

“The priorities of the state should be to combat the diseases of the majority of the people:” the
South African Cervical Cancer Crisis of the 1980s¹

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HIS 267

Dr. Wiemer

May 6, 2024

¹ Independent (Johannesburg), "Critical Health, No. 9," Critical Health, May 1, 1983, accessed on JSTOR, <https://jstor.org/stable/al.sff.document.1680.6859.000.009.may1983>, 42.

Known as “the silent killer,” cervical cancer, consisting of abnormal, cancerous growths on the cervix, is a disease of dichotomies: one of the rare forms of cancer that is easily treatable and can even be cured, it still kills the majority of women who contract the illness. This is the genesis of its reputation: the cancer can only be cured when detected in the early stages, when women are asymptomatic; if left untreated, it is certainly fatal. Therefore, in developing countries with little to no access to screening programs, there is little hope for women who fall ill.

This essay seeks to explore the history of cervical cancer in the 1980s in South Africa, especially the screening options and treatment programs available, and how that might be representative of sexual health resources available to women on a broader scale, hinting at why cervical cancer is so prevalent in South Africa. There is almost no historiography surrounding the history of cervical cancer in South Africa—it has been left entirely up to biologists. Therefore, in this project, I hope to make more explicit the connection between the history of female health resources for African women and the incidence of cervical cancer in this time period. In my work, I combine multiple lines of scholarly conversation to bridge this gap: particularly biological research done on cervical cancer in Sub-Saharan Africa and both political and historical research done on the anti-apartheid and women’s rights movements in South Africa, highlighting how the push for cervical cancer treatment fits into these factions.

Over the course of this essay, I seek to make a three part argument. First, I will outline how the high incidence of cervical cancer in South Africa in the 1980s is representative of the women’s health crisis and the lack of female health resources available. Second, I will shed light on the disparities within both locational (rural and urban) and racial (black and white) cases and

treatment options highlighting to Apartheid racial dynamics. Finally, I will argue the push for intervention in the cervical cancer crisis was part of the larger women's rights movement, a byproduct of the anti-apartheid movement.

Making an argument involving multiple streams of conversation requires blending various kinds of sources. For my primary sources, I pull from where the discussion around cervical cancer was the most prevalent, such as feminist publications, news articles, and reports on conference proceedings. For my secondary sources I pull from books and articles, but rely heavily on biological journal articles, as they contain the majority of the statistics on cervical cancer. Together, these sources give me a comprehensive view of the time, place, and issue I look to explore.

Before embarking on my exploration, it is vital to orient my work in the location and time period in which I am focusing. The women's movement in apartheid South Africa was deeply intertwined with the broader anti-apartheid struggle, meaning we cannot understand one without the other. During the 1980s, there was a tendency to amalgamate all progressive organizations under the umbrella of the anti-apartheid struggle, often at the expense of addressing specific women's issues.² As outlined by scholar Shireen Hassim, "nationalism was the dominant discursive frame for political mobilization, and women's liberation was defined within and against that frame."³ Despite this, the autonomy of women's rights organizations became crucial in ensuring that the battle for gender equality remained a significant aspect of the larger struggle. These groups not only worked towards exposing the injustices of apartheid and contributing to the nationalist movement but also laid the groundwork for a sustainable and inclusive

² UN Women, "State of the Women's Movement in South Africa," accessed May 6, 2024, https://africa.unwomen.org/sites/default/files/2023-10/state_of_the_womens_movement_in_south_africa.pdf, 4.

³ Shireen Hassim, "Voices, Hierarchies and Spaces: Reconfiguring the Women's Movement in Democratic South Africa," *Politikon* 32, no. 2 (November 2005): 175–193, <https://doi.org/10.1080/02589340500353417>, 178.

post-apartheid society.⁴ Feminists within these movements sought more than just a change in regime; they aimed for a fundamental restructuring of societal norms, challenging the private inequalities that perpetuated differential public capabilities between women and men. In essence, the women's movement of apartheid South Africa embodied the enduring quest for gender equality and social justice within the struggle against apartheid.

In the scholarly conversation, Marissa Mika in her book, *Africanizing Oncology*, is the only source that bridges the gap between history and biology, as she looks at the history of cancer research and care in Africa from colonial time to present day. While her focus is in Uganda, much of her analysis can be applied to South Africa, especially the link between cervical cancer and infectious diseases, like HPV, and intervention options for screening practices.

The remaining work consists of biological journal articles which emphasize screening and how cervical cancer must be considered a crisis in Sub-Saharan Africa. Articles like “Temporal Trends in the Epidemiology of Cervical Cancer in South Africa” provide vital statistics from the South African National Cancer Registry (SANCR) that highlight the demographic difference between cancer patients with higher socioeconomic status and greater access to health care and those who do not. Articles like “Improvement of Pathology in Sub-Saharan Africa,” argue that governments like South Africa need to invest more in their public health infrastructure, as the cancer crisis points to an ineffective health care system. Works like “Acceptability and Preferences for Self-collected Screening for Cervical Cancer within Health Systems in Rural Uganda” and “Exploring Women’s Preferences for HPV-based Cervical Cancer Screening in South Africa” explore alternate forms of cervical cancer screening that might help, as Mika outlines in her book, refashion medical resources to meet local cancer needs.

⁴ Hassim, *Women’s Organizations and Democracy in South Africa*, 54.

Studies like “Mapping the Cervical Cancer Screening Cascade among Women Living with HIV in Johannesburg, South Africa” and “The Increasing Burden of HIV-Associated Malignancies in Resource-Limited Regions” show that cervical cancer’s connection to other infectious diseases is demonstrative of a larger health crisis in South Africa as the dual burden of HIV and cancer combined with dismal public health funding might make this crisis appear insurmountable.

The final pieces of the conversation are historical sources that look at how the lack of participation in the South African healthcare system points to a lack of trust stemming from colonial times. “Medical Mistrust and Enduring Racism in South Africa” by Tessa Moll posits that “health disparities and medical mistrust are interrelated problems of racism in the healthcare provision” and explores institutional racism and the racialized political economy of South Africa.⁵ Moll highlights that, in South Africa, “wealth remains cloistered among a persistently white local elite,” and calls for culturally competent care when addressing major issues like the cancer crisis.⁶ Concurrently, “The Legacy of Colonial Medicine in Central Africa,” puts forth a large body of evidence of mistrust in medicine leading to an under-utilization of health care that must be understood when designing implementations to the health care system. In synthesizing a diverse array of sources spanning history, biology, and sociology, this exploration underscores the intricate nature of the cervical cancer crisis in South Africa and its broader implications for public health policy and social justice initiatives in the region.

The cervical cancer crisis in South Africa in the 1980s was the culmination of a lack of infrastructure devoted to women’s health care, leading to insufficient screening programs and a lack of education on the symptoms and effects of cervical cancer. At this time, cervical cancer was the biggest cancer killer of women in South Africa. A 1999 *New York Times* article

⁵ Tessa Moll, “Medical Mistrust and Enduring Racism in South Africa,” *Journal of Bioethical Inquiry* 18, no. 1 (2021): 117–120, <https://doi.org/10.1007/s11673-020-10072-1>, 117.

⁶ Moll, “Medical Mistrust and Enduring Racism in South Africa,” 119.

published research that estimated that only 5% of women were routinely swabbed for cervical cancer in developing nations, compared with 70% in industrialized nations.⁷ This figure points to the lack of a simple, inexpensive, and effective screening method in many developing countries, including South Africa. A journal article published by *Agenda*, an African feminist media organization, reported on a 1989 Papanicolaou Test (more commonly referred to as a “pap smear”) campaign among working women in South Africa. The article explains how, due to the cervix’s lack of sensitivity, women do not normally feel anything wrong in the early stages. Regular tests enable early detection and treatment, yet many “working class women do not have either the medical knowledge of the problem or easy and convenient access to pap smear facilities,” meaning their cancers go undiagnosed.⁸ Typically, the majority of South African women would only visit doctors or hospitals when a family member or themselves fall seriously ill, rather than for preventive check-ups. The article explained how The Organised Family Planning Association had initiated regular clinics at factories, advocating for pap smears for all female workers and ensuring notification of test results.⁹ Additionally, educational talks on contraception, cervical cancer, and prevention were being organized, along with newspaper campaigns to disseminate information about cervical cancer and its transmission, especially among working and lower class women, the largest group affected. However, *Agenda* explained how the campaigns, and others like it, were facing challenges, including the lack of active female shop stewards and “male shop stewards...delay[ing] taking forward the demand for pap smears.”¹⁰ At the time of publication efforts were underway to involve female gynecologists to hopefully implement screening programmes for cervical cancer into other more frequently

⁷ “Screening Method for Cervical Cancer,” New York Times (Online), New York: New York Times Company, 1999, 12.

⁸ Pat Horn, “Pap Smear Campaign,” *Agenda: Empowering Women for Gender Equity*, no. 4 (1989): 69–71, accessed on JSTOR, <http://www.jstor.org/stable/4547931>, 70.

⁹ Horn, “Pap Smear Campaign,” 70.

¹⁰ Horn, “Pap Smear Campaign,” 71.

visited STD clinics. This campaign highlights the pressing need for improved screening infrastructure in South Africa, shedding light on the disparities in access to preventive healthcare and the urgent requirement for comprehensive initiatives to address them.

The aforementioned *New York Times* article also presented an alternative screening method for cervical cancer for developing countries to implement while public health infrastructure was improved. The method consisted of swabbing the cervix with acetic acid, found in vinegar, a common household item, and seeing if the cells collected turned white, which would indicate precancerous lesions.¹¹ If the test produced this result, then the patient would go to a clinic for a microscopic exam for a second opinion. The method was developed by Dr. Blumenthal at Johns Hopkins University, and was intended to provide “immediate results in hard-to-reach populations.”¹² This self-collected process offered a promising solution for South Africa’s screening challenges, providing an accessible and cost-effective alternative that could alleviate the strain on overburdened clinics and address the lack of screening clinics.

On a broader scale, a significant lack of education surrounding cervical cancer prevailed, particularly among working-class women, making the lack of screening almost obsolete if the women affected did not know there was anything for which they needed to be screened. The knowledge and experience of pap smears, crucial for early detection, were severely limited within the demographic. The absence of educational materials on health activities further compounded the issue. Another article from *Agenda* reporting on the proceedings from the First African Regional Meeting on Women and Health, a conference to discuss women’s health issues in Africa, urged lawmakers to have relevant educational materials “produced and disseminated

¹¹ “Screening Method for Cervical Cancer,” 12.

¹² “Screening Method for Cervical Cancer,” 12.

on all health activities which improve women's health."¹³ Given that cervical cancer often progresses symptomlessly in its early stages, when it's easily treatable, the imperative for routine screenings is paramount. Failure to raise awareness about the importance of pap smears meant that individuals only sought medical attention once the disease had advanced to a critical stage and no treatment options were available.

While there was a cervical cancer crisis throughout the nation, the distribution of cases among South Africans was far from even—a disparity with the majority of cervical cancer cases and deaths being among black women living in rural areas points to Apartheid governmental policies which focused infrastructure and resources on urban white populations. A *Critical Health*, an anti-apartheid health journal, publication from 1983 explained that “among black South African women, the incidence of cervical cancer [was] among the highest globally.”¹⁴ Another edition, eight years later, showed a stark contrast of cases among black women to the rate among white women, which stood at 4 per 100,000 compared to 25 per 100,000 among black women.¹⁵ This discrepancy was further exacerbated by the fact that black women tended to present with the disease at later stages compared to white women, resulting in significantly lower rates of successful treatment, with 4 in 5 women presenting with cervical cancer too far advanced for further treatment.¹⁶ Contributing factors to this disparity included frequent changes in sexual partners and early sexual intercourse, common practices influenced by migrant labor and influx control policies.¹⁷

To address these issues, the Primary Health Care (PHC) system, designed to provide universally accessible health care with full community participation, was established in South

¹³ “Recommendations and Resolutions of First African Regional Meeting on Women and Health, October 1989,” Agenda: Empowering Women for Gender Equity, no. 6 (1990): 37–39, 38.

¹⁴ Independent (Johannesburg), “Critical Health, No. 9,” 70.

¹⁵ (Johannesburg) and Editorial Collective, “Critical Health, No. 36/37,” Critical Health, December 1, 1991, 102.

¹⁶ Independent (Johannesburg), “Critical Health, No. 9,” 70.

¹⁷ Independent (Johannesburg), “Critical Health, No. 9,” 71.

Africa in 1980, yet its effectiveness was hindered by various challenges present in more rural areas. Geographical barriers, transportation costs, and underprovision of health services for the rural poor contributed to difficulties in accessing comprehensive health care, particularly for cervical cancer screening.¹⁸ Furthermore, the separation of family planning services from other health services often resulted in inadequate examination for illnesses like cervical cancer, particularly in rural areas where clinics may have been the only health care facility available to women. *Critical Health* outlines all of these issues, arguing that “the priorities of the state should be to combat the diseases of the majority of the people,” subtly hinting at the fact that the health care system was designed to favor the small white minority.¹⁹ They claim the lack of attention to cervical cancer was because it was not seen as a disease “related to the western lifestyle,” and, because “the present provision of social and environmental services favors the white urban dwellers,” it was not given proper attention.²⁰

The push for intervention in the cervical cancer crisis, as outlined above, was part of an emerging women’s rights movement in South Africa in the 1980s, a byproduct and partner of the anti-Apartheid movement. In July of 1991 the first joint national conference for progressive health organizations was held, and one of the sessions was dedicated to developing policy interventions for cervical cancer. Various organizations all sent in messages of support, including the African National Congress, the Pan African Congress of Azania (PACA), the Congress of South African Trade Union, and the South African Communist Party, advocating for the establishment of a democratic, non-racist, and non-sexist health system.²¹ Each message came importantly with a connection to the anti-apartheid movement, like PACA’s message that “the

¹⁸ Independent (Johannesburg), "Critical Health, No. 9," 41.

¹⁹ Independent (Johannesburg), "Critical Health, No. 9," 42.

²⁰ Independent (Johannesburg), "Critical Health, No. 9," 42.

²¹ Independent (Johannesburg), "Critical Health, No. 9," 7.

health crisis in this country cannot be solved unless national liberation is won.”²² Women’s rights were intrinsically tied to health issues, with women across South Africa recognizing the unequal opportunities and systemic barriers they faced in accessing healthcare. Another conference held in October of 1989 aimed to strengthen networking on women’s health issues and prioritize women’s policy interventions at the national level.²³ The draft proposal of a National Women’s Health Policy for South Africa emphasized the importance of accessibility, community participation, and local initiatives in addressing women’s health needs.²⁴ Additionally there was a call for women’s representation in decision making processes, as activists believed “women in Africa should have representation on bodies which make decisions and policies.”²⁵ These policies looked towards a future with a new, democratic country, with the concerns being the entrenchment of women’s rights in the new constitution, women’s representation in government structures, and education programs to challenge gender norms.²⁶ As the progress towards a free South Africa snowballed, the women’s health crisis blended into the larger movement for change.

The exploration of cervical cancer in 1980s South Africa serves as more than just a historical inquiry—it offers crucial insights into the intersection of health, politics, and social justice. Understanding the complexities surrounding women’s health during this period is vital for several purposes. Firstly, it provides a lens through which to examine the impact of apartheid-era policies on healthcare access and outcomes, particularly for marginalized communities. Secondly, it underscores the importance of integrating women’s health concerns into broader liberation movements, highlighting the interconnectedness of social, political, and

²² Independent (Johannesburg), "Critical Health, No. 9," 7.

²³ "Recommendations and Resolutions of First African Regional Meeting on Women and Health, October 1989," 37.

²⁴ (Johannesburg) and Editorial Collective, "Critical Health, No. 36/37," 108.

²⁵ "Recommendations and Resolutions of First African Regional Meeting on Women and Health, October 1989," 39.

²⁶ "Recommendations and Resolutions of First African Regional Meeting on Women and Health, October 1989," 39.

medical issues. Moreover, by shedding light on historical disparities in cervical cancer screening and treatment, this research prompts critical reflection on present-day healthcare systems and the ongoing struggle for equitable access to healthcare. Ultimately, this study serves as a reminder of the enduring relevance of historical research in informing contemporary debates and shaping future policy interventions aimed at promoting health equity and social justice for all.

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