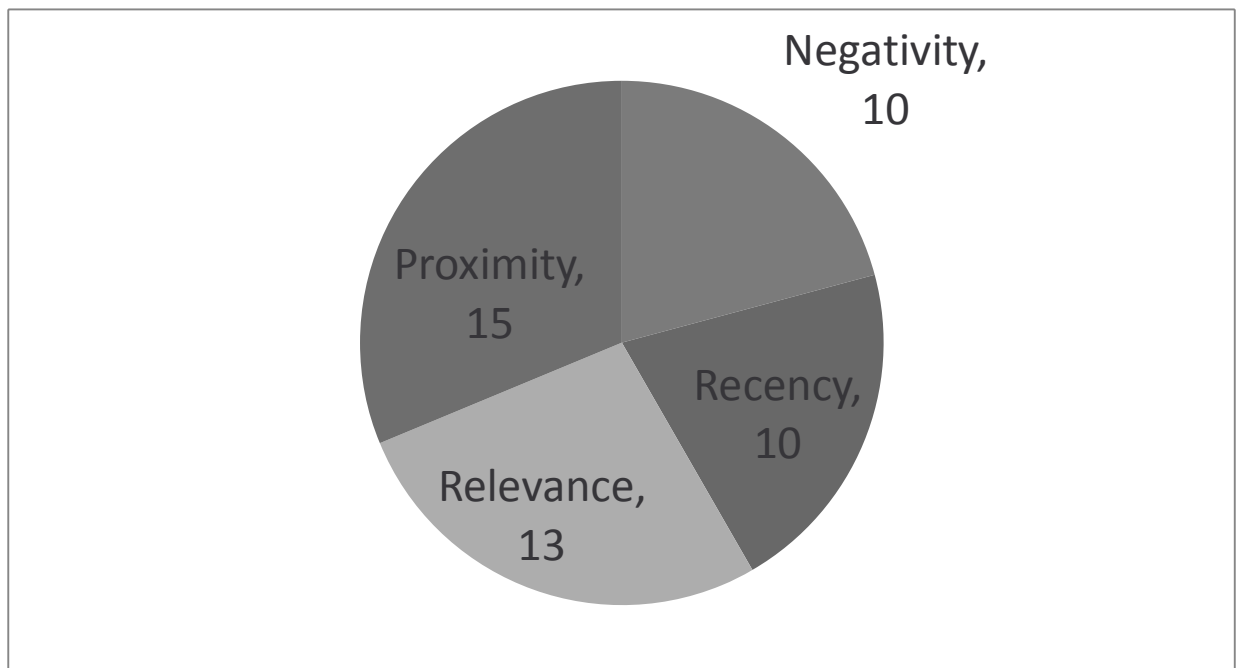


Figure 1: News Values, Daily Dispatch, 1980-1983

Obviously, proximity predominates as the factor making the outbreak newsworthy, followed by relevance, with recency and negativity being the least prevalent news values. This indicates that the epidemic was mostly of interest to the *Daily Dispatch* because of its situation in the neighbouring Transkei, but was not portrayed as an especial threat to the *Daily Dispatch's* region. This distribution of news values is in keeping with the *Dispatch's* concentration on the outbreak's local aspects: more articles appeared when the epidemic moved into the Transkei (coverage accelerated sharply in February and March 1982), accounting for the predominance of proximity. Relevance is a major factor for the same reason.

#### *The Eastern Province Herald, 1980-1983*

An examination of Figure 2 (see Appendix C, Table 4, for data table) reveals *Eastern Province Herald's* distribution of news values was not particularly similar to that of the *Daily Dispatch*, with 28 out of a total 33 articles having negativity as a news value. In this case, however, relevance (22) trumps proximity (20) as the second most prevalent news value, with recency (19) as the least common.

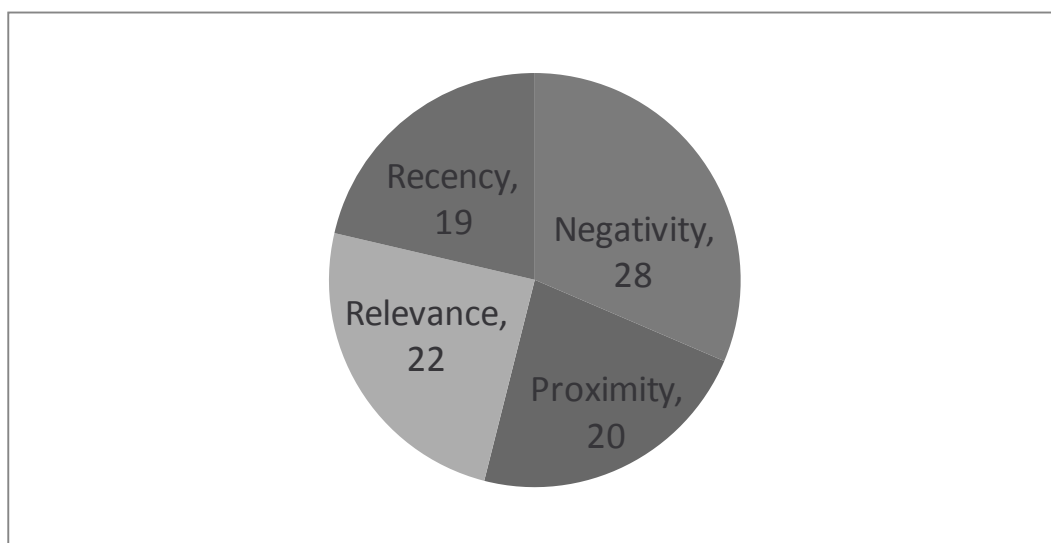


Figure 2: News Values, Eastern Province Herald, 1980-1983

That proximity and recency should lag behind relevance and negativity is in keeping with the fact that the *Eastern Province Herald* covered the entire span of the epidemic between 1980 and 1983, with information reaching the *Eastern Province Herald* after a time-lag of up to several days, via government officials and press releases. Much of the information dealt with by the *Eastern Province Herald* was not particularly “fresh”, and dealt with distant locations. Furthermore, as will be discussed more fully later in this thesis, the *Eastern Province Herald* constructed cholera as highly threatening to “white” South Africans, thus making it extremely relevant and negative. Negativity dominates because it is arguably *never* a good thing to have to worry about cholera, let alone have it present, albeit at a distance.

The articles with “relevance” as a primary news value are particularly interesting. Relevance occurs mostly in articles dealing with the spread of cholera into “white” areas, such as Johannesburg, Natal and Durban (as well as by implication into Port Elizabeth and East London). This implies that the *Eastern Province Herald* saw cholera as relevant to its readership only once it threatened “white” areas.

#### The *Daily Dispatch*, 2000-2003

As an examination of Figure 3 below (see Appendix C, Table 5, for data table) *Daily Dispatch* coverage of the more recent epidemic, recency (22) predominates among the news values, with proximity (13) proving to be rather less of an issue in the coverage than in 1980-1983. Negativity (12) remained the least prevalent news factor. The decreased role of proximity may result from the fact that post-1994 South Africa was not quite as rigidly divided as it had been pre-1994: that is, what counted as ‘close-by’ changed. Possibly, also, the disease’s restriction to the OR Tambo (ORT) District Municipality may also have led to proximity simply not being an issue a lot of the time. It is notable that the articles with proximity as an issue deal with new episodes of spread within the already-established infected area of ORT District Municipality.

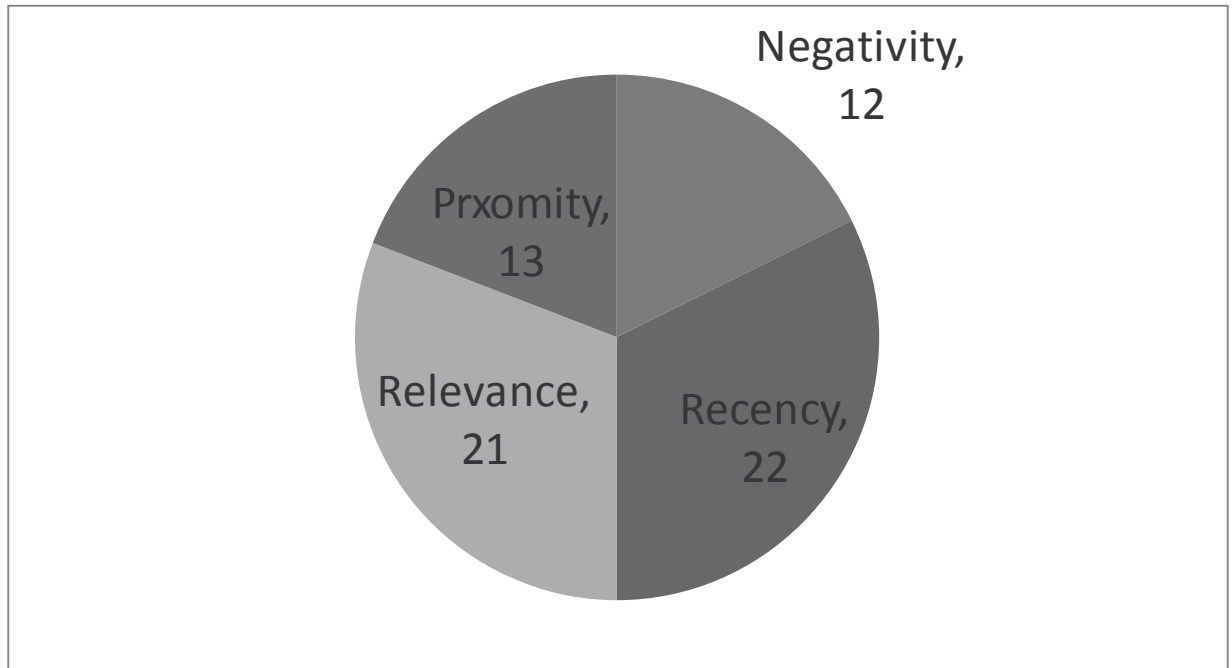


Figure 3: News Values, Daily Dispatch, 2000-2003

Likewise, negativity remains a comparatively minor factor in *Daily Dispatch* 2000-2003 coverage, due to the shift in emphasis from the medical aspect of the outbreak to the political issues it contained. Much space dedicated to the spread of the disease in earlier coverage is replaced in 2000-2003 coverage by information concerning government actions, commentary and critique.

Recency increases as a news value in 2000-2002 coverage by dint of the reductions in “turn-around time”: information, and thus events, are much “fresher” in *Daily Dispatch* coverage. This may be the result of improved technology between 1983 and 2000, but is also likely to be at least partly due to the *Daily Dispatch* covering a local outbreak, as opposed to one taking place elsewhere in the country. Relevance becomes the second-most important factor (after recency) for much the same reason: the readership of the *Daily Dispatch* is resident in the affected areas, and therefore each new development in the outbreak’s spread and containment is relevant.

The *Eastern Province Herald*, 2000-2003

Although much smaller in extent than the *Daily Dispatch* coverage, 2000-2003 *Eastern Province Herald* coverage also exhibits recency and relevance as its primary “news values”, with proximity and negativity being likewise relatively minor. As Figure 4 (see Appendix C, Table 6, for data table) indicates, recency (10) and relevance (9), outstrip negativity and proximity (both 7).

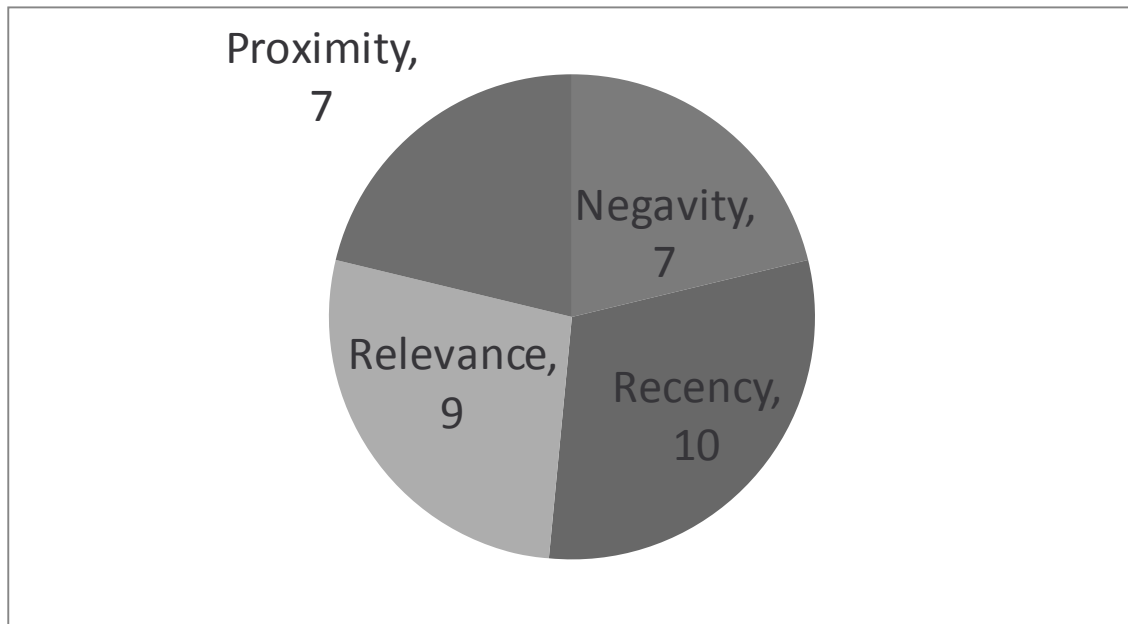


Figure 4: News Values, Eastern Province Herald, 2000-2003

This resemblance may result from the fact that several *Eastern Province Herald* articles were condensed versions of longer articles published in the *Daily Dispatch*. Also, as the 2000-2003 outbreak was located in areas removed from the *Eastern Province Herald's* usual sphere of concern, proximity and relevance ceased to be very important issues. This is supported by the predominance of recency as a news value – it is only the “freshness” and therefore the novelty of the epidemic that is keeping it in the news at all.

The news values evidenced in articles making up coverage in both the *Eastern Province Herald* and the *Daily Dispatch* are recency, relevance, proximity and negativity. Relevance, proximity and recency predominate in 1980-1983 coverage. During this time, cholera was seen as a gradually-encroaching threat to “white” South Africa – and thus very relevant to the “white” readership of both

newspapers under discussion, although they did not both construct it as a major threat. Recency, as well as relevance, dominates in 2000-2003 coverage, during which time period cholera was not as much of a threat as government ineptitude. Proximity and negativity become minor factors. This division of news values may be the result of changing beliefs around what kind of a challenge the cholera epidemic was. When it was believed to be a medical challenge, its spread was the most important factor. Once it came to be seen as a political challenge and the form and scope of governmental actions came under scrutiny, recency and relevance come to predominate, evidencing an increased interest in the relationship of the government to the affected regions.

The changes in news values in the coverage suggest that the 1980-1983 epidemic was reported in a rather straightforward manner: the spread of the disease, rather than reactions to it or its larger ramifications, was the focus of coverage. The 2000-2003 coverage of the epidemic, however, was not as concerned with the threat posed by the actual disease as it was with the disease's context and of the problems of service delivery and ill-governance that cholera foregrounded.<sup>77</sup>

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<sup>77</sup> For evidence that both the *Dispatch* and *Herald* paid close attention to problems within the Eastern Cape Department of Health over the period 2000-2003, please see: "Cholera Outbreak Highlights Challenges", *Eastern Province Herald*, 24 January 2002, pg. 4; Phumlani Mdolombe, "Go Out and Serve People, MEC Tells Officials", *Daily Dispatch*, 6 February 2002, pg. 3; Mphumzi Zuzile, "Acting Head Rejects Health Report", *Daily Dispatch*, 21 February 2002, pg. 9; Adrienne Carlisle, "Greater Demands, Less Cash for Health", *Daily Dispatch*, 16 April 2002, pg. 1; Adrienne Carlisle, "EC Health Care in Epic Crisis", *Daily Dispatch*, 25 April 2002, pg. 1; Adrienne Carlisle, "Monitor Tells Mamase to Accept Responsibility", *Daily Dispatch*, 6 May 2002, pg. 3; "Let Health's Healing Now Begin", *Eastern Province Herald*, 20 May 2002, pg. 6; Xolani Xundu, "Premier Admits Health Officials Forgot to Budget", *Eastern Province Herald*, 28 May 2002, pg. 1; Patrick Cull, "Minister Critical of Eastern Cape", *Eastern Province Herald*, 13 June 2002, pg. 1; Max Matavire, "Hospital Corrupt and Racist, Says MEC", *Eastern Province Herald*, 4 August 2000, pg. 2; "Goqwana: a Nose for Racists", *Eastern Province Herald*, 7 August 2000, pg. 4; "Upgrading of Clinics a Priority", *Eastern Province Herald*, 18 August 2000, pg.8; "Third World Conditions Can Improve", *Eastern Province Herald*, 18 August 2000, pg. 7; "Goqwana's Vision: A Caring Society", *Eastern Province Herald*, 18 August 2000, pg. 8; Sizwe Kupelo, "Health Department Points Out Its Successes", *Daily Dispatch*, 23 January 2003, pg. 4; "Strong Medicine Needed", *Daily Dispatch*, 21 April 2003, pg. 6. Please note that this is not the full extent of Health Department-related coverage carried in these newspapers.

### Self-Contradiction: Disjunctions between Headlines, Lead Paragraphs and Body-Text

Headlines are intended to attract the eye of the reader and are not usually written by the same person who produced the remainder of the article.<sup>78</sup> They are intended to pare the story down to its main event or point<sup>79</sup> and are thus usually representative of what the article's editors feel to be the story's main point. Lead paragraphs (usually printed in bold text below the headline) are likewise intended to be summaries of the stories they front<sup>80</sup> and usually concentrate on what makes the story newsworthy to begin with.<sup>81</sup> Leads and headlines are intended to correspond with each other;<sup>82</sup> that is, the lead expands – just barely – on the information contained in the headline. Leads and headlines, being intended to attract readers while presenting the main points of interest, are arguably the best indicators of what the newspaper believes to be the most important aspects of an article.

#### The *Daily Dispatch*, 1980-1983

Initially, the articles that constituted the *Daily Dispatch's* coverage of the 1980-1983 epidemic possessed corresponding headlines, lead paragraphs and article bodies: that is, the headline, lead and body-text all related to whichever particular aspect of the outbreak the article dealt with. For example, in the article headlined “Transkei Geared up to Combat Cholera”,<sup>83</sup> the lead paragraph expands on the headline thus: “From next week travellers passing through the Transkei will be given instructions at the country's borders on precautions to take against cholera”.<sup>84</sup> The remainder of the article expands on this by outlining the Transkei government's anti-cholera precautions both within the “homeland” and on its borders. Likewise, the article “Bid to Check Cholera Spread”<sup>85</sup> has as its lead the sentence “Transkei's Deputy Secretary for Health, Dr R.F. Ingle,

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<sup>78</sup> Reah, *Newspapers*, pg. 13

<sup>79</sup> Bell, *News Media*, pg. 186

<sup>80</sup> *Ibid.*, pg. 183

<sup>81</sup> *Ibid.*, pg. 177

<sup>82</sup> *Ibid.*, pg. 188

<sup>83</sup> “Combat Cholera”.

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

<sup>85</sup> “Bid to Check Cholera Spread”

yesterday outlined plans to halt the spread of the disease.”<sup>86</sup> The remainder of the article outlines Transkei’s plans, before outlining the anti-cholera precautions being taken by areas neighbouring Transkei, thus remaining true to the headline.

The congruence between headline, lead and body-text remains intact throughout the *Daily Dispatch*’s coverage of the 1980-1983 epidemic, suggesting that neither uncertainty nor dispute over the epidemic reached publication stage. The most important aspects of the coverage appear to have been agreed upon by the journalists and editors involved in producing the articles.

#### The *Eastern Province Herald*, 1980-1983

Like the *Daily Dispatch*, the *Eastern Province Herald* published headlines, lead paragraphs and body-texts that corresponded to each other with little or no disjuncture between what was said to be important by the headline and lead and what was portrayed as important by the body-text.

An exception to this, however, is the article “Stanger Gastric Infection Not Cholera, Says Health Official”.<sup>87</sup> Although the headline states simply that the infection is not cholera, the article begins with the much less straightforward lead “Doctors are mystified by a water-borne gastric infection raging in Stanger, Natal, which has so far killed eight people.” This sentence suggests that doctors are not sure exactly what the disease is, which might well raise questions about how sure they could be that it was not cholera, especially given the fact that cholera was present in the country in fairly nearby locales at the time.

The first few paragraphs of the article are equally ambivalent in comparison to the headline, stating the view of the Stanger Medical Officer of Health, who was “convinced that the gastric infection raging...in his area was cholera.”<sup>88</sup> The view of the “Health Official” alluded to in the article’s title is presented prior to

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<sup>86</sup> “Bid to Check Cholera Spread.”

<sup>87</sup> “Stanger Gastric Infection”.

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

the qualifier “however”: “Last Friday, however, the Department of Health announced the Stanger outbreak was not identified as cholera.”<sup>89</sup> This places the first half of the article in opposition to the second, and, as only the second is congruent with the title and lead paragraph, this suggests that there was some disagreement around whether Dr E.C. Borat, Stanger’s Medical Officer of Health, or Dr H.G. Küstner, the “Health Official” of the title, was to be given prominence. This in turn suggests that there was some dispute around whether or not Stanger could be considered to be cholera-infected. That this debate was presented to the public strongly implies a brief struggle around which governmental figure was given prominence.

The remainder of the *Eastern Province Herald’s* coverage of the 1980-1983 epidemic does not display much evidence of disputes within or around the coverage. As with the *Daily Dispatch*, this suggests a harmonised view of the epidemic and consensus on what views and facts each article was to emphasize. Whether this harmony was achieved forcefully or voluntarily cannot, unfortunately, be discerned, as there is no way of accessing information that *did not* make it to publication.

#### The *Daily Dispatch*, 2000-2003

As with the 1980-1983 era, the articles making up the *Daily Dispatch’s* coverage of the 2000-2003 cholera outbreak possessed, by and large, corresponding headlines, lead paragraphs and article bodies. The few exceptions, furthermore, did not contradict themselves so much as to suggest that the headline and lead were not “the whole story”.

For example, the article “Tests Confirm Cholera Cause of Deaths”<sup>90</sup> has a lead paragraph that does no more than expand on the headline by naming the area where cholera has been confirmed (Qingqolo). Between them, the title and lead paragraph give the impression that, now cholera has been confirmed in the region, the first stage of the problem - identifying the disease - has been solved. This is especially so as the preceding day’s *Daily Dispatch* had carried the

<sup>89</sup> “Stanger Gastric Infection”.

<sup>90</sup> Maqhina, “Tests Confirm Cholera”.

article “10 Killed By Mystery Disease”.<sup>91</sup> Compared to the amorphous threat of a potentially new and untreatable disease, the discovery of a known disease like cholera might come as a relief. However, the second paragraph of “Tests Confirm Cholera Cause of Deaths” introduces doubt by mentioning that the death-toll of the outbreak is disputed, with government officials giving a figure lower than that presented by residents of the infected community.<sup>92</sup> In this way, a reassuring headline and its corresponding lead paragraph are cast into doubt by a second paragraph that seems to suggest that although cholera has been identified, this does not mean that the outbreak will be any less severe.

Another article displaying disjuncture between the headline, lead and article body is “Cholera Kills 7 In T’Kei”, which appeared in early 2003.<sup>93</sup> The article’s headline makes mention of deaths; the lead paragraph, however, puts more emphasis on the OR Tambo District Municipality’s anti-cholera measures:

Qumbu – A cholera outbreak has claimed seven lives and prompted the provincial Health Department to provide R1 million to the OR Tambo District Municipality to fight the disease.<sup>94</sup>

This paragraph gives equal weight to government actions and cholera’s death-toll. As has been mentioned, the headline is intended to attract the reader<sup>95</sup> and present the story’s main point of interest.<sup>96</sup> That the headline mentions only the death-toll suggests that the *Daily Dispatch* believed this to be the most salient point in the article, with governmental action running second. However, the remainder of the article concentrates on governmental actions (as does the bulk of the period’s coverage). This suggests that the spreading epidemic was seen as a problem to be dealt with by the government, rather than an issue in itself. Although the death-toll is the first thing mentioned, it is mentioned not for its own sake but rather to attract readers and draw attention to governmental actions.

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<sup>91</sup> Mayibongwe Maqhina, “Ten Killed by Mystery Disease”, *Daily Dispatch*, 21 January 2002, pg. 1

<sup>92</sup> Maqhina, “Tests Confirm”.

<sup>93</sup> Madoda Dyonana, “Cholera Kills 7 in T’Kei”, *Daily Dispatch*, 6 January 2003, pg. 1

<sup>94</sup> *Ibid.*

<sup>95</sup> Reah, *Newspapers*, pg. 13

<sup>96</sup> Bell, *News Media*, pg. 186

Appearing on 21 February 2003, “Still More Cases of Cholera as Govt Tries to Curb Disease”<sup>97</sup> is the final instance of disagreement between headline, lead paragraph, and body text in the *Daily Dispatch*’s coverage of 2000-2003 epidemic. The headline stresses the spread of the disease seemingly beyond the government’s ability to contain it; the lead paragraph does likewise. However, more than half of the article outlines the purposes of various anti-cholera teams active in the Chris Hani District Municipality; furthermore, it does this in a theoretical way, outlining what the teams are intended to achieve without making mention of how useful these teams would be.<sup>98</sup> More than half of the article, therefore, bears no direct relation to the headline or the lead paragraph. This implies some disagreement between what is considered to be the article’s main point – that cholera is spreading despite government actions – and what the article in fact includes, which is a reassuring but essentially unnecessary breakdown of the intended purposes of various anti-cholera teams.

The *Eastern Province Herald*, 2000-2003

As with all previously-discussed coverage, the *Eastern Province Herald*’s coverage of the 2000-2003 epidemic displays, for the most part, agreement between headline, lead paragraph and article body text.

One such article is “E Cape Cholera Worries Increase”, published in May 2001.<sup>99</sup> The article’s headline does corresponds to its lead paragraph: “Cholera spreading to the Eastern Cape is a major national disaster, says a trade union.”<sup>100</sup> However, the body of the article and the lead paragraph do not correspond, in that the cholera-related concerns of South African Municipal Workers Union (SAMWU) dominate the remainder of the article, in which no mention is made of the spread of cholera within the region.

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<sup>97</sup> Ncedo Kumbaca, “Still More Cases of Cholera as Govt Tries to Curb Disease”, *Daily Dispatch*, 21 February 2003, pg. 3

<sup>98</sup> *Ibid.*

<sup>99</sup> “E Cape Cholera Worries Increase.”

<sup>100</sup> *Ibid.*

Similarly, the article “Poor Infrastructure Making Cholera Worse, Says Minister”,<sup>101</sup> published on 31 January 2002, is not internally consistent. The headline and the lead paragraph (“Shocking roads and a lack of electricity was exacerbating the cholera outbreak in Mqanduli, Transkei, Health Minister Dr Manto Tshabalala-Msimang discovered during a visit there yesterday”)<sup>102</sup> correspond with each other. The remainder of the article does not relate directly to either the headline or the lead paragraph – that is, it deals with infrastructural improvements rather than continuing about the problems alluded to in the headline and lead paragraph. This disjunction suggests that the *Eastern Province Herald* preferred to stress the existence of problems over their resolution.

It is to be expected that the majority of the articles covering the cholera epidemics should display internal coherence. After all, newspapers are, at least theoretically, intended to do not much more than impart information, albeit information with a particular ‘spin’ on it as determined by the newspaper’s particular politics and place in society. The few articles displaying incoherence – that is, splits between what is said in the headline, lead paragraph and body-text – are significant because they are so few in number. Why, in a genre where each piece of writing passes through three separate stages of editing<sup>103</sup> to ensure that it makes sense in itself and is therefore easily understood by the readership,<sup>104</sup> are such contradictions allowed to reach publication? Apart from human error and varying levels of competence among editorial staff, it is reasonable to argue that these contradictions are made public because they serve a certain purpose in terms of the general nature of the coverage. In this

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<sup>101</sup> Sam Mkokeli, “Poor Infrastructure Making Cholera Worse, Says Minister”, *Eastern Province Herald*, 31 January 2002, pg. 3

<sup>102</sup> *Ibid.*

<sup>103</sup> Bell, *News Media*, pp. 35-70. The process usually begins with a reporter/journalist, who is responsible for the article’s original form; the piece is then passed on to a chief reporter or a sub-editor, who is responsible for modifying the language and order of information. The article’s modified form is then forwarded to an editor for final suggestions and modifications, and then returns to a sub-editor, who finalises the article’s form. Articles are seldom edited by the same individuals who produce them; the aim of editing is to filter out mistakes, inaccuracies and contradictions in a text, fill in any gaps, and produce clear, concise, newsworthy articles. (Bell, *News Media*, pg. 75)

<sup>104</sup> *Ibid.*, pg. 83

case, that purpose would be to stress the spread of the epidemic and the dangers it poses.

The 1980-1983 coverage of the epidemic in the *Daily Dispatch* and the *Eastern Province Herald* does not contain many instances where headlines and texts are not in agreement with each other. This is in keeping with the generally non-argumentative nature of that era's coverage which, as outlined earlier,<sup>105</sup> tended not to challenge the authorities quoted as sources. Even in the case of the *Eastern Province Herald* report of the Stanger outbreak's cause,<sup>106</sup> it is notable that the opposing sides of the argument are given equal weight in the article, and are in any case both medical professionals in government employ. Simply put, there appears to have been little reason for the newspapers in that time period to introduce doubt to the reader; nor did they have any intention of contradicting the Health Department's version of events. The image of the 1980-1983 epidemic was relatively simple, at least in terms of whose responsibility it was, and whose "fault" it was said to be, both of which are expanded upon in a subsequent chapter.

The 2000-2003 epidemic is, however, much less homogenous in image. Although here, too, there are not many incidences of articles not being internally coherent, there are nevertheless more than were evident in the 1980-1983 period. This may be a side-effect of the epidemic's disputed nature: the cholera outbreak ceased to be merely a medical problem to be dealt with by the government and became instead a political issue. Disjunctions between headlines, leads and body-paragraphs may be evidence of newspapers' attempts to alert readers, who were possibly more concerned with the possibility of contracting cholera, to the political dimensions of the outbreak while still prioritising the health risks posed by the spread of cholera. This assumes a political stance on the part of the newspapers, but given that even articles with congruent headlines, leads and bodies are at least in part concerned with the political aspects of the outbreak, this is not unusual.

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<sup>105</sup> This will be much more fully discussed in Chapter 5.

<sup>106</sup> "Stanger Gastric Infection".

*Daily Dispatch* and *Eastern Province Herald* coverage of cholera changed significantly over the period 1980-2003. In 1980-1983, coverage consisted of fairly simple narration of the spread of the epidemic gleaned from Department of Health sources, with the accompanying tropes of a “black” threat to “white” health. This stance was, if not actively in favour of the government, at least neutral towards it, and did not challenge the South African *status quo* at the time. By 2000-2003, though, the climate of South African society had changed from being oppressive and based on legislated racial discrimination to becoming substantially more democratic. Newspapers, in keeping with the egalitarian mindset of post-1994 South African society, were able to challenge the incumbent government – indeed, many post-apartheid newspapers have adopted a “watchdog” role. This change is clearly visible in 2000-2003 cholera coverage, which is more concerned with the problems within the ECDOH than with cholera itself in the articles. The context of the disease supersedes the disease as a matter of comment and concern.

## Chapter 5 – NEWS SOURCES AND AUTHORITY IN THE 1980-1983 AND 2000-2003 CHOLERA-RELATED NEWSPAPER COVERAGE

In newspaper reports, attribution of sources serves to make it clear to readers that certain statements and information originated from particular individuals or organisations unconnected to the newspaper in which they appear.<sup>1</sup> The reliability of received information is theoretically proportionate to the status of its source – the more elite a source is, the more seriously the source’s information is meant to be taken.<sup>2</sup> In the case of the South African cholera epidemic of 1980-1983 and the Eastern Cape cholera epidemic of 2000-2003, examining the types of sources used, as well as the frequency with which they were used, reveals who the newspapers believed to be responsible for the control of the epidemic. Understanding who was believed to be in authority, furthermore, sheds light on what kind of problem - predominantly medical or political - cholera was seen to be.

In an examination of the *Daily Dispatch* and *Eastern Province Herald* coverage of cholera between 1980-1983 and 2000-2003, it is possible to divide sources into two approximate groups, with one group predominating in each epidemic. The first group, which predominates in coverage of the 1980-1983 national epidemic, is made up of medical professionals employed either by the South African government or by “homeland” governments.<sup>3</sup> The second group, which predominates during the 2000-2003 Eastern Cape epidemic, is much more diverse, being mostly made up of governmental administrators and civilians without medical training; government-employed medical professionals are in the minority. Government employees make up the bulk of both of these groups; they are the most commonly-quoted sources.<sup>4</sup> Their predominance makes it

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<sup>1</sup> Allan Bell, *News Media* (Oxford, 1991), pg. 190

<sup>2</sup> *Ibid.*, pg. 192

<sup>3</sup> Note that this group therefore excludes medical professionals employed in the private sectors of South Africa or “homelands”, as well as those employed by non-governmental organisations. It *includes* doctors, nurses and medical technicians employed at public hospitals in South Africa and in “homelands”, epidemiologists employed by government-linked research bodies, and spokespeople for the various provincial and regional subdivisions and subsidiaries of the “homeland” and South African departments of health.

<sup>4</sup> Bell, *News Media*, pg. 190. See also: Allan Bell, “Hot News – media, reporting and public understanding of the climate-change issue in New Zealand: a Study in the (mis)communication

clear that the cholera epidemic and issues surrounding it were always the responsibility of the government.

A higher proportion of medical professionals as sources, such as during the 1980-1983 coverage, would indicate that they were seen as the most appropriate source of information concerning the epidemic because of their expertise as doctors, medical officers of health and epidemiologists. This indicates that medical expertise was believed by the newspapers to be the most important factor in dealing with the epidemic because it was a medical, rather than overtly political, problem.

Conversely, a higher proportion of sources in 2000-2003 that are not medical professionals indicates that medical skills, while remaining necessary, no longer held centre-stage in terms of importance. Coverage of the epidemic extended beyond the issue of disease-containment and into more general issues around healthcare provision, service delivery and governmental priorities – indicating that the political aspects of the epidemic were at least as important as its medical aspects.

It is not possible to separate the medical and political aspects of an epidemic into pure categories. An epidemic, as noted in the introduction, extends far beyond the mere infection of a host body by a pathogen. However, it is possible for newspapers to give one category prominence over another in their coverage by including some sources and excluding others. This selection process results in a certain image of authority in the coverage.

### **Authority and Responsibility in the *Eastern Province Herald*, 1980-1983**

During the 1980-1983 South African cholera epidemic, the *Eastern Province Herald* carried cholera-related coverage that relied almost exclusively on medical professionals employed by the South African Department of Health for information. Presumably this meant that, in reproducing government

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of science”, Project Report to the Department of Scientific and Industrial Research and Ministry for the Environment (Wellington, 1989), and Leon V Sigal, “Who? Sources Make the News” in Robert Karl Manoff and Michael Schudson (eds.), *Reading the News* (New York, 1987).

information, the *Eastern Province Herald's* conception of the epidemic was similar to that of the South African Department of Health.

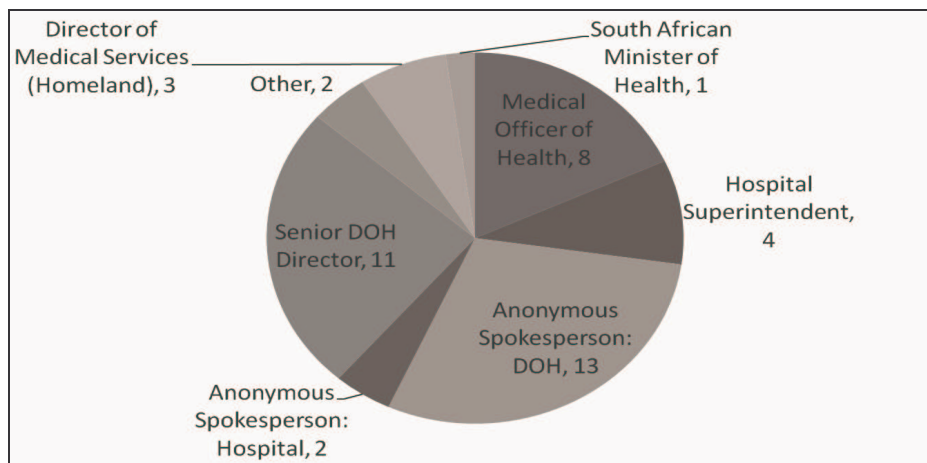


Figure 5: News Sources, Eastern Province Herald, 1980-1983

*Eastern Province Herald* coverage in 1980-1983 consisted of 44 articles containing discernable news sources. As seen in Figure 5 above (see Appendix D, Table 7, for data table), 29.5% (13) of these featured anonymous Department of Health spokespeople; 25% (11) featured senior South African Department of Health officials; and, 18% (8) featured city-based Medical Officers of Health. The predominance of Department of Health spokespeople can be accounted for by the fact that the *Eastern Province Herald* began covering the epidemic while it was still a fairly minor outbreak in the Eastern Transvaal and continued to do so until its last phase, in Transkei, had begun to wane. Covering the epidemic in various locations distant from the Eastern Cape led to a reliance on statements by spokespeople sent in by *Eastern Province Herald* correspondents at those locations. The quotes from senior Department of Health officials appear in articles dealing with potential cholera outbreaks in Port Elizabeth and Grahamstown as well as in articles mapping the spread of the disease outside the Eastern Cape. The Medical Officers of Health are found only in articles detailing the potentiality and treatment of an Eastern Cape outbreak.

Of the 44 officials quoted, 72% (32) were medical professionals; of the remaining 12, 8 (Directors of Medical Services in “homelands”, hospital superintendents, and the South African Minister of Health) were also medical

professionals, leading to a total of 40 medical professionals, 75% of whom were senior health-department employees. Their credibility was enhanced by their seniority and emphasized by the inclusion of their full titles in the articles. Their predominance in the coverage suggests that the *Eastern Province Herald* believed the epidemic to be the responsibility of the bodies controlled by these medical professionals.

The first cholera-related article published in the *Eastern Province Herald*, “Doctor Warns of Cholera Risk”, which appeared in January 1971,<sup>5</sup> cited the Grahamstown Medical Officer of Health, Dr C.J.A. Dreyer as its primary source. Dreyer is given his full governmental job-title, placing him within the government healthcare system. The title “Doctor” also emphasises his status as a medical professional. In the article, Dreyer outlines the precautions that could be undertaken individually to prevent cholera, suggesting that he was acting as a government-employed medical professional.

Published several years later, once cholera had broken out in South Africa, the article “Cholera Has Not Reached ‘Crisis Stage’”,<sup>6</sup> placed the epidemic firmly as a medical, not political, issue by quoting Professor Margaretha Isaacson, Head of Tropical Pathology at the South African Institute for Medical Research (SAIMR). As Isaacson is given her considerable full title, as well as the academic *and* medical title of Professor, her eliteness as a news source – and thus her version of where the epidemic is placed in society – is strongly established. Because Isaacson held a senior position in the SAIMR, a government body, her inclusion as a source further indicates that the cholera epidemic was seen as a medical problem to be handled by medical professionals in government employ.

Until June 1981, the *Eastern Cape Herald* took as its sources only senior South African Health Department employees, establishing their seniority and eliteness by giving their full government and medical-professional titles in the articles. This served to establish, for the reader, their credibility as sources of

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<sup>5</sup> “Doctor Warns of Cholera Risk.”

<sup>6</sup> “Cholera Has Not Yet Reached ‘Crisis Stage’.”

information, which in turn establishes as correct their situating of the disease. The *Eastern Province Herald* did not oppose the government's interpretation of the problem: that it had originated with "black" communities and that the Department of Health had the situation under control.

Even when two figures within the Health Department disagreed, they disagreed about the nature of the disease and the underlying causes of the outbreak, not about whether or not it was a medical problem that the government needed to deal with. In an article published 7 December 1981,<sup>7</sup> Stanger Medical Officer of Health, Dr E.C. Borat and Dr H.G. Küstner, Deputy Director of the Department's Epidemiology department, differed as to the nature of the disease affecting Stanger's "black" population.<sup>8</sup> Both, however, discussed the disease in terms of governmental action: Borat "blam[ed] it on the slum conditions of the affected population"<sup>9</sup> while Küstner maintained that whatever the disease was, it "was extremely difficult to contain...in the country".<sup>10</sup> Neither doctor questioned the assumption that medical intervention, rather than large-scale political change, was the primary driving-force of anti-cholera efforts, although Borat's reference to slum conditions does introduce a note of political dissatisfaction.

Soon thereafter, the article "Shanty Town Cholera May Hit Durban"<sup>11</sup> had as its central authority Dr N. Becker, the Medical Officer of Health for Durban. Becker issued a warning about potentially cholera-infected "black" workers returning from "cholera areas"<sup>12</sup> and suggested that employers be alert to the possibility that their employees may be ill with cholera. Also quoted in the article is Dr EC Borat. Becker's words deal with the need for individual vigilance on the part of Durban's employers ("[e]mployers whose workers have just returned from cholera areas should watch the situation carefully"),<sup>13</sup> while Borat once again blames "incredibly filthy living conditions"<sup>14</sup> in Stanger's "shanty-town" for the

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<sup>7</sup> "Stanger Gastric Infection".

<sup>8</sup> *Ibid.*

<sup>9</sup> *Ibid.*

<sup>10</sup> *Ibid.*

<sup>11</sup> "Shanty Town Cholera May Hit Durban", *Eastern Province Herald*, 28 December 1981, pg. 6

<sup>12</sup> "Shanty Town"

<sup>13</sup> *Ibid.*

<sup>14</sup> *Ibid.*

cholera outbreak – a repetition of his earlier statement. His authority comes from his position as a government employee in charge of the city's health.

As the possibility arose that cholera might spread into the Eastern Cape, the province's government needed to begin reassuring its populace that an outbreak was unlikely. The article "E Cape Geared for Cholera Danger," published 18 January 1982,<sup>15</sup> contained several quotes from the Regional Director of the Department of Health, Dr J.D. Krynauw, outlining anti-cholera measures to be implemented in the Eastern Cape should cholera appear.<sup>16</sup> This suggests that managing such an outbreak would be the responsibility of the ECDOH, directed by Krynauw, a medical professional.

Cholera's advent in the Transkei brought in a new level of health authorities in the form of "homeland" health officials. Up to this point, only Dr Charles Bikitsha had been included in the coverage as a source. The article "T'Kei Hospitals Get Set for Fight Against Cholera"<sup>17</sup> has the Transkei Deputy-Secretary for Health, Dr R.F. Ingle, and a Mount Ayliff hospital spokesman, Dr J.E. Naidas, as sources. Both of these sources are given full job-titles and medical-professional status in the article and describe Transkei health authority actions against cholera. In this way they remain, like their Eastern Cape and South African counterparts, medically significant government employees, reinforcing the newspaper's conception of the epidemic as a primarily medical problem.

### **Authority and Responsibility in the *Daily Dispatch*, 1980-1983**

Throughout the *Daily Dispatch* coverage of the 1980-1983 period, the cholera outbreak is constructed as the responsibility of the Department of Health, rather than the South African, Transkeian or Ciskeian governments as a whole. While this reservation prevents the epidemic from becoming a wholesale "political" problem, it does imbue the coverage with the sense that the cholera epidemic is a government problem, rather than an issue being dealt with by the broader

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<sup>15</sup> "E Cape Geared for Cholera Danger", *Eastern Province Herald*, 18 January 1982, pg. 9

<sup>16</sup> *Ibid.*

<sup>17</sup> "T'Kei Hospitals Get Set for Fight Against Cholera", *Eastern Province Herald*, 30 January 1982, pg. 3

medical community, “lay” members of government, or private citizens of any of the regions affected.

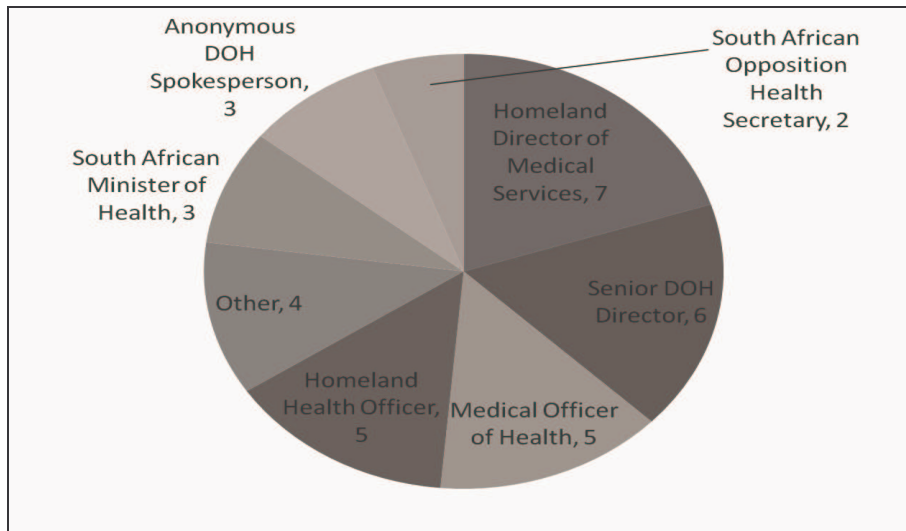


Figure 6: News Sources, Daily Dispatch, 1980-1983.

Figure 9 above (see Appendix D, Table 8, for data table), indicates which sources were used by the *Daily Dispatch* in its coverage of the 1980-1983 nationwide outbreak. The most widely-used sources were senior directors in the Department of Health (featured in 17% of the 35 articles); Directors of Health Services in “homelands” (20%); other health officers in “homelands” (14%); and, city-based Medical Officers of Health (14%). These sources make up 65% of the sources quoted. Their inclusion constructed the epidemic as a medical problem best dealt with by the government. The possible political implications of the outbreak did not receive much notice or inclusion in the articles.

In the *Daily Dispatch* article “Cholera: Water Being Checked”, published 20 November 1980,<sup>18</sup> the main source of information as in the *Eastern Province Herald* is Dr JD Krynauw, the Regional Director of Health Services in the Eastern Cape. Krynauw’s status as a medical professional dominates the article, which contains lengthy quotes from Krynauw concerning anti-cholera health precautions.<sup>19</sup>

<sup>18</sup> “Cholera: Water Being Checked”, *Daily Dispatch*, 20 November 1980, pg. 3

<sup>19</sup> “Water Being Checked”.

The next article, published five days later,<sup>20</sup> likewise quotes government employees, in this case the Director of Health Services in Bophuthatswana, Dr E.S. Theron, and an unnamed spokesperson for the Pretoria-based Department of Health. Both of these articles, although designating their sources as employees of government health departments (whether Bophuthatswanan or South African), also firmly identify two of the three as medical professionals in their own right – that is, as medical doctors as opposed to merely employees of a medical body. It is apparent from this that the *Daily Dispatch* constructed the cholera epidemic as a medical, rather than a political, problem until at least early 1981.

A third *Daily Dispatch* article, “Anti-Cholera Measures Underway on Border”,<sup>21</sup> focused on anti-cholera measures in place in the Ciskei “homeland”, located 40 kilometres west of East London. The article quotes Dr Charles Bikitsha, Ciskei Director of Health Services,<sup>22</sup> as well as the East London Medical Officer of Health, Dr J.R. van Heerden, and an anonymous spokesperson for the Department of Health in Pretoria. In this article, Bikitsha and Van Heerden are both given their full titles and are both identified by the title ‘Doctor’, again emphasising both their positions as senior government officials and their status as medical professionals (interestingly, the government of the Ciskei is given equal weight to that of South Africa). This is in keeping with the designations given to Krynauw and Theron in earlier articles.<sup>23</sup> However, the article deals with *government* actions in the Ciskei rather than making mention of individual precautions.<sup>24</sup> Likewise, Van Heerden mentions precautions taken by the East London municipality. Both sources are clearly government employees carrying out government orders, establishing that the *Daily Dispatch*, like the *Eastern Province Herald*, viewed the cholera epidemic as a medical problem falling under the umbrella of government health agencies, both in South Africa and in the various “homelands” facing infection.

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<sup>20</sup> “Cholera Case in Bophuthatswana”, *Daily Dispatch*, 25 November 1980, pg. 1

<sup>21</sup> “Anti-Cholera Measures Underway on Border”, *Daily Dispatch*, 15 January 1981, pg. 7

<sup>22</sup> “Anti-Cholera Measures”.

<sup>23</sup> “Water Being Checked”; “Cholera Case in Bophuthatswana”.

<sup>24</sup> “Anti-Cholera Measures”.

The article “Transkei Geared Up to Combat Cholera”<sup>25</sup> appeared in the *Daily Dispatch* in late January 1983. The article continued the trend of using high-level government health employees as sources, presenting the Director of Medical Services in the Transkei, Dr Hector Livingstone, as the article’s major authority. As the bulk of the article deals with the Transkei government’s anti-cholera precautions,<sup>26</sup> it is once again evident that Livingstone is a government appointee concerned with medical matters.

This trend is maintained in the 30 January 1982 article “Bid to Check Cholera Spread”,<sup>27</sup> the first report on Transkei cholera-containment measures following the outbreak of the disease in the region. In the article, Dr RF Ingle, the Transkei deputy secretary for health, “outline[s] plans to halt the disease”.<sup>28</sup> In addition to Ingle, the article also quotes Dr J.E. Naidas (spokesperson for Mount Ayliff Hospital), Livingstone, Van Heerden and an anonymous spokesperson for the Ciskei Health Department.<sup>29</sup> All except the Ciskeian spokesperson are given their full job titles and are designated “Doctor”. In this way, their status as medical professionals is established in tandem with their government positions.

All people named as sources in the *Daily Dispatch*’s cholera-related coverage between 1980 and 1983 were senior employees in government bodies dealing with health and medical matters. This served to establish their eliteness, and thus their credibility as news sources. The higher up in a hierarchy a source is situated, the more seriously the information that they provide is to be taken.<sup>30</sup> As these sources were constructed as taking medically significant government action, and all belong to government medical services, it could be argued that the 1980-1983 cholera epidemic as reported in the *Daily Dispatch* was, until early 1982, considered to be a medical, and not political, problem to be dealt

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<sup>25</sup> “Transkei Geared Up to Combat Cholera”, *Daily Dispatch*, 23 January 1982, pg. 1

<sup>26</sup> “Transkei Geared Up”.

<sup>27</sup> “Bid to Check Cholera Spread”, *Daily Dispatch*, 30 January 1982, pg. 1

<sup>28</sup> “Bid to Check.”

<sup>29</sup> *Ibid.*

<sup>30</sup> Bell, *News Media*, pg. 192

with by the government's medical bodies. This mirrored the *Eastern Province Herald's* representation of the epidemic.

In March 1982, East London authorities became concerned about the potential threat posed to the health of East London by the "black" area of Duncan Village, which did not have adequate sanitational infrastructure.<sup>31</sup> Van Heerden, the East London Medical Officer of Health, warned that living conditions in the area might result in an "uncontrollable" outbreak should cholera appear.<sup>32</sup> Van Heerden's role as a medically-significant governmental employee is less clear here than elsewhere but is, nevertheless, discernable through the article's minor mention of the installation of more water-points in the area.

An article published on the same day, "Cholera Expected in EL", had as its focus the South African Minister of Health, Dr L. Munnik.<sup>33</sup> Munnik constituted an extremely elite news source, as the head of the Pretoria-based South African Department of Health. "Border, East Cape Geared for Cholera",<sup>34</sup> an article written to supplement "Cholera Expected in EL", places regional authorities Krynauw and Van Heerden in the same hierarchy as Munnik, albeit several rungs lower on the ladder. In doing so, the articles make it clear that the epidemic is conceived of as a medical problem. All sources quoted until then originated from within governmental healthcare bodies; all are specifically designated as medical professionals; and, none of these sources are challenged.

Throughout the *Daily Dispatch* coverage of the 1980-1983 period, the cholera outbreak is constructed as "belonging" to the Department of Health, because it was a medical challenge falling under government control. This reservation prevents the epidemic from becoming a wholesale "political" problem, and imbues the coverage with the sense that the cholera epidemic is a government problem.

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<sup>31</sup> "Duncan Village Cholera Threat", *Daily Dispatch*, 3 March 1982, pg. 7

<sup>32</sup> *Ibid.*

<sup>33</sup> "Cholera Expected in EL", *Daily Dispatch*, 3 March 1982, pg. 1

<sup>34</sup> "Border, East Cape Geared for Cholera", 4 March 1982, pg. 11

### Authority and Responsibility in the *Eastern Province Herald*, 2000-2003

The coverage in the *Eastern Province Herald* consisted of only 15 articles featuring specific sources, as opposed to the *Daily Dispatch*'s 45 (see Figure 6, below; see Appendix D, Table 9, for data table). Of these 15, 75% featured medical professional sources, while only 25% featured non-medical practitioners. This proportion of medical professionals is relatively high compared to that of the *Daily Dispatch* coverage during the same period (discussed below), and resembles most closely the 1980-1983 coverage carried in the *Eastern Province Herald* and *Daily Dispatch*.

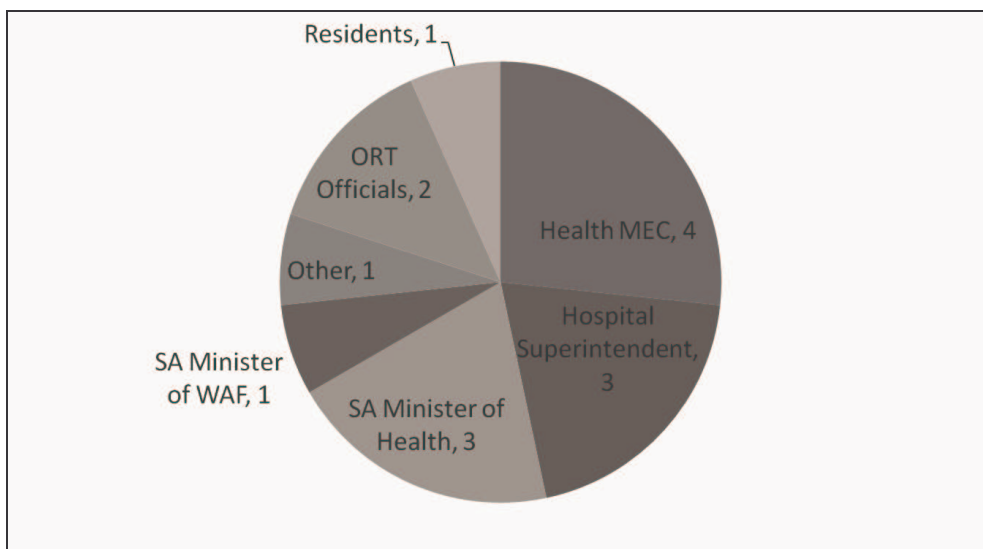


Figure 7: News Sources, Eastern Province Herald, 2000-2003.

The first cholera-focused article carried in the *Eastern Province Herald* regarding the 2000-2003 outbreak, “Anti-Cholera Alert”, was published on 1 December 2000.<sup>35</sup> Its main source the provincial MEC for Health, Dr Bevan Goqwana, focusing on the anti-cholera actions of ECDOH. The article “E Cape Hospital Has Cholera Patient”,<sup>36</sup> appearing four months after “Anti-Cholera Alert”, continues in this vein. Although Goqwana is once again the main source, his quoted remarks mainly concern the very small possibility that cholera would spread within the Eastern Cape.

<sup>35</sup> “Anti-Cholera Alert.”

<sup>36</sup> “E Cape Hospital Has Cholera Patient”, *Eastern Province Herald*, 2 March 2001, pg. 9

“Cholera Strikes in Eastern Cape”, published 1 May 2001,<sup>37</sup> once again quotes Goqwana, but also features as a source the hospital superintendent, Vetebese George, of St Patrick’s Hospital at Bizana.<sup>38</sup> The remarks of both are limited to general comments about the rapidly-improving health of the region’s few cholera-infected individuals and speculation around the possibility of boreholes in the region being contaminated with cholera. The article’s construction of Goqwana is quite straightforward: as the Health MEC for the province, he is evidently considered as an extremely elite news source. His credibility is suggested by the fact that the article contains neither any views opposing Goqwana nor a range of sources. As will be shown, this is not characteristic of cholera-related coverage in the period 2000-2003. Both Goqwana and George are healthcare administrators, while Goqwana is also a medical professional. His point of view, as an administrator *as well as* a medical professional, predominates in the article, suggesting that at this stage the *Eastern Province Herald* constructed the burgeoning cholera epidemic as a medical problem being dealt with by government agencies, rather than a problem with political overtones.

Two subsequent articles, however, introduced non-medical viewpoints to the *Eastern Province Herald’s* coverage, disrupting the initial construction of the epidemic as a medical rather than political issue. The first, “E Cape Cholera Worries Increase”,<sup>39</sup> carried extensive quotes from a South African Municipal Workers Union (SAMWU) official, Thobile Maso. The second, “R300m for Sanitation in Cholera Areas”,<sup>40</sup> had as its main source the South African Minister of Water Affairs and Forestry, Ronnie Kasrils. Neither of these sources were medical or healthcare practitioners. Both were concerned with the provision of sanitation and potable water to the Eastern Cape, albeit at different ends of the spectrum – Kasrils oversaw the entire country as National Minister of Water Affairs and Forestry, while Maso was a labour union representative and thus

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<sup>37</sup> “Cholera Strikes in Eastern Cape.”

<sup>38</sup> *Ibid.*

<sup>39</sup> “E Cape Cholera Worries Increase.”

<sup>40</sup> Cull, “R300m for Sanitation.”

non-governmental official, at least in this context.<sup>41</sup> While Kasrils commented on the difficulty of supplying “vulnerable areas”<sup>42</sup> with water-based infrastructure, Maso claimed that all Bizana-area cholera cases could be blamed on the local municipality disconnecting houses from the purified water supply. Both of these issues were connected to the inability of government bodies to adequately provide services to their constituencies.

The inclusion of these two viewpoints into the *Eastern Province Herald's* coverage complicated the newspaper's initial construction of the epidemic as a medical issue, and suggest that the *Eastern Province Herald* began to view the outbreak as politically significant, and not merely a medical issue.

This is also evident in the next *Eastern Province Herald* article on the cholera outbreak, “Poor Infrastructure Making Cholera Worse, Says Minister”,<sup>43</sup> which featured the South African Minister of Health, Dr Manto Tshabalala-Msimang, as its main source. Tshabalala-Msimang was identified as a medical professional by the title “Doctor” and the actions she was quoted as describing in the article were health-related infrastructural improvements, such as rebuilding access roads to clinics and supplying rehydration centres with generators. Once again, no opposing views were presented in this article.

Thus far, then, *Eastern Province Herald* coverage had concentrated mainly on elite medical-professional sources, who were presented as credible and were, furthermore, left unopposed in the coverage. The only non-medical sources used until early 2002 were the South African Minister of Water Affairs and Forestry, and a SAMWU official, both of whom were presented as credible in their own right. It is evident that the epidemic was seen as a medical issue rather than a political one because of the predominance of medical professionals, rather than administrators or other healthcare professionals, in the coverage.

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<sup>41</sup> “E Cape Cholera Worries Increase”.

<sup>42</sup> Cull, “R300m for Sanitation”.

<sup>43</sup> Sam Mkokeli, “Poor Infrastructure Making Cholera Worse, Says Minister”, *Eastern Province Herald*, 31 January 2002, pg. 3

From 2003, however, there was a distinct drop-off in the *Eastern Province Herald's* interest in the cholera outbreak, with only two articles appearing. Both were condensed versions of articles written by *Daily Dispatch* reporter Madoda Dyonana that appeared simultaneously in the *Daily Dispatch* and the *Eastern Province Herald*. From January 2003, then, the *Eastern Province Herald's* coverage contained some of the same sources as the *Daily Dispatch*. Because of this, it is not possible to determine for certain whether the *Eastern Province Herald's* construction of the outbreak was different to that of the *Daily Dispatch*, although the fact that the *Eastern Province Herald* merely reproduced *Daily Dispatch* articles militates against the possibility that the constructions were different.

#### **Authority and Responsibility in the *Daily Dispatch*, 2000-2003**

The *Daily Dispatch's* coverage of the 2000-2003 coverage of the cholera outbreak in the Eastern Cape was much more extensive than that of the *Eastern Province Herald* for the same period. Like both newspaper's coverage of the 1980-1983 epidemic, most of the sources in the coverage were government employees.<sup>44</sup>

As Figure 7 (see below; see Appendix D, Table 10, for data table) shows, of the 56 sources included in the coverage, 89% were current government employees, and one source was a former government employee (former Eastern Cape MEC for Health, Dr Trudy Thomas). Only very few of the sources for the *Daily Dispatch's* 2000-2003 coverage were medical professionals – while Goqwana was a medical professional, Max Mamase, the MEC for most of the cholera outbreak, was not.

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<sup>44</sup> Bell, *News Media*, pg. 190. This is important in terms of correlation between the 'eliteness' of a news source and the credibility of the information they impart. The *Daily Dispatch*, although somewhat challenging this by including a number of sources not usually considered 'elite', nevertheless mostly adheres to it.

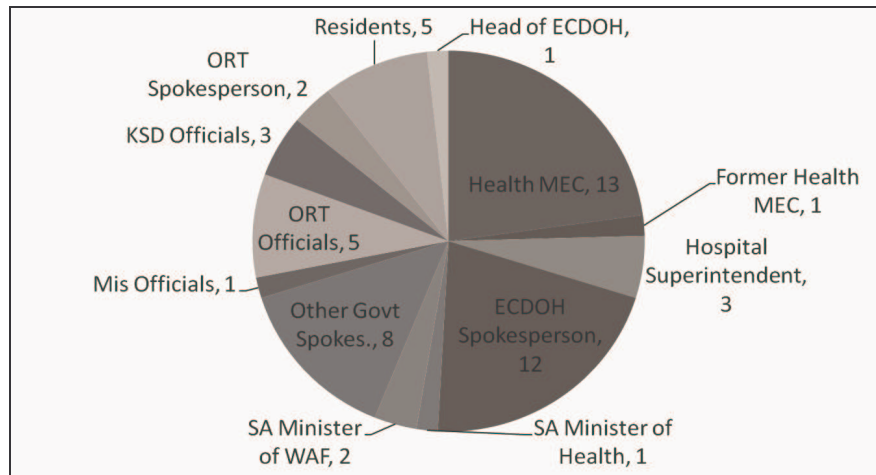


Figure 8: News Sources, Daily Dispatch, 2000-2003

Likewise, ECDOH spokespeople were not medical professionals, and neither were the ORT District Municipality and King Sabata Dalindyebo (KSD) Local Municipality officials quoted. Overwhelmingly the sources quoted in the coverage were administrators and politicians with little or no professional medical training.<sup>45</sup> This suggests that the *Daily Dispatch* saw the 2000-2003 epidemic firmly as a politically-significant governmental problem rather than primarily medically one. While it is of course not required for a health administrator or a spokesperson to have medical qualifications, it is arguably preferable that people assigned the responsibility of dealing with a health crisis – such as a cholera outbreak – have some medical expertise.

*Daily Dispatch* coverage of the 2000-2003 Eastern Cape outbreak began in January 2002, when the first suspected cholera-related deaths occurred in Qingqolo, near Mqanduli. The article, “10 Killed by Mystery Disease”,<sup>46</sup> quoted five separate sources – a local chief’s councillor, Mthinjeni Sonyana; a cholera patient Nobile Walters; the ORT District Municipality environmental officer, Sabelo Mkentane; the KSD Local Municipality’s disaster committee chairman, Lungile Bosiki; and, acting MEC for Health, Max Mamase. These sources range from local residents of the infected area to the local government’s environmental

<sup>45</sup> This may also be partly the result of changing government communication strategies, where a group of professional “spokespeople” and “media liaisons” place medical professionals at a further remove from media audiences.

<sup>46</sup> Mayibongwe Maqhina, “10 Killed by Mystery Disease”, *Daily Dispatch*, 21 January 2002, pg.

officer and the provincial mec for Health. Of these sources, not one was a medical professional; the closest equivalent is the area's environmental officer, whose stated action in the article is the taking and testing of water samples.

Although two government employees are used as sources, one (Mamase) was an administrator in the Health Department and the other was a municipal employee. This suggests a definite political investment in the outbreak, as well as a move away from conceiving the cholera epidemic as a non-political medical problem. This move is also suggested by Bosiki and Mamase's mention of the anti-cholera actions in the region, which were community-based rather than aimed at individuals.<sup>47</sup> It is possible to argue that the wide range of sources quoted in the article represent an attempt by the journalist to be inclusive of a range of experiences, evidencing an attempt to break away from the superiority of medical professionals as sources prevalent in the 1980-1983 coverage and the 2000-2003 coverage of the *Eastern Province Herald*.

A subsequent article, "Tests Confirm Cholera Cause of Deaths",<sup>48</sup> included two different sources: Alice Siphambo, the nursing service manager at Umtata General Hospital (a public hospital under the Department of Health's control), and the ORT District Municipality's chairperson for community services, water and sanitation, Nombulelo Mngoma. Siphambo confirmed the presence of cholera in the region, while Mngoma commented on the provision of fresh water and nursing staff.<sup>49</sup> Both Siphambo and Mngoma described government anti-cholera actions, placing the responsibility for handling the epidemic firmly with the government. That handling a public health issue such as the cholera epidemic was by definition the responsibility of the South African government, specifically its Eastern Cape branch, cannot be disputed. What is interesting is the way in which medical professionals are not prioritised over "lay" members of the government, or even over civilian commentators.

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<sup>47</sup> Maqhina, "10 Killed."

<sup>48</sup> Mayibongwe Maqhina, "Tests Confirm Cholera Cause of Deaths", *Daily Dispatch*, 22 January 2002, pg. 1

<sup>49</sup> *Ibid.*

The range of people sourced as authorities by the *Daily Dispatch* during the 2000-2003 epidemic suggests that their responses, though medical or at least health-related in subject, were mainly of political significance. This is evidenced by problems surrounding the formation of the anti-cholera Joint Operation Committee formed by members of the ORT District Municipality.<sup>50</sup> This committee was intended to include delegates from KSD Local Municipality, but employees of the latter claimed that they were not aware of the committee's formation. The article reporting this, "Cholera Committee Set Up",<sup>51</sup> was arguably intended to report on the lack of cohesion among the various government bodies fighting the epidemic (rather than the anti-cholera measures proposed by the committee, though there are mentioned). This is evidenced by the paragraph:

KSD is the only UDM-controlled council and has been involved in a protracted battle with the ANC for control of the municipality. [Nombulelo Mngoma, chairman *[sic]* of OR Tambo District Municipality community services, water and sanitation committee] claimed that contact with the KSD was lost on Sunday following a visit to Qingqolo.<sup>52</sup>

Elsewhere in the article, this lack of co-operation is emphasised:

KSD disaster chairman Lungile Bosiki said he was unaware of the JOC, as he was still scheduled to meet its OR Tambo counterparts on how to deal with the disease. Bosiki said he had, however, been told by the KSD's chief of fire services that the municipality had been invited to a meeting to be held today where Bisho officials would be in attendance. He said there was an urgent need to join forces to fight cholera.<sup>53</sup>

Although this might simply indicate a breakdown in communication, that in itself would be symptomatic of problematic relations between the two authorities, particularly because the KSD Local Municipality is a subsidiary of the ORT District Municipality.<sup>54</sup> By having as its sources officials from both the ORT and

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<sup>50</sup> Mayibongwe Maqhina, "Cholera Committee Set Up", *Daily Dispatch*, 23 January 2002, pg. 1

<sup>51</sup> "Cholera Committee",

<sup>52</sup> *Ibid.*

<sup>53</sup> *Ibid.*

<sup>54</sup> This tension is evident in a later article, "Cholera Comment Criticised", *Daily Dispatch*, 15

KSD municipalities, and by giving them equal weight, the article made it clear that combating the cholera epidemic was a politically-charged issue and not just a simple matter of co-ordinating healthcare services to contain the disease.

The article “Death Lurks in Qingqolo River”<sup>55</sup> likewise presented a wide range of sources. Of the six people quoted, three were government employees: the Assistant Director for the Mqanduli health district, Nowinile Gwazela; the Department of Public Works Assistant Director, Thami Vena; and, the KSD Local Municipality disaster-management chairperson, Lungile Bosiki.

The article “Mageda Says Cholera Threat Under Control”<sup>56</sup> published on 1 February 2002, had Eastern Cape Health Department spokesman Mahlunbandile Mageda as its sole source. Although Mageda was not a medical professional, he nevertheless presented the views of the province’s major medical authority, the ECDOH.<sup>57</sup> that the cholera epidemic was under control. This claim was made and repeated several times, at various junctures, by Max Mamase, Dr Bevan Goqwana and departmental spokespersons Mahlunbandile Mageda and Sizwe Kupelo. This indicates that there existed a co-ordinated government interpretation of the epidemic.

The politicized nature of the 2000-2003 epidemic was emphasized by the inclusion of sources that had apparent authority as government figures but no medical expertise. A 7 February 2002 article, “Umtata Sewage Cause of Cholera, Says Mamase”,<sup>58</sup> features Max Mamase, acting MEC for Health in the Eastern Cape, explaining that the cholera epidemic was the result of a leak at the Umtata sewerage works. Mamase was in a position of authority in a healthcare body but was not a medical professional. Likewise, the article’s other main source, Minister for Minerals and Energy, Phumzile Mlambo-Ngcuka, was

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February 2002, pg. 2

<sup>55</sup> Mayibongwe Maqhina, “Death Lurks in Qingqolo River”, *Daily Dispatch*, 24 January 2002, pg. 2

<sup>56</sup> Mayibongwe Maqhina, “Mageda Says Cholera Threat Under Control”, *Daily Dispatch*, 1 February 2002, pg. 3

<sup>57</sup> *Ibid.*

<sup>58</sup> “Mphumzi Zuzile and Phumlani Mdolomba, “Umtata Sewage Cause of Cholera Says Mamase”, *Daily Dispatch*, 7 February 2002, pg. 3

also not a medical professional.<sup>59</sup> Mlambo-Ngcuka makes reference to the role played by traditional healers in hindering cholera-control efforts; her authority and eliteness as a source comes from her position as a national minister holding a very important portfolio, and it is most likely because of this eliteness, rather than any expertise she possesses, that she is quoted. It is a recorded phenomenon in journalism that certain statements become newsworthy purely because they are made by an elite speaker.<sup>60</sup>

The inclusion of the wide range of commentators in *Daily Dispatch* coverage raises questions around the “credibility” of many of these sources. Although the eliteness of a source determines how credible it is theoretically, many of the sources in *Daily Dispatch* coverage of the 2000-2003 epidemic are not what is generally accepted as elite at all. They are included nevertheless. This particularly applies to quotes by local residents of cholera-infected regions. It has been proven by various news-language analysts that non-elites only ever make the news when something bad happens to them.<sup>61</sup> The local residents were neither politically nor economically powerful – indeed, they made up the underclass.<sup>62</sup> However, their inclusion broadens the scope and appeal of the articles they appear in, perhaps because they represent the *vox populi*, and journalists may consider their readers to resemble these people more closely than they resemble the government employees also quoted.<sup>63</sup>

Likewise, the inclusion of many low-level municipal employees is interesting. Like the civilian residents of infected areas, these employees were certainly less elite sources than the provincial and national authorities are also quoted, although they were more elite than the civilians quoted. That is, a hospital superintendent was not as ‘elite’ a source as, for example, the Department spokesperson Sizwe Kupelo, who in turn was not as ‘elite’ as Dr Bevan Goqwana. Ordinarily, the more ‘elite’ a source is the more likely it is to be

<sup>59</sup> Nor is her presence explained by the Eastern Cape’s role as a major labour reserve for the mining industry, as Mining is not the same portfolio as Mineral Affairs and Energy.

<sup>60</sup> Bell, *News Media*, pg. 193

<sup>61</sup> *Ibid.*, pg. 194

<sup>62</sup> For a lengthier definition of this term, please see the Introduction.

<sup>63</sup> This is especially likely in view of the press media’s assumption of a “watchdog” role, as put forward by Wasserman and De Beer in “Which Public? Whose Interest?”.

included in an article. That rule does not appear to fully apply here, in light of the fact that ‘civilians’ and low-level government employees were both often quoted. Their inclusion, therefore, is indicative of the *Daily Dispatch*’s focus on the epidemic’s wider implications. Coverage focused not only on the health implications of the cholera outbreak, but also on the way in which the various organs of government related to each other and to the affected communities in handling the outbreak. Furthermore, the inclusion of equally weighted opponents – for example, the members of the KSD and ORT municipalities disagreeing over the make-up of the Joint Operational Committee<sup>64</sup> - suggests that the *Daily Dispatch* did not subscribe to the idea that elites are unchallengeable, or even uniform in mindset.

This is further evidenced by the article “Cholera Comment Criticised”,<sup>65</sup> in which the KSD Local Municipality’s mayor, Dowa Mgudla, refuted Health MEC Max Mamase’s ascription of the cholera outbreak to a leak at the Umtata sewerage treatment plant. Mgudla was quoted as stating that “[Mamase’s] statement [was] calculated to incite people in the affected areas against the KSD municipality...[Mgudla added that] the issue of cholera...was too serious to be used for political point-scoring.”<sup>66</sup> This placed Mgudla in direct opposition to Mamase. although the two were neither in the same department nor at the same level in the hierarchy, one was the provincial MEC for Health, and the other was the mayor of a local municipality. The focus on Mamase and Mgudla firmly located the epidemic as a politically significant governmental issue, rather than as a medically significant governmental issue. It also spoke to the problem of party politics hindering the provision of healthcare in the province.

The return of Dr Bevan Goqwana to office in late 2002<sup>67</sup> did not disrupt the *Daily Dispatch*’s choice of sources or its depiction of the epidemic as politically significant. In fact, it was, if anything, *more* concerned with the political aspects

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<sup>64</sup> Maqhina, “Cholera Committee”.

<sup>65</sup> “Cholera Comment Criticised.”

<sup>66</sup> *Ibid.*

<sup>67</sup> Dr Bevan Goqwana was suspended while under investigation on fraud charges in 2001. During this time, he received full salary.

of the epidemic than the medical challenges it presented. For example, in the article “Cholera Kills 7 in T’Kei”,<sup>68</sup> Goqwana is extensively quoted:

“No one can dispute the fact that government is working hard to address the apartheid backlogs still hindering rural development. I want to assure our people that the ANC-led government is well on track in turning things around... My visits to all the affected area are about showing residents that the government cares about its people wherever they are.”<sup>69</sup>

This explicitly situated the cholera epidemic as a political challenge with medical aspects, rather than vice versa. Although Goqwana was a medical professional, he was also – as MEC for Health – a political appointee and concerned with administering provincial healthcare delivery that cast his party in a favourable light. That the post of MEC was a political position rather than a medical post is made clear by the replacement of Goqwana, when on trial for fraud, by Agriculture MEC Max Mamase, rather than another medical professional. Likewise, many of the municipal and departmental positions mentioned above – the disaster committee chairperson, and departmental spokesperson, for example – apparently do not specifically require medical qualifications. At any rate, the incumbents of those positions are not identified as medical professionals in the articles. Also, only a very few medical practitioners and healthcare professionals are cited as sources in the coverage.

The remainder of cholera-related coverage in the *Daily Dispatch* was dominated by the MEC, Dr Bevan Goqwana, and departmental spokesperson Sizwe Kupelo, usually stating that anti-cholera measures were in place, and that the efforts of the Department were effective in combating the disease. The sources cited placed less emphasis on the state of cholera in the province than on the strides being made against it,<sup>70</sup> suggesting that cholera – a medical problem –

<sup>68</sup> Madoda Dyonana, “Cholera Kills 7 in Transkei”, *Daily Dispatch*, 6 January 2003, pg. 1

<sup>69</sup> Dyonana, “Cholera Kills 7.”

<sup>70</sup> For example, Madoda Dyonana, “Goqwana Assesses Progress on Cholera”, *Daily Dispatch*, 14 January 2003, pg. 2; “‘No Need to Panic’ Over Cholera”, *Daily Dispatch*, 16 January 2003, pg. 3, and particularly Madoda Dyonana, “Health Department Winning Cholera War”, *Daily Dispatch*, 18 January 2003, pg. 2

ceased to be seen as a health threat and became, rather, a political problem to be resolved.

The concentration on medical professional sources in the coverage of the 1980-1983 may stem from the same repressive socio-political atmosphere that led to that period's highly racialised attributions of blame.<sup>71</sup> It is also possible that the version of events put forward by the government-employed medical professionals, particularly those of the South African Department of Health and its subdivisions, fitted in with preconceptions held by the *Eastern Province Herald* and *Daily Dispatch* concerning the course of action to be taken regarding the epidemic. In this case, then, it would be both impolitic and unnecessary not to select professional medical government employees as the most elite sources. The construction of the 1980-1983 cholera epidemic as a medical, rather than political, problem melded with the political climate of the decade, as well as with the racist mindset arguably possessed by a fair proportion of the newspaper's readership.

That is not to say, however, that the *Eastern Province Herald* and *Daily Dispatch* produced coverage identical in mindset and execution. Significantly, the *Herald* began reporting much earlier and much more broadly than the *Daily Dispatch*, which only began carrying coverage once the Eastern Cape was threatened. The *Eastern Province Herald's* more extensive interest in the epidemic suggests that it was more worried about the spread of cholera than the *Daily Dispatch* was, possibly indicating a more racialised and more anxious understanding of the epidemic than that held by the *Daily Dispatch*.

That the *Daily Dispatch* had a less racialised, more co-operative understanding of who was responsible for containing the 1980-1983 epidemic is evidenced by the articles containing quotes from "homeland" ministers of health. Their inclusion as sources alongside South African authorities suggest a more inclusive conception of who was responsible for containing the epidemic,

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<sup>71</sup> Discussed extensively in Chapter 6.

although this possibly also followed the government line of trying to make the puppet governments of the “homelands” seem legitimate.

The 2000-2003 Eastern Cape epidemic occurred in a political and societal climate vastly different from that of the 1980-1983 national epidemic. Most significantly, criticism of the government was allowed (and, nominally, encouraged), while institutionalised racial discrimination, which had allowed for a comfortable expression of racialised understandings of disease in newspapers, had been made unacceptable, legislatively and constitutionally. These profound changes caused shifts in conceptions of who was in authority and exactly what authority meant.

As a result, the *Daily Dispatch* and *Eastern Province Herald* coverage of the 2000-2003 Eastern Cape cholera epidemic did not rely on medical professionals in government employ for information. Instead, medical professionals were only a small proportion of the sources quoted in articles, being replaced by government administrators and even, to a small degree, civilians with little ‘eliteness’ as sources. These changes suggested that the problem was no longer the sole province of medical professionals, but also – because of the appearance of civilians – called into question the source eliteness of government employees.

The *Eastern Province Herald*, although carrying only small amounts of cholera-related coverage during 2000-2003, adheres to this trend throughout 2000 to 2003, at first by quoting union spokespeople in tandem with medical professionals employed by the ECDOH, and later by carrying the same coverage as the much more outspoken *Daily Dispatch*. The *Daily Dispatch* coverage undermined the superiority of medical professionals as sources by including a wide range of government-employed administrators, and in turn undermined the eliteness of government sources by including civilian sources. This is unsurprising in view of the newspaper’s suggestion that it was the

government, and not the affected communities that was to blame for the spread of the cholera epidemic.<sup>72</sup>

The period 1980-1983 saw a perception of cholera that remained constant over time and between commentators: medical professionals were given the responsibility for dealing with the outbreak, and were not questioned once they were quoted in that capacity. This suggests an extremely complacent attitudes towards government efficiency during the 1980s, a consequently a sheep-like adherence to the racially discriminatory mindsets of the time. In the 1980s, cholera was not a lens through which to scrutinize the performance of the government or criticise its policies. It was rather a medical emergency granted importance only because it threatened the health security of “white” populations.

The period 2000-2003, however, is much more democratic in outlook. The wider range of sources consulted, incorporating non-medical professionals and even civilians, indicates both a wider understanding of the disease’s effects and causes. In turn this suggests a reluctance to accept the Health Department as the final authority on the epidemic, a distinct departure from the unquestioning agreement of the 1980s. Thus cholera, in the 2000s, provided a vehicle for challenging existing authority and increasing the input of people most directly affected on constructions of the epidemic.

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<sup>72</sup> For an extended discussion of this point, see Chapter 6.

## CHAPTER 6: APPORTIONING BLAME IN NEWSPAPER COVERAGE OF THE 1980-1983 AND 2000-2003 CHOLERA EPIDEMICS

### Placing the Blame in the *Eastern Province Herald*, 1980-1983

The article “Doctor Warns of the Cholera Risk”, published in *the Eastern Province Herald* in 11 January 1971, located cholera firmly outside South African borders while at the same time suggesting that distance did not equal safety. Indeed, the article suggested that South Africa was under threat from the remainder of the African continent. The article's first three paragraphs specifically name infected areas and their links to South Africa:

Anyone returning to Grahamstown from *out of South Africa* should see a doctor as soon as possible if he suspects that he has been in contact with cholera, says Dr CJA Dreyer, Medical Officer of Health.... “I am not scaremongering, but Grahamstown is in the unique position that there is a *big traffic of overseas visitors* constantly through the town...Many schoolchildren and students go on *overseas trips*...Many more *pour in from Central and East Africa* once the schools and university open... Official World Health Organisation reports had confirmed cholera in Guinea, Ghana, the Ivory Coast, Sierra Leone, Libya and Tunisia...<sup>1</sup>

Here, Central and East Africa and anywhere “out of South Africa” - that is, everywhere *but* South Africa - are constructed as threats. In the case of Central and East Africa, this is because cholera had been officially identified in those regions. Further, the areas designated as “out of South Africa” are established as a threat by being mentioned in conjunction with cholera – that is, anyone returning from a trip over South African borders may possibly have come into contact with cholera. The article continues under the subheading “At Risk”, to state that “Doctors had been warned [by the South African Department of Health] that South Africa...must be considered at risk.”<sup>2</sup> It should be noted that the countries mentioned as World Health Organisation (WHO)-certified cholera sites are all situated in West or North Africa.

<sup>1</sup> “Doctor Warns of Cholera Risk.”; my italics.

<sup>2</sup> *Ibid.*

The first report of cholera in South Africa was published on 11 October 1980<sup>3</sup> on the front page of the *Eastern Province Herald*. The article is careful, like the “Doctor Warns of Cholera Risk” article, to establish the location of the outbreak in relation to “white”-dominated areas that were as yet uninfected. The liminal<sup>4</sup> location of each infected area is mentioned repeatedly: Matsulu, for example, is described as being “in” KaNgwane, “east of” Nelspruit, “bordering” the Kruger National Park” and “near” the Mozambican border.<sup>5</sup> “In” and “bordering” suggest much closer proximity than “east of”. The article includes an admission by a hospital superintendent that the Department of Health had the area under cholera surveillance “because of the possibility of disease coming from over the border”.<sup>6</sup>

Matsulu is, moreover, designated as a “township”, while other infected individuals are said to come from “farms in the Malelane district”.<sup>7</sup> This functions to make these locales distinct from towns and cities by emphasising their non-urban nature. Neither Nelspruit nor Barberton are specified to be “towns” or “cities”, which would suggest that urban areas are considered to be the default form of “well” regions.

Sue Denny's feature article, “Death Lurks in the Fields”, presents a less straightforward idea of the link between “ruralness” and “sickness” by providing a more in-depth, personalised image of the infected area of KaNgwane. In doing so, she went against the established grain of *Eastern Province Herald* coverage, which had heretofore taken most of its information from the Department of Health's press releases. Denny travelled to cholera-infected KaNgwane and did personal research. Despite being much more humane and

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<sup>3</sup> “Cholera Claims Four.”

<sup>4</sup> Liminal: adjective 1. Relating to a transitional or initial stage. 2. At a boundary or threshold. (Oxford Concise English Dictionary, (Oxford, 2003)). In this chapter, liminal is used in the second sense.

<sup>5</sup> “Claims Four”.

<sup>6</sup> *Ibid.*

<sup>7</sup> *Ibid.*

detailed than previous constructions of infected areas,<sup>8</sup> her conclusions do not challenge the “official version” of cholera being essentially a “black” disease resulting from the inherently diseased nature of “black” communities.<sup>9</sup>

Describing the Eastern Transvaal as “hold[ing] a tragic secret of death”, Denny ascribes the infection in the region to the influx of “emigrants from Mozambique and Swaziland”. She incontrovertibly states that the disease was imported into the region from outside South Africa, which returns to the image of “sick” Africa threatening to infect well “South Africa”. Unlike the 11 October 1980 article (in which it is admitted that the “homeland” of KaNgwane had been under surveillance), Denny’s article draws infection from “sick” Africa directly into “well” South Africa without the “filter” of a “black” and therefore “sick” so-called homeland inbetween.

At this point, even though the Eastern Transvaal is officially identified as a cholera-infected area by the Department of Health, subsequent outbreaks on the East Rand<sup>10</sup> are nevertheless not ascribed to emigrants from the Eastern Transvaal in the same way that the Transvaal outbreak was blamed on “emigrants from Swaziland and Mozambique”. This may be because the “white”-dominated Eastern Transvaal was not considered “black” - unlike the previously mentioned sources of infection such as KaNgwane (a nominal “black homeland”), and Mozambique and Swaziland (two independent “black” countries). The Eastern Transvaal’s “white” nature may have prevented the *Eastern Province Herald* from labelling it as “sick”. KaNgwane, however, because it was already labelled “black”, could easily be called “sick”. The nexus of “white” with “well” and “black” with “sick” came into full play. It is nevertheless more likely that cholera was introduced to the East Rand by a traveller from the Eastern Transvaal than by someone from further away.

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<sup>8</sup> See, for example, “Cholera Claims 4”, “Doctor Warns of Cholera Risk”, “Cholera Has Not Yet Reached ‘Crisis Stage.’” For examples of constructions of cholera in longer works, see Briggs, “Modernity, Cultural Reasoning or Charles E. Rosenberg, *Explaining Epidemics and Other Studies in the History of Medicine* (Cambridge, 1992).

<sup>9</sup> For an extended discussion of this stereotype, please see Chapter One.

<sup>10</sup> “Cholera Outbreak: Nine Now Isolated in Johannesburg”; “14 Whites.”

That the outbreak in the Eastern Transvaal was becoming increasingly severe is reported in the *Eastern Province Herald* on 28 November 1980.<sup>11</sup> In this article, titled “47 More Cases of Cholera in Transvaal”, the headline suggests that the entire Transvaal is now infected with cholera, but the body of the article makes it clear that only the Eastern Transvaal is as yet infected. Nevertheless, the origin of newly-infected individuals is given as “Louw's Creek settlement”, and the “nearby lower portions of the De Kaap River”.

These areas are suggested to be rural: “settlement” is used rather than “village”, suggesting a rather more temporary and/or “primitive” setup. Likewise, the rather vague “lower portions of the...river” also suggest an absence of formal settlement. Taken in conjunction with the article's statement that “between 15 and 20 of the cases were hospitalised at Shongwe, Temba and Barberton hospitals”, these designations suggest that once again the bulk of infection was in a rural area. This adds up to an image of the Eastern Transvaal's rural areas being particularly prone to cholera, with the rural “black” populations most likely to be infected.

The resurgence of the epidemic in December 1981 brought with it a new emphasis on locating the precise sites of infection, their proximity to uninfected areas, and the route by which they were infected. Cholera germs were discovered in Johannesburg sewers at that time, an event sufficiently interesting to warrant publication on the front page of the 2 December 1981 edition of the *Eastern Province Herald*.<sup>12</sup> The article quotes Johannesburg Health Department officials as stating that the infection “may have been carried into the Johannesburg area by travellers from the KwaZulu and Bophuthatswana homelands, where the dreaded infection has so far killed 14 people and hospitalised hundreds.”<sup>13</sup>

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<sup>11</sup> “47 More Cases of Cholera in Transvaal”, *Eastern Province Herald*, 28 November 1980, pg. 1

<sup>12</sup> “Cholera Germs in Jo'Burg Sewers”, *Eastern Province Herald*, 2 December 1981, pg. 1

<sup>13</sup> *Ibid.*

Although KwaZulu and Bophututswana had, by December 1981, experienced outbreaks of cholera, the epidemic in the Eastern Transvaal was much more likely to have been the original source of the bacteria found in Johannesburg's sewers. However, as KwaZulu and Bophuthatswana were both "homelands", like other sites of infection, they were already part of the nexus of "black" and "sick" that existed in the *Eastern Province Herald's* coverage. This is supported by a statement later in the article, which warned Johannesburg residents that they "[might] still get the infection of [*sic*] employees [if those employees] do not observe proper hygiene when preparing foods".<sup>14</sup> Residents of Johannesburg are warned about their "employees", who are evidently not also considered residents; thus, migrants from outside Johannesburg are implied to be the vectors of infection.

The infection of Stanger in early December 1981 further illustrates this, as does subsequent concern surrounding the spread of cholera into the rest of Natal from KwaZulu, and the possible spread into the Eastern Cape from Transkei. The article "Stanger Gastric Infection Not Cholera", published in the *Eastern Province Herald* on 7 December 1981,<sup>15</sup> showcases official denials of the presence of cholera in the "white"-dominated Natal town of Stanger. Although a local health official, the Medical Officer of Health for Stanger, Dr E.C. Bhorat, maintained that it was cholera, the official South African Health Department stance was that it was *not* cholera. Although Bhorat is mentioned, it was the Health Department's refutation that was elaborated on in the article. The refutation is phrased as "..[the Stanger outbreak was] not caused by the vibrio cholerae bacteria which ha[d] swept through some other parts of South Africa"<sup>16</sup>, implying that Stanger was *different* from those "other parts".

On 24 December 1981, an article entitled "Cholera at Epidemic Stage in KwaZulu" appeared in the *Eastern Province Herald*. In stark contrast with the article denying Stanger's infection, this article locates cholera firmly in Maphumulo, a town in the "homeland" of KwaZulu. There is no doubt, according

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<sup>14</sup> "Cholera Germs in Jo'burg Sewers".

<sup>15</sup> "Stanger Gastric Infection."

<sup>16</sup> *Ibid.*

to the article, that the disease in question is cholera.<sup>17</sup> KwaZulu, as a “homeland” and consequently designated “black”, “sick” and “rural”, is much more readily admitted to be cholera-infected than Stanger. Indeed, Stanger is more threatened than threatening. In an article printed on 28 December 1981 in the *Eastern Province Herald*, cholera is located in a “shanty-town near Stanger”<sup>18</sup> inhabited by factory workers living in “slum conditions”, constructed as the “sick”, “black” location posing a threat to the “well”, “white” holiday capital of Durban.

The position of Natal in the schema of “well” versus “sick” areas was precarious. As a “white”-dominated province, it was automatically classed as “well” and predominantly “urban”. The infection of Natal with cholera cast doubt on the immutability of the divisions between “sick”/“black” and “well”/“white” areas – if Natal could become infected, then did “white” necessarily link to “well” in all cases? The *Eastern Province Herald*, from the point at which Natal became infected, treated it in much the same way that it had treated the “black”, “sick” areas infected by cholera.

From January 1982, in *Eastern Province Herald* coverage, Natal came to be seen as a threat to its nearest “white”-dominated neighbour, the Eastern Cape, from which it was separated only by the “homeland” of Transkei. The article begins with “The cholera-stricken areas of Transvaal and Natal may seem a distance from the Eastern Cape, but this does not mean the area is immune to similar outbreaks”.<sup>19</sup> This lead paragraph stressed the distance between Natal and the Eastern Cape but suggested that this distance was no guarantee of safety at all through the use of “may seem” and “but this does not”. The article states that a “cholera outbreak in the city [Port Elizabeth] was quite possible”<sup>20</sup> - presumably due to its similarities to now-infected Natal.

Differences between Natal and the Eastern Cape are, however, clearly indicated

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<sup>17</sup> “Cholera At Epidemic Stage in KwaZulu.”

<sup>18</sup> “Epidemic Stage”; my italics.

<sup>19</sup> “E Cape Check for Cholera”, *Eastern Province Herald*, 5 January 1982, pg. 3

<sup>20</sup> *Ibid.*

by statements such as, “If such an outbreak did occur we [the Eastern Cape] would be in a better position to control the spread of the disease than they are in the areas where it has broken out, as we have a reticulated water supply.”<sup>21</sup> This of course implies that the areas infected in Natal, Transvaal, KwaZulu and so on did *not* have reticulated water supplies, distancing them from the Eastern Cape. The suggestion of a threat posed by Natal in this article is on a par with earlier articles’ depictions of Mozambique and Swaziland as threats to South Africa, Bophuthatswana and KwaZulu as threats to Johannesburg, and KwaZulu as a threat to Natal.

Part of this about-face may have been because Natal's infection brought cholera uncomfortably close to the Eastern Cape. Transkei, an independent “homeland” between Natal and the Eastern Cape, was a “black”-dominated area that was predominantly rural. It was believed to be “sick”, “black” and “rural” – and, therefore, by default, to be extremely vulnerable to cholera. Natal became a threat in itself, largely because it would likely facilitate cholera in Transkei.

The first article dealing with cholera in Transkei appeared on 30 January 1982, shortly after the first cholera-related death in the region.<sup>22</sup> In the article, the infected individual is twice said to have contracted the disease outside Transkei. The first statement to this effect - “[cholera killed] a migrant worker shortly after his return home from Durban last week”<sup>23</sup> - implies this by stating that his death occurred “shortly after” his return to Transkei, suggesting that he contracted the disease before leaving Natal. The second statement - “[he] had contracted the disease outside the Transkei” - is much more straightforward and implicitly denies that cholera had been present in Transkei before this man's return, despite the area's vulnerability. In this way, the article makes it clear that the disease was imported into Transkei from Natal, which is thus a “sick” space presenting a threat to the previously-uninfected Transkei.

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<sup>21</sup> “Check for Cholera”.

<sup>22</sup> “T'Kei Hospitals Get Set for Fight Against Cholera.”

<sup>23</sup> *Ibid.*

The spread of cholera within Transkei, like that in Natal and KwaZulu, was mapped carefully in space and time by the *Eastern Province Herald*. On 12 February, four cases in the Port St Johns area were reported;<sup>24</sup> five days later, the number of confirmed cholera cases in Transkei was announced to have doubled to 22, with another death occurring at Tekwini.<sup>25</sup> This report was published on the front page of that day's edition. Neither Port St Johns nor Tekwini are given the qualifying term "township" or "settlement". This suggests that they were considered to be normal "urban" areas rather than temporary or informal settlements. This is unusual in terms of *Eastern Province Herald* coverage. As Transkei is a "homeland" (such as Bophututswana or KwaZulu), it is to be expected that it would be conceptualised in the same terms: that is, as being "sick", "black" and "rural". It is, however, *not* constructed in these terms: its rural nature goes unremarked on, and while the epidemic's spread is carefully documented,<sup>26</sup> it does not seem to be thought of as a "sick" area in the same way as KwaZulu, KaNgwane or indeed Mozambique or Swaziland.

However, this semi-neglectful attitude towards the Transkei changes in March 1982, when a sizeable article discussing the likelihood of a cholera outbreak in the Eastern Cape is published in the *Eastern Province Herald* on 12 March 1982.<sup>27</sup> The article states that:

Several confirmed cases [of cholera] have already been reported from Transkei and population movement between the independent homeland and the rest of the Eastern Cape meant carriers would "almost definitely" bring the disease, [Dr J Dippenaar] added. So far no cases have been reported in Ciskei, but local authorities believe it is only a matter of time before cholera occurs there.... What made the spread of cholera almost inevitable in areas where there was large population movement was that 75 percent of all cases were carriers, displaying no overt symptoms of disease themselves."<sup>28</sup>

<sup>24</sup> "Transkei Cholera 'In Control'".

<sup>25</sup> "Man Dies of Cholera."

<sup>26</sup> "Transkei Cholera 'In Control'"; "Man Dies of Cholera"; "T'Kei Hospitals Get Set for Fight Against Cholera."

<sup>27</sup> Jennifer Hyman, "Possibility of Cholera in East Cape", *Eastern Province Herald*, 12 March 1982, pg. 3

<sup>28</sup> Hyman, "Possibility of Cholera".

This extract explicitly states that Transkei presents a threat to the Eastern Cape. Transkei is said to be infected, and therefore “sick”, threatening the “wellness” of the Eastern Cape by possibly importing cholera into it. In this way, Transkei is made to occupy the same position in the coverage Natal, KwaZulu and KaNgwane had occupied – that is, as a “sick” area threatening to import cholera into a neighbouring “well” area. The Ciskei had not been mentioned in the coverage at all thus far, despite being a “homeland” like Transkei. This may have been because the epidemic was approaching the Eastern Cape from the east, moving through KwaZulu, Natal and Transkei in sequence from east to west. Ciskei, being further west than the Eastern Cape, may not even have entered into the *Eastern Province Herald's* thinking.

Coverage of the 1980-1983 cholera epidemic in the *Eastern Province Herald* deals almost exclusively with the spread of the epidemic: its routes, and modes of transmission, as well as, to a lesser degree, its severity. The coverage carefully maps the starting-point of the epidemic, based on information supplied by the Department of Health or one of its regional subsidiaries, and analyses the origins of every new outbreak. The *Eastern Province Herald* coverage is concerned with the danger posed to one region by another, by the other's “sick”, “black” and “rural” nature. In its constant evaluation of the degree of this danger conceptualises the epidemic as a system of threats posed by one area to another and the changes undergone by newly-infected regions. The *Eastern Province Herald's* coverage effectively divides the eastern half of South Africa into infected and uninfected regions, and constructs infected regions as particular threats to uninfected regions.

This threat goes beyond the simple physical transmission of cholera, as articles deal with less tangible qualities such as “sickness”, “wellness”, “blackness” and “whiteness”. The link between race and sickness, long established in racist thought and therefore at least partially informing the mindset of racially divided South Africa, transmuted the threat of cholera into the threat of “black” to “white”, and of “rural” to “urban”. Although these binaries are never consciously stated in *Eastern Province Herald* coverage, they inform it, as can be seen by

the *Eastern Province Herald's* construction of infected areas and their interrelationships. That the binaries of “sick”/“black” and “well”/“white” are at play in the coverage is discernible through the newspaper’s descriptions and constructions of infected versus uninfected areas.

### **Placing the Blame in the *Daily Dispatch*, 1980-1983**

*The Daily Dispatch* covered the cholera epidemic from 20 November 1980 until 11 May 1983, beginning and ending later than the *Eastern Province Herald*. The first article concerning cholera in South Africa was published on 20 November 1980, entitled “Cholera: Water Being Checked”.<sup>29</sup> It dealt with the East London Department of Health's monitoring of the city's harbour and main sewerage drains and gave advice on anti-cholera precautions. The articles situated the disease in “areas of the Transvaal”<sup>30</sup>, but in the same sentence noted that the local Department of Health had recently begun to monitor the city's main sewerage lines in addition to its harbour.<sup>31</sup> Given that cholera was present in many port cities worldwide at the time,<sup>32</sup> as well as in other African states,<sup>33</sup> monitoring the harbour for cholera imported by cargo ships was an unsurprising precaution.

However, although sewerage lines often open into harbours, the reverse does not happen – if cholera were to enter the city's sewerage system, it would have to enter via toilets and drains on land. The article's mention that sewerage lines were now also under surveillance “following the outbreak of cholera in parts of the Transvaal”,<sup>34</sup> therefore, suggests that there was now the expectation that cholera would be imported into the city by infected travellers from that region. In this way, the Transvaal is constructed as a threat to East London and presumably the Eastern Cape as a whole.

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<sup>29</sup> “Cholera: Water Being Checked”, *Daily Dispatch*, 20 November 1980, pg. 3

<sup>30</sup> *Ibid.*

<sup>31</sup> *Ibid.*

<sup>32</sup> The seventh global cholera pandemic had been seeded by a cargo ship which had collected cholera-infected water for ballast off Indonesia, and released it in various South American ports.

<sup>33</sup> See Chapter 4.

<sup>34</sup> “Cholera: Water Being Checked”.

The main part of the threat outlined in “Cholera: Water Being Checked” consists of people already resident in East London. The Eastern Cape Regional Director of Health Services, Dr J.D. Krynauw, stated:

Under no circumstances should people use unpurified water. This applies particularly to those who use rivers or pools for their water supply. Drinking water must be boiled and even after washing clothes these people must wash their hands.

Otherwise they could contaminate food they're preparing should the water have carried the infection...

A pitfall in preventing cholera spreading once it strikes is that some people are asymptomatic, which means that if they are infected they don't exhibit symptoms and there's no way of detecting the disease in them.<sup>35</sup>

This article clearly identifies a certain group of people (“those who use rivers or pools for their water supply”)<sup>36</sup> as being most likely to contract cholera. Furthermore, this “risk-group” of potentially infected individuals is constructed as a threat to uninfected individuals through the possibility that they “could contaminate food they're preparing”.<sup>37</sup> The pinpointing of groups using open-air water sources suggests a suspicion of their hygiene, which is highlighted by the injunction that “*these people* must wash their hands”<sup>38</sup>.

These two factors – importation of cholera from outside East London, and the at-risk status of groups using unpurified water – locate the article's conception of threat in a very particular space: “black”, “sick” communities living and working in close proximity to the communities they threaten, which are by implication “well”, “white” communities. In this way, the *Daily Dispatch* locates threats to the safety of its readership as close-by rather than distant. Local communities, rather than the distant and amorphous Transvaal, are the real threat to the “wellness” of “white” East Londoners in this article. While this threat is certainly constructed as existing, it is done in a way that is less antagonistic to the “threatening” party: the close inter-relationship between “black”, “sick” and “well”, “white” communities in and around East London is acknowledged. This

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<sup>35</sup> “Cholera: Water Being Checked”.

<sup>36</sup> *Ibid.*

<sup>37</sup> *Ibid.*

<sup>38</sup> *Ibid.*; my italics.

acceptance of inter-relationship comes to characterise the *Daily Dispatch* coverage of the epidemic, and perhaps accounts for that publication's lack of interest in the more distant outbreaks in the epidemic.

The article "Anti-Cholera Measures Underway on Border"<sup>39</sup> begins with an assurance that although no infection was yet present in the Eastern Cape area, it was prepared for: "Although no cases of cholera have been reported in the Ciskei and East London, precautions against the spread of the disease in the areas are being undertaken."<sup>40</sup> This paragraph firmly locates the disease *outside* the area, declaring the Ciskei and East London "well", but also suggesting – through the emphasis on being prepared – that it is under threat from infected regions elsewhere. This effectively places Ciskei and East London in one camp, and infected regions in another. That is, Ciskei is not constructed as "foreign" to East London:

One cannot...just urbanise health [said Dr Charles Bikitsha, Ciskei Director of Health Services]. If I do not look after my neighbour and he gets into problems, he may spread some of his health problems to me and my family.<sup>41</sup>

This statement explicitly points out that the threat of cholera can be neutralised by exercising "good neighbourliness" in the form of some kind of control, or co-operation, over the health of other regions in order to prevent health problems from spreading. If, as Bikitsha says, health is "just urbanised", it is implied that non-urban regions go without healthcare and come to pose a threat to other regions. Given that the article consists mainly of quotes with the Health Director of a "black" state who is presented in a positive light as pro-active and well-informed, it may be assumed that only "sick communities are presented as threatening "well" communities. "Black" is not implied to be threatening "white"; indeed, the article makes a particular point that "the spread of disease had nothing to do with colour",<sup>42</sup> a conscious refutation of the subconscious link between "sickness" and "blackness".

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<sup>39</sup> "Anti-Cholera Measures Underway on Border."

<sup>40</sup> *Ibid.*

<sup>41</sup> *Ibid.*

<sup>42</sup> *Ibid.*

The *Daily Dispatch* was sold in Ciskei, Transkei and the Eastern Cape, and despite problematic relationships with the “homeland” governments, was nevertheless concerned with conditions in those regions. Its approach to covering the cholera epidemic was less concerned with what was going on in distant areas than with what could be done in the Transkei, Ciskei and East London area to prevent outbreaks there. This explains the attention paid to Charles Bikitsha and Ciskei’s anti-cholera precautions. Evidently, the *Daily Dispatch* was also working on Bikitsha’s assumption that “looking after my neighbour”<sup>43</sup> prevented problems. This is not to say that the *Dispatch*’s coverage entirely disregarded the idea that the Ciskei and Transkei, as well as “black” communities within the Eastern Cape, presented a threat – the coverage does suggest that some wariness existed. In fact, the *existence* of the coverage, as well as its content, suggests this. Rather, the coverage included in the newspaper tended towards sympathy rather than fear.

Thus far, the coverage in the *Daily Dispatch* focused mainly on the existence of a threat from outside the Transkei, Ciskei and Eastern Cape. Cholera was not explicitly situated in any particular region or type of region – it is only “elsewhere”, although both “Anti-Cholera Measures Underway on Border” and “Cholera: Water Being Checked” suggest that potential problem areas are “rural” communities in close proximity to, in particular, East London. The racial makeup of these communities, strongly implied in the *Eastern Province Herald* through various repeated mentions of “homeland” infections and the specific mention of “white” infections (implying that all other infections were “black”), goes almost unmentioned in *Daily Dispatch* coverage. This is possibly a function of the newspaper’s concern with the local, rather than national, cholera situation, as well as its more liberal stance regarding racial politics.

The movement of cholera into the “homeland” of Transkei, situated between the Eastern Cape and Natal, saw a continued focus on anti-cholera measures from the beginning. The article “Transkei Geared Up to Combat Cholera”, published

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<sup>43</sup> “Anti-Cholera Measures Underway on Border”

on the front page of the 23 January 1982 *Daily Dispatch*,<sup>44</sup> outlines anti-cholera measures implemented in Transkei. The article mentions that “travellers through the Transkei [would] be given [anti-cholera] instructions at the country's borders”.<sup>45</sup> Later in the article, the region's Director of Medical Services is quoted as being concerned mainly with the “spread of disease by travellers”. The context of both these references to “travellers” suggests that they are not residents of Transkei, but rather immigrants into the region from infected areas.<sup>46</sup>

The first cholera-related death in Transkei was reported in “Bid to Check Cholera Spread”, published as the main headline on the front page of the 30 January 1982 *Daily Dispatch*.<sup>47</sup> Like previous articles, this one deals with anti-cholera measures but extends its scope to include Ciskei and the Eastern Cape's measures in addition to those of Transkei. The article is careful to make it clear that the deceased individual contracted cholera in Natal, not Transkei, and that plans are in place to “halt” the spread of the disease. In this respect, early coverage of the Transkei epidemic in the *Daily Dispatch* is similar to that in the *Eastern Province Herald* in that it situated the threat outside the Transkei.

From February 1982 onward, the *Daily Dispatch* began to map cholera carefully in space and time, giving precise locations of infections. On 17 February 1982, “Seven Cholera Cases Proved” locates the disease in the “Port St Johns area” and the “Ngqeleni area”: both rather imprecise, but the most particular situating of the disease in *Daily Dispatch* coverage that far.<sup>48</sup> The source of infection is once again stated to be Natal, and some of the reported cases are described as “not serious”; this mild description was in keeping with the *Daily Dispatch*'s image of Transkei as a neighbour rather than an enemy. Furthermore, this may

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<sup>44</sup> “Transkei Geared Up.”

<sup>45</sup> “Transkei Geared Up”.

<sup>46</sup> It is also likely that, as this was occurring at the height of summer, that some of these “travellers” were “white” South Africans holidaying in the region, although the possibility that “whites” might contribute to the spread of cholera is not commented on. It might not be overstating the case to say that although the *Dispatch* had comparatively “good” anti-apartheid politics, it was not necessarily above consigning the blame for cholera's spread entirely to “blacks”.

<sup>47</sup> “Bid to Check Cholera Spread.”

<sup>48</sup> “Seven Cholera Cases Proved.”

be an attempt by the *Daily Dispatch* to reassure its readership that even though the threat was now on their doorstep, it was not serious. Nevertheless, two articles published within a week of “Seven Cholera Cases Proved”, list fatalities at Tekwini, Port St Johns and Canzibi,<sup>49</sup> and new infections at Mqanduli, Flagstaff and Butterworth.<sup>50</sup>

The comparatively gentle cholera-related coverage of the *Daily Dispatch* did not, despite its sympathy, deny that since cholera was present it might spread and therefore presented a problem. This problem, however, was not addressed in terms of neutralising the “black” threat to “white” health, but rather in terms of improving conditions in such a way that the spread would not occur. On 3 March 1982 a *Daily Dispatch* article, entitled “Duncan Village Cholera Threat”, appeared. The article constructs Duncan Village, a peri-urban settlement in East London, as an area extremely vulnerable to cholera, even though cholera had not yet entered the Eastern Cape or Ciskei. The East London Medical Officer of Health is quoted as stating that living conditions in Duncan Village “[are]...extremely undesirable”,<sup>51</sup> but attributes them to overcrowding without in any way blaming this on the residents of Duncan Village. The installation of better water and sanitation infrastructure in the Village is presented as being a move to prevent cholera breaking out *at all*, since cholera in the area would be “extremely difficult to control”, especially since “[although] there is a pure water supply...with slops being thrown into the street [cholera] might find its way into stormwater channels and rivers”. In this way, the *Daily Dispatch* presented anti-cholera measures in Duncan Village as benefiting Duncan Village *as well as* the greater East London area: the sanitation improvements are not solely intended to protect “white” East London. Two subsequent articles on the Duncan Village improvements, “Preventive Measures as Cholera Spreads”<sup>52</sup> and “Anti-Cholera Measures”<sup>53</sup>, continue this theme of improving Duncan Village infrastructure to prevent cholera in the region.

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<sup>49</sup> “Another Transkei Cholera Death”, *Daily Dispatch*, 19 February 1982, pg. 1.

<sup>50</sup> “Third Cholera Death.”

<sup>51</sup> “Duncan Village Cholera Threat.”

<sup>52</sup> “Preventive Measures as Cholera Spreads”, *Daily Dispatch*, 5 March 1982, pg. 7.

<sup>53</sup> “Anti-Cholera Measures”, *Daily Dispatch*, 6 March 1982, pg. 7.

Although the *Daily Dispatch* constructs the improvements to Duncan Village as benefiting the Village itself as well as surrounding East London, it is significant that three separate articles are dedicated to these improvements. As constant attention paid to an issue suggests that it is a cause of concern, it can be assumed that Duncan Village had not been selected at random as a site for improvements – *something* must have made it a candidate for the changes as well as for inclusion in the coverage. It is most likely that the area’s “densely-populated shanty area”<sup>54</sup> had already been a cause of concern for the area’s health authorities, as the link between overcrowding, informal housing, and water-borne diseases was well-known.<sup>55</sup> The continued focus on the area suggests that the *Dispatch*, although more sympathetic towards communities affected by cholera, was not immune to assumptions surrounding “sickness” and “blackness”.

The final large-scale coverage of the cholera epidemic in the *Daily Dispatch* appeared in two articles, published in December 1982 and April 1983. “53 Cholera Cases in Transkei”, published 29 December 1982 on the front page of the *Daily Dispatch*, once again enumerates the location of new cholera infections in Libode, Mqanduli and Lusikisiki, although the article states that most of the infected people had in fact contracted the disease in Natal.<sup>56</sup> This article forms part of the post-March 1982 coverage, which replaces the image of the Transkei as a “well” region with the more threatening image of being “sick” and “black”. As it was published at the height of the summer holiday season, and concerned an area that was a popular holiday destination, it can be assumed that it being published at all meant that there was still widespread concern about the possibility of its infection spreading to the Eastern Cape. Ironically, its most likely importers would have been “white”, “well” holidaymakers returning home to East London.

The *Daily Dispatch* coverage of the 1980-1983 epidemic ends in mid-1983, at a point distant from the relatively laconic, local-emphasis articles that

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<sup>54</sup> “Anti-Cholera Measures.”

<sup>55</sup> This has been explained more fully in an earlier chapter.

<sup>56</sup> “53 Cholera Cases in Transkei.”

characterised its 1980 and 1981 coverage. Entitled, “Unite to Survive”, the editorial opinion piece appeared in the 11 April 1983 edition of the *Daily Dispatch*. This piece is not concerned with locating cholera's origin in any particular region. Instead, it is most concerned with the dangers posed by “rural” areas to “urban” areas, and as it names these “rural” areas specifically as being located in Transkei, Ciskei and KwaZulu (all “homelands”), it may be assumed that the real threat the article is concerned with that of “black”, “rural” areas to “white”, “urban” areas. This is in fact baldly stated:

Advancing relentlessly with hunger, thirst and famine are deadly diseases.

Nor are the town and the cities in any better position to withstand the threat, despite all their sophisticated means. People and animals are already fleeing the country to seek shelter and sustenance in urban areas. Soon there could be new problems of overcrowding and a serious deterioration in urban standards could follow..<sup>57</sup>

Here, rural areas are effectively – and prematurely – blamed for the collapse of urban infrastructure and the importation of sickness. Although cholera is not the central point, it is unlikely that this image of the “rural”, “black” threat to “urban”, “well” areas could have arisen in such a developed form without the foregoing anti-“black”, anti-“sick” and anti-“rural” sentiments expressed after the infection of the Transkei.

By late 1982, *Daily Dispatch* coverage of the cholera epidemic had moved from being concerned with local precautions (rather than distant outbreaks), to mapping a local outbreak, to once again concentrating on local precautions. Throughout the period, outbreaks in Natal, KwaZulu, KaNgwane and the Transvaal received only passing mention. Only once Transkei became infected did the newspaper begin to carefully keep track of the disease, as only then was it believed that it might spread into the Eastern Cape. Proximity and racial makeup, rather than racial makeup alone, made up the threat as constructed in *Daily Dispatch* coverage. Initially, infected areas were believed to be threatening because of the possibility that they might export their infection; uninfected areas were not considered threats, as is evidenced by the “ally” status of pre-February

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<sup>57</sup> “Unite to Survive!”, *Daily Dispatch*, 11 April 1983, pg. 12

1982 Transkei.

The vast majority of cholera-related articles carried by the *Daily Dispatch* and the *Eastern Province Herald* in the period 1980-1983 did not in any way challenge the “white”-dominated<sup>58</sup> South African government’s assertion that cholera was introduced into South Africa from a neighbouring country. Nor did the coverage challenge the Department of Health’s accompanying assertion that cholera was spread by and among “black”<sup>59</sup> communities. That is, the Health Department constructed the disease as something alien to “white” South Africa, disallowing the possibility that its systematic denial of infrastructure and health facilities to “black” communities was in fact more likely to be a catalyst for a severe cholera epidemic than any innate properties the “white” hegemony ascribed to the “black” population. Throughout the coverage, then, the *Daily Dispatch* and the *Eastern Province Herald* failed to challenge statements released by the South African Department of Health. The coverage carried in these two publications in the period 1980-1983 included Health Department statements without any accompanying independent research or critique. This similarity of opinion was made almost inevitable by both the ingrained racism of “white” South African society represented by the *Daily Dispatch* and *Eastern Province Herald*. Although these publications were nominally anti-apartheid, it is nevertheless likely that there was not a wide gulf between the South African government’s conception of the epidemic and that of the newspapers.

The net result of this was a remarkably un-argumentative period of coverage. Department of Health spokespeople and press releases noted the extent and locations to which the epidemic had spread, as well as noting who was thought to be responsible for that spread. At the same time, it monopolized authority over containing and treating the epidemic. The combination of this monopoly and the muzzled press climate of the time, as well as, to a lesser degree, the racism ingrained in South African society (particularly with regard to sickness), led to cholera being constructed as the fault and affliction of the country’s “black” communities, rather than the result of apartheid-era maladministration.

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<sup>58</sup> See the Introduction of this thesis for an extended definition of this term.

<sup>59</sup> As above.

Cholera resulted from the lack of healthcare provision for “black” communities under apartheid, particularly the lack of infrastructure, disorganisation and absence of basic treatment facilities. Coverage of the 1980-1983 epidemic, however, made no mention of the culpability of apartheid in the appearance and spread of cholera in South Africa. Instead, it concentrated on toeing the government line, partly out of fear, partly out of necessity and partly because the newspapers were in agreement with the government’s interpretation of the epidemic. The coverage located cholera in the “black”, “sick” communities of South Africa, which were constructed as separate from the country’s “white” population.

*Daily Dispatch* and *Eastern Province Herald* coverage of the 2000-2003 cholera epidemic did not resemble that of 1980-1983. These changes were the result of changes in South Africa’s socio-political situation between 1983 and 2000. After 1994, a relatively amicable relationship developed between the press and government; in this relationship, the government, though obviously not welcoming criticism, was at least open to receiving it. At the same time, the change to democratic rule brought with it a new conception of the relationship between the South African government and the citizens of that country: the government, voted into power by the citizens, was now obliged to act in their best interests. The outbreak of cholera in the impoverished eastern half of the Eastern Cape in 2000 – a full presidential term into the democratic era – cast doubt on the extent to which the government could be said to be acting to improve the lives of South African citizens. More specifically, the *Eastern Province Herald* and *Daily Dispatch* paid increasing attention to service delivery failures within the Eastern Cape, with the provincial Health Department’s apparent inability to co-ordinate and implement its healthcare services attracting a good percentage of the coverage. When cholera broke out, the newspapers’ already-existing dissatisfaction with the Eastern Cape Department of Health led to the publication of cholera-related articles that did not share governmental constructions of the epidemic. As a result, the newspaper coverage of the 2000-2003 cholera outbreak, particularly that of the *Daily Dispatch*, presents a view of the epidemic opposing the view put forward by the ECDOH.

### Placing the Blame in the *Eastern Province Herald*, 2000-2003

The first *Eastern Province Herald* article about the probability of an Eastern Cape cholera outbreak appeared in the 1 December 2000 edition. Entitled “Anti-Cholera Alert”,<sup>60</sup> it situated cholera in KwaZulu-Natal, which the article therefore constructed as a threat to the Eastern Cape by outlining the anti-cholera precautions the Eastern Cape was taking to prevent cholera spreading from KwaZulu-Natal.

Several months later an article entitled “E Cape Hospital Has Cholera Patient” reported that an individual infected with cholera had been hospitalised in the Eastern Cape.<sup>61</sup> The Eastern Cape’s as-yet uninfected status was alluded to in the second paragraph, which noted the victim’s origins as “Harding, in southern KwaZulu-Natal”.<sup>62</sup> The lead paragraph stated, however, that the individual was the “first Eastern Cape cholera case.”<sup>63</sup> This ambiguity is interesting; the lead paragraph and headline suggest that cholera had entered the province, but the second paragraph refuted this by identifying the patient as a resident of the infected KwaZulu-Natal. That the Eastern Cape remains uninfected was stressed in the article:

There is no reason to panic. This was a lone carrier and we are satisfied that the disease itself has not yet spread into the Eastern Cape,’ [Goqwana] said. Health authorities have, however, been instructed to step up emergency measures...<sup>64</sup>

The uninfected nature of the Eastern Cape in the face of encroaching infection from KwaZulu Natal was the main preoccupation of early *Eastern Province Herald* coverage of the 2000-2003 outbreak. Between the advent of the threat from KwaZulu-Natal in late 2000 to the infection of the Eastern Cape in May 2001, KwaZulu-Natal was constructed as the locale where all Eastern Cape

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<sup>60</sup> “Anti-Cholera Alert.”

<sup>61</sup> “E Cape Hospital Has Cholera Patient.”

<sup>62</sup> *Ibid.*

<sup>63</sup> *Ibid.*

<sup>64</sup> *Ibid.*

cholera victims became infected. For all that, the region was not categorised in any particular ways – it was merely “not the Eastern Cape”. That is, KwaZulu-Natal was not considered to be infected because it is inherently “black”, “sick” or “underdeveloped”. Indeed, these artificial states are not present in the early coverage at all.

This changed with the advent of cholera in the Eastern Cape in May 2001. In an article entitled “Cholera Strikes in Eastern Cape”, published in the 1 May 2001 *Eastern Province Herald*, the Eastern Cape residents that were infected are located very firmly in “the Mampisi area, and shacks around Bizana”.<sup>65</sup> These locales, particularly the “shacks around Bizana”,<sup>66</sup> were constructed as “underdeveloped” in the article. This image of the infected area was reinforced by a quote from a hospital superintendent included later in the article, who noted that “the areas had a lack of toilets and that people drank from unprotected boreholes”.<sup>67</sup> This indicates a lack of infrastructure in the region, a very definite argument in favour of its classification as “underdeveloped”. That cholera should have broken out among residents of this area leads to a linkage of “underdeveloped” to “sick”.

The “sickness” of “underdeveloped” areas was stressed in “Cholera Named as Killer in Remote Area”, published in the 22 January 2002 *Eastern Province Herald*. The area in which cholera had arisen was described as “the remote Qingqolo village near Mqanduli”.<sup>68</sup> This description constructed the region as extremely underdeveloped. As well as being “remote”, it is also only “near” Mqanduli – that is, not likely to be “developed” in the least. In this way, “underdeveloped” was linked to “sick”. This linkage was strengthened by the description of potentially infected people in the region as “villagers”, who “have received treatment from medical practitioners in Mqanduli”,<sup>69</sup> suggesting that Qingqolo had no medical practitioners of its own. This, to many of the *Eastern*

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<sup>65</sup> “Cholera Strikes in Eastern Cape.”

<sup>66</sup> *Ibid.*

<sup>67</sup> *Ibid.*

<sup>68</sup> “Cholera Named as Killer in Remote Area”, *Eastern Province Herald*, 22 January 2002, pg.

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<sup>69</sup> “Cholera Named as Killer.”

*Province Herald's* readers, would have signified a serious lack of health infrastructure in Qingqolo, which in addition to the lack of sanitation already established by the existence of cholera in the region added up to a comprehensive image of the area being “underdeveloped” and “sick”.

On 31 January 2002, an article titled “Poor Infrastructure Making Cholera Worse, Says Minister” appeared on the third page of the *Eastern Province Herald*. The article explicitly linked the lack of infrastructure in “underdeveloped” areas to the spread of cholera:

Shocking roads and a lack of electricity were exacerbating the cholera outbreak in Mqanduli, Health Minister Dr Manto Tshabalala-Msimang discovered during a visit there yesterday.<sup>70</sup>

Once again the article presented the cholera outbreak as contained, or rather, in no danger of spreading to a larger area. It was described as being “in Mqanduli”, located with precision and specificity. No mention was made of the possibility that Mqanduli threatened any neighbouring areas. The article did, however, make it clear that this cholera outbreak was the Eastern Cape’s “baby”: “The Eastern Cape health department would lead the campaign against cholera...while the national department would offer some ‘technical support’.”<sup>71</sup> Clearly, there was little fear that cholera in the Mqanduli area would present a threat to the Eastern Cape as a whole, and there was certainly no concern about the possibility of a national outbreak is evident anywhere in the coverage up to that point.

This continued to be the case in *Eastern Province Herald* coverage as the epidemic in the Eastern Cape progressed into its third year. The lack of concern about a nationwide outbreak led to a decrease in the amount of space the *Eastern Province Herald* dedicated to citing the disease in particular areas. Consequently, there was no construction of certain areas as threats and others as threatened in the coverage. However, the spread of the disease *within* already-infected areas was carefully followed.

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<sup>70</sup> Mkokeli, “Poor Infrastructure.”

<sup>71</sup> *Ibid.*

An article entitled “New Cholera Outbreak in Transkei Claims Seven Lives”, published in the 6 January 2003 *Eastern Province Herald*,<sup>72</sup> located the disease firmly within the ORT District Municipality. The article mapped the spread of the disease *within* that region quite specifically:

...the affected areas...include Baziya and Buhlungwana village, both near [Qumbu], Gxulu village in Libode and Mampube village in Port St Johns.

...The first case was recorded at Ngcongane village near Umtata on December 23 [2002] when a group returned from a traditional feast in port St Johns...Investigations showed that water in the Ndwalane River in Port St Johns was carrying the bacteria that causes the disease.<sup>73</sup>

The article therefore sites cholera firmly within the ORT District Municipality, and also gives a potted history of the outbreak’s spread by suggesting the probable source of the infection (the Ndwalane River, in Port St Johns); the location of the first infections (Ngcongane village, near Umtata); and, the route by which infection was carried from Port St Johns to Umtata and thence to the other infected regions.

The 2000-2003 cholera outbreak in the Eastern Cape was not of great concern to the *Eastern Province Herald*, located as it was in the western half of the province; this region was likewise not the *Eastern Province Herald’s* primary focus area. The fairly small scope of the epidemic fell within the province’s eastern regions, traditionally the concern of the *Daily Dispatch*, which indeed produced a great deal more coverage of the outbreak. The coverage that does exist, however, is interesting in that it evidences a new way of constructing the threat.

In the early coverage, the threat is not said to be posed by “sick”, “black” or “underdeveloped” communities, but rather by the large and unanalysed region of KwaZulu-Natal. Once the threat is realised, however – that is, once cholera

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<sup>72</sup> Dyonana, “New Cholera Outbreak”.

<sup>73</sup> *Ibid.*

has moved into the Eastern Cape – there is no further comment on the possibility of its spread, and therefore no concern over who might be threatened by the infection. The link between cholera, “sickness” and “underdevelopment” established in the article “Cholera Named as Killer in Remote Area” pervades the remainder of the coverage. The lack of concern surrounding spread suggests that it was taken for granted in the *Eastern Province Herald* that only “underdeveloped” people would be affected, effectively removing the need to worry about the possibility of spread into a region that considered itself “developed”.

### **Placing Blame in the *Daily Dispatch*, 2000-2003**

The first *Daily Dispatch* article dealing with the 2000-2003 outbreak of cholera in the Eastern Cape appeared in the 21 January 2002 edition. Entitled “10 Killed By Mystery Disease”,<sup>74</sup> it mapped the spread of the disease in the Mqanduli area of the KSD Local Municipality, a subdivision of the OR Tambo District Municipality. The disease was not officially identified as cholera; in fact, a quoted government official stated that the illness was *not* cholera: “The results show...no trace of typhoid bacilli, cholera bacilli, or shigella bacilli.”<sup>75</sup> Later in the article, however, the likelihood that it was cholera was admitted: “...the residents are drinking from stagnant pools, which means that it is most probably cholera.”<sup>76</sup> On this point, the newspaper and government officials are in agreement.

The article located the disease – even before it is suggested to be cholera – in the Eastern Cape, and did not suggest that it was imported from KwaZulu Natal, or that it might spread to the remainder of the Eastern Cape. The various locations at which cholera was found are named as Qingqolo “near [Mqanduli]”, Mqambule and “nearby villages”. The area’s “underdeveloped” nature was constructed by the description of settlements as “villages”;<sup>77</sup> the mention of problematic water-sources later in the article cements this construction.

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<sup>74</sup> Maqhina, “10 Killed By Mystery Disease.”

<sup>75</sup> *Ibid.*

<sup>76</sup> *Ibid.*

<sup>77</sup> *Ibid.*

Throughout the coverage, the *Daily Dispatch* takes care to emphasize the infrastructure-poor nature of the infected communities and contrast this – the actual cause of the cholera outbreak – with the explanations put forward by the government officials quoted in the articles.

In the article “10 Killed by Mystery Disease”, representatives of the two municipalities involved were described as “officials” who found “locals...confused”.<sup>78</sup> It is clear from this that in the newspaper’s estimation, a division existed between the infected “underdeveloped” area and the area from which the “officials” were sent, which might arguably be described as “developed”. Alternatively, it is possible that the division between the two groups as described by the newspapers arose not from physical location (though it is not likely that municipal employees were living in rural villages) but rather from a difference in mindset. That is, it is possible that the “officials” considered themselves, or were considered by the *Daily Dispatch*, to be more “developed” than the “locals”.

The next day, an article entitled “Tests Confirm Cholera Cause of Deaths” appeared on the front page of the *Daily Dispatch*.<sup>79</sup> The article’s lead paragraph situated the infection in “the remote Qingqolo village near Mqanduli”,<sup>80</sup> a description which placed the disease very firmly in an “underdeveloped” context and linking that location to “sickness”. In doing so, it created a nexus between the imagined qualities of “underdeveloped” and “sick”. It is implied there that “underdevelopment” leads to “sickness”, and thus that “developed” areas are “well”.

The article mentioned neither the possibility of cholera spreading out of the Qingqolo area, nor speculated about the route by which cholera entered the region. The coverage constructed “underdeveloped” as very different to “developed”<sup>81</sup> – but rather than constructing this difference as a threat, it

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<sup>78</sup> Maqhina, “10 Killed by Mystery Disease”.

<sup>79</sup> Maqhina, “Tests Confirm Cholera Cause of Deaths.”

<sup>80</sup> *Ibid.*

<sup>81</sup> For extended definitions of these terms, please see the Introduction to this thesis.

constructed it as a difference between two particular “lifestyles” or “mindsets”. If anything, “developed” areas and/or groups were a threat to “underdeveloped” areas and groups because they consistently failed to combat existing problems or forestall potential ones, concentrating instead on protecting their reputations and maintaining positive public images. Cholera as constructed by the *Daily Dispatch* did not threaten “developed” areas with physical infection from “underdeveloped” areas, but rather brought to the fore the differences between the province’s “developed” and “underdeveloped” groups – notably the government and the rural underclass - which highlighted the social and class-based inequalities being left uncorrected by government.

This may account for why cholera continued to be covered and receive prominent placement in the *Daily Dispatch* even after the concern about a large-scale outbreak fell away. This bears a direct relation to the great volume of space the *Daily Dispatch* devoted to the various problems within the ECDOH over the same time period. The continued difficulties that the Department faced in establishing its own credibility and providing accessible health-services was evidence of the same set of conflicts between being “developed” and “underdeveloped”. That is, the ECDOH’s attempts to develop the province’s health services were met with frequent *Daily Dispatch* articles seemingly intended to indicate that the ECDOH was failing in this mandate, and thus leaving the province as “underdeveloped” as it had been before. This suggests that the *Daily Dispatch* placed much of the blame for the cholera epidemic on the “developed” government bodies and representatives who were failing to improve the living conditions of communities for which they were responsible.

The article “Death Lurks in Qingqolo River”, published in the 24 January 2002 *Daily Dispatch*,<sup>82</sup> reverted to a more ‘traditional’ form of covering the epidemic by locating the disease and attempting to account for its presence in the region. First stating that cholera “has now moved into the poverty-stricken Eastern Cape rural areas”, it went on to describe the infected villages as “remote and

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<sup>82</sup> Maqhina, “Death Lurks in Qingqolo River.”

inaccessible”, as well as “unprotected”.<sup>83</sup> This “underdevelopment” was emphasized by the article’s listing of the area’s various infrastructural problems:

The village is reached via two rough tracks down steep hills...Residents must walk several kilometres to catch a taxi, or pay R100 to hire a vehicle.

There’s no electricity, no toilets, no piped water, no cellphone reception and the closest phone is some distance away at the nearest school.<sup>84</sup>

The article furthermore constructed this “underdevelopment” as threatening to the village itself. This was suggested by the description of the infected villages as “unprotected”.<sup>85</sup> Exactly what they were unprotected from is not explicitly stated. However, elsewhere in the article it was noted that “locals [were] learning how to treat the disease and not spread it”.<sup>86</sup> Taken in combination with the infrastructural problems enumerated above, this suggested that what the villages were unprotected from is cholera, presumably because of their lack of clean water, sanitation and health services.

In late January 2002, the epidemic spread from the confines of Qingqolo to Orange Grove, located “just eight kilometres from [Umtata]”.<sup>87</sup> The article, entitled “Cholera Hits Second Village”, appeared in the 31 January 2002 *Daily Dispatch*. Its second paragraph, after locating the newly-infected village as being within walking distance of Umtata, narrowed down the location of the new infection by placing it “en route to Mqanduli...along the Umtata River”.<sup>88</sup> Although relatively close to a “developed” area, Orange Grove was established in the coverage as “underdeveloped” by the mention of its lack of piped water supply: “Some Orange Grove villagers usually fetch ‘chocolate brown’ water from the Umtata River, while others depend on rain...as there is no piped water there.”<sup>89</sup>

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<sup>83</sup> Maqhina, “Death Lurks in Qingqolo River.”

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

<sup>85</sup> *Ibid.*

<sup>86</sup> *Ibid.*

<sup>87</sup> Maqhina, “Cholera Hits Second Village.”

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

<sup>89</sup> *Ibid.*

It was at this point that *Daily Dispatch* coverage of the cholera epidemic returned to a more 'traditional' form. It began once again to be concerned with the possibility of infection spreading from already-infected areas into uninfected areas, and to reassure as yet uninfected areas that there was little danger posed to them by infected areas. It did this without abandoning the theme of earlier articles, which was that the regional authorities were constructing "underdevelopment" among rural communities as a threat to the provincial government's attempts to "develop" the province. The *Daily Dispatch's* construction of the problem, as mentioned above, was the converse of this.

The first article that evidenced this was "Mageda Says Cholera Threat Under Control", published in the 1 February 2002 *Daily Dispatch*. The lead paragraph established the existence of a physical threat: "The outbreak of cholera at Orange Grove near [Umtata] and at Qingqolo near Mqanduli was still manageable, and attempts were being made to prevent it from spreading to other areas."<sup>90</sup> The likelihood that this threat would spread was also stated: "It was expected that the disease would spread to certain areas due to the movement of people, as was the case in KwaZulu-Natal."<sup>91</sup> At the same time, the article includes quotes from Department of Health employees stating that the epidemic in the area was still manageable, and was in fact being managed at that very moment: "attempts were being made to prevent it from spreading to other areas".<sup>92</sup> Although this mention of anti-cholera measures does not cancel out the threat that cholera posed to the region, it does to some degree allay it.

This raises the question of why this issue remained of enough interest to the *Daily Dispatch* to continue reporting on the spread of cholera through the "underdeveloped" areas of the Eastern Cape's eastern half. That government actions and officials are often mentioned in the articles provides a clue to this continued attention.

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<sup>90</sup> "Mageda Says Cholera Threat Under Control", *Daily Dispatch*, 1 February 2002, pg. 3.

<sup>91</sup> *Ibid.*

<sup>92</sup> *Ibid.*

The *Daily Dispatch* was deeply concerned with the successes and failures of the ECDOH throughout the period 2000-2003. Many of the articles dealing with the cholera outbreak detailed the latest government action taken regarding cholera. Therefore, the *Daily Dispatch* may well have been concerned with the threat cholera, as a “rural” disease of “underdeveloped” areas, posed to the credibility of the “development”-oriented government, which already HAD trouble maintaining its equilibrium.

This is evidenced by a pair of articles appearing on 7 February 2002 and 15 February 2002 respectively in the *Daily Dispatch*. The first, “Umtata Sewage Cause of Cholera Says Mamase”,<sup>93</sup> quoted the Acting MEC for Health, Max Mamase, as blaming the cholera outbreak on overflow from the sewerage treatment plant at Umtata. Directly after threat of disease had been situated in badly maintained Umtata infrastructure, the infected areas were specifically identified as “Qinqolo in Mqanduli, and Orange Grove near Umtata, [as well as] Nqanda near Ngeleni”.<sup>94</sup> Infected areas were established as “underdeveloped” in the article by making reference to “historical factors like poor sanitation, lack of water supply and lack of infrastructure” as well as referencing the “inaccessib[ility of] Qingqolo village”.<sup>95</sup> Furthermore, the infected communities were suggested, by quoted government officials, to believe in witchcraft. In commenting on this belief, the National Minister of Minerals and Energy – a representative of the “developed” South African government – stated that:

This is not a disease caused by witches and you must stop going to traditional healers for a cure. This is a bacteria found in water and in order to fight it you have to boil your drinking water before you drink it.

Those traditional healers who say they can cure this and claim that the disease is being caused by witches are lying.<sup>96</sup>

This statement indicates that the speaker, a representative of the South African government, directly links belief in witchcraft to “underdevelopment” and

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<sup>93</sup> Zuzile and Mdolomba, “Umtata Sewage Cause of Cholera Says Mamase.”

<sup>94</sup> *Ibid.*

<sup>95</sup> *Ibid.*

<sup>96</sup> *Ibid.*

“sickness”, by accusing the traditional healers of lying and consequently promoting the spread of cholera. The juxtaposition of the article’s original image of infrastructure-poor infected communities and the government’s quoted suggestion that traditional healing was aiding the spread of the disease suggests a distinct disjuncture between the newspaper’s views on the causes of the epidemic and those of the government.

Published as a reply to “Umtata Sewage Cause of Cholera Says Mamase”, “Cholera Comment Criticised” appeared on the second page of the 15 February 2002 *Daily Dispatch*.<sup>97</sup> In the article, the mayor of the KSD Local Municipality refuted Mamase’s claim that sewerage in the Umtata River had caused cholera downstream: “None of the people who died of the illness later diagnosed as cholera drank water from the Umtata River.”<sup>98</sup> He also suggested that Mamase’s statement was “calculated to incite people against the KSD municipality”.<sup>99</sup> Publishing this evidence of internal disagreements leading to service delivery problems within the provincial government suggests that the *Daily Dispatch* was certainly not siding with them, but rather with the communities adversely affected by the infighting.

Evidence that “underdevelopment” was said by the *Daily Dispatch* to present a massive threat to the government’s attempts to “develop” the province is provided by the article “Report Highlights Cholera Risk Profile”, which appeared in the 30 January 2003 *Daily Dispatch*.<sup>100</sup> The article identified cholera risk factors as “lack of sanitation, lack of a potable water supply, *lack of personal hygiene, and funeral gatherings*.”<sup>101</sup> A subsequent article, “Sanitation, culture impacting on fight against cholera”, published on page five of the 7 February 2003 *Daily Dispatch*,<sup>102</sup> contains explicit evidence of the government’s

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<sup>97</sup> “Cholera Comment Criticised.”

<sup>98</sup> *Ibid.*

<sup>99</sup> *Ibid.* The King Sabata Dalindyebo Local Municipality was dominated by the United Democratic Movement, but fell within the ANC-dominated OR Tambo District Municipality. In January 2002, a cholera task-team set up within the OR Tambo District Municipality had omitted to invite delegates from the KSD Local Municipality. (“Cholera Committee Set Up”).

<sup>100</sup> Mphumzi Zuzile, “Report Highlights Cholera Risk Profile”, *Daily Dispatch*, 30 January 2003, pg. 2

<sup>101</sup> “Risk Profile”; my italics.

<sup>102</sup> Madoda Dyonana, “Sanitation, Culture Impacting on Fight Against Cholera”, *Daily Dispatch*,

construction of the epidemic as the result of the “underdeveloped” nature of rural communities. Bevan Goqwana, the Eastern Cape Health MEC, is quoted as saying:

I wish to appeal to our people to understand that witchcraft doesn't cause the disease and I urge everyone to seek professional medical attention whenever feeling sick.<sup>103</sup>

Once again, the newspaper suggests that the government authorities were linking “underdevelopment” to “sickness” by suggesting that seeking treatment from traditional healers – anathema to the “developed” government – was contributing to the spread of cholera in “underdeveloped” communities. A later article “Still More Cases of Cholera as Government Tries to Curb Disease”<sup>104</sup>, makes this link even clearer by extensively quoting a government spokesperson who noted that a health-and-hygiene promotion team was “[evaluating] the attitude and practices of the community on health and hygiene”.<sup>105</sup> That these attitudes are believed to need evaluating suggests that they were considered to be a problem by the “developed” officials that dispatched the team.

*Daily Dispatch* cholera-related coverage between 2000 and 2003 struck a careful balance between the “official” government version of the epidemic – that it resulted from historical disadvantages in the Eastern Cape and was spread due to problematic behaviour among “underdeveloped” groups – and their own - which was that government inaction and the gap between the government and the citizenry were the main driving forces behind the epidemic's spread.

Between the end of the cholera outbreak of 1980-1983 and the beginning of the severe Eastern Cape outbreak of 2000-2003, South Africa underwent a profound change. The race-based socio-political oppression and deprivation of the apartheid era was discarded. The democratic system which replaced it in 1994 was built around ideas of universal equality and an egalitarian distribution

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7 February 2003, pg. 5

<sup>103</sup> *Ibid.*

<sup>104</sup> Kumbaca, “Still More Cases of Cholera.”

<sup>105</sup> *Ibid.*

of resources. These changes released the National Party government's hold over the English-language South African press, and created a press climate much more welcoming to government-related debate and contestation than that of the preceding 50-odd years.

Despite the apparently open forum in which the post-apartheid press operated, tension arose between the newly-elected ANC-led government and the South African print media, largely because of the “watchdog” role the press assumed early on in the democratic era. The new democratic government experienced a myriad of problems as it attempted to implement transformation in government departments while simultaneously delivering services to the country's vast number of previously disadvantaged communities. While these wide-reaching changes were taking place, lack of skills and widespread corruption among government employees hampered the quality and speed of service delivery. Given that the press had cast itself as “defender of the public interest”,<sup>106</sup> it concentrated on reporting around issues of corruption and poor-governance, and tended to highlight government failures rather than successes.<sup>107</sup> This caused tension to arise between the new government and the print media.

The Eastern Cape's two major daily newspapers, the *Daily Dispatch* and the *Eastern Province Herald*, both English-language, devoted extensive space to covering these failures, particularly those of ECDOH. Unsurprisingly this led to a strained relationship between the Eastern Cape English-language press and the ECDOH. The *Eastern Province Herald's* coverage during the period 2000-2003 was not quite as extensive as that carried by the *Daily Dispatch*. Although the articles in both newspapers contain a fairly straightforward thread of information on the spread and extent of the epidemic, they make use of a wide variety of sources, not all of which are medical professionals or even Department of Health employees. This inclusion of non-medical sources and sources outside both the healthcare authorities and the government meant that the newspapers were not reliant on the Health Department for information. The coverage,

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<sup>106</sup> Discussed in Chapter 4.

<sup>107</sup> It should also be remembered that “negativity” is one of the cardinal news values!

therefore, does not “toe the line” in the same way that the 1980-1983 coverage did, but rather is much more independent.

This independence extended to the point where the government ceased to be only a source of information and itself became a subject of scrutiny in the coverage. In the 2000-2003 coverage, cholera-related articles are spaces in which the Health Department is as much the point of the article as is cholera. This is symptomatic of the much more permissive media society, the “watchdog” role of the media and also of increasing public impatience with government ‘s failure to deliver.

The reaction of the Eastern Cape media to groups and areas infected by cholera underwent profound changes between 1980 and 2003. In the 1980s, cholera-infected groups were viewed as threats to the “white” population, and the appearance of cholera among “black” communities was depicted as a result of their inherent predisposition to sickness. Reactions to cholera were therefore focused on placing the blame on the victim rather than examining the root causes of the epidemic. In the 2000s, however, the government was blamed for the outbreak of cholera, which was depicted as a result of poor service delivery and lack of infrastructure development rather than of any inchoate deficiencies on the part of infected groups.

## CONCLUSION

It is impossible to understand the significance of cholera within, and to, South Africa without an understanding of its spread and extent during the two major epidemics of the late 20<sup>th</sup> century. Cholera broke out in isolated areas but spread easily and quickly to affect wider regions. Beginning in the far northeast of South Africa in the early 1980s, cholera spread to the eastern and southeastern regions of the country, an area including all of the so-called “homelands” as well as three major “white” provinces (Transvaal, Natal and the Eastern Cape). By the early 2000s, although the disease no longer infected large tracts of South Africa, its re-appearance in the Eastern Cape indicated that the conditions originally conducive to its spread had not been adequately dealt with in the two decades separating the outbreaks.

The explanation for cholera’s appearance and tenacity in South Africa is simple. Even in two vastly different socio-political contexts, separated by 20 years and massive political changes, the underlying causes remain the same. Lack of infrastructure and adequate healthcare, the result of government neglect, left South African communities vulnerable to cholera outbreaks. This vulnerability was not explained so much as *explained away*, first by long-standing stereotypes around race and illness embedded in South African society, and then by more recent but equally tenuous nexuses between “underdevelopment” and illness. The net result of this denial was a death toll in the thousands and unquantifiable human misery.

Cholera in South Africa first broke out in a country under a brutal totalitarian regime that preached racial difference, brooked no disagreement and consigned millions of people to appalling living conditions that rendered them vulnerable to poverty-related diseases. The fall of this regime and the subsequent adoption of democracy was expected to improve these living conditions and in doing so reduce the prevalence of poverty-related diseases. These improvements did not come quickly enough, or at all, and 10 years into

the new democratic period, cholera once again broke out, affecting the same regions and the same people that it had during the apartheid era. Until the “underdevelopment” fostered by apartheid and left uncorrected by the democratic regime, is reversed, cholera will continue to threaten South Africa’s health.

Charles E. Rosenberg, in his analysis of cholera in the 19<sup>th</sup> century,<sup>1</sup> notes that epidemics were once assumed by commentators to be “alien visitations”<sup>2</sup> to the societies they affected, rather than the effects of the societal inequalities of those societies. That is, cholera was assumed to have arisen almost spontaneously, the result of innate failings on the part of those communities and groups affected by it. Although Rosenberg’s work focuses on moral judgements made against cholera sufferers in North American and European epidemics, the same holds true of explanations given for the infection of “blacks” during the South African epidemic. In the case of local epidemics, however, such “blame the victim” racist explanations were so ingrained in “white” South African mindsets that they appeared unchallenged in the newspaper coverage of the 1980-1983 epidemic. The press’s capacity to inform and educate is dependent on the political climate in which it operates.

The 1980-1983 epidemic occurred in the midst of apartheid’s most repressive era, making the publication of anti-governmental opinions in English newspapers difficult if not impossible. At the same time, it is likely that the staff and readers of the *Daily Dispatch* and *Eastern Province Herald* shared many of the same opinions and preconceptions held by the Department of Health sources from which the newspapers received information.

The *Eastern Province Herald* and the *Daily Dispatch* thus reported on the 1980-1983 cholera epidemic without mentioning the government’s role in creating that epidemic. The result of this muteness was a body of coverage that presented only the official version of the cholera epidemic, including no alternative opinions or criticism of the government. This form of cholera-related coverage

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<sup>1</sup> Rosenberg, “Cholera in Nineteenth-Century Europe”, pg. 111.

<sup>2</sup> *Ibid.* pg. 111

reflected the larger relationship between the press and the government: one in which the government's authority was generally accepted, leaving neither room nor indeed much willingness to introduce news coverage critical of governmental actions. The South African Department of Health was treated as the chief authority on the epidemic and constructed as the most qualified to explain and combat it. The epidemic was constructed as a problem resulting from the appalling conditions created by "black" communities, who thus threaten "white" communities. The "sick", not the government that made them "sick", are the problem.

The 2000-2003 epidemic, however, took place in a political climate much more open to criticism, though not so open that the press did not become *personae non grata* with the government following the publication of large numbers of articles critical of the new ANC-led government. The *Eastern Province Herald* and the *Daily Dispatch* were no longer subject to governmental repression, and this freedom of expression is evident in the highly critical attitudes towards the government, particularly the ECDOH, apparent in cholera-related coverage. At the same time, the racially discriminatory explanations the newspapers reproduced so effortlessly during the apartheid era were now socially, culturally and politically anathema. The post-1994 Eastern Cape English press did not automatically assume the Health Department's authority in representing the cholera epidemic. Instead, they took in a wide variety of sources within and outside the government, in fact going some way to eroding the credibility of the Department and the government it represented. As a result, the coverage situated the blame for cholera with the government and its sluggish implementation of service delivery, rather than with the "sick". The victims of cholera, rather than being held responsible for their own predicament, were instead portrayed as having been betrayed by a government which was both divorced from the reality of the province's health situation and actively engaged in maintaining a false image of the Eastern Cape as a healthy and well-developed province.<sup>3</sup>

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<sup>3</sup> For an extended discussion of this point, please see Chapters 2, 3, 4, and 6.

Between 1980 and 2003, cholera struck South Africa two major blows. In each case, the human cost was vast, and the same sector of society paid it each time. In 1980-1983, the appalling racism that allowed this to happen was left unchallenged even by the Eastern Cape English-language press, which was supposed to be opposed to apartheid. The reverse occurred in 2000-2003, with every government move being examined and critiqued by the free press, which did not see itself as obliged to curry favour or avoid giving offense. This fearlessness is encouraging: it may be that in subsequent cholera epidemics, press – and public – pressure may result in the implementation of adequate and widespread anti-cholera measures.

## Appendix A: GENERAL MAPS



Figure 9: Map of South African Provinces before 1994.<sup>1</sup>

<sup>1</sup> Taken from <http://www.geographicsguide.com/pictures/maps/provinces-1994.jpg>, accessed 1 September 2009.

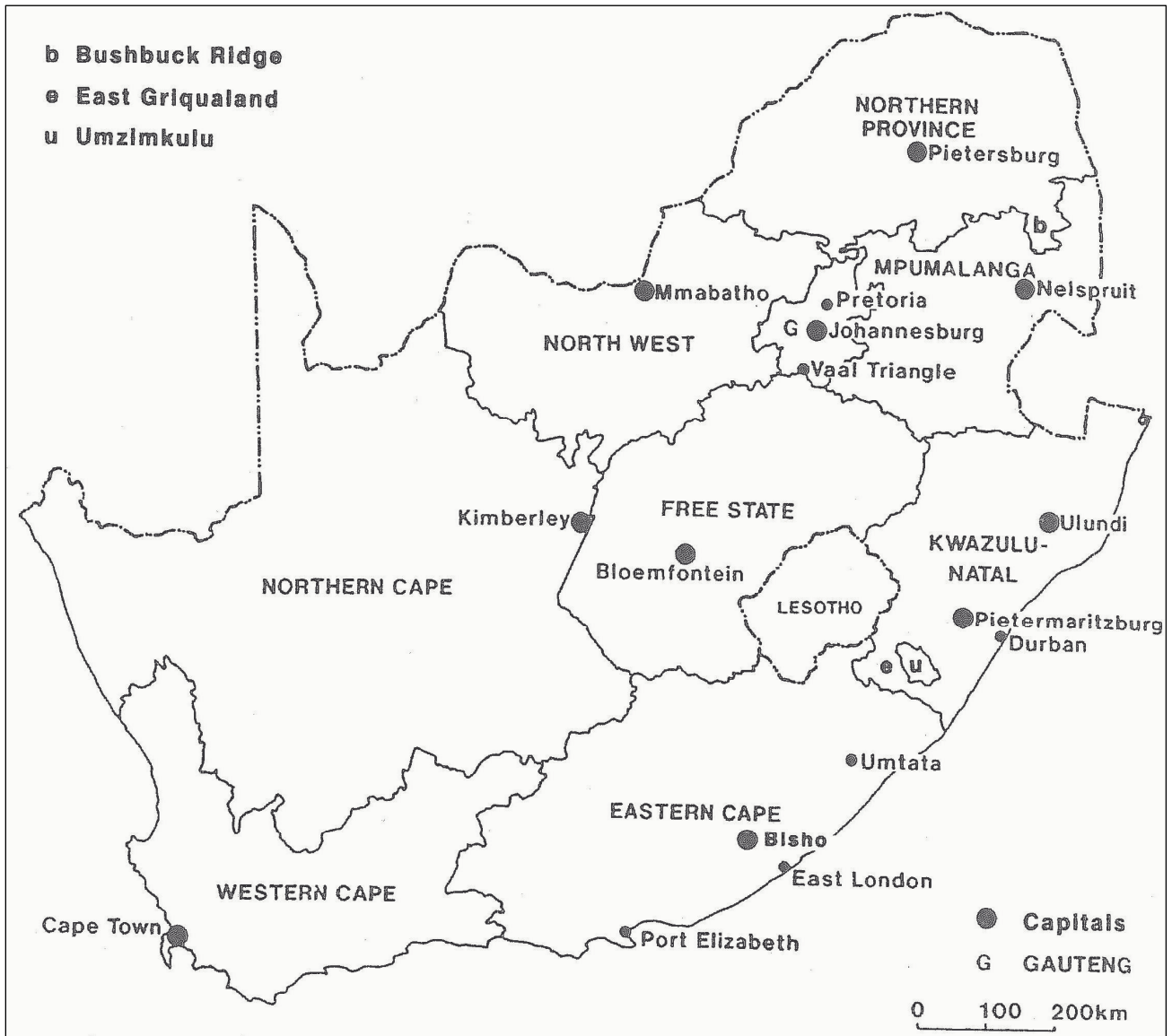


Figure 10: Map of South African Provinces after 1994.<sup>2</sup> taken from

<sup>2</sup> A.J. Christopher, *The Atlas of Changing South Africa* (London, 2001), pg. 200

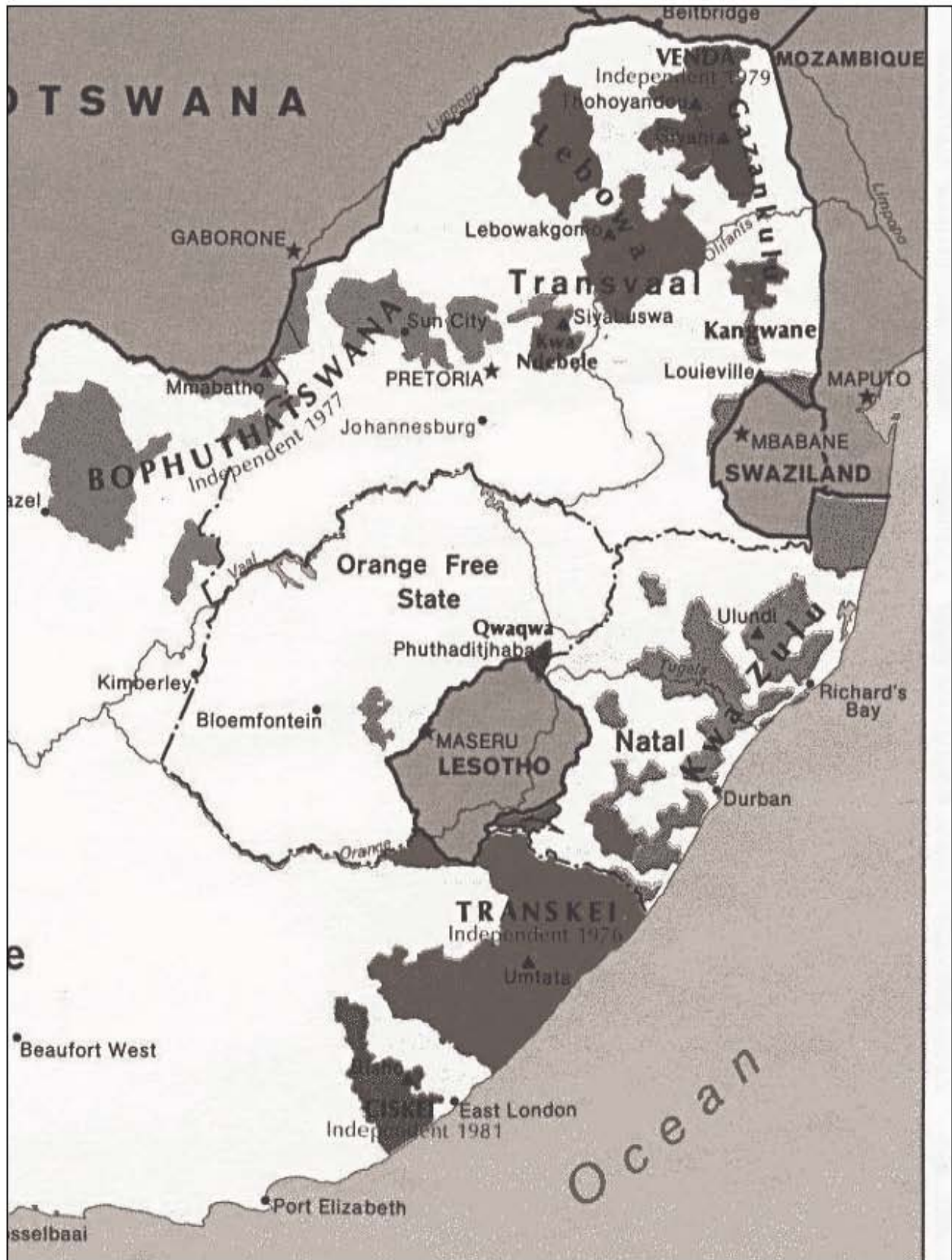
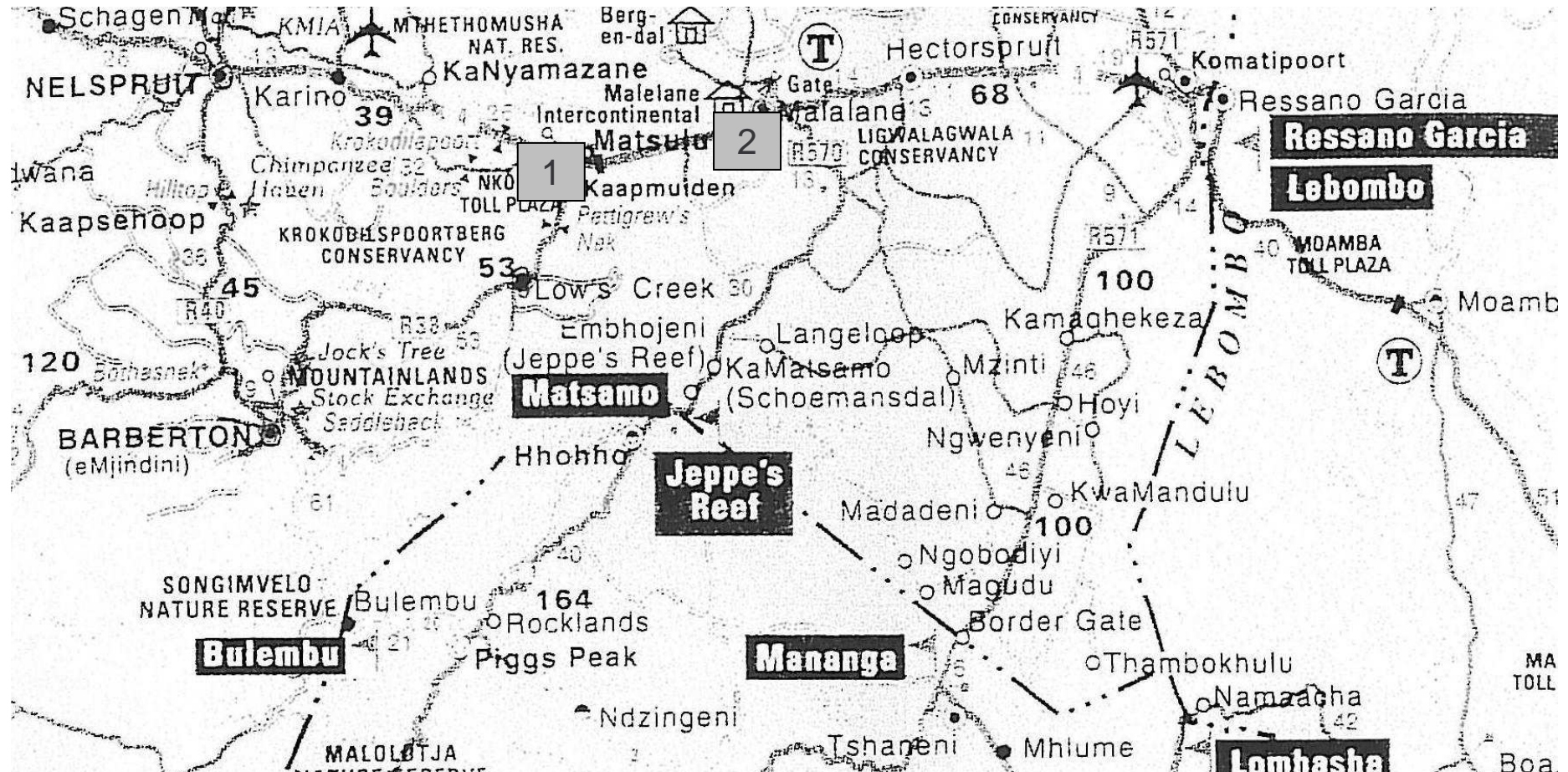


Figure 11: South African Homelands.<sup>3</sup>

<sup>3</sup> [http://www.africancrisis.org/images/Apartheid\\_South\\_Africa\\_Map\\_of\\_Black\\_Homelands.jpg](http://www.africancrisis.org/images/Apartheid_South_Africa_Map_of_Black_Homelands.jpg), accessed 2 September 2009. Note that all "homelands" were situated in the eastern half of the country.

**Appendix B: MAPS OF CHOLERA-INFECTED AREAS, 1980-83 AND 2000-03**

Please note, all maps in this Appendix are taken from Automobile Association of South Africa, 2009 *Automobile Association Road Atlas of South Africa* (Johannesburg, 2009)



Map 1: KaNgwane and Eastern Transvaal, c. 1980-83







Map 4: north-eastern Transkei, c. 1980-83



Map 5: Eastern Cape/KwaZulu-Natal border area 2000-2003



## Appendix C: NEWS VALUES

Table 3: *Daily Dispatch* News Values, 1980-1983

| ARTICLE TITLE                          | DATE         | NEGATIV   | RECEN     | RELEV.    | PROX.     |
|--|--------------|-----------|-----------|-----------|-----------|
| Cholera: Water Being Checked           | 20/11/80     |           |           | X         | X         |
| Cholera Case in Bophuthatswana         | 25/11/80     | X         | X         | X         |           |
| Bid to Check Cholera Spread            | 30/01/82     |           |           | X         | X         |
| Seven Cholera Cases Proved             | 17/02/82     | X         | X         |           | X         |
| Another Transkei Cholera Death         | 19/02/82     | X         | X         |           | X         |
| Third Cholera Death                    | 23/02/82     | X         | X         |           | X         |
| Duncan Village Cholera Threat          | 03/03/82     | X         |           |           | X         |
| Cholera: Penalty of White Neglect      | 03/03/82     |           |           | X         | X         |
| Cholera Expected in EL                 | 03/03/82     | X         | X         |           | X         |
| 53 Confirmed Transkei Cases            | 04/03/82     | X         | X         | X         | X         |
| Border, East Cape Geared for Cholera   | 04/03/82     | X         | X         | X         |           |
| Border Ready to Fight Cholera          | 04/03/82     |           |           | X         | X         |
| Preventive Measures as Cholera Spreads | 05/03/82     | X         | X         |           | X         |
| Anti-Cholera Measures                  | 06/03/82     |           |           | X         | X         |
| Cholera: Borehole Advice to Farmers    | 09/03/82     |           |           | X         |           |
| EL Sewage: Weekly Test for Cholera     | 11/03/82     |           |           | X         | X         |
| Cholera: Wages of Poverty...           | 06/04/82     |           | X         | X         |           |
| Health System Facing Breakdown         | 20/11/82     |           |           | X         |           |
| Cholera Warning for E Cape             | 30/11/82     | X         | X         |           | X         |
| 53 Cholera Cases in Transkei           | 29/12/82     |           |           | X         | X         |
|  | <b>TOTAL</b> | <b>10</b> | <b>10</b> | <b>13</b> | <b>15</b> |

Table 4: *Eastern Province Herald News Values, 1980-1983*

| ARTICLE TITLE                                     | DATE         | NEGATIV   | RECEN     | RELEV.    | PROX      |
|---|--------------|-----------|-----------|-----------|-----------|
| Doctor Warns of Cholera Risk                      | 11/01/71     | X         | X         | X         |           |
| Cholera Claims Four, 31 Others in Hospital        | 11/01/80     | X         | X         |           | X         |
| New Cases of Cholera Reported                     | 13/10/80     | X         | X         | X         | X         |
| Cholera Has Not Reached 'Crisis Stage'            | 03/11/80     |           |           | X         | X         |
| Death Lurks in the Fields                         | 07/11/80     |           | X         |           |           |
| Cholera Outbreak: Nine Now Isolated               | 17/11/80     | X         | X         | X         |           |
| 14 Whites Display Cholera Symptoms                | 20/11/80     | X         | X         | X         |           |
| 47 More Cases of Cholera in Tvl                   | 28/11/80     | X         | X         |           |           |
| Cholera Cases Rise to 125 in SA                   | 09/01/81     | X         | X         | X         |           |
| 15 New Cases                                      | 01/12/81     | X         | X         | X         |           |
| More Cholera                                      | 15/12/81     | X         | X         | X         |           |
| Cholera Deaths                                    | 17/02/81     | X         | X         |           |           |
| Cholera Germs in Jo'Burg Sewers                   | 02/12/81     | X         | X         | X         | X         |
| Stanger Gastric Infection ...                     | 07/12/81     | X         | X         | X         |           |
| Cholera at Epidemic Stage in KwaZulu              | 24/12/81     | X         | X         |           |           |
| Shanty-Town Cholera May Hit Durban                | 28/12/81     | X         |           | X         | X         |
| Killer Epidemic Spreads in Natal                  | 29/12/81     | X         | X         |           | X         |
| Further 275 Cholera Cases                         | 30/12/81     | X         | X         |           | X         |
| Killer Disease Sweeps Across Natal                | 04/01/82     | X         |           | X         | X         |
| E Cape Check for Cholera                          | 05/01/82     | X         |           |           | X         |
| Natal Cholera Still Not Contained                 | 08/01/82     | X         |           | X         | X         |
| First Tests on PE Man Point to Cholera            | 16/01/82     | X         |           | X         | X         |
| E Cape Geared for Cholera Danger                  | 18/01/82     |           |           | X         | X         |
| T'Kei Hospitals Get Set for Fight Against Cholera | 30/01/82     | X         |           | X         | X         |
| Cholera: Crash Course in PE                       | 10/02/82     |           |           | X         | X         |
| Transkei Cholera 'In Control'                     | 12/01/82     | X         | X         |           | X         |
| Man Dies of Cholera                               | 19/02/82     | X         | X         | X         | X         |
| Oysters, Mussels Cholera Warning                  | 01/03/82     | X         |           | X         | X         |
| PE, EL Shellfish: No Threat of Cholera            | 02/01/82     |           |           | X         | X         |
| Cholera's Toll Now 90                             | 06/03/82     | X         |           |           | X         |
| Four More Cholera Clinics Opened                  | 08/03/82     | X         | X         |           |           |
| Possibility of Cholera in East Cape Says MOH      | 12/03/82     | X         |           | X         | X         |
| 188 Killed by Cholera                             | 05/06/82     | X         |           | X         |           |
|   | <b>TOTAL</b> | <b>28</b> | <b>19</b> | <b>22</b> | <b>20</b> |

Table 5: *Daily Dispatch* News Values, 2000-2003

| TITLE   | DATE         | NEGATIV   | RECEN.    | RELEVAN.  | PROXIM.   |
|---|--------------|-----------|-----------|-----------|-----------|
| 10 Killed by Mystery Disease                              | 21/01/02     | X         | X         |           | X         |
| Tests Confirm Cholera Cause of Deaths                     | 22/01/02     | X         | X         |           | X         |
| Cholera Committee Set Up                                  | 23/01/02     |           | X         | X         |           |
| Death Lurks in Qingqolo River                             | 24/01/02     | X         |           | X         | X         |
| Cholera Hits Second Village                               | 31/01/02     | X         | X         | X         | X         |
| Mageda Says Cholera Threat Under Control                  | 01/02/02     |           | X         | X         |           |
| Umtata Sewage Cause of Cholera, Says Mamase               | 07/02/02     | X         | X         | X         | X         |
| Cholera Comment Criticised                                | 15/02/02     |           | X         | X         |           |
| Cholera Kills 7 in T'Kei                                  | 06/01/03     | X         | X         | X         | X         |
| Plea for United Effort as Cholera Worsens in T'Kei        | 07/01/03     | X         | X         | X         | X         |
| Goqwana Assesses Progress on Cholera                      | 14/01/03     |           | X         | X         |           |
| Locals Urged to Fight Cholera                             | 15/01/03     |           | X         | X         | X         |
| No Need to Panic' Over Cholera                            | 16/01/03     |           | X         | X         |           |
| Health Dept Winning Cholera War                           | 18/01/03     |           | X         | X         |           |
| Ministers Assess Cholera Impact                           | 29/01/03     | X         | X         | X         |           |
| Report Highlights Cholera Risk Profile                    | 30/01/03     | X         | X         | X         | X         |
| Sanitation, Culture Impacting on Fight Against Cholera'   | 07/02/03     | X         | X         | X         |           |
| Cholera Under Control Says Health Dept                    | 13/02/03     |           | X         | X         | X         |
| Medical Services on Cholera Alert                         | 17/02/03     |           | X         | X         | X         |
| Govt Acts to Beat Cholera                                 | 18/02/03     |           | X         | X         |           |
| Still More Cases of Cholera as Govt Tries to Curb Disease | 21/02/03     | X         | X         | X         | X         |
| Another Cholera Outbreak                                  | 31/03/03     | X         | X         | X         | X         |
| EC Health Department Keeping Cholera in Check             | 13/01/04     |           | X         | X         |           |
|   | <b>TOTAL</b> | <b>12</b> | <b>22</b> | <b>21</b> | <b>13</b> |

Table 6: *Eastern Province Herald News Values, 2000-2003*

| TITLE   | DATE         | NEGATIV | RECENC. | RELEV. | PROX. |
|---|--------------|---------|---------|--------|-------|
| Anti-Cholera Alert                                      | 01/12/00     |         | X       | X      | X     |
| E Cape Hospital Has Cholera Patient                     | 02/03/01     | X       | X       | X      | X     |
| Cholera Strikes in Eastern Cape                         | 01/05/01     | X       | X       | X      | X     |
| E Cape Cholera Worries Increase                         | 04/05/01     | X       | X       |        |       |
| R300m for Sanitation in Cholera Areas                   | 16/05/01     |         | X       | X      |       |
| Mystery Disease in Transkei Kills 10                    | 21/01/02     | X       | X       | X      | X     |
| Cholera Named as Killer in Remote Area                  | 22/01/02     | X       | X       | X      |       |
| Poor Infrastructure Making Cholera Worse, Says Minister | 31/01/02     | X       | X       | X      | X     |
| New Cholera Outbreak in Transkei Claims Seven Lives     | 06/01/03     | X       | X       | X      | X     |
| Cholera 'Under Control'                                 | 29/01/03     |         | X       | X      | X     |
|   | <b>TOTAL</b> | 7       | 10      | 9      | 7     |

## Appendix D: NEWSPAPER SOURCES

Table 7: News Sources, *Eastern Province Herald*, 1980-1983

|   |           |
|---|-----------|
| <b>Total Quoted</b>                     | <b>44</b> |
| Anonymous Spokesperson: ECDOH and SADOH | 13        |
| Senior DOH Director                     | 11        |
| Medical Officer of Health               | 8         |
| Hospital Superintendent                 | 4         |
| Director of Medical Services (Homeland) | 3         |
| Other                                   | 2         |
| Anonymous Spokesperson: Hospital        | 2         |
| South African Minister of Health        | 1         |

Table 8: News Sources, *Daily Dispatch*, 1980-1983

|   |           |
|---|-----------|
| <b>Total Quoted</b>                       | <b>35</b> |
| Homeland Director of Medical Services     | 7         |
| Senior DOH Director                       | 6         |
| Medical Officer of Health                 | 5         |
| Homeland Health Officer                   | 5         |
| Other                                     | 4         |
| South African Minister of Health          | 3         |
| Anonymous DOH Spokesperson                | 3         |
| South African Opposition Health Secretary | 2         |

Table 9: News Sources, *Eastern Province Herald*, 2000-2003

|  |           |
|--|-----------|
| <b>Total Quoted</b>                              | <b>15</b> |
| Health MEC (Bevan Goqwana/Max Mamase)            | 4         |
| Hospital Superintendent                          | 3         |
| SA Minister of Health (Manto Tshabalala-Msimang) | 3         |
| SA Minister of WAF (Ronnie Kasrils)              | 1         |
| SAMWU Official                                   | 1         |
| ORT Officials                                    | 2         |
| Residents  | 1         |

Table 10: News Sources, *Daily Dispatch*, 2000-2003

|   |           |
|---|-----------|
| <b>Total Quoted</b>                                   | <b>56</b> |
| Health MEC (Bevan Goqwana/Max Mamase)                 | 13        |
| ECDOH Spokesperson (Mahlubandile Mageda/Sizwe Kupelo) | 12        |
| Other Govt Spokes.                                    | 8         |
| OR Tambo Municipality Officials                       | 5         |
| Residents   | 5         |

|   |   |
|---|---|
| Hospital Superintendent                                     | 3 |
| King Sabata Dalindyebo Local Municipality Officials         | 3 |
| SA Minister of Water Affairs and Forestry (Ronnie Kasrils)_ | 2 |
| OR Tambo Spokespersons                                      | 2 |
| Former Health MEC (Trudy Thomas)                            | 1 |
| SA Minister of Health (Manto Tshabalala-Msimang)            | 1 |
| Miscellaneous Officials                                     | 1 |
| Head of ECDOH   | 1 |

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