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Beyond the male-migrant: South Africa's long history of health geography and the contemporary AIDS pandemic

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ABSTRACT

This article begins by noting the contribution that past South African writings on health can make to the field of health geography—especially writings on male migration and syphilis from the 1940s that conceptualized space as *relational*. However, the second part of the article notes that the rapid rise of AIDS in the post-apartheid period influenced the problematic projecting forward of the male-migrancy model. Ethnographic and secondary data show how AIDS is embedded in under-researched social and spatial structures after apartheid. In tracing these processes the article combines anthropology, geography, and political economy to chart an interdisciplinary analysis of the uneven geographies of health.

The shift to "health geography" signals a widening of inquiry beyond the traditional emphasis within "medical geography" on disease ecology and health services distribution (Kearns and Joseph, 1993). Although GIS has facilitated something of a renaissance in the positivism that characterized medical geography, a more qualitative and theoretical agenda has emerged (for instance Kearns, 1993; Kearns and Joseph, 1993; Kearns and Moon, 2002). At the same time, health geography is generally (but by no means wholly) centred on the West and, with some exceptions, does not yield much influence beyond the sub-discipline (Kearns and Moon, 2002). Its most well-known work derives from the strong influence of humanism in rejecting medical geography's positivism (for instance Gesler, 1992; Gesler and Kearns, 2002; Kearns and Joseph, 1993).

This article's first aim is to bring attention to South African health geography writings from the 1940s (on postcolonial geographies and recognizing knowledge from outside the West see Robinson, 2006; Gilmartin and Berg, 2007). While critical reviews of health geography have recently argued that the sub-discipline has not embraced a "relational" understanding of space (Cummins et al., 2007), in South Africa, as I show, the conceptionalization of places as enmeshed in socio-spatial processes of migration and dispossession has been central to critical health research for over 60 years. A second aim of the article is to contribute to interdisciplinary approaches to health geography by exploring South African health inequalities in the contemporary era. Here, the approach draws on analysis of political economy, the household, and gender to discuss the rapid rise of HIV/AIDS. I therefore add to recent moves to incorporate race and gender into the field of health geography (see for instance Dyck, 2003, 2006) and emphasize spatial health inequalities (for a recent review see Doyle, 2005).

The article begins by laying out how in 1940s rural KwaZulu-Natal medical doctor Sidney Kark confronted the health consequences of racialized land dispossession and circular male migration to espouse a powerful model to explain the syphilis epidemic, which I shall call here the *male-migrant-infector-model*. This model highlighted how some rural-born "African" men moved to the distant gold or diamond mines for long periods, became infected with syphilis and then returned to infect their rural partners. From the 1970s, however, many scholars embraced a more explicitly Marxist approach to theorize the health consequences of deepening links between capitalism and racism. High rates of malnutrition and disease in rural areas, these writers showed, were inextricably linked to racial segregation and capitalist development.

Although democracy replaced minority white rule in 1994, it coincided with the onset of an AIDS pandemic that today infects nearly 30% of pregnant women.[1] This urgency ensured that some

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[1] Annual HIV prevalence figures in South Africa are compiled through anonymous tests on pregnant women's blood taken during antenatal visits. In 2007 this found HIV prevalence of 28% (Republic of South Africa, 2008). More detailed trends, including geographical difference, are calculated from wider surveys of the country's population, the largest of which in South Africa is a household study conducted by the Human Science Research Council. In 2002 this found that 12.8% of women and 9.5% of South African men were HIV positive; the 2005 study found that 13.3% of women were infected and 8.2% of men. Unlike antenatal figures these include all of the population including the elderly and the young (HSRC, 2002, 2005).

observers drew somewhat unquestionably on the earlier model of male-migrancy to explain AIDS' spread. In doing so, I argue, they downplayed new configurations between social inequalities, the household, and geography. Through a brief study of one place, Mandeni, KwaZulu-Natal, the article tracks the increased movement of women, new forms of dependence some women have on men, and the considerable rise of informal/shack settlements that have nearly twice the HIV rates of both rural and urban areas (on informal settlements and HIV prevalence see HSRC [Human Science Research Council], 2002, 2005). This analysis also suggests new geographies through which health is racialized. One recent household study found HIV infection rates of 13% for "Africans", 1.9% for "coloureds", 1.6% for "Indians", and 0.5% for "whites" (HSRC, 2005). What requires explaining today, then, is not only how colonialism and apartheid led to the "premature death" of black bodies but the socio-spatial dynamics that underpin this today.[2] (At this point it must be noted that the use of colonial/apartheid-based racial terms is problematic but unavoidable if the legacy of institutionalized racism that divided society along these lines is to be recognized.[3])

Health debates in South Africa 1940s–1980s: male migrancy, households, and uneven geographies

The Union of South Africa was born in 1910 following the reconciliation of previously antagonistic white groups, specifically descendents of mainly Britain (English-speakers) and Holland, Germany, and France (Afrikaans-speakers). Compared to other countries in the region, the discovery of diamonds and gold in the late 19th century encouraged a heavy settler presence. At the core of the racialized capitalism that ensued was the oscillating migration of black African men from rural areas to mines. All but the oldest African men were forced by economic conditions (including taxes) to work for most of the year in distant urban areas. In turn, most African women and children were forced to live on the languishing "reserves" that occupied only 13% of the country. After 1948, these racial contours became further hardened when the National Party assumed power under the banner of apartheid ("separateness" in Afrikaans). During this period the state segregated cities more intensely, forced African women to join men in being required to carry "passes" that restricted their movement, and recast rural "reserves" as more autonomous ethnic "homelands" (granting "independence" to four).[4]

In 1940, just prior to the period of apartheid, medical doctors Sidney and Emily Kark established a pioneering community health project at a rural location called Pholela. This area, then part of a rural "reserve", is today located in the KwaZulu-Natal province. In this languishing rural setting diseases such as TB, polio and cholera were common. But no disease pattern demonstrated the effects of population displacement on health more than the syphilis epidemic that reached its peak in the 1940s; it was only in the 1950s that penicillin became widely available to drastically cut (but never end) the burden of the disease.

In 1949, the Karks' considerable experience in studying and treating syphilis led Sidney Kark to author a famous article on the subject in the *South African Medical Journal (*Kark, 1949).[5] This piece broke new ground by laying out what can be called the male-migrant-infector-model. In it, Kark combined local household data with national statistics and medical reports to argue that the syphilis epidemic had its roots in racial segregationist policies that fostered patterns whereby African men circulated between rural and urban areas. Men, he showed, were leaving rural areas and becoming infected with syphilis. Then, they returned to infect their rural wives. Consequently, "The first line of treatment", Kark (1949, p. 83) wrote, "must be to remedy the unhealthy social relationships which have emerged as the inevitable result of masses of men leaving their homes every year."[6]

I will return later to explore the weaknesses of the male-migrant-infector-model when applied to the contemporary period and argue that more attention needs to be given to gender dynamics when considering the household. But it is worth commenting on the extent that the Karks' research represented considerable theoretical/methodological advances in the study of health. From the early colonial period, doctors and missionaries in Africa tended to see syphilis as resulting from either the inherent promiscuity of Africans or the dangerous loosening of controls on African women (Vaughan, 1991). In the post-world war II era, the linear lens of modernization theory came to mold studies of health in the "developing world" (described in Stock, 1986). In contrast, living for a long period in the Pholela community, the Karks blended an historian's sensitivity to social change with an anthropologist's eye for household dynamics. This was also history and ethnography that could not ignore geography: the devastating effects of circular male migration were so painfully obvious.[7] Immersed in this rural area, Sidney Kark was forced to conceptualize "local" places in terms familiar to today's human geographers as unbounded and intertwined with multi-scalar processes, including those forged by mining and, increasingly, secondary industry. Hence, foreshadowing critical human geographers' work in the 1970s, Kark wrote about the rural and urban areas as being relationally produced and power-laden:

> This concept of Pholela social structure *as a complex of rural and urban processes* assists in us understanding the related factors influencing the state of well-being and the incidence of ill-health of the Pholela community" Kark (1950, p. 33, my italics)

[2] On race, geography, and 'premature death' see Gilmore (2002).

[3] By the end of the apartheid era there were four widely used "racial" categories: African, white, Indian, and coloured. I use the lowercase for coloured and white to reflect their social construction but uppercase for African and Indian since, although socially constructed, the words are derived from geographical places. The article mainly discusses South Africans previously categorized as "African"; at times I use the term "black African" to stress the shared sense of oppression among non-white groups. I use scare quotes conservatively to improve the article's readability.

[4] There is, of course, an enormous amount written about male migration and urban segregation under apartheid. Within geography see for instance Lemon (1991), Parnell and Mabin (1995), and Robinson (1996).

[5] Most of the writings associated with the Karks were single authored by Sidney Kark. I largely follow this convention in the paper but recognize that at other times Sidney and Emily Kark describe themselves as working closely together (see for instance Kark and Kark, 1999).

[6] The Karks are also well known today as pioneers of what came to be called Community Orientated Primary Health Care (COPHC). In essence, this involved the integration of prevention and cure at a local level. The Karks eventually left South Africa in the 1950s; their model of community-based health influenced many countries but was only revisited in South Africa when the country embraced democracy in the 1990s (Yach and Tollman, 1993).

[7] On the Karks' methodological innovations see Yach and Tollman (1993) and Trostle (1986). In their student days at Witwatersrand University the Karks associated with anthropologists such as Hoernlé, Gluckman, Kuper, Krige, and historian MacMillan: "It was the influence of these men and women that led to our life-long interest in the use of social anthropology and social history as integral parts of our social and epidemiological knowledge" (Kark and Kark, 1999). One needs, of course, in assessing the values of the Karks' work, to flag some limitations, if they are not fully explored here. The most obvious is that they operated through a largely biomedical framework and did not give great attention to non-biomedical understandings or meanings around health.