

**A historiography of South Africa's public health care governance affecting health  
system strength from the 1940s to 2023**



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## **Abstract**

Segregationist minority rule socially engineered a system built on the brutality of black and brown people in South Africa leading to the aggravation of opportunistic infections. Centuries of white capitalist governance enslaved Black populations through settler colonialism and continued to inflict violence through the apartheid regime. Circulatory migrant labour and various forms of racist economic, health and land policies entrenched deliberate social disintegration in the country. The political economy formalised the maldistribution of health by ensuring the expansion of debilitating diseases like tuberculosis (TB) and HIV/AIDS throughout the twentieth century. Systemic violence by state government structures exploited Black vulnerabilities through the demonstration of structural violence. This shows how government-sanctioned policies affect not only health institutions within health systems, but also in wider constructions of power and health inequalities in South Africa. So, the unequal distribution of life-threatening diseases was contingent on the racialised dimensions of state power that impacts our contemporary health system.

After the materialisation of democracy, scepticism arose toward the ANC's ambitious and unstable re-articulation of social justice and equity, particularly in its propulsions for development and economic growth. In some way, this offers a retrospection on the ANC-led public health system and their shortfalls in redressing deep-rooted health inequities since the injection of systemic racism. In the thesis, I provide openings to question the strength of South Africa's health system through an assemblage of the Health Systems Research and the Health Humanities. These linkages deepen the scholarship and relationship between subjectivities (experiences) of health and the connections to public health legislature among its regulatory bodies. I navigate the histories of the colonial and apartheid public health systems through to the advent of liberation to consider how layers of structural violence plague negative experiences of health, and factors inhibiting access to health facilities and efficient treatment. Engaging with Foucault's theorisation on governmentality is necessary to frame a critique of the structure and scope of state power and its role in the regulation of health. The effects of neoliberal policies directly inspired transnational activism during the HIV/AIDS epidemic by compromising the fundamental freedoms and rights to health outlined in South Africa's Constitution. The thesis thus concentrates on neoliberalism as practiced during apartheid and post-apartheid contexts which has prominently targeted marginalised and vulnerable populations within the wider arrangements of globalisation and

global public health. To do so, the project illustrates how democratic governance and health systems designed in South Africa are inextricably connected to neoliberalism which affects the potential for liberatory, equitable and transformed iterations of health care. Therefore, the thesis aims to contribute to the growing literature on health systems research and the health humanities through the construction of a historical account of the public health care system and its impact on the implementation of equitable programs for health and improved health outcomes provincially.

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## Acronyms and Abbreviations

AIDS - Acquired Immunodeficiency Syndrome

ART - Antiretroviral Therapy

ARVs- Antiretrovirals

AZT - Zidovudine

CHW - Community Health Worker

*Comprehensive Plan* - Comprehensive HIV and AIDS Care and Treatment Programme

DoH - Department of Health

GDP - Gross Domestic Profit

GNU - Government of National Unity

Health Act of 1977 – *Health Act*

Health GAP - Health Global Access Project Health

HFA2000 - Health For All by the Year 2000

HIV - Human Immunodeficiency Virus

*HIV/AIDS and STD Strategic Plan for South Africa 2000-2005 - Strategic Plan*

*HIV & AIDS and STI National Strategic Plan on AIDS 2007-2011 - NSP 2007-2011*

HPSR - Health Policy and Systems Research

HR Human Resources

HSS - Health System Strengthening IHR

IHR– International Health Regulations

*Medicines and Related Substances Control Amendment Act 90 of 1997 – Medicines Act*

MoH - Minister of Health

MSF - Médecins Sans Frontières

NAP - *National AIDS Plan for South Africa*

NDoH – National Department of Health NHC - National Health Council

NHI – National Health Insurance NHS

National Health Service OOPs – Out  
of Pocket Payments

PACHA - Presidential AIDS Advisory Panel

PHA - Public Health Act of 1919

PHC - Primary Health Care

PLP - Presidential Lead Project

PMA - Pharmaceutical Manufacturers' Association of South Africa  
PMTCT - Prevention-of-Mother-to-Child Transmission  
SAHPRA - South African Health Products Regulatory Authority  
SAHRC – South African Human Rights Commission  
SANAC - South African National AIDS Council  
SAP – structural adjustment programme  
SARS - Severe Acute Respiratory Syndrome  
SHI - Social Health Insurance  
TB – Tuberculosis  
UHC - Universal Health Coverage  
UNAIDS - Joint United Nations Programme on HIV/AIDS UNDP  
UNDP- United Nations Development Programme  
UNESCO - United Nations Educational, Scientific and Cultural Organization  
WC – Western Cape  
WCDoH – Western Cape Department of Health  
WTO - World Trade Organisation

## Glossary of Key Terms

<b>Affordability</b>	Reasonable costs required based on the need for sustainability within the context of a country's resources (NDoH 2015).
<b>Comprehensive Services</b>	A continuum of care that emphasises an integration of primary health care services coverage that focuses on the modalities of health promotion and disease prevention along with cure, rehabilitative and palliative care, basic surgery and obstetric care (Van Rensburg & Engelbrecht 2012; NDoH 2015; McKenzie et al. 2017).
<b>Coverage</b>	Universal access to health benefits, services and programs as a social protection measure against negative financial and social consequences; the ability to measure the proportion of a target population that benefits from the broadening range of packages or extended coverage (WHO 2007).
<b>Decentralisation</b>	The delegation of responsibilities from top-down (from the central government to the provinces); the transference of some of the state's responsibilities and obligations in a formalised system to secure health performance provincially (Van Rensburg & Engelbrecht 2012).

<b>Equity</b>	The ability of provinces to allocate a fair share of their resources to the health sector nationally and inter-provincially to district facilities; the provision of proportional funds and resources, or equal shares for equal needs, and the allocation of unequal shares for unequal needs as long as proportionality is maintained (McIntyre 2011; Benatar 2012).
<b>Financial risk protection</b>	The elimination or minimisation of financial hardship like direct payments e.g. user-fees, co-payments and direct out-of-pocket (OOP) payments so that individuals and households will not be deterred from accessing and utilising the necessary health services and benefits (NDoH 2015).
<b>Governance</b>	The emphasis is on creating participative citizens with the state as a partner and facilitator their own economic advancement and developing a new set of vocabularies and devices for managing individuals' skills (Rose 2000; Miller and Rose 2008). The capacity for administrative authorities to regulate and stimulate political and economic control within the health system and the planning and policy organisation required for health system performance (WHO 2008).

<b>Governmentality</b>	Michel Foucault's theory of governmentality analyses the way social authorities administer, regulate and guides the lives of citizens and institutions and their linkages to political objectives; political power is exercised through an array of agencies and intellectual techniques connected to state bureaucracies in a liberal democratic way as they mediate wealth, health and labour (Miller and Rose 2008).
<b>Health care</b>	Activities and institutions that promote, protect or restore the health of individuals and the population; organised action to treat and prevent disease (Van Rensburg et al. 2012).
<b>Health systems</b>	An institution of <i>health care</i> that refers to the totality of organised resources, action and planning to respond to diseases and other health risks and to formalise services that directly influence health i.e. activities organised to prevent diseases and maintain health beyond the general scope of the health sector to encompass broader influences of health like nutrition, housing, education that affect the population (Van Rensburg et al. 2012).

<p><b>Health System Strengthening (HSS)</b></p>	<p>The application of systems thinking to devise innovative and sustainable intervention designs and evaluations of the health system to prevent or manage challenges in the health system; Initiatives that improve a singular or collective element in the health system that results in improved health outcomes, coverage, quality and efficiency (WHO 2009; Witter et al. 2019).</p>
<p><b>Hegemony</b></p>	<p>In Gramscian writings, hegemony refers to the practices of domination at the level of ideas and connects to governance through its underlying social relations by highlighting the long-term strategic components in governance projects; hegemony within international social relationships (the economic and political structures) orders the world economy with a dominant force of production and penetrates all countries by linking to other forms of subordinate modes of production (Rose, O'Malley &amp; Valverde 2006; Joseph 2014).</p>

<p><b>Multidisciplinary</b></p>	<p>The facilitation of teaching, research and practical action of an expanded conception of knowledge across a variety of stakeholders and/or investors who work toward a common goal (Benatar 2012); the co-production of research, theory, policy and practice that embraces collaborative processes and emphasises knowledge mobilisation blurring the lines between disciplines (Cape Hpsr Journal Club Team, T. W 2022).</p>
<p><b>Neoliberalism</b></p>	<p>An economic policy of the new Conservatism (1970s to 1980s) that emphasised fiscal austerity or monetarism at the macroeconomic level and at the microeconomic level that placed attention to the free market (Jones 2012); neoliberal governmentality or neoliberal political rationalities entails a realignment of contemporary technologies of government by ‘automating’ the state from direct controls over and obligations to welfare organisations and businesses (Miller and Rose 2008).</p>

<p><b>Political economy</b></p>	<p>The dynamics of capital investment, under the guise of social and economic development, is interlaced with widening inequalities driven by colonial expansion, and more contemporarily neoliberalism and imperialism (Wengraf 2018).</p>
<p><b>Primary Health Care (PHC)</b></p>	<p>A principle of the Alma-Ata Declaration of 1978 advocated for a unified, single policy health care model for the development of universal access to therapeutic technologies, benefits, and cost-effective treatments, equity, intersectoral action and community participation (WHO 2007).</p>
<p><b>Universal Health Coverage (UHC)</b></p>	<p>Increasing the number of people protected by the health system, to accelerate the proportion of expenditure or costs covered by pre-financing – more funding and less waste, and to increase the range of services and benefits covered by the health system and health care delivery (Van Rensburg et al. 2012:121).</p>

## Table of Contents

<b>Submission Checklist.....</b>	<b>4</b>
<b>Abstract .....</b>	<b>5</b>
<b>Acknowledgements .....</b>	<b>7</b>
<b>Acronyms and Abbreviations.....</b>	<b>8</b>
<b>Glossary of Key Terms.....</b>	<b>10</b>
<b>Chapter One: Introduction to the health humanities in public health.....</b>	<b>17</b>
<b>Chapter Two: The prioritisation of global health authorities for health goals .....</b>	<b>25</b>
<b>Chapter Three: Methodology – Questions amid Epidemic Realities and Health Emergencies.....</b>	<b>30</b>
<b>Chapter Five: The ANC ‘catching up’ to the rest of the world .....</b>	<b>46</b>
<b>Chapter Six: Mbeki administration – the AIDS scandals.....</b>	<b>55</b>
<b>Chapter Seven: Health System Strengthening (HSS) - looking to the future of governance in South Africa .....</b>	<b>69</b>
<b>Chapter Eight: Conclusion – the unfolding and renegotiated processes of doing research on health and health systems .....</b>	<b>80</b>
<b>References.....</b>	<b>83</b>
<b>Primary Sources .....</b>	<b>83</b>
<b>Secondary Sources.....</b>	<b>85</b>
<b>Appendices.....</b>	<b>98</b>
Appendix 1: Selected health status, mortality and morbidity indicators from 1990 to 1995 .....	98
Appendix 2: Demographic and health system indicators from 2015 to 2023 .....	100

## **Chapter One: Introduction to the health humanities in public health**

### **The health humanities**

HIV/AIDS is a global epidemic that has made attempts toward health equity in South Africa especially challenging in a post-apartheid context. The Alma-Ata Declaration proclaimed that primary health care addresses issues concerning, for example, maternal and child health care, family planning, and immunisation against significant infectious diseases (WHO 1978, cited in Van Rensburg 2012:31). For sub-Saharan Africa, the HIV and AIDS epidemic has worsened poverty, the nutritional status of children, and compromised the goal of universal primary education as well as maternal and child mortality rates (Rispel & Kibua 2011, cited in Van Rensburg 2012:46-47). According to Hodes and Morrell (2018, cited in Pentecost & Ross 2019:751-752), the social science archive on the HIV/AIDS pandemic in South Africa denotes that “sex, race and risk” foregrounds the conceptualisation of the social determinants of transmission. Furthermore, these authors state that pregnant women are the central figure within this nexus: the distribution of disease burdens (an instrument political-economic histories); sexual transmission (the issue of regulating and controlling intimate relationships); and vertical transmission (Coovadia et al. 2009, cited in Pentecost & Ross 2019:752). And so, Johnson, Dorrington and Moolla (2017, cited in Pentecost & Ross 2019:752) elaborate by saying that pregnant women became the:

epidemiological proxy by which the pandemic has been measured, and while antenatal bias is thought to be significant, especially in provinces with high rates of private health care use, antenatal statistics are still the most commonly used snapshot for national HIV prevalence in South Africa today.

The “temporalities of care” in the HIV/AIDS period was depicted as a “powerful discourse of personal responsibility” by connoting these women as “ignorant mothers” who generationally spread the virus and who shaped the provision of antiretroviral drugs (ARVS) and arguments about the vertical (i.e. mother-to-child) transmission of HIV (Hausman 2006; Robins 2008, cited in Pentecost and Ross 2019:752). In addition, Nkululeko Nkomo asserts that this surveillance and control over pregnant women’s bodies, although not new to the politics of reproduction, emerged anew as a “rights bearing and neoliberal self-governing HIV-positive subject” (2015, cited in Pentecost and Ross 2019:752). Inspired by Sara Ahmed’s research (2004) Nkomo states that policy discourse in the early-2000s drew from ethical values in

connection with forms of self-recognition to normative or governmental principles (Nkomo 2015, cited in Pentecost and Ross 2019:752). The cultivation of this mother figure as an active participant in state mandated health policies and programmes reinforces the idea of her as a liberalised individual who is responsible for their own health outcomes (Landecker and Panofsky 2013; Mansfield 2012, cited in Pentecost & Cousins 2017; Pentecost & Ross 2019). And so, these women who abide by such responsabilisation are also characterised as a site for intervention (Pentecost & Cousins 2017; Pentecost & Ross 2019). Major post-1994 maternal and child health policies aimed to reform the health sector and public health services in South Africa (Van Rensburg & Engelbrecht 2012). Health interventions included *Policy and Guidelines for the Implementation of the PMTCT Programme* (2008) which provided a structured plan for the guidance and reduction of mother-to-child HIV transmission to synthesise PMTCT (prevention of mother-to-child transmission) (Van Rensburg & Engelbrecht 2012:130). Fortification of maternal and child health programmes continues to be a crucial component of primary health services. Preventing and minimising the transmission rates of diseases like HIV and AIDS, malaria and tuberculosis (TB), to name a few, begins in utero and requires consistent vigilance and monitorisation neonatally and beyond. The focus on maternal and child health with regards to HIV/AIDS infection trends like mortality, for example, has particular significance for understanding how important the restructuring of the South African health system was. The predominance of HIV and AIDS and related diseases constrains the health system and its resources leading to a deterioration of health outcomes due to poor performance (Van Rensburg & Engelbrecht 2012:173-175). For example, the *Health Road-map* by the Development Bank of Southern Africa (DBSA 2008) conducted a study to investigate the complications in the health system. In this study, the DBSA (2008) detailed strategic and institutional proposals for the national government at the time, the African National Congress (ANC), to inspect the connection between South Africa's problematic health outcomes (relative to other countries of comparable socioeconomic status) and indicators noting the deterioration in the health of the population (DBSA 2008; also DoH 2010; 2011a; Engelbrecht & Crisp 2010; Rispel & Moorman 2010; Sanders & Chopra 2006; Sanders, Bradshaw & Ngonga 2010; WHO 2000b; 2011, cited in Van Rensburg & Engelbrecht 2012:175 ). Through decades of research into maternal and child health care, global health literature has been drawn to epidemiological models based on a "life-course approach that focuses on multiple generations" meaning that the maternal body is a site for intervention (Ben Shlomo and Kuh 2002; Jablonka and Lamb 2002; Kuh et al. 2003, cited in Pentecost & Ross 2019:750). For Michelle Pentecost (2015), early life nutrition studies state that nutrition and food security is an integral factor or determinant for the future potential of

infants. The purpose of this public health intervention bolstered the idea that mother and child, in this connected relationship, must be protected from biological harm instigated from such negative health affects brought on by diseases like HIV/AIDS.

The health humanities enhance anthropology's role in global public health research and health systems scholarship. Global public health constitutes a macro-level awareness of political, historical, social, and economic spheres (Prah and Levine 2021). Some African tertiary institutions have propelled the ideals of reciprocity by interweaving the social sciences, medical sciences, and artistic expression further within the discipline of the health humanities. Atkinson and others posit several advantages of the medical humanities toward global health by:

better understanding its conceptualization and representation, its regulation through government and other policies, its history, and the complex ways in which cultures influence and are influenced by “medicalized” accounts of human endeavour (See also Carel and Cooper 2012; Metzl and Kirkland 2009; Foucault 1994; 2002; Murray 2008; Woods 2011, cited in Atkinson et al. 2015:72).

This thesis demonstrates how historical context shapes the way in which health systems operate in connection to global health politics. Medical humanities practitioners negotiate the complexities of questions related to health care and quality of care. My training in anthropology, and more recent immersion in public health scholarship, has engendered an awareness about how institutional power and governance operates on micro and macro levels. Medical anthropology is a biocultural discipline that combines medical history, biological and sociocultural subfields like public health to assess the influence of power and inequality on patterns of health and disease by ameliorating these intersections (Foster and Anderson 1978, cited in Helman 2007:7-8). Sometimes referred to as the father of medical anthropology, Cecil G. Helman (2007) was well versed in many disciplines including pathology, epidemiology, nutrition, microbiology, and chemistry. In his classic textbook, *Culture, Health and Illness* (2007), Helman described the relationship between political and economic factors that produce and reproduce health system inequalities and how multisectoral aid agencies and civic participation help in the implementation of health care programmes, and how health agencies address the efficacy of various health planning strategies (Helman 2007:12-13).

## Research question

This thesis draws attention to state power hierarchies and the dual perspective, interpretation and experiences of medicine as having a liberating quality as well as a constraining one. Key aspects of this inquiry draw from Foucauldian historiography wherein biopolitics act as a disciplining power in public health that is infused into global health objectives (Foucault 2003, 2008). South Africa's implementation of democratic forms of governmentality encourages individual and collective participation in empowering the sense of self (Juhila, Raitakari & Hall 2017). Social services and welfare programs have been regarded as simultaneously an autonomous endeavour for citizens to activate their part in their personal maintenance as well as the states obligations to its citizens (Foucault 2003:66-75; Rose, O'Malley & Valverde 2006:90; Juhila, Raitakari & Hall 2017:4). Foucault's (2003) concept of governmentality set the perimeter for state control, surveillance and responsabilisation also known as structures of self-governance and "technologies of self" - political rationalities that emphasises empowerment and motivations to hold oneself accountable over their own lives and morality (Dean 1999; Lemke 2001; Rose et al. 2006; Cossman 2007; 2013; Miller and Rose 2008; Houdt and Schinkel 2014, cited in Juhila, Raitakari & Hall 2017). The trajectory of South Africa's application of liberal governmentality has exercised its power to structure interventions by enfolded agencies, institutions, and legal parameters for the behavioural conduct of citizens (Foucault 1977, 1982, 1988, 1991, 1997; Miller and Rose 2008, cited in Juhila, Raitakari & Hall 2017). I consider how the political economy of diseases like Human Immunodeficiency Virus (HIV), acquired immunodeficiency syndrome (AIDS), and tuberculosis (TB) intertwine into South African patterns of disease. I will work with the construction of differential public health provision enforced prevailing structural inequalities to address concerns around worsening health outcomes (Marks and Andersson 1987; Jochelson 2001; Farmer 2003; Foucault 2003; Fidler 2004:18; Rose, O'Malley & Valverde 2006; Coovadia et al. 2009; Marais 2011; Delobelle 2013; Shamir 2008, cited in Juhila, Raitakari & Hall 2017). Furthermore, I am interested in finding out how the South African health system and its policies, programmes and interventions have been employed to dispense relief and also to inflict harm on different demographics throughout history. I am thinking about how national governments are at the forefront of authorising the use of many new and innovative biomedical changes and advancements, and yet the politicisation of medicine and the construction of race and racism creates and entrenches health disparities. Building the capacity to strengthen the deliverability of quality health care that enriches people's experience of the health system at every level of care is paramount to achieving health goals.

Thus, this thesis will assess the matrices of South Africa's health system architecture (elements in the system), like health servicing, which influence existing inequities and subsequent health disparities. To do so, I am borrowing and extending Levi-Strauss's (1966, cited in Kasfir 1992:49-50) 'bricoleur' or the bricolage as an assemblage - an artistic notion of aesthetics that juxtaposes different schools of thought in social science, public health literature and health systems research, to evaluate these arguments about South Africa's health system capabilities in reference to various epidemics in recent history like HIV/AIDS and TB. 'Access', as used in this thesis, refers to constraints like physical (geographical/spatial, historical, urban planning and legislation) and economic (financial resource distribution) barriers which hinder, marginalise and/or prevent the public from recognising their full right to health (WHO 2007:33). I am utilising an assemblage of theories in public health, anthropology, political economy and development approaches to engage with the infrastructural and leadership capabilities that construct and govern various multisectoral actors in South Africa's health system. These assemblages are made possible by using discourse analysis as a methodological tool to assess diverse argumentation around health system research, public health care, primary health care, and anthropological critiques in various local and international locations. The theoretical basis for this thesis acts as a guiding force to assess the 'strength' of South Africa's contemporary health system against global public health objectives, goals and outcomes outlined in the Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs).

## Outline of chapters

The introductory chapter, Chapter One, outlines the multidisciplinary edge of the health humanities and its connections to global public health frameworks. Chapter One contextualises global public health care and the interconnections of countries to forge regulations, policies, directives and technologies to examine gaps in resourcing, service delivery and access to health facilities and programs. I stitch together South Africa's application of liberal governance throughout the apartheid and newly developed democratic periods to assess how leadership capacities order and influence patterns disease, and the overall 'strength' of the public health system.

In Chapter Two, I provide an overview of public health as a concept within wider arrangements of health securitisation and obligations by the state toward its citizens. Within this conceptualisation, I traced the trajectory of public health as characterised within the existing international politics on health security and the political economy. Further in this chapter, I utilised health system research to contour South Africa's involvement with international global public health authorities like the World Health Organisation (WHO) to collaborate across borders and information systems.

Chapter Three outlines my methodological practices, detailing how the project will engage with South Africa's experiences with macro-level structures within global public health institutions and health systems concepts. I started this project with health systems research and anthropological (health humanities) perspectives. I also utilised discourse analysis to interweave the multiplicities of theories, concepts, and arguments grounded in a bricolage of texts across practices.

Chapter Four reflects on the pathologisation of race in South Africa and how these segregationist systems marked themselves in various industries to conflate morality with biology and the predisposition of diseases. This chapter is grounded with anthropological linkages between public health and humanity to speak to the relationship between health insecurity and segregationist policies. In Chapter Four I show how the deliberate deprivation of living and working conditions for Africans worsened the maldistribution of health through diseases like TB.

Chapter 5 examines how the new democratic government adhered to global processes of growth and development through a series of macroeconomic policies and "fiscal austerity" while simultaneously attempting to deliver on the promises of redistributive justice. In Chapter

Five, I provide background for the ANC's newfound alliances to neoliberal policies under the demands of international economic order under the Reconstruction and Development Programme (RDP) and later the Growth, Employment, and Redistribution (GEAR) economic policies. These economic policies were foundational for the shift in prioritisation toward the reallocation of social welfare expenditure away from necessary health sector transformation to improve the material conditions for all marginalised and vulnerable populations.

Chapter Six explains how the macroeconomic processes of the RDP and GEAR impacted on the health sector decision-making by the ANC government, and how the National Department of Health (NDoH) formulated sets of health policies to combat co-epidemics of tuberculosis (TB) and HIV/AIDS. Chapter Six details how global health security risks and the co-infection of epidemics noted above, broadened existing disparities in health. Also, I assess how the Thabo Mbeki administration, and by extension its AIDS denialism, formalised anxieties around evidence-based scientific arguments supporting HIV/AIDS treatment options. Thus, this chapter argues that slow-footed responses by central health authorities in South Africa aggravated structural inequalities which claimed would ease post-apartheid.

Chapter Seven describes the architecture of the health system and its embedded elements which make it function across an array of technologies, stakeholders, and resources as an interrelated structure. This chapter highlights how important health authority and guidance is for the efficiency and effectiveness of the health system elements. In Chapter Seven, I outlined how systems thinking and Health System Strengthening (HSS) is for the sustainability of the health system to deliver services and to be adaptable to changes in the health system architecture. Here, I explain how global health securitisation comes together toward a set of health goals through partnerships with the Millennium Development Goals (MDGs) and more recently the Sustainability Development Goals (SDGs) to improve upon existing socioeconomic conditions and health insecurity. Here, I expand on the impact of disease burdens on the health system and how important strategies are to develop greater equity and service delivery to achieve as proposed in the National Health Insurance (NHI) Bill. Chapter Seven concludes with the concerns of financial flows and South Africa's expenditure on health and how feasible the NHI Bill is in the near future.

In the final chapter, Chapter Eight begins to summarise South Africa's history of deprivation, calculated and deliberate mismanagement of health system resources among Black populations, and the racist foundations of the public health system during the years of the Union of South Africa and apartheid. I focus on detailing how the governing styles of these periods was built on extractive industries like mining to displace and oppress citizens and ensured that the political economy of disease was bound up with moralistic arguments about the pathologisation of the Black majority. The thesis shows the astonishing scale of South Africa's health system governance and the crystallisation of inequalities and disparate health outcomes for different demographics and geographical regions. I explored how intricate the health system architecture is and how delicate these elements are to adaptation, especially the organisational capacity to deliver services and resources. The South African health sector has a long way to go to achieve the desired equality, sustainability and strength outlined under post-apartheid public sector-related policies and programs.

## **Chapter Two: The prioritisation of global health authorities for health goals**

### **Health systems within the parameters of global public health**

The Institute of Medicine (1988, cited in Fidler 2004:17) defined public health as the collective activities of countries to ensure the achievement of health goals across borders and other matters related to international society. In the nineteenth century, “international society” or international diplomacy was characterised as the conscious efforts of a group of states and their institutions whose shared values aligned to meet health security goals via the standardisation of rules and innovative solutions on infectious disease control (Bull 1977, cited in Fidler 2004; Hotez 2021). Contemporary global health security threats like HIV/AIDS, malaria, TB, and other widespread illnesses are generally derived from poverty-related insecurities that threaten the livelihoods of people everywhere with significant impacts felt in the Global South. As such, existing global political structures have recognised the importance of integrating resources and technologies to monitor pathogens and their potentiality for illnesses to occur (Fidler 1998; Fidler 2004). The World Health Organisation’s (WHO’s) *Everybody’s business: strengthening health systems to improve health outcomes: WHO’S framework for action* defines a health system as:

all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities (2007:2).

The health system includes intersectoral activities that are responsive, financially fair, and able to demonstrate an efficient use of available resources for suitable health and health equity goals (WHO 2007:2-3). As such, health system goals track the progress of selected inputs and outcomes in the system to achieve greater access and coverage of health interventions and benefits that are fair and safe (WHO 2007).

As a scholar in the health humanities with former training in medical anthropology, the journey into public health has led me to learn about the multiple intersecting components within a health system. Since the Alma-Ata Declaration (1978), medical anthropologists have contributed to public health research by evaluating the intricacies of socioeconomics to network and modify the centrality of policy decisions (Helman 2007:444). Medical anthropologists apply their knowledge of traditional and biomedical systems to bridge connections across disciplines by aiding in the development of holistic and multidimensional

collaboration (Helman 2007). Although anthropology's strengths lie in providing detailed ethnographic research that is seeped with rich multidimensional perspectives its methods also contain various limitations for health research (Helman 2007:454). Public health and global health care as a practice requires that practitioners have the relevant knowledge attuned to various medical studies and training backgrounds (Helman 2007). Although social studies and humanities scholars are continuously engaging with health research and intervention strategies in multidiscipline ways, anthropologists have been critiqued for being 'ill-equipped' in some respects (Helman 2007; Van Rensburg et al. 2012). For Helman (2007) and Benatar (2012:689) anthropologists have limited training in epidemiology and biology and may be too slow to action when emergent crises and urgent care overrides the need to do length ethnographic research (Helman 2007:454). Although these authors praise the multidisciplinary endeavours that have flourished for social sciences and medical sciences, they are also keenly spotlighting some instances where anthropologists may find difficulty in translating empirical evidence in widely actionable ways.

#### The global prioritisation of Primary Health Care (PHC) programmes

In 1978, the WHO declared that the Alma-Ata 'Health for All by the Year 2000' (HFA2000) would develop the Primary Health Care (PHC) approach to provide essential health services for citizens (WHO 2007). PHC embrace principles of universal health coverage (UHC), equity, public participation, and multisectoral action globally (WHO 2007). Evidently, the promise of universal health security did not come to fruition (Rose 2000:327). With collaboration with the United Nations Children's Fund (UNICEF), 'Health for All by the Year 2000' was the WHO's (1975 to 1978) proposal for the urgent implementation of the PHC globally by stating that:

essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community (Harrison 2004).

At the International Conference on Primary Health Care in Alma-Ata, the WHO and UNICEF jointly aspired to configure new health programmes with the principles of equality and community participation (Harrison 2004). Administrative and diplomatic orders to safeguard the wellbeing and general health of the population required agreements along international collaboration to influence health action (Rosen 1993). 'Primary' signifies the first contact-level – typically at a health district – and is integrated to “encourage continuity

of care for an individual across health conditions, across levels of care, and over a lifetime”

(WHO 2007). Finally, the PHC approach aimed to fundamentally reform health systems by establishing affordable, universally accessible and essential health care-based models (WHO 1978; Dennill, King & Swanepoel 2001; CSDH 2008; Schneider & Barron 2008, cited in Van Rensburg et al. 2012:30-31). For Baer, Singer and Susser in *Medical Anthropology and the World System* (2004:3-4), the dialectical relationship between bodies and sociocultural evolutions prompts a critical approach to the determinants of health and the assessment of health issues. The concept of ‘health’ has accumulated different meanings over the with health authorities like the WHO defining health as the “total physiological and emotional wellbeing” of an individual or population, and not just the absence of disease (Baer, Singer and Susser 2004:4; Van Rensburg et al. 2012:3). Further definitions by Benatar, Gill and Bakker (2011, cited in Van Rensburg et al. 2012:4) describe health as attuned to the “social determinants of disease” and the ability and opportunity for people to prosper with stable and supportive care systems. The “social determinants of health” or “socioeconomic determinants of health” denotes the intimate, external environmental and macrostructural factors that affect access to health as well as trends in health care such as poverty, unemployment, housing, and nutrition (Jochelson 2001; Coovadia et al. 2009; Van Rensburg et al. 2012; Delobelle 2013). Within the Alma-Ata philosophy there is a sense of responsibility bestowed onto the public for how they interact with and seek health care, and how their decisions and behaviours impact their own health (Engelbrecht & Van Rensburg 2012:484). In this way, the interrelationship between the physical environment, health infrastructure and health care providers depend on the state's organisational capacities.

#### Clusters of epidemics: public health care between the 19<sup>th</sup> to 20<sup>th</sup> centuries

Historical epidemiologists, social scientists, and scholars of intellectual history have studied the propagation of disease epidemics and other contagion imbued within political unrest, urbanisation and mass migration, famine, and mostly economic turbulence (Rosenberg 1992:158). During the seventeenth century, the Scientific Revolution - which borne the Enlightenment period - spread “disenchantment” about the magical and mystical properties of religious symbolism to explain the natural world and its phenomena (Rosen 1993; Harrison 2004). By the nineteenth century, medical practitioners observed that the symptoms of various diseases became characteristic of disease pathologies that involved “causal organisms of many bacterial and parasitic diseases” across class, race, gender, and geographies (Marks

1997; Harrison 2004). In this same period, globalization, colonisation, imperialism, war and conflict, and commerce networks created extraordinary circumstances for the transmissibility of diseases, and the inevitability of premature mortality (Rosen 1992; Marks 1997; Harrison 2004). Additionally, globalisation has created opportunities for the advancement of health care technology to combat risks to health (Van Rensburg et al. 2012:24). International diplomacy was developed to formalise and regulate public health activities by centralising the responsibility of health care into the hands of local government authorities (Rosen 1993). During the 1940s, the WHO and League of Nations (1920 to 1946) aimed to universalise health management standards and norms, and campaigns to target disease-specific interventions (Harrison 2004; Marchal, Cavalli and Kegels 2009, cited in Lyttleton 2018; Roth 2020).

### Cleanliness: the socioeconomic determinants of health

George Rosen (1993:1-3) offered a multi-sited historical analysis of the relationship between sewerage systems, and the ritualised hygiene methods that individuals employ to evade epidemics and the transmissibility of communicable diseases. Rosenberg (1992: xiv-xviii) stated that the nineteenth century was marked by social negotiations between individuals as responsible citizens and the state which structured "disease-specific responses" that provided institutional structures with physicians and scientists. The idea of cleanliness went beyond bathing one's own body but extended to the living conditions of individual and its effects on the wider community in disease prevention. Mark Harrison (2004:18-19) utilised Michel Foucault's social constructionist perspective stating that the 'social lives' of infectious diseases and outbreaks were contextually distinct and informed by subjective experiences. Rosen (1993:68-69) then draws on intellectual history to explore the cultural and economic shifts brought on by Enlightenment and the Industrial Revolution in Europe in the seventeenth and eighteenth centuries. Beyond diagnostics, diseases may be influenced by the symbolic behaviours (ritualised activities and purification rituals) converged with spiritual identities (Rosenberg 1992; Harrison 2004). It was also acknowledged that caring about one's own wellbeing extended to the wellness of wider society. Sanitation movements swept through Europe as a signal to the relationship between environmental and personal cleanliness (Rosen 1993; Harrison 2004; Coovadia et al. 2009; Szreter 2021). In John Locke's *Essay concerning Human Understanding* – he raised the public's attention to health and hygiene to create a moral imperative towards citizens' 'responsibility' over their own wellbeing (Rosen 1993:68-69; Harrison 2004). According to Rosen (1993:109-110), a

political economy approach consisted of a new economic order in the Industrial period that aimed toward an “unfettered private enterprise [as a marker] of social progress [...] to liberate the immense potential of individual initiative” and to affirm a framework of law and order. Jeremy Bentham and his colleagues, the Philosophic Radicals (1820s to 1870s), believed in the political, social, and economic reformation of the English government (Rosen 1993:110; Harrison 2004). Utilitarians believed that human beings should embrace their capacity for happiness by earning a living and learning – by which they mean not being prevented from achieving these goals by illness or untimely death (Harrison 2004). By 1834, the Board of Commissioners of the New Poor Law, and the Poor Law Commission spearheaded by Edwin Chadwick (1800 to 1890), centralised and regulated public health administration (Rosen 1993:110-116; Harrison 2004). Inspired by utilitarian philosophy under Jeremy Bentham, Commissioner Chadwick advocated for state assistance measures for the poor and working classes in urban areas alongside protecting the economy from the reduction of labouring bodies caused by cholera and other plagues (Rosen 1993:110-118; Harrison 2004:11). Due to the Chadwick Commission’s recognition of the interrelationship between poor environmental factors like overcrowding and poverty manifesting into epidemics, Chadwick informed England’s first national Public Health Act of 1848 (Rosen 1993:120-121; Szreter 2021:52-53). Therefore, the new General Board of Health urged the national government to implement:

the great preventives [...] Drainage, street and house cleansing by means of supplies of water and improved sewerage, and especially the introduction of cheaper and more efficient modes of removing all noxious refuse from the towns [...] the disease that results from the neglect of proper administrative measures, and has alleviated the sufferings of the victims (Rosen 1993:120-121).

By highlighting the nexus between environmental conditions and its impact on ill-health, public health officials were urged to recognise that for the sake of the economy proper sanitation measures must be implemented to protect the overall health of working populations (Rosen 1993; Marks and Andersson 1987; Harrison 2004; Coovadia et al. 2009; Delobelle 2013; Szreter 2021). Sanitation reformation showed that rates of infectious diseases could only be lessened through the state’s political power and responsibility for public health care (Rosen 1993; Harrison 2004; Szreter 2021).

## Chapter Three: Methodology – Questions amid Epidemic Realities and Health Emergencies

### Research questions: fine-tuning the questions

My methodology shifted significantly over the course of researching and writing this project. In the beginning of the research process, I explored an entirely different research question that focused on COVID-19 vaccine hesitancy and the relationship between vaccine misinformation, vaccine diplomacy, poverty and its connections to disenfranchised youth in Cape Town. However, as the unfolding events of COVID-19 restrictions dissolved, my thesis needed reconstruction. I had to rethink the connections between the government and institutional capacities and capabilities and public health response to citizens. In the final year of my master's degree, I enrolled in a course called Introduction to Health Systems at the University of Cape Town (UCT) which set my thesis in motion toward a new research objective. My attention was brought to the South African health system which consists of micro and macro structures and their multiple interrelationships with the support of multisectoral actors (WHO 2009:30-33; Benatar 2012:653-685). I wanted to engage with the historiography of South Africa's application of liberal governmentality and responsabilisation as key mechanisms featured in social policies and political discourses as an advanced form of neoliberal ideologies (Foucault 2003; Rose, O'Malley & Valverde 2006; Brown and Baker 2012, cited in Juhila, Raitakari & Hall 2017). Thus, I wanted to explore various dimensions of governmentality in South Africa and how their iterations of liberal governmentality and implementation of social and economic policies ordered how epidemics and other health-related illnesses were dealt with, particularly for the HIV/AIDS and TB epidemics. For Foucault et al. (1991:55), the episteme is not the completion of knowledge or research but consists of the oppositions as well as the interconnections of various scientific discourses. To work through these relations between interdisciplinary fields, I have employed discourse analysis as my primary method. I have grounded this thesis in multidisciplinary research across the health humanities, public health and political economy and development studies (Marks and Andersson 1987; Helman 2007; Marais 2011; Van Rensburg et al. 2012; Atkinson et al. 2015).

### Discourse Analysis

This project will employ discourse analysis to synthesise multidisciplinary theories in health

systems studies and the health humanities. For Teun van Dijk (1990, cited in Fairclough 1992:193) discourse analysis is a strategic form of discourses on a local and global level that considers the social, political contexts and the text or language required for “explicit and systematic analysis, and this analysis must be based on serious methods and theories”. This qualitative method considers the intertextuality of interdisciplinary diversity of micro and macro examination on social phenomena – mediating the pluralism in genres, narratives and discourses between literature, contexts and language (Fairclough 1989, 1991; van Dijk 1990, cited in Fairclough 1992:193-195). Thus, the concept of bricolage (artistic assemblages) and intertextuality establishes a pluralism of methods, theories and approaches to scientific research by creating a consensus over key theoretical bases and methodological issues in the practice (Levi-Strauss 1966, cited in Kasfir 1992:49-50; Fairclough 1992).

This report will provide a synthesis of various theoretical insights derived from social studies like anthropology and the health humanities, political analysis, economists, public health literature, and health system research to evaluate the underpinnings of social transformation principles in South Africa. The health humanities focus on cultural and social factors in illness and health, preventive and curative medicines, and health education and aid programmes, and in the delivery of health care (Helman 2007:13-17). In *Ethical quandaries in social research* (Posel and Ross 2014:21-62), Christopher J. Colvin (2014) ponders on the benefits of research for health science and anthropology researchers as simultaneously insiders and outsiders to the research subject. For Posel and Ross (2014:21), social research is “always paradoxical” because we are both “aspiring to varying degrees of cognitive intimacy depending on the chosen methodology”; the sociality of qualitative research balances the ethics of being inside and outside the object of study. These authors argue that the standards and norms inherent in “rigorous scientific practice” are situated between varied levels of detachment and commitment typical in qualitative research characterised by relationships with research subjects (Posel and Ross 2014:21-22). Although this thesis does not speak to individuals or groups affected by the various epidemics and health emergencies in South Africa so directly, it does generate questions about the subject matter in its afterlife. The affect that this research has institutionally cannot be minimised as it critiques the very structures (health and politics responses) that uphold or instigate poor health outcomes and experiences.

My research design methods initially involved consultation with my supervisor on themes and concepts that were relevant to COVID-19 as the most recent global pandemic at the time.

During this initial stage, I aimed to sort out commonality between different contagion and how they were monitored, managed, and controlled on a global scale. What is meant by ‘commonality’ here refers to the similar conceptual threads in the literature that binds contagion, diseases, pandemic, epidemics and illness together in a post-globalisation world. Then, I made an appointment with a Clinical Librarian who is a Librarian for Paediatrics, Child Health & Neonatal Medicine, Obstetrics & Gynaecology, Psychiatry & Mental Health, Anaesthesia & Perioperative Medicine, Biomedical Engineering, Forensic Medicine, General Surgery & Ethics, at UCT to guide me in terms of the most appropriate search terms to use, search engines, and key words and synonyms whose applicability is more connected to my research aims. Doing this preliminary work allowed me to find the most applicable and relevant results on pandemics and vaccines. These key terms included: “vaccines”, “vaccine hesitancy”, “pandemic”, “epidemic”, “contagion”, “chronic diseases”, “plagues”, “non-communicable diseases”, “universal health care”, “epidemiology”, and “political economy”. These concepts were chosen for their synthesis regarding my original plan to write about COVID-19 vaccine hesitancy which then shifted and expanded to speak about pandemics and epidemics broadly. As a result, “vaccine hesitancy” and “vaccine diplomacy” became terms that were not useful or relevant to my research aims and evidently fell away. I found it insightful to also consult with my *Theory and Method in Histories of Medicine, Health and Healing* course which had highly relevant books and journal chapters on these abovementioned themes as well as others that I could use like “governance”, “disease diplomacy”, “global health”, “global public health”, “global public health care”, “global health security”, “health security”, “primary health care”, “structural violence”, “inequality”, “inequities”, “Microbialpolitik”. From there, the choice to focus on South Africa’s forms of governmentality and management of pandemics became clearer and allowed me to create a more concise list of terms and concepts that would suit my intentions. Here, I mainly utilised digital libraries and research platforms like the UCT digital library called Primo, Google Scholar, ScienceDirect, and EBSCOhost using the abovementioned key terms.

This thesis seeks to highlight mechanisms that negated any attempts to move toward health equity. In doing so, my methodological practice of discourse analysis prompts future research on the accessibility of the health system’s resources, facilities and information systems (Anthropology Southern Africa 2005). It is my hope to escalate the ontology of the health humanities in health systems research to further the analysis of systemic violence in South Africa and how those inequalities, violence and policies interact to oppress, marginalise, disadvantage or even empower and mobilise members of society. Previous violent policies and

the current mismanagement of resources provincially reflects disproportionate health care access and issues to receiving adequate treatment and other services as observed by academics since the colonial and apartheid periods.

### Pedagogical imperatives

South Africa's entanglement with violence and politics is not a new phenomenon and is evident by the experiences of marginalisation across different modalities within their historical and geographical environments (Balibar 2009:9-10). Extreme state violence may take form through administrative, physical or moral suffering that constricts life and dignity in domains like education, health, work, and through acts of displacement (Balibar 2009:11). Domination, subordination and other exclusionary actions created potentiality of politics constituting practices of resistance, contestations of order, and demands for social justice "where active subjectivities and collective solidarities are formed" (Balibar 2009:10-19). This thesis evaluates governmentality in the 'state' and the health system as they pertain to ordering social life and the possibilities for upward transformation, access to health facilities and the impacts of political and economic decision-making therein. Calls for social justice have been stressed in recent literature on health systems research and anthropological works due to the overwhelming influence of capitalism and globalisation on ill-health (Marais 2011; Van Rensburg et al. 2012; Delobelle 2013). Jade Gibson (2020:258) suggested that an "interdisciplinary mode across text, emotion, vision" urges disciplines to develop new or common ground of language engagement rather than disengagement in research approaches. Gibson (2020) raised the importance of interdisciplinary or multidisciplinary work that extends beyond a singular approach, perspective or ideological basis. Interdisciplinary research has the objectives to approach a problem from multiple angles, forces one to think beyond and in-between critiques, recommendations and theories to think diversely toward a common goal. In this way, learning becomes an "empirical lantern" whereby the responsibility to think about life in all its limitations and crossroads finds intersections in technology and interpersonal relations, and where unexpected futures emerge (Hirschman 1998, cited in Biehl and Locke 2010:318). Deleuze's ideas about the "ethnographic realities" of war and poverty have been used to describe the limits of human agency and acts as a helpful addition to the analysis of Michel Foucault's concepts of biopower, governmentality and neo-Marxist theorisations of structural violence in anthropology (Foucault 2008; Bourgois 1995; Farmer 2001; Scheper-Hughes 1992; Rose 2000; Fassin 2007; Ferguson 2006; Foucault 2007; Lovell 2006; Ong and Collier 2005; Rabinow and Rose 2006; Biehl, Good,

and Kleinman 2007; DeIVecchio Good et al. 2008; Jenkins and Barrett 2004, cited in Biehl and Locke 2010:318). The concept of the “empirical lantern” illuminates the processes of individual mobility through “broken institutions and infrastructures in the making” while not caricaturising complex experiences by missing the multiplicities of living that complicate and enrich analytics inherent in political, economic and technological worlds (Biehl and Locke 2010:318-320). What this project assesses is how these discourses around public health policies and other organising forces influence patterns of ill-health, exclusion, marginalisation which can coalesce in an unjust society. Possibilities for equity in the health system and inclusion in decision-making processes is acknowledged at state-level and district-wide with varied attempts to put these ideas into action.

## Results

My research approach allowed me to understand the complexities of South Africa’s construction and implementation of its health system, particularly as it interlinks with global efforts towards universal primary health care. Insight was presented and ascertained according to governance methods for the management, reduction, and prevention of diseases like HIV and AIDS, malaria, TB, and syphilis. Historically, health research and trends since the nineteenth and twentieth centuries have showcased how environmental factors have a major influence into how communicable and non-communicable illnesses are spread. Correspondingly, factors relating to how structural violence and the physical mapping of people and places creates microcosm for the proliferation of diseases. Displacement, mobility and migration into cities and urban areas also produces the opportunity for this ‘breeding ground’ to occur and for the spread of diseases. In this way, I gained knowledge into how different governance mechanisms like health policies, interventions, and programmes can and have categorically emboldened disparities as well as the rectification methods used to balance these inequities with varied success.

In the Chapter 4, I explore a social constructivist approach to South Africa’s public health system, and what those experiences of exclusionary legislation meant for ‘previously disadvantaged’ citizens in their everyday lives. Here, we look at the impact of separatist laws on the patterning of ill-health enforced by state health authorities. I will evaluate how South Africa’s transitionary period into democracy battled with the consequences of extreme violence and major global macroeconomic restructuring (Bond 2000; Coovadia et al. 2009; Baker 2010; Marais 2011; Van Rensburg et al. 2012; Delobelle 2013). These factors have greatly impacted

the health effects caused by pervasive inequalities and poverty on the health of the South African public. And raised the importance of fortifying institutional arrangements that adhere to the distribution of optimised public health policies disseminated from the central government to local/district health systems

## **Chapter Four: A social constructivist approach to race in South Africa**

### The pathology of race

In *The Colour of Disease: Syphilis and Racism in South Africa, 1880-1950*, Jochelson (2001) uses a social constructionist perspective to analyse South Africa's implementation of morality discourses in the justification of ascribing social and moral disorders to African, coloured, and poor white populations. Metaphors were used to explain how the biological factors inherent in these 'subordinate' populations made them susceptible to moral decay and more viable to spreading venereal diseases (VD) during the syphilis epidemic (Jochelson 2001). The pathologization of Africans legitimised the production and reproduction of racial hierarchies in the medical field (Vaughan 1991, cited in Marks 1997; Jochelson 2001). Eugenic depictions of African and coloured races were used to imbue "racial anxiety" under the impetus of colonial and imperial pursuits of 'superiority' interpreted from Social Darwinist thought (Marks 1997; Jochelson 2001). The two main arguments for the syphilis epidemic derived from "medical orthodoxy in Europe and America" (Jochelson 2001:23-24). Firstly, the impacts of urbanisation caused by the migrant labour system required Africans to relocate into cities which created overcrowded residential spaces and became a factor toward the socioeconomic determinants of ill-health (Jochelson 2001:22-137; Coovadia et al. 2009:819). Secondly, the proximity to Africans and coloureds made poor whites 'naturally' susceptible to moral and social denigration (Jochelson 2001:4-124). The connection between sexual promiscuity and race science emboldened medical racism in South African medical institutions in the 1920s and 1930s (Marks 1997; Jochelson 2001). Thus, diseases, persons and biomedical institutions are entwined in public policies to legitimise the perception and response to such biological events (Rosenberg 1992:xiii).

### The state of the Union of South Africa (1910 to 1948)

The Public Health Act of 1919 (PHA) was an educational and health-based state intervention positioned as a "national obligation" toward white citizens by establishing a new three-tiered health system (Jochelson 2001:77-85; Delobelle 2013:165). In 1910, the Union of South Africa (hereafter the Union) was founded after former colonies became provinces while remaining territories of the British Empire (Coovadia et al. 2009:818). According to Coovadia et al. (2009:819), the Union altered the economic development of the country from an agricultural economy to an industrial economy. Following the 1913 Land Act, the mining

industry employed rural African workers from their legislated “reserves” that increased demand for cheap migrant labourers “from 10 000 in 1889 to 200 000 in 1910, and 400 000 in 1940” (Coovadia et al. 2009:819; Delobelle 2013:166). The mining industry and manufacturing sector formed part of the industrial complex of the “white elite” to attract foreign investment into the country (Coovadia et al. 2009:819; Delobelle 2013:166). Therefore, discriminatory legislation dictated the movement and occupational opportunities for Africans. Domestic spaces were rife with unsanitary conditions caused by overcrowding which exacerbated the rate of TB for African and poor white workers (Marks and Andersson 1987:178; Coovadia et al. 2009:819). By 1919, the PHA stated that each province would control their own hospitals, but municipalities were required to provide clinics with preventive, environmental, antenatal, and childcare services (Delobelle 2013:165). After the devastation caused by the 1918 Spanish Flu, the state needed to bolster their strategies against future epidemics as they negatively impacted the efficiency of the industrial workforce (Jochelson 2001:77-136). During the 1920s and 1930s, welfarist and philanthropic efforts proposed to strengthen the “respectable white body politic” by improving the social and economic conditions of the white population (Jochelson 2001:77-81). Under a Foucauldian understanding of the ‘modern state’, state power is concerned with regulation, surveillance, and acts as a disciplining force that securitises identity and the ability to “access the benefits of liberty” (Rose 2000:326; Vaughan 1991, cited in Jochelson 2001:6). This theorisation of state control proclaimed that modern statehood should define social and scientific discourses and the parameters of normal and “deviant” behaviours in its subjects through legislative and administrative laws (Foucault et al. 2008:38-39; Vaughan 1991, cited in Jochelson 2001:6). Thus, the central government declared that health services were inexplicably linked to the state’s responsibility to provide adequate social services by segregating the races (Jochelson 2001:81).

In 1936, the Chamber of Mines financed the adoption of medical aid training schemes for African practitioners in rural areas as the distribution and costs of health services for African miners were heavily segregated in rural areas (Marks and Andersson 1987:183-183). So, the two-tiered health system was devised as a response to class-based and race-based discriminatory practices as it limited the allocation of health services (Marks and Andersson 1987:183). For instance, this system limited the allocation of health services like the number of trained medical professionals allowed into training institutions (Marks and Andersson 1987:183). Moreover, the two-tiered health care system ensured that government-initiated rural health schemes entrenched white monopoly over public health care (Marks and

Andersson 1987). Consequently, the racial representations and social inequalities embedded into the health system, through legacies of colonialism and apartheid legislation, exacerbated the plurality of disease burdens for African miners as well as for their families (Marks and Andersson 1987; Marks 1997; Coovadia et al. 2009; Delobelle 2013; Abney 2014).

### Proposing comprehensive welfare for all South Africans during the 1940s

By 1942, the National Health Services Commission (NHSC) conducted a second inquiry into the connections between poverty and health outcomes that prompted the question of a health system reformation (Delobelle 2013:169). On November 9<sup>th</sup>, 1946, the South African Medical Journal (SAMJ) published a nationwide address conducted by the Minister of Health (MoH), Dr. Henry Gluckman (Gluckman 1946:655-656). In association with the Federal Council of the Medical Association of South Africa, Dr. Gluckman was inspired by the British Beveridge Report's blueprint for social welfare transformation called National Health Insurance (NHI) and the National Health Services (NHS) which became a guide for the future (Gluckman 1946; Delobelle 2013:169). In this post-war context, Dr. Gluckman, contended with concurrent epidemics like TB and VD (Gluckman 1946; Jochelson 2001). In this post-war context, Dr. Gluckman contended with concurrent epidemics and thus needed to professionalise South Africa's welfare policies (Gluckman 1946; Jochelson 2001). Dr. Gluckman's assessment of the health system showed that the maldistribution of health required rearrangement to account for the economic basis of medical practice (1946:655-657). The NHS advanced the principles of universal health care which endorsed the right to health by making health services free for all; and advocated for promotive health services that was integral to the wellbeing of all South Africans no matter their demographic or geographic area (Gluckman 1946; Jochelson 2001; Klausen 2004). Further, "means-testing" for lower-income groups served to combat the socioeconomic determinants of health (Gluckman 1946:656-660; Jochelson 2001:137). "Means-testing" aimed to alleviate the economic burden of the poor by taxing (health taxation) according to an individual's health needs and their ability to pay (Gluckman 1946:660-661). The Gluckman Commission recommended that health services concerns itself with the prevention of disease and the promotion of health such as nutrition, hygiene, housing, and water supplies (Gluckman 1946:656-658; Klausen 2004:149). Commissioners undertook a three-and-a-half-month tour of the country's civil society, traditional leaders, voluntary organisations, existing health units in rural regions, and discussions with government representatives to curate the Gluckman Report (Delobelle 2013:169). The Gluckman Report found four major problems: (1)

insufficient coordination due to the three-tier system, as well as mission and mine hospitals and private service providers; (2) scarcity of services like hospital beds and personnel; (3) a large profit-driven private practice sector focused on curative service within affluent white urban areas; (4) and an emphasis on curative and institutional care, not formulated to ‘modern’ ideas of health (Jaques and Fehrsen 2007, cited in Delobelle 2013:169). The efficacy of these proposals is debateable, but what is known is that these recommendations faced resistance in the implementation of a renewed health system.

For the departure of the Union’s health system, provinces would be required to forfeit their control of local authorities’ role in municipal clinics and infectious disease hospitals; relinquish private agencies of their control of medical benefit schemes; and stop general practitioners of private practices to form one national health authority (Gluckman 1946:658). Due to the central governments’ policy of non-interference in provincial management, and the bubbling discordance between health centres and the vested interests of medical practitioners, the fledgling suggestions by Gluckman were swiftly rejected (Gluckman 1946:658-661). Although the Department of Health’s (DoH) vision for public health was popular with members of Parliament it failed to gain support by Cabinet, which did not intend to address the underlying socioeconomic causes of ill-health (Jochelson 2001:136-137; Klausen 2004:149). Theoretically these recommendations appear socially ‘progressive’ given South Africa’s apartheid state, but these health policies were conditional for “Native” populations whose indigenous healing systems were considered “superstitious” (Gluckman 1946:657; Jochelson 2001:141-143; Klausen 2004:149). Indigenous African medicine and “Native education” were considered restrictive and responsible for their own barriers toward effective education about health and ill-health (Gluckman 1946:657; Klausen 2004:3). Segregationist policies like the Native Urban Areas Act (NUAA) of 1923 were already stigmatising African populations and worsened their morbidity rates (Gluckman 1946; Jochelson 2001:116). Furthermore, African peoples were previously reliant on financing from the general revenue stream under the Native Trust Fund, however the NHS would be subject to financing from the country’s general revenue administration (Gluckman 1946:657). The demand of moral scripts onto African populations about their ‘inherent’ infectivity strengthened the contrast between the Gluckman Commission’s universal welfarist objectives, and the states insistence on discriminatory treatment toward so-called “Natives” (Gluckman 1946; Jochelson 2001; Klausen 2004). However, before any serious attempt at the implementation of the NHS, the right-wing Nationalist Party (NP) took power in 1948, and

the momentum of universal health care diminished quickly and consolidated social and economic exclusion (Coovadia et al. 2009:819; Delobelle 2013:170).

### The apartheid-era health system (1960s to 1990)

Segregationist laws and the political economy of disease during the late-twentieth century aggravated the transmissibility of diseases like TB (Marks and Andersson 1987:177-178; Marks 1997:215-218; Jochelson 2001:93-124; Klausen 2004:3; Coovadia et al., 2009:819-832). The National Party's (NP) Population Registration Act of 1950 and Group Areas Act of 1950 forced relocations of African, coloured, and Asian peoples to specific ethnic living areas – dictating education and access to health care (Marks and Andersson 1987; Jochelson 2001; Delobelle 2013). According to Coovadia et al. (2009:825), the apartheid regime worsened the fragmentation of the health system for different ethnicities through the creation of Bantustans and engineered the maldistribution of health through social inequalities (Marks and Andersson 1987; Jochelson 2001; Delobelle 2013). Bantustans functioned as quasi-independent government powers, with fourteen separate health departments that experienced weak and underfunded primary-level health services (Coovadia et al. 2009:825). Additionally, Bantustan government authorities were financially limited in offering better PHC health services (Baldwin-Ragaven et al. 1999, cited in Delobelle 2013:176). The Health Act of 1977 (hereafter the *Health Act*) defined the roles and responsibilities of the Department of Health (DoH) towards its citizens (Delobelle 2013:178). The *Health Act* stipulated new guidelines for curative and preventive services for the national, provincial, and local authorities in the health care system (Coovadia et al. 2009:820; Delobelle 2013:178). The lack of physical and intangible resources impaired the accessibility to and quality of health care services to residents in Bantustans, such as transport shortages, understaffing, and severely overcrowded hospitals (Delobelle 2013:176).

Decades of migratory cycles and neglect of African medical services exposed themselves through high morbidity rates during the 1970s to 1980s (Jochelson 2001:93-94; Marks 1997:215; Delobelle 2013:173-174). Neil Andersson and Shula Marks (1987) referenced the “hidden violence in South Africa” that took form through the systematic decimation of family life and human health under the migrant labour system; and increased mortality and morbidity rates associated with preventable diseases caused by poverty (WHO 1983, cited in Marks and Andersson 1987:177; Marks 1997:215). The draconian ideological role of the NP government enforced the burdens of capitalist growth that resulted in comparative mortality

and morbidity rates between ethnic groups (Marks and Andersson 1987:178; Marks 1997:215; Coovadia et al. 2009:819). According to Delobelle (2013), health indicators showed that mortality patterns for white populations more closely aligned with those in developed nations, while African and coloured populations resembled approximations in ‘developing’ nations. During the 1980s, Marks and Andersson (1987:177) stated that South Africa’s political and economic developments created negative repercussions for the health sector. For example, by 1987, public sector health care expenditure per individual ranged between R23; R91; R150; R200 in Lebowa, Ciskei, Transvaal and the Natal and Cape province respectively (Coovadia et al. 2009:825). The Second Carnegie Inquiry into Poverty and Development (1982) stated that the maldistribution in health services from apartheid legislation worsened access to primary health care for African and coloured peoples, and that the health repercussions caused by poverty indicated a major connection between poverty and health (Marks and Andersson 1987:178; Wilson and Ramphele 1989, cited in Delobelle 2013:179-180). Therefore, the Commission supported social justice and redistributive political power for marginalised groups, and the fundamental restructuring of apartheid policies toward pro-poor models of the PHC (Wilson and Ramphele 1989, cited in Delobelle 2013:179-180; Kautzky and Tollman 2008, cited in Delobelle 2013:180). It is evident that discourses in medical privilege and the “political economy of medicine” consider the influence of class and power for the reproduction of inaccessible and (in)adequate medical services and resource availability in health facilities (Marks 1997:215-216; Coovadia et al. 2009:825-826).

### Privatisation and the promises of prosperity

#### *Embodiment & Social control: bodies in the system*

Structural adjustment programmes during the 1970s and 1980s aimed to reorganise the “body social and the body politic” to separate the state from social provision and welfare responsibilities that was entrenched decades earlier (Marias 2011:110). *The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology* conceptualises the “body politic” within the “three bodies” mode of analysis which deconstructs Western ideas about the individual and society, and the body and mind within theoretical and research domains (Scheper-Hughes and Lock 1987). According to Scheper-Hughes and Lock (1987:6-24), the three bodies: 1) individual – embodied self that experiences health and sickness, existing as the interrelationship between psyche and soul 2) social – nature, society and cultural

constructions of the body and 3) body politic – power and control of social groups. Here the body politics refers to social and political management, regulation and surveillance of individual and collective bodies in all types of government like totalitarianism, monarchies and democracies (Scheper-Hughes and Lock 1987:6-8). Embodiment is a process that is not only structural (physical) but temporal (placed within time and space; context-dependent) – social, historical and diverse, and applies to the body in an industrialised world (Scheper-Hughes and Lock 1987; Farquhar and Lock 2007). Scheper-Hughes and Lock (1987:21) stated that ethnomedicine does not separate the mind from the body and self, and so understand illness and health situated within social relations; the body is seen an amalgamation of self and social relations and the environment. In sum, anthropologists and popular culture have established the interrelationship between political regimes of control and surveillance and bodily autonomy and subjectivities which are affected by economic and gender inequalities (Farquhar and Lock 2007). Moreover, embodiment has become a site of interest for medical anthropologists to critique discord in the formation of political regimes and the proliferation of various forms of inequities based on the compression of bodily autonomy and dissemination of health care services and/or quality of care (Scheper-Hughes and Lock 1987; Farquhar and Lock 2007; Coovadia et al. 2009; Marias 2011; Delobelle 2013). The compression of autonomy and inadequate health provision has been assessed in the apartheid regimes inability to curb the burdens of disease caused by the migrant labour system like TB and HIV/AIDS, forced removals into ‘homelands’, and gaps in health care workers in segregated areas (Coovadia et al. 2009; Marias 2011; Van Rensburg et al. 2012; Delobelle 2013).

The apartheid state aligned with other transnational corporations and governments enforced neoliberal globalisation whose economic policies threatened social welfare prioritisation efforts established decades prior (Marias 2011:110-111). Paul Farmer’s (1999:40-41) structural violence may appropriately suggest that forms of governance, economic policies and discrimination can restrict people’s agency, rights and voices in ways that are inseparable from the physicality of existing and body politic under South Africa’s democracy (Scheper-Hughes and Lock 1987; Farquhar and Lock 2007). Due to the specificity of political, cultural and economic context, bodies are constantly structured in connection to the “powers of built worlds over and within the bodies that live in them” (Farquhar and Lock 2007:11). That is to say that anthropologists must have an awareness of the logics of medicine and sociology for addressing how health systems “have their own geologies and a

linked array of powers that loop back into reality” (Farquhar and Lock 2007:11-12). In association with this rationale of order, health systems’ bureaucratic structures and organisational culture have norms and values with standardised health care procedures and provider-patient relations (WHO 2008; Van Rensburg et al. 2012; Delobelle 2013). ‘Bodies’ under South Africa’s apartheid regime was ordered and controlled within the broader sense of health whereby state policies were inextricably linked to the causality of disease and maintenance of ill-health patterns for African, coloured and Asian populations (Bond 2000; Jochelson 2001; Coovadia et al. 2009; Marais 2011; Delobelle 2013). Under Scheper-Hughes and Lock (1987) and Farquhar and Lock’s (2007) conceptualisation, ‘the body’ moves away from this prior Cartesian dualism where the mind and body are separated from experiencing illness, and instead prompt anthropologists to think about the influence of social relations in our analyses of health systems, health outcomes and trends.

### *Restructuring the world economy*

During the 1970s, “powerhouse” countries like the United Kingdom (UK) and the United States of America (USA) aimed to halt economic instability through the establishment of macroeconomic policies under a neoliberal framework (Marais 2011). Industrialised countries aimed to shift social development schemes from a welfarist approach to “monetarist austerity” (Bond 2000; Marais 2011; Price 1989, cited in Delobelle 2013). During the 1980s, the geopolitical divisions of the Cold War enabled ‘developing’ nations to pursue “alternative development models” (Bond 2000; Marais 2011). Wendy Larner (2006:199-200) argues that neoliberalism is a prominent political ideology that seeks to transform governmentality and “welfare state restructuring”. Neoliberalism is an alternative to Keynesian welfarism by “infusing public funds to rehabilitate and expand infrastructure, and extend the public works programme” and distributing goods and services nationally (Larner 2006:199-201; Marais 2011:98-101, 148). This is better understood through Hein Marias’s (2011:110) definition of neoliberal globalisation which stated that the free-market economy required state intervention by introducing economic and social adjustment programmes (SAPS) (Van Rensburg et al. 2012:47). The International Monetary Fund (IMF), World Bank, and international donors enforced oppressive financial sanctions against burgeoning transitions to democracy in South Africa and other ‘developing’ countries resulting in a Third World debt crisis (Bond, 2000:157-158; Marais 2011:65-79). In 1982, the IMF and World Bank loan conditions as well as the apartheid government’s rigid monetary policy and rapid interest rates resulted in imposing the “fiscal burden onto the poor by increasing indirect taxation...To lower living

standards” (Marais 2011:85). Although South Africa repaid its loan to the IMF within five years, the country’s ratio of foreign debt to Gross Domestic Profit (GDP) was relatively low by international standards (Marais 2011:89). And so, negligible monetary policies and welfare protection led to deeper inequalities in social infrastructure (Marais 2011:85-86). By the mid-1980s, international boycotts and sanctions against apartheid deepened while the African National Congress (ANC) gained support from many Western countries (Marais 2011:65). The mounting global economic recession and neoliberal adjustment programs catalysed the NP government to remove state subsidies in African areas (Marais 2011:44-45). The municipal privatisation of health services resulted in an increased demand from Africans to pay for medical aid schemes due to worsening public sector facilities as well as the disparate resource distribution between racial, and ethnic groups, and socio-economic groups provincially (Bond 2000:105; McIntyre and Gilson 2002, cited Delobelle 2013:179).

The White Paper on the Report of the Commission – also known as the Browne Report – supported the creation of a national health policy to prioritise PHC services, and the “privatisation and deregulation of health care services, which the government could no longer afford because of spiralling costs” (Delobelle 2013:178). Privatisation and fiscal austerity (fiscal conservatism) meant that the “industrial powerhouses” tightened control over intellectual property and removed barriers to exports and capital (Bond 2000; Marais 2011). Therefore, neoliberalism acted as a form of governmentality and intellectual and political was introduced to reduce social welfare policies through privatisation and highlighted the maximisation of productivity and capital in the world market economy (Larner 2006:199-201). Although there was a recognition for the need for some sort of social safety nets – mostly to prevent mobilisation against social and political protests – SAPs included spending cuts in public expenditure like medical staff and essential health services (Bond 2000; Marais 2011; Van Rensburg et al. 2012:47). SAPs aimed to strengthen efficiency and cost effectiveness in service delivery, however the minimisation of social development led to a reduction of responsibility for the central government during the debt crisis (Bond 2000; Marais 2011; Van Rensburg et al. 2012). For example, in the 42 poorest countries in Africa, public expenditure on health care reduced by 50% during the 1980s resulting in a decline in the public health sector – closure of hospitals, clinics and medical facilities, expulsion of health practitioners and shortages of essential medical supplies (Van Rensburg et al. 2012:47). The previous health care model distributed low cost but albeit unequal health services for racial groups but was shattered and replaced with user-fees (Marais 2011; Van

Rensburg et al. 2012; Delobelle 2013). Therefore, any semblance of equality within divisive Southern African countries that saw marginalised populations accessing PHC was disrupted through opting out of the universal health coverage (UHC) initiative (WHO 1978; Bond 2000; Harrison 2004; WHO 2007; Marais 2011; Van Rensburg et al. 2012; Delobelle 2013; Cooper and Szreter 2021).

## Discussion

Research regarding how socioeconomic and environmental factors coalesce to influence the mapping of diseases. Structural violence enacts hardship onto the mapping of minimised opportunities for growth and constrains the potential for development out of situations that produce poverty and inequalities (Farmer 2013:5). Further, structural violence produces and maintains injustice and accompanies psychological, moral and/or economic factors (Farmer 2013). Farmer (1999, 2013) interprets this as generating “historically given (and often economically driven) processes and forces conspire to constrain individual agency” which, in the context of HIV/AIDS and other major diseases, assesses the political economy of risk. Additionally, health policies, programmes and interventions as well as the physical manifestation of structural violence as racism, and poverty and the political economy of risk (Farmer 1999, 2013) becomes vehicles for health disparities. Exclusionary and discriminatory policies and legislation had a powerful hand to play in health outcomes across South Africa. Future research can be formulated to discuss the intricacies of these policies and how governance and international diplomacy over health influences the degree to which health interventions and programmes can succeed. The potentiality for interventions to be successful is based on a multitude of factors, much more than a silver bullet solution can offer. However, research should be conducted with universal health care in mind and how the legacy of such aims continues to inform health interventions presently. Health preservation and disease prevention should align with global indicators to safeguard the general population from serious harm. Researchers should evaluate how health determinants and the total environment from the natural and built environment (rural, urban, and suburban areas, landscapes, infrastructure, transportation, urban planning and urbanisation) (Adebusoye et al. 2020) as well as structural violence (poverty and inequalities) (Farmer 1999, 2013) have the potential to either negatively or positively affect health outcomes and trends.

## **Chapter Five: The ANC ‘catching up’ to the rest of the world**

The new democratic government, the ANC, attempted to maintain a serious footing in the world economy. In the 1990s, the ANC asserted their commitment to the *Freedom Charter’s* (1955) redistributive principles by enacting liberal economic policy reforms (Marais 2011:99). The *Freedom Charter* (1955) declared that liberty shall be bestowed to all people by pledging preventive health schemes assuring free medical care (UN 1979). The Department of Economic Policy (DEP) published the Congress of South African Trade Unions’ (COSATU) ‘Discussion Document on Economic Policy’ outlining radical restructuring of the financial sector by raising corporate taxes to meet basic needs (Bond 2000:55; ANC Department of Economic Policy 1990, cited in Marais 2011:99). In 1991, the Development Bank of Southern Africa (DBSA) condemned the “growth through redistribution” approach launched by the socialist ANC as it would presumably lead to severe inflation and currency devaluations (Bond 2000; Marais 2011). Additionally, Marais (2011:99-100) argued that mainstream economists warned against this new economic order as the ANC had limited experience with economic literacy in neoliberalism as exercised by global superpowers. Corporate scenario planners utterly rejected redistribution under Nedcor/Old Mutual’s *Prospects for a Successful Transition* (1990-1993), the South African Chamber of Business’s (SACOB) ‘Economic Options for South Africa’, and Sanlam’s *Platform for Investment*, instead viewing welfare as an addition to economic policy and as the government’s primary objective (Bond 2000:59; Bond 1996, cited in Marais 2011:101-102). Thus, the central tenet found that “macroeconomic stringency, restraint in social restructuring” would prevail (Marais 2011). SACOB’s document proposed that these policy documents were dangerous for South Africa’s post-apartheid welfarist schemes and newfound social alliances. The prevalence of neoliberal policies with its transformed international economic ideology as well the demands of the new democratic state challenged the ANC’s leadership capacities. Suggestions from the World Bank’s 1994 *Reducing Poverty in South Africa* concluded that while South Africa keeps an approach of “fiscal discipline” government should also invest in structural reforms to achieve universal access to health and improving quality of life (World Bank 1993:3-4; Marais 2011:102). Conversely, the IMF’s ‘Key Issues in the South African Economy’ urged to avoid ‘excessive’ government spending on areas of health and complementary infrastructure (Marais 2011:102). These conflicting suggestions trampled on the ANC’s socialist underpinnings found in the *Freedom Charter*

(1955) to minimise marginalisation caused by apartheid (UN 1979; World Bank 1993; Bond 2000; Marais 2011; Coovadia 1985, cited in Van Rensburg et al. 2012).

### The Reconstruction and Development Programme (RDP): an observation

The ANC's leadership capacities were tested as they needed to establish themselves as global players economically. In 1991, US Agency for International Development consultant, George Peterson focused on national economic growth and export-led development by suggesting a reallocation of government capital investment away from subsidies for public services (Bond 2000:168-170). Much to the dismay of citizens in many Third World countries, these public policy changes would effectively lower social wages and limit public financing of social services (Bond 2000). By 1994, the World Bank gained a foothold into the RDP Office which created a serious debate over the responsibilities and obligations of the central government to meet the social needs of the public (Bond 2000:168). In November 1994, the *White Paper on Reconstruction and Development Programme (RDP)* was introduced as an arrangement of macroeconomic policies to target growth-centred development strategies by ensuring cost-savings for South African citizens (RSA 1994:1-4). The World Bank (1994) promoted two key goals of the RDP namely improving equity and strengthening economic performance by redressing poverty; enhancing service delivery of urban services like water, housing, and transportation through "central fiscal transfers" to compensate for these inequities; investing in small and medium enterprises (SMEs); and investing in education and access to health care. In the early-1990s, the World Bank (1994) reported that less than 5% of the health budget would be spent on primary care due to the "fragmented levels of care and racially-based administrative mechanisms" which maintained uneven access and coverage of care.

Under globalisation, a free-market economy requires nations to play a central role in regulating the reproduction of capital alongside transnational companies, foreign investors and mineral exports, and other governments in industrial countries (Marais 2011:88-111). In 1982, the General Agreement on Tariffs and Trade (GATT) influenced the economy according to the IMF and World Bank's standards on fixing balance-of-payment for the poor via indirect taxation (RSA 1994:10; Marais 2011:84-87). During this period, personal tax burdens stood at an alarming 70% which prompted the Tax Commission to advise the Minister of Finance to facilitate a general tax based on international standards (RSA 1994:31). The *RDP White Paper* (1994) sought to offset these financial issues by redirecting

into a cost-benefit analysis for their social policies. Furthermore, this policy aimed to coordinate welfare services to deliver a “tailor-made social security net...existing welfare services and facilities should be enhanced, maintained and be made accessible to all” accompanied by the establishment of clinics in urban and rural areas and informal settlements (RSA 1994:27-47). The RDP aimed to encourage “people-driven culture” by empowering the public to participate in the provisioning and monitoring of health services, and assured that partnerships with civic organisations and other transnational corporations would come down to collective responsibility (Marais 2011:404; DoH 1996b; 1997; Harrison 1997; Ministry of Provincial Affairs & Constitutional Development 1998; Ngwenya & Friedman 1995; Owen 1995, cited in Van Rensburg & Engelbrecht 2012:153). The National Health System (NHS) aimed to encourage stakeholders for public and private health systems to organise pro-equity policies and programmes at all levels of care (Van Rensburg et al. 2012; Delobelle 2013). Additionally, the RDP was meant to construct goals for public and private sectors to target the TB and HIV/AIDS epidemics by concentrating on the most vulnerable members of society, and to strengthen the health budget (Van Rensburg & Engelbrecht 2012:124). Although these goals did not materialise, they served as an aspirational blueprint for future health system reform (Van Rensburg & Engelbrecht 2012:124-125). But the National Health Accounts (1996 to 1999) found stark contrasts in provincial funding and expenditure per capita (Coovadia et al. 2009; Baker 2010; Delobelle 2013). The National Health Accounts found that the vision for equality was disrupted due to the issues between the public-private mix and drainage of health professionals due to the maldistribution of staff and competency through the loss of training institutions, the geographical disparities of health professionals in the public sector and migration out of South Africa which affects the “equitable provision of health services” (Coovadia et al. 2009:830; Baker 2010:87; Delobelle 2013:183-184). To illustrate this point, health status, mortality and morbidity indicators from 1990 to 1995 show various data on the health outcomes for different racial groups during South Africa’s transition years in Appendix 1. For example, in 1993, this data shows considerably worse incidences of TB in every 100 000 for Coloured (712.5) and Black (206.6) groups. These selected indicators point to the fact that health outcomes were worse for Coloured and Black populations, and as such required a radical restructuring of the health system and/ or pooling of resources into affected groups. Moreover, the initial ideas of redistribution proposed by the ANC was undermined by the apartheid in health care that cemented a fragmented two-tiered health system from generations earlier (Marks and Andersson 1987; Coovadia et al. 2009; Marais 2011; Van Rensburg et al. 2012; Benatar and Vanrensburg 1995, cited in Delobelle 2013).

## The introduction of Growth, Employment and Redistribution (GEAR)

Neoliberal practices greatly influenced the trajectory of health systems planning by compromising reformation that was promised through the creation of the Growth, Employment and Redistribution (GEAR) (Marais 2011:176). GEAR was a macroeconomic strategy devised in 1996 by various mainstream economists who argued that centralising development would attract foreign investment—this arguably did not focus on redistribution as lamented in the RDP earlier (Coovadia et al. 2009:824; DoF 1996, cited in Van Rensburg & Engelbrecht 2012:131; Delobelle 2013:182). According to the Department of Finance’s Minister, Trevor Manuel (Department of Finance 1996, cited in Marais 2011), redistribution would manifest from job creation, focusing on public expenditure, and facilitating macroeconomic sustainability. For Marais (2011:113-114), this connection seemed implausible as GEAR centred on an obligation to reduce public sector debt and restraining budgets down to 3% of the GDP by the year 2000. GEAR reasoned that government spending “consumption” expenditure on services and wages was excessive and thus needed to decrease the overall deficit (the amount of money government borrows above what it receives in revenue) by half in 1999 (Bond 2000:78). Although the health sector was relatively reserved from budgetary cuts, the public-private mix of the health system resulted in the maintenance of pre-democratic inequity which alternated to class-based and income-based inequalities (van Niekerk 2003, cited in Delobelle 2013:182). According to Coovadia et al. (2009), the Gini coefficient is a measurement of income inequality that ranges from 0 (complete equality) to 1 (the maximum level of inequality). Efforts to increase the allocation of social grants did little to deter inequalities in the country – only rising to 0.8 when these grants were not accounted for partly because this decade was focused on GEAR activities i.e., growth and not redistribution (Coovadia et al. 2009). According to Hilary Cooper and Simon Szreter (2021:30-31), many of the world’s poorest countries suffered the fallout of major structural and sectoral adjustment loan repayments which degraded their previous free universal PHC systems during the 1980s. The IMF and the World Bank’s “market-oriented structural and sectoral adjustment loans” enforced a scheme wherein citizens would have to financially contribute to their health services (Marias 2011:110-111; Cooper and Szreter 2021:30-31). These loan repayments were estimated at "\$20 billion-plus apartheid foreign debt" which suggests that fiscal austerity would deepen class inequalities by tightening social safety nets (Marks and Andersson 1987; Bond 2000; Marias 2011).

Between 1989 to 1993, the economic recession resulted in large-scale disinvestment in South Africa which majorly constrained temporary welfare provision against social security like unemployment and nominal wage increases (Marais 2011). The changing economic tide and globalisation pressured the ANC government to ‘catch up’ to the world economy through “conservative” macroeconomic policies and formed the ideological foundation for policy packages (Marais 2011:108-111-114). Patrick Bond (2000:93-95) suggested that defences for GEAR stated that the decommodification and destratification or universalism of basic needs were fundamentally socialist ideals, but majorly ambitious (RSA 1994). Regarding the *RDP White Paper* (1994), Bond (2000) continued by saying that the RDP failed to effectively address socio-economic disadvantages caused by apartheid that resulted in an ‘over-dependence’ on social grants. GEAR intended to generate enough employment and create a trickle down of wealth to relieve the state of its responsibility in a welfarist state (Marais 2011:396). Acting as a catalyst for innovation and development, GEAR’s rationalisation sought to achieve a semblance of social democracy bountiful in opportunities (Marais 2011:396). However, these gains did not materialise (Marais 2011:396). Poor citizen’s reliance on social grants coupled with the challenging demands for social transformation via equitable quality of care would prove increasingly difficult for the ANC. Also, the condition of state infrastructure highlighted how racial and economic disparities from apartheid spilled over into health burdens in the following years.

#### The practicality of reformed health policies – the National Health Act (NHA)

The *White Paper for the Transformation of the Health Systems in South Africa* (1997) (Baker 2010:81; DoH 1997, cited in Van Rensburg & Engelbrecht 2012:125-132; Delobelle 2013:180) motivated the ANC to placate disjuncture in the inequitable distribution of health care. The *National Health Plan* (1994) proposed to fund a National Health Service (NHS) from general tax revenue for the fourteen separate health departments nationally, provincially and community/district level (ANC 1994; DoH 1997, cited in Van Rensburg & Engelbrecht 2012:125-494). This included training health personnel in the PHC model and fostering intersectoral relationships under a unified health system to provide maternal and childcare services and expand social welfare grants to curb the social determinants of health (Marais 2011; Kautzky and Tollman 2008, cited in Delobelle 2013; ANC 1994; DoH, cited in Van Rensburg & Engelbrecht 2012:125-132). To redress these inequalities, the ANC sought to launch the *National Health Plan* (1994) as a ‘socially progressive’ (RSA 2004b) framework

based on the PHC system which would integrate health services under the Ministry of Health (MoH) by:

decentralising the organisation and management of services through a well-coordinated district health system, and rendering comprehensive, community-based health care accessible to all by establishing PHC centres at the basis of the national health system (Delobelle 2013:180).

The district health system (DHS) includes all aspects of community life that affect health and thus requires extensive community and stakeholder involvement (private, traditional healers and social security) to meet health-related goals (Gilson, Balfour & Goosen 1997, cited in Van Rensburg et al. 2012). Decentralisation delegates responsibilities from the central government to its provinces through the transference of power and authority to integrate smaller, less bureaucratic and more sufficient units, and securing greater accountability from the ‘bottom up’ (Van Rensburg & Engelbrecht 2012:151-152). This is with the intentionality of enhancing health program performance under the PHC model (Van Rensburg & Engelbrecht 2012). Although decentralisation aims to entrench accountability and unification across provinces it also has notable negative attributes such as a lack of coordination between the different levels of care (DoH 1997; WHO 1998; Hall, Haynes & McCoy 2002; McCoy & Engelbrecht 1999; Nicholson 2001; Pillay, McCoy & Asia 2001, cited in Van Rensburg & Engelbrecht 2012:152). Thus, provoking divergent development resulting in differential working conditions and unequal pay across municipalities (DoH 1997; WHO 1998; Hall, Haynes & McCoy 2002; McCoy & Engelbrecht 1999; Nicholson 2001; Pillay, McCoy & Asia 2001, cited in Van Rensburg & Engelbrecht 2012:152).

During 1994, considerable disparities remained fixed in the public expenditure on health care across the nine provinces and among their respective districts from the legacy of poverty-related deprivation, and ineffective and/or insufficient vaccines for waterborne and other infectious disease epidemics maintained by segregated health services (Marais 2011; McIntyre 2011; Turshen 1986; de Beer 1986; Price 1986, cited in Delobelle 2013:174-179). In 1996, the Constitution established a “fiscal federal system” in the nine provincial health departments to allocate autonomy to these provinces to improve upon the distribution of health services, providers, resources, and institutions (McIntyre 2011; DoH 1997; RSA 2003, cited in Van Rensburg et al. 2012). Additionally, the public health sector reasoned to transfer resources from tertiary care towards PHC and community/district-based care from wealthier

provinces like the Western Cape (WC) to historically disadvantaged regions (Mbatsha and McIntyre 2001, cited in Delobelle 2013). For example, health sector data from the early-1990s showed that the best resourced province like the WC had health care spending estimates 4.5 times greater than the least resourced province (Mcintyre et al. 1995, cited in McIntyre 2011). Motivations for this shift reasoned that the creation of an equitable health care system should be relative to the health needs across the provinces as observed from several health trends and historical analyses (Delobelle 2013). Such specifications were inexplicably connected to the RDP's principles of redistribution that highlighted the urgency for universal basic welfare which the NHA aimed to systemically address (RSA 1994; Delobelle 2013). Alarming, the private-public funding imbalances and "piecemeal changes to medical scheme regulation" resulted in an estimated 13.8 million South Africans unable to qualify for social security as of 1996 (Desai 2003; Baker 2010). To fulfil the duties of the state, the National Health Act of 2003 (NHA) aimed to standardise provincial and municipal health comprising of private and public health care providers, under the guidance of the Minister of Health, Director-General (the head of the national department), and the Minister of Finance (RSA 2004b). Decades of segregated health care coordination and management was required to be replaced by sets of health policies, like the NHA, to integrate health services and the allocation of resources more equitably (McIntyre 2011; DoH 2003a, cited in Van Rensburg et al. 2012; Delobelle 2013).

### Disparate health outcomes persist post-apartheid

The intentional transformation of the post-apartheid health system toward redistribution required a realistic look into how allocation and coordination between provinces (World Bank 1994; Bond 2000; RSA 2003; Coovadia et al. 2009; Baker 2010; McIntyre 2011; Marais 2011; Van Rensburg et al. 2012; Delobelle 2013). According to Harriss (2007, cited in Marais 2011:207), poverty is the division between processes of capital, resources and other forms of material accumulation and the distribution of wealth which depoliticises this social process. In these analyses of poverty, power and privilege, ascertain that the accumulation and distribution of wealth and resources is a relational process where inequality is present (Marais 2011). Under a capitalist system in South Africa, various forms of race-based and class inequality have been attributed to a moral and political issue according to systemic trends (Marais 2011; Delobelle 2013). According to the United Nations Development Programme (UNDP) (2003, cited in Marais 2011:204), the number of South Africans surviving on less than USD 1 per day doubled between 1995 to 2002, from 9.4% to 19.5%; for Statistics SA,

from the mid-1990s to 2001 showed an average annual household income and expenditure decrease from R51 000 (USD 6 380) to R45 000 (USD 5 630) and R51 000 to R40 000 (USD 5 000) respectively (Statistics SA 2002, cited in Marais 2011:204). This decline was due to a decrease in income and spending of mostly African households; Africans became poorer in the years immediately following the end of apartheid (most of these decreases were a result of massive job insecurity and job losses (Statistics SA 2002, cited in Marais 2011:204). Other social issues included access to health care and the provision of water, sanitation which showed improvements since 1994, especially for urban and peri-urban residents (Marais 2011:212). In 2008, South Africa's GDP toward health care was 8.7% which was lower than Sweden's 8.9%, but South Africa's health status indicators were far worse than most other middle-income countries (McIntyre et al. 2007; World Bank 2008, cited in Marais 2011:310). In effect, this data suggests that South Africa's legacy of racial and spatial apartheid has an extensive effect on the desired health outcomes for the new government and reflects legacies of unhealthy living and working conditions and superficial or inaccessible health care (Marais 2011; Delobelle 2013).

The distorted patterns of health spending and resource distribution within the two-tiered health system (private and public) impact the social determinants of health (Coovadia et al. 2009; Marais 2011:310). The split between public health care spending and private constitutes an approximate 60% of the health care funds paying for the health care of 7 million people (between 14 to 16%) who are typically a minority, but wealthier demographic, and who belong to private medical aid schemes in well-resourced for-profit facilities (Statistics SA 2008, cited in Marais 2011). Marais (2011:311) stated that, in general, income determines the differential access to and quality of health services in the public sector; the private sector operates independently from the public sector as an "exclusivist" system (Kautzky & Tollman 2008, cited in Van Rensburg et al. 2012:89-164). So, the proportion of government expenditure on public health lowered between 2000/2001 and 2007/2008 from 11.5% to 10.9% while the budget share of economic services and social security and welfare services rose rapidly (Marais 2011:312). According to McIntyre and Thiede (2007, cited in Marais 2011:312), public sector health care expenditure has become dormant for per capita standards, despite dramatic demands on public sector services due to the dual burden of TB and the HIV/AIDS epidemic (Delobelle 2013:189). By 2009, South Africa experienced modest but consistent economic and infrastructural growth with local government planning systems focused on expanding health care and other access to social services (Gwagwa &

Everatt 2005, cited in Marais 2011:212). Improvements in access and utilisation of social services shown in official statistics found that at least 1 600 health care clinics were constructed, half of the 400 public hospitals were refurbished, and childhood immunisation rates reflected at 80% full immunisation before one year (Bradshaw et al. 2008, cited in Marais 2011:212). Although these improvements suggest that public health policies were moving in the right direction to promote and protect citizens' access to health there were still many issues (Marais 2011). Studies in public health concluded that GEAR's policies obstructed "institutional capacities to manage, monitor and sustain boosted service delivery" exacerbated by the limited infrastructure spending (Schneider, Barron & Fonn 2007; IDASA 2009, cited in Marais 2011:214). For these reasons, the interruption of local government service-delivery was mainly due to outdated tools and systems that led to stagnated infrastructure and delays (Schneider, Barron & Fonn 2007; IDASA 2009, cited in Marais 2011:214).

As mentioned previously, fiscal austerity (fiscal conservatism) largely contributed to target-driven programmes over quality or outcomes-driven public service provision (Bond 2000; Roberts 2005, cited in Marais 2011; Price 1989, cited in Delobelle 2013). Quantity has tended to outweigh quality-based provisioning connecting to issues of maintenance and sustainability despite the paradox of continuously poor health outcomes notwithstanding "high health expenditure and many supportive policies" (Roberts 2005, cited in Marais 2011:214; Chopra et al. 2009, cited in Van Rensburg & Engelbrecht 2012:175). Cracks in the institutional capacity, resource allocation, and expenditure revealed themselves more starkly during the transition years. Efforts to mobilise inter-provincial coordination faced many challenges which worsened under the dual burden of the HIV/AIDS and TB epidemics that further devastated the South African health care system (Coovadia et al. 2009; Marais 2011; Delobelle 2013). Evidently, differential quality and access to treatments, services and resources tested the President Thabo Mbeki's administration in their leadership capabilities and exposed vulnerabilities that were brimming on the surface.

## **Chapter Six: Mbeki administration – the AIDS scandals**

### **The co-epidemic of HIV/AIDS and TB**

The Thabo Mbeki administration became embroiled in medical controversies during the 1990s and early-2000s. The South African health system still contended with rising morbidity and mortality rates related to TB and HIV/AIDS co-infection (Baker 2010; Marais 2011; Heunis, Wouters & Kigozi 2012; Delobelle 2013). Co-infection primarily contributed to shaping future social and economic security development and health trends due to the extensiveness of TB and HIV/AIDS treatment programs (WHO 1998, cited in Van Rensburg et al. 2012). Regional differences between HIV/AIDS infection rates illuminated the widening development and financial gaps between rich and poor countries, especially for Southern African countries (UNAIDS & WHO 2010, cited in Van Rensburg et al. 2012:294-295). For instance, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the WHO (2008, cited in Delobelle 2013:189) estimated 5.7 million people were living with HIV in South Africa – the highest figures in sub-Saharan Africa at the time. AIDS-related illnesses stood at 43% of all deaths for “economically productive population[s]” with 250 000 people dying of AIDS in 2009 (Statistics SA 2009, cited in Marais 2011:262; Statistics SA 2010, cited in Delobelle 2013:189). Staggeringly, an estimated 1.5 million adults and 106 000 children needed antiretroviral (ARV) treatment to manage high rates of drug resistance and the intensification of TB (Statistics SA 2009, cited in Marais 2011:262-264). Health sector criticism calcified under decades of limited education and the reduction of postgraduate medical training institutions (Coovadia et al. 2009:831; Benatar 2004, cited in Delobelle 2013:183).

### **The moral and racial components of discrimination toward HIV-infected populations**

The pathologisation of Africans and homosexuals living with HIV/AIDS have been deeply influenced by colonial metaphors of social and moral decay (Vaughan 1991, cited in Jochelson 2001:5-24; Marais 2011:287-299; Heunis, Wouters & Kigozi 2012:296-318). As Chapter 4 explains, early-twentieth-century medical discourses were embedded with racial and anthropological justifications for segregation based on culture and biology (Vaughan 1991, cited in Jochelson 2001:6-136). While HIV/AIDS affects all demographics, this moral argument was once again being wielded over Africans and homosexuals more than others which was reminiscent of colonial depictions (Jochelson 2001). Apartheid-era health policies reasoned that race and sexual orientation entwined for the proliferation of HIV by arguing

that it was a “black disease of immoral sexual behaviour” thereby referencing colonial moralistic discourses (Jochelson 2001; Van Rensburg et al. 2012:297). For Clarke (2005, cited in Juhila, Raitakari & Hall 2017 :4-5), state expectations included a moralistic stance because it viewed citizen’s choices through acts of irresponsibility and responsible behaviours and values rather than anything related to “structural inequalities and a lack of opportunities”. What these moralistic and racist arguments, however, do not account for is the issue of structural violence as a barrier for equitable, fair and inclusionary distribution of resources, and as a contributor to continued political violence (Farmer 2003:40-43). Within the social production of disease theories, Farmer (1996) argues that the causality and systemic variations of the “pathogenic roles of social inequalities” provides critical perspectives about the relationship between emerging infectious diseases and bureaucratic responses to them. By primarily concentrating on ‘risk groups’ without foregrounding evaluations about the socio-historical context that influences behavioural choices, patterns and population health, modern epidemiology models may be limited by approaches that position the political economy of disease secondary to these evaluations (McMichael 1995, cited in Farmer 1996:261; Marais 2011:267-268). It has been argued that AIDS worsens under structural violence due to the reproduction of poverty and destitution (also lack of human resources for health), especially in rural areas (Farmer 1996, cited in Marais 2011:267-268; Shisana et al. 2004, cited in Delobelle 2013:190). Stronger national evidence pointed to the association between income inequality and HIV risk with poverty as a viable factor in the chain of causality which South African researchers showed as “the distribution of HIV does seem to closely mirror the spatial order established under apartheid” (Gillespie, Kadyala, Greener 2007, cited in Marais 2011:268-269). Although these trends highlight strong connections to poverty and disease, it should also be noted that HIV infection rates are not distributed in neat, linear patterns and dramatically differ provincially (Shisana et al. 2005, cited in Marais 2011:269-270). For example, adult HIV prevalence in 2005 showed that: 22-23% in Mpumalanga and KwaZulu-Natal; 16-19% in Gauteng, Free State, North West and Eastern Cape provinces; 9-11% in Limpopo and the Northern Cape; and 3% in the Western Cape (Shisana et al. 2005, cited in Marais 2011:269). Thus, the assumption that HIV/AIDS was a ‘black and homosexual’ disease does not accurately portray the severity of the disease, nor does it sympathise with all population-groups affected by the disease. Therefore, the development of stringent, proactive health frameworks should be utilised to mitigate the opportunistic nature of HIV/AIDS (Jochelson 2001; Marais 2011; Van Rensburg et al. 2012; Delobelle 2013).

## HIV/AIDS legislation during the President Thabo Mbeki years (1999 to 2009)

Between 1999 and 2009, HIV/AIDS policies were continuously adapted to combat the severity of the epidemic during President Thabo Mbeki's presidency (hereafter referred to as Mbeki). In good faith, "progressive health workers" and the Government of National Unity (GNU) planned to implement a *National AIDS Plan for South Africa* (NAP) once democracy was achieved in 1994 renaming it the *HIV/AIDS and STD Programme 1995-1996* (Marais 2011:277; DoH 1995; NACOSA 1994, cited in Heunis, Wouters & Kigozi 2012:311). Initially, AIDS was declared a Presidential Lead Project (PLP) and was given preference to funds to lessen the rising risks to human life (DoH 1995, cited in Heunis, Wouters & Kigozi 2012:311). But shortly after the succession of Mbeki in 1999, his administration faced major barriers as interrelated social, developmental and political issues progressed (Van Rensburg et al. 2012:311-312). The Mbeki administration inherited two interconnected structural constraints that diminished potential comprehensive AIDS strategies: the fragmented government-civil society relations, and the existing discontinuity between policymaking and policy implementation (Van Rensburg et al. 2012:311). After taking office, Mbeki ordered the construction of the *HIV/AIDS and STD Strategic Plan for South Africa 2000-2005* (hereafter *Strategic Plan*) along with the South African AIDS Council (SANAC) - with representatives from government and civil society (Heunis, Wouters & Kigozi 2012:314). According to Heunis, Wouters & Kigozi (2012, cited in Van Rensburg et al. 2012), South Africa developed one of the most comprehensive AIDS policies and legislative documents globally but also faced inconsistencies between governments' statements versus their actions.

During Mbeki's term, Health Minister Nkosazana Dlamini-Zuma was accused by "progressive" health workers of delaying action on HIV/AIDS by refusing to provide anti-viral drugs (ARVs) for pregnant women; admonished for hospital budget cuts before the materialisation of new clinics; and de-emphasising community health workers (CHWs) (Bond 2000:220; Marais 2011:277). The Mbeki administration clearly illustrated a disconnect between policy statements and their inaction regarding the provision of lifesaving treatment (Youde 2007; Marais 2011; Van Rensburg et al. 2012; Delobelle 2013). Following the *Strategic Plan*, the government devised the Comprehensive HIV and AIDS Care and Treatment Programme (hereafter the *Comprehensive Plan*) of 2003, to provide the equitable distribution of ARVs to local municipalities within a five-year period (Heunis, Wouters & Kigozi 2012:315). The *Comprehensive Plan* outlined resources, training, and the procurement of medicine at the lowest available prices district-wide for hospitals and health centres (DoH

2003b:3). In 2000/1, the budget for HIV/AIDS increased from R213 million to R1 439 billion in 2004/5 with the share of the total funding for care rising from 6.6% to 59.3% respectively (Heunis, Wouters & Kigozi 2012). Lastly, the *HIV & AIDS and STI National Strategic Plan on AIDS 2007-2011* (hereafter *NSP 2007-2011*) aimed to guide collaborative networks with multisectoral and civil society partners by focusing on prevention, treatment and counselling support for HIV-infected people, research and surveillance in medical and scientific knowledge for the assessment on national strategy, and human rights agenda for social justice and non-discrimination (SANAC 2007:7; Van Rensburg et al. 2012). This shift in policy also focused on reviving and restructuring the South African National AIDS Council (SANAC) as a key stakeholder in these collaborative networks (Van Rensburg et al. 2012:315). Thus, the journey to enact efficient and comprehensive HIV/AIDS policy was deeply unsettling due to contradictory messaging by the Mbeki administration and the MoH.

#### Framing “counter-epistemic” discourses under AIDS denialism

By the mid-2000s, Mbeki and his constituents, like Health Minister Mantombazana “Manto” Tshabalala-Msimang, were accused of medical negligence due to their callous stances on the severity of the HIV/AIDS epidemic in South Africa (Bond 2000; Youde 2007; Marais 2011; Van Rensburg et al. 2012; Delobelle 2013). TB and HIV/AIDS interconnected with histories of dispossession and dislocation coupled with the enduring fragmentary health system (Marais 2011:264). However, when presented with globally recognised evidence directing local public health officials and central government to the efficacy of ARVs, these revelations were met with denialist attitudes by the “counter-epistemic community” (Youde 2007:108-115). Both members of the epistemic community and counter-epistemic community consisted of credible and respected scientists whose expertise in public health included credentials from high profile tertiary institutions with published journals on non-AIDS-related scientific subjects (Youde 2007:108-109). It should be acknowledged that the counter-epistemic community did not fall into the same category as AIDS conspiracy theorists who believed the disease formed part of biological warfare conducted by figures like Henry Kissinger and Nelson Rockefeller who targeted “undesirables” in the 1960s to 1970s (Youde 2007:108-109). Mbeki’s government responded to the HIV/AIDS epidemic with dismissals of its severity “marked by denialism, ineptitude, obtuseness and deliberate efforts to undermine scientific evidence as the basis for action” (Cameron 2003, cited in Youde 2007:113-115; Karim et al. 2009, cited in Marias 2011:264). During the 1990s, Mbeki’s government was pressured to account for the provision of AZT to HIV-pregnant women, and

so, he sought the guidance of notable AIDS dissidents like Peter Duesberg and David Rasnick among others (Youde 2007:103-110). According to Youde (2007:109-121), Mbeki's motivations for AIDS dissidence lay in the "African Renaissance-inspired identity" which encouraged the development of African solutions for African problems. The counter-epistemic community advocated for locally produced solutions by challenging Western pharmaceutical companies' intentions to distribute ARVs in Africa (Youde 2007:109). AIDS dissidents proposed that scientific knowledge about AIDS from outside of Africa could not be neatly applied to an African context and questioned the reliability of Western-based tests (Youde 2007:111). Allegedly, early investigations debating the efficacy of AZT prompted Mbeki to consult with known AIDS- dissident Anthony Brink, which sparked the inclusion of dissidents on Mbeki's Presidential AIDS Advisory Panel (PACHA) (Youde 2007:110). PACHA aimed to evaluate expert opinion on the accuracy of HIV tests, the coalescence of poverty and malnutrition on AIDS, the connection between AIDS, TB and malaria epidemics, and the relationship between HIV and AIDS (Youde 2007:110). The report would provide a local scientific consensus to inform the appropriate response to the epidemic (Youde 2007:110). However, the Panel's discussions remained inconclusive regarding policy recommendations, although they did agree to gather more and better data on AIDS (Youde 2007:111).

Mandisa Mbali, historian of medicine and anthropologist specialising in HIV/AIDS policy and research, explicitly argues that government denialism incorporates and relies upon past racist public health policies and "caricatured notions of African sexuality" to forward its dissident beliefs (Youde 2007:114; Mbali 2013). By the mid-2000s, the AIDS epidemic was categorised as a "hyper-epidemic" and claimed the lives of an approximate 330 000 preventable deaths between 2000 and 2005, due to failure of introducing ARV's early (Chigwedere et al. 2008, cited in Marais 2011:220-281). By using Gilson and McIntyre's "South African Living Standards and Development Survey" (1993), Baker (2010) argued that health inequities persisted for 'previously disadvantaged groups' due to the higher proportion of medical need, yet received less health care also known as the "inverse care law" (Hart 1971, cited in Baker 2010:84). The "inverse care law" is defined as the availability of what is classified as "good medical care" that varies disproportionately to the rate of mortality and sickness in the population, thus services do not match the scale of need (Hart 1971:411). The AIDS epidemic is enmeshed within circuits of power, opportunity and entitlements that remain consistently unequal as represented in mortality and morbidity rates (Marais 2005,

cited in Marais 2011:276). The momentum of the epidemic reproduced deprivation, need and “layered inequalities, truncated capacities and excessive responsibilities” (Marais 2011:276). Yet, the language employed by government officials regarding AIDS denialism emanated from “an obsession with the colonial and late apartheid era discourses on race, sex, and disease in Africa, and this obsession encouraged the new ANC government to deny the extent of the country’s AIDS epidemic (Mbali 2004, cited in Youde 2007:114).

Defenders of denialist attitudes within the ANC positioned their views on ARVs as a continuation of dehumanisation suffered by Africans (Youde 2007). Citing that pharmaceutical companies were profiting from the continent’s resources through extractive processes, dissidents implied that they were the “protectors of the democratic system for challenging the authorities and sticking up for the oppressed” (Jones 2005, cited in Youde 2007:114-116). The discourse around dissidence prompted political science scholars like Krista Johnson (2005, cited in Youde 2007:115) to question the language of denialism as it assumes that political leaders were unwilling to be educated about the realities of the epidemic or just ignorant. So, Youde (2007:115) supposed that Mbeki’s framing of the epidemic was socioeconomically inspired rather than biomedically signified in his restructuring of the South African economy. This reasoning argued that this approach would alleviate much of the poverty and maldistribution of the former leadership (Youde 2007). From this economic perspective, it is assumed that economic growth would minimise the cycle of poverty that perpetuates illness by providing greater equity and social justice reformation (Youde 2007:115). Additionally, Sitze’s (2004, cited in Youde's 2007:115) argument pointedly accuses Western countries of deflecting from their position in the distribution and development of ARVs by accusing the Mbeki administration of denialism in a bid to “absolve” themselves from their authority. Diverging analyses and ideologies regarding the intentions of denialist “counter-epistemic” stances as well as globally acknowledged AIDS discourse all highlight South Africa’s issue with affordability and accessibility of life-saving drugs (Youde 2007:115). The amplification of “counter-epistemic” discourses, is suggestive of an endorsement of claims to protect the nature of democracy by protecting the liberty of “oppressed” citizens who are misled, dehumanised or marginalised under large government interventions in health (Youde 2007:116). Democratic governance and its strategies render visible the complex costs and rationalities that govern through freedom under “technocratic rationality” under a decentralised system (Rose, O’Malley & Valverde 2006:92; Hickey & Mohan 2003; Pieterse 2003, cited in Marais 2011:353-354;

Schnieder & Barron 2008, cited in Van Rensburg et al. 2012). This presupposes that the capabilities of “good governance” and its links to development in the case of South Africa, is tested under the lived reality of its technological and ideological programs (Marais 2011:353).

Dissidents prided themselves on challenging “hegemonic” narratives within a democratic state by utilising the notion of “truth” as a provocation to health officials to speak honestly to their citizens (Youde 2007:116). Regarding Antonio Gramsci’s (1971) concept of “hegemony”, Jonathan Joseph’s (2014:2-3) proceeds to define its inherent processes of power and domination within capitalist societies wherein social leadership is constructed. Within Joseph’s (2014:2-12) assessment of neo-Gramscian theory, hegemonic processes penetrate the world’s economic and social structure and their interrelationship in global governance. Other political science applications of hegemony refer to an emphasis on consensus or consent over coercion connected to an exertion of power – of political and ideological means – that is cultivated and “imposed on social life by the dominant fundamental class” (Gramsci 1971; Eagleton 1994, cited in Marais 2011:391). Ultimately, hegemony has been applied as a lens for thinking about the complex and malleable relationship between government and societal groups as a legitimisation of an ideology or worldview that is diffused into the public’s lives (Bottomore 1983, cited in Marais 2011:391). So, the crux of this philosophy contends that capitalism and capitalist states produce and reproduce “ideological state apparatuses” to invalidate or counteract opposing ideas, traditions and practices (Althusser 1977, cited in Rose, O’Malley & Valverde 2006:85; Marais 2011:391). Additionally, hegemony under Joseph’s (2016:4) neo-Gramscian thought considers the lens that hegemony provides to understand how “social agents are stratified across a number of social layers... groups of agents act through the state in order to implement certain policies”. This complex relationship cannot reduce the role of either government or civil groups or agents as merely exercising agency through each other but as interacting through specific social and historical contexts (Joseph 2014:4). So, this interrelationship argues that hegemony explains how state actions are emergent social features which are dependent on the agency of social groups but are not reducible to these actions themselves (Joseph 2016:4). Admittedly, Rasnick (2001, cited in Youde 2007:116-117) stated that the AIDS debacle highlighted the requirement of democracies to be receptive to scepticism of institutions to prevent them from becoming “autonomous, authoritarian regimes”. For Mbeki and AIDS dissidents, the democratisation of science argues for the inclusion of “alternative viewpoints” of its aetiology by supporting

“anti-establishment” talking points from members like Duesberg (Guccione 1993; Cohen 1994, cited in Youde 2007:116-117). Such “anti-establishment” rhetoric is lauded as “revolutionary” by its members for its heretical approach toward “medical establishment” and by resisting or defying “official scientific knowledge” (Guccione 1993, cited in Youde 2007:117; Schneider and Fassin 2003, cited in Marais 2011:412). Following their aim to confront “international pharmaceutical companies that want to bleed Africa dry. The pro-drug scientists...are really elitists and anti-poor”, the counter-epistemic community with Mbeki’s support, invokes the imagery of participatory democracy – emphasising an empowered identity within policy processes (Schneider 2002, cited in Youde 2007:117-120). But as Mbali (2013:2-5) contends, Mbeki’s denial of “basic science” of the efficacy of ARVs should be considered a human rights violation against the new Constitution (1996) that “enshrined the socioeconomic right to access to health care” and non-discrimination. Fundamentally, questioning the validity of public health policies and science itself should not be inspire negative connotations, yet when these discourses are not supported by peer-reviewed tests, opinions and hypotheses, they cannot be taken seriously as legitimate. More so, claims that are embedded with colonial or racist undertones finalised its own illegitimacy within the global scientific community (Jochelson 2001; Youde 2007; Marais 2011). Therefore, “counter-epistemic” discourse against prominent HIV/AIDS research arguably slowed down action toward the distribution of ARVs and other actionable treatment options (Foucault 1980, 1987, 1991; Vaughan 1991, cited in Jochelson 2001; Youde 2007; Marais 2011; Van Rensburg et al. 2012; Delobelle 2013).

### A brief encounter with bioethics during the AIDS epidemic in South Africa

During the Mbeki administration, a heated civil suit ensued between HIV/AIDS activists and the government over access to treatment like ARVs. This ideological and ethical dispute signalled a challenge to democracy and the bioethical relationship between the public and government (Youde 2007; Marais 2011; Delobelle 2013; Ferber 2013; Scher & Kozłowska 2018). During the twentieth century, modern health care ethics emerged to establish bioethics as a new field (Ferber 2013; Scher & Kozłowska 2018). Derived from Western moral and political philosophy, bioethics entangled the biological sciences with the goal of improving quality of life (Ferber 2013:1; Rawls 1971, cited in Scher & Kozłowska 2018:37). The Universal Declaration on Bioethics and Human Rights, adopted by the United Nations Educational, Scientific and Cultural Organization (UNESCO) in 2005, endorsed the principles that govern dignity, human rights and fundamental freedoms, and broader social

domains of bioethics like solidarity and cooperation (Article 13) and social responsibility and health (Article 14) (UNESCO 2006:2; Scher & Kozłowska 2018:40-41). The definitions of bioethics have been disputed; however, this thesis will refer to “cultural bioethics” - the historical, political, ideological, cultural and social context that grounds bioethics in public policy (Ferber 2013:3-9). The following paragraphs will speak to transnational activism and solidarity linkages between HIV-infected individuals and other civic organisations who mobilised to support the development and distribution of life-saving medicines in the early-to-mid 2000s (Marais 2011; Delobelle 2013; Mbali 2013; Mbali 2020). Transnational activism refers to individuals or groups who mobilise their local and international resources and opportunities to promote civic claims or on behalf of an organisation or agent (Tarrow 2005, cited in Mbali 2013:9). The fight for the affordability and accessibility of these drugs are crucial to understand larger questions about bioethics in biomedical settings and the globalised world, and issues of the monopolisation of the pharmaceutical industry and threat to life (Marais 2011; Mbali 2013; Mbali 2020).

#### Transnational AIDS activism and the Treatment Action Campaign (TAC)

South Africa’s health system “collapse” is attributed to systemic issues related to the unequal distribution of wealth, opportunities and resources that persisted during the hyper-epidemic of HIV/AIDS (Whiteside 2008, cited in Marais 2011:293). Between 2000 and 2005, the *Strategic Plan* aimed to develop multisectoral action but stopped short due to AIDS dissidence by Mbeki and the Dr. Tshabalala-Msimang (the Minister of Health) (Youde 2007; Marais 2011; Heunis, Wouters & Kigozi 2012). Instead, the accessibility of lifesaving treatment like ARVs faced critical opposition because of “counter-epistemic” discourses and denialism (Youde 2007; Marais 2011). For instance, pricing acceleration for ARVs was compounded to R6 000 and R8 000 per year for each patient, with drug expenses equating to two-thirds of total costs (Youde 2007:109-121; Marais 2011:294). Generic versions of first-line ARVs (initial regimens) were widely used and materially cheaper than patented first-line ARVs, however, most second-line ARVs like nelfinavir, abacavir, saquinavir and lopinavir/ritonavir were still under patent and therefore extremely expensive to the average patient (Marais 2011:295-295; Mbali 2013:7). Mbali (2013:4-7) argues that transnational AIDS activism, led by the Treatment Action Campaign (TAC), aimed to formulate “moral legitimacy to the international HIV treatment access movement” by mobilising foreign alliances with science-based advocacy groups like the Médecins Sans Frontières (MSF), the Health Global Access Project (Health GAP) and Oxfam. Formed on 10 December 1998 in

Cape Town, South Africa, the TACs members (the working class, unemployed and township-based activists) lobbied against the state against the exorbitant pricing of and accessibility to ARVS and other generic AIDS drugs (Robins 2004:662-663; Mbali 2013:11). Social and political mobilisation relied on middle-class activists during the anti-apartheid struggles whose social capital and institutional links garnered resources to contest the states and other stakeholders' neoliberal policies which entrenched excessive drug pricing by companies like Pfizer (Ballard et al 2005; Habib 2005, cited in Marais 2011:451; Mbali 2013, cited in Mbali 2020:460). For example, in 2002, the TAC litigated against the MoH of South Africa to provide necessary ARVs to HIV-positive pregnant women for the prevention-of-mother-to-child transmission (PMTCT) (*Minister of Health v Treatment Action Campaign* 2002; Youde 2007; Mbali 2013; Van Rensburg et al. 2012; Mbali 2020). Furthermore, South African AIDS activists who lobbied for universal HIV treatment were granted greater support through international solidarity by arguing for the reduction of HIV drug pricing, especially in resource-poor areas (Marais 2011:452; Mbali 2013:4-7).

The “counter-epistemic” community reasoned that the ‘intentions’ of pharmaceutical companies were to uphold “hegemonic” technologies and ideologies (Schneider 2002; Farber 2006, cited in Youde 2007:117-118). They also claimed that these companies were planning to inject Africans with toxic drugs like nevirapine alongside other ARVs (Farber 2006, cited in Youde 2007). However, according to Marais (2011:221-222), a distinctive feature of neoliberalism places emphasis on altruism of the poor and community “resilience” to overcome adversity through empowered solidarity. In this way, state obligations and resources are directed away from welfare (i.e. HIV treatment) and places “the community” (HIV-infected individuals) in a redemptive role who must act responsibly within a market-governed context (Marais 2011:221-222). Nested within an economical and philosophical perspective, Amartya Sen (2001:18) asserts that for upward income and financial development to be maximised and for the reduction of poverty, the “capabilities” of individuals to lead ‘valuable’ and improved quality of lives is largely determined by public policy and the political economy (Marx 1844, cited in Sen 2003: 3-4; Mbali 2013:18). Within this framing, “self-reliance” focuses on ‘the poor’ as subjective agents capable of organising their “social power” through reciprocity, trust and voluntarism, and who are no longer beneficiaries of social provisioning (Friedmann 1992; Escobar 1995; Bayat 2000, cited in Marais 2011:222-223). The political moment post-1994, offered an opportunity for the democratic state to rectify some of the welfare and responsabilisation rhetoric lamented by

previous leaders. However, according to Mark Hunter's (2006, cited in Marais 2011:286) assessment of the connection between neoliberalism and the subsidisation of 'the poor', "social citizenship" or "biological citizenship" (Rabinow 1996, cited in Rose and Novas 2005; see also Rabinow 2007, cited in Gibbon and Novas 2007) has manifested into market citizenship (Giese et al. 2003, cited in Marais 2011:286-287). Market citizenship asserts that citizens become responsible for their own welfare alongside their physical and emotional demands pertaining to HIV/AIDS health care (Rabinow 1996; Rose 2001; Rose and Novas 2005; Hunter 2006; Hunter 2007; Orner 2006; Giese et al. 2003, cited in Marais 2011:286-287). The logics of "life strategies" generates into "biological responsibility" also known as the choices based on one's knowledge and beliefs that individuals make toward their health (Rapp 1999, cited in Rose 2001:19). Biosociality connects networks of solidarity which are shaped by human rights-based politics and commands control over medical and technical expertise (Rabinow 1996, cited in Rose 2001; Bradley 2021). Social and economic marginalisation like poverty and unemployment couples with historical structural inequities promptly exposed citizens to poor affordability of ARVs (Marais 2011:294). Therefore, AIDS dissidence was a powerful analytical move against "Western" scientific knowledge that clouded governments judgement around distributive health care (Youde 2007; Mbali 2013). As a result, "medical apartheid" was solidified into the social, economic and political spheres of South Africa (Youde 2007; Marais 2011; Van Rensburg et al. 2012; Mbali 2013).

#### Patient rights and transnational HIV/AIDS activist networks

The TAC attempted to destabilise global medical apartheid by opposing considerably high HIV/AIDS treatment costs (Marais 2011:295; Mbali 2013:6-7). Initial government response (prior to legislature like the *NSP 2007-2011*) provided an opportunity to redress aspects of health system inequities by distributing life-saving drugs (Marais 2011:295-297; Heunis, Wouters & Kigozi 2012:315; Delobelle 2013:179-181). The TAC denounced market-based delivery of biomedical products and services under neoliberalism; emphasising the 'right to health' and supporting global health justice and health equity as denoted by David Hunter and Angus J. Dawson (2011, cited in Mbali 2013:4-11). The "post-apartheid bureaucracy" pivoted from its socialist ideals toward reliance on "local private elites" by centralising transnational capital toward local accumulation of wealth (von Holdt and Murphy 2007; Von Holdt 2009; Evans 2007, cited in Marais 2011:347-352). This is suggestive of an ethos of modernity – sovereignty, empowerment and self-definition (von Holdt 2009, cited in Marais 2011:352). Rabinow's (1996, cited in Rose 2001) biosociality concept expands upon the

domain of medical access wherein the state brokers or purchases essential protections based on demands for scientific and medical criterion. So, exclusionary and inclusionary medical properties, technologies, diagnoses and legalities become enfolded into a larger political history of risk and economic entitlement (Rabinow 1996, cited in Rose 2001; see also Rabinow 1996, cited in Gibbon and Novas 2007).

During the early 2000s, South Africa's biotechnology industry remained underdeveloped compared to other multinational corporations which impacted the approval of biosimilar AIDS treatment (Mbali 2020:449-451). Yet, South Africa's pharmaceutical industry was advanced enough to produce generic AIDS drugs at an affordable rate, especially since they were eager to acquire market shares from their multinational competitors (Marais 2011:346). Firstly, biotechnology (biotech) refers to industries that develop genetic diagnostic tests and biologic drugs whose active ingredients are made of or derived from living organisms for products like vaccines, recombinant therapeutic proteins and monoclonal antibodies (Mbali 2020:449-465). The pharmaceutical industry and the capitalisation of "biotech enterprises" - industries for the development of products, technologies and diagnostic tools - formalised the politics of life sciences by managing technical and financial resources (Rabinow 1996, cited in Rose 2001:15). Secondly, biosimilars differ from generic small-molecular versions of already approved biological medicines because biosimilars entail longer programmes of clinical testing and regulatory approval to be sold feasibly and have the same procedure of action in treating diseases i.e. the biologic (Mbali 2020:459-455). Earlier, the government committed itself to international free trade agreements guaranteeing sustained and inflexible pharmaceutical patents (Mbali 2020:459). In 1995, South Africa joined the World Trade Organisation (WTO) which required members to sign up to the Trade-related Aspects of Intellectual Property Rights (TRIPS) Agreements (Mbali 2020:459). Former MoH Dlamini-Zuma introduced the *Medicines and Related Substances Amendment Control Act 90 of 1997* (hereafter the *Medicines Act*) as a new piece of pharmaceutical legislation aimed at restructuring the procurement and distribution of medicines as well as minimising the prices of medicines (President of the Republic of South Africa 1997:11-26; Marais 2011:277; Mbali 2020:459). The *Medicines Act* enacted the provision of free health care for pregnant women and children under the age of five years and generic substitutions that was approved by health activists and the ANC (President of the Republic of South Africa 1997:11-26; Marais 2011:277; Mbali 2020:459). MoH, Dlamini-Zuma, attempted to revise the national drug policy by endorsing a variety of affordable generic drugs to combat the "ethical" practices of

key pharmaceutical companies like Pfizer and Glaxo Wellcome (now GlaxoSmithKline or GSK) (Marais 2011:277-278; Mbali 2020:459). However, the Pharmaceutical Manufacturers' Association of South Africa (PMA) (representing all major multinational pharmaceutical businesses) appealed to the Pretoria High Court to suspend the passage of the *Medicines Act* (Marais 2011:277-278; Mbali 2020:459). According to Mbali (2020:459), the PMA disputed section 15c of *Medicines Act* which aimed to allow the:

parallel importation (importing brand-name drugs from places where they were cheaper), compulsory licencing (where pharmaceutical companies were forced to allow production of generic medicines) and the establishment of a pricing committee (President of the Republic of South Africa 1997:11-12).

Transnational AIDS-related activism formed against hegemonic pharmaceutical companies over the right to health (WHO 2007; Mbali 2013:2-16; Mbali 2020:455-460). Thus, these multinational pharmaceutical giants had (and continue to have) significant market monopoly on the generation and distribution of generic AIDS drugs and its patenting rights (Mbali 2013:16; Mbali 2020:449-455). The South African Health Products Regulatory Authority (SAHPRA), which acts as the country's drug regulatory authority, regulates the registration, supply and re-evaluation of essential and affordable medicines and generic substitutes (Van Rensburg et al. 2012:136; Mbali 2020:249-451). Sen (2003) argues that political economy models for economic development and public policy planning should also make assessments for the functioning and outcomes of quality of life and value-added to its citizens (Sen 2001; Marais 2011; Mbali 2013). However, this period presented a combination of the scars of apartheid ideological and experiential divisions characterised by self-dependency and hatred for civilian statuses of 'dependents' (Meth 2008, cited in Marais 2011:254-255). Instead, inconsistencies arose concerning South Africa's "nationalist morality" narrative that detested disability and debility (due to political economy concerns/fiscal austerity and the "African Renaissance") (Youde 2007; Molyneux 2008, cited in Marias 2011). "Co-responsibility" outlined that citizens would assume the risks and responsibilities over their education, employment and health while the market (through private interests) would be detached from expectations of welfare (Youde 2007:87-121; Molyneux 2008, cited in Marias 2011:125-278). The politics of biologics and intellectual property agreements and laws in South Africa authorises the granting of:

inflexible patents ensuring that multinational pharmaceutical companies have exclusive marketing rights, enabling them to operate monopolies and, therefore, artificially maintain high drug prices (Mbali 2020:453).

Transnational access-to-medicines networks reveal how ensnared global capitalism is in the socio-economic essence of biotech companies (Mbali 2020:455-465). Moreover, the pharmaceutical industries' stronghold over patenting rights and the development and distribution of biosimilars and generic essential medicines accelerates pricing and leads to worsened health effects from HIV/AIDS (Youde 2007; Marais 2011; Mbali 2013; Mbali 2020). After a highly contentious and publicised civil suit over the provision of free antiretroviral treatment (ART) in 2002, universal access to ART was actualised in the public health sector in 2004 under the guidance of the Operational Plan for Comprehensive HIV/AIDS Care, Management and Treatment (*Comprehensive Plan*) (DoH 2003, cited in Delobelle 2013:190; Heunis, Wouters & Kigozi 2012:315). Although the NSP scaled up ART programs after 2007, significant barriers have yet to be reduced such as a lack of horizontal integration of ART in district-based PHC facilities, limited comprehensive HIV/AIDS care related to psychosocial and economic advancement, severe human resources (HR) shortages and coverage differentials across provinces which leads to gaps in universal implementation (Wouters et al. 2011, cited in Delobelle 2013:191). The conflation of "dependency" on the state with irresponsibility on part of citizens instils a norm of social provisioning delinks the government's obligation to welfare which had disastrous on public trust and health figures (Youde 2007; Marais 2011; Van Rensburg et al. 2012; Mbali 2013). The legal battle for access to treatment required transnational social networks to mobilise against the systemic failures of local government and wider problems facing vulnerable and marginalised groups (Robins 2004; Youde 2007; Marais 2011; Mbali 2013; Mbali 2020). And finally, the AIDS disaster set the precedent for how democratic governance will handle contemporary and future epidemics while occupying the notion of saving lives and livelihoods if they are to remain viable world players.

## **Chapter Seven: Health System Strengthening (HSS) - looking to the future of governance in South Africa**

Individual experiences of illness are not divorced from larger socioeconomic circumstances within a country (Roth 2020). In Chapters 5 and 6, AIDS was described as a disease catastrophe which altered how policymakers and health experts governed their citizens. Anthropologists have noted a shift in public health rationalities and temporalities that shows how prevention methods facilitate the construction of epidemic preparedness (Lakoff 2017, cited in Roth 2020). Emergent infectious diseases summon epidemiologists to configure new knowledge as “preparedness policies” that constructs viruses as an enemy needing to be eradicated (Herrick 2019; King 2002, cited in Roth 2020). More recently, the world experienced the COVID-19 pandemic which tested the strength of global and local health systems. Chapter 7 details how South Africa’s history of violent oppression, inequitable distribution of health care and misguided and/or mismanaged public health systems responses have impacted the current state of health.

### **How the health system functions**

#### *The entanglements of bodies, technologies, and health*

Health system frameworks contextually-inform the prioritisation of financial planning, communication, and technologies to guide health policymakers and practitioners (Shroff, Marten and Hanson 2022:9-19). For over two decades, Health System Strengthening (HSS) has fundamentally altered the way ‘developing’ countries strategize “critical components of health systems to achieve more equitable and sustained improvements across health services and health outcomes” (WHO 2006, cited in Lyttleton 2018:328). Epidemics are “biosocial crises triggered by political, economic and socio-cultural processes which produce violence and inequality.” (Farmer 1999, cited in Roth 2020). Systemic violence like structural violence historically, economically and contextually constrains the agency and choices afforded to people who are affected by racism, sexism, political violence, and poverty (Farmer 2003:19-40). The impact of pathogenic flows and emerging infectious diseases have promoted global health authorities to formulate global health security with guidelines and standards to identify and contain outbreak responses (Rodier et al. 2007, cited in Lyttleton 2018:334). Globalisation accelerated the transmission of microbes across borders which intensified growing humanitarian crises and emphasised the role of post-Westphalian politics to align with international health regulations and to problematise non-intervention principles

from previous generations (Rosenberg 1992; Rosen 1993; WHO 1999; Institute of Medicine 2003, cited in Fidler 2004). Deriving from international relations scholars, Westphalian governance principles refer to the number and character of sovereign states' legal relations with one another (Fidler 2004:22). The Westphalian governance structure is defined by the interactions of two or more states and their interconnected elements which is determined by the nature of "anarchy" across the central structuring role that states dictate (Fidler 2004:22). Here, "anarchy" does not mean political chaos or disorder, but rather that the interactions between the units of the whole system (state) affect the behaviour on the system and do not recognise or share a common, supreme authority (Dunne and Schmidt 2001, cited in Fidler 2004:22-23). So, the Westphalian structure fragments political authority and power throughout the states and therefore does not allow a world government to flourish because of its potential to cause war and disorder as it would be deemed "dangerous to human well-being" (Rousseau 1756; Kant 1795, cited in Fidler 2004:22). Sanitary conferences in the nineteenth and twentieth centuries formulated counteractive measures to dispel waterborne diseases which was strengthened through the establishment of the WHO and International Health Regulations (IHR) (IHR 1969; Goodman 1971; Rosen 1993; Fidler 1999; Fidler 2004:19-32). According to Lakoff (2010, cited in Lyttleton 2018:329), epidemiological mechanisms quantify risk through statistical data to minimise the threat and severity of diseases mapped out through disease intervention, categorisation, and mobilising efforts for heightened health securitisation (Lakoff 2013; Horton and Das 2015, cited in Lyttleton 2018:329). Militaristic surveillance is conceptualised as "sentinel devices" better known as the generation of politicised and militant health vigilance, interventions and "medicalizing security" of human biological processes for global infectious diseases control and health protection (Lakoff 2013; Elbe and Voelkner 2014; Horton and Das 2015, cited in Lyttleton 2018:327-331). As such, local health security concerns are emblematic of wider geopolitical issues at the level of bodily functioning and embodies social and structural influences (Lyttleton 2018:327).

#### *Systems thinking as a public health commitment for health system strengthening*

In the WHO's (2009) report on *Systems thinking for health systems strengthening*, the Alliance for Health Policy and Systems Research (HPSR) ("the Alliance") refers to the international collaboration "to promote the generation and use of health policy and systems research as a means to improve health and health systems in developing countries". The Alliance's *Flagship Report Series* facilitates the enhancement of evidence-based research and

policy and the acceleration of “new conceptual thinking on health systems, system-level interventions, and health system strengthening” (WHO 2009:28). Medical systems are social institutions that intertwines disease theory i.e., the causality of disease, and a health care system which involves a complex bureaucratic structure in which healers and patients interact (Foster and Anderson 1978, cited in Baer, Singer and Susser 2004:7-8). Socioeconomic factors of health and disease proliferation attracted the WHO and other stakeholders to advocate for HSS to better health outcomes globally (Swanson et al. 2010, cited in Van Rensburg et al. 2012:36). In addition, from 2005 to 2015, global leaders like President George W. Bush, and principal member states established the Millennium Development Goals (MDGs) to mobilise large-scale capital and resources to combat diseases that were most urgently affecting the poor (Hotez 2021). The MDGs aimed to provide effective coverage to tackle widespread health inequities by curating health interventions aligned with global economic, UHC, and social development goals including the US President’s Emergency Plan for AIDS Relief; the Global Fund to Fight AIDS, Tuberculosis, and Malaria; and the US President’s Malaria Initiative (WHO 2009:29; Van Rensburg et al. 2012:34-35; Hotez 2016, cited in Hotez 2021). Disproportionate health burdens affecting the Global South prompted programs to counteract child mortality and maternal health challenges, extreme poverty and hunger, and communicable diseases like HIV and AIDS, malaria and other diseases (Van Rensburg et al. 2012:34-35). However, prominent changes in health intervention cannot be achieved without seriously reconfiguring plans to target factors and elements in the health system which make it function like resources and power, governance and surveillance, staffing, and health equity (WHO 2009:29; Van Rensburg et al. 2012:34-36). Health systems provide the opportunity to contest existing patterns of inequality and to contribute to social development by informing wider norms and values (Gilson et al. 2007, cited in WHO 2008).

### *Health system architecture: elements in the machine*

The South African health system is a complex matrix of interconnected elements that work toward a common goal – public health care and the prevention of diseases. These elements were shaped by colonial and apartheid government public health legislation, and current global multisectoral partnerships. Health system complexity lies within the interrelationship of these elements to interact among decades of inequalities and disparate financial and physical resourcing, and contemporary politics. Health system architecture comprises of staffing or HR, governance, information systems, pharmaceuticals and technologies, service

delivery, and the public (de Savigny & Adam 2009, cited in Gilson 2012:25). These six sub-systems are interlinked within wider arrangement of the national health system by affecting and reflecting the broader interactions in the system (WHO 2009:19-31; Gilson 2012:23-24). By assessing the health systems internal structural behaviours, systems thinking aim to adapt to the needs and interventions of these elements (WHO 2009:40-41). Therefore, each element of the health system is highly contentious and sensitive to changes and adjustments in the system as they are interconnected to strengthen and provide the utility of health care.

The PHC model is an inherently relational process that responds to the burdens of disease by calling upon intersectoral social protection (Gilson 2003; Loewenson and Gilson 2011). Since the democratisation of South Africa, the NHA embedded the principles of the PHC as a key health model (McKenzie et al. 2017:4). The PHC is provided mainly through a nurse-based, public infrastructure of approximately 3 500 clinics and health centres that provide a comprehensive package of basic services including maternal and child health, TB and HIV testing and treatment, screening and care for common illnesses (McKenzie et al. 2017:4). In 2010, the National Department of Health (2010, cited in McKenzie et al. 2017:5) implemented the PHC Re-engineering Strategy to strengthen community-based and preventive mechanisms aimed to prioritise community health workers (CHWs) and professional nurse teams; maternal, child, neonatal and women's health district clinical teams; integrated school health programs; and contracting private general practitioners to work in public facilities. Key health prioritised have highlighted the demand to redress the social determinants of ill-health, strengthen programs for universal access to ARV therapy, supporting broader health system needs like health sector redistribution of resources and staffing and general inequalities (McKenzie et al. 2017:6). Comprehensive PHC philosophy aims to bolster pro-equity principles, universal coverage and access to health care through the facilitation of multidisciplinary health teams, planning interventions and assessing health risks across different levels and places of care in the health system (Pan American Health Organization and WHO, cited in Engelbrecht and Van Rensburg 2012:485). However, several crucial elements of the *2001 PHC Package* and subsequent revisions in the *2010 PHC Package* have not sustainably altered the utilisation of resources in the health system (Engelbrecht and Van Rensburg 2012:497-506; McKenzie et al. 2017:4). Key reforms demanded more equitable access to health care and health services in district facilities under a continuum of care (Daviaud & Cabral 1997; DoH 2001a, DoH 2001b; Van Rensburg 2004,

cited in Engelbrecht and Van Rensburg 2012:497). However, the quasi-federal system of governance resulted in unequal implementation of PHC services across the nine provinces and exposed gaps in policy implementation connected to HR skills shortages; poor integration between local government and province; old infrastructure and financial constraints (Rispel et al. 2010, cited in Engelbrecht and Van Rensburg 2012:497-500; McKenzie et al. 2017:4). Therefore, systems-wide transformation toward more equitable and comprehensive services were jeopardised.

### Health indicators and Goals according to the Sustainable Development Goals (SDGs)

During the Jacob Zuma presidency, the South African government invested in local and international health programmes for the achievement of health goals which South Africa still adheres to. The National Planning Commission devised the National Development Plan (NDP) 2030 to minimise apartheid's spatial, political, and social divisions in health care accessibility and outcomes (RSA 2012:24-26). These public health reforms aim to strengthen institutional capabilities by providing comprehensive, universal access for the prevention and mitigation of diseases and promotion of health (RSA 2012:24-51; McKenzie et al. 2017:3). Moreover, the NDP aims to strengthen governance capacities to tackle the roots of poverty and inequalities by stabilising public services and sustaining proactive intergovernmental management (RSA 2012:54-55). In *Readings in Human Development* (2003), Sen's utilitarian approach invokes a value-based system wherein welfare economics sees value in terms of subjective wellness and the absence of material deprivation. Quantitative measurements for health indicators like morbidity and mortality can also be paired with qualitative data that factor in a utility-based assessment of basic needs fulfilment that invest in the utility of public policy (Sen 2003). Thus, health systems require a consistent synergy between essential public health services, policy outputs, and co-production with communities to combat the "quadruple burden of disease" like HIV/AIDS and TB; maternal and perinatal, and nutritional and communicable diseases (Hunt & Backman 2008; Backman et al. 2008; Allotey et al. 2019; Sacks et al. 2019; Kruk et al. 2015; Topp, 2020; WHO Maximizing Positive Synergies Collaborative Group, 2009; McKenzie et al. 2017:10; Travis et al. 2004, cited in Shroff, Marten and Hanson 2022:11-17). According to the Sustainable Development Goals (SDGs), global health programs envision holistic innovations to combat the social determinants of health (also referred to as macroeconomic determinants) that low-and-middle income countries (LMICs) experience (WHO 2017:x; Shroff, Marten and Hanson 2022:9-12). According to Krieger (2011, 2012, cited in Smit et al. 2016:250) noncommunicable diseases

(NCDs) refer to the causal relationship between the social and physical context to proliferate or exacerbate ill-health patterns and negative health outcomes, especially in lower-income areas. By the 1970s, the WHO started applying the term ‘noncommunicable diseases’ in various epidemiological analyses in LMICs (Vaughan and Adjaye-Gbewonyo 2021:11). In 2015, South Africa embarked on the 2030 Agenda for Sustainable Development which emphasised the importance of health targets between the NDP and SDGs (Statistics South Africa, 2019:1). These collaborative partnerships addressed the importance of improved access to social services, and the prioritisation of the causes of the social determinants of health like sanitation, poor infrastructures which have a connection to poverty and inequality (Naledi et al. 2011:18-22; Delobelle 2013:195; McKenzie et al. 2017:6-22; Statistics South Africa, 2019:1-4).

In 2019, Statistics South Africa (Stats SA) released its country report aimed to address South Africa’s triple burden to health such as poverty, inequality and unemployment (Stats SA 2019:v). Health system indicators track health status of populations and evaluate trends toward health system goals as well as highlighting gaps in policy implementation and health programs (Redelinghuys 2012:237-247; McKenzie et al. 2017:7). Appendix 2 outlines various types of health indicators, outcomes and goals set at a national level to be achieved within specific periods. As presented in Appendix 2, health system indicators have shown considerable improvements in the overall targets for their respective years (McKenzie et al. 2017; StatsSA 2019; StatsSA 2023). The NDoH has asserted that improving life expectancy figures, reducing the quadruple burden of disease and under-five mortality rates, significantly transforming the health sector toward effective and quality health care provision, UHC, and access associated with the social determinants of disease and adverse ecological influences is key (NDoH 2021:16). So, the NDoH and WHO devised strategic outcome-based objectives to envisaged aims within the NDP 2030 to strengthen South Africa’s health system (NDoH 2021:16-27). What remains is to be achieved is the development of sustainable health system transformation and equity, especially for affordable medicines and health financing under UHC principles (NDoH 2021:16-27). The values of investing in health system indicators to monitor programs and policies. Investment and assessment of these health system elements requires stringent leadership and delegation across levels of care. In this way, governance affords us the opportunity to find faults in the system and apply the necessary tools to fix what is broken or missing. This is not a linear, clear or easy task, but it is rewarding to see results as they impact across the social and economic sphere i.e. having healthy populations

who work; commute; use public services; pay for health services; finance their health care through medical aid/schemes.

### Equity in health systems for sustainable systems

#### *National Health Insurance (NHI)*

Universal health coverage (UHC) is integral to health system transformation as a marker for comprehensive health care access. National Health Insurance (NHI) has been proposed as a “health financing system that will pool funds to provide access to quality health services for all South Africans, based on their health needs, irrespective of their socio-economic status” (NDoH 2021:16). The NHI Bill aims to restructure cross-subsidisation by connecting funding to an individual’s ability-to-pay by ensuring benefits from health services based on the level of need (NDoH 2015:9; NDoH 2021:16). By removing user-fees and out-of-pocket payments (OOPs), financial risk protection should ensure that households and individuals will only pay out-of-pocket and/or co-payments for health services that are not included under the NHI (NDoH 2015:29). Likewise, the NHI Bill strongly contests the full-scale reduction of resources caused by macroeconomic restructure introducing financial risk protection (Marais 2011; NDoH 201). Co-payments (additional payments or levies) are a type of OOP for those on medical schemes but does not cover all the costs of service (NDoH 2015:16). User-fees (direct out-of-pocket payments in public facilities) will be terminated to reduce financial hardships and to increase access to health facilities and services (NDoH 2015:3). In connection the NHI structure, an estimated R451 million per annum is derived from user-fees with these payments directed as OOPs expenses (NDoH 2015:16). The health system’s organisational structure results in inequitable expenditure between the public and private sector (NDoH 2015:9; NDoH 2021:16). The NHI aims ensure that the most vulnerable in society (the sick and socio-economically disadvantaged) would receive suitable care through a social security system (Baker 2010:86; NDoH 2015:9). Thus, the NHI Bill would vitally restructure South Africa’s two-tiered health system by addressing deep-rooted structural and financial issues resulting in worsened insecurities of health through a taxation system (Marais 2011; Delobelle 2013; NDoH 2015; NDoH 2021). However, several challenges have been raised that would against the NHI that would undermine its implementation as South Africa’s public health sector needs intense reconstruction before the implementation of NHI (Kahn 2008, cited in Marais 2011:314). Endemic fragilities within the health system compromise the whole system functioning which creates and maintains dysfunctional organisational structures interprovincially (Coovadia et al. 2009; Von Holdt 2009; Harrison 2010, cited in

Marais 2011:319-320). Other notable concerns have stated that the feasibility of the NHI and its administrative sophistications would require a comprehensive benefit package without co-payments which generally increases the total cost of health care like hospitalisation or in case of serious injury or illness (Keeton 2010, cited in Delobelle 2013:188; NDoH 2015:16). Therefore, the NHI presents an attractive opportunity as a pro-poor and pro-equity policy but faces complex structural within the health systems organisation (Marais 2011; McIntyre et al. 2008). Additionally, competing stakeholder interests between socialist/communist ideals versus those defending private or free-market interests (Marais 2011; McIntyre 2010, cited in Van Rensburg and Engelbrecht 2012).

### *Accessibility – financial flows*

Global health authorities have extensively written about the sustainability of Health Systems Strengthening (HSS) and the adaptive quality required from these structures. Equity is commonly associated with HSS frameworks and markedly reveal the intricacies of balancing the architectural elements in the health system. In health systems research, equity is defined as “the provision of equal shares for equal needs or to the allocation of unequal shares for unequal needs as long as proportionality is maintained” (Benatar 2012:674). Instead of a market-based approach, an indirect approach sees the embeddedness of social justice as a major influence of health by emphasising agency and wellbeing – having the capabilities that an individual can achieve (Peter & Evans 2001; Powers & Faden 2006, cited in Benatar 2012:674). For Kate Sherry (2014:90), equity connects to access to health care, rather than being comparable to equality as a prerequisite for fulfilling the human right to health. However, resourcing gaps between mainly urban provinces like the Western Cape and Gauteng and mainly rural provinces like the Eastern Cape shows disproportionate flows of financing between district facilities (Cooke et al. 2014:112). Thus, concerns surrounding the extent to which equity in access can be achieved provincially is still up for debate (Benatar, Daar & Singer 2003, cited in Benatar 2012:682-690). During 2005, governments adjustments converted the presidency as the “core of the system of governance” to better align with global trends in an efficient, cost-effective and transparent manners (Marais 2011:409). Therefore, health is not just a state of being but is also dependent on elements in the health system to reflect greater access, quality, and safety of care nationwide (WHO 2007b).

## People-centredness as a model to think about equity in health systems

Achieving a more uniform experience of equity lies in advocating for a holistic approach to health. The people-centred approach centralises system wide issues by advocating for informed knowledge of clinical information/medical education and promoting the capacities of stakeholders in public health (WHO 2007b:5-6). People-centredness supports the evaluation of the health system design to reconfigure parts in the system by formulating considerations for optimal and sustainable health care financing to meet all members of the public (WHO 2007b:6). For the issue of financial sustainability and equity, Lucy Gilson (1997) offers a critique from *Health Policy and Planning* that explains how user-fees have been applied in Africa, and summarises its impact on health systems equity, efficiency and sustainability since the 1980s to mid-1990s. “Financial sustainability” is a critical factor for health “system sustainability” as a national objective for policymakers to generate reliable resources (user-fees) for the continued and manageable improvement of health care provision (Leighton 1995, cited in Gilson 1997:274). “System sustainability” aims to attain “the capacity of the health system to function effectively over time with a minimum of external inputs” (Adams and Harnett 1995; Gilson 1995; LaFond 1995, cited in Gilson 1997:274). This means that the securitisation of adequate resources is used effectively and efficiently and is self-reliant among the elements in the health system (Adams and Harnett 1995; Gilson 1995; LaFond 1995, cited in Gilson 1997:274). As it stands, user-fees are in direct conflict with the principles of the NHI as proclaimed by the South African Human Rights Commission (SAHRC) (2009; NDoH 2015). Under the National Health Act of 2003 (NHA), primary health care (PHC) provides free health care to vulnerable persons (pregnant women, the disabled, and children under 6 years of age) who do not pay user-fees for higher levels of care (SAHRC 2009:41; NDoH 2015:16). Therefore, user-fees contradict the holistic and pro-equity principles of the NHI (Gilson 1997:279-283; SAHRC 2009:41; McIntyre 2010, cited in Van Rensburg & Engelbrecht 2012:133; NDoH 2015:16-29). Gilson’s (1997) findings show that user-fee systems are more likely to increase inequities in access to health care than those which permit risk-sharing and/or pre-payment; fees do not seem to produce adequate revenue to cause substantial and sustained improvements in health care for the poor; and differential implementation of fees between geographical regions nationally can cause geographical inequities as wealthier areas charge less than poorer areas (Diop et al. 1995; Ensor and San 1996, cited in Gilson 1997:276). Furthermore, Gilson (1997:278-280) evaluates the complexity of the health system and wider contextual constraints that influence

inequities in health, and to consider how health financing strategies are one part of an array of elements in the system in addressing resource limitations. South Africa's health sector expenditure of the total government budget decreased from 11.5% in 2000/2001 to 10.9% in 2007/2008 (McIntyre et al. 2007, cited in McIntyre et al. 2008:873). Still, 120 schemes with several benefit options remain in operation under separate funding pools, seriously fragmenting the pooling of risk across the insured population, and unlinking risk-equalization from materialising (CMS 2007, cited in McIntyre et al. 2008:873). Risk-equalization is supposed to allocate resources that are pooled via health insurance with allocations from the general taxation system ensuring "relative risk of ill-health or likely health-care needs of the population served are taken into account" (McIntyre et al. 2008:873-874).

Health economists, Ataguba and McIntyre (2012), argue that universal systems demand cross-subsidies for health service benefits as a financing system guaranteeing that public and private sector health services have the necessary resources (Wagstaff and van Doorslaer 1993, cited in Ataguba & McIntyre 2012:22). Therefore, policy development should focus on increasing multisectoral stakeholders who are honed into the goals of a more equitable fee structure by investing testing and adjusting policies according to community response, and addressing the contextual factors that influence appropriate policy designs (Gilson 1997:282-283; WHO 2007b:9-13). Likewise, inequalities must be confronted as an unavoidable reality steeped in layers of oppression, dispossession, and ill management in education, health, wealth and land-holding (Coovadia et al. 2009; Marais 2011; Van Rensburg et al. 2012; Ferguson 2013; Delobelle 2013). However, Ferguson (2013:234-235) is apprehensive about 'solving' political and social problems with technological or technical restoration and questions neoliberal notions of "dependency" of the welfare state. For Ferguson (2013:234-235), the welfare system inherently obscures and oversimplifies configurations of personhood and social belonging. Further, Ferguson (2013:233-234), attempts to explain how modern neoliberalism contradicts with the proponents of enhanced social assistance and other social policies contingent on "a patronage-based system of distribution". Bureaucracy or corruption in the health system and its organisational structure/culture threatens the accessibility of economic rights for even the poorest citizens (Ferguson 2013:234). And while social payments or other proposals for the equitable distribution of finance may marginally redress some of the historical layers of inequality and other structural violence imposed by the state, campaigns for material transformation beyond cash transfers persists (Farmer 1996, 1999; Marais 2011; Ferguson 2013; Delobelle 2013).

Finally, Ferguson (2013) posits that social policy, in this case the NHI and other forms of fairer health financing, should construct desirable forms of “dependency” where social obligations do not rely on hoarding resources in contexts of strife and rapidly expanding inequalities (NDoH 2015; NDoH 2021). In other words, equity, transparency and competence have become powerful descriptors in HSS and health systems literature which indicate that these concepts should be considered when addressing health system inequities (Gilson 2003; Loewenson and Gilson 2011).

## **Chapter Eight: Conclusion – the unfolding and renegotiated processes of doing research on health and health systems**

South Africa's history of dispossession, impoverishment, and corruption of state resources has intensified the actions of post-apartheid public health theorists to reconstitute disparities in health (Jochelson 2001; Klausen 2004; Coovadia et al. 2009; Marais 2011; Delobelle 2013). The overwhelming racialised and classist ideological underpinnings of extreme violence imposed by the colonial and apartheid regimes maintained the uneven distribution of resources (Bond 2000; Jochelson 2001; Klausen 2004; Coovadia et al. 2009; Marais 2011; Van Rensburg et al. 2012; Delobelle 2013). As a result, medical humanities scholars and public health practitioners are urging state officials to address the socioeconomic determinants of health (Bond 2000; Jochelson 2001; Klausen 2004; Helman 2007; Coovadia et al. 2009; Baker 2010; Marais 2011; Loewenson and Gilson 2011; Van Rensburg et al. 2012; Delobelle 2013; Atkinson et al. 2015). Governance practices and extractive industries like mining during the colonial and apartheid regimes worked to actively suppress and displace the Black majority (Jochelson 2001; Klausen 2004; Coovadia et al. 2009; Marais 2011; Delobelle 2013). Under these conditions, health care was largely inaccessible due to land and wealth dispossession, and threatened housing, and food security by producing structural violence in the form of diseases like TB, malaria and HIV/AIDS (Farmer 1996, 1999; 2003; Jochelson 2001; Coovadia et al. 2009; Marais 2011; Van Rensburg et al. 2012; Delobelle 2013). The political economy of disease was intrinsically linked to these extractive processes which patterned ill-health for Black populations which was inextricably linked to racist ideologies (Marks and Andersson 1987; Jochelson 2001; Foucault 2003; Klausen 2004; Coovadia et al. 2009; Marais 2011; Delobelle 2013).

To briefly recap, I began the thesis with an overview of the health humanities and the multidisciplinary and multisectoral approaches to health care in South Africa. In the first part of the thesis, I provided the onto-epistemic form of the project to show the linkages of different disciplines and their practices between my methodology, and the concepts that are brought forth from these disciplines into reality. I also structured this project in way to enfold concepts and arguments drawn from Health Systems Strengthening (HSS) and other global health policy literature that support multisectoral stakeholder investment in health programs. Throughout the breadth of this thesis, I engaged with multidisciplinary concepts surrounding governmentality in South Africa's public health system, and the possibilities of fostering the production of models to tackle health inequalities and drivers of ill-health.

Governmentality, as understood within the domain of neoliberal ideology and policies, has gone through cycles of utilisation in South Africa's implementation of health responses. Neoliberalism as it connects to advanced liberalism acts as one lens to conceptualise welfarism, surveillance and responsabilisation that manifests between the state and its citizens (Rose 2000; Rose, O'Malley & Valverde 2006; Larmer 2006; Foucault et al. 2008; Juhila, Raitakari & Hall 2017). The apartheid regime reproduced "passive" forms of class and race relations in health that perpetuated itself into the fabric of the new democratic state as another form of state violence (Marks and Andersson 1987; Jochelson 2001). The democratic state adjoined the autonomous drive of self-actualisation and personal achievement with development goals by enfolding itself in macroeconomic and social transformation on par with global elites (World Bank 1994; Bond 2000; Baker 2010; Marais 2011; Van Rensburg et al. 2012; Delobelle 2013). Also, the securitisation of global public health conceptualises human biological processes metaphorized as zones for security policy (Elbe and Voelkner 2014, cited in Lyttleton 2018:327; Horton and Das 2015, cited in Lyttleton 2018:327). Since the nineteenth and twentieth centuries, epidemics such as syphilis and more recently HIV/AIDS and TB have tested the strength and capacity of South Africa's health system (Marks and Andersson 1987; Jochelson 2001; Harrison 2004; Coovadia et al. 2009; Delobelle 2013). An analysis of South Africa's health care system cannot overlook the implications of political and economic power, and structural inequalities in the quality of care within different levels of care in the health system (Farmer 1996, 1999, 2003; Marks 1997:215; Marks and Andersson 1987:178).

Of course, state-mandated health policies are one part out of a series of integrated elements in strengthening health system performance and organisational capacity. Other contextual barriers and systemic issues continue to affect the everyday system operations and wider institutional lapses which cannot be targeted from a policy agenda alone. Future global health systems researchers, health humanities scholars and practitioners should aim to prioritise framing health-related challenges within wider contextual constraints by concentrating on the dynamic processes, disturbances and levels within the health system (Topp 2020:3). In the interest of avoiding critical risks to health system functioning, Topp (2020) argues that mobilisation toward assessing *who* and *what* benefits from adaptations in the system would be more productive. Further studies should focus on cultivating the health humanities to embrace multisectoral action and relationships in LMICs, and most importantly maximise the governance capacities for service delivery to close resource gaps (Kruk et al. 2010:910).

Specific areas for improvement must evaluate the limitations and its successes of the PHC methods and how they are arranged in facilities, especially in resource-strained areas (Kruk et al. 2010:910).

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## Appendices

*Appendix 1: Selected health status, mortality and morbidity indicators from 1990 to 1995*

<b>Population Group</b>	<b>Black</b>	<b>White</b>	<b>Coloured</b>	<b>Indian</b>	<b>Total</b>
Total Life expectancy at birth (years): Males (1990) Females (1990)	60 67	69 76	59 65	64 70	62 68
Infant mortality/1000 live births (1994)	54.3	7.3	36.3	9.9	48.9
Under-five mortality % deaths < 5 years (1994)	20	12	19	13	16.3
Maternal mortality/100 000 live births (1990)	58*	8	22	5	32
Incidence of TB/100 000 (1993)	206.6	18.8	712.5	50.8	224.9

Reported AIDS cases: Total 1982– 89) Total 1990– 1995) Total and % (1994)	7 703 90.3%	302 3.5%	504 5.9%	16 0.2%	356 8 571 3500
HIV prevalence rate:  % women attending antenatal clinics (1994)	7.3	0.4	1.3	7.0	7.6

Sources adapted from Coovadia & Buthelezi 1995; Health Systems Trust 1995; 1997; SAIRR 1996, cited in Van Rensburg et al. 2012:111. \*Note: Exclude “independent” homelands.

*Appendix 2: Demographic and health system indicators from 2015 to 2023*

<b>Indicator</b>	<b>Results</b>	<b>Year</b>	<b>Source</b>
Infant mortality (IMR) under age 1 occurring per 1000 live in births in a year	36.4	2010	Statistics South Africa (2023)
	27.0	2015	
	22.1	2018	
Under-five mortality deaths (per 1 000 live births)	52.9	2010	Statistics South Africa (2023)
	36.7	2015	
	29.7	2018	
Maternal mortality in facility ratio/100 000 live births	160.0	2010	Health Systems Trust (Massyn et al. 2015) Statistics South Africa (2019) Statistics South Africa (2023)
	132.5	2014	
	121.0	2016	
	86.0	2018	

HIV prevalence:			
Populations 15-24 years (2008-2012):	7.1	2023	Statistics South Africa (2023)
Populations 15-24 years (2012-2017):	7.9	2023	
Men and women 15-49 (2008-2012):	8.8	2023	
Men and women 15-49 years (2012-2017):	20.6	2023	
% of mothers and children who receive post-natal care either at home or in a facility and within 6 days of delivery (1+ visit)	69.7 78.0	2015 2021	Statistics South Africa (2023)
Public expenditure as % of total health expenditure (including donors)	48.5%	2015	National Department of Health

Out-of-pocket payments (OOP) as proportion of total expenditure on health	6.4%	2015	National Department of Health
Voluntary health insurance as proportion of total expenditure on health	42.8%	2015	National Department of Health

Sources adapted from: Health Systems Trust 2015; Statistics South Africa 2015, cited in McKenzie et al. (2017); National Department of Health 2015a, cited in McKenzie et al. (2017); National Department of Health 2015b, cited in McKenzie et al. (2017); Statistics South Africa (2019); Statistics South Africa (2023).