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NORTHWESTERN UNIVERSITY

Reproductive Labors: The Politics of Women's Health in South Africa, 1900 to 1960

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SUBMITTED TO THE GRADUATE SCHOOL
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

for the degree

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Field of History

By

Catherine Eileen Burns

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ABSTRACT

Reproductive Labors: The Politics of Women's Health in South Africa, 1900 to 1960

Catherine Eileen Burns

This dissertation opens the thematic of reproduction in southern Africa to historical scrutiny. To do this, the work is divided into nine chapters, each tackling related aspects of this field of inquiry. It examines the development of a definition and practice of public health in the early decades of this century in Johannesburg and traces the local history of maternal health, mothercraft and midwifery in the context of urban segregation. Healing practices which existed outside of official control, namely the work of family midwives and health practitioners many of whom were black women with skills and experience acquired in rural settings, are explored. Here, the commonplace separation of "western biomedicine" and "indigenous African" practices concerning health and midwifery is challenged, using the records of an extraordinary herbalist and midwife, Louisa Mvemve. In 1928 the Bridgman Memorial Hospital was established as a site for a massive project to train and certify a cadre of black midwives and as space for scientific research concerning the bodies, birthing capacities, and gynaecology of black women. The development of a local specialty termed "Bantu Gynaecology" is traced, indicating the powerful linkages between the development of anthropological and scientific knowledge about black women.

The heart of this dissertation is an examination of the complex and contradictory history of the Bridgman through archival records and the oral testimony of women who trained at the Hospital and who gave birth there from 1930 to 1962. The politics of contraception and birth control in Johannesburg and the history of debates about sexuality and illegitimacy leads into a discussion of the increasingly didactic involvement of local and central state officials in the policing of black women in the city. *This increasingly invasive state intervention in birth, "family planning" and controlling the reproductive labor of black women after 1950 is the subject of the last section.*

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and hard work of thinking and finding out. I am indebted to the time I have spent around him (and his book collection), from Johannesburg, through Cape Town, to Evanston.

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Introduction

Today the staff of the Bridgman Memorial Hospital for Women have taken up their residence in the fine new building which stands on the open veld to the south of the Brixton Cemetery, and in about a week the first patients will be admitted. Dreams do sometimes take substantial shape, and the Bridgman Hospital, long dreamed of and ardently desired, is now at last in being.¹

Our mother, the late Letta Mosikatsana, has been a true disciple of nursing and midwifery... She was never off duty... She was a missionary for women and children's lives.²

The six decades separating the birth of the Bridgman Memorial Hospital and the death of Letta Mosikatsana mark off a period of profound change in the lives of black South African women. The Bridgman was founded by Christian missionaries, black and white social reformers, physicians and scientists and midwives, as a site of transformation and reproduction, both physiological and social. This 'house of friendship'³ as Clara Bridgman described the Hospital, provided black women in and around Johannesburg with the option of an institutionalized birthing space. It became a centre for obstetrical emergencies and gynaecological diagnosis and treatment, a hub for ante and prenatal care, and a home for mothercraft education. Its research wing, lead by consulting physicians and graduate medical students, set out to investigate and analyze the functioning of black

¹ "The Bridgman Hospital for Women: A Dream that Has Come True" Feature article Rand Daily Mail 28 July 1928.

² Tribute to Letta Mosikatsana from an Alexandra Clinic Midwife, on the occasion of her funeral; Anglican Church, Alexandra Township, 2 May 1992. Notes of Speeches made by C. Burns; Copy of printed Memorial Pamphlet, 3.

³ Clara Bridgman's speech at the opening of the Bridgman Hospital, quoted by the "Special Correspondent", Umteteli wa Bantu 1 September 1928.

women's bodies and birthing capacities and the foetal characteristics and infancy profiles of black children, to design treatments and procedures to improve women's health, and to add to the store of local and world scientific knowledge in such fields as abdominal anatomy, childbirth pain, caesarean procedures, gynaecological surgery, obstructed pregnancies, disease and fertility, breastfeeding, and early infant care. From its inception, the Hospital initiated an ambitious program of midwifery training, which became a model for programs launched throughout the ensuing decades. The Bridgman was also intended to serve as a locus for the didactic purposes of "civilizing" both patients and trainee midwives, moulding them into productive Christian women, who would eschew the faulty health practices and corporeal beliefs of their kith and kin, and who in turn would fan out across communities in adjoining areas of settlement, proselytizing about the benefits of biomedical maternal care, hygiene and Christian motherhood. The life long labors that midwives trained at the Bridgman maintained became legion in urban communities throughout the Witwatersrand and beyond. Three generations of Bridgman midwives could meet with one another in the 1990s after years of professional and community work, and comment on the importance of midwifery as a craft and a service to the women and children of South Africa.

We are the mothers of the mothers, we know so many of these children here. Now they are mothers too. Everywhere we go, we can see someone one we have assisted. That is true.⁴

In many ways, the intentions of the founders were more than met. Women such as Letta Mosikatsana came to adopt and adapt a vision of mission and service in their labor

⁴ Interview: Letta Mosikatsana, Alexandra Clinic, 19 March 1992, Transcript, 3.

as women and as midwives which survived the destruction of communities, the closure of political space, the impoverishment of workers, and the violence of the widespread rebellions and state repression of the 1970s and 1980s.

Opening the politics of reproduction to historical scrutiny has profound implications, not all of which are yet realized in these pages. This project does attempt to assemble a range of sources and arguments to suggest that any crude dichotomy between "production" (that is, work, wage labor and the creation of surplus) and "reproduction" (both physiological and social in its broadest sense) cannot be sustained. Quite clearly the reproduction of South Africa's working class was of great concern and interest to both capital and the state. While the existing literature on economy and society in South Africa does shine light on the interests of capital and industry in relation to the reproduction of workers, particularly male workers, no previous study exists which attempts to map out the origins of public health in South Africa in relation to the emerging fixation of local and central authorities with maternal and child health. However, chapters on gynaecology, contraception and the daily work of the Bridgman Memorial Hospital underscore a central theme running throughout this work: "reproduction"-- even when it refers specifically to the physiological production of human beings-- has no single or constant referent. Thus, the work of mothercraft and postnatal care was as important to the Bridgman project as the development of technological aids in the final stages of an obstructed birthing labor, and the frustration of Hope Trant at the high rates of child mortality among Bridgman babies a year after their birth eclipsed her interest in contraception research.⁵

The objectification of black women's bodies and labors that paralleled the creation of new medical institutions and services forms a recurring subject of every chapter. Yet, despite the authority and power vested in the offices of physicians and scientists, this dissertation demonstrates that the will and subjectivity of black women at prenatal classes, in examination rooms, and on birthing tables, arrested the full implications of scientific inquiry based on racial taxonomies and interrupted easy dichotomies between notions of civilization and primitivity so present in expert discourses across South Africa in the first half of the century. This project has sought to dismantle the constructs "western" and "indigenous" which have bedevilled so much anthropological and cultural analysis in the region since the 1920s. The figures of Louisa Mvemve, the midwives from Alex Clinic and the women who sought medically assisted births such as Rosina Kotane undermine simple minded assertions that the discourses of science and authority created total institutions or dioramas out of the lives and labors of women in the city of Johannesburg.

This dissertation is divided into nine chapters. Chapter one raises many of the major issues and themes discussed in much greater detail in the remainder of the chapters, introducing the subject of "public health" and the way that both "health" and "the public" were being constituted in early twentieth century Johannesburg. The masculine countenance of the city was transformed in the twentieth century, and chapter one points

⁵ Linzi Manicom has been particularly important in providing stimulation and encouragement for this project. Her paper on the gendered nature of the South African state has inspired many of these ideas. See: Linzi Manicom, "Ruling Relations: Rethinking State and gender in South African History" *Journal of African History* 33 (1992).

to the migration of women, increasingly black women, into the city from surrounding rural areas, and the waged and informal work that women took on and carved out for themselves as they reshaped the urban milieu. Along with this reshaping of the cityscape, a concomitant discussion of the value and role of women began to emerge. Chapter one points to the concern of city officials, white and black social reformers, and religious leaders with the immorality and danger of city life and their developing discourse around the need to control and direct the bodies and labor of particularly black women. The chapter discusses the role of a prominent social welfare worker in the city, Charlotte Maxeke, and her contributions to the debate about black urban women, a theme returned to again in chapter five. This concern with black women was closely connected to ideas about the scientific management of urban space and labor, and this chapter indicates the particular relevance of these ideas for women, as authorities increasingly defined "public health" as the instillation of regimes of hygiene and medical management over women and infants. This chapter also points to the healing and medical care of herbalists, indigenous doctors and midwives which thrived in the city before the late 1920s, and the relative absence of alternative sites of licensed western biomedicine, especially institutions catering for black women and children. Chapter one ends by announcing the establishment of maternal health care as a public project in the city.

Chapter two takes up this theme and traces the history of midwifery training and maternal health schemes inaugurated by the Public Health Department of the city. The chapter also grapples with the changing history of "motherhood", and the implications of

indigenous and imperial conceptions of motherhood for the women in Johannesburg in the early decades of this century. The history of the Public Health Department itself is discussed, and the crucial role of Charles Porter, the Medical Officer of Health, and his concern with infant mortality and morbidity in the city is addressed at some length. His interest in census data and statistical evidence as a basis for health planning led Porter to a series of investigations of vital statistics of Johannesburg's poor, and his scope was inclusive of both black and white working class people in the city. Under his authority Johannesburg created several new posts for women health officials whose task it was to oversee the health of infants and the postnatal care of women and babies. The role these Lady Health Visitors played in promoting the need for improved midwifery services and maternal health schemes is charted, as is their emphasis on the increasingly dire conditions of black women and children which led to investigations and the promulgation of several new municipal services. The role of these city health visitors in establishing a system to enumerate and regulate women's birthing labor is examined, as is the work of inspectors within the Department of Labour charged to fulfil the mandate of the 1918 "Confinement Act". In this section of the chapter the changing view of the central state concerning its responsibilities and interests with regard to pregnant women will be examined. These efforts occurred against the backdrop of local state initiatives to further segregate the city and its residents. By the mid 1920s, the success of Porter and his coterie of Health Visitors in addressing the health needs of poor city dwellers, especially the city's black inhabitants, was severely circumscribed. The discussion in chapter two then shifts away

from the work of local state authorities and their concerns and lack of concerns for public health, to an examination of the nascent professional medical community in the city, especially the emergence of a group of academic physicians, and within their ranks, a small cluster of gynaecologists and obstetricians. The connections between these physicians based at the new University of the Witwatersrand Medical School, and local public health initiatives is discussed. Under their auspices, maternity homes for white women were opened, and local midwifery training and certification of white women began. Chapter two ends by detailing the increasing role of missionary and philanthropic bodies in the health and welfare of the city's poor, especially as the city more clearly defined its responsibilities along racial lines. Here the presence of the American Board Mission is broached, particularly through the person of Clara Bridgman, whose keen observance of the need for comprehensive health care was summed up by her mission statement in 1927, after over a decade of planning maternity and mothercraft schemes in the city and fund raising in South Africa and the U.S.A:

It is proposed to inaugurate a comprehensive scheme of Public Health work for Natives in co-operation with the authorities and other private agencies. Using the existing site at Doornfontein, it is proposed to extend to all Native Locations and Townships along the Reef, the following services: baby-welfare clinics; pre-natal clinics and classes for mothers; crèches for babies and small children left without supervision by working parents; ... and District Nursing with special emphasis on instruction in Sanitation, Hygiene, and the prevention of diseases.⁶

The chapter closes by providing a sense of the wider context for the opening of the Bridgman Memorial Hospital.

⁶ HPC/AD 843 B91.32 "Meetings of the Provisional Board" 18 January 1927.

Chapter three is a detailed discussion of a woman who described herself variously as a midwife, healer, a herbalist, a diagnostician, and innovator of cures.⁷ Louisa Mvemve practised as midwife and healer in Johannesburg and the Witwatersrand from 1914 until she was forced to leave the city in the late 1920s. The chapter traces Louisa Mvemve's battle to gain recognition as a woman with valuable healing power, skill and talents in a specialized arena, and uses the remarkable record of her activities as a vital source for the history of healing and medical care in Southern Africa. Unlike the testimonies, autobiographies, accounts, papers and reports of the many officials, health administrators, medical missionaries, doctors and nurses, which besides the oral testimonies of midwives and women who gave birth at the Bridgman, form the basis for this dissertation, Louisa Mvemve's account is authored by a black woman. In these records, if not in her day-to-day life, her words take up more than equal space with those of white male officials. Here her particular experiences of male-dominated medical guilds, and the scepticism of newspaper reporters, police officers and Government Officials' concerning the capabilities and intelligence of women, are given voice. We see too that her gender lent a particular authenticity to her treatments for women. In certain circumstances this opened the way for special comradeship with other women, including white women, on the basis of her healing mission, and her personal experiences of, and ideas about, motherhood. Louisa Mvemve's status derived both from her position as a healer of note (a role she saw in some measure as an inheritance from her grandparents, and for which the patterned role of

⁷ CAD/NTS 3901 3/376 Part I, 1915: "WOMAN'S ADVICE: A woman's advice to the public on the cure of various diseases".

healers in various Xhosa-speaking societies at the time would have prepared her and her patients) but it was a role largely self-engineered as well. She wanted to create a niche for herself not as a nurse or western doctor, nor as a diviner, "traditional healer", or as a mere hawker of goods: she wanted to carve for herself no less than the role of a kind of new medical broker. But she embarked on this journey to fashion a new craft from the skills of her ancestors and the techniques of western biomedicine at just the time when the Medical Academy in South Africa began closing its ranks, centralising its authority, and undermining the independent expertise of a host of practitioners such as midwives and herbalists. The chapter closes by returning us to this broader context, and the creation of new institutions, such as the Bridgman, which provided black women with needed services, but ironically, also simultaneously criminalized the work of skilled healers and midwives such as Louisa Mvemve.

Chapter four begins a series of chapters focused on the Bridgman itself. In this chapter the urban milieu of the 1930s, and the black communities from which the Bridgman would draw its patients and to which the Bridgman would direct its services, are described. Then the chapter moves on to a discussion of 1930s contexts of rural and urban health more broadly. A major theme of the period was the drive by an alliance of white segregationists, church collectives and middle class whites for the salvation of "poor whites". The chapter analyses the implications of this in relation to a push by progressive health activists and philanthropists for similar measures to be extended across South Africa. Here the interests and concerns of the mining industry are addressed at some

length. The chapter ends by returning to the formation of the Bridgman itself, and its place in the panorama of debates and initiatives sketched in the bulk of the chapter.

The main focus of chapter five is on the founders of the Bridgman. The role played by Clara Bridgman takes centre stage, especially her efforts to inaugurate mothercraft work in the city in the late teens, and in the establishment of a hostel for urban black women, the Helping Hand Club. Her allies, notably people such as her husband Frederick Bridgman, Ruth Cowles and Edith and John R. Jones helped raise funds in Johannesburg and the U.S.A. In the 1920s she worked increasingly with women such as Charlotte Maxeke and men such as Selope Thema, local members of a growing black elite of educated and public spirited men and women and the city, who supported the creation of the maternity hospital and the establishment of midwifery training for black women. By the late 1920s Bridgman was able to draw upon networks in the city Public Health Department, the University of the Witwatersrand Medical School and the mining industry, and the chapter details the manner in which these bodies of people contributed to the founding of the Hospital. Finally, the chapters discusses the crucial involvement of a number of women physicians, such as Dora Dart, Mary Tugman and M. Crinzos de Cottens, as well as the support of Alfred Xuma, Raymond Dart and Alexander Orenstein in the medical work of the Bridgman.

Chapter six is concerned with the energies and presence of the women who created and oversaw the daily work of the institution, and the hundreds of midwives who came to the Bridgman for training in the period from 1928 to the early 1960s. The chapter is based

on the records of the Bridgman Hospital, the letters and correspondence concerning nursing of the co-ordinator of health for the South African Institute of Race Relations, Edith R. Jones, and the oral testimony of elderly and retired midwives trained at the Bridgman in the 1930s to late 1950s period. Interviews with Letta Mosikatsana, Mirriam Mphahlane, Wilhemina Madiba, Mirriam Mokoana and Elsina Kaben, form the basis of sections of the chapter which explore the childhood contexts of the midwives and their reasons for taking up midwifery training, as well as their experiences at the Bridgman. Discussions of working relationships with other nurses and physicians as well as with women patients are taken up, and placed against a broader canvas of the history of midwifery and nursing training in South Africa. The testimony of Ruth Drubin, an elderly physician who served her Housemanship at the Bridgman is drawn into this chapter for the light it sheds on the craft of midwifery, and the relationships between physicians and trained midwives. Finally, this leads into a discussion of the theories and practices of midwifery which emerged from the testimony of the group of midwives. Both their developing conceptions of the craft and skill of midwifery, and the roots of these ideas, are explored in the last section of the chapter.

Chapter seven takes up the story of the thousands of women who sought-out the Bridgman's services through the ensuing decades. The archives of the Bridgman as well as testimony and analysis drawn from oral interviews, particularly the testimony of Rosina Kotane, are used to explore questions about how and why women came to the Bridgman; to understand its importance as a site for the daily reproductive and health struggles of

thousands of black women in Johannesburg, as well as to assess whether or not the records of the hospital provide any evidence of improving the health of the women and children who were admitted and who visited the various outpatients clinics. The final section delves into aspects of the Bridgman records not addressed in the previous chapters, particularly material concerning infant and maternal mortality, and the services offered by the Hospital. The research work conducted at the Bridgman in the 1930s to early 1960s period forms the subject for chapter nine, but its importance is alluded to at the close of this chapter.

Chapter eight explores the complexities of the history of contraception and "birth control" in South Africa from the turn of the century to the mid 1960s when a didactic State population plan was introduced which emphasized the reduction of black women's fertility. A body of anthropological literature is examined for its insights into sexual practices and pregnancy prevention skills used by young men and women in many rural regions of the country before the 1930s, and this is set alongside testimony from a present day family planning professional, Patience Tyalimpe, who grew up in the rural Transkei and trained as a nurse. This section also draws on the recollections of midwives at Alexander Clinic, and of women who were given hormonal contraceptives at the Bridgman just as it was about to close. This chapter explores the interconnections between genetic theory and the branch of eugenics that gained salience in South Africa through the "race welfare" movement of the 1930s. Throughout the chapter references are made to the lingering appeal that direct controls over fertility and reproduction continued to have for

certain sectors of the state. The chapter ends by tracing the way in which the loose, rather irregular provisions for contraception services and advice across the city, were drawn under central state control in the period between 1960 and 1964.

Chapter nine, the final chapter, investigates the layers of anthropological, scientific and particularly medical research constituting "Bantu Gynaecology", a particular local branch of the broader science of women which developed and flourished in South Africa from the 1930s to the early 1960s. "Bantu Gynaecology" was forged from three mutually interlaced concerns. First, perceived characteristics of black women's bodies became diacritica in anatomical and physical anthropological research dedicated to the categorization and hypothesizing of the evolution of African peoples in southern Africa. Second, black women became the subject of research concerning the measurement of their body parts, particularly pelvises, and significance was attached to these measurements. And third, the birthing practices of black women became the focus of close examination on the part of medical and anthropological authorities. The academic context of South African universities and hospitals in the 1930s and 1940s, was predicated on scientific thought and practice obsessed with physical, cultural and behavioural difference. The particular racial and tribal lexicons under construction in southern Africa in this period, provided a fertile soil for these scientific discourses. In the southern African context an overriding concern about the laboring and reproductive potential of black men and women, remained a recurrent theme of state authorities and as well as the initiatives and company reports of mining and manufacturing capital. After a discussion of these

thematics in the work of Schapera and Dart, the implications of the work of Dick-Read, and the obstetrical observations and heroic narratives of Marchand, the chapter moves into a close reading of the work of O. S. Heyns, the chief progenitor of "Bantu Gynaecology". In this section of the chapter the contradictions and ambiguities that forced their way into the discourse of official knowledge of and about black women are raised, particularly in relation to Hyens' work at the *Bridgman Memorial Hospital*. In this regard, the final project which Heyns initiated, the creation of a depressurized "Birthsuit" is discussed, as is the associated demise of "Bantu Gynaecology". The chapter concludes with testimony concerning black women's changing birth practices and the ramifications of the medicalisation and hospitalization of birth, drawn from interviews with midwives who worked and trained at the Bridgman during Heyns' period of tenure.

A conclusions follows, which reiterates major themes of the dissertation, and sketches the final destruction of the Bridgman in 1965.

Chapter One

The Origins of Public Health in Johannesburg and the Gestation of The Bridgman Memorial Hospital

The opening of the Bridgman Memorial Hospital last Saturday was a great event in the life of the Bantu people on the Rand.

Umtateli wa Bantu; Major black-edited newspaper on the Rand, subsidised by the Gold Mining industry.¹

You see, I had to go to the Bridgman, because, you know with the Hospital Certificate in those days, you aren't paid very much. ... So I decided rather to do midwifery to make up./... It was my first time in Johannesburg. I was scared, but it was not so frightening really. But the only thing, it was just strange for a person from outside. But the people, they were nice there so ... I did not feel so much out of the way.

Letta Mosikatsana, retired Midwife, trained at Bridgman.²

I knew the Bridgman because I was working near Brixton. I could see it every day when I went past.

Rosina Kotane, Office Cleaner and Domestic Worker; two of her children were born at the Bridgman.³

People all knew about the Bridgman. It was well known. It had a reputation.

Ruth Drubin, retired Physician and Advisor to the Administrator of the Johannesburg Hospital; Obstetric and Gynaecological training at the Bridgman.⁴

When this institution was founded the Bantu still placed their trust in the witchdoctor and superstition like a thick black curtain prevented many a health-giving ray of light from entering into their lives. Since then many mothers who have received tender care in your maternity wards have in ever-increasing measure spread the gospel of health most effectively.

W Eiselen: Minister of Native Affairs, former Chief Government Ethnologist⁵

¹ Umtateli Wa Bantu, 1 September 1928, 3.

² Interview: Letta Mosikatsana, Alexandra Township, 6 February 1992, Transcript, 2.

³ Interview: Rosina Kotane, Johannesburg, 2 November, 1992, Transcript, 3.

⁴ Interview: Ruth Drubin, Johannesburg, 4 November 1992, Transcript, 3.

The opening of the Bridgman Memorial Hospital in 1928 represented the culmination of two decades of public and philanthropic health work in the largest city in Southern Africa. By the time it was forcibly closed in 1965, 93 000 black women patients had passed through its well-kept gardens and enamel painted doors, into its often crowded wards, shiny operating theatres, and open-air ante and post natal verandahs. No equivalent institution in Southern Africa brought together so many black women, to prepare for birthing labor, to bear children, to learn the craft skills of midwifery in "delivering" babies, to receive and communicate hygiene and mothercraft instruction, and for both emergency and routine medical care. Its wards were dedicated not only to live healthy births, but also to a vision of exemplary African Motherhood, and through this the reduction of infant and maternal mortality, the improvement of child rearing practices, and ultimately, the betterment of the class of labourers upon whose exploitation the riches of the city and state depended. A constant mantra of missionary, anthropological, medical and official expertise designated that projects of social and biomedical sanitation deemed necessary for the reproduction and improvement of "the Native population", depended for their success on black women. This mantra existed in complex relation to the position of Bridgman in a city and a country committing itself by 1928, through legislative and executive policies, to the exclusion of black women from permanent residence in urban areas. These same local and state policies and procedures severely proscribed black women's access to material,

⁵ Eiselen, W Bridgman Memorial Hospital Silver Jubilee Commemoration, 1953, Africana Library, Johannesburg, 4.

legislative and social resources which at the same time were being recognised by Public Health advocates and their associated armies of experts, as the essential foundation for achieving designated aims of healthy motherhood and the protection of infant life.

The complex institution that centred on Bridgman Memorial Hospital was also the site of extensive research conducted into the bodies, tissues, bones, capacities and birthing labors of black women. Publications, dissertations, surveys and the gathering of statistics were supported and enabled by the labors of nurses, tutors, matrons, administrative staff, medical interns, honorary physicians, researchers, particularly anthropometricians and anthropologists from the University of the Witwatersrand, and the thousands of women who came to the hospital over three decades. Although Johannesburg expanded rapidly during the early decades of the century, by the late 1920s the array of experts, interested parties and officials gathering around the creation of welfare and health regulations and institutions was small enough to overlap again and again in intersecting circles of local state, philanthropic and scientific communities.

In the midst of this dense but discernible web, the Bridgman, its founders, office bearers and staff, played a key anchoring role both in debates about Public Health and Native Health Administration on the Witwatersrand, and in the implementation by the white local state of structures and procedures from 1928 until the 1950s. White women played a major role in these debates. The Bridgman was one of a handful of important sites in the city where white women philanthropists, nurses and matrons, physicians and specialists, concentrated their energies. At the opening of the Bridgman in 1928 white

women in South Africa were on the eve of winning the right to vote, but their participation in civic, commercial and political life was severely circumscribed. Thus, for the middle class white women involved with this institution, their efforts brought not only personal satisfaction from their Bridgman work, but also made of it a space from which to participate in these local state discussions around public health and administration, the medical training of black men and women, and welfare policy implementation and fed into political debates about the capacities, potentials and rights of black women in particular.

A reading of newspaper accounts and published articles based on the testimony and appeals of the white founders, office-bearers, municipal supporters and medical scientists based at the Bridgman, lends itself to the a view of this site as emblematic of the gender prescriptive, racialized, civilizing and domesticating vision of white civic employees and missionaries of the day. In many ways, as this work will show, the Bridgman was just the sort of institution whose history provides material for an analysis of the powerful workings of discourse and representation in the elaboration of oppressive regimes. Here we see the languages of hegemony being elaborated, simultaneously directed towards intimate and national arenas, and at the same time carving out these separate spheres of "private" and "public", "domestic" and "civic".⁶ Within this corpus of published texts, the production of a genre of heroic narratives, authored by

⁶ K. T. Hansen, Distant Companions: Servants and Employers in Zambia (Ithaca: Cornell University, 1989), and Nancy Fraser, Unruly Practices (Minneapolis: University of Minnesota 1989).

self-representing white doctors in white coats tending black patients, raises the spectre of a space of dualistic inscription: black and white, death and life, ignorance and knowledge.

Studies of social health and medicine in Europe and North America have focused on the class and gender dualisms at the heart of scientific and official discourse,⁷ while analogous studies in colonial contexts have explored the constructions of race and the violence of colonial representations more fully.⁸ In her recent work on illness and colonial medicine in Malawi, Megan Vaughan grapples with the challenges and insights of subtle theories of representation and discourse, particularly the work of historian and psychiatrist, Sander Gilman.⁹ After recording her indebtedness to many of his insights on stereotypes and human psychology, Vaughan comments:

⁷ For example: Ludmilla Jordanova, Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries (Madison: University of Wisconsin Press, 1989); J. Walzer Leavitt, (ed) Women and Health in America (Madison: University of Wisconsin Press, 1984); Emily Martin, The Woman in the Body (Boston: Beacon Press, 1987); Ornella Moscucci, The Science of Women: Gynaecology and Gender in England, 1800-1929 (Cambridge: Cambridge University Press, 1993); A. Oakley, The Captured Womb: A History of the Medical Care of Pregnant Women (New York: Blackwell, 1984); and A. Rabinbach, The Human Motor (University of California Press: Berkley, 1992).

⁸ See for example: D. Arnold, (ed) Imperial Medicine and Indigenous Societies (Manchester: University of Manchester, 1988); S. Feerman, "Struggles for Control: The Social Roots of Health and Healing in Modern Africa" African Studies Review 28 (1985) and C. F. Sargent, Maternity, medicine and power: reproductive decisions in urban Benin (University of California Press: Berkley, 1989).

⁹ Vaughan refers here to: S. Gilman, Difference and Pathology: Stereotypes of Sexuality, Race and Madness (Ithaca: Cornell University Press, 1985). Gilman's analysis of the power and endurance of the iconography of black women's bodies and genitalia in Southern Africa informs the later section on the Anthropological and Anthropomeric work of Dart and colleagues. See: S. Gilman, "Black Bodies, White Bodies: Toward an Iconography of Female Sexuality in Late Nineteenth Century Art, Medicine, and

Of course cultures as systems of representation are constituted by a very wide range of 'signifying practices', and Gilman traces the resonances of these as they apply to race, sexuality and madness... but ... There are few cracks or dissonances in the picture he paints... Gilman's work is primarily concerned with the process of objectification... Gilman does not discuss, as Fanon and other writers on colonialism have, and as a body of feminist work has, the question of the effects of this process on those who are so objectified.

In her own analysis, Vaughan goes on to stress, that while "the crude simplicity of the biomedical discourses on Africa" appears again and again, her wider object is to:

...create a picture, not so much of the inevitability of insistent objectification and the endurance of images, but a more complex, and sometimes more blurred one, which can incorporate resistances and fractures.¹⁰

The case of South Africa itself possibly offers a unique conjuncture of both the powerful prescriptive and normative discourses at work in every piece of legislation and executive act on the part of the ruled, as well as continuous instances of just the blurry, contradictory fissures and leaks which animate Vaughan's Malawi study. Further, as we shall see, sites such as the Bridgman, as well as being spaces for the production and the transmission of knowledge on the part of medical authorities and experts, were also sites offering rest, comfort, support, and relief from pain. It is vital to incorporate these equally essential aspects of the historical experiences of the thousands of women and their infants who filled the beds and wards of Bridgman, of their own volition, from the month it opened. Michel Foucault's work on the history of mental health, penal institutions and punishments, clinical medicine, the archaeology of scientific knowledge, and the history of sexuality, has profoundly affected all subsequent work on madness, medicine, institutional

Literature" Critical Inquiry 12 (1985).

¹⁰ M. Vaughan, Curing Their Ills: Colonial Power and African Illness, (Palo Alto: Stanford University Press, 1991) 3 - 4.

knowledge and analyses of the revolutions in thought and practice which have reshaped human society since the Enlightenment.¹¹ His powerful categorizations of the invasive and capillary nature of bureaucratic, rationalizing institutions and official discourses has stimulated an array of research in the past two decades. However, this present project does not reveal a homogenous "master narrative" at work in the discursive and institutional power of medical authority in South Africa. Indeed, it is instead clear that medical institutions, such as the Bridgman, far from constituting "total institutions", were sites full of internal, simultaneous contradictions. Thus, despite the creative insights of his work, and the field of inquiry suggested and inspired by it, a Foucauldian vision cannot be sustained.

At the very heart of medical, ethnographic and even state documents from the 1910s onward--although after 1948 attempts were made to severely tighten and centrally define the State's agenda--a series of internal debates raged, which at times brought about short-term alliances, and at others deep cleavages between liberal and reform-minded academics, physicians, missionaries and state officials. Furthermore, within individually authored texts multiple arguments, reconsiderations, ambiguities and efforts to produce strategic voices of authority, are discernible through careful and contextual reading. Medical treatises, articles and annual reports of medical officers, read as historical as well

¹¹ See especially M. Foucault, The Birth of the Clinic: An Archaeology of Medical Perception (London: Tavistock, 1973); The Archaeology of Knowledge, (London: Tavistock: 1972); and The History of Sexuality: An Introduction, (Harmondsworth: Pelican, 1981).

as scientific texts, do not appear as fixed, or stable today as they may have seemed at the moment of their production. As indicated above, many of those who headed university medical departments and hospital teaching units were concerned with their own international reputations, and with the pursuit of medical theory and practice which would enhance their prestige. At the same time the very fact that they spent time in research and clinical settings instead of more lucrative, if less prestigious, private practice and the very fabric of their working lives on a day to day basis, was deeply engraved by the economic, political and social contradictions of southern African society. Virtually all of the prominent medical specialists, anthropologists and philanthropists connected to the Bridgman, allied their research to visions of future of public health and social services.¹² By the early 1940s, a mosaic of positions had emerged, spurred on by the war experience. The massive Health Report, issued at the close of the war by the Gluckman Commission, pointed the way towards a non-racial, socially supported, preventative and community oriented future national health service, a direction ultimately thwarted by the decisive shift in State policy after the 1948 election.¹³ But the competing visions of public health in the 1940s were barely hinted at in 1910.

¹² We return to a discussion of the role anthropologists and social ethnographers played in the production of knowledge about black women's sexuality and birthing practices in chapters eight and nine.

¹³ S. Marks, and N. Andersson, "The State, Class and the Allocation of Health Resources in Southern Africa", Journal of Social Science and Medicine 28:5 (1989).

Randall Packard's monograph on the history of tuberculosis in South Africa traces the political economy of this disease from the era of the first mineral discoveries through to the 1980s. His work directs attention to the intersection of the disease with segregated industrial labor. His work indicates that while race was perhaps the organizing category in the aetiology of the disease, the epidemiology of white workers and the complexity of the developing settler state, especially before the 1940s, makes stark distinctions between "colonial" and "indigenous" less water-tight. The examination undertaken here, of maternal care, birth labor and gynaecological history in South Africa, a history connected to industrial labor and migrancy but also distinct from the direct control of mines and male officialdom, suggests that the systems of representation contained in the "texts" of the ruling classes in South Africa do not exhaust the sources of meaning and personhood.

Besides the official publications, notes and volumes emanating from the work of people centred around Bridgman, oral testimonies, minute records, unpublished archival sources illuminate different paths of inquiry, contradictions and ambiguities at the very heart of the history of the Bridgman. Here too was a site where women met other women at crucial moments in their lives, moments which became important markers of the passage of time, and opened new chapters in their personal narratives of travail, success and struggle. Here women, who were laborers in the kitchens and nurseries of white men and women, who were battling to provision households through hawking, sex work, brewing and service work, often far from rural homes, and struggling to build a space for their futures in this city, could and did gather to meet women from all over Southern

Africa who found themselves in similar material and social contexts. Here they met wealthier women too. Women whose positions within the ranks of the growing, but increasingly vulnerable black petty bourgeoisie of Johannesburg did not protect them from racial segregation legislation preventing them from entering white clinics or nursing homes as patients. Thus the meeting of these women at the Bridgman provides a vital source for investigation into the cross-class alliances, as well as the contour and fault lines running between and among black women.

In considering the legacy of the Bridgman we have a chance to explore a classic, virtually clichéd, assertion of social thinkers and every day conversationalists, feminists and misogynists among them, that: "childbirth is a most basic bonding connection between all women, in its pain and its rewards, cutting across region and class, experience and politics". Whatever their experiences of childbirth (and we shall have something to say to this later on) the black women who came to the Bridgman shared much: the anticipation (in dread and happiness, poverty and sufficiency) of the birth of their children and the meeting and re-meeting of other women, now mothers, at vaccination clinics and postnatal visits. Here at the Bridgman, these women found a measure of succour and dignified treatment, a recognition of the importance and moment of their birthing labor, day-to-day care by black and white women midwives, and access to the same University-based obstetricians and gynaecologists that treated white women in the Queen Victoria Maternity Hospital and the maternity wards of the Johannesburg General Hospital.¹⁴

¹⁴ This "measure of dignity" is intended to stand as a qualified statement: some

Here too, the first and successive generations of high-school educated black women gathered for midwifery certification, equal in requirement and craft, though not remuneration or status, to that of their white peers. These women built working, clinical, and social relationships which sustained them long after the demise of the Bridgman, networks which formed the basis of their life-commitments in maternal clinics, civic organizations, religious groups, parent bodies and even study groups, in Alexandra and Soweto townships through to the 1980s and 1990s. The study of these inter-generational exchanges and networks is central to the search for a nuanced and dynamic understanding of class relations in South Africa, and crucial to an analysis of the everyday workings, replications and transformations in the realms of scientific knowledge and practice. The working lives of black women belie the easy and caricatured epistemological divisions so often drawn between western biomedicine on the one hand, and kin, community and herbal medical treatments and systems on the other.¹⁵

women experienced brusque treatment even from black midwives, women who were often younger and usually more school-educated, and often conspicuous in their display of middle class aspirations. Further, and more acutely, the political and gender biases of the white staff (particularly the training physicians as well as the honorary Gynaecologist-Obstetricians, as evidenced in their writing and indicated in records of their Professional Associations) clearly shaped their interactions with women patients. Women however, seemed to have distinguished between paternalistic behaviour (which was anticipated and even accepted as an integral part of the landscape of gender inequality in rank, salary, skill, recognition and right, in South Africa as a whole), and racist behaviour, which they associated with non-permanent members of the staff. These complex class and race issues will be discussed at greater length below.

¹⁵ These issues, and a detailed discussion of the work of scientists at the Bridgman, form a central part of a later arguments.

The work of scientists at the Bridgman included studies on infertility and venereal disease, anthropometric work on pelvic size, foetal weight and cranial size, experimentation in vaginal fistulae repairs, ectopic pregnancies and cesarean section techniques, dramatic inventions in suction and aspiration devices for women with difficult labors, as well as the attempt to create a subdivision of "Bantu Gynaecology" within the speciality itself. Even the legacy of these endeavours cannot be fully measured by an analysis of the discursive formulations and prescriptions embedded within every project and publication alone. The challenge of assessing this scientific work is to chart the intellectual and political context and the self-aggrandisement inherent in each undertaking, while simultaneously assessing its impact on other registers of human experience, for example, the easing or not of physical pain and mental anxiety and an appraisal the diagnosis and remedy of disease and dysfunction. More difficult than the reading of racial and misogynistic tones in the score of the extant research material, is the tracing of the impact of the unexpected on the work of experts. To detect the impact of findings on researchers, with virtually unchallenged local institutional, material and discursive powers, who yet sometimes altered their views and methods, changed their minds, gave up or transformed even some of their misconceptions, requires engagement with historical actors and sources seldom referenced in these texts. Even in the work of perhaps the best known scientist based at Bridgman, Ossie Heyns, the subjects and objects of Heyn's research were not unequivocally disempowered.

Before we can turn to a close examination of the records and testimony surrounding the Bridgman itself, we need to trace the history of how it was that maternal care, midwifery training and licensing, as well as infant mortality concerns and mothercraft training came to occupy the focal place in the Public Health planning and funding of South Africa. These issues have not been addressed in the secondary literature on South Africa, although a vast body of historical literature on midwifery, welfare state policies and public health in Europe and North America has demonstrated the crucial links between public and maternal health. In the case of white South African women, recent research has pointed to the importance of nationalist constructions of "motherhood", and in passing, has mentioned the formation of institutions such as maternity homes and mothercraft schools for poor white women.¹⁶ In the case of black women, however, much more remains to be said about the relationship between black women in the cities and the other Grand Social Issue of the Day: the fate and circumstances of "poor whites". Themes such as the eugenic concerns about "race health", vitality and nation building, focused in the main on poor white women, although high infant and maternal mortality across racial lines focused widespread attention on "mothers" as pivotal to betterment schemes, or more narrowly, social stability and control. In the case of black women, racial paranoia fed into anxieties around "family and tribal" breakdown, sexual immorality and disorder. These

¹⁶ Here the work of Elsabe Brink is key. See "Man-made women: Gender, class and the ideology of the *volksmoeder*" in C. Walker, (ed) Women and Gender in Southern Africa to 1945 (Cape Town: David Philip, 1990). We shall return to this theme below.

outcomes were feared and predicted by white missionaries, anthropologists and officials, and black social workers, intellectuals and political leaders alike.

Just as the field of Public Health and the professionalizing of midwifery, obstetrics and gynaecology was taking shape abroad and in South Africa, with the passage of National Health Acts, as well as "Confinement" or Maternity Grant Acts, so too herbalists, birth assistants, diviners and healers outside of this emerging Bastille of categories and certifications continued and developed their practices. Facing increasingly harsh circumscription outside of Natal (where Native Code Laws carved out a particular, although regulated, space for Native Herbalists), healers began to register their cures, advertise their products and services and sue and petition for the right to exist in the face of mounting opposition from the Medical academy.

In 1928, the year the Bridgman opened, no pristine system of indigenous medical and healing existed. This is not to suggest that there ever was a moment when traditional healing remained frozen in time or space, and similarly, this is not to contest the many intricate diagnoses and treatments which emerged before western biomedicine gained any footholds in southern Africa (and in Europe and the Americas for that matter) and which remained efficacious in the eyes of many South Africans through this century. Birthing and medical practices in communities across Southern Africa were kept alive and adaptive throughout the period of this study. Pointed examples of this include women who gave birth at Bridgman one year, recorded births in rural villages, helped by female kin and local specialists in preceding or later years.¹⁷ The point worth stressing at the outset, is that just

as health officials and legislators caricatured, for their purposes, the vast regional, ethnic and gendered array of indigenous healing systems with terms such as "witchcraft", "superstition" and "the meddlesome interference of ignorant grandmothers", so too have recent commentators tended to overstate the hegemonic closed-boxes of western biomedical regimes, and simultaneously described vast epistemological disjunctures between these different practices and theories of healing.¹⁸ This subject is vast, and worthy of study in its own right. But in order to understand the options available to women who came to the Bridgman, in order to assess the available evidence on birthing practices and infant care within the various therapeutic landscapes of communities across the region, in order to assess the wider Southern African context of maternal care and midwifery, this project must also take account of the armies of *amaxhwele*, *zinyanga*, *amagqirha*, *dingaka*¹⁹, who practised in both rural areas and in Johannesburg, and cities and towns along the Rand, and indeed in the rural reserves as well.²⁰ In order to address this terrain, a discussion of an exemplary women healer, midwife, fertility specialist and entrepreneurial chemist, Louisa Mvemve, will be broached in chapter 3.²¹

¹⁷ Interview: Rosina Kotane, Johannesburg, November 2 1992.

¹⁸ See references to these romantic visions of indigenous healing systems in the Louisa Mvemve chapter.

¹⁹ IsiXhosa, isiZulu and seSotho words for "healer" and "doctor".

²⁰ "Rand" and "Reef" are local versions of the term "Witwatersrand", a region with Johannesburg in the center and municipalities and settlements to the east and west of it.

²¹ Indigenous birth practices, as evidenced in three anthropological monographs and several interviews, as well as in two detailed studies by physicians and one by a clinical psychologist, will be referred to in later chapters.

The formation of the Bridgman was a physical manifestation of several key debates and themes in the state-building projects of local and central authorities during the first three decades of the century. A concern for order and control through the instruments of "race and sanitation" efforts originally took the form of "black peril" agitation against black men and venereal disease, a form gradually grafted together with eugenic anxieties about the control and betterment of "poor whites". These concerns fed in turn into obsessions about the sexualized, immoral dangers of black women as they increasingly migrated to the city and surrounding areas. These migrations and settlements led inexorably to agitation for Passes, Medical Examinations, Influx Controls, and anti miscegenation legislation. At the same time these racist and misogynistic interests existed in some tension with anxieties concerning the demographic profile of the city and countryside from the perspective of mining capital and industry. Industry's requirement for cheap and plentiful male labor began translating into concern about the morbidity and mortality of the labouring classes upon which capitalist endeavour depended. These double headed, sometimes conflicting interests, required human statistics and population profiles to explain and remedy their concerns. These in turn spurred the interest both in information about adult males and females entering cities, but also in infant and maternal morbidity and mortality. Evidence of ill-health and disease, beyond the mining industry's data banks of industrial medicine, began to tax the energies of the small group of publicly minded medics. Along with state officials and capitalists, they began focusing on issues of "reproduction": at first, material and then, increasingly, physiological and social.

These interconnected fixations shared and replicated similar ones in other contexts, particularly in the industrial centres and on the national stage in Britain. Britain remained the touchstone for state formation and health practice in South Africa throughout the early decades after political union, and before white republican nationalism further displaced the binds of empire. Curious contradictions emerged at the heart of the definition and practice of Public Health, especially in relation to its maternal and midwifery projects, and it is to the history of this that we now turn.

Gender, Class, Race and State Formation in the Creation of Public Health:

...medical officials and other public authorities in South Africa at the turn of the century were imbued with the imagery of infectious disease as a social metaphor... this metaphor powerfully interacted with British and South African racial attitudes to influence the policies and shape the institutions of segregation... urban public health administration was of considerable importance in accounting for the 'racial ecology' of South Africa and of colonial societies generally ...²²

In his work on the history of Bubonic Plague and urban segregationist policies in the decade after the South African War of 1899-1902²³ and before the formal act of Union in 1910, Maynard Swanson convincingly elaborated the interconnections between local state-formation, racial segregation and the representational power of disease and

²² M. Swanson, "The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909", *Journal of African History* xviii, 3 (1977) 387.

²³ Until recently this war was referred to as the "Anglo Boer War" or the "Boer War". Several historians working on this period have convincingly suggested these terms reflect official ideology of the day. In fact this war involved many more combatants than the two Boer Republics and the Imperial forces. Thousands of black combatants fought in the war on both sides, and many black civilians perished.

contagion metaphors in early twentieth century Southern Africa. His apt naming of this confluence of agendas as the "sanitation syndrome", as well as his detailed analysis of the history of bubonic plague outbreaks in the Cape, has elevated his 1977 essay to the centre of commentaries about health and governance in Southern Africa. Between cessation of the South African War and the Influenza pandemic (which decimated communities in Southern Africa and many other regions of the world) a piecemeal public health infrastructure for the newly formed Union of South Africa built its foundations upon the "sanitation syndrome".²⁴ Only after the "great 'flu'" of 1917/8 was a Public Health Act passed into law, with greater powers of jurisdiction to shape and intervene in the health of its citizens and subjects.

For the Public Health Department of the new Union of South Africa, the Spanish 'flu epidemic was a very severe baptism of fire. It had existed as a separate sub-department within the Department of the Interior only since December 1917 and even then, the change from the largely advisory role which its officials had performed since 1910 was, in the words of its head, Dr F. A. Arnold, "really very slight". In the absence of a Union Public Health Act, its functions remained undefined, its powers unspecified and its establishment small.²⁵

Between 1902 and the 1919 Health Act, the proliferation of venereal diseases remained one of the chief concerns of officials, religious leaders and respectable residents of urban

²⁴ The outbreaks of Bubonic Plague in Johannesburg in 1904 and the 1920s were traced to the Malay Location, where, by the late teens, half of the residents were black. Along with other slum-areas, forced removals and wholesale destruction measures, such as burning all the buildings to the ground, were authorized by city sanitation laws. See N. Kagan, "African Settlements in the Johannesburg Area, 1903-1923, (M.A., University of the Witwatersrand, 1978) 25-28.

²⁵ H. Phillips, 'Black October': The Impact of the Spanish Influenza epidemic of 1918 on South Africa (Government Printer: Pretoria, 1990) 101; R. Bernstein, "Medicine and Health in Early Johannesburg: the First 25 years, 1886-1911", Adler Museum Bulletin 12:3 (1986).

centres. At first white women sex workers working in the dock and downtown areas of port cities, and after the mineral discoveries, in Kimberly and Johannesburg, were the focus of these concerns. Charles van Onselen has carefully detailed the history of European and American women who came, and were brought, to Southern Africa in the years leading up to and just following the South African War.²⁶ As van Onselen notes, at first city officials in Johannesburg tolerated the fairly formally organized networks of "pimps and prostitutes" as long as they resonated with city and Randlord attempts to attract male workers. A growing concern of the self-appointed moral middle class of the city, however, condemned not only "vice", but also the dangers of "vice across the colour-line", as black male workers frequented the hotels and rooms of white women sex-workers. Soon after the first notable influxes of black women from the Cape (Coloured women in the main), and black women from rural areas (officially designated African or Native women), anxieties about the venereal threat shifted to black men, and increasingly, black women. By 1910, black women were seen as the major vectors of these contagions, which threatened the fabric of social order, jeopardising the strength of the labouring force, and spreading through domestic contact into the homes of the cities' elites.

The roots of this obsession lay in nineteenth century health initiatives. In urban centres of the Cape Colony, especially Cape Town, in Natal, and to a limited extent in the

²⁶ C. van Onselen, Studies in the Social and Economic History of the Witwatersrand, 1886-1914: Volume One, "Prostitutes and Proletarians, 1886-1914" (Johannesburg: Ravan Press, 1982).

two Boer Republics of the interior, health authorities and sanitation committees were formed after the 1850s. Largely ineffective outside of Cape Town, they nevertheless did muster the needed alliances to pass into law certain regulations for the benefit of the public's health. Heading the short list of matters deemed "public health" at the time were anti-venereal disease strategies, increasingly aimed at women, who were designated the vectors of disease. The Contagious Diseases Act, No. 25 was passed into law in the Cape parliament in 1868, just four years after its namesake in Britain. The history of its subsequent repeal, and then reinstatement into Law, followed similar trends in Britain, with the support of contending and vocal "publics" alternating in their defence and attack on the aims and efficacy of the laws²⁷

Luise White's important study of the history, geography, economy and languages of prostitution in colonial Nairobi begins by addressing itself to similar "pollution" metaphors and discourses connecting prostitution and venereal disease.²⁸ Her account describes elaborate relationships, developed by key groups of Kenyan women migrants, involving sex as well as intimacy, comfort and provisioning in return for protection, money and access to urban accommodation. The study suggests rich comparisons to the South African case, but unlike in Kenya, the existence of white prostitution in South Africa and its vast historical corpus of "official concern", dating back into the early nineteenth

²⁷ P. W. Laidler, and M. Gelfand, South Africa: Its Medical History, 1652 - 1898 (Struik: Cape Town, 1971) 454- 455; J. Walkowitz, Prostitution and Victorian Society, (Cambridge: Cambridge University Press, 1980).

²⁸ L. White, The Comforts of Home: Prostitution in Colonial Nairobi, (Chicago: University of Chicago Press, 1990).

century played a central role in South African debates, impinging directly onto the development of health and welfare discussions.

The fixation of local health authorities and municipalities with venereal disease continued into the 1930s, but wider health policy gradually gave way to a more broadly defined schema of mortality and morbidity, with labor resources and the reproduction of the poor taking centre stage. Thus, the roots of maternal and infant health policies, and the creation of local health networks, were firmly planted in the soil of anti-venereal campaigns.

Karen Jochelson's work on the historical epidemiology of venereal disease in South Africa delineates the complex shifts in diagnosis and treatment and the associated metaphors which continued to animate segregationist discourse after 1910.²⁹ Recognizing the particular role that anti-venereal disease campaigns took on, in the context of Johannesburg in the early decades of this century, Kathy Eales has extensively explored the representations of dangerous sexuality and pollution behind municipal legislation although her focus has been on the history of black women's movement into the city in the 1910s and 1920s, rather than on the history of venereal disease itself.³⁰ In a series of recent

²⁹ K. Jochelson, "Patterns of Syphilis in South Africa, 1880-1940", South African Research Seminar, Oxford, (1989).

³⁰ See for example: K. Eales, "'Good Girls' vs 'Bad Girls'" *Agenda* 4 (1989); "Popular Representations of Black Women on the Rand and their Impact on the Development of Influx Controls", University of the Witwatersrand History Workshop, February (1990); "Patriarchs, Passes and Privilege: Johannesburg's African Middle Classes and the question of night passes for African Women", University of the Witwatersrand History Workshop, February (1987).

papers, Eales has established key interconnections between a number of levels of social and political life in Johannesburg: anxieties on the part of white elites about the licentiousness and innate immorality of black women, anti-venereal campaigns, the debate about Pass Controls for black women, and the complex dialogue between white officials and members of the African petty bourgeois including religious leaders, political and civic activists (such as members of the social hygiene movement, notably Charlotte Maxeke), concerning the status of black women in Johannesburg.³¹ A distillation of her findings indicates that the steady and then rapid influx of black women into Johannesburg heightened the already evident tensions and contradictions in official policy regarding the efficacy of "single" male migrancy versus a settled work force, made up of men and women, on the Rand. Proponents of "cheap labor" devoted their efforts to the policy that maintenance of rural reserves should form the basis of provisioning, reproducing and sustaining male work forces, and supported forceful measures to prevent female migration. These proposals were, however, challenged on at least two fronts.

First, the increasing, although regionally diverse, impoverishment of the Native Trust lands and reserves as well as the constraints on black sharecroppers and tenants on white farms, forced a series crisis migrations into the city, including increasing numbers of women. The years around 1906, the early 1920s, the aftermath of the Depression of 1929, and the Second World War era, marked out these migrations, and each crisis occasioned

³¹ The subject of non-marital sexuality will be considered in greater detail in the chapter on Contraception. See: CAD/NTS 7601 9/328.

heightened debate over the ramifications of urban black women's presence in the city as well as introducing legislative and procedural measures designed to contain and prevent further influxes.³²

While these crises in rural production may have catalyzed the movement of men and women to urban areas, they do not in themselves help explain the shape and form of these movements, nor the deep-seated opposition that black women were to face in their migrations. The roots of the attempts by both white and black men to set the terms for the migration and movement of black women, lie in the nineteenth century history of the region. Histories of homestead and communal life in late eighteenth and nineteenth regional African polities have underscored the central productive and reproductive responsibilities of women as agricultural producers and as the source of the productive capacity through their responsibilities for reproductive life and provisioning of children and adult men in each society. This literature has also begun grappling with the massive revolutions reshaping the social, material and cosmological fabric of indigenous communities.³³ Umbilically tied to imperial expansion, wars of conquest and rebellion, land

³² Besides Eales and van Onselen, these authors have remarked upon and detailed the pre-World War Two influx of black women to Johannesburg: D. Hindson, Pass Controls and the Urban African Proletariat (Johannesburg: Ravan Press, 1987); I. Matsepe, "African Women's Labor in the Political Economy of South Africa, 1880-1970" PhD, Rutgers University (1984); C. Walker, "Gender and the development of the migrant labour system c.1850-1930", in C. Walker, (ed) Women and Gender in Southern Africa to 1945 (Cape Town: David Philip, 1990) and J. Wells, "The History of Black Women's Struggle Against Pass Laws in South Africa 1900-1960" PhD, Columbia University (1982).

³³ M. Kinsman, "'Beasts of Burden': The subordination of Southern Tswana Women, ca. 1800--1840" Journal of Southern African Studies 15:23 (1983); W. Beinart and C.

dispossession, the creation and extension of systems of taxation, contract and indenture, and passes, the gestation of capitalist agriculture, Christian proselytising missions, commoditization and the expansion of new trading networks and frontiers, these revolutions also brought with them attempts to rebuff and reshape the exigencies of colonial rule.

In the latter part of the nineteenth century, as men in large numbers began to migrate to white capitalist farms and to the mining centres in the interior, burdens of farming, land clearing, food storage and trading fell even more heavily onto the shoulders of women. The gender dynamics within households and larger communities played a crucial role in the late nineteenth and early twentieth century responses of men and women throughout the subcontinent, and in the last decade researchers have begun to recognise this. In a paper of 1983, which eloquently directed attention to this and other themes in the writing of a South African history centrally informed by gender, Belinda Bozzoli observed:

It was not simply the men's *absence* that placed the burden of domestic agricultural labour on the women; nor is it just that male tasks had been undermined by the destruction of the African states; it was *also* that these societies possessed a capacity to subordinate women's labour. Indeed one might even suggest that the giving up of migrant labour by these societies partly rested upon their capacity to subordinate women's labour; and that it is in this capacity, that the resilience of these systems to 'full proletarianisation' may have rested.³⁴

Bundy, Hidden Struggles in Rural South Africa: Politics and Popular Movements in the Transkei and Eastern Cape, 1890--1930 (Johannesburg: Ravan Press, 1987) and J. Guy, "Gender Oppression in southern Africa's precapitalist societies", in C. Walker (ed), Women and Gender in Southern Africa.

³⁴ B. Bozzoli, "Marxism, Feminism, and South African Studies", Journal of Southern African Studies 9:2 (1983) 151.

Attempting to incorporate an understanding of precolonial patriarchal forms within early twentieth century debates over the entry of black women into Johannesburg, Eales has articulated a sensitive account of the various legislative attempts by the Johannesburg Municipality and the central State to curtail direct female in-migration. Building on the frameworks of pass controls, vagrancy laws and single-sex accommodation schemes for men, city officials dreamed of similar systems of regulation for women. From the start, however, as Wells and Eales have shown, opposition to the carrying of passes by African women, on the part of liberal philanthropists, black male elders and respectable black Christian women, effectively sabotaged the complete efficacy of all other measures. Plans to insist on the inspection of women for venereal disease foundered on the inability to track and screen recently arrived women. In 1924 and 1930, amendments to the 1923 Urban Areas Act with its net of restrictive segregationist laws, attempted to further enmesh women by insisting that their presence in the city be connected to the already constrained rights of men, men with whom they had to be connected as dependants, that is, as daughters or wives. The latter prescription was the most flagrantly trammelled, as in the same rush of legislative enactment the state passed the 1927 Native Administration Act, formally sanctioning a parallel system of recognised marriage forms, without any effective concomitant system of the registration of customary marriage. Walker, has perspicaciously summarized the ramifications of these enactments:

Given ... [the] exemptions and without an effective pass system for women, enforcement of these measures proved difficult... Until a uniform and national system of passes for women was hammered into place by the Nationalist Government after 1948, women determined to move about town were able to take

advantage of the central government's reluctance to intervene too decisively. The measures imposed before 1930 signalled the central government's commitment to the migrant system and to the principle that African women belonged in the rural areas, under the control of male guardians and chiefs, but their limited reach indicated that at that stage the state intended to rely mainly on indirect controls, in the form of a reinforced patriarchal tradition, to achieve this.³⁵

However, whether or not the passage of even more draconian legislation would have effectively kept women out of Johannesburg is highly questionable, particularly since there were contradictory demands being made, on behalf of women's urban labor, to Johannesburg city officials in particular.

Thus, the second onslaught on official visions of a city without black women was led by arguments about the need to replace male domestic labor with the labor of women as child-carers, cleaners, laundry workers, cooks and to a limited extent, factory workers. These arguments were buttressed by vocal and organised calls (on the part of white philanthropists, missionaries, black petty bourgeois leaders and some local state officials) petitioning for the social necessity of establishing a moralized black working class life, bounded by marriage and family perimeters, even if this was to be circumscribed by the needs of white capitalists and city officials.

Charlotte Maxeke, a leading reformer and welfare worker on the Rand, founder member of the Bantu Women's League, and Board Member of the Bridgman, had returned from the United States after obtaining her B.A. from the Wilberforce Academy in 1901. Amongst other projects she attempted to set up a recruitment system for female domestic

³⁵ C. Walker, "Gender and the development of the migrant labour system" in Walker, C (ed) Women and Gender, 186.

workers, complete with registration cards, medical certificates and references. The timing of her initiatives corresponds directly with similar attempts in American and British cities, and she may indeed have gleaned her plan from her experiences in the USA.³⁶ However, the well established systems of recruitment and contract in the local mining industry must have provided a compelling local example. Ultimately her planning was not supported by either the local state or by white employers, who seemed to chaff at the idea of any regulation of service and contract (even for what would seem to be their own benefit), of domestic workers in their employ. Two newspaper accounts from 1923 and 1924 outline her plans for women domestic workers, and also the fears and dangers she associated with the evil temptations city life for young black women, associations shared no doubt by many readers of the Star and the Rand Daily Mail. Maxeke outlined her plans for a labor bureau for "native girls", and indicated some early successes, in a 1923 article headlined:

NATIVE GIRL SERVANTS TO OUST THE BOY/ A USEFUL AGENCY ON BUSINESS LINES.³⁷

In 1924, a more extensive feature was heralded by banner headlines proclaiming:

RUIN OF NATIVE GIRLS/ HOW THEY FLOCK TO THE RAND/ A SOCIAL EVIL/ MRS MAXEKE ON REMEDIAL MEASURES/ LANDLORDS WHO ASK NO QUESTIONS.

After introducing readers to Maxeke's impeccable credentials for the subject at hand, the article continues:

³⁶ D. Katzman, Seven Days a Week: Women and Domestic Service in Industrializing America (London: Oxford University Press, 1981) and R. Rosen, The Lost Sisterhood, Prostitution in America 1900-1918 (Baltimore: The Johns Hopkins University Press, 1982).

³⁷ Star, 17 October 1923 and see CAD NTS 7601 9/328.

Mrs Maxeke considers that the habit of white housewives of giving nursemaids outside rooms often in close juxtaposition with native men, rooms which cannot be locked, is likely to put a premium on immorality, and to result in a falling away from grace.³⁸

In a third article Maxeke is quoted in direct speech marks, making her most explicit appeal to white women to hire black women rather than black men domestic workers. She argued this move would solve in one fell swoop all potential problems of black male sexual aggression (the infamous "black peril" fears of the era), and reorganise domestic life in Johannesburg along more "natural and efficient" lines. She was quoted as saying:

I know it will be difficult to overcome the preference which the European women has for the native houseboy. The average white women is obsessed with the idea--infact the conviction--that the native girls are immoral and diseased. As a worker among the girls I know that this is not so--that the services of many decent, respectable girls can be secured... Nature itself ordains that the European woman's handmaid should be one of her own sex... It is ridiculous to think of a big able bodied man moving about a house and ousting a woman from her natural duties. From the better class of European woman the native girls would learn how to conduct themselves with propriety, and receive instruction in domestic science and housecraft generally, and thereby become useful members of society.³⁹

Although Maxeke speak of "young girls", and suggests that these domestic workers would leave their employ upon marriage, returning to their "homes", other "native experts" in the city were recognising that women migrants soon ceased to be so. Arriving in the city was itself frequently a sign that material conditions and social relations at home had been undermined enough to obviate the possibility of women remitting income in order to help maintain a rural homestead, and thus women usually arrived and remained permanently. The literature supporting this observation is formidable: missionary, sociological,

³⁸ Rand Daily Mail, 14 July 1924.

³⁹ Star, 19 August 1923.

anthropological and official surveys and inquiries from around 1911 through the early 1940s, proffered evidence that women's moves to the city were more permanent than many men's, and advanced reasons for this.⁴⁰

An almost hegemonic set of explanations began to emerge explaining both the influx of women to the towns and the immorality of town life. These contemporary accounts, which have been closely scrutinized by Eales and, in the context of black Christian women's responses, by Deborah Gaitskell, attributed the increasing influx of single younger women to the breakdown of "tribal conditions" in rural areas.⁴¹ Other favoured motifs included the dangers associated with the absorption of some tenants of missionary Christianity (the theoretical moral equality of individual women, the onslaught on polygamous and patriarchal powers, the rising expectations of young black women), and the unexpected consequences of this (personal freedom spawned moral laxity in women not yet fully civilized thus undermining of elder male authority).

Contemporary commentators suggested a two-pronged response: shoring-up rural controls by senior men, and discouraging women to move without the oversight of urban

⁴⁰ See for example: CAD NTS "Repatriation of Undesirable Native Women" 7715: 57/333; E. Hellman, Rooiyard: A Sociological Survey of an Urban Native Slum (London: Oxford University Press, 1948); M. Hunter, Reaction to Conquest: Effects of Contact with Europeans on the Pondo of South Africa (London: Oxford University Press, 1936); R. Phillips, The Bantu in the City (Alice: Lovedale Press, 1938) and I. Schapera, Married Life in An Africa Tribe (New York: Sheridan House, 1941).

⁴¹ D. Gaitskell, "Devout Domesticity? A century of African women's Christianity in South Africa", in C. Walker, (ed) Women and Gender; and "'Wailing for Purity': prayer unions, African mothers and adolescent daughters, 1912-1940", in S. Marks, and R. Rathbone, (eds) Industrialisation and Social Change in South Africa (London: Longman, 1982).

men, and the close supervision of black women in the urban centres. Anthropological accounts of the period emphasised the cultural and sociological adaptations in black women's self-definitions and expectations, but also emphasised the hardships of rural life. Historical research conducted since the 1970s has provided greater detail concerning the collapse of rural economies, the harsh and increasingly unmitigated burdens on younger women, with men migrating for longer periods, and many never returning permanently to rural birthplaces at all.⁴² One major exception to these visions of women city dwellers as "permanent immigrants", has recently been published. In Belinda Bozzoli's research, aided substantially by Mmantho Nkotsoe's interviews, the lives of twenty-two women born in the region of Phokeng are explored. Unlike the majority of black women, all of these women returned to their home districts:

Born at the turn of the century, they grew up in a rural economy that was both viable and resilient, but one that had already had to make significant adaptations to survive the newly emerging order of the times. Many of them became migrants to the city, however, in their early twenties, as migrancy became both an economic necessity and an institutionalised expectation. For many, what were planned as temporary sojourns in the city lasted up to forty years, during which they lived a life defined by family, work and community, a life that was only partially proletarian in character. In the end they returned to their village to live as pensioners and grandmothers...

⁴² The starkest examples of this pattern have been drawn for Basutoland, (Lesotho). See the work of P. Bonner, "'Desirable or undesirable Basotho women?' Liquor, prostitution and the migration of Basotho women to the Rand, 1920-1945" in C. Walker, (ed) Women and Gender; J. Kimble, "'Runaway Wives': Basotho Women, Chiefs, and the Colonial State, c. 1890-1920", Women in Africa Seminar, School of Oriental and African Studies, June (1983); and C. Murray, Families Divided (Cambridge: Cambridge University Press, 1981). For the Transkei and Eastern Cape see P. Mayer, and I. Mayer Townsmen or Tribesmen (London: Oxford University Press, 1974).

However, from all other available evidence it would seem that the overwhelming majority of women who left home for the Rand before the 1950s, and those born in the city itself, did not leave.

From amidst the wealth of all of these contemporary sources and recent historical analyses, a more nuanced portrait of women's movement into the city, and their material subsistence within it, has begun to emerge. Utilizing state statistical, municipal records and census data, Eales, Bonner and Gaitskell have all emphasised the sharp increases in the numbers of black women in Johannesburg between 1910 and the 1930s. An examination of the results of the Census of 1911 indicates that the percentage of "native women" in South African towns and cities stood at 19% of the total African population.⁴³ Eales's reading of the Johannesburg Municipality records of this period indicates that the total number of black women in Johannesburg trebled between 1911 and 1921, an assertion backed-up by the countrywide assessment by the Bureau of Statistics, which indicated that from 1911 to 1921 the numbers of African women in urban areas increased by 4.1 per cent per annum, as opposed to a figure of 1.5 per cent per annum for men.⁴⁴ Unterhalter examined the records of the Johannesburg Medical Officer of Health from 1910 to 1979, and estimated that the black population of Johannesburg increased from around 100, 000 in 1910 to nearly 200, 000 by 1920.⁴⁵ Black women numbered less than

⁴³ Union Statistics For Fifty Years (Pretoria: Bureau of Statistics, 1961).

⁴⁴ K. Eales, "Patriarchs, Passes and Privilege", 3 and D. Hindson, Pass Controls and the Urban African Proletariat (Johannesburg: Ravan Press, 1987) 33.

⁴⁵ B. Unterhalter, "Inequalities in Health and Disease: The case of mortality rates for

10, 000 in 1910, but by 1928, the year that the Bridgman opened, official statistics recognized just under 30, 000 women.⁴⁶ The same city records recorded the presence of 120, 000 white women by 1928, almost the same figure as white males.⁴⁷ In cities bordering Johannesburg, Municipal authorities took great pains to "count" the numbers of black women, as part of their particular campaign against the "influx of undesirable native women" from Basutoland. Bonner has examined the history of Sotho women's migrations and official reactions in some detail, and he notes that one result of Municipal concern was the commissioning of data and evidence of their presence. Their research indicated, that by the late 1920s,

...most Reef towns experienced a phenomenal growth in their female populations. The percentage increase recorded for five Reef municipalities in this period was as follows: Brakpan (1921-31) 58.6%; Germiston (1921-1931) 158.9%; Krugersdorp (1921-1931) 99.0%; Roodepoort-Maraisburg, (1925-1931) 84.7%; Springs (1924-⁴⁸1931) 67.4%.

But despite the confidence with which these figures were touted in newspapers and official commissions of the day, unpublished memoranda and correspondence between the Medical Officer of Health, Johannesburg and Native Affairs Department officials indicated that these records were incomplete and hardly reflected real numbers of women

the city of Johannesburg, South Africa, 1910-1979", International Journal of Health Services, 12:4 (1982) 618.

⁴⁶ J. Hyslop, "The Representation of White Working Class Women in the Construction of a Reactionary Populist Movement", African Studies Institute, University of the Witwatersrand, May (1993) 9.

⁴⁷ E. Brink, "The Afrikaner Women of the Garment Workers Union, 1918-1939" M.A. University of the Witwatersrand, (1986) 191.

⁴⁸ P. Bonner, "Desirable or undesirable Basotho women?" in C. Walker, (ed) Women and Gender 230.

present, and also provided no data on places of origin, age and form of employment. Many women lived illegally in cramped yards and had no interest in official detection of their presence, and many others laboured uncounted as domestic workers in white homes. Unlike black men in this period, women were not required to carry the passes which forced many men to register their existence in the city. Further, city officials began speaking about the crisis of black health: figures from the one central city hospital indicated an alarmingly high morbidity and mortality rate for black city dwellers. Besides adult statistics, health authorities began noting the high infant and young child mortality rates, based on the slim pickings of hospital records. The interests of city Health Officers and Native Affairs administrators combined to create an infrastructure for gathering data, and, in the case of health officials, for combating disease. These efforts met with strong support from philanthropic bodies, particularly from Missions conducting health work in small, underfunded, charity clinics.

This concern for data on infant mortality in particular formed part of a broader conversation about maternal and infant health sweeping through the medical schools, halls of government and social organizations of Europe and the United States of America. The fixation of South African public health authorities with venereal diseases and theories of contamination did not die away after the 1920s, and the continued pressure of segregationists ensured that issues such as "inspections" for venereal disease continued to be debated into the 1930s. Yet the emphasis of public health as a whole shifted, and this

was due in great part to the new configuration of public health itself, emerging from the Maternal Health movement.

Central to these debates were ideologies about scientific management of hygiene and motherhood, and in South Africa these ideologies directly connected official concern about black women and black child mortality with poor white women and their children. The many stark comparisons in the mortality and morbidity rates of poor white women, and the virtual confluence between black and white infant mortality rates in the poorest parts of the city, opened up a curiously non-racialized space within public health discourse, a space increasingly closed off in the later 1920s and 1930s. This period saw the implementation of the first countrywide statutes concerning midwifery registration and training, as well as the implementation of labor laws providing some measure of material support for women factory workers eligible for maternity leave. In order to both account for and ameliorate health conditions, an inspectorate of women Health Visitors had to be created, and the creation of the first tiny corps of District Midwives soon followed. All of the first inspectors and midwives were white women, as until 1928 no black women in Johannesburg held recognised midwifery qualifications. Thus this first corps, although white, spent much of their time in the racially mixed and black slum areas, yards and shanty towns of the city's working class.

Chapter Two

The Politics of Motherhood:

Maternity, Midwives and Infant Mortality in

Johannesburg, 1911 to 1928

By the late 1920s in South Africa, public health and the medicalization of infant and maternal care had become chief conduits through which women's work as mothers was being channelled and defined. To chart these developments, and to appreciate the singular importance of black women in the unfolding of this history in South Africa, we need to trace earlier strands connecting maternal health, motherhood and public health.

Late nineteenth century developments in industrial medicine, asepsis and public sanitation suggested new ways to tackle the threats of disease and plague, and even poverty, through the application of science. In the 1870s and 1880s, the influence of Social Darwinism and the creation of a barrage of Reform measures in England designed to bolster the Poor Laws and isolate or quarantine, if not eradicate, the poor in cities such as London, occupied the attentions of scientists, legislators and members of religious bodies. Historians of late nineteenth century England have noted the application of metaphors of internal colonialism and missionary exploration to the dark heart of London's East End at this period. In his singular discussion of class relations in Victorian London, Gareth Stedman Jones drew on contemporary chronicles of welfare work in their descriptions of the material and social conditions of the poor to argue that:

The poor districts became an immense *terra incognita* periodically mapped out by intrepid missionaries and explorers who catered to an insatiable middle-class demand for travellers' tales.¹

Recent new accounts of the missionary endeavour in southern Africa in the latter part of the last century have offered insights into the ways in which metropolitan representations of savage, diseased and undomesticated Africans both shaped the "field" encounters of colonial missions and explorers, and were in turn recast through these encounters. The southern African explorer narratives, missionary ethnographies and annual reports read by a wide audience of middle class literate sympathizers in England, provided a discursive and interpretative template for Victorian constructions of domesticity, the civilized, the hygienic, at the centre of which stood the efficient, healthy and moral mother.

The work of anthropologists Jean and John L. Comaroff on hegemony, modernity and domesticity in the shifting cultural and cosmological worlds of nineteenth century Tswana society, has engaged with the crosscurrents between the metropole and the periphery, throughout this period.² They argue that:

Carefully disinterred and read anew, the evidence suggests that colonialism itself, and especially colonial evangelism, played a vital part in the formation of modern domesticity *both* in Britain and overseas; that each became a model for, a mirror image of, the other; ... Scenes of distant battles with savagery... became the cautionary currency of an urgent moral offensive in the urban "jungles" of Victorian Britain... here lay the basis of a *dialectics* of domesticity, a simultaneous, mutually sustaining process of cultural construction at home and abroad.³

¹ Gareth Stedman Jones, Outcast London: A Study in the Relationship between Classes in Victorian Society (London: Pantheon, 1984) 14.

² J. Comaroff and J. L. Comaroff, Of Revelation and Revolution: Christianity, Colonialism and Consciousness in Southern Africa (Chicago: University of Chicago, 1991). On a similar theme, see Fred Cooper and Ann Stoler (eds) "Tensions of Empire" American Ethnologist 16:4 (1989).

The Comaroffs cast new light on the conjunctures between nation, empire and gender previously suggested by scholars such as Anna Davin in her history of imperial motherhood.⁴ The contingencies of empire-building, and the perceived need to secure the fertility of white English women as reproducers of the 'imperial race', took on a particular force in South Africa after the South African War. In their work on the history of the emigration of single young British women to the Transvaal after the War, Van-Helten and Williams demonstrated the commitment of the post-war Milner administration to transform the lives of white males on the Rand. To achieve this goal Milner, with inducement and co-operation from the Colonial Office in London, as well as numerous British-based women's emigration societies, concentrated on the importation of potential wives and the staffing of richer white homes with British female domestic workers. Colonial Office support for these schemes was premised on the idea that there existed in Britain a dangerous surplus of young women, and in the ensuing decade a series of ideologically motivated studies underscored the eugenic consequences of this

³ The Comaroff's richly suggestive work argues that factories of ideology and technologies of hegemony operated out of church halls and the chambers of Whitehall, as well as in the capitals of Tswana chiefs, the homesteads and pasturelands of Tswana commoners, and in the verandahs of trading stores and labor recruiters in the colonial hinterland. The Comaroffs' history of encounter between Tswana polities and Nonconformist missionaries underscores the synchronicity between revolutions in space and architecture, cultivation and agricultural labor, time and work discipline, domestic life, and the work of cosmological revelation and conversion. See J. Comaroff and J. L. Comaroff "Home-Made Hegemony: Modernity, Domesticity, and Colonialism in South Africa" in Karen T. Hansen (ed) African Encounters with Domesticity (New Jersey: Rutgers, 1992) 39-40.

⁴ A. Davin, "Imperialism and Motherhood" History Workshop Journal 5 (1978).

demographic 'imbalance'. At the same time official discourse drew attention to the crowding of cities and the degeneracy of the poor. Thus emigration schemes were conducted within the parameters of Malthusian inspired British national policies designed to corral women's labor and alleviate the pressures of the masses of poor described in

Stedman Jones' Outcast London. It was in this context, that between

... 1901 and 1910, over four thousand single women left Britain for South Africa by assisted and 'protected' emigration through the medium of the major women's emigration societies. Over half of these women were settled in the Transvaal. Most were destined for domestic service on the Witwatersrand ... besides Canada, no other empire state attracted single women through the assisted emigration schemes on such a large scale. ... while all white settler colonies welcomed single women immigrants as domestic labour, the colonial administration in the Transvaal between 1902 and 1905 placed more explicit demands on British women... the ideology of 'imperial motherhood' was paralleled by and shared common ground with one which prompted the emigration of British women to the settler colonies, including South Africa.⁵

The emigration of British women to South Africa was supported and organized with the direct assistance of networks of philanthropic women's organizations in Britain, such as the Metropolitan Association for the Befriending of Young Servants and the Workhouse Visiting Society. Their work, in "saving" young women sex-workers from vice, in training and supporting orphans, and in readying working class women for domestic service, although an early example of women's activism in Britain, was:

... nevertheless enmeshed in, and contributed to the reproduction of the dominant patriarchal ideology which determined gender relations in Victorian and Edwardian Britain. It suggested that women could find real fulfilment only in wedlock, childbearing and a predominantly domestic role.⁶

⁵ J. J Van-Helten, and R. Williams, "'The Crying Need of South Africa': The Emigration of Single British Women to the Transvaal, 1901-1910" Journal of Southern African Studies 10:1 (1983) 17-18.

As the nineteenth century drew to a close the establishment of delineations and boundaries between private and public domains of social and material life were established enough to adopt the mantle of "the natural".⁷ The intellectual and social history of this process has engaged the attention of an array of historians during the past two decades in Europe and the United States.⁸ Scholars have, in addition, grappled with the implications of this bifurcating process on state formation, definitions of state responsibility and claims to rights on the part of organised groups and publics. Feminist histories of welfare have interrogated the contradictions inherent within the private/public or domestic/national categorizations, and have demonstrated the inseparability of these twin categories, both analytically and as they worked out in every day life.⁹ By the turn of the century, the process which engendered these sibling conceptions had successfully marked off issues of reproduction--physiological, material and emotional--as the domain of the "domestic", a domain ideally occupied and managed by mothers. The human actors in this process were both male and female, and part of the challenge assumed by historians of this era has been to analyse and weight the role that different groups of women played in political struggles

⁶ J. J. Van-Helten and K. Williams, "'The Crying Need'", 19.

⁷ A. Oakley, Women's Work: The Housewife Past and Present (New York: Vintage, 1976).

⁸ A rich literature has developed on these interlinking themes. A few key texts informing this project include: N. Cott, The Grounding of Modern Feminism (New Haven: Yale, 1987) and N. Fraser Unruly Practices: Power, Discourse and Gender in Contemporary Social Theory (Minneapolis: University of Minnesota, 1989).

⁹ G. Bock, and P. Thane, Maternity and Gender Policies: Women and the Rise of European Welfare States (London: Routledge, 1994).

within nation states, wherein their citizenship rights, as with poor men and black men and women, were severely constrained. As with the case of groups supporting the emigration of British women to South Africa, complex and even contradictory alliances and ideological unions across class lines, underwrote social movements. These complexities have received sustained attention during the last fifteen years in particular, and a nuanced portrait of the history of categories and concepts such as "the domestic", "the family", "the home", and "motherhood", has begun to emerge.¹⁰

At the very same time as domestic ideologies gained footholds outside of the bourgeois class, newly perceived crises in the laboring classes of Europe and the United States forced social agitators and reformers to consider afresh the role of the state in the regulation of social and physical ill. For example, although ideologies of family life privileged notions of privacy and separation from official sanction or involvement in family affairs, these same ideologies were harnessed to arguments for state-regulated aid as a panacea for the "problems" of poverty, delinquency, and unemployment. Scientific Medicine provided a needed bridge between the authority of local and central Government, and the idealized sacrosanct domain of the family. In colonial and

¹⁰ In the wake of the work on the family by Friedrich Engels, the linkages between capitalist relations, the ownership of private property, and the commodification of relations between humans, were amplified and clarified by historians who emphasised the material interests and struggles at the heart of this process of bourgeois consciousness formation. However, during the last twenty years particularly, the works of feminist historians have asserted anew the cultural and political importance of suffragette battles, struggles over work conditions, and the role women played in the eras of Reform and Progress as agents of in the creation of capitalist welfare states.

neo-colonial contexts, this bridge was constructed and constrained by similar pressures of capitalist waged labor, the reshaping of household work and gender relations, and the growth of urban poverty. To these, local pressures added new dimensions: the potency of racial ideologies and concomitant segregationist policies, and, crucially, enduring and recast features of precolonial social forms.

The last ten years of research in southern and east Africa have seen the flowering of research into the history of gender, the relationship between wage labor and domesticity, and the entanglement of precolonial and colonial sex-gender systems.¹¹ This research has been undertaken in the spirit of a lively engagement with related European and American histories. South Africanists have attended to the thematics of the working lives, material sustenance, and increasingly, the cultural fabric of black women's lives, through discussions of domestic waged work, factory labor, informal sector production and retail, as well as women's political and cultural struggles via church and community networks such as *manyano* associations,¹² sewing clubs, savings and rotating credit association and civic organizations. In the past decade, several studies of white working class women in South Africa have similarly been undertaken, examining questions of class

¹¹ For example: D. Jeater, Marriage, Perversion and Power (Oxford: Clarendon Press, 1993) and Karen T. Hansen, (ed) African Encounters with Domesticity (New Jersey: Rutgers University Press, 1992).

¹² For more on the women's prayer associations or '*manyano*' groups see D. Gaitskell, 'Female Mission Initiatives: Black and White Women in the Witwatersrand Churches, 1903-1939' Phd diss. University of London, 1981 and M. Brandel-Syrier, Black Women in Search of God (London: Lutterworth, 1962).

consciousness, political struggles, nationalism and the intersections of race and gender in South Africa.¹³

Motherhood in South Africa:

Two key essays have grappled with the ideological construction of "Motherhood" in South Africa, and the connections between this project and, on the one hand, white Afrikaner nationalism, and on the other, African nationalism. These two essays, have traced the history of a familiar South African slogan: "Mothers of the Nation", suggested further avenues for historical research.¹⁴ Gaitskell and Unterhalter discuss the political capital traded and garnered by black male political leaders, through the currency of the martyrdom and courage of black women as "mothers of the struggle for national liberation". Their paper also takes account of the powerful material and symbolic capital of motherhood as a common, binding and enduring focus of women's community,

¹³ E. Brink, "The Afrikaner Women of the Garment Workers' Union, 1918-1939" M.A.diss., University of the Witwatersrand, 1986; I. Berger, Threads of Solidarity: Women in South African Industry (Indiana University Press: Bloomington, 1992); J. Hyslop, "The Representation of White Working Class Women in the Construction of a Reactionary Populist Movement: 'Purified' Afrikaner Nationalist Agitation for Legislation against 'Mixed' Marriages" African Studies Institute Paper, University of the Witwatersrand, May 1993; S. Parnell, "Council Housing Provision for Whites in Johannesburg: 1920-1955" M.A. diss., University of the Witwatersrand, 1987; and A. Van Niekerk, "The Use of White Female Labour by the Zebediela Citrus Estate, 1926-1953", M.A.diss., University of the Witwatersrand, 1988.

¹⁴ D. Gaitskell and E. Unterhalter, "Mothers of the Nation: A Comparative Analysis of Nation, Race and Motherhood in Afrikaner Nationalism and the African National Congress" in N. Yuval-Davis and F. Anthias (eds) Woman-Nation-State (Basingstoke: Macmillan, 1989); E. Brink, "Man-made women: Gender, Class and the ideology of the volksmoeder" in C. Walker, (ed) Women and Gender, 273-292. Cheryl Walker has begun to explore this theme too in a paper delivered at the December 1993 ASA Conference in Boston, "The Politics of Motherhood in Twentieth Century South Africa".

individualized and broader struggles. They point to the uneasy but politically fruitful alliances in the 1910s and 1920s between Afrikaner Nationalists and the Labour Party, whose members emphasised white labor protection through a wage and skill colour bar.

By the early 1930s, the calls of white male workers, white middle class women, and a small number of organized groups of white women workers, were drawn together under the rubric of Hertzog's scheme: white women would be granted the franchise, whilst simultaneously depriving black men in the Cape Province of their highly circumscribed access to the vote.¹⁵ At the turn of the century, when commentators in Southern Africa spoke of "race warfare", they often had in mind the deep-seated enmity between English and Afrikaans speaking whites, an enmity not completely replaced, but sharply sidelined by the increasing elaboration of anti-black racism on the part of whites.¹⁶ South Africanist historians have emphasised the class and labor alliances between whites, which gradually uncoupled Afrikaner and English, from notions of racial difference.¹⁷ Through this

¹⁵ Walker's history of the women's suffrage movement in South Africa has indicated the twists and turns taken by white women suffragettes, who overwhelmingly supported the exclusion of black women from the vote, and thus the status quo of racial segregation. That they did so, was intimately connected not only to class and racial prejudices, but also to the very terms upon which they argued for inclusion into the ranks of voters in the first place, notably their right, as the mothers and wives of the state's white male subjects, and thus as legitimate members of society's enfranchised civil order. The final deal-making surrounding the parliamentary vote which admitted white women, was thus explicitly framed on the premise of excluding African male voters, and at the same time harnessing white women's sanctioned roles as guardians of the nation's morality, proprietary, and civilized norms, to white nation-building. See: C. Walker, The Women's Suffrage Movement in South Africa, (Cape Town: David Philip, 1979).

¹⁶ B. Bozzoli, The Political Nature of A Ruling Class: Capital and Ideology in South Africa, 1890-1993 (Routledge & Kegan Paul: London, 1981).

characterization, scholars have presumed a male subject as their template of the white citizen. In doing so they have ignored the central place of female subjects in the debates over racial purity and indeed the very definition of 'whiteness'. From the late teens and through to the published findings of the Carnegie Commission into poor white poverty in 1932, an emphasis on racial purity increasingly fastened upon poor white women as targets of racial improvement.¹⁸ Here, women's habits of hygiene, methods of mothering and even manners of birthing, were increasingly used to distinguish "whiteness" from the social and cultural markers of "blackness", and white women who failed these tests threatened the nature of white nation-building itself.¹⁹

In analysing the links between nationalism and motherhood, Brink, Gaitskell and Unterhalter explore the history of Afrikaner women as idealized, heroic subjects, emphasizing the impact of Victorian conceptions of motherhood in both white Afrikaans

¹⁷ See for example: F. Johnstone, Class, Race and Gold: A Study of Class Relations and Racial Discrimination in South Africa (London: Routledge & Kegan Paul, 1976) and D. O'Meara, Volkskapitalisme: Class, Capital and Ideology in the Development of Afrikaner Nationalism 1934 -1948 (Cambridge: Cambridge University Press, 1983).

¹⁸ Carnegie Commission Report The Poor White Problem in South Africa (Pro Ecclesia: Stellenbosch, 1932).

¹⁹ Linzi Manicom has eloquently criticised the presumed male subject lurking unstated in much of the 1970s and early 1980s literature on South Africa. In her work, this criticism takes two forms: on the one hand she points to the blindness evident in these works, which seem able to penetrate official discourses concerning race and class, but incapable of distinguishing that explicitly male/female construction of "subjects". On the other hand, her work challenges scholars to recognise that the executive, legislative and rhetorical power harnessed in the formation of the South African State, was a profoundly gendered process. See L. Manicom, L "Ruling Relations: Rethinking State and Gender in South African History" Journal of African History 33 (1992).

and working class English households, especially in the wake of the South African war.²⁰

Brink explores the gradual establishment of the representation of white trekboer women as figures in the mythologizing of the frontier, populated both by male soldiers and defenders and by fair-skinned mother figures. She analyses the complex interconnections between Afrikaner activists and intellectuals' early twentieth century search for solutions to the "poor white problem", and the growth of Afrikaner nationalist movements, and suggests that a view of Afrikaner women as mothers was a central building block in this formation.

Neither study, however, delves much beyond citing motherhood as the key to both women's self-definition and to the lexicon of representations defining women. These two papers consistently argue that motherhood is a cultural not biological construct, shifting and changing over time. Gaitskell has echoed the view of commentators writing of black South African women from the 1930s, that:

Motherhood was central to African women's personal and cultural identity as well as their social and economic roles long before the advent of Christian missions in South Africa. But church groups served to transform, elevate and entrench the importance of marriage, wifehood and motherhood for women. They were among the powerful ideological forces contributing to the ongoing centrality of the notion of motherhood in African women's organization in the twentieth century...²¹

²⁰ Lis Lange's research on the history of white working class families in Johannesburg and the connections between poor English and Afrikaans speakers, taking into account work histories, patterns of communal life, religion, savings and accumulation, as well as fertility and family size, promises to expand our understanding of the period before 1910. See the unpublished chapter from her dissertation in progress, "White Working Class Families in Johannesburg, 1890-1906", University of the Witwatersrand, n.d.

²¹ D. Gaitskell, "Devout Domesticity?" 272.

Historians of East Africa have made similar observations, for example those in a recent compendium volume with contributions on gender and domesticity from eastern, western and southern Africa. Here, while cautioning the reader that "motherhood" has been one of many self-defining roles adopted by women whose life work and social worlds held out and demanded other options, the editor Karen Hansen argues:

Throughout Africa, women have historically defined themselves as individuals whose self-validation was associated in important ways with their sex, as wives, mothers and nurturers of children.²²

While contributors to the Hansen volume take care to emphasise that they recognize the multiple ways different groups of women claimed motherhood as their chief animating characteristic and trait throughout the past one hundred years and more in southern Africa, they do not offer any analysis of what constituted the work (physiological, material, psychological and emotional) of mothers at any given period. Research into Victorian motherhood has indicated that one of the difficulties of crafting an historical account of motherhood, is precisely its perceived, yet not usually stated, layers of ingredients at particular historical periods, for example: sexuality and pregnancy, household co-operations and struggles, property and work relations, and the emotional and cultural milieu enmeshing and constraining fertility and parenting decisions and choices.

As hinted at in chapter one, historians of precolonial and nineteenth century South African indigenous societies have wrestled with the history of gender and definitions of

²² Karen T. Hansen, (ed) "Introduction" African Encounters with Domesticity 6.

marriage, reproduction and sex-gender relations. Key distinguishing features of southern African societies have been noted in every scholarly text on the subject since the late 1800s. These include: an emphasis on women's agricultural labor and the valuing of women's reproductive capacities (both in terms of their fertility and in terms of their work as provisioners and socializers) and the importance of age and gender hierarchies in the arranging of marriages through bridewealth institutions, in land settlement and rights of tenure, labor relations and matters of dispute.

Recent work has begun to chart the legacy of these social forms through the revolutions in material and cultural life in the latter part of the 1800s and into the 1900s. What notions of motherhood, birthing, and sexuality did black women bring with them from the northern, eastern, western and southern parts of Africa, into the Witwatersrand in the early decades of this century?²³ In the case of white women, their relational and material work as mothers, both English and Afrikaans, has been discussed in close proximity to that of European and American histories on the subject. Thus Brink and Walker agree that the essentially middle class idealisations and actualisations of space, hygiene, nutrition, valuation of children, and separations between domestic and waged-work realms, although unrealized for most late nineteenth century, settler women, were nevertheless regarded as exemplary, and ideal. The rigorous and rigid parameters defining motherhood in Victorian and Edwardian England particularly, meant that the

²³ We will return to consider this question more closely in later chapters.

working class woman, however she attempted to garner the material means to replicate this ideal,

... would not appear as a model housewife, or as one properly dedicated to motherhood.²⁴

In the case of white Afrikaans women,

...similar processes can be identified in the development of the image of the *volksmoeder* in South Africa. However, a distinctive role in the development and articulation of this concept was played in particular by the Anglo-Boer War and the emergence of Afrikaner Nationalism during the early decades of the twentieth century. After the Anglo-Boer War the concept of *volksmoeder* ... was propagated in a self-conscious manner by a new generation of Afrikaner nationalists who, in a manner reminiscent of the British preoccupation with working-class degeneracy, concerned themselves with the ever-increasing numbers of poor whites and the so-called degeneration of the Afrikaner.²⁵

For black women, as they entered the industrial cities of the Witwatersrand--bringing with them complex identifications concerning family life, sexuality and motherhood--the ramifications of late nineteenth and early twentieth century domestic revolutions were also very strongly felt. The impact of these ideas and practices of child care and domestic hygiene spread in the early twentieth century beyond elite Christian families, especially in cities such as Johannesburg where large numbers of black women earned wages as domestic workers.²⁶

²⁴ A. Davin, "Imperialism and Motherhood" 33.

²⁵ E. Brink, "Man-made women" 274.

²⁶ This vast subject will be returned to again and again in succeeding chapters. A growing literature is developing concerning the increasing validity and impact of Christian and Victorian ideals of womanhood and domesticity in the lives of black women. See the life story, constructed through letters, of 'Lily Moja', in S. Marks, (ed) Not Either An Experimental Doll: The Separate Worlds of Three South African Women, (Durban: University of Natal, 1987) and H. Hughes, "'A Lighthouse for African Womanhood': Inanda Seminary, 1869-1945" in C. Walker (ed) Women and Gender.

..what about the large numbers of women.. described as flocking to the cities during the early years of the century? What means of survival did they find? The new 'industry' of washerwomen was born from the desperate need of these black women. The more affluent white families introduced several specialised categories of domestic work: the general workers who carried the major load in the house, as a cook and general overseer; the cleaner/washerwomen; the ubiquitous nanny (a term used to describe the child-minder). All these jobs were done by black women, some of whom received training in their tasks from the mistresses of the home.²⁷

With the development and expansion of the gold mining industry in the latter part of the nineteenth century--as well as with the concomitant expansion in secondary industry, service work, building, retailing, and various informal economies--the Witwatersrand, and the city of Johannesburg in particular, became an important center, drawing male migrants from rural reserves and nominally independent protectorates in the southern African region. Conquest, taxation and land annexure, combined with ecological pressures, to undermine the rural reproductive base of the male migrant system, although the pace and extent of this varied across different regions.²⁸ By the 1920s the viability of rural subsistence for African women and their households was, in many regions, extremely fragile. The groundswell of women moving into the cities took on greater momentum in the late 1920s and 1930s in the context of droughts and the far-reaching effects of the Depression.²⁹ This immigration of women into Johannesburg alarmed local authorities,

²⁷ E. Kuzwayo, Call Me Woman, (San Francisco: Aunt Lute Books, 1985) 22.

²⁸ See for example: W. Beinart, "Labour migrancy and rural production: Pondoland c. 1900-1950" in P. Mayer, (ed) Black Villagers in an Industrial Society (Cape Town: Oxford University Press, 1980) and papers in S. Marks, and R. Rathbone, (eds) Industrialization and Social Change in South Africa (London: Longman, 1982).

²⁹ K. Eales, "Patriarchs, Passes and Privilege: Johannesburg's African Middle Classes and the question of the night passes for African Women, 1920-1931", University of the Witwatersrand History Workshop, Johannesburg, February 1987; E. Koch, "Without

who regarded the urban settlements of black women as more permanent, and thus a threat to their increasingly defined plans for white segregated cities, which initially offered virtually no infrastructure or amenities for male migrant workers independent of their waged work.

Our knowledge of the paid work of African women is in no way complete, but ethnographic accounts written at the time and work of the last decade has substantially added to our understanding of the limited options available to women, (certain work in the garment industry, domestic service, beer brewing and sex work), and the creative use they made of these openings.³⁰ Women in the cities could occasionally carve out greater independence and control over their income and sexuality than could their sisters in rural areas, who lived under the watchful eye of elder kinswomen and men. However, Bonner, Koch and Gaitskell's research has also suggested that the potentialities of women's greater independence in the cities were tenuous and ambiguous.³¹ Women were highly vulnerable

Visible Means of Subsistence': Slumyard Culture in Johannesburg 1918-1940" in B. Bozzoli, (ed) Town and Countryside in the Transvaal (Johannesburg: Ravan Press, 1983) and J. MacKenzie, "African Women and the Urbanization Process in Natal, c.1920-1949", University of Natal, 1983.

³⁰ Examples include: H. Bradford, "'We are now the men': women's beer protests in the Natal countryside, 1929" in B. Bozzoli (ed) Class, community and conflict: South African Perspectives (Johannesburg: Ravan Press, 1987); P. Bonner, "Desirable and undesirable Basotho women? Liquor, prostitution and the migration of the Basotho women to the Rand, 1920--1945", in C. Walker (ed) Women and Gender, (Cape Town: David Philip, 1990); J. Cock, Maids and Madams: A study in the Politics of Exploitation (Johannesburg: Ravan Press, 1980).

³¹ For example: E. Koch, "Without Visible Means of Subsistence; Slumyard Culture in Johannesburg, 1918-1940", in B. Bozzoli, (ed) Town and Countryside in the Transvaal, (Johannesburg: Ravan Press, 1983).

to the absence of any labor contracts with employers, to the violence and harassment of sex work, to police raids on beer-brewing operations, and to the lowest wages in domestic work. By the 1930s and 1940s, black women replaced men in domestic service, establishing themselves in a labor niche that they continued to occupy through to the last decades of the twentieth century. By the late 1930s, the demographic profile of black women in and around Johannesburg began to shift away from younger women, to that of older women, with children of their own, often living with male partners, husbands and male relatives. The descriptions of the urban family life of the majority of black men and women in the late 1920s and the 1930s, detailed by Hellman and Phillips among others, provide a stark portrayal of poverty, crowded slums, broken households as the breeding ground of physiological and social disorders. In later chapters we shall examine the evidence that these ethnographic accounts provide of early Johannesburg, and the clues contained therein concerning the meanings and methods of birth, motherhood and healing for black women, in the first decades of this century.

It is notable here, however, that these ethnographies of urban life, as well as the rural studies of Hunter, Schapera, Junod and others, all comment on the centrality of women's fertility and mothering capacities to women in their self-valuation, as well their valuation by others: older women and men, mothers-in-law, husbands and siblings. These texts, as well as accounts by black intellectuals from the 1930s, such as Soga and Plaatje and Maxeke, stress the importance of women's capacity to nurture and birth children as a

key determinant of their position within local social hierarchies.³² After the 1920s, it is insufficient to consider the topography of "the domestic", or interrogate the meanings of motherhood for white women, without considering the vital role black women increasingly played in the nurturing of white infants and children, both Afrikaans and English speaking. At the same time, after the 1920s, no pristine indigenous ideology of motherhood existed outside of the swirling social and material revolutions of the region either.

In reflecting upon what she had learned over four decades of social and civic work with women in Johannesburg and the Witwatersrand, Ellen Kuzwayo commented:

These are... the sufferings and endless struggles born by some of these great mothers of South Africa who have brought up and nurtured children of all communities, some at the sacrifice of their own children. ... Some have cared for white babies from their birth, up to those babies' own child-bearing age... I know of cases of black mothers who have remained with white infants aged two to three months over varying periods from one to six months.. Indeed, some of the leading white men and women of this country are the products of the ingenious hands and minds of the black 'nurse', 'nanny' or 'mother' who has been, and still is, underpaid for one of the outstanding responsible human services: that is, bringing up children.³³

Largely through Cock's research into the history of domestic work in South Africa, as well as through a growing corpus of oral interviews and life histories (undertaken by Bozzoli, Cock, Emdon, Nkotsae, Matsetela and others)³⁴ and the autobiographical

³² These scholars and commentators have drawn attention to a common linguistic feature of all the major indigenous Southern Africa language groups, namely that the vocabulary describing an adult woman is inseparable from that denoting "mother".

³³ E. Kuzwayo, Call Me Woman, 23-24.

³⁴ See for example: J. Cock, Maids and Madams: A Study in the Politics of Exploitation, (Johannesburg: Ravan Press, 1980); B. Bozzoli with M. Nkotsae Women of Phokeng (Johannesburg: Ravan Press, 1991) and T. Matsetela, "The life story of Nkgono Mma-Pooe: aspects of sharecropping and proletarianisation in the northern Orange Free

writings of Kuzwayo, Mashinini, Magoma and Ntantala, (all published in the last ten years), a tapestry of black women's experiences as domestic workers has begun to emerge.³⁵

In 1937 I got a job in Melrose working for Mrs Sinclair. And there I got a very nice job because I was a baby carer. Yes, that child was Shelly. I used to care for her. And sometimes her mother used to just leave and go to Durban and leave me with the child and the granny. Because she knew I knew everything about the child. The child used to be like my child. Because she never used to bother me. If the child was sick I phone the doctor and the doctor came, treated the child and I nursed the child until she was well.³⁶

In early twentieth century Johannesburg, as well as in London, Nairobi, Accra and Chicago, connections between motherhood and medicine, with deep roots in the varieties of social life across continents in previous centuries, were being refashioned. This process of interweaving the therapeutic landscapes of women's labor together with biomedical institutions generated a crucial space wherein the work, emotional meaning and purpose of motherhood in Johannesburg transpired.

Mission societies and liberal philanthropic groups in Johannesburg began in the 1920s to move into urban spaces left untended by the segregationist local state. The efforts of white and black women's organizations, and clubs and church societies of urban

State, 1890-1930" in S. Marks and R. Rathbone, (eds) Industrialisation and Social Change, (London: Longman, 1982).

³⁵ E. Kuzwayo, Call Me Woman; E. Mashinini, Strikes Have Followed Me All My Life, (New York: Routledge, 1991); S. Magoma, To My Children's Children (London: The Women's Press, 1991) and P. Ntantala, A Life's Mosaic, (Berkeley: University of California Press, 1993).

³⁶ Quotation drawn from interview with Johanna Masilela in J. Cock and E. Emdon, "'Let me make history please': The Story of Johanna Masilela, Childminder" in B. Bozzoli (ed) Class, Community and Conflict (Johannesburg: Ravan Press, 1987) 463.

African elites, gradually generated a local network of social centers, recreation facilities, homecraft training programmes for women, mission schools and eventually health centers.³⁷ The history of the Johannesburg Municipality's relationship to black women either has been overshadowed by discussions of the definitions and operations of the Urban Areas Act of 1923 and its ensuing amendments, or has been sidelined completely. At the same time, the focus on the ramifications of the Urban Areas Act, Pass Controls, and Housing regulations and passes in the extant literature has been very productive, demonstrating how the central state in the 1920s and 1930s began to refine and generalize local initiatives. During this period the state enacted a series of laws designed to restrict the mobility of black women, yoking their right of entry into urban areas to the length of time their fathers or husbands had been employed in a particular region. Eales and Wells have argued that an attempt was thus made to control women's moving and laboring bodies by making African men partners of the state in the regulation of their mothers, wives, lovers, sisters and daughters.

Existing portraits of the local state and its relationship to black city dwellers, have focused on the state's labor infrastructure and less often on housing and residential regulations, but virtually ignored its agency in public health, especially preventative health

³⁷ See background for this in P. Rich, White Power and the Liberal Conscience: Racial Segregation and South African Liberalism, 1921-1960 (Manchester: Manchester University Press, 1984) as well as D. Gaitskell, "Wailing for Purity: Prayer Unions, African Mothers and Adolescent Daughters, 1912-1940" in S. Marks and R. Rathbone, (eds) Industrialization and Social Change, and R. Phillips, The Bantu in the City (Alice: Lovedale Press, 1938).

services, beyond commentary on the obsession with plague, venereal disease and sanitized effluent. Yet it is within these very domains of less publicly debated state actions, that the engineering of legal and professional medical codes (procedures and forms of public expenditure concerning midwives and nurses, health visitors and inspectors, and the regulation of maternity homes) occurred.³⁸

By the late 1920s in South Africa, black and white women were being channelled and defined through the conduits of public health and the medicalization of birth and infant care. These conduits were home-made, with particular local characteristics, yet they shared much with similar movements in Europe and, in particular, Britain. Besides the recent project on the history of abortion undertaken by Helen Bradford, and the legal histories of infanticide and illegitimate births by Sandra Burman, (which interrogates legal case involving doctors, abortionists and healers),³⁹ no detailed study exists of the history of

³⁸ Although debates over definitions of the state's responsibilities towards the urban poor, both black and white, do feature in the literature surveyed, very little mention is made of the crucial debates over maternity funding, the contradictions inherent in the history surrounding midwife licensing, or the implications of the daily operations of local and central state employees and funding officers overseeing these enactments. In the years following the South African War, the outcome of local state policy regarding, for example, the funding of medical services for the waged workers, beer brewers, hawkers and domestic workers of Johannesburg had not yet been ascertained. It is here that a new and closer look at the workings of the Municipal authority needs to be located.

³⁹ H. Bradford, "Herbs, Knives and Plastic: 150 Years of Abortion in South Africa" in T. Meade and M. Walker, (eds) Science, Medicine and Cultural Imperialism (New York: St Martin's Press, 1991) and S. Berman, and M. Naude, "Bearing a Bastard: The Social Consequences of Illegitimacy in Cape Town, 1896 - 1939" in Journal of Southern African Studies 17:3 (1991).

health and medical science in relation to South African women. Shula Marks drew attention to this in a series of articles on research papers in the late 1980s, and at a symposium in 1988:

When Neil Andersson and I wrote a monograph for the WHO on health and apartheid, we were very aware that we had not been able to find very much material on women. It was a major gap in the survey which reflected and still reflects the inadequacy of our knowledge of women and health in that country. [South Africa] Following upon that, we set ourselves the project of looking into the matter and I have begun work on a history of nursing in South Africa.⁴⁰

Marks points out the besides the silence in official Archives around black women's health (there are few files specifically designated as such in the Central Archives Depot, Pretoria), the collection of statistics of morbidity and mortality for black women was never systematized or subject to detailed research countrywide. In the case of black men, their vital statistical profiles were likewise never the subject of a comprehensive state investigation, but unlike black women, many men were subject to large-scale comprehensive health testing and statistical enumeration at work sites and recruiting stations under the auspices of mining and secondary industry. Deploring the difficulty of recovering evidence of black women's health profiles from the past, Marks comments:

It is much easier to find out about the health of white women than the health of black women, both historically and in the present. Until 1978 there were no

⁴⁰ S. Marks, "Women's Health in South Africa", Columbia University: Third Workshop of the Project on Poverty, Health and the State in Southern Africa, May 13-15, 1988, 6-7. Marks researched and co-wrote several papers on Apartheid and Health in the late 1980s, including: with Neil Andersson, "The State, Class and the Allocation of Health Resources in Southern Africa" Social Science and Medicine 28:5 (1989); and with Andersson again, "Issues in the Political Economy of Health in Southern Africa" Journal of Southern African Studies 13:2 (1987); as well as "The Nursing Profession and the Paradox of Apartheid", unpublished paper, Northwestern University, Workshop: "Women on the Frontline in Southern Africa", June 1991.

national statistics on birth and deaths for Africans in South Africa. At that time, deaths were reported only for thirty-four selected Magisterial Districts.⁴¹

This lack of official record keeping renders the task of historical analysis more difficult, but not impossible. Read carefully, and across a wide range of subject-divisions and categorizations, the archives of Johannesburg's Public Health Department, as well as the reports, speeches, research and published papers of the community of public health experts of the day, contain the elements needed to create a more nuanced portrait of working class women's lives in the city, as captured through the lenses of biomedicine and public health.

Infant and Maternal Health

In the years after Union, the fledgling journals of South African medical professionals began publishing their first editorials on issues of Public Health. In their first edition after Union, the South African Medical Record printed a series of articles and minutes from the 1910 Medical Congress calling for the creation of a more powerful state health apparatus with which to intervene in the "grave social ills" of the day.⁴² This call was amplified in a lengthy Editorial of 1912, titled "An Urgent Question of Sociology", which invoked scientific and explicitly medical, diagnoses and solutions for the pathologies of native life on the Witwatersrand.

Sociological questions are never properly investigated unless the investigation is conducted along lines almost exactly analogous to those employed in the practice of medicine... The body politic has its physiology, its pathology, its hygiene and its

⁴¹ S. Marks, "Women's Health in South Africa" 7.

⁴² South African Medical Record, (28 January 1911).

therapeutics just as definitely as the animal body, and the laws by which it is governed can be, and should be, interpreted in terms of biology, and what is more, in terms of evolution, as a galaxy of brilliant writers from Herbert Spencer and Kidd downwards have taught us. .../... [P]ractically every canon of sociological public health is violated in connection with the employment of native labour on the Witwatersrand...⁴³

"Native Health", a subject barely mentioned in the 1890 to 1910 period, became a familiar sub-heading in the two major South African medical journals. Articles detailing medical mining statistics and new treatments for tuberculosis and respiratory conditions, as well as papers on the mortality and morbidity of black city dwellers outside of the mining industry, began appearing alongside patient histories of unusual cases, news of operative techniques, medical advertisements and book reviews.

Before 1900, the pace and tone of public health legislation throughout southern Africa, such as existed, was set at the Cape.⁴⁴ As noted in the previous chapter, except for legislation dealing with venereal disease, leprosy and plague, Cape legislation explicitly took white residents as exemplars of the citizenry of the city, with only occasional references to "Coloureds, Hottentots and Malays".⁴⁵ However, most towns and cities

⁴³ Editorial, "An Urgent Question of Sociology" South African Medical Record (25 May 1912) 201-203.

⁴⁴ C. Searle, The History of Development of Nursing in South Africa, 1652-1960 (Cape Town: Struik, 1965) 103; P. W. Laidler and M. Gelfand South Africa: Its Medical History: 1652-1898 (Cape Town: Struik, 1971) 442- 454.

⁴⁵ As late as 1925, the Medical Officer of Health for Cape Town, Dr. Shaddick Higgins, delivered a paper at the South African Medical Congress of that year entitled "Public Health in Relation to Social Welfare" in which he explicitly discounted 'Bantu natives' from the purview of public health in the region, including only "Europeans" and "Coloureds" in his Department's work. CPA 3/C7 4/1/5/461: E403/5, July 1925, 9.

across the rest of the country had, by this time, begun formulating health priorities linked to the exigencies of their local context.⁴⁶

Discussions about the collection of population data and, emerging from this, a concern with infant and maternal statistics, began to rival the languages of contagion and quarantine that had dominated the field. Especially in Johannesburg, and a few cities with very active health officers, such as P. W. Laidler from East London, a new focus on 'Native Health' was beginning to take on some urgency. Health authorities and city officials in Johannesburg were gradually forced to recognise the grave poverty, malnutrition, and ill-health of the majority of black men and women living in the city, aside from earlier fixations with venereal disease, (in the case of men and women), and fitness for industrial labor, (in the case of men).

As indicated above, after 1910, this burgeoning discussion about "Native Health" (and especially the ill-health of black women and children), began its long and elaborate dialogue with the subject of "Poor Whites", concerning the morbidity and mortality of working class, rural immigrant and unemployed whites, especially women and children. Afrikaner nationalist movements, both local and countrywide, developed strategies in the teens, and especially in the late 1920s, around health and welfare policies as much as around issues of job reservation and state protection of white supremacy. Throughout this

⁴⁶ Largely missing in the histories of tuberculosis, venereal disease, influenza and plague in South Africa, has been this new emphasis on preventative medicine as a task for local and central Government.

period, a present and expanding fear was that "Poor Whites" were dangerously close to "becoming Natives", and white women were the designated frontier zone.

At the same time, local and central state authorities began to worry about the morbidity and reproduction of the black working class.⁴⁷ The existing health infrastructure and health policy of Johannesburg at the close of the nineteenth century focused on the eradication of slum conditions, the need for regulated sewerage and refuse disposal, the inspection of foods, the notification of cases of plagues and certain diseases. All of these operations came into existence in Johannesburg just on the eve of the South African War and framed the extent of preventative health measures. For emergency cases and chronic illness, the first tent, and then tin and wood hospital, opened in Johannesburg in the wake of gold discoveries. With less than five certified nurses on the Rand, the makeshift hospital was run by a French-based Catholic order of nurses, joined after 1895 by a handful of lay nurses recruited in Europe. Only in 1915 did Johannesburg boast enough certified lay nurses to fully staff the hospital, although by 1896 seventy-four doctors had registered to practice in Johannesburg, many of them associated with the mines. In 1890 the building of a new stone and brick hospital with 130 beds on Hospital Hill was completed, paid for with funds from the government of the *Zuide Afrikaanse Republiek*. In the next four years two new wings were added, financed by the railways and the mines. In 1896/7 the first

⁴⁷ There is a growing literature on this subject. See R. Morrell, (ed) White But Poor: Essays on the History of Poor Whites in Southern Africa (Pretoria: University of South Africa, 1992) as well as the study, conducted under the auspices of the Carnegie Corporation, in the early 1930s: The Poor White Problem in South Africa: Report of the Carnegie Commission, (Stellenbosch: Pro Ecclesia, 1932).

mining hospitals were opened by the Simmer and Jack Mining Company and the New Primrose Mines, and at the Johannesburg General Hospital (or 'the Gen' as it came to be known) the emphasis on male health continued into the 1910s.

It took two years before the Johannesburg Hospital provided any beds for women and children, and although the Hospital did have an emergency section set-aside for black patients of both sexes and wards for black men, it was not until 1925 that special wards were created for "Non-European Women".⁴⁸ At the close of the nineteenth century virtually no other public health facilities or services were available for preventative or non-emergency care, and even fewer for women and children, white or black.

Thus, in South Africa the recognition that advances in "preventative public health" were necessary at all developed widespread acceptance only in the wake of the South African War. In her outstanding study of child and maternal health and welfare in England, Jane Lewis has summarised the central role of the War experience, and her comments are worth quoting at length for the light they shed on the South African context:

The campaign to 'glorify, dignify, and purify' motherhood and to transform this image into reality began in earnest soon after the Boer War. /.../ Interest in maternal and child welfare began with the recognition that infant mortality was a problem of national importance... but infant welfare did not become a national issue until after the Boer war... Concern over physical efficiency first arose when attention was drawn to the poor quality of army recruits. The large amount of publicity that was generated led to the appointment of an Interdepartmental Committee on Physical Deterioration. The committee's report, published in 1904, devoted much attention to the welfare of infants and school children, recognising

⁴⁸ Material in this section is drawn from R. Bernstein, "Medicine and Health in Early Johannesburg" Bulletin of the Adler Museum of the History of Medicine 12:3 (1986) 24-33 and P. W. Laidler and M. Gelfand South Africa 476-480.

that it was in the national interest to safeguard the next generation and thereby improve the quality of the race.⁴⁹

As indicated at the start of this chapter, delineating the boundaries of motherhood in Britain at this time was a process irrevocably tied to British colonial endeavour, and like other colonial civilizing missions, sharp contradictions imbricated official intention. These are graphically evident in the debates over infant mortality and midwifery by local and central state health officials.

In 1903, in the wake of the Vereeniging Peace Treaty which marked the end of the South African War, a group of middle class women in Johannesburg organized into a group called "The Guild of Loyal Women" began to raise funds for a memorial to those slain in the war, a memorial considered suitable for the patronage of women, because it would emphasize infant and maternal life. This memorial would also stand as an act in the nation-building process necessary for the future of Southern Africa. This Guild had in mind, though, only fellow white women and believed themselves magnanimous in their intention to include both Afrikaans and English speaking women patients, while nevertheless preserving the Victorian designation in the title of the institution. In 1904 their efforts bore fruit in the establishment of the Queen Victoria Maternity Home.⁵⁰ In 1913 the 36 bed Home was absorbed into the Johannesburg Gen, which, after 1922

⁴⁹ J. Lewis, The Politics of Motherhood: Child and Maternal Welfare in England, 1900-1939 (London: Croom Helm, 1980) 13-15.

⁵⁰ R. Daly "The Origin and Development of the Johannesburg Hospital and its Branches", South African Medical Journal (February 1922) 143- 145. In 1905 the Ellershaw Maternity Home opened its doors. This privately funded institution was for some time the only place where white women could train as midwives.

became connected to the newly founded University of the Witwatersrand Medical School. The Medical School established its first Chairs in Medicine, Obstetrics, Surgery, and in 1923, its Chair of Gynaecology, and the 'Queen Vic' became the site of gynaecological and obstetrical training and research for the first local academic divisions in these fields. Although the years 1903 to the mid-1920s saw many developments in maternity and infant care, no single institution was established for black women, nor was there provision for even emergency obstetric surgical cases in the so-called Non-European wards of the Johannesburg General. These limited facilities for white women, and non-existent facilities for black women, are not easily explained in the face of persistent official and expert testimony on the part of Johannesburg's public health officials from 1911 onwards, concerning the dire necessity for improved maternal and infant care.

Recruited by Lord Milner to form part of his "Kindergarten" of British officials, Charles Porter was installed as Johannesburg's Medical Officer of Health (MOH hereafter) in 1901.⁵¹ His major reference point for the health infrastructure of the city remained his British training and experience, but he began to turn to colonial officials in India and Australia for advice in matters of town planning and sanitation. In the case of white infant and maternal care, Porter, like officials in the Union's central health department, studied reports from England, Wales, Scotland, New Zealand, Canada and Australia for insights into infant and maternal mortality and morbidity statistics, especially from poorer and urban districts. Porter noted the connection between examples of improved statistics and a

⁵¹ L. Curtis, With Milner in South Africa (Oxford: Basil Blackwell, 1951).

focus on preventative care and maternal medicine in these regions. From the available records, and several "spot census" takings, Porter and his staff pieced together data which provided a rough estimate of the size of Johannesburg's population in 1910, indicating that Johannesburg had grown from a small if bustling mining town into a sizeable city of around 220,300 people, at least half of whom were black (broken-up into the categories "Coloured", "Asiatic" and "Native").⁵²

As we shall see, Porter was, by 1911, rather sceptical that infant mortality and maternal health could be improved in poor white communities by anything less than higher wages and better living conditions. His belief was founded on the premise that his department had already tried health propaganda campaigns and that any further improvement would require the dedicated work of highly skilled "lady health visitors", who would burden the city health budget, with no guaranteed results. Porter explicitly compared the available statistics of white infants with those for black infants, and concluded that his the first duty of his Department was to the latter. But white women activists in the city, organized into associations, particularly the Women's Reform Club, insisted on a more vigorous response from Porter regarding the reported rates of white infant mortality, which were higher than those for New Zealand and for most of England and Wales, the countries most commonly compared by middle class white settlers to

⁵² B. Unterhalter, "Inequalities in Health and Disease: The Case of Mortality Rates for the City of Johannesburg, South Africa, 1910-1979", International Journal of Health Services 12:4 (1982) 631 and IAD/JDPH MOH Reports from 1903, 1905 and 1910.

themselves. In her survey of infant mortality in Johannesburg from 1900 to 1970,

Unterhalter points out that:

White infant mortality rates of between 110 and 117 in the first decades of the 20th century were high by the standards of the day, with one child out of every 10 dying before attaining its first birthday. A gradual fall began only in 1921 and even then the rate remained high (between 72 and 88). The white infant mortality rate was higher than the national figure for the white population (96 in 1910 compared with Johannesburg's 10, and 90 in 1920 compared with 110). It was only in 1939 that Johannesburg's white infant mortality matched the national figure... The white infant mortality rates provide a picture of ... deprivation among whites... in 1919 the infant mortality rate was as low as 63 in the northern parts of the city where the affluent whites lived, while in working class neighbourhoods like Newtown, Fordsburg, and Mayfair it was as high as 113.⁵³

In January and February of 1911 Porter was called to submit his opinion on women health visitors before the Health Committee of the Municipality, after a series of letters from the Women's Reform Club, and several articles in the daily Johannesburg press, catapulted the issue into public debate among the city's white middle class.⁵⁴ He was further called to answer why Pretoria had led the way in hiring the first women health inspector ahead of Johannesburg. Porter replied by presenting the Health Committee with a series of arguments concerning his doubts about the efficacy of health visitors amongst the white poor of Johannesburg, and his doubts that suitably qualified women would be found to take on the task. First, Porter set-out the various duties a Lady Health Visitor would be expected to perform (and here Porter borrowed from the British legislation, as

⁵³ B. Unterhalter, "Mortality Rates" 631. Her figures follow the standard ratio used for these determinations, that is 1:1000 live births.

⁵⁴ IAD/JPHD: "Female Health Visitors" 41/3233: Letters and press clippings from 1911.

well as the procedures already established in Cape Town and Pretoria), which included: house visits in the case of all infants in district areas; notifications and investigations of infant deaths; visiting workshops employing females to ensure sanitary settings; and the keeping of a Health Visitor's Report Book for the records of the MOH. Porter then listed the required qualifications (three year nurse training; a midwifery certificate, and the certificate of the Royal Sanitary Institute for Health Visitors and School Nurses) and then continued:

The Committee will, however, readily recognize that very much more than 'technical' qualifications are necessary, especially in Johannesburg; for a woman may have all the certificates obtainable, and yet possess little of that personal tact which engages the sympathy, confidence and compliance of those amongst whom she will have to work. In addition she must be business-like, accurate and restrained in official statement and work, and amenable to official discipline, and not likely to 'put up the backs' of mothers by the assumption of superior airs or 'frills'. This is a list of characteristics which the MOH is satisfied are not easily to be had for the asking. Further she must speak both English and Taal fluently.⁵⁵

The grave obstacles to finding the correct person could be overcome, agreed Porter during questioning, but along with the influential physicians professional organization, the Transvaal Medical Society, and the Transvaal District Surgeons who had replied to the Committee's questions on the matter, he argued that:

The circumstances of the population in Johannesburg are rather different from those towns in with high infantile mortality in England, and though it has not suggested that your infantile mortality rate is incapable of improvement, it has fallen from 185 infant deaths per 1000 live births in 1903-4, to 117 in 1909-10.⁵⁶

⁵⁵ IAD/JPHD 41/3233 March 10, 1911, 5-7.

⁵⁶ Porter then went on to list the infant mortality statistics for English and Welsh towns and for London as evidence for the compatibility of the South African white infant statistics. He omitted the New Zealand and Canadian statistics most often quoted in the newspapers and by the Women's reform Club. IAD/JPHD 41/3233, March 10 1911, 6.

Porter obtained the support of the organized medical professional and District Surgeons because of their explicitly stated fears that health visitors and municipal health funding their work, would cut into their own pool of prospective and actual patients, and they complained about the already constrained conditions for registered practitioners in

Johannesburg.⁵⁷ They supported Porter when he further stated:

...with the exception of a certain number of the very poorest dwellers in Fordsburg and Vrededorp, there is much less poverty, more comfort, more qualified medical advice, and probably less want of information and intelligence as to childrearing, than in English slums, where the ignorance and poverty are often appalling.⁵⁸

But Porter parted ways with fellow physicians in his next set of comments. More than anything else, he argued, Health Visitors would only be of real benefit if they were empowered on behalf of the city, to seek-out and register infant births and deaths in a systematic fashion, and to note not only white but also black infant mortality. He argued further that any really effective service would also create legislation so that Health Visitors could inspect and regulate the conditions of the few lying-in homes in and around Johannesburg.⁵⁹

Porter's comments in this regard must have startled his erstwhile allies at the meeting, but it was these last comments that City Council committee members seized upon to broker an agreement and satisfy their constituents and the organised wrath of the Women's Reform Club. Thus, when the first two women officers were appointed later that

⁵⁷ IAD/JPHD 41 3233 and also see South African Medical Record, Letters to the Editor, 1911.

⁵⁸ IAD/JPHD 41 3233, March 10 1911, 6.

⁵⁹ Privately run birthing homes.

year, it was with the assurance of the Health Committee to Porter that they would craft and promulgate new legislation, consolidate and toughen existing Transvaal ordinances regarding births and deaths notification, and begin work on midwifery and maternity home legislation in return for his support.

Despite these agreements Porter remained sceptical, even after two highly qualified white women health visitors, both of whom spoke English and "die Taal"⁶⁰, were appointed. In reply to a letter from the MOH of Germiston Municipality in May 1911 about the Health Visitor scheme Porter sent on the procedural information, and then added:

You will observe that the appointments are not being made on my recommendation, but they seem to appeal to members of Health Committees, who, I think, are rather sanguine as to the good they expect from the work of these women. This is, of course, my personal opinion.⁶¹

Constance Morisse, one of the two women health visitors, was to challenge Porter's scepticism in the ensuing years, because she not only worked with poor whites, but also pioneered similar schemes in the black slums and locations. Her efforts in promoting black infant welfare surpassed any expectations Porter may have held, and indeed she was a key member of the team of people whose meetings about the dire health needs of black women in the mid-1920s, led to the formation of the Bridgman Memorial Hospital. Morisse's work with poor black and white women in the next decade as a

⁶⁰ Sometimes called 'Dutch', the 'Taal', meaning 'the language', was the term used to refer to what became the language of Afrikaans in the ensuing decade.

⁶¹ IAD/JPHD 41 3233, May 12 1911, 1.

Health Visitor in Johannesburg did more to institutionalise a local system of birth and deaths notification, familiarize factory owners with the role of female inspectors, and bring attention to the need for extensive district midwifery in the city, than any other single person. Although Morisse was hired to work with poor whites (at least that was the intention of the Health Committee), segregation legislation had not yet wedged itself fully into the official discourse of practitioner/patient relationships, and thus Morisse and her colleagues carved up their district work under the direction of Porter, including the predominantly black areas of the city. Ironically, her work with poor black women brought attention not only to their needs, but also to the needs of the hundreds of white women each year not served by the limited services of the Queen Vic. In 1928, the year Bridgman opened its doors, a large conference on the crisis in maternity care was held in the city. Here, her successful work, combined with the work of the Bridgman's and local physicians and missionaries, in the opening of the Bridgman Memorial Hospital, was presented as an example of the type of institution and training needed across the city for white women as well as black.⁶² Of course, Morisse would not have been appointed in the first place if she had not met the stringent standards demanded of female officials, which included total public commitment to official policy. Without great public caution regarding her work with black women, and Porter's support, it is doubtful whether she would have survived as a health official.

⁶² IAD/JPHD 41 3233. See the letters of application and recommendation for Eveline Sisterson and Constance Morisse. Note the continuing discussion of the 1928 conference below.

Unlike most of the other Public Health Committee members, and his fellow health officers throughout South Africa (with a handful of notable exceptions, such as P.W. Laidler of East London) Porter was focusing his attention in 1911 on the question of "Native" health, and he quickly despaired of any help from British colonial and most local white settlers in the matter of the health of black infants. Yet it was in the mortality of black infants and in the improvement of care for black women that Porter saw his greatest chance for success in the application of scientific methods to public health problems. In early 1911, Porter began to commission and gather advice and expertise on this topic from medical missionaries and local health officials throughout South Africa. His efforts suggest that the evidence of black women's maternal ill-health and the high rates of black infant mortality were pervasive and obvious enough to force themselves on his attention. His own predisposition and training led him to concentrate most vigorously throughout the years of his tenure on town planning, slum destruction and the creation of sanitized and maintainable urban landscapes.⁶³ Thus, his 1911 initiatives in researching "Native" infant ill-health were extraordinary.

In that year Porter wrote to labor experts, magistrates and medical officers whom he considered experts in both urban and rural health. His aim was to ascertain the causes for the high rates of mortality among black infants (and he included here Native, Coloured

⁶³ S. Parnell, "Creating Racial Privilege: South African Public Health and Town Planning Legislation, 1910-1919" I am grateful to Sue Parnell for sending me this unpublished chapter from her dissertation-in-progress in the Department of Geography, University of the Witwatersrand, n.d.

and Asiatic infants) reported to him in his slum surveys and through sanitary inspectors, mortuary officials, private doctors, and in reports prepared by the staff of the Johannesburg General Hospital. He wrote to the MOH for Pretoria, Durban and Cape Town, and for the Cape Colony, and the Transvaal, as well as the chief health officers for Kimberley, Basutoland, Burgersdorp and Albertinia. He also contacted the heads of missionary hospitals in Natal and the Transvaal. In his letters to the Municipal officials he concentrated on questions of statistics and the records of certified causes of infant death, asked about infanticide rates, and called for their comments on the housing and nutrition of infants. In his letters to rural health experts, Porter concentrated on questions of "custom and tradition": how did "Native" women feed their infants, how were they clothed and cared for, and what did these experts know about local rural rates of infant mortality and morbidity. He also wrote to the former head of the Native Labour Bureau, Mr Taberer, as well as the Commissioner of Police for the Transvaal, and the Johannesburg Superintendent of Native Locations, asking them for input and information.⁶⁴ The tart response from the office of the Deputy-Commissioner of Police, which stated that the "Police have no special means of enforcing or checking the Native, Indian or Coloured births in Johannesburg", was unlike any of the other detailed replies Porter received.⁶⁵

⁶⁴ IAD/JPHD 123 3567, "Native Infant Mortality, 1911-1915" Letters from March to April 1911.

⁶⁵ IAD/JPHD 123 3567: 31 March 1911.

From the extant archival records of his official correspondence Porter does not seem to have written to any among the small number of black elite men and women in the city due, no doubt, not only to his disregard for the opinions of black intellectuals on this matter (he did not, for example, write to any of the small town or rural notables such as Jabavu or Soga either) but also to the limited nature of organized black political and welfare groups in the city before the formation of the South African Native National Congress in 1912, or black women's organizations in the ensuing years. At this time it would seem that Porter was unaware of the presence of welfare activists such as Charlotte Maxeke in and around Johannesburg, suggesting that it was on his own initiative that he instituted these investigations into black infant health. He did, however, contact figures known to him from among the Indian communities in Johannesburg and Durban, notably M.K. Gandhi and James Godfrey, specifically asking them for information regarding infant feeding and rearing customs and habits in these communities, but there are no indications Porter ever received replies from either man.⁶⁶

Porter presented his detailed Report of April 1911 to the Johannesburg Public Health Committee, into subsections summarizing the available statistical material (both that sent to him, and that gleaned the figures his own city officials had provided) and the

⁶⁶ During the 1904-196 period, city officials such as Porter had cause for contact with Johannesburg's Indian community through a series of debates over Anti-Asiatic commercial and residential measures. For the political, legal and social work of Gandhi in South Africa, as well as detail on the Indian communities of Natal and the Transvaal at this period, see: M. Swan, Gandhi: The South African Experience (Johannesburg: Ravan Press, 1985).

narrative replies he had received on "Causes for Infant Deaths" and "Infanticide". He compared the figures from Johannesburg, Cape Town, Kimberley and Pretoria with the figures he had obtained the year before from officials in the Indian cities of Bangalore and Bombay, placing the Johannesburg statistics under those of the two Indian citations. Porter's Johannesburg figures, like those for Cape Town and Kimberley, made no distinction between "Natives" and "Coloureds" but, unlike other cities, Johannesburg did maintain separate records for "Asiatics", due in no small measure to the successful lobbying of the local Indian community for access to city resources in the wake of the War, and also to certain zealous city planners' racist determination to segregate "Asiatic" groups off from whites and also black communities. Based on the available evidence at the time, this table accompanied the Report. The infant mortality rates were computed per 1000 births.⁶⁷

INFANT MORTALITY RATES per 1000 BIRTHS:

TOWN	Year ending	Natives	Cape-Col. or mixed	Asiatics	White
Pretoria	30/06/09	340	126	304	121
Cape Town	30/06/10	216 for all Coloured races	"	"	104
Kimberley	31/12/09	302 for all Coloured races	"	"	80
Bombay	31/12/09	--	--	404	?
Bangalore	31/12/09	--	--	352	?
Johannesburg	30/06/10	361 for Natives&Cape Col	"	295	117

⁶⁷ IAD/JPHD: 123 3567 "Report of the MOH", 3 April 1911, Table Adapted from Report.

Porter informed the Committee that the figures were so poor for Durban that he could not include them in the table, and proceeded to quote the explanation provided by the Acting MOH for Durban, Dr Murison, for why this was so:

From the paucity of numbers as well as other circumstances, it would be absurd to calculate an Infantile Mortality figure for the native population in this Borough. Owing to the inability of the general Indian population to understand what is meant by "one year", it is impossible at present to state an Indian Infantile Mortality figure.⁶⁸

Porter offered no comment of his own concerning this patently absurd statement, but he followed it with an extract from the report of the MOH for Natal as a whole, who had calculated that the rates for Indian and Native infant mortality were 127 and 151 respectively, compared with 64 for whites. Although this official also mentioned the unreliability of the records, he blamed this on poor statistical procedures and a lack of health infrastructure. Of course the registration of official birth and death certificates for infants was not dependent on their parents' ability to determine the length of one year (even putting aside Murison's racist assumption about the inability of people of Indian origin to calculate monthly calendar time) but this example is extracted as one among many such similar comments proffered by officials in the documents Porter assembled over the next decade when they were unable to otherwise explain the absence of any records of infant mortality, even for the small clinics, hospitals and health districts that did fall under their control.

⁶⁸ IAD/JPHD: 123 3567 "Report" 2.

Porter was constantly reminding officials in Johannesburg that the 1906 Transvaal Births and Deaths Ordinance, modelled on a similar law in the Cape, required the registration of every birth and death in an urban areas within seven days, and in rural areas within three months, from the actual date of the event. However, Porter had no battalion of inspectors able to enforce this law, and officials of black locations and townships, revenue and tax inspectors, housing authorities and the police, as we have seen above, all eschewed any ability to enforce the ordinance. That was his underlying intention in tying his cautious support for the appointment of women health visitors to greater powers of enforcement and regulation.

In fact, right thorough to the late 1970s, there was no systematic effort to regulate the birth and death statistics of black males and females for the country as a whole, although every single Department of Public Health Annual Report from 1919 through to 1948 lamented the ramifications for planning and health work as a whole caused by this lack of official data. Although each successive health act (1919, 1928, and the various amendments thereafter) increased the scope of urban and rural requirements for the registration of births and deaths, and although certain magistrates (notably in parts of the Eastern Cape) as well as most hospitals took these injunctions seriously, from the very start differentiation in the framing of these laws and ordinances, and in the executive power vested in them, varied according to racial classification.⁶⁹ For those who

⁶⁹ D. W. T. Shropshire, "Report of an Investigation Concerning Bantu Marital Unions", Conducted under the auspices of the South African Institute for Race Relations, (Johannesburg, 1940). SAIRR 329 , Part III, 9. Brownlee's evidence suggests that before

continued to insist on the need for more accurate statistics, the burden fell on cities and local health authorities, as well as large urban hospitals, such as those in Durban, East London and Johannesburg, to furnish the richest samples of data available for health planners, scientists and demographers. This was noted in 1932 by the influential MOH of East London, P. W. Laidler, a noted authority on the anthropology of local Xhosa-speakers, an amateur archaeologist, a medical historian, and the first MOH to write extensively on urban health problems of black men and women. In an article which received wide acclaim and attention across Southern Africa in the early 1930, entitled "The Relationship of the Native to South Africa's Health", Laidler pointed to the problems inherent in the central states relinquishment of census taking for all South Africans:

From 1921 a separate Census form was used for Europeans and non-Europeans; since then the separation has become complete, and in 1926 and 1931 there was no Native Census, except East London's private one in 1926. If in future the taking of a Native Census is to be left in the hands of local authorities, whose financial responsibility it will become, there will be in time an accumulation of statistics of local areas of merely local and urban interest rendered less useful because of the rural-urban influx.⁷⁰

1923 a system had been instituted whereby once a month local Headmen would bring in lists of births and deaths occurring within their jurisdiction. This scheme was dropped, it would seem, on the advice of Pretoria based Native Affairs Department officials, who decreed that the system was unreliable, which seems astounding in the face of the paucity of other available records. It once again underlines the manner in which lines of authority and funding were constantly bifurcated in the administration of health and social welfare matters concerning black men and women, with each step in the hierarchy passing responsibility onto the next, and with different Departments' arguing over jurisdiction.

⁷⁰ P. W. Laidler, "The Relationship of the Native to South Africa's Health" South African Medical Journal (8 October 1932) 619. In the next edition of the same journal, (October 22 1932), an editorial on Laidler's piece noted that the paper had first been read before the South African Medical Congress of that year, and had been published because of overwhelming commendation of the points raised by Laidler, and in order to make the

Before the 1950s, official explanations for the incomparability of white and black vital statistics, centered on the difficulties of gathering data in urban conurbations, ghettos, remote rural areas, citing the lack of staff and funding needed to accomplish the task. These explanations were offered by people in the employ of departments of State, whose powers to generate documentation on the movement of black subjects, to track, trace and police men and women through minute channels of formal and informal employ, through myriads of official certificates and levels of permission, have become notorious.⁷¹

Segregation and Black Infant Health:

But if health officials, missionary doctors, philanthropists and activists were sincere in their statements about the worrying evidence that did exist for infantile mortality rates and for tracking the morbidity and mortality rates of black people more generally, why were their pleas never fully addressed? To arrive at some answer to this question we need to consider in greater detail the reasons public health officials called for better statistics, full address more widely available.

⁷¹ Citations for the Reports calling for improved statistics are listed below. After the 1950s, the creation of the Bantustans provided a new avenue of explanation for the lack of centralized or region-wide data collection, but even in the case of population planning and state demography, arenas wherein the State would seem to have had a great deal of vested interest in some form of "accurate figures" (even if these were to be suppressed) census statistics seem to have continued to be ideologically generated, enumerated and analysed to a degree not yet fully apprehended. The work of social demographers such as O. Chimere Dan, Carol Kauffman and Heston Phillips on the methodological assumptions built into past statistical data collection in South Africa, as well as their work on the first forthcoming countrywide Census in the wake of the 1994 non-racial election, promise to elucidate these and other aspects of the politics of population statistics in South Africa far more thoroughly.

and to track parallel arguments and calls for documentation of the similar ills of poor whites.

The constant bifurcation of lines of authority in matters concerning black men and women, constantly interrupted any unified approach to health or welfare services, despite the efforts of individuals such as Constance Morisse. The basic premise of segregation cut-through every provision, funding measure and executive plan that public health officials crafted. Ironically, just as joint planning at least in maternity health and infant care did get underway, local white city officials, representing white male voters (including poor, unemployed and working class whites) began to agitate for the separate funding of every measure designed to improve services for black men and women. Increasingly, the Native Affairs Department, based in Pretoria, was called upon by Municipalities along the Rand, including Johannesburg, to finance the costs of black health and welfare through their "Native" revenue accounts. This basic premise, of accepting a different structure of revenue and taxation, and of insisting on separate services, forced massive compromises in the initiatives that health officials put forward.

Yet, it is still not sufficiently clear why despite the demands of key health officials in South Africa--including Mitchell (Secretary for Public Health); Boyd (MOH for Pretoria); Laidler (MOH for East London); Gear and Cluver (Assistant Health Officers for the Union)-- for greater attention to the gathering of vital statistics for black South Africans, the funds and support for these investigations were never forthcoming from

other organs and departments of State. From 1924 to the mid 1930s, the pages of the South African Medical Record, the South African Medical Journal, The Leech, the Journal of the Medical Association of South Africa, and even the published Annual Reports of the Department of Public Health, called for the allocation of new funding and new attention to "Native health and mortality". Articles titled "The Avoidable Wastage of Childlife in South Africa"; "The Influence of the Native on Public Health"; "Municipal Health Problems of the Non-European Population"; "The Economic Factor in the Health of the Bantu in South Africa"; and "A Plea for Improved South African Medical and Vital Statistics", essentially repeated warnings about the lack of data, and about the interconecion between the health of whites and blacks, and thus the absurdity of collecting and recording data for white, but not black, subjects. That most of these pleas were made during the 1920s, a period when urban segregation legislation accumulated, and when municipal hysteria around the presence of black women in cities mounted, might help to explain why different branches of the central state ignored or deflected these calls. Perhaps this is why, by 1937, when Gear in the high echelons of the Union Public Health Department, made a renewed plea for improved statistics, he framed his call in terms of the disgrace this absence brought upon the claim to expertise of the South African state and indicated the wider implications for the lack of statistical material in nationalist language:

That so much of the Census report should be in the nature of a revelation is indicative of the weakness of the system of demography in this country. That so many vital phenomena --births, deaths, age, sex, racial and demographic distribution of populations-- are imperfectly known is of serious consequence to the statesman, scientist, and administrator. In the absence of knowledge of the

birth and death rates of the non-European, guidance and control of important social forces in impossible, and the forecasting of and preparation for future national needs in such fields as labour, education, industry, and the general social system is haphazard.⁷²

While further research into the politics of the Bureau Census and Statistics is needed, it seems clear that in the years leading up to the 1923 Urban Areas Act, and before the most tenacious of urban segregation bills had been passed into law, officials such as Porter were less constrained in their linking of white and black health issues, at least at the municipal level.

It was in this atmosphere that Porter drew the attention of the Public Health Committee of Johannesburg to black infant ill-health, in the month before the Committee voted in 1911 to fund the proposal for Health Visitors. Porter reported to the Committee that his findings and those of the health officials who had responded to his questions indicated that the major causes for black infant mortality in Johannesburg during the first month of an infant's life were respiratory diseases, and ill-defined conditions, (such as "low vitality", "debility", and "convulsions"). After the first months of life, infants from 8 to 13 months died in the main from diarrhoeal diseases. Similar statistics were reported for infants designated "Asiatic" and "Coloured". Porter indicated that the information he had assembled from missionary hospitals and authorities on rural "Native Life" demonstrated

⁷² H. Gear, "A Plea for Improved South African Medical and Vital Statistics" in South African Medical Journal (13 March 1937) 149. The remaining articles cited can be found in the South African Medical Record (26 July 1924) and (9 August 1924) and (8 October 1932); and in the South African Medical Journal (28 October 1933); as well as The Leech (September 1934). And see the Annual Report of the Department of Public Health for 1928, 1930 and 1937.

that infant mortality in what he called "the Kraals" was far lower than in Johannesburg. Porter wanted to know, as he said, what "special predisposing or other circumstances" could account for the high rates of black infant mortality in Johannesburg. The answers he received were summarized in his report:

...much of the excessive native infantile mortality in Johannesburg is due to feeding infants on cheap inferior and often bad condensed milk; and that condensed milk when left open for several days in tins to invasion by flies and dirt, is a potent cause of diarrhoea in infants... other special causes [include] inherited syphilis, poisoning by carbon monoxide gas from fires lit in ill-ventilated smoke-filled dwellings, burns and other results of general neglect, and want of medical attendance.

Porter ended his fifteen page report with an approving mention of the schemes instituted in Bombay and Bangalore where infant mortality was being combated by the diffusion of health leaflets and health propaganda concerning feeding of infants, and through the training of midwives.⁷³

"Maternal Irresponsibility" and Infant Feeding Practices:

From the replies Porter received, it is clear that his respondents all stressed the lack of hygiene and neglect of children by black city mothers as chief causes of infant ill-health and death. In his stress on poverty, poor dwellings and lack of medical care to the Committee, Porter was putting his own particular spin on the data he had gathered. One strong claim for the cause of infant deaths made by two of his correspondents, underplayed by Porter in his report, was infanticide. Presenting a case for the evil of black city women, and the need to strengthen rural family ties, both Dr Mehliiss and Mr

⁷³ IAD/JPHD 123 3567 "Report", 13 to 15.

Taberer⁷⁴ argued that large numbers of black children in Johannesburg were the "offspring of prostitutes" and were therefore neither "wanted children", nor legally sanctioned in the eyes of family members or according to "tribal customs". These unwanted children, they argued, were often "allowed to die", and were occasionally deliberately killed. Porter himself commented that he could find little evidence for this, although he granted that as so few investigations of infant deaths occurred, and many births and deaths in general went unreported, detection of infanticide cases was impossible under prevailing conditions. Porter agreed instead with several of his rural experts who replied to his questions arguing that infanticide seemed to be declining as cause of rural death, a shift he and his respondents attributed to greater missionary influence in rural areas.

The emphasis on maternal irresponsibility and ignorance in many of these commentaries is indicative of a widely shared sensibility. Missionaries, black and white women welfare activists, medical specialists and officials shared an ideology simultaneously valorising the "duty of mothers", and pillorying "failed mothers". Indeed,

The principle aim of the majority of child and welfare services was to promote a greater sense of moral responsibility on the part of the mother... Nineteenth-century social policy had been based on the belief that need was attributable to individual moral failure and the early infant welfare service reflected the close connection that existed between social and moral reform... Health visitors and infant welfare centres set out to reform the character of the working-class mother...⁷⁵

⁷⁴ Taberer had been Director of Native Labour until 1907, when he took up a post at Rand Mines, and Dr Mehliiss was a Rand physician considered an expert on black health. It is interesting that both men made this argument and supported the expulsion of the majority of black women from the city, suggesting that most social ills as well as public health problems regarding black would be solves in this manner.

⁷⁵ J. Lewis, The Politics of Motherhood 18-19.

Lewis' description of a "moral motherhood" consensus in the first decades of the twentieth century in England, corresponds closely with the attitudes evinced by social reformers in South Africa at the time. But in South Africa, women's groups and missionary organizations were increasingly making the argument that these moral teachings would have to be accompanied by economic reforms addressing the roots of poverty. In England too radical Christian groups dedicated to health, welfare, and political reform, drew women into Women's Cooperative Guilds where they fought battles on several fronts: women's access to the franchise; local health spending; and poverty. In a 1915 publication, one of the leaders of this British movement, Margaret Llewelyn Davies drew together the letters of working women concerning their experiences of pregnancy and birthing. This collection provides an unparalleled glimpse into the lives of women as mothers, spouses, lovers, cooks, healers and workers. Davies concludes her Introduction by quoting approvingly from an address of a Guild member at the opening of a municipal maternity clinic in Bradford, England, 1915:

We stand on the threshold of an age which is to herald the recognition of the mother and her child, to give public health work that human touch it has hitherto lacked, and to modify those glaring inequalities in social life and conditions which are destructive alike of infancy and the ideals of Christian citizenship.⁷⁶

While Porter and officials in his Health Department were virtually silent about the causes of inequity and poverty in Johannesburg, Porter's propensity to focus on solutions to

⁷⁶ M. Llewelyn Davies, (ed) Maternity: Letters from Working Women, (1915, London: Virago Press: London, 1989) 17.

specific small-scale problems underplayed the ideological invective of many of his peers, and pushed him towards pragmatic programs.

In the 1920s, official concern over "infant feeding practices" mounted in Britain, America, France and colonies such as the Belgian Congo. The emphasis on infant nutrition and breastfeeding focused on the duty of women to nourish their children, and castigated women who did not successfully breastfeed, and thus caused infant disorders.⁷⁷ A generalized concern over women's duty to breastfeed soon developed specialist branches, theories and methodologies, with scientists detailing correct technique, disciplined time-allocation, and in Southern Africa, attacking what they regarded as superstitious lactation taboos and the dangerous implications of "feeding on demand".⁷⁸ As late as the mid 1931, surveys of health experts canvassing their views on black infant mortality, indicated that besides ignorant midwifery, and high rates of pulmonary and venereal disease, physicians often listed "irrational infant feeding techniques" as a major cause of infant sickness and death.⁷⁹

⁷⁷ This attitude towards breastfeeding altered dramatically in the United States after World War Two, and to some degree in Britain. For an interesting discussion of the Congo material, where colonial infant welfare centers sponsored 'disciplined' breast feeding, at the same time as encouraging the use of commercial milk products, see N. R. Hunt, "Le Bebe en Brousse: European Women, African Birth Spacing and Colonial Intervention in Breast Feeding in the Belgian Congo", The International Journal of African Historical Studies 21:3 (1988).

⁷⁸ We shall return to some of these themes in the next chapter. For a fascinating account of lactation theories and practices emanating from the South African medical community at the time, see E. Salber, The Mind is not the Heart: The Recollections of a Woman Physician (Durham: Duke University Press, 1993) 64 .

⁷⁹ Even in an article ostensibly devoted to a socio-economic approach to infant

Porter's survey elicited similar comments but his approach was to focus on aspects of infant nutrition over which his Department could exercise some control. He was struck by the emphasis in the reports on the poor quality of infant nutrition in Johannesburg compared with rural areas. Porter concentrated attention on the hygiene of milk depots and the local condensed milk industry, and with his spouse, Dr Annie Porter, began to investigate and assemble inspections of milk hygiene throughout the city. After the founding of the South African Institute of Medical Research in 1914, which opened right next door to the Johannesburg Hospital, Annie Porter enlisted the help of the newly appointed scientific staff in this matter and published several papers on the subject through the Institute itself.⁸⁰ Interested in the question of infant feeding more generally, and in a perceived decline in breast feeding among both poor black and poor white women, Porter collected material on infant feeding practices, and his files contain a letter, heavily inscribed and annotated by Porter, from Dr Borle of the Elim Swiss Mission Hospital in Spelonkin, Transvaal. Borle offered an explanation for why fewer urban black women breast fed successfully, based on his observation that black women who wore clothing on their breasts evinced a marked tendency for breast inflammation. He titled this section of his letter to Porter, 'Effects of Clothing on Nursing at the Breast', and continued:

mortality, the emphasis on the culpability of black mothers dominates; see E. Earty, "Stillbirth and Infant Mortality in South Africa from the Social and Economic Point of View", International Nursing Review VI: 4 (1931).

⁸⁰ F. Daubenton, "Medical Education in Johannesburg" The Leech, 44:3 (1974) 94. During the teens and twenties, Dr Annie Porter pioneered research into food hygiene and urban sanitation provisions, as well as methods to test and store milk supplies.

The reason is a simple one. As Natives very seldom wash their clothes, the breast is in constant rubbing contact with dirty linen which is generally of a bad quality and which dye comes off easily. The result is obvious. Infection sets in which is followed by a severe inflammation, and abscesses form. In these cases there is no wonder why many children do not do well. Some of them die, if both of the mother's breasts are diseased. ... These clothed natives are called civilised natives! Thank God! I should like to tear off all their clothes from their body and set fire to the heap of them. This would mean Public Health and civilisation!⁸¹

While Porter clearly agreed with Borle's enthusiasm for public health measures, as well as his biomedical explanation for infant feeding disorders, he did not comment upon the bizarre remedy suggested by Borle.

Soon after the March and April 1911 Public Health Committee meetings concerning black infant mortality and the appointing of health visitors, Porter turned most of this work over to the two new members of staff. Morisse and Sisterson compiled a district map and began post-natal visits to women recently discharged from the Queen Vic, and from small private homes, as well as ante-natal visits to pregnant women whom they heard of largely by word of mouth. By September, Porter was impressed enough with the work undertaken by the two visitors that he successfully argued before the Committee for the upgrading of one of their positions to that of Sanitary Inspector so that, in addition to health work with women, they would have the authority to report and comment upon unsanitary conditions in street refuse, manure, milk consumption and housing. Finally, health visitors would be expected to enumerate and collect data on maternal and infant health.

⁸¹ IAD/JPHD 123 3567 Borle to Porter, 4 April 1911.

But these successes brought with them ironical results. The heated discussion around infant mortality was diffused and displaced until the mid 1920s, and Porter's early enthusiasm was replaced with complacency, as he turned to what he considered to be the more pressing matters of housing provision and slum clearance. And, after 1914, Porter's attentions were increasingly involved with the war effort both locally and abroad. Until 1919, issues of maternal health and infant welfare remained dormant, only reigniting in the early 1920s with a new emphasis on midwifery regulation and a call for maternity institutions. In the wake of the war, and The Spanish Influenza epidemic of 1918, debates surrounding the passage of the 1919 Public Health Act opened new discussions of pregnancy, fertility, birthing labor and infant care. Central to all of these, was the role and regulation of midwives.

Midwives and Maternal Health:

In 1907, the Transvaal passed an Ordinance, modelled on a Cape law in operation since the last decades of the nineteenth century, regulating the work of nurses and midwives, and setting up a midwifery register.⁸² Originally, untrained women who had practised as midwives for at least one year before the passage of the bill were allowed to

⁸² C. Searle, History of Nursing Chapter XII: Searle provides a detailed history of Dutch home midwifery at the Cape, and provides a summary of the 1891 Medical and Pharmacy Act of the Cape, which made provision for the regulation of Midwives. She notes that the first midwives registered in either Britain or the British Empire, were the nurses and midwives in Cape Town in 1891. Also see IAD/JPHD 101 58 "Midwifery" Memoranda from Porter, and letters from Porter to the MOH of Pretoria, 1907 to 1913.

continue practising, subject, in theory, to obtaining registration, for which they had to supply testimonials and a residential address as well as to pay a fee. In 1911, in the flurry of activity surrounding infant welfare, a number of unlicensed midwives were investigated and several charged with misconduct and fined.⁸³ In 1913, the Transvaal Medical Council opposed the promulgation of new measures to register and investigate midwifery practice on the grounds that it would take powers of medical control away from physicians organized into Medical Councils, giving authority to determine a midwife's eligibility, confirm registration and extract fines and punishments from illegally practising midwives, to municipal officials. They argued that this step challenged all the existing provincial ordinances governing public health and medical practice.

Articles and letters published in the South African Medical Record of the period, underscored physicians anxieties with three interlinked facets of midwifery reform. First, they argued that medical authorities needed to clamp down on the armies of so-called "gamps" whose unsanitary and unlearned techniques were causing infection and worse in their women patients.⁸⁴ Second, they demanded full control over the examination and licensing of midwives in the hands of the physician controlled Medical Councils. Third, they insisted that women found guilty of misdemeanours under new laws, should pay fines

⁸³ See cases reported in the South African Medical Record (26 October 1912); and see 1913 letters and case extracts in IAD/JPHD 101 548 "Midwives".

⁸⁴ This term was most commonly used in South Africa to refer to unlicensed midwives at the time, and was taken from the character of Sarah Gamp, a nurse in the Dickens novel, Martin Chuzzlewit, (1864). See the Transvaal Medical Council's letter of 1913 in IAD/JPHD 101 548 "Midwives".

to the Medical Council. In none of these letters and articles did physicians explicitly argue that midwives should be outlawed altogether, but the general tenor of their argument was that competent midwives were scarce in Johannesburg, and that even these few women were technically and legally unqualified to treat women in need of surgical assistance. Furthermore, better qualified physicians, they argued, and especially the newly emerging specialists in the fields of obstetrical medicine and gynaecology, should not find themselves outnumbered and outcompeted by midwives charging cheaper rates.⁸⁵

The published and archival records of these physicians' anxieties and petitions have been preserved, and the authority and volume of their opinions makes reading between and around their intentions a challenging task, especially in the absence of any similar record on the part of midwives, both formerly trained as well as untrained practitioners. This is particularly acute in the history of midwifery and maternal care in South African, because so many of the community midwives, both black and white, were not organized into formal networks, and no similar written records of their work or attitudes has been preserved. This is one of the reasons why the quality as well as quantity of evidence contained in the archival records of Louisa Mvemve, a midwife, fertility specialist and herbalist, practising in and around Johannesburg at this time, provide such a profound

⁸⁵ Histories of comparative struggles over midwifery and the encroaching powers of organized physicians in North America and Europe include: J. Barrett Litoff, American Midwives 1860 to the Present (Connecticut: Greenwood Press, 1978); J. Lewis, The Politics of Motherhood and J. Walzer Leavitt, Brought to Bed: Childbearing in America, 1750-1950 (Oxford: Oxford University Press, 1986).

resource for tracking a wider history of midwifery and birthing care, and this historical resource forms the basis for the next chapter.

The impression gained from a reading of the professional journals and archival letters of physicians is of a city landscape overrun by untrained midwives whose patients obstinately refused physician care, and of physicians desperately seeking work. In fact, the poor of Johannesburg, who had not the money anyway to pay high physician fees, and who were often without extended families and support networks in the city, turned to neighbours, local herbalists and older women recommended by word of mouth to help them though their birthing in cramped conditions without privacy and often without the domestic assistance of close relations. When Morisse and Sisterson began their work, they noted the grave need for better trained and equipped midwives, and pointed out both the acute shortage of women with established midwifery reputations, and the existence of even fewer licensed and medically trained midwives. Besides noting that the chief causes of maternal and infant mortality and morbidity in the city remained dirty and cramped living conditions, the ill health and undernourishment of pregnant women, as well as the overtaxed work of many midwives, health officers reported that many cases of puerperal sepsis occurred because midwives attended too many cases at one time.⁸⁶

Perhaps recognising the straw arguments lodged within the expressed fears of local physicians, an Editorial in the South African Medical Record of 1916 noted these medical concerns, but also hinted that local conditions were not analogous to those in Europe or

⁸⁶ IAD/JPHD 101 548 "Midwives" 1907-1919.

North America. The Editorial claimed instead that local physicians were less harmed by the actions of midwives than their peers abroad, both because there were fewer midwives, and because local physicians were able to charge more for their obstetrical care than practitioners overseas. This meant that they earned at least as much from pregnancy cases though they had fewer patients treating a group of often richer, and also self-selected patients who were anticipating their need of more technically skilled assistance. The Editorial went on to pinpoint the real reason for the local physicians' concerns, namely the greater professional independence of trained midwives from the purview of mainly male physicians. In this arena, despite different local constraints, South African physicians were in agreement with their foreign peers:

One of the great advances of recent years, both in this and other countries, has been the more effective training of midwives, this training being mainly based on the conception that, as distinguished from nurses, who must always be essential assistants to the medical attendant, the midwife must be regarded as an independent practitioner within her limited sphere.⁸⁷

Barrett Litoff has tracked the history of opposition to midwifery on the part of American physicians during the same period. She argues that in the period when obstetricians and gynaecologists were battling to gain credibility amongst their scientific peers, and to exercise control over the medicalization of birth, a key turning point was the institutionalising of birth in hospitals under specialist medical control. Thus, for as long as hospital births were considered the purview of indigent women, and until home-birthing was challenged by the onslaught of scientific testimony and research which argued that

⁸⁷ Editorial, South African Medical Record (14 October 1916) 289.

hospital births were better managed, less painful, less risky, and more prestigious than

home-births, midwives were seen to pose the greatest threat to obstetric science:

Most of the opposition to the midwife originated from physicians who felt that the status of obstetrics needed to be upgraded. These physicians, many of whom were obstetric specialists, feared that the obstetrician would never receive due recognition in the 'over-crowded' medical profession as long as women, untrained in the medical sciences, continued to serve as birth attendants. Thus they embarked on a campaign to persuade both the medical profession and the public that obstetrics was a complicated medical speciality requiring the skill of a highly trained physician.⁸⁸

Once specialist medical doctors had elevated the hospital birth to the level of a scientific and social good, their anxiety about midwives was replaced by an emphasis on the need for stricter standards of midwifery training, in hospitals, under physician control. At precisely the same time that South African physicians debated the merits of training and registering more midwives, continuing to set this option up against one which would emphasise developments in obstetrical science, internationally regarded American obstetricians and gynaecologists such as Whitrage Williams and Lee continued to advocate great caution in the work of midwifery training. It took until 1930 for North American specialists in women's health to gain full and separate professional status when the American Board of Obstetrics and Gynaecology was formed. Local South African physicians of the same period were, in the main, trained either in England or Scotland and after 1910 a growing number qualified for postgraduate obstetric and gynaecological qualifications, through Royal Institute examinations, becoming members of the British Specialist Associations and their South African branches. Thus the push for greater

⁸⁸ J. Barrett Litoff, American Midwives 64.

professional acceptance was less marked than in North America in the period before the opening of the University-linked Medical Schools.

Local obstetricians and gynaecologists began searching for local and international recognition only after the establishment of institutions such as the Bridgman after the 1930s and beyond, in the scientific work behind such projects as "Bantu Gynaecology".⁸⁹ An even more important local difference was that in South Africa, besides a few Provincial institutions such as the small Queen Vic, and private homes such as The Ellershaw home in Johannesburg and St Monica's in Cape Town, few maternity beds were available in the 1920s, and these were mainly in small, homely institutions run by family midwives. It was this recognition of quite differing local circumstances that lay behind the advice proffered to agitated physicians in the 1916 local Editorial. Doctors were urged to sit back and enjoy the slow increase in the number of local trained midwives, as this would ultimately take taxing and mundane cases off their hands, and leave them with time to explore more technically sophisticated work:

To our mind, the less midwifery a man does, the better for his health, for his comfort for his calmness of mind, and for his chance of taking much needed holidays.⁹⁰

While the Editor's views may have been shared by smaller numbers of local medical men during the war years (as many doctors went into the medical services of the military) a

⁸⁹ See chapter nine.

⁹⁰ Editorial, South African Medical Record (14 October 1916) 289-290.

new mood in obstetrical medicine developed after 1920, with the creation of Chairs of Obstetrics and Gynaecology at the new Johannesburg medical school.

In the intervening years, these arguments, along with the focus of attention on the war effort, prevented the passage of any substantially new local or central regulations. Through out this period, women continued to seek and obtain midwifery registration, and hearings continued to be held in cases of suspected infringements of sound midwifery practice. But overwhelming evidence of the grave need for midwifery care and the lack of available services, pushed the 1913 to 1916 complaints of local physicians off the front pages of medical publications. After 1920, a shift occurred away from discussions of "meddlesome midwifery" in home births, towards the need for institutional care for pregnant women. The debates and conferences among physicians and health officials leading up to the promulgation of the 1928 Public Health Act resulted in the establishment of a series of new and stricter procedures and rules for the legal practice of midwifery. At the same time, the Act determined that by 1931 all midwives in towns and cities falling within the newly prescribed areas, would have to fully comply with the regulations. The passage of this legislation was clearly a response to generalized fears within South Africa's medical academy that herbalists, patent medicine producers, and "all manner of quacks" threatened the grip of medical science on the populace, particularly rural whites and blacks and the urban poor. But the passage of the Act did not guarantee that enough doctors,

hospitals or medical services would be provided in the wake of the criminalizing of a host of unrecognized health treatments and services.⁹¹

In Johannesburg, health officials, University medical and Johannesburg Hospital staff, as well as the women running the fledgling district midwifery service in the city, realized that the grave shortage of hospital beds and the small number of trained midwives would have to be addressed if the city were to meet the act's requirements by 1931. From 1924, when the midwifery provisions of the proposed Act were beginning to be considered, groups of public health activists in the city began meeting to discuss the crisis in maternity health. For the first time these discussions emphasized not slum control, poverty, women's ignorance or infant feeding, but the responsibilities of the local and central state in training midwives and providing hospital maternity beds.

The underlying reason for this shift in emphasis was a new sense that the reproduction of the industrial and agricultural workers of South Africa itself was under threat.⁹² The 1920s ushered in a decade of Commissions of Inquiry into economic conditions in rural and urban areas⁹³ Evidence of the success of the small maternity hospital, 'Die Moedersbond', opened in Pretoria in 1919, was cited as a model for the

⁹¹ The implications of the 1928 Act will be discussed in greater detail in the next chapter.

⁹² F. W. Fox, and D. Back, A preliminary survey of the agricultural and nutritional problems of the Ciskei and Transkeian territories with special reference to their bearing on the recruiting of labourers for the gold mining industry (Johannesburg: Chamber of Mines, 1938).

⁹³ Economic and Wage Commission, 1925, UG 14-26; Report of the Native Economic Commission, 1930-1932, UG 22-32.

types of institutions needed countrywide.⁹⁴ In this institution, poor white women who were recent immigrants from rural areas, were tended by biomedically trained nurses and doctors, often for the first time in their lives. These women's previous experiences of childbearing had relied on networks of healers and family midwives, as well as many highly regarded rural, Afrikaans-speaking, Coloured midwives.⁹⁵ Although the Queen Vic in Johannesburg took in some cases of poor women, there was no equivalent institution specifically for the treatment of poor white, and no facilities at all for black women.

A series of missionary conferences and meetings were held to discuss the issue in the mid and late 1920s, out of which people such as Clara Bridgman began to assemble support for the health needs of black women and children in the city. These conferences simultaneously emphasized the failures of the Johannesburg City Public Health Department in adequately addressing urban health needs of black men and women, and recognized the permanency of black urban life on the Reef for the first time, at least within philanthropic and missionary discourse.

⁹⁴ This institution was started by middle class Afrikaans women as part of a philanthropic nationalist movement. It focused on training rural midwives, and in 'Mothercraft', and was the first such institution in South Africa. See "The Moedersbond Maternity Hospital and Training School in Pretoria", The Journal of the Medical Association of South Africa (12 May 1928) 247.

⁹⁵ Many biographies of white Afrikaans South Africans refer to the importance of black women, (designated Coloured, which is why I retain the term here, for its historical and regional specificity), in family and community healing networks. For example see the memoirs of Krige, a well known South African gynaecologist and obstetrician born in 1893, particularly his recollections of 'Ai Sarie' in C. F. Krige, To Cure Sometimes (Johannesburg: Da Gama Publishers, 1967) and Searle's extensive discussion of Cape and trekker family midwifery in C. Searle, History of Nursing Chapters V and VII.

The movement of women into Johannesburg in the 1920s had stretched city services to the point that even ardent segregationists on the City Council were forced to allocate revenue increases for district work in black areas of the city. By 1923, the monthly reports and records of the Health Visitors (who had only increased in number to six women by the mid 1920s) indicated that the limited support the city had begun to provide for midwifery care at home in the case of women described by officers as "completely indigent", had only touched the surface of local women's need for assistance during birthing labor.⁹⁶ Seldom were any of these women officials able to fulfil their ambition to provide ante natal care or advice to women, and they were happy to manage one or two post natal visits to women in their districts. In spite of the 1923 Urban Areas Act, and the official emphasis on preventing black women from permanently residing in the city, the City Council began to accede to limited services for black women outside of their homes. Under heavy pressure from the Senior Health Visitor, and after presenting three years of recorded visits of black women flocking to the city centre infant and mother welfare clinics which themselves had been established by the Health Visitors with Porter's help, the City agreed to set up three black infant and maternal clinics, where ante and post natal supervisions could take place, and where emergency cases could be screened, and referred to a small number of physicians, such as the Swiss physician, 'Madame' Dr de

⁹⁶ IAD/JPHD A1113 "District Midwives" Reports and Memoranda from 1919 to 1928; and 48 3233 "Female Health Visitors", 1919-1938.

Cottens, (as she was known), who tended to black women patients in her Doornfontein rooms.⁹⁷

Preparing himself for this debate with the city officials, Porter noted in his 1924 detailed report into "Maternal and Child Welfare", that the four welfare centres operating in Johannesburg (in the new Market buildings, Newtown, and in Vrededorp, Turffontein and Jeppe) were being "inundated" by black women seeking advice, medication and treatment. Porter noted the gradual development of connections between the Queen Vic and his Department since 1919, especially in relation to the district training of white midwives at the Queen Vic under the auspices of the Department's Health Visitors, in return for which white "indigent" women were booked into the Hospital on the recommendation of the Health Visitors. But, Porter noted, there were still no publicly funded maternal hospital beds available for black women, and although they had not been turned away from the welfare clinics run by the Department in poor white areas, funds were needed to provide clinics for black women specifically. Here Porter used the segregationist trump card to good effect: few City officials were prepared to publicly assert that they would rather black women and children suffered, and possibly died, without basic medical assistance, but they were not prepared to countenance services for poor white women being compromised further, in the manner Porter suggested was already happening. Through these methods, Porter eventually won the allocation of a

⁹⁷ Dr de Cottens figured prominently in the establishment of the Bridgman, persuading the Bridgmans and the ABM to set up the hospital in the first place.

small amount of funding for three black nurses to be stationed at three cottage clinics in the most densely settled black locations, each under the supervision of the white Senior Health Visitor.⁹⁸

By 1928, the health officer in charge of these clinics in the Eastern and Western Native Townships reported that she could no longer supervise the massive increase of work each clinic had taken on in two years, and she appealed to the MOH to garner extra funding for more nurses and health visitors from the city health budget.⁹⁹ These clinics concentrated on ante and post natal consultations, infant care and immunization, and despite the large number of patients and small number of officers the work load that each health visitor was expected to fulfil included supervision of these clinics as well as extensive record keeping and documentation.

The activities and energies of philanthropists, missionaries, physicians and experts who worked on the fringes of the local state, were responsible for most local initiatives in women's health and welfare and their efforts shaped the daily worlds of black women in Johannesburg before World War II more than any other body of activity or state institution. The connections between these groups of people and black women midwives, patients and activists, forms the basis for this project.

⁹⁸ IAD/JPHD A1113 "District Midwives", Report, 11 July 1924, 5.

⁹⁹ IAD/JPHD 48 3233, "Female Health Visitors" Noted in Minutes of meeting on "Maternal and Child Welfare Council's Locations", March 1928, 17.

However, it is vital to consider the implications of the day to day work of the small number of individuals who were funded by the state, and whose explicit task it was to enumerate, investigate, regulate the health and welfare of women, including larger numbers of black women, in the city. The implications of the work these health visitors and inspectors undertook provides a basis for reconsidering the formation of the South African state and suggests that local and central state structures, elaborated in the 1920s and 1930s, were concerned not only with the influx of black women from rural areas, but also with how to interpret, formulate and manage the reproduction of a desired social order, wherein black women as mothers and labourers played a central role.

The Records of the Health Visitors:

A close reading of the reports and weekly memoranda submitted by the Health Visitors to Porter and his subordinates provides insight into the gradual emergence of a system of reporting, documentation, registration and investigation focused on women and infants. The only other arena of the local or central state active at this period in the creation of a bureaucratic system focused on women, was located in the Labour Department's division of inspectors charged with carrying out the Confinement Grant subsections of the Factory of 1918.

As historians of central and Southern Africa have demonstrated, through the exigencies of colonial rule, labor recruitment networks, and the work and discipline regimes instituted by large industrial corporations, techniques and systems of control

were devised and deployed in the enumeration and regulation black men and their labor power. In these contexts the work of medical personnel and related services was explicitly tied to the particular aims of colonial rule and capitalist extraction.¹⁰⁰ The elaboration of this system of governance and ordering in South Africa in particular after the 1920s, has been and will continue to be the subject of detailed analysis.¹⁰¹ Little attention has been paid to institutions set up to regulate, enumerate and over women's laboring bodies.

Unlike black men, black women before the 1950s were not employed in any numbers in factories or in mineral extraction work, such as mining. Although they did not face the invasive examinations and systems of control experienced by their male relatives, children and partners, this period saw the beginnings of official interest in the regulation of the bodies and corporeal capacities of women. Unlike men, black women's experiences of medical services while seldom empathetic, usually inadequate and often laced with racist presumption, were nevertheless, before the 1950s, removed from direct association with their daily employers and bosses in domestic waged labor and the informal economy.

However, the less draconian and less obviously interested systems of knowledge production and regulation that were being established in around marriage legislation and state involvement in birth and health were just as vital to the developing project of white

¹⁰⁰ R. Packard, White Plague, Black Labor: tuberculosis and the political economy of health and disease in South Africa, (Berkeley: University of California Press, 1989) and V. Navarro, Medicine Under Capitalism (New York: Prodist, 1976).

¹⁰¹ C. van Onselen, "Crime and Total Institutions in the Making of Modern South Africa: the Life of Nongoloza Matibula, 1867-1948", History Workshop 19 (1985).

minority rule and the reproduction and subjugation of black South Africans. While more difficult to annotate and track across southern Africa, these procedures were born from efforts to control and regulate births and deaths, definitions of legal medical practice and pregnancy itself.

The Factory Act, promulgated in 1918, set out a series of clauses dealing with the regulation of women's labor in factories and workshops recognised as such by the Department of Labour if they met certain conditions of size and numbers of employees.¹⁰² Women at the time, and through to the late 1930s, were not covered by "workmen's" compensation", medical benefits, or labor protection, in terms of rights surrounding dismissal to which some male workers had access. In line with similar measures introduced in Britain and North America at the time, the South African parliament recognized women workers in special categories under this Act. Women who were more than eight months pregnant were not allowed to work in factories, until 8 weeks after giving birth, and if their earnings combined with that of their spouse, or the earnings of the father of the prospective child, were below a low minimum set by the Act, they were eligible for some compensation for a limited time surrounding their birthing and postnatal period.

The passage of the Act, hailed as it was in the early 1920s, by groups such as the National Council of Women of South Africa, did little to disturb the interests of capitalists

¹⁰² This subject deserves separate and detailed treatment outside the parameters of this study. For the records of these grants and the reports and bureaucratic machinery associated with them, see: CAD/ARB 93 LA 153/8; CAD/ARB 94/LA 153/8; CAD/ARB 112 CF2/18/2; CAD/MNW 477 MM2187/19; CAD/VWN 741 SW106; CAD/VWN SW 4731/1-12; and CAD/VWN FAG Vol 1-3.

and organised industry.¹⁰³ First, the Act did not require companies or employers to rehire female workers after their postnatal weeks were over or to provide maternity benefits of any sort, nor did it take on any responsibility regarding unemployment benefits beyond this narrowly defined period for women workers fired because of pregnancy and birth labor. Second, the definition of a "factory" under the Act succeeded in excluding the sites employing the majority women waged workers: all domestic work situations (such as private homes, hotels and institutions) and most laundry works, small garment manufacturers and food processing concerns of the day. Finally, the Act required that any claimant had to have worked for the same industrial concern for at least twelve months prior to her birthing labor, and proof of this had to be furnished on the basis of company records, not the testimony of the women. The Act represented, therefore, a very constrained recognition of state responsibility and interest in women wage labourers.¹⁰⁴ The framers of the Act certainly had white women, and perhaps Coloured women in mind, as they argued for the state's "moral responsibility" to protect pregnant women, and in cases of indigency, provide some minor measure of state aid to the sustenance of the new infant. In the first decade of its operation, less than 200 women per year countrywide

¹⁰³ CAD/MNW: 719 MM 1416/24 Report on the Conference of the National Council of Women of South Africa, held in 1924 in Pietermaritzburg.

¹⁰⁴ For comparative material on the Family Allowance movement in Britain, and on the history of women-focused welfare policies in France, Germany, Italy, Spain, Norway and Germany, see G. Bock, and P. Thane (eds) Maternity and Gender Policies: Women and the Rise of the European Welfare States, 1880s-1950s (London: Routledge, 1994) and J. Goodnow, and C. Pateman (eds) Women, Social Science and Public Policy (Sydney: Allen and Unwin, 1985).

gained access to this benefit. Most eligible women worked in canning, fowl and tobacco factories in the Cape. But after 1930, the entry of large numbers of white and increasingly black women into waged labor in new factories on the Witwatersrand, particularly garment, furniture and food industries, catapulted the issue of "Confinement" grants--as they were called--onto the national stage. In the 1930s, the Garment Workers Union, under the leadership of Solly Sachs and Anna Scheepers, mounted a series of campaigns to bring attention to the limitations of the legislation, the insufficiency of the allocated grants, and the maze of bureaucracy women faced in gaining access to these benefits, even when they met all of the requirements.¹⁰⁵

In order to ascertain the eligibility of a women for benefits under the Act, the Labour Department had created an elaborate network of Inspectors and procedures for eligibility. For the first time the Department hired women inspectors whose tasks under the Act were manifold: to ascertain reliable evidence of pregnancy by co-ordinating medical examinations at the factory site or in municipal offices; to obtain the "estimated confinement date", in order to comply with the Act's demand that women stop work 4 weeks prior to birth labor; to inspect the employment records of women at factories to ensure that a woman claimant had worked for at least 12 months for the same factor; to ascertain the legal status of the child (whether the women was married or unmarried, and under what circumstances), and to track down and establish the whereabouts of husbands

¹⁰⁵ We return to discuss the 1930s focus on working class white women at the start of chapter four.

and partners, ascertain their level of remuneration to ensure that they did not earn more than the set maximum; and in the case of unemployed men, ensure that they had applied for work seeking help in an accredited agency. But the Inspectors were never able to completely meet their job descriptions, inspectors were not hired in sufficient numbers and the machinery necessary to their full investigations was never fully institutionalized. From the late 1940s until the early 1980s, black were explicitly excluded from further reforms in maternity legislation.¹⁰⁶

Thus the wide parameters and detailed investigations enabled by the legislative aspects of the Act were never fully met in practice. The situation was reversed in one other major arena of local state bureaucratic regularization of women at the time: Lady Health Inspectors.

This very small body of women in Johannesburg and other large cities, working under more tightly constrained authorizations from the central state penetrated the intimate aspects of thousands of women's lives for more pervasively and invasively than their counterparts in the Labour Department. After the 1919 Public Health Act had stipulated that Birth and Death notifications had to be regularized, it was the duty of female health inspectors in Johannesburg to track down births through registered midwives (both trained and untrained) nursing homes and hospital registers, as well as

¹⁰⁶ E. Mashinini, *Strikes Have Followed Me All My Life* (New York: Routledge, 1991). In her autobiographical study, Mashinini details the struggles of black women for Trade Union recognition in the 1970s and early 1980s, and for the right to claim maternity, and later parental benefits from employers, as well as some form of state protection.

births reported by word of mouth and at children's clinics, and to assemble this data, and send it to the local statistics and accounting office. It was easier for health inspectors to gain access to records of the lying-in homes and hospitals along the Reef, and to investigate their services and conditions, than it was for them to investigate complaints concerning midwives. Health visitors were charged both with ensuring midwives' compliance with the notification aspects of their legal duties, as well their patient care, equipment, cleanliness, attention to neonatal ophthalmia, and charges for services. A letter, from health inspector Miss Grinley Ferris, to Porter in November 1925 is indicative of the types of reports these officers made regularly, when they suspected midwives of lax practice:

On visiting Mrs McEvan, 40a Terrace Road, Fordsburg ... this morning, I found that her newborn baby had a discharge in each eye, and on enquiry found that she was attended to at her confinement and up to today, by Nurse Greyling--untrained-- of 68 Avenue Road, Fordsburg. The nurse did not call in a Medical practitioner nor has she notified this Department of the condition of the baby's eyes. I would like to draw your attention to the fact that I have previously warned Nurse Greyling that it is her duty to comply with the act, (Ophthalmia Neonatorum).¹⁰⁷

Porter signed a letter calling Nurse Greyling, along with other midwives, to his assistant MOH's office, where they received warnings and were presented with new notification cards, eye medications and disinfectants. Porter protested to his peer in Durban, that doctors in the Transvaal Medical Council were erecting obstacles in the path of women inspectors from his department in the matter of midwife regulation because they regarded the control of professional medical practitioners as a key part of their legal purview under

¹⁰⁷ IAD/JPHD "Midwives" 101 548, 2 November 1925.

the 1919 Act. Yet, complained Porter, they did not have the personnel to carry out investigations nor the real commitment of his Department to enforcing these regulations.¹⁰⁸ Despite these impediments, health visitors succeeded in enumerating and investigating hundreds of births, deaths and midwifery visits per year.¹⁰⁹ They also noted information on the legal status of the child (illegitimate or legitimate birth was based on the marriage status of the parents), methods of infant feeding employed by the mother, the condition of the home surroundings, and health of the mother and infant.

A sense of the detail entailed in these investigations can be gleaned from the summary of health visitors reports for the six months before June 30 1926, filed by the chief Lady Health Inspector in July of that year.¹¹⁰

General Summary: Part I

No.s of 1st visit	No.s of 2nd visit	mothers ref. to Mater.Hosp	Midwife	Hospt	Mothers attending Jeppe	Dept. Hlth Visit	Welfare Turf. Milner
802	3,512	71	34	87	1,456	114	1,271 1,593

¹⁰⁸ IAD/JPHD "Midwives" 101 548, 7 August 1926, Porter to Clegg.

¹⁰⁹ IAD/JPHD "Early Notifications of Births" 35 2/25/4 Vol 1. From 1919, theoretically all births in urban areas had to be reported within 24 hours, and official forms included questions on the name; race; occupation; age and address of each parent; as well as the place and time of the infant's birth; its sex; whether the infant had siblings; and the name of the medical practitioner, midwife or person in attendance at the birth. These requirements were met in less than half of the estimated births, and health Inspectors were responsible for gathering this data in many of the poor districts of the city.

¹¹⁰ The data in the following Tables has been abstracted from IAD/JPHD 48: 3233 "Health Visitors", Report, 30 June 1926.

General Summary: Part II

Inquiries re: Deaths under 5 Years	Ante Natal Visits	Women Assisted at Municipal C
5	293	

Births Investigated: Part I

Legitimate	Illegitimate	Full Term	Premature	Stillbirth
792	10	792	10	

Births Investigated: Part II

Attended by:	Doctor	Trained Midwife	Untrained Midwife	Friend	Noone
	106	410	389	3	0

Births Investigated: Part III

Condition of Mother	Good	Fair	Poor	Sick
	747	28	11	16

Births Investigated: Part IV

Condition of Infant	Good	Fair	Poor	Sick	Dead
	760	14	9	6	13

Births Investigated: Part V

Condition of Home	Good	Fair	Bad	Clean	Dirty
	687	102	13	793	9

Methods of Feeding:

Breast Milk	Cow's Milk	Tinned Milk	Breast Milk + Other Foods	Other Foods	Bottle Feeding	Com Used
762	9	8	16	7	32	

It is interesting that the Report, for all its detail, did not break down the data collected by race or language group, although district reports from each of Health Visitors allowed Morisse and other senior health visitors to comment on the increasing numbers of black women attending clinics. The records kept by the health visitors also enabled the collation of data on numbers of practising midwives in the city, which upon Porter's request the senior health visitor broke into two racial categories informing him in 1926 that according to their records there were 136 "European" midwives practising in Johannesburg, of whom 34 were untrained, and 147 "Non European" midwives, 44 were untrained and unregistered, and 103 of whom were registered, but not necessarily trained.¹¹¹ By the late 1920s, when the Department advertised for new Health Visitor posts, they specifically sought applicants with the "ability to speak and understand a Bantu language". In July 1930, when the department hired two new white women, they were chosen for their experience with "native people", and because they could each "make themselves

¹¹¹ IAD/JPHD 48: 3233 "Health Visitors" August 1926. I have surveyed the 1920 Government Gazette Listing of all Registered Midwives in the Transvaal as of 1919, and counted approximately 190 white and Coloured trained and registered midwives as operating in Johannesburg. (No African women held midwifery certificates as of 1926). This figure cannot be precise, as some addresses were listed 'care of' other parties, and we cannot be sure where these women practised. Of this number, 12 midwives were employed at the Queen Vic full time, 11 at Ellershaw's Private Maternity Home on Caroline Street, leaving approximately 160 women registered and eligible to practice. The Health Inspector's figures seem accurate, given that this was 6 years later on, and remembering that many women who married and had children of their own, retired from, or took a break from, their midwifery work. See Government Gazette, No. 195, 29 January 1920.

understood" in Bantu languages, one of the chosen applicants testified that she was fluent in "Xosa".¹¹²

The records of the health visitors furnish a complex set of evidence. Besides the numerical data and dry reports of investigations (which, as we have suggested above, formed part of a developing discourse and set of procedures on the part of the local and central state), these records also contain brief letters, memoranda, minutes of meetings and notations, more qualitative in form and more suggestive of the daily politics of their work. For example, through to the late 1920s, Morisse (by then the Senior Health visitor) reported that most black women who attended the clinics were reluctant to be examined, and did not press for district midwives to attend them in their birthing labors at home, although there would have been too few available trained midwives if these women had asked for their services.¹¹³ Morisse's view was shared, but arguably false, wisdom among other health officials at the time. They suggested black women needed further exposure to western medicine and greater public health education before they would be "ready as a group" for medicalized birth even though they were beginning to respond to the support services offered by district clinics in after care and nutritional advice. These observations were proved false as soon as the Bridgman opened its doors a few years later.

¹¹² IAD/JPHD 48:3233 "Health Visitors", See copies of newspaper advertisements and notes from interviews with applicants, July and August 1930.

¹¹³ IAD/JPHD 101 548 "Midwives" Morrisse and Webb in Minutes of Meeting with Mitchell, 5 December 1929.

Why then were black women who attended the local clinics in great numbers, less enthusiastic about the attentions of clinic nurses at their births? One hint, gleaned from the records of district clinics in increasingly segregated residential areas is helpful in indicating the reasons for poor women's reluctance to have trained midwives attend them at home births: health visitors and district midwives commented on the cramped and unhygienic conditions in these women's home, and spoke of the time and effort involved in sanitizing and equipping parts of these homes for birthing labor, insisting on the departure of family members, lodgers and children, as they arrived with sheets, newspapers, towels and scrubbing equipment. While their intentions were no doubt in the best interest of asepsis and sound clinical care, these actions on the part of district midwives were no panacea for the humiliation, disempowerment and perhaps fear anticipated by women who did not press for their assistance. It would seem that Morisse and other commentators were wrong to equate trained midwifery in home births under these conditions with hospital births, away from personal surrounds which for many of the poorest black women included slumyards, back rooms and, crucially for many women who attended Bridgman (and for whom no district provisions were in place) the quarters of domestic servants on the properties of white employers.

The end of the 1920s and the dawning of a new era in midwifery and maternity care:

Thus, by the mid and late 1920s, the city had established the skeleton of a system of regulation of births condition and the enumeration of births, the beginnings of a system

of district midwifery, and the nucleus of area clinics devoted to infant and maternal care. For the first time, the city had hired black women nurses. These women were among the first graduates of mission hospitals in Natal, the Northern Transvaal and the Cape. None of them had any midwifery qualifications, and indeed in 1928, when the Bridgman opened its doors, only one African women had as yet qualified as a midwife in South Africa, Poppy Bud-Mbelle, who had trained at St Monica's' Maternity Home run by Anglicans in Cape Town. St Monica's had been established in 1917, specifically to treat and train women designated "Cape Coloured and Eurafican". Poppy Bud-Mbelle was immediately hired onto the Bridgman staff.¹¹⁴

From 1926 to 1928, health officials, doctors, missionaries, representatives of the mining industry, and influential members of the newly established medical fraternity of the University of the Witwatersrand, began to meet to discuss the crisis in maternal care. By 1927, they announced that this could not be tackled without an immediate intervention into the training of not only white, but also black midwives. In January 1926 Milne (Acting MOH for Johannesburg) reported to Dr Mitchell (Secretary for Public Health) that a study by his Health Visitors and officials had determined that Johannesburg was served by 136 white midwives, 102 of whom were qualified, and 34 of whom held no medical certificates; and that in the case of black midwives (and here he included women designated Coloured and Native) only 1 qualified midwife, and 10 registered but

¹¹⁴ See the beginning of chapter six.

uncertified midwives, were known to his Department.¹¹⁵ Later that same year, Milne wrote to Dr Clegg (MOH for Durban) that despite all official notices to the contrary, and despite the city's adoption of 1919 Legislative requirements, his Department's supervision and control of midwives was "... very much a matter of bluff."¹¹⁶

In one of his first public statements, the newly appointed Professor of Obstetrics at the University of the Witwatersrand, John McGibbon, addressed the Medical Association of South Africa about his concerns for maternal health in Johannesburg. After having spent three years reviewing existing services, and having participated in meetings and discussions throughout 1926, he stated:

Such are the difficult conditions under which medical men have to conduct midwifery in this country.. [that] there is no public service in the Union which has been so shamefully neglected as the maternity service.¹¹⁷

Here McGibbon issued the first in a series from within local ranks of obstetric science, urging the need for hospital and institutional care for pregnant women, and an end to home deliveries as they had been known in South Africa. This was startling news even for his audience of the local medical community, but his speech was also unusual for its emphasis on the needs and care of black women, as an "urgent national and civic task". After a lengthy discussion of the causes behind maternal infection and death, in which he drew on his work in South Africa, but also indicated his professional expertise by

¹¹⁵ IAD/JPHD 101 548 "Midwives" 1919-1931, 20 January 1926.

¹¹⁶ IAD/JPHD 101 548 "Midwives" 1919-1931, 20 August 1926.

¹¹⁷ The full text of John McGibbon's address was published in the Journal of the Medical Association of South Africa (11 June 1927) 271. Word in parentheses has been added.

discussing his research and experience in Edinburgh, McGibbon outlined his suggestions for local changes:

So far as the appalling and uncivilized state of midwifery in South Africa is concerned, no member of the medical profession can have anything but a feeling of true sadness in his heart.

He went on to appeal to the scientific rationality lurking the male hearts of his audience:

The days in which midwifery was regarded as an inferior sort of art as compared with medicine or surgery should be gone, and midwifery in South Africa must, as in other countries in Europe, take its seat in the front row of clinical education...

This ambiguous association of South Africa with Europe was followed by more direct suggestions:

Public effort is most desirable, but to attain real success, and place the midwifery service of the Transvaal on a proper footing, it must have the backing of the Administrator and his Council. Now the direction in which that help is most needed is unquestionably in the creation of more hospital beds, both for white and native women. Every maternity hospital in the Transvaal must have its native wards attached to it, and why these were not provided many years ago, is beyond my comprehension. In Johannesburg, for instance, they should have been erected when the Queen Victoria Hospital was built in 1904, and here we are in 1927, with no such provision. It is indeed a great wrong, and it is up to the medical profession to see it righted.¹¹⁸

McGibbon concluded this section of his address by focusing on the issue most alarming to health professionals as the 1920s drew to their close: the perceived proliferation of herbalists, quacks, and untrained practitioners, who would thwart the development of medical science in South Africa, and most particularly, in cities such as Johannesburg.

McGibbon struck a chord with his next pronouncement, and his views were reflected in the 1928 amendments to the 1919 Medical, Dental and Pharmacy Act:

¹¹⁸ J. McGibbon, "The Reduction of Maternal Mortality and Morbidity in its Clinical Aspect" Journal of the Medical Association of South Africa (11 June 1927) 275-6.

The country... is crying out for an organized service of midwives and maternity nurses, instead of which, what has it got? Bands of dangerous and irresponsible women spreading death and disease everywhere.¹¹⁹

The reason for the state of midwifery education in Johannesburg in the late 1920s, surprising in the light of more than a decade of agitation on the part of women activists and health officials, was clearly outlined in a series of large conferences between December 1928 and 1931.¹²⁰ Four sets of overlapping personnel and authority gathered to try and sort out how best to address the need for midwifery training and service. The first Public Health Act of 1919 contained provisions for the local supervision of midwives and the regulation of maternity homes.¹²¹ However, no delineation of authority or responsibility between the cities and the four provinces was specified for implementing or funding this measure. Paperwork, memoranda and queries fluttered back and forth between Cape Town, Pretoria and Johannesburg throughout the 1920 to 1927 period, convincing the Secretary for Public Health that greater clarity was needed, and so the 1928 amendment added a series of clauses:

Empowering the Minister to contribute towards the costs incurred by provincial administrations in training midwives or carrying out any other functions...¹²²

¹¹⁹ J. McGibbon, "The Reduction of Maternal Mortality and Morbidity" 276.

¹²⁰ IAD/JPHD 101 548 "Midwives: 1919-1931" contains these records: Summary of 1928 meetings in the Circular No. 25 of 1918, sent out by the Secretary for Public Health; Conference Minutes from "The Shortage of Midwives", 5 December 1929; Minutes of the Meeting of the Joint Committee, re: The Shortage of Midwives, 30 January 1930; 31 March 1930 and 22 May 1930; Circular No. of 1930: "Provision of Midwives", 12 February 1930; Notice of the City of Johannesburg Regulations Regarding Persons Practising as Midwives, 20 February, 1931.

¹²¹ Public Health Act: Section 135 (b) of Act No. 36 of 1919.

¹²² Department of Public Health, Annual Report (1928) 11.

The key ingredient in bringing together the Transvaal Provincial authorities, the city officials, Johannesburg hospital employees and physicians from the Medical School in 1929 and 1930, was the growing consensus that maternal and child welfare was a medical problem and the expanding role of medical specialists in legitimizing an authorizing the allocation of resources, particularly into institutions under their supervision, such as hospitals.¹²³ Whereas in the 1910s, as we have seen, organized general practitioners resented any intrusion into their realm of home health care their grip on obstetrics was begging to face a challenge from within the medical profession itself. Lewis' summation of the implications of a similar process in England at the same time are worth repeating:

While child and maternal welfare workers shared a common approach to the problem, at the administrative level the self-interests of, and tensions between, the groups involved served to further restrict the services offered. ... the influence of the medical profession in formulating maternal and child welfare policy was particularly great. General Practitioners demanded that state clinics and infant welfare societies give nothing but preventative care so as not to threaten their private practice. In general preventative medicine was kept separate from curative medicine and this was clearly the case in the field of infant welfare. With regard to childbirth, obstetricians used the interest in child and maternal welfare and the desire to reduce maternal mortality to advance their own neglected speciality.¹²⁴

The powerful role played by the fledgling Medical School was evident in the midwifery training scheme eventually hammered out. At the same time, the interest generated by the

¹²³ By 1928, Porter had been appointed to a Professorship in the University of the Witwatersrand Medical School, which had opened in 1919, and registered with the General Council of Medical Education in Great Britain in the mid 1920s, and so was empowered to grant degrees. McGibbon had been replaced in 1928 by the new Chair of both Gynaecology and Obstetrics, Dr Gordon Grant. His active participation at all of these meetings helped to tie together the medical work of the Johannesburg General, (and its maternity unit, the Queen Vic), with the training and research work of the Medical School.

¹²⁴ J. Lewis, The Politics of Motherhood 19.

formation in 1926 of the South African National Council for Child Welfare (SANCCW) forced the urgency of midwifery training onto public attention, as women dominated organizations had done with the issue of infant mortality in the 1910s. In 1928, the Department of Public Health recognized the importance of this new umbrella organization with its 62 welfare centres, in its Annual Report.¹²⁵

The Department noted that along with its annual grant of £1000.00 to the Moedersbond Hospital in Pretoria, it had allocated the same grant-in-aid to the SANCCW. This precedent for Departmental grants-in-aid to private institutions, was noted by the Bridgman Board and formed the basis for their requests for aid later that same year. Thus lobbying groups of women activists spurred on the debates about maternal welfare by acting to legitimize and promote the medical lobby led by state appointed and university-based physicians in big cities such as Johannesburg. In early 1931 after a series of conferences spearheaded by Dr Milne (the new MOH for Johannesburg), Dr Mitchell (Secretary for Public Health in the Union), and the head of the Wits Medical School and its Anatomy Department-- who played an increasingly important role in physician, nurse and midwife training, and in the field of scientific research into "Bantu Studies"--Professor Raymond Dart, a compromise was reached regarding local midwifery training.¹²⁶ The Queen Vic would remain the site of maternity institutional care for white

¹²⁵ Department of Public Health, Annual Report (1928) 52.

¹²⁶ Raymond Dart will be the subject of some discussion in a later chapter. The University of the Witwatersrand will be mentioned many times in the ensuing pages, and I have taken the liberty of referring to it by its local nickname: "Wits".

women, and district midwives would be trained in larger numbers from within the institution in conjunction with employees of the Medical School, connecting up with existing municipal clinics for their practical work. The financial burdens of this training and service would be shared by the Johannesburg Municipality, the Transvaal Province, but also, and this was a key ingredient in garnering support from the aforementioned bodies, the Medical School itself.¹²⁷

In each of these conferences, whenever the needs of black women were mentioned, it was to stress that fact that each trainee midwife would be able to find ample numbers of required cases for district work in demarcated black districts of the city. In every one of these meetings, therefore, the increased numbers of prospective district midwives were spoken of with the presumption that they were white women as each of them would be connected to the Queen Vic for their certification, and the Queen Vic accepted only white midwife and nurse trainees. Further, these officials perceived as yet no contradiction in reiterating that many of the district cases for these white midwives would be black women patients. The minutes of these meetings reveal that no debate was raised about whether the Queen Vic should accept black women patients. Besides their racist presumptions and broad acceptance of segregated facilities in an increasingly segregated city, the establishment of a new Johannesburg institution foregrounded these officials' comments on black women midwives and patients.

¹²⁷ IAD/JPHD 101 548 "Minutes", 30 January 1930.

The formation of the Bridgman Memorial Hospital, the funds raised for this venture, its broad schemes for district midwifery, mothercraft and the radical restructuring of public health on the Reef envisaged by the hospital's founding board, posed a direct challenge and example to the city's provision for white women and infants. Indeed the work of the Bridgman Board and its committees, which had been going on for four years before 1928, and which continued to proceed in the background of these high-level meetings, had in essence provided the catalyst for the discussion of white midwife training and mothercraft by the end of the decade. Although health officials in the early 1920s mentioned the Moedersbond as an exemplar of the type of institution they wished to create in Johannesburg, by 1928 the existence of the Bridgman Memorial Hospital provided a more immediate reminder. When city officials repeatedly brought up the difficulties inherent in establishing connections between these differing bodies and institutions, including the housing and transportation of midwives, Dr te Water, a senior obstetrician connected to the Queen Vic, was prepared to say only a year after its opening that:

The Bridgman Memorial Hospital successfully trained native midwives in their district, and there was no trouble with transport etc. They turned out excellent midwives.¹²⁸

The precedent for connecting the new district midwifery service with the University Medical School through hospital maternity work on the part of its University obstetricians

¹²⁸ IAD/JPHD 101 5485 "Minutes" 5 December 1929, 7.

and gynaecologists, had been pioneered by the Bridgman three years before the arrangements were extended for the Queen Vic.

By the mid 1930s, the training of midwives was regarded as a central pivot of public health. The Annual Report of the Department of Public Health for 1937, commenting on the high maternal mortality statistics, focused its attention on the need for specialized midwife care:

The incidence of puerperal sepsis in the Union is unnecessarily high; ... Numbers of instances of this disease have been traced by the Department to cases which have been attended by trained midwives or "gamps"... Meddlesome midwifery is probably to blame for most of the tragedies of child-birth, and when it is backed up by dirt and ignorance, the distressing results are not to be marvelled at.¹²⁹

Thus, although public health officials of the late 1920s and 1930s drew attention to midwifery training, they continued to explain "tragedies" of infant and maternal mortality with reference to the "dirt and ignorance" of mothers as Porter had in 1911 when commenting on the vital statistics of working class whites. This emphasis on unskilled, unhygienic motherhood did not disappear in the 1930s, indeed, the mothercraft training project was a central element of missionary endeavour at the Bridgman. But after the late 1920s, the culpability of bad mothering was twinned with a new emphasis on the material context of birth. The state at both the local and central level, began to reckon in an unprecedented fashion with poverty and a lack of access to health and social services, emphasizing children and mothers who were almost exclusively white. At the same time, religious bodies, philanthropic organizations, and progressive medical workers in

¹²⁹ Department of Public Health, Annual Report (1937) 73-74.

Johannesburg, called for a similar analysis of and similar solutions to, black poverty. People such as Kark, Clara Bridgman, Cowles, Xuma and Trant de-emphasized "ignorance and dirt", and drew attention to the material and social context of maternal and infant mortality, as well as the need for improved midwifery services and mothercraft training, .

A quiet revolution in the conception of public health had been taking place in Johannesburg in the last five years of the 1920s. A much more comprehensive view of public health, with women's health and infant care forming an integral aspect came together under the aegis of the individuals and organisations responsible for the Bridgman. This vision of a central hospital and its attached clinics being integrally connected to an institution of medical research (a University) but conceiving of itself as working within a community was a dramatic intervention in the public health landscape of South Africa. It was at precisely the same time that one of the most prestigious institutions of public health in the world, the Johns Hopkins School of Hygiene and Public Health in Baltimore, was turning its attention to "the Community as Public Health Laboratory".¹³⁰ In her detailed history of the development of the field of Public Health in the United States of America, Elizabeth Fee traced the earlier establishment of such schools in Europe and the long battle to gain acceptance for this approach to medical care in North America. Fee explores

¹³⁰ E. Fee, Disease and Discovery: A History of the Johns Hopkins School of Hygiene and Public Health, 1916-1939 (Baltimore: The Johns Hopkins University Press, 1987). See her title in Chapter VII "The Community as Public Health Laboratory". Also see P. Starr, The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry (New York: Basic Books, 1982).

the involvement from around 1914 of such philanthropic bodies as the Rockefeller organization in the creation of the first school of its kind in the country, at Johns Hopkins in 1916. A shift in School policy and research occurred after the Depression. Fee argues that:

Perhaps the most important change in the school in the 1930s was a new orientation toward applied research. The most striking initiatives of the thirties occurred in applied public health programs... The locus of much of the school's research thus moved from the laboratory bench to the streets, especially the streets and houses immediately surrounding the School of Hygiene in East Baltimore. For the first time, the school developed a close working relationship with the City Health Department and was actively involved in the delivery of public health services.¹³¹

In Johannesburg, it took the work of people such as Clara Bridgman, Raymond and Dora Dart, Edith and John Rheinallt Jones, Alfred Xuma, Charlotte Maxeke, Ray and Dora Phillips, Constance Morisse, Selope Thema, M. Crinsoz de Cottens, Howard Pim, Walter Webber, Ossie Heyns, Mary Tugman and Ruth Cowles, to persuade University officials, city health authorities and the women and men of the Johannesburg, that the Bridgman could become such an institution. Of course this roll-call of people included not only missionaries and social welfare activists, but also scientists, university professors, wealthy Johannesburg solicitors and accountants, and officials in the employ of the Johannesburg City Health Department. Thus the work of persuasion was to some degree an "inside job". Yet the unique conception behind the Bridgman's gestation must be emphasised as well as its impact in setting an example for public health throughout the city. Clara Bridgman in particular was canny enough to recognize that if the Bridgman

¹³¹ E. Fee, Disease and Discovery 182.

could draw two strands of interest and expertise together under one roof, its chances for survival in a racially and class segregated city would be greatly enhanced. The Bridgman should offer a site for path-breaking scientific research, combined with all the attraction of great public service, the alleviation of suffering and an unsurpassed opportunity for civilizing missionary upliftment. Key to this latter project was Bridgman and her colleagues' ambition to install a new vision of motherhood in the hearts and minds of black women. These women would in turn proselytize to others about values they acquired while in the Bridgman's care, of Christian family life, hygiene and scientific motherhood, throughout the urban and rural landscape of southern Africa.

After Bridgman's return from the United States of America in 1927, her early memoranda on the hospital sketched a panorama of activities never achieved in practice.

In a fund-raising letter of January 1927, she wrote:

It is proposed to inaugurate a comprehensive scheme of Public Health work for Natives in co-operation with the authorities and other private agencies. Using the existing site at Doornfontein, it is proposed to extend to all Native Locations and Townships along the Reef, the following services: baby-welfare clinics; pre-natal clinics and classes for mothers; crèches for babies and small children left without supervision by working parents; ... and District Nursing with special emphasis on instruction in Sanitation, Hygiene, and the prevention of diseases.¹³²

Although, as we shall explore in later chapters, Clara Bridgman and the Board of the Hospital, were never able to achieve all of these ambitions, her foresight in describing the institution as a site both for scientific and philanthropic work, earned the institution the support and prestige it would require to survive through the massive onslaughts on

¹³² HPC/AD 843 B91.32 Meetings of the Provisional Board, Bridgman, C 18 January 1927, 2 .

institutions, communities and movements focused on black South Africans in the 1950s. Ten years after it was opened, a leading academic and official in the field of public health, J. S. Gear, remarked that the past decade had seen extensive developments in paleoanthropological and medical research focused on black South Africans. He spoke of the, "unique opportunities offered by the problems of the Bantu population" and ended:

In meditating on this future the outstanding thought that occurs to one is how very fortunately we in Johannesburg are situated. In close proximity to, and working in, collaboration with one of the largest hospital organisations in the world, having at our disposal for investigation the material offered by one of the largest and most efficiently organised labour groups in the world, there is abundant opportunity for valuable and original research work...¹³³

The 1930s and 1940s were to inaugurate a period of intensive research into the bodies and birthing capacities of black women. These decades saw the establishment of the largest and most prestigious training centre for black midwives in southern Africa. The Bridgman became a center for public health and the medicalization of childbirth practices. Whereas Victorian conceptions of motherhood, home hygiene and domesticity ushered in the new century, the establishment of the Bridgman Memorial Hospital constituted a new era of South African motherhood. This peculiar institution straddled a series of locally manufactured contradictions: the valorization of "African motherhood" in a city wherein most black women battled to find ways for themselves and their children to survive, often spending many hours of their lives caring for other people's children; the recitation of the stoicism of black women, at the same time as these women were systematically denied rights of parenthood, tenure, residence, legal representation, adulthood, mobility, wage

¹³³ J. H. Gear, "Ten Years of Research at the Medical School" The Leech (1935).

parity and corporeal integrity. Arguing that the Bridgman touched the lives of all city dwellers is not a claim that all black women in Johannesburg and its surrounds knew of or visited the hospital. But after 1928, this institution played a vital role in shaping the long and continuing dialogue between the social history of motherhood, maternity and infant health and the politics of medical science in this region of the world.

Chapter Three

Louisa Mvemve: A Woman's Advice to the Public on the Cure of Various Diseases¹

It is with great pleasure that I Peter Zwana husband of Johanna Zwana do hereby publicly certify that my wife gave birth to a daughter on the third of August 1913. I took my wife in 1908 and since then I have not had a single child alive ... I had given up all hope of getting her cured I intended to part from her and give her up as a bad job when on a sudden I met a girl that I thoroughly knew from home. I found her with a baby where-as I knew that she was also suffering from not having children. So I asked her how she got the baby. She therefore explained to me and advised me to see Louisa Mvemve. I went straight to Louisa Mvemve ... She accepted my case and took my wife and gave her a thorough course of her herbal treatment. I have no power to express my gratitude for her remedies work wonders. Moreover now as I am writing this my wife gave birth to a daughter healthy and strong as well as the mother. I never knew that amongst our race there was one who could do such wonders its marvellous.²

Introduction:

Louisa Mvemve was born in the Port Alfred region of the Eastern Cape towards the close of the nineteenth century. From at least May 1914 until the early 1930s she embarked upon a series of ambitious and daring attempts to "... be granted the might of a medical man to examine the people who wants to be cured by my herb and Root Mixtures".³ As a midwife and herbalist, Louisa Mvemve brought together in one person

¹ CAD/NTS 3901 3/376 Part I 1915: Title of Louisa Mvemve's 9 page pamphlet, "A Woman's Advice to the Public on the Cure of Various Diseases".

² Here, and throughout the paper, I have not altered the spelling, expression or grammar of the original text quoted from in any way. CAD:NTS 9301 3/376 Part I: Peter Zwana, Benoni Location, 6/8/1915.

³ CAD/GG 1109 48/504: Louisa Mvemve to the Governor General, Lord Buxton,

the skills, knowledge and networks of nineteenth century practitioners, but she adapted her expertise and developed her range of services with a canny sense of the needs of her fellow twentieth century South African. The full measure of her efforts may not be realized by those of us alive decades after her death. However the particularity of the records she left, and the range of life-experiences to which these testify, do provide a glimpse of the complexity of the life of an extraordinary, independent and talented women.

Louisa's life bore witness to the shift from British Colonial rule to white settler Government, from a world of African peasant communities competing on the frontier lands of the Eastern Cape, to the migration of men and women north into the "city of gold". At times debt-ridden, imprisoned and ill-treated in city jails, and willing to travel vast dusty distances to set-up dealer networks for her cures in rural parts of the Transkei, Eastern Cape, Transvaal and even Lesotho, she also tasted the life of a property owner of some means, holding land in the peri-urban areas on the eastern edges of Johannesburg, in municipalities that would become known as the "East Rand". In many ways, she aspired to the life of a respected Victorian woman, and her sometimes desperate attempts to win friends and influence among white clients, as well as her often patronising and objectifying references to working class and rural black men and women, reveal her ambivalence about her position as an aspirant person, distinguished from her black working class peers by her talents, capacities and networks, but also not formally educated nor the respectable

(from here onwards 'LM to GG'), 13/5/1914.

wife of a professional man. She was also not a part of the movements of other men and women of colour who sought to reform or challenge the status quo in the 1920s and 1930s by working in organised groups, in trade unions, political parties and hosts of welfare and social improvement associations. However, her individual actions continuously threatened the boundaries of Urban Legislation, and the very intentions of Medical Acts and statutes, as well as the social expectations of her peers, both black and white, and those who deemed themselves "in Authority" over her. As a woman without formal education--and thus without the concomitant network of mission-trained "respectable", elite men and women--the social world within which she moved was largely of her own making, and although she observed and acted upon 'distinction', the lines of cleavage she drew between those she spoke of well, and those she avoided did not follow set patterns. The spatial geography of her life's journey was inseparable from her economic ties, kinship networks, crop-sources and self-identity as she traversed dust paths, cart-trails, railway routes and paved roads from Cape Town through Johannesburg to the Union's new capital, Pretoria.

Louisa Mvemve represented herself variously as a midwife, healer, a herbalist,⁴ a diagnostician, and innovator of cures⁵. She also testified that she stored the curative

⁴ CAD/NTS 3901 3/376 Part I, 1915: "WOMAN'S ADVICE: A woman's advice to the public on the cure of various diseases".

⁵ In November 1916 she informed Lord Buxton: "... I intend opening a factory in Graham's Town to make my medicines to supply the Chemists in different towns." it is clear from her 1916 case in Benoni that she had a workshop for bottling and preparing herbs, and by 1930 she had a mature herbarium and an extensive workshop on the

practices of past generations, and crucially, the nursing skill of her maternal grandmother and the medical knowledge of her maternal grandfather.⁶ At the same time Louisa viewed herself in the company of scientists: willing to have her methods tested and "proved",⁷ and whilst respectful of western biomedicine (indeed she often praised doctors and medical institutions for their work among "her people", and mused over starting her own "nursing home"⁸), she nevertheless saw herself as able to afford cures when "Doctors had given up the case".⁹ Although she wanted to keep many of the "recipes" for her remedies secret, and did see at least some of her talent as preordained in her birthing circumstances and

property in Hastings Avenue, Brakpan. See CAD/NTS 9301 3/376: 21/11/1916, 23/2/1916 and 15/1/1930 respectively.

⁶ See her printed pamphlet "WOMAN'S ADVICE" above, p 5. After describing the manner and circumstances of her own birth, and her grandfather's intervention, she states: "These herbs were all my grandfather's secrets; they will cure all manner of diseases".

⁷ The first evidence of this is provided by E Barrett himself, after an interview with Louisa Mvemve in April 1915, "... her anxiety to submit here cures to analysis seem to remove her very far from the impostor class." (CAD/NTS 9301 3/376: 20/4/1915) She also made numerous attempts to get certified physicians "of the government's choice" to examine leprosy patients she claimed to have healed. (CAD/NTS 9301 3/376: 7/6/1915 and 15/8/1915). As a final example, the Cape Times, of 12/3/1931 reported the examination of her herbs by doctors, and that they were tested in the Kleinfontein Hospital.

⁸ She mentions this several times, but her most extensive comments can be found in letters from Kingwilliamstown, in February 1919. She claims that her "European" clients want her to open a Nursing Home for Europeans in the town. CAD/NTS 9303 3/376, 20/2/1919. In 1928, in correspondence with the Governor General she again cited the need to open a Nursing Home for her "European" patients, this time in Brakpan. CAD/GG 3/4864: 10/1/1930

⁹ Throughout the records she continually testifies to having take-on patients, especially cancer patients, given up by other doctors. One example is CAD/JUS 576 01 418/31: 30/1/1931.

ancestry, she explicitly explained herself and pleaded her case through discourses of "good healing", of Christianity and civilisation, and she repudiated what she termed witchcraft and dangerous practices.¹⁰ She sought-out, commissioned, and on occasion, won, the company of many certified physicians and chemists. She aroused the admiration and curiosity of scientists, administrators, chiefs and elders, as well as a spectrum of ordinary men and women, black and white, in the four provinces of the Union of South Africa, and beyond the borders of the country (in Bechuanaland, Basotholand and the Rhodesias).¹¹ For eighteen years she initiated and maintained the most detailed and voluminous series of communications with officials and representatives from virtually every level of central and state government in the land.¹² Louisa Mvemve's successes and

¹⁰ This is most explicitly stated in a 4-page letter she wrote to the Secretary of NAD in May 1916, CAD/NTS 9301 3/376: 42/5/1916; and in a letter to Lord Buxton in May 1916 on the same subject, CAD/JUS 231 01 3/98/16/1: 31/5/1916.

¹¹ She won the friendship of Dr Kerr-Muir and his wife in her Benoni days, and in the 1920s, the partnership of Dr Scott of Grahamstown. She also maintained tempestuous relationships with chemists such as Mr Miller, Mr Carnegie and Mrs Neal. These people will be referred to again below. Examples of her letters of testimony from patients, and letters containing references to people she cured occur throughout the files. For one example which contains no less than 18 letters of reference (sent in by black and white women and men) from Grahamstown, Benoni, Van Ryn, Port Elizabeth, Pretoria, Somerset East, Brakpan, Beggars Bush, Uitenhage and Roodepoort, see: CAD/GG 919/01 33/67: 2/2/1916.

¹² In detailed searches through all the files relating to herbalists in the central State Archives, I have not found a single other example of such repeated or prolific communication. Her "communications" are remarkable, not only because they extend across so many Departments of Central and Local government, involving hundreds of letters, many notes and telegrams and dozens of interviews, but also because the NAD and others recognised her as most prolific, and unusually so, too. For instance, on 22/5/1931, A L Barrett, of the NAD, noted to the Secretary for the Justice Department, when

tribulations framed her engagement with different layers of authority, so that the extant record of her activities and thoughts is varied, uneven and complex. For certain periods she was able to navigate the twisting channels of bureaucracy with astonishing aplomb, and she achieved some of her ends. But at other times her economic circumstances and personal judgements were unequal to the massive obstacles she faced in her battles to win admiration, respect, legality and financial success.

Thus, Louisa Mvemve was a complex person in her day, and the ambiguities of her self-representation and her reception provide a central thread throughout what remains of her documented narrative.¹³ Her story is an unusual and vital, if partial, biography of an African woman living through, and having some effect upon, a period of great turbulence. The 1920s and 1930s saw the increasing systematisation of oppressive laws and practices directly affecting the lives of black South Africans, and increasingly black women. Despite this, Louisa moved in the space of five years, from laboring as a domestic servant, to employing scribes, messengers and domestic workers of her own. Her class mobility was not unequivocal or permanent. She suffered complete financial ruin on several occasions, and as we lose sight of her in the early 1930s, her chances for a continued hold on a comfortable existence seemed doubtful.

forwarding files of correspondence: "This woman is one of our most prolific correspondents" CAD/JUS 576 01 418/81. Finally, and crucially, although I have found letters from a handful of women herbalists to the NAD and the GG and Attorney General in the period after the 1940s, nearly all of Herbalist correspondence is from men, and no case involves more than a few letters back and forth at most.

¹³ See my brief examination of her self-representation below.

These experiences, and the "archive of communications" occasioned by her activities over two decades, offer a nuanced insight into a much broader arena than this chapter can address. Two subjects lie at the heart of this "archive". The first focuses upon the politics of medical knowledge, authority, and practice, and this theme will constitute the core of the present chapter. Here Louisa Mvemve's battle to gain recognition as a woman with valuable healing power, skill and talents in a specialised arena, provides a vital contribution to the history of healing and medical care in Southern Africa. Unlike the testimonies, autobiographies, accounts, papers and reports of many other health administrators, medical missionaries, doctors and nurses, this account is authored by a black woman. In these records, if not in her day-to-day life, her words take up more than equal space with those of white male officials.¹⁴ Here her particular experiences of male-dominated medical guilds, and the scepticism of newspaper reporters, police officers and Government Officials' concerning the capabilities and intelligence of women, are given voice. We see too that her gender lent a special authenticity to her treatments for women, for their menstrual needs (including pills and treatments "for irregularities"), her empathy for "sterile" couples and her reputation as a fertility restorer, her "marvellous" midwifery skills, as well as her venereal disease treatments for both men and women. In certain circumstances this opened the way for special comradeship with other women, including

¹⁴ I will return briefly below to the complexities of the "technologies" of her communications, her scribes, her use of stamps and letterheads, and the effects these interlocutors had on her ability to represent herself and persuade others.

white women, on the basis of her healing mission, and her personal experiences of, and ideas about, motherhood.¹⁵ As a woman her claims to respectability could not filter their way through the same channels as the handful of women "noted" in the barometer of bourgeois acceptance, the African Yearly Register, published in 1931 by T. D. Mveli Skota, where-in nurses, teachers and the wives of prominent men were afforded some recognition. It would seem that Louisa's status derived both from her position as a healer of note (a role she saw in some measure as an inheritance from her grandparents, and for which the patterned role of healers in various Xhosa-speaking societies at the time would have prepared her and her patients), but it was a role largely self-engineered as well. She wanted to create a niche for herself not as a nurse or western doctor, nor as a diviner, "traditional healer", or as a mere hawker of goods: she wanted to carve for herself no less than the role of a kind of new medical broker. But she embarked on this journey to fashion a new craft from the skills of her ancestors and the techniques of western biomedicine at just the time when the Medical Academy in South Africa began closing its ranks, centralising its authority, and undermining the independent expertise of a host of practitioners such as midwives and herbalists.¹⁶

¹⁵ See letters of testimony written to her, particularly those contained in CAD/GG 919/01 33/677 from 1916, and as well as the letter and photograph from the Du Preez family, CAD/NTS 9301 3/376: 10/1/1930.

¹⁶ Previous chapters have examined the formation of the Public Health Department in 1919. In the 1920s debates around maternal health and welfare led to the creation of new legislation sharply circumscribing the activities of family and local midwives. However, these laws were ineffective even in the eyes of their progenitors because of the lack of training facilities for certified black midwives, and the absence of any maternity homes for

The second major subject given expression and form in these archives, concerns Louisa Mvemve's battles over "her rights". Although she expressed herself in individualised terms, the battery of systematic discriminatory racial legislation that she faced, had more than Louisa in mind. Specifically, the new Urban Acts were directed against both the increasingly permanent settlements of Africans in cities, as well as against one of the most threatening features of this migration: independent African women. The work they carved out for themselves, as beer brewers and sex-workers, was the subject of sustained debate amongst the NAD, Municipal authorities, as well as "respectable" African men and women.¹⁷ Documented in the pages of Louisa's correspondence, is a powerful history of her reactions over time to the changes in legislation and official attitudes towards black South Africans, especially in urban areas. We also glimpse a personal view of her experience of changes in laws affecting rights of citizenship, of movement and occupation, of access to tenure and property, to hire and occupy space, as well as rights of

black women. In the same year that a new Health Act was passed in 1928, an Act which would be directed at herbalists and independent healers, a group of philanthropists in Johannesburg opened the Bridgman Memorial Hospital for black women, and embarked on a program to train black midwives. It took until the late 1930s before the local state was able to offer any alternatives to uncertified midwives for black city dwellers. These themes are taken up in the next chapter.

¹⁷ See K. Eales, "Patriarchs, Passes and Privilege: Johannesburg's African Middle Classes and the Question of Night Passes for African Women, 1920-1931", University of the Witwatersrand History Workshop, (1987); P. Bonner, "'Desirable or Undesirable Basotho Women?' Liquor, Prostitution and the migration of Basotho women to the Rand, 1920-1945" in C. Walker, (ed) Women and Gender in Southern Africa to 1943 (Cape Town: David Philip, 1990) and E. Kuzwayo, Call me Woman (San Francisco: Aunt Lute Books, 1987).

access to local and central institutions such as courts, police authorities and transport. We see especially towards the end of the archive, in the early 1930s, that the odds, stacked so heavily against an African woman herbalist (providing treatment for whites and blacks, and living and working and growing herbs in a "white" area), were insurmountable, and in these terms she lost her battle, and was forced to retreat to the Eastern Cape.

These two subjects: "medical politics and practice" and "segregation" intertwined and were in fact inseparable in the daily lives of both Louisa Mvemve and the people with whom she interacted. They form the basis of a series of powerful debates throughout the documents, concerning tensions between "policy and practice" and they were used in contestation with one another by various participants, to highlight contradictions, inconsistencies and impracticalities. Of course the very legislation regulating the practices of medical authorities, medical institutions and public health policy, was itself generated by the wider history of colonial conquest, industrial and agricultural capitalism, and segregation, and the eventual passage of the Medical, Dental and Pharmacy Act of 1928 (almost a decade in the making), reflected this tempestuous history.¹⁸

¹⁸ A summary of the history of the Act can be found in E. H. Cluver Social Medicine, (Johannesburg: University of Witwatersrand Press, 1951) 767-780. When referring to Health Legislation and debates around its passage in this paper I have also drawn on research conducted for a broader purpose in the collection of the South African Institute for Race Relations housed in the Historical Papers Archive of the William Cullen Library, University of the Witwatersrand, (AD 843/RJ Health and Social Services), as well as the Public Health Records of the City of Johannesburg, (Intermediary Archives) and the records of the Department of Health, Central Archive Depot Pretoria, (GES series, 1920-1955).

After a brief discussion of the nature of the documents forming the basis for this chapter, and a more comprehensive biographical glimpse into Louisa Mvemve's life to the extent allowed by the records, the second part of this chapter will focus on Louisa Mvemve's battle to practice as a midwife and herbalist, including her licensing and patenting attempts, court cases against her for "contraventions" of various Acts, and her remedies and cures including testimonies of her patients. The last section of the paper will attempt to draw together her experiences of medical politics and of the impact of segregationalist legislation on her life-course. Here her forced departure from the Rand marks a significant moment, and provides a taste for us of the pungency of the mingling of struggles over medical authority, economic interest, and the elaboration of racial segregation.

Literacy, Communication and Representation:

The "archives" of Louisa Mvemve consist of a collection of hundreds of letters, as well as telegrams, notes, court documents, testimonials and advertising booklets, spread across the boxes and files of several Departments of the Central State, and housed today in the Central Archive Depot, Pretoria. Communications with her engaged the energies of dozens of state officials because of her compelling and unusual requests, insistent questioning and solicitation of advice, and the correspondence necessitated by her tireless zeal in lodging complaints and reporting unfair treatment. She constantly disrupted Official Explanations, by falling outside of anticipated "categories". Louisa Mvemve laid claim to

"traditional" cures and knowledge, and yet employed chemists and doctors to work for her, and patented and packaged her herbs as modern medicines. The NAD was unable to pin-her-down regionally either: she moved between rural districts in the Eastern Cape and Transkei, as well as through the urban smog of burgeoning reef towns, such as Benoni. The analytical insights and historical writing of Michael Foucault have of late begun to shape the work of historians and sociologists on the evolution and bureaucratization of the South African State.¹⁹ Louisa Mvemve's recorded narrative provides vivid evidence of these increasingly systematised operations of the central state, whilst simultaneously furnishing a corollary to the panoptical vision offered by Foucault. She may not have vanquished the objectifying mechanisms of officialdom, but she found ways to work within, manipulate, and at times disrupt various systems of rules and procedures to great effect.

One of the languages and set of images Louisa drew upon in her attempt to gain the ear of Authorities would have been familiar to a woman coming of age in the late nineteenth century Eastern Cape, namely: the call to "Patriarchal Protectors". She never mentioned a male partner until late in the correspondence when she termed herself a "poor widow", and yet her status as an independent woman has to be set alongside her calls on Lord Buxton, as her "father and protector", and her establishment of powerful relationships of patronage with Native Affairs Department (NAD) officials, (such as

¹⁹ See: D. Posel, The Making of Apartheid (Oxford: Clarendon Press, 1991).

Edward Barrett, and later Edward Dower) and physicians such as Dr Kerr Muir and Dr Scott. Her chief communications were with the various Secretaries and their assistants in the NAD, as well as the Office of the Governor General of South Africa.²⁰ She also made contact with, and sparked enquiries from, officials of the Department of Inland Revenue, the Department of Lands, the Justice Department and the Attorney General's Office, as well as the Office of the Secretary of the Interior, various sections of the South African Police, the Native Commissioners and officials of several Municipalities including Johannesburg, Benoni and Brakpan, and crucially, the Magistrates and Commissioners of Grahamstown, Kingwilliamstown, Pietermaritzburg, Witzieshoek, Peddie, Alice, Umtata and Butterworth. Her communications occurred against the backdrop of substantial changes in policy and methods of administration within the Native Affairs Department itself.²¹ Louisa Mvemve's personalised correspondence began at a time when Dower and Barrett, with their experience of administration in the Transkeian Territories, were attempting to run an embattled Department, overshadowed by those of Labor and Justice, and fragmented along the regional lines bequeathed to it at the time of Union. Saul Dubow

²⁰ Mvemve also cultivated relationships with three important Chiefs: Menzime of Grahamstown, David Molapo of Basutholand, and Mopedi of Witzieshoek, helping them with personal cures, and assisting in the birth of Menzime's grandson.

²¹ For a detailed analysis see S. Dubow, "Structure and Conflict in the Native Affairs Department" and "The Ideology of Native Administration" in Racial Segregation and the Origins of Apartheid in South Africa, 1919-1936 (London: St Anthony's/MacMillan, 1989) as well as S. Dubow "Holding 'A Just Balance Between White and Black': The Native Affairs Department in South Africa c. 1920-33" Journal of Southern African Studies 12:2 (1986).

has detailed some of the tensions and debates between the NAD and the Smuts government, which led to the forced resignation of E Barrett in 1923. After his demise, a tightly systematised Department came alive under the tutelage of Herbst and a corps of energetic officials -- more sympathetic towards the increasingly segregationist ideals of the central state. There was less time devoted to maintaining the detailed correspondence with Louisa Mvemve that E Barrett had achieved. Although, it must be noted, the Native Affairs Department and its officials continued to expend energy on Louisa Mvemve's enquiries, and continued to represent her sympathetically to officials from other Departments beyond their brief. For example, towards the end of the correspondence, in January 1931, and in the midst of Louisa's final trial, A L Barrett (not connected to Edward) wrote to the Public Prosecutor in Grahamstown:

Louisa Mvemve has been known to this Department for many years as a Native herbalist. She is believed to be a well-meaning person, and, in so far as this Department is aware, there is nothing against her character.²²

This statement leaned heavily on the side of Louisa, as the Department by his time had files of letters in which white chemists and other correspondents had complained of her unscrupulousness and inefficiency, and after three court actions against her activities. It would seem that even at this late stage, the vivacity of her personality, and a sense of perhaps nostalgic responsibility, moved even younger and committed officials. Finally, and most crucially, the NAD recognized that without the services of people such as Louisa Mvemve, most black urban dwellers would have had few alternatives in sickness and

²² CAD/NTS 9301 3/376: 27/1/1931

physical need. D L Smit, (the head of the NAD) met in the same week in January 1931, with officials from the Health Departments of Johannesburg and Pretoria, to discuss the dire shortages of black nurses and the overcrowded hospital facilities for black men and women across the region.

Recently, Isabel Hofmeyr has offered some interesting and suggestive insights into the relationship between forms of communication and political authority.²³ The long-standing feud between the Native Commissioner of Potgietersrus and Chief Masibi of Zebediela provides the backdrop for her examination of Masibi's use of a variety of media and communication technologies, as well as oral forms of dialogue (letters telegrams, interviews, secret reports and speeches), in his attempt to "bend the language of official correspondence". Louisa Mvemve's weighty correspondence makes wide use of different technologies of communication too. Like Masibi and his aids, she would often begin a letter by reminding the NAD official, or Buxton, of a previous communication or interview with them, thus personalising the relationship, and implying continued contact. To create and sustain the form of a dialogue, she would usually close by soliciting advice, even at the end of letters which opened "Just a line to let you know", and she usually received a letter of acknowledgement to even her most personal and rambling letters. She would often add weight to her letters, by including originals or copies of testimonials from

²³ These ideas draw upon the arguments in I. Hofmeyr, "The Spoken Word and The Barbed Wire: Oral Chiefdoms versus Literate Bureaucracies", African Studies Seminar, University of the Witwatersrand, March 1992, 1-7 .

patients, or letters of thanks, and every few months she would ensure that the Governor General's Office and the NAD at least, received copies of her latest brochures and pamphlets. When involved in court-action she would make use of telephones and telegrams, especially when she called upon the NAD to provide her with copies of letters she had received from them in the past, and which she had either mislaid, or could not get access to quickly enough. When anxious about being observed by officials in a district, her correspondence would read almost as a diary of her daily events, as a way to use their offices as her own body of evidence. On several occasions in she mentioned moving her box of letters around with her during her frequent trips, and on two occasions she loses most of her correspondence. However, she seemed to realize early on that she could rely upon the record-keeping of the NAD in particular, and thus in certain ways it functioned as her own archive. She made frequent trips to Pretoria to interview and question NAD officials, and when in the Eastern Cape and Transkei, made certain to present her case in person to local Magistrates.

In an attempt to understand Louisa Mvemve's ability to sustain her sheer volume of correspondence, and the lengths to which she went to make her frequent and costly "trips in person", an analysis of the handwriting and style of the letters was undertaken for this study. At times of crisis she would often send three or more letters a day to different Departments, and this figure reflects only those in the collection which have remained intact today. Excluded from this are the notes and letters she was sending to her agents

and chemists and patients, which we know about because of numerous cross-references, and from the written testimony of one the chemists she dealt with throughout the 1920s, Mr Miller.²⁴ For the first few months of her correspondence with Lord Buxton and the NAD, her letters were written in the same hand. Suddenly, between July 1915 and August, the handwriting in her letters shifted three times. Although the style, lucidity, grammar and expression of the letters remained very similar. Clearly Louisa Mvemve was employing at least two "scribes" on some kind of permanent basis, and perhaps dictating letters to them. However her ability to recall details of previous correspondence, her spidery, but distinctive signature (which appeared on the odd document from 1914-1932), her obvious command of fluent oral English, evidenced by the court-records, and her representation by Barrett as "a highly educated woman" in his first four years of contact with her, suggest that she was at least to some degree, literate in English. It would seem that in an attempt to "fix" the authenticity of her documents, and to "officialize" her correspondence, she wrote, whenever she had supplies, on paper printed with her address and Tiger Trade Mark on the letterhead, and she signed most of her correspondence with a purple-inked stamp, very similar to those of the NAD! Her linguistic command of English was never in question, and when she could pay for and obtain the service of scribes fluent in English, she maintained the image of a highly educated woman. However, as soon as she left Benoni, in 1916, she relied on less able scribes, and the tone of her letters (still as

²⁴ Mr Miller, Grahamstown, to NAD, saying he received more than three letters a day for sustained periods. CAD/NTS 9301 3/376: 21/1/1921.

confident as before), was not matched by their erudition. Clearly her case suffered accordingly in the minds of officials. Soon Barrett realized she was employing others as her correspondents, and began to see her in a different light. After a particularly poorly expressed set of letters concerning her dispute with chemists and Magistrates in Grahamstown, at a time when her finances were at a low ebb, E Barrett, perhaps forgetting the years in which he viewed her as a "civilised and educated woman", wrote:

I strongly advise you to accept some offer of employment in the ordinary course and to give up your present manner of life. You claim to have effected many remarkable cures, and for aught I know you may have done so but you are an ignorant almost illiterate woman and the difficulties against which you are contending are too great for you. As your sincere well-wisher, this is the best and kindest advice I can offer you. I am enclosing the letters you wished me to return.²⁵

Louisa Mvemve did not take his advice, or respond to this patronising, and probably hurtful letter. Five months passed before she called on the NAD again, and she made certain that her scribe was very skilled.²⁶ The clearest examples of the link between her financial security and her access to scribes literate in English, occur when she travelled around small towns such as Kingwilliamstown and Grahamstown between 1919 and 1931. Her financial affairs and litigation were the cause of much correspondence in the 1920s, as she attempted to sue chemists and agents for moneys she felt she was owed. During this period, and before she returned to Brakpan, and engaged the able services of a J Gumede,

²⁵ E Barrett did not impress his views on others in his Department, as throughout the 1920s, (after he had resigned from the NAD), Louisa Mvemve received warm testimonials from the other officials. CAD/NTS 9301 3/376: 20/7/1920

²⁶ Louisa Mvemve sent a most erudite letter following NAD enquiries on her behalf in January 1921, CAD/NTS 9303 3/376: 25/1/1921.

(whether as a scribe or lawyer is not certain), she battled to "express" her case lucidly. On occasion, however, she was able to find an eloquent interlocutor, as in her letter to Prime Minister Hertzog in 1930, and her statement about her life and activities to the Native Sub-Commissioner in Benoni in the same month when she expressed, with her previous confidence:

I am a Native woman Herbalist. I began my work as a herbalist in the Transvaal in 1915, and my affairs are well known in the Native Affairs Department, Pretoria. ... I am a Linguist. I speak English and Afrikaans besides my language.²⁷

"I could trace myself if anyone wants to know..."²⁸

What we know of Louisa Mvemve's biography is scattered in hints throughout the records, offered mainly by her, but also by friends such as the Kerr Muirs, as well as newspaper reports of the day. What is clear is that she could and did draw on layers of identity to represent herself in particular circumstances. She was often referred to as a "Fingo" woman, although she herself did not use this designation.²⁹ This description of her by others in authority carried some meaning. The term "Fingo" (or Mfengu, a more recent "africanized" term), implied an ambiguous identity at the time. Historical and anthropological opinions on Eastern Cape history from the 1920-1940 period, as well as

²⁷ The letters to the Prime Minister, Hertzog, and to the Native Sub-Commissioner of Benoni, were both in connection with her imminent removal from Brakpan. CAD/NTS 9301 3/376: 10/1/1930 and 15/1/1930 respectively.

²⁸ CAD/NTS 9301 3/376: 1/12/1919.

²⁹ She also spoke of "natives" as "her people", and of herself as a "native herbalist", see CAD/GG 145 01 3/2232/1; 21/11/1916.

commonly expressed sentiments in white newspapers of the day, spoke of the "Fingo" people as having originated from a group of refugees, dispossessed as a result of the upheavals set in motion by the rise of the Zulu Kingdom in Natal in the 1820s. In this narrative, the "Fingo" were regarded as both debtors to the British, who were their "saviours", and also as allies, against more hostile Xhosa-speaking groups in the region, and thus rewarded with access to land and cattle, albeit through forms of bondage or apprenticeship to white farmers and officials. Despite being Xhosa-speakers themselves by the 1930s, astute researchers such as Monica Hunter continued to set them apart from their Xhosa, Pondo, Bhaca, Hlubi and Thembu neighbours, pointing out that although extensive interfamily connections existed with "Fingoes" by that period, there was a remaining sense of their greater affiliation with whites, and at times a sense of their greater exposure to western education and Christianity. In this context it is relevant that Louisa Mvemve was viewed as a "Fingo", with all that connoted, by several Magistrates in the Eastern Cape and to the Transkeian-trained officials of the NAD.³⁰

³⁰ The studies of the Mayers, and of Hammond-Tooke amongst others, have continued to "explain" the "Mfengu" in similar terms. However, a recent reworking of this "mfecane-based" thesis is underway, in the work of the Cobbing School of students, and although not many new "answers" have been forthcoming from the work of people such as Alan Webster, the entire edifice of documentary evidence upon which the narrative rested for so long, has been vigorously questioned. A. Webster, "Unmasking the Fingo; The War of 1835 revisited", Conference Paper: "The 'Mfecane' Aftermath", University of the Witwatersrand, September 1991. See also M. Hunter, Reaction to Conquest: Effects of Contact with Europeans on the Pondo (London: Oxford University Press, 1936); P. Mayer, and I. Mayer Townsmen or Tribesmen (London: Oxford University Press, 1961); W. D. Hammond-Tooke, Bhaca Society (London: Oxford University Press, 1962); R. A. Moyer "A History of the Mfengu of the Eastern Cape 1815-1865" PhD diss., University of

Born in the Eastern Cape, in a coastal region near Port Alfred, Louisa Mvemve grew up in daily contact with white farmers from an early age, and also had access to a large family network, which at some point extended into Grahamstown. It would seem that Louisa Mvemve had the opportunity to draw on a wide range of experiences, histories, and types of education. Perhaps one of the key ingredients in her extraordinary success as a herbalist and a personality of note, was an ability to seize and draw-upon her rich heritage and context. In 1919, infuriated and indignant, Louisa Mvemve complained to the Secretary of Native Affairs, E Barrett, and Mr Tippet, of the South African Railways and Harbours, about the treatment she had received from a clerk at Komgha station. She revealed something of her past, and of her self-perception in this angry missive:

Well I must say according to the language that was used by the clerk at Komgha to me; I was never a red kafir I never wore red blankets I have never used kafir mats for mattress and I have never used stones for my pillows either, I myself was born to the farm near Port Alfred, the farm was Mr Maclock's I could trace myself if anyone wants to know where I was brought up. My mother was working for Mrs Maclocks, and my father was also a servant of the Magistrate in Silem When I was nine years old I went out to work to play with baby I was getting a shilling a month, and my food and clothes. The lady I was working for was Mrs Webber. When I explain this I mean I can prove I was never a red kafir as he calls me and also my grand father never seen him with Red blankets, and my grand mother is still alive.³¹

London, 1976; J. Cock, "Domestic Service and education for Domesticity: The Incorporation of Xhosa women into Colonial Society" in C. Walker (ed) Women and Gender in Southern Africa to 1945, (Cape Town: David Philip, 1990).

³¹ CAD/NTS 9301 3/376: 1/12/1919, 1-2.

The Maclock family is not mentioned again, but in April 1916, Louisa applied through the NAD to the Department of Lands for permission to have access to Crown Lands to dig for her herbs, and one of the farms she named was that of the "Webbers".³² It is possible that she gleaned some of her knowledge of planting and tending herbs, and of their medicinal properties, in her youth working as a baby-minder for the Webber family. Certainly by this time, her training as a care-giver and nurse-maid had begun; and her concern with women and their children featured as an important part of her recorded work. She worked again in the household of a white family, doing "occasional housework", when in 1905 she made contact for the first time with the Kerr Muir family, on the East Rand.³³ She remained in contact with them until the death of Dr Kerr Muir in 1927, when according to her, she received a bequest in his Will.³⁴ At several key moments Louisa Mvemve represented herself as a Victorian woman, proud to be "born under the British flag".³⁵ However, just as she represented herself as a "civilised" and Christian woman, she could also draw powerfully on aspects of her heritage that reflected her family's skills and pride in an arena outside of the mission, white-farm or school setting. In 1916, concerned to "do her bit" for the War effort, she contacted Lady Buxton, through the Offices of Lord Buxton, the Governor General, and offered to raise money for the

³² CAD/NTS 9301 3/367: 28/4/1916, 27/5/1916 and 12/7/1916.

³³ Dr Kerr Muir to E Barrett, NAD. CAD/NTS 9301 3/376: 25/5/1915.

³⁴ Louisa Mvemve to the Native Sub Commissioner of Benoni, housed in CAD/NTS 9301 3/376: 12/3/1927.

³⁵ CAD/GG 3/4 834: 17/7/28.

Governor General's fund by collecting curios. It would seem that Louisa did not dash around the Eastern Cape (from Cape Town, to Grahamstown, to Peddie, to Alice, to Umtata and back to Grahamstown) solely for altruistic reasons: she always took the opportunity of mentioning her medicines and herbal cures to the women from whom she solicited articles and "curios". She nevertheless was zealous enough in her "recruiting" activities to please the Buxton's and instill herself in their memories, at least for a few years. She provided for their faulty memories, when in correspondence to the Governor General in the late 1920s and in 1931, she reminded him of curios she had collected during the great war, "which had even been sold in Europe". Her excited letter to Lady Buxton, of November 1916, provides a different glimpse into her concept of ethnic identity and selfhood:

Just a few lines to let Madam know I am in Graham's Town. I met my coloured friends and explained to them about the "curios" which we want to sell for the Governor General's Fund. They were surprised for they hadn't heard of it before. All the same they took my word and started at once to gather curios... we have already Baskets, Kaffir Mats, Fancy Sticks, I'm sending you a sample for a present, Basket and Basket Cups made by my own Mother The things will be sent first week in January. I am going to Fort Peddie next week I wrote to the women there they are also preparing to send things. From Peddie I am going to Transkei. I wrote to the different chiefs and asked them to explain everything to the women what to make, Skins, Karosses, Clay Cups, Mats, Door Mats, Walking Sticks... I must tell you Madam that some women would like to bring their presents themselves so as to bring them safely. They fear to have them broken. Others would like Her Excellency to see how they crush and grind their food. I dont want to praise my Nation but Madam will see some wonderful things. Better than what came from Basutoland... I'll gather samples of things made by different tribes... Besides what the Kaffirs, Fingoes, and Amaxosas will send.³⁶

This letter, in which Louisa Mvemve praised her "Nation", underscores again her ability to maintain a complex visions of her self-identity, and her determination to refuse any one categorization her herself or her work. It is not clear what her own family and household thought of her work, or how they participated in her projects. In the remainder of her records, all other references to her son, her two brothers,³⁷ and her other children, relate to her medicinal work,³⁸ and it is to this that we will now turn.³⁹

"I am a Native woman Herbalist"

During the 1920s a new interest in the debate about "rationality and science" versus "superstition and witchcraft" began to take shape in southern African medical, scientific, anthropological, religious, philanthropic, government and popular circles.⁴⁰ The

³⁷ CAD/NTS 9301 3/376; 17/4/1916.

³⁸ The only references to her son, speak of him working on a herb farm in Orange Grove, and her attempts to move him to Mrs Kerr Muir's care instead, "as he is still under age". CAD/NTS 9301 3/376; 24/12/1917.

³⁹ One possible clue to the view of Louisa Mvemve that black men and women could have had is the reference to her in a 1917 "Grahamstown Riots" Report, where, in a section titled "Native Unrest: Grahamstown", issued from the Office of the Deputy Commissioner of Police of that town, a reference was made to a 'Louisa Mvemve': "... During the early hours of the morning, the natives again forcibly prevented male and female servants from preceding to their work. One native woman, Louisa Mvemve, who insisted on going to her work when stopped by a native picket, was assaulted, badly knocked about, and seriously injured." SAP 34 6/498/17: 28/04/1917. Many thanks to Keith Shear for passing on this reference to me.

⁴⁰ Debates about rationality and deduction, about supernatural powers and religious beliefs have, obviously, a more ancient history than "southern Africa, 1920s". However, my periodization here refers to a new interest, almost to the point of obsession, in "African witchcraft vs science", which took hold of the imagination of "experts" in southern Africa during the 1920s, and for the next two decades.

lineaments of this debate influenced popular discourse as well as medical legislation, educational curriculum, and theological arguments in the period. Medical missionaries and doctors connected to mission hospitals, were at least in the early years, the chief protagonists. As the only people offering any western medical care to the majority of southern Africans, except for a few Municipal clinics in major cities, and the Mines hospitals, medical missions and their staff of doctors and nurses were at the forefront of training black men and women as nurses, assistants, and eventually, doctors. From amongst this community several large autobiographical works emerged in this period, and countless papers and articles, focused on the idea that medicine and Christianity, as a team effort, were the only bulwarks against the ubiquitousness of superstition in the "native mind".⁴¹ Even the most progressive medical missionaries believed that Africans had to be disabused of their concepts of the supernatural and of destiny in order to truly "convert" and be healed. Public Health Officials also entered this debate, and people such as the Medical Officers of Health of East London (Laidler), Benoni (Anning) and the Chief Officers of the Union, Thornton, Cluver, and Gale lectured on the topic, and campaigned to "let science win the day".

⁴¹ Amongst others see: R. D. Aitken Who is my Neighbour: The Story of a Mission Hospital in South Africa? (Cape: Lovedale, 1944); M. Gelfand, Christian Doctor and Nurse: The History of Medical Missions in South Africa from 1799-1976 (Natal: Mariannhill, 1984); R. H. Shepard, Lovedale: The Story of a Century, Lovedale (Cape: Lovedale, 1942).

A central contradiction lay at the very core of this debate. From the time of Union, in 1910 (and earlier in the Cape, where Thornton had helped to draw up comprehensive Health Laws), medical officials and the organised guilds of doctors and chemists, lobbied to curtail the activities of "native medicine men and women", and to criminalize certain healing practices, define and outlaw "witchcraft", and prohibit the selling of "dangerous" concoctions. But the central state was not willing to marry these measures with a comprehensive health plan for black South Africans. Thus the health facilities available over the vast expanses of the land, for most blacks as well as many rural whites, were either widely scattered missions clinics, and "traditional" or community healers, midwives, diviners and grannies and grampa's with herbal remedies and local training. In Natal, a Native Ordinance of 1895 was still in force even after Union, which protected existing "Native Medicine Men and Women", and provided for their licensing by Magistrates (and later the Department of Health), on the advice of Chiefs, and in the absence of other medical facilities. Because of the active work of Thornton in the Cape in the later 1890s, similar Codes were repealed, and this was also the case for the Transkeian Territories. The two Boer Republics had never constructed similar legislation, and so after Union the Transvaal, the Orange Free State and the Cape recognised only certified and western trained medical practitioners. There were loopholes in the Medical Legislation, exploited throughout the teens, and thus in 1919, a process to bolster the authority of medical knowledge and the right to heal began in earnest. These efforts bore fruit in the

1928 Medical, Dental and Pharmacy Bill, which only saw major revisions after the Second World War. But the "Natal Exception" as it came to be known, occasioned the most voluminous correspondence, petitioning and legal action imaginable through-out the decades 1912-1960. Individuals, referring in their letters to themselves as herbalists ('inyanga', 'ixwhele', 'igqira', 'bongaka' and 'dingaka'), assaulted the NAD and the Public Health Department with enquiries, petitions and legal action, to no avail: no medical men and women outside of Natal received licences to practice after 1910.⁴²

However, there were ways and means for herbalists to continue their trade, especially before the passing of the 1928 Legislation. At almost exactly the time that Louisa Mvemve began her battle to gain recognition, it was dawning on the officials in the NAD that the issue of the "Natal Exception" was going to become an administrative thorn. For the period when Dower and Barrett were in office, they avoided pursuing herbalists whose practices did not come within the ambit of the law, although their Department and the Offices of the Governor General and the Attorney General, attempted to create legislation which would better control "witchcraft". Almost without exception, the debate at the time was voiced as one between two opposing and contradictory discourses and bodies of knowledge and practice: western biomedicine and a primitive "native" cosmology of cures.⁴³ Even in the early decades of this century the debate, formulated by

⁴² Much of this correspondence can be found in these files: CAD/NTS 9303 1/376/-; 7/76; 8/376, CAD/NTS 2871 38/303; CAD/UG 19, 1936, CAD/GES 1783 25/30 A - D, and SAIRR AD 843/RJ Na: Herbalists.

⁴³ This entire formulation was gravely at fault, and that nothing like a closed system

health officials such as the Minister of Health, Mitchell, ignored the vast range of patent medicines, chemists and hawkers "tonics and devices" and their "regimes" which were obtainable, legally, and at a price through registered Druggists as well as via the mail-order companies such as W. R. Pimm & Co, whose large and illustrated advertizements in the major English papers, as well as Imvo Zabantsundu Zomzantsi Afrika, Ilanga Lase Natal, Abantu Batho, and Umteteli Wa Bantu attracted wide attention.⁴⁴ Newspapers at the time also gave space to discussions of the quackery of western trained physicians, and many Native Affairs Officials privately voiced their suspicion about the full viability of eradicating "traditional healers", not only because of

existed on either side of the divide. See the work of Feierman, Jansen, Marks and especially A. Young, "The Creation of Medical Knowledge" and Jean Comaroff, "Healing and Cultural Transformation" in Journal of Social Science and Medicine, 15:b (1981). The only contemporary commentary that I have found, which "complicated" the concept of logical and thought systems within indigenous medical crafts, is that of J. D. Krige, (spouse of the noted anthropologist) who argued that the framework of criteria, categories of thought and explanatory principles of "Bantu" health practices, bore a great resemblance to those of biomedicine; observation, physical and chemical knowledge, theories of causation. He focused his analysis of "difference" on available technologies, and pointed out the religious thought embedded in the practice of many medical missions. Krige also reminded readers of the short history that western biomedicine could claim, and its own well-springs in the traditions of Judaeo-Christianity and European cosmological ideas. J. D. Krige, "The Magical Thought-Pattern of the Bantu in Relation to Health Services" African Studies III (1944).

⁴⁴ Mitchell played a key role here, as did role as did other members of the Public Health Administration, such as Gale. In Natal a sometimes tense relationship between the official "watchdogs" of the Medical Profession and Magistrates lasted until the 1940s, as the Magistrates were vigorously lobbied by local Chiefs to continue issuing herbalist and "Medicine Man" licenses.

the paucity of other options, but also because of the tenuous efficacy of western techniques in the treatment of many conditions and maladies.

Another group of professionals were increasingly called upon, by applicants, to speak in support of the "rights" of Herbalists: advocates and attorneys. About a third of all applications to the NAD for licenses throughout the 1920s to the late 1950s were accompanied by "lawyers letters". Of course it would be fair to assume that many of these letters were motivated by the lucrative fees, and many of Louisa Mvemve's experiences with lawyers underscores this assumption. However one Natal Attorney in 1936 went beyond the call of his contract when he wrote this spirited critique of the Health Department in his application for the renewal of the lapsed license of his client, Samuel Mweli:

... If any advocacy from us is needed to persuade you to resist the machinations of the Health Department or to persuade the Health Department itself, may the writer say that ... (O)ur Health Department should not be afraid of competition from our Client. *Magna est Veritas et prevalebit* and if our Client's brand of fetishism is inferior to that sponsored by European Medicine-men, competition will soon eliminate our unfortunate client. We know Sir Edward Thornton will say that the our client's passage through the arcana of medicine will be marked by more corpses than are to be found at the doors of such medicine-men as he will condescend to recognise, but I really don't know what statistical data he can adduce in support of such an assertion. I rather fancy there is a bigger mortality rate amongst urbanised and detribalised Natives whose misfortune it is to live in Model Boroughs which are infested by Health Officers and medicine-men bearing Sir Edward's imprimatur upon their low receding foreheads than there is in the purely Native areas where the only torch of science illuminating the darkness which broods over Africa is carried by practitioners like our client.⁴⁵

⁴⁵ CAD/GES 1785 25/30 G: 26/02/1936.

Of course the letter writer targeted the innate contradictions in Public Health policy with great accuracy, as the Johannesburg material in the previous chapter has detailed.

The aspirations, successes and ambitions of Louisa Mvemve as a herbalist and chemist belied the simple categorisations that were asserted in her life time. Thus when Louisa Mvemve applied in writing for the first time for a licence to practice a herbalist, legislation already existed to forestall her. However, built into her request was the option of "selling through others", and so it is possible that she had already done some informal investigating before she petitioned the NAD and Lord Buxton. After asking to be "granted the might of a medical man to examine the people who wants to be cured", she continued:

There is a large number of Europeans and Natives who have approached me asking me to give them my Herb Mixture for cures of Cancer, Leprosy, Rheumatism, Paralytic, Sterile As I know where the roots and herbs are obtainable in the District. ... P.S I enclose the addresses of chemists which I am about to supply with the Herbal Mixture to avoid crush because the people they all rush to where they hear of me. LM⁴⁶

After receiving no substantial help from the Governor General, Louisa Mvemve went to interview the NAD about the matter in Pretoria, in April of the following year, after she moved back up to the Reef. Her first written communication to the Secretary for NAD, on April 15 1915, referred to this meeting (which took place the same day), passed on the name of her "reference", Dr Kerr Muir, and included an 8-page booklet on her herbal remedies, as well as three letters of testimony from satisfied patients.⁴⁷ Her booklet,

⁴⁶ CAD/GG 1109 48/504: 13/4/1914.

⁴⁷ CAD/NTS 3901 3/376 Part I 1915: Title of Louisa Mvemve's 9 page pamphlet, "A

entitled "A Woman's Advice: A Woman's Advice to the Public on the Cure of Various Diseases" included detailed descriptions of how to take her Herbal Mixtures, how and when to bathe and eat and sleep, and how to bandage wounds and apply compresses. In this way it predated First-Aid manuals and booklets which the Department of Health and the Red Cross brought out a decade later. The booklet is interesting for a variety of perspectives: it reads as a morality tale and rings with the style of biblical stories prepared for children. There are also suggestions of the influences of simple adventure novellas. Despite being set and printed in a rather conventional manner, the expression and punctuation are idiosyncratic. Unfortunately there is no indication of who helped with its preparation or execution.

But the most important section of the pamphlet, with its own separate title, focused on conception and birthing advice for women. Entitled "The 'Little Woman's Advice", Louisa offered help to "the woman who wants children". After describing the herbal remedy and how to take it and ways to comport oneself during pregnancy in order "to ensure safe passage of the child", she continues in a vein both designed to give weight to the veracity of the cure, and to personalize and humanize the "advice":

It seems quite hard to believe what I shall now tell you, but it is quite true: When my mother got married to my father she only had two children, after which she had several miscarriages. She didn't know what to do, and tried all sorts of remedies without effect. Then my father said, "If you cannot carry a child until the proper time come you will have to go back to your father, it is not you that I want, but a family." She was then bearing another child. She then went back to her father and told him what my father had said, then my grandfather said: "I am sorry that you

Woman's Advice to the Public on the Cure of Various Diseases".

didn't send for me when you first felt the pains, I would have helped you to stop the child from coming too soon; come, and I will show you something that will prevent the child from coming too soon." When they came to the forest he showed her the root and said "Take this root when you get home and boil it, and then take the bark away from the roots, twist it into a rope, make a knot in the middle of the rope, and put it around your hips; that will stop the child from coming too soon, but always drink the water in which you boil the root" She did as he told her and the pain went away. Then she said, "What am I to do now Father?" He said: "Go back to your husband and keep on drinking the herb and wear the rope around your hips and the child won't be born until the proper time, and then you will have a fine, strong child." She didn't have any more miscarriages; the treatment stopped the trouble; the child came duly, covered with a skin (caul) and so she sent for her father and said I didn't have the child. Then her father said the child was only covered with a skin and prophesied that she would be a wise and strong child, and would know all his secrets. Then he said to his daughter: "You will always have children now and no more miscarriages". And his words were true; I am that child and I am here to-day, alive, well, and strong⁴⁸.

Recent research conducted into the power and resonance of eastern Cape oral and narrative traditions, has suggested that women played a crucial role as local experts in the fields of medical and historical knowledge. In a collection of oral texts, recorded in the late 1960s, Harold Scheub translated from Xhosa into English a series of interlaced narratives told and performed by an elderly woman from the Transkei region of the eastern Cape, Nongenile Zenani, who was probably born in the last years of the nineteenth century.⁴⁹ Considered a particularly talented explicator of *intsomi*, a repertory of local

⁴⁸ It should be clear to the reader at this point that this paper is not an attempt to substantiate Louisa Mvemve's powers as a herbalist, or to call Western biomedicine into question. CAD/NTS 9301 3/376 Part I: 15/4/1915. I have attempted to track-down some of the more common cures she described, and have found this one mentioned in J. M. Watt and M. Breyer-Brandwijk's study, The Medicinal and Poisonous Plants of Southern Africa (Edinburgh: E. and S. Livingstone, 1932), created from the *Agapanthus Umbellatus* plant. It would seem from Watt and from the testimony of Frank Brownlee, Magistrate of Butterworth, that this pregnancy-aid was widely used across the Transkei and Eastern Cape. See also CAD/NTS 27/400 7750.

historical narratives, mythical tales and motifs and stories, Nongenile Zenanai's renditions and enactments of gestation, birthing and death stories, and her specialists knowledge as a herbalist and healer, provide an interesting parallel to Louisa Mvemve's narratives in her pamphlet from 1915. The descriptions of herbal fluid medications and tied waist ropes in Louisa's story, are mirrored in uncanny ways in the conception and pregnancy tales of Nongenile Zenani fifty years later. Interviews of present day herbalists and midwives in the Transkei region suggest that a corpus of knowledge and practice around pregnancy and birth survives into the 1990s. As with the additions and developments initiated by Louisa Mvemve in the early decades of the century, practitioners in the last decades of the twentieth century have welded together techniques, recipes and exegeses from a variety of local sources as well as experiences of hospital and clinic care, school teachings and Christian cosmology into their own corpus of knowledge.⁵⁰

In 1915, when Barrett the Secretary of the NAD received the copies of Louisa Mvemve's pamphlet, envelopes with her bread powders and copies of testimonials from her patients, along with her application to practice as a herbalist and "women's healer", he

⁴⁹ H. Scheub, The World and the Word: Tales and Observations from the Xhosa Oral Tradition: Nongenile Masithathu Zenani (Madison: University of Wisconsin Press, 1992).

⁵⁰ A detailed examination of the legacy of nineteenth and early twentieth century medical practices in the late twentieth century, and the transmission of knowledge and skill on the part of younger chosen specialists, awaits further research. I intend to make some of these questions the basis of a future research project. Interview: Mamtolo Dubazana, Isiyaya, 22 August 1992. My thanks to Nokhatazeka Mzayifani for her assistance in translating during this interview and to Nontobeko Lugqola for producing the translated transcript of the interview.

was evidently impressed with the plethora of materials before him, as well as with the presence of Louisa herself. She had by this time established some connections in the eastern part of the city, particularly Benoni and Brakpan, which were increasingly connected to the urban centre by railway lines. As soon as he received her initial materials from Benoni, Barrett wrote off to her "reference", Dr Kerr Muir:

I have been approached by a Native woman, Louisa Mvemve, who has, or claims to have, a knowledge of a number of herbs possessing healing properties. The list of diseases she claims to cure is so formidable as to almost take one's breath away but the woman's manner and appearance, and her anxiety to submit her cures to analysis seem to remove her very far from the impostor class. She evidently has faith in the efficacy of some of her remedies as do also a number of others, both European and Native, whose letters she is able to produce. You are aware of the difficulties in the way of according any measure of recognition or assistance to persons of this class and I should be much obliged if you would favour me with any information in your possession regarding this woman.⁵¹

Kerr Muir's reply began by describing his and his wife's relationship with Louisa's, indicating that she had worked for them intermittently in about 1905 and 1906. This evidence suggests the possibility that she could have learnt certain medical terminology, and common practices, such as the manner of dealing with patients common to a western trained physician, the names and diagnosis of certain ailments and the conventions of dealing with and ordering from chemists through her connection to this physician and his family. His letter also revealed his anxiety that he should not be seen to be agreeing to Louisa Mvemve's scheme to involve him in the examination of her patients. In fact it

⁵¹ CAD/NTS 9301 3/376: 20/4/1915.

would seem that in the early 1920s he did see a number of her patients, although on what terms it is not clear. He commented:

Recently she turned up at my house with a proposal that I should see her patients and merely diagnose their diseases. I was to get £1 per patient and she calculated that there would be about 30 per day. So she obviously has a good practice. Of course I refused to have anything to do with the matter. My wife however advised her to see someone in authority in the Native Affairs Department. ... My opinion about this woman is that she is a very able person and has evidently faith in the efficacy of her remedies. I believe that in some cases she does good to her patients; in many cases of course she can do no possible good. I am aware that the Medical Council is averse from allowing unqualified persons to practice, but I have for long been of the opinion that natives should be allowed to consult natives, in whom they may have faith, although such may not be qualified legally. Often all-faith in one's medical advisor is a powerful factor in effecting a cure.⁵²

In some ways Kerr Muir evinced a position that was open-minded for his day, even suggesting that many cures were aided by faith. He also described Louisa's work using medical terminology, rather than the language of "quackery". In one respect he followed a well-worn script: he believed her activities were acceptable, if she practised "among natives". A great fear of doctors in Natal and along the Reef in particular at the time, was that their own coffers were being reduced by the energetic activities of "armies of herbalists". Many of the more progressive supporters of the Natal Native Code's licensing provisions, argued their case on the basis of native custom and faith, but nowhere have I found recognition amongst the medical fraternity of the fact that white South Africans, both in rural dorps and trading-posts, and in the cities along the coast and on the Reef, visited herbalists, and believed there was efficacy to their cures.⁵³

⁵² CAD/NTS 9301 3/376 25/5/1915.

⁵³ This is well documented in works such as E. Hellman, Rooiyard: A Sociological

Following these communications, Barrett set into motion a series of enquiries and elicited recommendations on Louisa Mvemve's behalf, from the Commissioner of Patents, attached to the Office of the Attorney General. He also obtained advice for Louisa from the patent company of D. M. Kirsch, and put her into contact with their agents. After months of discussing legal options back-and-forth, Louisa decided to patent certain of her remedies, (at some expense and inconvenience, as she had to repeat the process in each province) and to take out a patent on her "Trade Mark", which she decided within days, would be a Tiger's Head. This was despite the fact, (which she found out to her dismay) that far from "securing" her secrets, the patenting process demanded that she reveal the exact ingredients of her remedies, and thus although she protected her own packages and bottles from being copied, and although she could begin a vigorous advertising campaign and win customers and patients to on the basis of her trademarked "Tiger's Head" cures, she could not prevent others from attempting the same process.⁵⁴ Neither could she ensure that people paid her for her services and advice. After writing to Barrett at the end of 1915 about her success in obtaining the services of a chemist, through the help of Kerr Muir, Louisa asked if the NAD could help her to recoup moneys owed to her by "800 natives including native ministers". Barrett replied, with a barely concealed warning about her even reporting such "debts":

Study of an Urban Native Slumyard (Cape Town: Oxford Univeristy Press, 1948); R. Phillips, The Bantu In the City (London: Oxford University Press, 1938) and L. Longmore, The Dispossessed (London: Jonathan Cape, 1959).

⁵⁴ CAD/NTS 9301 3/376: letters between 15/4/1915 and 17/9/1915.

I fear that I cannot advise you in regard to the recovery of debts which you state are owing to you. For any other than a registered medical practitioner to undertake the cure of diseases for remuneration would constitute a contravention of the Medical, Dental and Pharmacy Ordinance of 1904, nor would a binding contract result.⁵⁵

But Louisa Mvemve could not contain her activities to the realm of supplying chemists with herbs. Despite warnings and harassment and three major court cases, as well as many instances of civil litigation, she never gave up her "calling" to minister to her patients, to offer her advice, and to diagnose, however much she attempted to cover her tracks with the use of Chemist shops and helpful doctors. From the late teens to the late 1920s, testimonials from women in particular to the NAD and to Louisa, who then sent them onto the NAD, offer thanks for help with difficult births, a child with polio, a sickly child, a child who would not eat. Photographs of toddlers, with grateful notes attached, containing questions about new problems and ailments, testify to the Louisa's continuing, if increasingly fragile, practice.⁵⁶

On the 17 January 1916 calamity struck Louisa's medical practice. A Greek man died whilst in her care, and within a few days, a charge of culpable homicide was brought against her.⁵⁷ Before ten days had passed however, she had marshalled all the support

⁵⁵ CAD/NTS 9303 3/376 4/12/15 and 8/12/15 respectively.

⁵⁶ CAD/NTS 9301 3/376: letters between 15/4/1915 and 17/9/27.

⁵⁷ There are some telling and rich passages in her written testimony to NAD and the Governor General concerning this case. She was represented at her best by her interlocutors, and when she appeared in court she evidently impresses reporters from the Star and Rand Daily Mail with her command of English and her unusual and powerful responses to cross-questioning. See the letters, court records, telegrams, police reports and testimonials in CAD/NTS 9301 3/376 January 27 1916-June 1916; CAD/GG 919/01

structures at her disposal calling for evidence, backing and help from friends around the country, especially in Grahamstown, where she first developed her healing reputation. From these friends she received dozens of letters of support, including a petition signed by more than thirty people from town, men and women, black and white. She sent detailed letters to the Governor General and the NAD, setting-out her own case in a compelling manner, and she received a sympathetic hearing from Barrett and his officials. According to her evidence (which, in terms of these details was not disputed in court), a Greek man suffering from advanced stages of syphilis had approached her for help and relief from pain in the early days of January 1916. Louisa rented rooms from a boarding house on the edge of town, and when the man appeared at her "rooms" on the weekend of the 16th, she arranged for him to take the room adjacent to hers, and set about overseeing his food intake, and instructing him in the administration of her famous Bread Powder remedy. It would seem that she was already in contravention of certain Ordinances, as she clearly was an active "practitioner" during these sessions with the man. Nevertheless, her quick thinking before and after the man's death saved her from conviction. An hour before his demise she called upon the man's regular doctor in Brakpan, going to some lengths to get his name and number through the dying man's friends in the town. Upon his death, she immediately contacted the chemist who had supplied him with the Bread Powder,

summonsed his doctor once again on the landlady's phone, and his friends, as well as the Police Surgeon of Benoni.

One of the first people on the scene was a certain Detective Murphy, who immediately expressed his antagonism for Louisa, telling her that he had been following her around for some time already, and that he would see to it that she was locked behind bars. Wary of his actions, she retrieved the bucket of waste which the dead man had earlier discharged, and which Murphy had tossed away as he went through her things and rooms, and she took care to find out if a proper post-mortem had been conducted on his corpse. Before the first hearing of the case, she had already set out these basic facts to several officials, and had written to the Governor General, calling for a proper post-mortem to be conducted, a plea which was fulfilled when the Attorney General's office prompted a fair examination of the corpse. She also followed the examination of her Bread Power and medicine bottles very carefully, and felt vindicated when the poisons experts for the state could find nothing more harmful than vegetable compounds and emetics in her remedies. The case was reported with excitement by the Rand Daily Mail:

SENSATION AT BENONI: GREEKS'S MYSTERIOUS DEATH: REMARKABLE STORY OF BLACK HERBALIST: The finding of the dead body of a man in a room near the Benoni Hotel this afternoon has led to the unravelling of a remarkable story of a native woman "herbalist", her practices, and her patients. .../... Enquiries made by a "Mail" representative reveal the astounding fact that Louisa had an extensive practice as a herbalist, even amongst white people, the business being sufficiently lucrative for her to advertise and distribute handbills extensively. She is one of the best known characters in Benoni, having been in the district for something like ten years, her patients being drawn from all classes of the community.³⁸

After weeks of delay, secured by the Prosecution, the Attorney General withdrew the charge of Culpable Homicide, and instead Louisa was fined £35 on a charge of contravening the 1914 and 1915 Medical Ordinances. It seems that she was convincing in her testifying: "I was trying to do some kindness to this dead man, but unfortunately he died in my hands", and the fact that she claimed to have "cured nearly all the Greeks in Benoni of this very same complaint", probably helped to explain the dearth of people who came forward to testify against her.

But another test of her capabilities awaited her. Hours after her first case had begun, Detective Murphy arrested her, and nine others who were in her Benoni rooms, namely "visitors asking about her herbs" and her "servants", (including a messenger). He did so under a Trespass Clause in the Gold Law, whereby "natives" were not allowed access to certain sections of Mine-owned property. After coming-up with bail for this large company, and having spent another night, in what she described as a foul and dank jail,⁵⁸ Louisa managed to obtain the services of an Attorney, who in turn persuaded a member of the Mine Commission willing to testify that the rooms she occupied actually fell just outside of Mine property, (after parts of it had been sold-off to the Municipality),

⁵⁸ Rand Daily Mail, January 17 1916.

⁵⁹ She did not lose the chance to report the filthy conditions of her cell, and caused, unknown to her, as flurry of letters between the Commissioner of the South African Police and the Secretary of Justice, on the subject of white-washing versus tarring walls, the conditions of cell blankets and the disposal of human waste from the Benoni jail.
CAD/JUS 231 01 3/98/16/1: 18/2/1916 and 20/2/1916.

and so her bail was returned to her and she was vindicated once again. After all, as she communicated to both Lord Buxton and Barrett in the NAD,

It is necessary for me to reside at my present residence so as to be able to manufacture my Herbal Remedies in the building a few yards away from my residence, also to interview intending patients both Europeans and Natives. It is quite impossible for me to do so at the Location. As I am a Public Benefactor by curing so many people, I consider that I should be exempted from the law compelling natives and coloured people to reside in the locations who are not BONA FIDE servants of Europeans.⁶⁰

Even in the mist of a murder trial, she maintained her confidence, and demanded recognition. Her faith in the remedies of litigation and the "justice" obtainable through law was perhaps born in these two cases, and throughout the 1920s, she brought civil suits against her debtors, principally chemists, winning many of them, though at great cost. She seemed to grow wary of certain Magistracies, keeping her distance after losing petitions for licences. In July 1920 she wrote to Lord Buxton:

I found out the Law of Kingwilliamstown is not for Natives as I am a Native Woman nothing could be done for me.⁶¹

And in the same letter, complaining about the unscrupulousness of the lawyer she had hired, who had demanded a £40 deposit before he would take-up he Appeal, she commented;

This reminds me of slaving time, which our Queen Victoria done away with if a Native Woman or Native Boy, if they were put on the market to be sold, they had no one to stop, til our Queen Victoria stopped it.

These set-backs and disappointments were matched by successes, and Louisa continued to chart them, by sending copies of testimony and letters of thanks to the new

⁶⁰ CAD/NTS 9301 3/376: 23/2/1916, 2.

⁶¹ CAD/NTS 9301 3/376: 8/7/1920.

set of officials who took-up their places in the offices of the NAD. However two Legislative turning points in the 1920s, irrevocably altered the terms under which she could manoeuvre. The passage of the 1923 Urban Areas Act, and the 1928 Medical, Dental and Pharmacy Act. The passage of the former Act resulted in her eventual expulsion from Brakpan, and indeed the Reef, and the consequences of the latter, especially the new clauses restricting the work of uncertified midwives as well as reinforcing prohibitions on herbalists, resulted in Louisa Mvemve retreating to a severely circumscribed practice in Grahamstown.

After a period in the Eastern Cape in the 1920s, Louisa re-established herself rapidly on a farm in Hastings Road, Brakpan, where within a short time she had cultivated a large herbarium, sought-out by such "experts" in Pharmacology as Professor Watt from the University of the Witwatersrand. Her success and her notoriety were directly related to the actions she faced in her battle for legitimacy. She could not remain unnoticed in the white designated areas of Hastings Road for long. The passage of the 1923 Urban Areas Acts and its attendant amendments, did not translate immediately into action by Municipal authorities, as writers such as Eales and Bonner have demonstrated.⁶² But by the early 1930s, local governments such as Benoni and Brakpan, had begun a process of devising tighter pass controls, influx measures and permit systems to regulate their black

⁶² K. Eales, "Patriarchs, Passes and Privilege: Johannesburg's African Middle Classes and the Question of Night Passes for African Women, 1920-1931"; and P. Bonner, "'Desirable or Undesirable Basotho Women?' Liquor, Prostitution and the migration of Basotho women to the Rand, 1920-1945".

townships, enforce segregation more fully, and control access to housing and employment.⁶³

After a series of complaints by members of the Public, and reports by the Chief Sanitary Inspector of Brakpan, Louisa was ordered to quit her rented property, and abandon her famous herb garden.⁶⁴ Interventions for a "stay of time" from the NAD, who again, ironically, received her case with some sympathy, were to little avail. Served with her Quit orders by Chief Inspector Botha in January of 1930, she eventually left Brakpan in late April or May of that year. For the last few months she had to ride into and out of the town daily, sleeping in Johannesburg, where she found a place in Jeppe, two blocks from the Fairview property of the Helping Hand Club for Native Women.⁶⁵ She had to retain her Rail Warrants as proof that she had not slept the night in the town she had called her home off-and-in for six years. In a series of erudite letters, she appealed to the Governor General once again, reminding him of all she had done for his Office; she called on Prime Minister Hertzog, informing him of her cures for Dutch people, and her ability to

⁶³ J. Cohen, "A Pledge for better times: the local state and the ghetto, Benoni, 1930-1938" Honours diss., University of the Witwatersrand, (1982); and H. Sappire, "African Urbanisation and Struggles against Municipal Control in Brakpan, 1920-1958", PhD. diss., University of the Witwatersrand, 1989.

⁶⁴ This paragraph is taken from evidence in CAD/NTS 9301 3/376 from the 8/1/1930 to the 26/4/1930.

⁶⁵ This hostel for black city women was started in 1919 by the same women philanthropists who opened the Bridgman Memorial Hospital in 1928. See chapter six.

speak Afrikaans and of the justice in her claims for fair treatment after paying licences and taxes for nearly twenty years. She appealed to Hertzog:

... I could not be ordered to leave the town as I had business, unlike other natives ... I have lived in Towns all my life and never in a Location. When I was ordered to go and live in the Location I was surprised. I lost no time. I called on the Authorities and protested, but I was told that it is Segregation Law that is driving me to the Location... I held some rights long before the birth of the Native Urban Areas Act of 1923.⁶⁶

Within months of her departure from the Rand, she faced legal action again. The 1928 Act was being more forcibly applied, and her work had reached the ears of Authorities, even in Cape Town. In early 1928 Louisa, now back in Grahamstown, again applied to the Governor General for a licence to sell medicine, this time in the Transkeian Territories. She stated that her requests had been poorly received by the Chief Magistrate at Umtata, and she requested the Governor's intervention, to which she merely received an acknowledgement letter.⁶⁷ Clearly agitated by her treatment, she approached the Magistrate of Butterworth, who received her "in a civil way". Her long-standing Eastern Cape Chemist partner, Mr Carnegie apparently warned her that the reason behind the rudeness of the Umtata Chief Magistrate, was that:

... he must have mistook me for an American woman, the Magistrate in Umtata. As there was little trouble here before with the natives, trying to form colleges, saying they are instructed by Americas. Well, I am not in with those natives doing that although they are my nation. As I was born under the British Flag, I don't remember nothing, what the America did for them. So I do not want to be included with any of those people what are working against the law...⁶⁸

⁶⁶ CAD/NTS 9301 3/376: 15/1/1930.

⁶⁷ CAD/GG 207 3/4864: 21/06/1928.

⁶⁸ CAD/GG 207 3/4864: 17/07/1928.

Both Louisa Mvemve's concern to present herself as a loyal subject, and her references to rumours of American "influences", point to the history of prophetic "israelite" and Separatist Africanist movements in the Eastern Cape, chiefly signalled in the existing and growing historiography on the subject, by the figure of Wellington Buthelezi.⁶⁹ They uncannily prefigure another series of "American involvements", in the form of the American women such as Clara Bridgman and Ruth Cowies, who at this very same time, were raising funds for the Bridgman Memorial Hospital. We have seen how under threat from Urban Areas Legislation Louisa was forced to move out of Johannesburg, and that the passage of the 1928 Medical Act curbed her enterprises even more severely. Perhaps the fears of Magistrates in the Eastern Cape, of a ground-swell of radical activities on the part of rural poor and working people, soured their views on extending patronage and courtesy to an unusual, and thus potentially troublesome, if not dangerous, black woman.

The final evidence we have of Louisa Mvemve's activities returns us to the definition of the Medical Act itself. Almost as a test case, in January 1931, in Grahamstown, Louisa was arrested on a more serious charge under the Act for "practising" unlawfully as a doctor, for gain. On this occasion she was charged with acting

⁶⁹ Some of the best writing on this subject includes: W. Beinart and C. Bundy, Hidden Struggles in Rural South Africa: Politics and Popular Movements in the Transkei and Eastern Cape, 1890--1930 (Johannesburg: Ravan Press, 1987); R. Edgar, "The Prophet Motive: Enoch Mgijima, the Israelites and the Background to the Bulhoek Massacre" Journal of Southern African Studies 15:3 (1982); H. Bradford, A Taste of Freedom: The ICU in Rural South Africa, 1924--1930 (New Haven: Yale University Press, 1987); B. Sundkler, Bantu Prophets in South Africa, (London: Oxford University Press, 1961).

beyond the bounds the law allowed for a limited number of registered, but not certified, midwives. Using the new clauses on Nurses and Trained Midwives in the 1928 Act, the prosecutor presented evidence of her guilt in the form of a douche-bag, two sets of rubber gloves and large syringes. These implements of the "Certified Midwife's trade" were laid before the court, and witnesses were assembled to swear that she had diagnosed pregnancy, inserted her gloved hand into the vagina of a woman in birth labor, and used the syringe to draw off fluid after the birth. She was not charged with gross negligence or with harming her patients, and indeed the procedures she seems to have followed (such as the use of antiseptics and gloved hands), met the standards of midwifery practice at the time.

Incredibly, given the armoury of new legislation, and the presence of physicians (no doubt anxious to protect their turf) in the court house, she was again acquitted. The presiding Magistrate found that the Act did not specify tightly enough the definition for "practising" as it related to the activities of a registered doctor or midwife, and found that there was some doubt as to whether Louisa had actually received payment for her services to a woman at the centre of the State's case. Central to the vulnerability of the State's prosecution was the tenuous definition of the "ills" of women, and of the intimate "nursing" required for terminal cases. Was Louisa merely acting as a "good Samaritan", holding herself to higher ethical standards than the physician who had "abandoned" his patient? Was the patient so ill anyway, that the little Louisa did, merely made the

terminally-ill woman more comfortable? Louisa Mvemve used her status as a mother herself in her defence, urging that this be taken into account in her care for "this tragic case of the intractable cancer" of a fellow mother with seven children. The patient in question, a Mrs Khol, was dying of womb cancer, a case abandoned by the local medical fraternity, and these circumstances contributed to the Magistrate's uneasiness with the definition of "practice" and home nursing as described in the Act. Louisa described her treatments and the circumstances of her case to the Governor General in a January 30 1931 letter:

A Mrs Khol suffers from cancer, when she came to me she had been in Hospital and was operated upon. I asked her whether she had a Doctor attending her and she said no. The Doctor told her to go home and comfort herself with her children. I asked her if she had anyone who cleaned and washed her wound and she said no, she had no one to help her. I told her I must get a permission from the Doctors who operated on her, Dr. Drury and Dr. Mullins before I can do anything for you and if they refuse then I can not do anything. I saw Dr. Mullins and he told me she had cancer and the womb was taken away. I asked him whether I could give her any herbs to clean her. He gave me permission to do so and told me not to incur any expense as she was dying within a month's time. ...I told him I don't want to be blamed if she dies, and he said I would not be blamed. He told me to get a small syringe to clean her with... I gave her treatment up to the time I was arrested. I reported her case to Dr Mitchell Health Department Pretoria. I said in that letter she needs help also a Doctor to watch the case she is a mother of seven children. She got no Doctor to watch her case, and no one to help keep her clean. I did it for her. She has lost the severe pain also the bad smell. Now she is neglected, for I am not allowed to go near her. I have taken no payment from her. I am out on bail, and my case is coming on 2nd February. The reply from Dr. Mitchell was that I must not treat cancer, as I am not a qualified Doctor. In my trade mark it states that I have a right to sell my herbs. In my trade mark it does not mention that I must cure this and not that. I could not see this woman suffering when I knew I could help her...⁷⁰

After several weeks of deliberation, Louisa Mvemve was found "not guilty" once again.⁷¹

Louisa Mvemve's story, briefly sketched in these pages, is a powerful and often ambiguous one. As an aspirant petty-bourgeois woman, she often repudiated her connections to other people of colour, by distancing herself from them in her determination to be respected and sought after. On the other hand, her ambitions did not blind her to the plight of poor black women and men, or to that of working class whites in Reef towns in the 1920s, as well as in the rural hamlets and towns throughout the Eastern Cape and Transkei. Against all odds she developed and maintained relationships with, amongst others, the Thimbler family of Grahamstown, the Kerr Muir family of Brakpan, as well as her extensive networks of black men and women supporters throughout South Africa, and beyond, (for example, Chief David Molapo of Lesotho). She laid bridges between herself and working class white women and men, that went beyond attempts at snobbish social climbing. She charged high prices for her remedies, but often gave free advice, and supplied herbs without hope of repayment, to people in whom she took an interest. In her work as a midwife in Johannesburg and the East Rand towns she provided a service and a level of expertise not easily available to any women of colour. She was not, unlike the black women who would train at the Bridgman Memorial Hospital after 1928, a high-school educated woman. Indeed she had worked as a domestic servant in her youth and early adulthood. However she aspired to the gentility of a Victorian woman in her

⁷¹ CAD/NTS 9301 3/376: 27/1/1931 and CAD/JUS 576 01 418/31: 8/12/1930 to 9/7/1931.

self-representation. Her humour, tenacity and confidence remain the most compelling aspects of her remarkable record, and these qualities animate our understanding of debates around medicine and healing, literacy and authority, the impact of segregation, and the day-to-day difficulties of an ambitious and talented black woman healer, gynaecologist and midwife.

Chapter Four

Mapping Maternal Health in the 1930s: The Rural and Urban Contexts of the Bridgman Memorial Hospital

The Bridgman Memorial Hospital, opened to great fanfare in 1928, was located on the western edge of the city, adjacent to working class white suburbs such as Melville, Brixton and Westdene, as well as mixed communities in Fordsburg, Vrededorp, and the Western Areas townships of Martindale, Newclare and Sophiatown.¹ Throughout its existence, the Bridgman's closest affiliation was to the freehold community of Sophiatown, a tram ride of less than two miles distance. Famous for its eclectic mix of writers and artists, traders, landlords, shop keepers, musical hall owners and funeral directors who hailed from rural parts of Southern Africa, Eastern Europe, India, China and Portugal, Sophiatown was also the site of a working class community increasingly made up of women domestic and laundry workers, beer brewers and small scale garment makers and hawkers.² Sophiatown was the home of a growing black petite bourgeois class of

¹ The shifting boundaries of class and colour on the western edge of Johannesburg, in Vrededorp, Fordsburg, and Western Areas before World War II are poetically narrated in the autobiography of Peter Abrahams, Tell Freedom (London: Faber and Faber, 1981). He introduces his readers to the city squares and terminuses, where domestic workers (male and female), mine labourers, street-smart teenagers, gangsters, traders, music makers and respectable matrons and professional men, met at dusk on weekends.

² Evocative descriptions of Sophiatown and the vibrancy as well as poverty of daily life for most of its residents can be found in D. Mattera, Sophiatown: Coming of Age in South Africa (Boston: Beacon Press, 1989) and T. Huddleston, Naught For Your Comfort (London: Collins, 1965). For a comprehensive historical overview of

clerical workers and entrepreneurs and the centre of South Africa's professional elite of men and women of colour, teachers, lawyers, nurses, and a few physicians, such as the Xuma, Sita and Rathebe and Mattera families. Lodge, Proctor and Magubane, amongst others, have analysed the political affiliations and class ambitions of these salaried and professional black men and women, arguing that until the late 1940s, possibilities for accumulation on the part of richer black Johannesburg residents were to some degree accommodated within the boundaries of Sophiatown.³ Their work has also demonstrated that the radical political movements, campaigns and boycotts which exploded into life in the 1940s and 1950s, were supported and led by many among these same "notables", as well as by the backyard residents, laundries, piece workers and wage earners of

Sophiatown:

Certainly, intellectuals and small scale entrepreneurs in the African community may have had petty-bourgeois aspirations, but there is evidence in their literary culture, in their welfare activities, and in their political commitment of a degree of social compassion and a depth of anger that went beyond their immediate class interests.⁴

Across the city, on its north eastern edge, another spatially confined and increasingly vulnerable freehold community, Alexandra Township, or "Alex", became a magnet for newly arrived city dwellers after the 1920s. In Alex and Sophiatown, black men and

Sophiatown, see A. Proctor, "Class struggle, segregation and the city: a history of Sophiatown, 1905-1940" in B. Bozzoli, (ed) Labour, Townships and Protest (Johannesburg: Ravan Press, 1979). For a history of the political opposition which developed in Sophiatown around the apex of the anti-removals campaigns, see T. Lodge, "The Destruction of Sophiatown" in Black Politics in South Africa since 1945 (Johannesburg: Ravan Press, 1983).

³ See Ben Magubane's "Introduction", in D. Mattera, Sophiatown.

⁴ T. Lodge, "The Destruction of Sophiatown" 92-93.

women had succeeded in purchasing land and property before the passage of the 1923 Urban Areas Act with its prohibitions on the property rights of Africans. White residents in suburbs adjacent to both Alex and Sophiatown in the 1930s opposed the presence of these high density, overwhelmingly poor and mainly black communities, but:

Such opposition, strongly expressed at the municipal level, was unable to outweigh emergent industrial interests, reluctant to subsidise working class housing and unwilling therefore to support any municipal attempts to assume responsibility for African housing.⁵

Instead, after Johannesburg was "proclaimed" under the Urban Areas Act in 1933, (which gave the city powers to segregate residential areas, and relocate black communities outside of areas proclaimed 'white'), the townships making up Western Areas, including Sophiatown, (excluded from the areas proclaimed under the Act), and Alexandra Township, (which had never been incorporated into the city boundaries), were inundated with in-migrations of new residents. Densely settled pockets of the city, such as the many-roomed "slumyards" of Doornfontein, were the first targets of "removal" under the 1933 Proclamations.⁶ The city had also been obliged by the Act to set up new townships, but the new housing was totally inadequate for the people already earmarked for "removal" by the city, and many more people from farming towns and rural areas congregated in Johannesburg after 1930. Thus, many thousands of Africans were unable to secure rented municipal accommodation in the new Western Native Township, and the

⁵ T. Lodge, "The Destruction of Sophiatown" 93.

⁶ The term used to describe the crowded plots of land, with makeshift sub-divided buildings and lean-to structures around common taps and latrines, common throughout Johannesburg in the 1920. See the discussion of Hellman's work below.

poorest among these began to erect shanty towns on unused farming land and peri-urban plots adjacent to townships and peri-urban areas.⁷ Many more chose instead to head for the crammed back yards of Sophiatown:

Certainly, measured by such criteria as living space, building regulations, provision of social facilities and so forth, the inhabitants of Western Native Township were better off... But to adopt such a narrow perspective is to miss the crucial characteristic of Sophiatown, Martindale and Newclare. The point is that the Western Areas were not locations, they were suburbs. Admittedly they had many features of the ghetto: poor inhabitants, external ownership of most businesses, little local investment... Unlike locations, these townships were not fenced off, there was no superintendent, nobody had to ask permission to live there.⁸

Emma Mashinini, whose father worked as a dairy worker, and whose mother sewed and sold garments from home, remembered that her parents were forced to leave the declared "white" working class suburb of Rosettenville in the early 1930s, (where they lived in a cottage at the rear of the house owned by a white family), but chose to head for

Sophiatown:

We could have moved to Orlando, which is now part of Soweto, but my parents chose instead to go to Sophiatown, which in those days was a racially mixed area, apart from whites, with many African, Indian, and Chinese families all living harmoniously together. Our home was in Toby street. On the corner of Toby and Edward Street lived a distinguished, Dr Xuma, one time president of the African National Congress, who was married to a black American... Just across a vacant field from us, was the white suburb of Westdene. The field was there to divide us, but black and white children used to meet there regularly and play with one another. It seemed the most natural thing to do.⁹

⁷ For a history of squatter settlements and a settlements leader, see K. French, "James Mpanza and the Sofasonke Party", M.A. diss. University of the Witwatersrand, 1983.

⁸ T. Lodge, "The Destruction of Sophiatown" 95.

⁹ E. Mashinini, Strikes Have Followed Me All My Life (New York: Routledge, 1991) 4.

Not all Sophiatown residents recalled Dr Xuma, or spoke of Sophiatown in the ringing phrases of Mashinini, Mattera, or the historian Ben Magubane, as an "amalgam of ethnic social and cultural groups, a cosmopolitan centre of intellectuals, radical politics, jazz, and gangsters".¹⁰

Rosina Kotane made her way to Sophiatown at the age of sixteen, to live with her Auntie Ruth, a widow who worked in "the kitchens" of surrounding white suburbs. Her memories of life in Sophiatown resonate with comments made in interviews by other elderly women who lived in Sophiatown and laboured as domestic servants in the 1930s and 1940s. Her memories are of long working hours, of scraping together money for basic subsistence, and of the bearing and rearing of her first two children, born at the Bridgman.¹¹ While Rosina Kotane did not recall Dr Xuma, she did remember details about the landlord from whom her aunt rented their accommodation and of her first day-job as a domestic worker:

My Auntie Ruth had a job in the Kitchens ... we stayed together in Sophiatown, and then my brother came to live with us. My Auntie's husband, he had died... we lived all together on Edwards Street, Number 36, Sophiatown. A house with a veranda, and also a house in the back.... Ooh, it was very nice. We just caught a bus to town, and then took a tram. It was very close by town.../...My Auntie rented

¹⁰ B. Magubane, "Introduction" in D. Mattera, Sophiatown xii.

¹¹ For example, the interview with Johanna Masilela, conducted in 1983. Masilela recalled the forced 'removal' from Sophiatown experienced by her family in the late 1950s, but when pressed emphasized the grave inconvenience of the distances she then had to travel to work each day, rather than her anger and sadness at the destruction of the cultural entropot and community life that Mattera recalls so vividly. See J. Cock, and E. Emdon, "'Let me make history please': The Story of Johanna Masilela, Childminder", in B. Bozzoli, (ed) Class, Community and Conflict: South African Perspectives (Johannesburg: Ravan Press, 1987).

from a black man. His name, ahh, something like Shabalala. Our Aunty paid all of our rent. Then I was lucky, friends did help, and I did start the work, in Westdene... The family's name was Roberts. ...They were Afrikaans, and he did some work with the Milk, [the nearby dairy]. They were elderly people... I had to wash the grandchildren's clothes for school each day, because they were not as rich as others, they needed these clothes for the next day. They did not have a car, and their house, it was like the houses in Sophiatown. They paid me money, twelve rand.... I was very rich with that money!¹²

A young single woman at this time, Rosina Kotane spoke of this period as one of relative wealth, with no children or younger siblings to support, and she underscored the proximity of Sophiatown to the city centre, and to her first suburban job. Not only spatial, this proximity was discerned in the design and layout of houses in areas such as Westdene and the more substantial "front yard" houses of Sophiatown, as well as in the distinction between the wealthier white employers she came to know in the northern suburbs of the city, in later years, and the class status of her first permanent employers.

The testimonies of a group of elderly women from the Phokeng area, near present-day Rustenberg, collected in the early 1980s by Mmantho Nkotsoe and woven into a narrative by Belinda Bozzoli, speak of Sophiatown and Alex in the 1930s to 1950s period as places of relative freedom from the constraints of segregated township life. They also draw distinctions between the wealthier, more substantial infrastructure of Sophiatown, with its numerous established churches and schools, and its proximity to the city centre, and the grimy conditions, inadequate transport and road systems, and the

¹² Interview: Rosina Kotane, Johannesburg, 2 November 1992, Transcript, 2-3. The text break: "..." indicates that words have been omitted. The break ".../..." indicates a question was asked by the interviewer in-between one response and the next. Explanatory comments in parenthesis added by author. All interviews were conducted and transcribed by Catherine Burns, unless otherwise stated.

relative isolation of Alex. It is interesting to note that Dr Alfred Xuma, who was so central to the founding of the American Board initiated Clinic at Alex, and a close ally of Ruth Cowles, chose to live in Sophiatown, while commuting to his work as the Medical Officer of Alex, where women such as Letta Mosikatsana worked and lived for over five decades.¹³

As we shall see, the fate of the Bridgman Hospital was inextricably connected to that of the community of Sophiatown, whose forced removal under the Group Areas Act in the late 1950s and early 1960s coincided with the forced closure of the Bridgman itself. A strong tie also bound the Bridgman to Alex: the same missionaries, medics and philanthropists set up a health clinic in the township and sent pregnant women to the Hospital for obstetric and gynaecological care. Perhaps most crucial of all the ties between these two institutions were the three generations of midwives and health visitors trained at the Bridgman, who staffed Alex Clinic into the 1990s.

The dreams of the Bridgman's founders for creating an ordered Christian institution, crafting young women into good mothers and midwives, were partially met. Women coming to the Bridgman for training already possessed certain ideas about service for others, the dignity, status and earning potential of nursing, the importance of doing battle against disease and superstition, and this "bundle of concepts" was reinforced and

¹³ The testimony of the women interviewed for the Bozzoli text, will be referred to again. See B. Bozzoli, with M. Nkotsie Women of Phokeng: Consciousness, Life Strategy, and Migrancy in South Africa, 1900-1983 (Johannesburg: Ravan Press, 1991). See pages 166, 167, 168, 173, 187, 202-3.

elaborated during their years learning the craft of midwifery. While these calls for dignity and sobriety, regulation and Christian morality, and the adherence to scientific management of the body were objectifying, narrow in scope and conservative in many respects, as they would be in other contexts at the same period, these ideologies and practices recognised the capacities and humanity of black women, challenging discourses of racist paternalism increasingly hegemonic among ruling elites of the day. The midwives who imbibed and generated this bundle of concepts recognised the progressive possibilities within them, and witnessed the growing hostility on the part of the white state and many fellow white health workers to their claims for professional and political equality. Letta Mosikatsana was among the first cohort of black women to undertake midwifery training in South Africa. The route she travelled to get to the Bridgman, as well as her life's journey after her period of training, as a midwife and community activist in Alexandra township, marked off key milestones in the social history of women, including the emergence of a new and vital community of black nurses and midwives on the Witwatersrand, and a massive shift in the birthing practices, social networks and daily lives of urban black women.¹⁴

Earlier chapters have pointed to the waves of anxiety among those in the local professional medical community in the early decades of this century. A wellspring for many of these anxieties were fears of contamination on the part of the white elite, through

¹⁴ We return to a discussion of Letta Mosikatsana's life history later in this chapter and in chapter six.

diseases borne by the bodies of the poor, increasingly black poor, of cities such as Johannesburg. After 1910, new sets anxieties were fanned by compelling, if scattered, evidence of high infantile mortality, maternal illness and death. Arguments about causes and responsibility, procedures and resources, were enunciated and elaborated in the 1910s and 1920s, with particular view points gradually gaining adherents and coalescing with larger questions, such as the definition of the new "nation state" of the Union of South Africa, questions of citizenship and constitutional rights, and battles over segregation, land and labor. We have seen that the process of defining local and central state policy regarding landless, urban based, poor women, increasingly black women, was hammered out at the very same time that institutions and services designed for monitoring and regulating health were conceived. Indeed, the designs of urban planning and administration were imprinted with schemes and procedures born not only in industrial factories, mining centers, and pass offices, but also through the application of public health acts and local health ordinances by health visitors and inspectors. The 1930s ushered in a new era of racial politics in South Africa. The economic depression, tied as it was to the increasing fragility of rural production for the vast majority of black and white small-scale, sharecropping and peasant farmers, propelled the ideologues of poor white salvation to the forefront of local and national politics. This decade witnessed the attempt to draw iron curtains between the economic and social lives of black and white men and women, curtains fabricated from the creation of welfare institutions for whites, the extension of the

franchise to white women, and the elaboration of legislation controlling the movement and labor of black men and increasingly, black women. At the same time, a growing, but never prevailing discourse, insisted that the connections between the ill health and poverty of black men and women--as in the case of whites--should form the basis for increased state responsibility. These arguments articulated economic, socially pragmatic as well as ethical reasons for state fiscal support of medical and welfare services.

Women were at the centre of the ambitious dream of building the Bridgman. The overwhelming majority of people involved in garnering the resources for the Hospital and its services, in publicising its work, and in defining its projects, were women. Many of these individuals were white missionaries, some of them social activists outside of direct church links, others nurses and medical practitioners. A much smaller group of black women were drawn into the discussion and planning of the institution, but they never held positions of central authority or administrative power. Men, both white men and a small but influential group of black men, were involved as board members, legal and economic advisors and consulting physicians (usually University of the Witwatersrand Medical School staff members).¹⁵

To fully contextualize the work of these groups of people and utilize the archives of the Bridgman, the medical and scientific work of the institution has to be carefully considered. The social history of medicine in South Africa as a whole is a vast and

¹⁵ The University will be referred to by its colloquial name 'Wits' throughout the remainder of this Chapter.

important project, yet only recently has it been defined as a vital topic of research by social historians of the region.¹⁶ The work of Packard on the history of tuberculosis, and the recent work of Marks on the history of health legislation and nursing, has helped to underscore the intimate connections between biomedical knowledge and the political and material context of its production. This chapter suggests that women in Southern Africa have been at the very centre of health and welfare efforts of the part of armies of experts and professionals, and that the health work undertaken at a site such as the Bridgman was shaped very obviously by the agendas of missionary physicians and philanthropists. In retrospect many of the claims of medical and social science articulated in the 1920 to 1960 period, are highly fallible and problematic when scrutinised today, infused as they were by very particular moral visions and social ends, often plainly stated by individuals who employed an objectifying, gendered and often racialized discourse as a matter of course, and who naturalized even relatively novel ideas about black women and their capabilities, through their daily communicative acts. However, this is not to argue that the intentions or the efforts of physicians, nurses, missionaries, welfare workers and anthropologists were unmitigated by genuine empathy and lives of hard labor. Nor were all of their efforts co-ordinated towards one totalizing aim, one colonial/neo-colonial project. Furthermore,

¹⁶ Before the late 1970s two compendium histories of great men and medicine in South Africa, and Charlotte Searle's overview of the history of nursing, were the only substantial works on the subject. Harriet Ngubane's anthropological discussion of what she termed 'Zulu medicine', published in 1977, marked a new moment in contemporary interest in the intersections between precolonial and colonial therapies and healing practices. See H. Ngubane, Body and Mind in Zulu Medicine (Cambridge: Cambridge University Press, 1977).

very often it was the responses of ordinary people, very often women, to the health needs of their communities ravaged by hunger, poor housing and facilities and ill-health, that secured the attention of health and mission officials.¹⁷ Black women's responses to biomedical therapies and technologies were vital to the building and maintenance of medical centers, and many of the struggles and demands of black communities in the early decades of this century and beyond were for available and affordable health care.¹⁸

At the funeral service for Letta Mosikatsana in 1992, held in the main Anglican Church in Alexander Township, the mourners, many of them from families whose children and children's children had been born with the help of Bridgman midwives, memorialized her for her work in words that hearken to the rhetoric articulated by Clara Bridgman and the Christian founders of the Hospital. Letta Mosikatsana was described as an exemplary mother, a woman never "off duty" in her community, as a "missionary for women and

¹⁷ See S. Feerman, "Struggles for Control: The Social Roots of Health and Healing in Modern Africa" African Studies Review 28 2/3 (1985).

¹⁸ See S. Marks, "The Origins of the National Health Services in Britain and South Africa" Towards a National Health Service, Proceedings of the NAMDA Conference: Johannesburg, 1987; "Women's Health in South Africa", Proceedings of Third Workshop of the Project on Poverty, Health and the State in South Africa, Columbia University, 1988, as well as her highly suggestive edited collection Not Either an Experimental Doll: The Separate Worlds of Three South African Women (Indiana: Indiana University Press, 1987); R. Packard, White Plague, Black Labour (Berkeley: University of California Press, 1989); The work of Jean Comaroff on the symbolic power of colonial discourse concerning sexuality, fecundity and disease, has also helped to extend the boundaries of this research, see J. Comaroff, "The Diseased Heart of Africa: Medicine, Colonialism and the Black Body" in M. Lock, and S. Lindenbaum, (eds) Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life (Berkeley: University of California Press, 1993).

children's lives". Sealed into a tape recorder, recorded on a church pamphlet, these words call our attention to the successes and longevity of the hegemonizing project at work in the Christian endeavour of the missionaries throughout the Rand in this century:

Our mother, the late Letta Mosikatsana, has been a true disciple of nursing and midwifery... She was never off duty... She was a missionary for women and children's lives.¹⁹

It is clear that Clara Bridgman and her closest allies would have derived deep satisfaction from knowing that a midwife and mother trained under the auspices of their institution should have lived a life remembered in this way. However, these words were spoken in a time and place and under circumstances far removed from the experiences of either 1930s philanthropists or early 1990s white suburban Christian gatherings. These epitaphs convey the Christian convictions of Letta Mosikatsana and her network of friends, neighbours and fellow midwives, as well as their respect for her biomedical work, her self-discipline, her commitment to the improvement projects initiated by her work at the Alex Clinic and with local women's self-help groups. The spatial and temporal context in which these commendations of a woman's life were voiced, are significant, not only for what they tell us of the missionary project and its legacy. They offer insights into the scale of human effort and determination, and the depth of commitment an individual could invest in fusing her knowledge of inequity, oppression, injustice and human suffering, her empathy with local explanations of ill-health, pain and healing, with the discourses and practices learned

¹⁹ Tribute to Letta Mosikatsana from an Alexandra Clinic Midwife, on the occasion of her funeral; Anglican Church, Alexandra Township, May 2 1992. Notes of Speeches made by C. Burns; Copy of printed Memorial Pamphlet, 3.

in mission schools, scrubbed hospital surrounds, in lecture classes, and at the side of surgeons in theatres of scientific technology and skill.

These eulogies to Letta Mosikatsana were orated within the crumbling plaster walls of the Alex Anglican church, built before World War II, with crannies and gaps wide enough to see through to the outside, where crowds too large to fit inside the church gathered along the path to the dusty street. The high ceilingless roof, made from sheets of bent tin, leaked cool autumn wind, and a nest of loudly cooing pigeons flapped and scratched above the sound of singing and prayer. Two weeks before her death, Letta Mosikatsana was forced to leave her red brick house on 4th Avenue, fleeing the home in which she had lived since taking up her first job after training at the Bridgman.

Widespread violent conflict in Alex, which had started during the 1986 State of Emergency, reached new heights by April of 1992. At the same time the Clinic, which had been a central institution in the region since the 1930s, received a boost of local and international funding after democracy talks began in early 1990, and Letta Mosikatsana had finally been able to retire from full time work, as funding allowed the appointment of new midwives. But in late 1991, a new phase of conflict ripped apart the fragile peace, and sent old time residents fleeing from the areas around the Hostels, where snipers fired in full view of the military forces, at commuters and residents in the oldest and most established areas of the township in range of their guns.²⁰ At first Letta Mosikatsana

²⁰ The war in 1991/2 in Alex was primarily waged between Inkatha Freedom Party supporters, (mainly male migrants from northern Natal and Zululand), dwelling in the large prison-like barracks that bordered the edge of the township, and groups of residents,

refused to move, and in the month before her death, she boarded up her east facing windows, and waited for the Clinic Bus to fetch her when it dared venture into the now deserted streets around her home, so that she could volunteer her time at the Clinic, and receive the medical treatments she too needed. In the Annual Report from that year, the clinic director wrote:

Every report on the Alexandra Health Clinic... has to start with violence. It is the context in which we have been and are all working, and it effects everything we do.... In the midst of all the chaos and violence... women and children streamed into the Health Centre seeking refuge ... and they found peace and order. Throughout this year, quite apart from the hundreds of people who have been shot and assaulted and brought to casualty for treatment, hundreds of others have come for ordinary medical care, or come just to visit or to sit on the grass. All found an air of calm, where they could greet and be greeted, where they could relax and act normally.²¹

(some of them younger in age than the length of time the Zulu speaking 'migrants' had lived in the hostels). But the roots of the conflict traced a line to the uprisings against the State of Emergency and the brutal crackdown on activists and revolutionaries by the South African state in 1986. The stationing of military police and the establishment of an Army encampment in Alex in that year marked the area as a battle site for the next 4 years. The months following Letta Mosikatsana's death, saw even more bloodshed. The Clinic's role as a place of peace was threatened more than once in 1992 when patients and staff came under attack in wards and the large casualty department. In November of that year a truce situation was achieved, and in 1993 the fear and tension diminished, with community groups and non-governmental development organizations returning to reconstruction and new building projects. Since 1994 living conditions and services have improved, and the township's revenue base is now part of the municipal structures of the adjoining wealthy and middle class mainly white suburbs. Sources for this include my notes from January 1992 until November 17th 1992; sixteen interviews I conducted at the Clinic, (which will be referred to later in this chapter) and since 1993, letters from Sister Mirriam Mokoana and articles in The Weekly Mail and Guardian Newspaper.

²¹ Wilson, T and P. Ngakane, "Report", Alexandra Health Centre and University Clinic, 63rd Annual Report (Johannesburg, 1992).

The Report goes on to speak of the courage of the Clinic staff in creating the atmosphere of order, cleanliness and normalized routine, which provided the necessary medical space for physical healing, as well as a site for psychological relief. At Letta Mosikatsana's funeral, prayers were offered for peace and for the progress of democracy talks, but the focus for the day was the value of this woman's life as a midwife and healer.

To grasp the legacy of institutions such as the Bridgman, and kin organizations such as Alex Clinic, a layered understanding of the prejudices, interests and successes of missionaries, administrators and health professionals is required. These in turn must be juxtaposed with the meanings, and often unplanned consequences, that black women wrought from their experiences of the ideologies, skills, social setting and daily work of the institution.

The 1930s: Poor Whites and Public Health

In 1928 the Carnegie Corporation of New York earmarked £2000 for a comprehensive survey into the "causes of European indigency" in South Africa. This donation was made after Carnegie representatives visited South Africa in 1926 and 1927, meeting with state officials and organizations concerned with the impoverishment of rural whites, and their recent migrations into small towns and cities. Anxiety was expressed by both the reporting Carnegie representatives and their contacts in South Africa, that out of a total population of 1.8 million whites, of whom more than half were Afrikaans speaking, at least 300 000 people were paupers, having "sunk" below not only the economic

poverty line, but below the living standard of "more advanced natives".²² The members of the Carnegie Commission began their investigations in the prelude to a period of rural drought, and midway through the project, witnessed the effects of the international and national economic depression on the movement of sharecroppers and small-scale farming people off the land and into cities and agricultural towns across South Africa.²³ Their brief was to focus on poor whites, and the staff of experts they assembled made little comment about the widespread poverty and scarcity among black South Africans, except to underscore the seriousness of white poverty in its comparison to estimated levels of nutrition and wage remuneration in neighbouring black communities. Of particular concern to the investigators were the dangers they perceived in the striking similarity between family patterns, communal arrangements and social behaviour of poor whites and their black neighbours. White women, especially mothers, were targeted as conduits of negative social attributes, which when combined with poverty, led to indigency, sloth and degradation.

So anxious were the Commission investigators to stress this aspect of their inquiry, that they allocated a special team to concentrate on this theme. Under the authorship and guidance of Maria Rothman, the Commission recorded its investigations into maternal

²² J. R. Albertyn, et al The Poor White Problem in South Africa, Report of the Carnegie Commission, Five Volumes (Stellenbosch: Pro Ecclesia, 1932).

²³ A decade after the Commission began its enquiry, E H Cluver, a prominent public health expert in South Africa reflected on its implications for public health and welfare provisioning. See E. H. Cluver, "A Decade of Public Health" The Leech (April 1938).

care, childhood socialization, birth practices, home craft skills and articulated the grave need for mothercraft and domestic training and support, publishing these findings and recommendations in a separate volume of the Report.²⁴ Rothman emphasized the backwardness of poor white women, suggesting that their purportedly weak social abilities as mothers were attributable to their contact with "Coloured and Native" women. She argued that their isolation from white civilization and their poverty prevented them from gaining access to western biomedical services. This was particularly felt, she noted, in birthing labor, where dependence on granny midwives, usually women of colour from surrounding communities, instilled dangerous notions of body management and comportment in the minds of white women, at moments of great susceptibility. Her report includes descriptions of white women giving birth on animal skins spread upon a mud floor, of the newly born infant's umbilical cord remaining untied until the expulsion of the placenta, and the interfering actions of birth assistants motivated by superstition.²⁵ Not mentioned in the report, was the long history of birthing assistance and aid between white and black women in rural communities, particularly Afrikaans speaking communities across the Northern Cape, Orange Free State, and most of the Transvaal. Not only did white women, living on farms far from other white families, receive help and support during their birth labor from black women but the exchange was often mutual. Rosina

²⁴ M. Rothman, "The Mother and Daughter of the Poor Family" in Carnegie Commission.

²⁵ M. Rothman, "The Mother and Daughter of the Poor Family" in Carnegie Commission, See pages 169, 178, 183, and 189.

Kotane recalled that after her own mother died giving birth to her, her paternal grandmother approached a white woman on the nearby farm where Rosina Kotane's uncle worked, a woman with a reputation for helping black women. Klara Hanson gave her grandmother fresh cows milk for Rosina Kotane until she was able to walk, and helped with medical treatment and home remedies as she grew up, so that she developed a long standing relationship with this woman. The longevity of these sorts of gender support networks across colour lines in rural communities in times of childbirth labor, as well as in the healing work of daily communal life, were frequent and persistent and were recorded in autobiographies, diaries and family histories.²⁶ In Johannesburg in the 1920s and 1930s women recognised as "Coloured" seem to have carved out a special role for themselves as birth assistants, many of them having gleaned their experiences of child and infant care, the aetiology of sickness, and knowledge of herbal and patent medicines from their own family specialists, as well as multi-generational connections to white Afrikaans families, often as long term domestic workers.

The phenomenon noted by Rothman and her team was not new. Undoubtedly, poverty, ill-health and a lack of access to the relatively new biomedical technologies,

²⁶ For a detailed section on rural birthing assistance networks, particularly between poor rural white women and black neighbours and servants, and very often women recognised as 'Coloured', based on family histories, see C. Searle, The History of the Development of Nursing in South Africa, 1652 to 1960 (Cape Town: Struik, 1965) and C. F. Krige, To Cure Sometimes: A Doctor's Autobiography (Johannesburg: Da Gama Publishers, 1967). Also see IAD/JPHD 101 548 "Midwives" 1919-1931, 20 January 1926, in which the MOH for Johannesburg speaks about the number of Coloured uncertified midwives in Johannesburg.

available to richer and urban women, undermined the survival of communities, both white and black.²⁷ But, it is possible that the pooling of healing resources and even inadequate midwifery skills, was indicative of resilience rather than ignorance, and certainly not evidence of "recent degeneration". In addition to birthing conditions, the fertility of poor white women was the subject of much anxious discussion. The Commission noted that the white birth rate in South Africa had nearly doubled from 1904 to the early 1930s, and suggested that a large measure of these births were into families and communities ill equipped to bring up healthy, useful citizens.²⁸

Besides the new wage and labor provisions for white men, and the training and educational institutions established for men and women across the country, three major shifts in state policy towards poor and working class whites were made in the wake of the Commission's Report. First, a Department of Social Welfare was established specifically to focus on white educational, schooling and housing needs (although it took until the end of the 1940s for the state to effect the specific exclusions of Africans from its provisions).²⁹

²⁷ By the late 1920s, the major scientific contributions to birthing labor were largely confined to a deeper understanding of antiseptic techniques and their importance, and developments in the field of anaesthesia. See chapter six. For discussions of the history of medicalized birth, see J. Lewis, *The Politics of Motherhood* (London: Croom Helm, 1980); J. Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750-1950* (Oxford: Oxford University Press, 1986); and O. Moscussi, *The Science of Women: Gynaecology and Gender in England, 1800 - 1929* (Cambridge: Cambridge University Press, 1993).

²⁸ Questions of 'race suicide' and the history of contraception are addressed in chapter eight.

²⁹ E. H. Cluver, "A Decade of Public Health", 38. Cluver makes it clear that the creation of the Department of Social Welfare was bitterly contested by officials in the Public Health Department who argued that 'slum clearances', hygiene propaganda work,

Second, the machinery for Maternity Grants for wage earning white women was extended and the rates increased, (and although black women were not completely excluded from the provisions until the 1950s, very few received grants, and then at rates far below those for white women).³⁰ Third, legislation regulating the practice of untrained midwives was further tightened, especially in relation to white women.³¹ Immediate benefits were measured by state officials. In 1938 the rates of white maternal mortality dropped below 4 per 1000 for the first time, and never again reached levels comparable with recorded hospital and clinic rates for black women.³²

and a host of other branches of social welfare work were inseparable from public health concerns. There are hints here that the connections Porter and other leading figures in the Public Health community were drawing between the creation of health services for whites and blacks angered white segregationists, and ignited their determination to create a separate department of state, staffed with sympathisers, and focused more tightly on white health and welfare.

³⁰ CAD/ARB 93 LA 153/8 and ARB CF2/18 D "Confinement Allowances"; CAD/VWN 741 SW106 "Motherhood Endowment", 1930 - 1951.

³¹ Before the 1930s there were so few trained black women nurses, and even fewer black physicians, that the question of the care of white patients in hospitals by black professional staff was not a major issue. However, after the 1940s, steps were taken in the passage of Nursing Bills to determine that black nurses should not care for white patients, and similar provisions asserting that under no circumstances should black doctors be appointed to state hospitals to tend white patients. As early as 1912, groups of 'concerned citizens' had rallied support for measures to prevent white nurses from being placed under the authority of black doctors, and to prevent white women from tending to black men. While the Medical Council depreciated these attempts, they did concur with the need for training increased numbers of black nurses and medical professionals, 'to care for their own people'. We return to this discussion in Chapter 7. See: Editorial, "the Nursing of Coloured and Native Patients" South African Medical Record (August 10 1912).

³² D. Bradshaw, et al "Review of South African Mortality", Institute for Biostatistics, SAMRC, Parow, 1987; and S. Marks, "Women's Health in South Africa", Proceedings of the Third Workshop of the Project on Poverty, Health and the State in Southern Africa,

"Bantu" Health in the 1930s: Attempts to Articulate a National Issue

In the late 1920s, as we have seen in chapter two, the community of philanthropists in cities such as Johannesburg, began focusing on the ill-health and social conditions of black men and women. P. W. Laidler's influential speeches of the early 1930s, his address at the Medical Congress of 1932, and his published articles, all drew attention to the specific needs of urban, permanently settled black men and women and to the interconnections between the health of black and white residents of East London, where he served as the Medical Officer of Health.³³ Laidler's politics were in no sense liberal: he clearly viewed black men and women as socially and racially inferior, and he had

Columbia University, New York, 1988, 11-12.

³³ In the 1920s and 1930s Laidler gained recognition for his work in public health, his publications of the histories of the Cape, and in his findings and writings as an amateur anthropologist. His correspondents included the anthropologist Radcliffe Brown (then at the University of Cape Town); Dart (the paleoanthropologist, anatomist and head of the Medical School for some time at the University of the Witwatersrand), and public health officials throughout South Africa and in Britain, where he attended several major conferences on town planning and social hygiene. He was also a prolific contributor to the local press in Cape Town, East London and Johannesburg, writing on topics as diverse as stone age tool making in Southern Africa, eugenics and model sewerage systems. His contributions to the growing discussion of 'native' health, by a small but growing group of medical professionals, were widely read and cited. Laidler emphasized that knowledge of the cultural practices of Africans (in his nomenclature these included: tribal folklore, customs and superstitions), was vital to the extension of settler rule and the extension of biomedical services, and his views were influential at a key moment in the creation of the field of South African ethnography in the 1930s. His Annual Health Reports from the late 1920s and early 1930s were considered models of public health investigation and analysis, and several were reprinted in journals. See for example, "The Influence of the Native on Public Health", South African Medical Journal (October, 1932); "Infant Mortality Amongst Natives", The Blythsworth Review (March 1932); "Modern Public Health Problems", East London Daily Despatch (2 June 1931).

no quarrel with the gradualist paternalism evinced by white Cape politicians. However, he openly mocked the calls for complete segregation as illogical and unachievable, and decried the abdication of responsibilities towards permanently settled urban blacks on the part of white municipalities and industrialists. His views were widely read and reported and younger medical professionals and health officials, such as George Gale and particularly Sidney and Emily Kark, seized upon the comments of the seasoned MOH as a starting point for their more progressive statements on community and preventative health work.

Johannesburg in the early twentieth century depended almost entirely for its revenue base and economic viability on gold mining and its related industries. As indicated in chapter two, virtually all funding for hospitals and health services before the late 1920s came directly from the mining industry, as did the bequests which inaugurated the University of the Witwatersrand (Wits) and its Medical School. Besides a small community of private medical practitioners (many of whom depended for some portion of their income on mining related sources) most doctors, chemists and medical scientists in the region were connected directly with various institutions and private corporations within the mining industry. The unusual emphasis of Porter (the MOH for Johannesburg, trained in England in public health work) on infant care and prevention work, limited as it was, did not receive support from the industry (although the revenue garnered from taxing the industry as well as wage and salary earners provided the funds). Much has been

written about the overwhelming interest of the mining industry in maintaining a cheap, easily accessible labor force of healthy males, and in repudiating the social, material and physiological reproduction of future workers.³⁴ Marks and Packard, among others, have intimated that when presented with high rates of disease in mining compounds and black settlements along the Rand, mine owners and municipal authorities often justified migrant labor as a means to prevent the spread of diseases "incubated" by the conditions of urban life by "providing opportunities for rest and recuperation in the reserves".³⁵ They vigorously supported the 1923 Urban Areas Act, and subsequent attempts to prevent women from settling permanently in urban centres, regarding these movements of women as inimical to their ability to regulate male life on the Rand, and to ensure the reproduction of a future supply of cheap labor from the rural reserves.

Marks and Andersson have argued that after the Depression era, a new group of medical professionals decried these arguments and the medical practices they spawned:

...this theory came to be challenged by medical men outside of the mines and by members of the Department of Health in particular who were beginning to be aware of the deteriorating conditions in the rural areas and the appalling social conditions in the towns. In the forefront of those who stressed environmental factors... were doctors like... George Gale who came to the Department of Health from a mission hospital in Natal... and Sidney and Emily Kark, whose pioneering community health centre in Polela was funded by the Department as a means of finding, in a segregationist framework, an alternative to the expensive, provincially-run hospitals...³⁶

³⁴ See for example, H. Wolpe, "Capitalism and Cheap Labour Power in South Africa: From Segregation to Apartheid" Economy and Society 1: 4 (1972).

³⁵ S. Marks, and N. Andersson, "Issues in the Political Economy of Health in Southern Africa", Journal of Southern African Studies 13:2 (1987) 180.

³⁶ G. Gale, "The Rural Hospital as an Agent in Native Health Education" South

Noting the work of the team assembled under the auspices of the Carnegie grant, Sidney Kark and a small group of his fellow medical graduates (whose studies at the Wits Medical School were largely underwritten by the resources of the Mining Industry), began calling for similar investigations into the health of urban blacks. In 1934, Kark began developing these ideas in a paper he wrote in the Wits Medical School journal, The Leech entitled "The Medical Factor in the Health of the Bantu in South Africa". Kark drew his examples of the poverty of African reserve territories and of wage and nutritional levels in cities from the 1925 Economic and Wage Commission and the 1930 to 1932 Reports of the Native Economic Commission.³⁷ Using the figures cited in these reports for average wages, he asserted that from 1925 to 1930, the majority of black males in Johannesburg earned an average of £3.50 per month. Kark drew on the evidence presented to the 1930 Commission by the Johannesburg Joint Council of Europeans and Natives which calculated the minimum "Native family budget" needed to sustain a working class household of four in the city was £5.00 per month in 1927.³⁸ He drew up tables of food price increases, as well as average rent and fuel increases to indicate that while the cost of these basics had risen between 1927 and 1933, wages had decreased. Kark's conclusion was the same as that of the 1932 Commission Report, and indeed every survey of urban

African Medical Journal (8 August 1936).

³⁷ Economic and Wage Commission, 1925, UG 14-26; Report of the Native Economic Commission, 1930-1932, UG 22-32.

³⁸ S. Kark, "The Economic Factor in the Health of the Bantu in South Africa" The Leech, (September 1934) 20-21.

household needs from the 1930s to the 1990s: that a black male earner could not sustain a household, and that the wages and earnings of women partners, as well as children, were vital to bare survival. Kark also drew up a chart, based on the visits by Native Economic Commission officials to some of the poorest regions of Johannesburg, which he believed powerfully underscored the 'definite relationship' between economic conditions and ill-health in the city:³⁹

Slumyards of the City and Doornfontein

Property	Square Feet	No. of Rooms	No. of Inhabitants	No. of Inhabitants Per Room
A	18 000	43	367	8.5
B	15 550	33	238	7.2
C	3 275	35	308	8.8
D	15 000	26	242	9.3
E	35 000	47	220	4.7

The conclusions drawn by Kark towards the end of his article seem quotidian when read sixty years later, but the stark simplicity and implicit criticism of white employers, mine owners and city officials in their assertions that ignorance and superstitions were the causes of ill-health among black urban dwellers, was startling in 1934, and went beyond those articulated in the Report of the Native Economic Commission:⁴⁰

³⁹ Table taken from: S. Kark, "The Economic Factor in the Health of the Bantu" 21.

⁴⁰ Packard points out in his chapter "Slumyards and the Rising Tide of Tuberculosis,

From the analysis made above we can conclude the following facts:

- (1) The vast majority of the Bantu are living in unfavourable conditions in respect of diet, sanitation and dwellings;
- (2) The main cause for this is poverty;
- (3) Their ill health can, to a great extent, be explained by poverty;
- (4) In order to have a healthier South African Native we must first look to the economic welfare of this section of the people, who can then be accordingly instructed.⁴¹

In 1933, Ellen Hellman, a sociologist in training, based at Wits University, set out to write an ethnography of an urban slum yard, "Rooiyard", in the Doornfontein area referred to by Kark in his research paper. Hellman was encouraged to undertake her study by the academic staff at Wits, especially Raymond Dart and Winifred Hoernle, and by her colleagues such as Kark.⁴² The rich and nuanced work of Monica Hunter, on the anthropology of Xhosa speaking communities in Pondoland, and on the effects of "culture contact" between whites and Xhosa speakers in rural areas and in the cities of the Eastern Cape, impressed Hellman deeply. Hunter had received advice and encouragement from P. W. Laidler (the aforementioned MOH of East London), and he had given her access to municipal health and population records, and provided her with a base for her urban

1914-1938", drew on the statistics and information gathered in the Native Economic Commission, to explore the history of chronic illnesses such as tuberculosis in cities before World War II. See R. Packard, White Plague, Black Labor 138.

⁴¹ S. Kark, "The Economic Factor in the Health of the Bantu" 22.

⁴² Hellman's findings were published fourteen years after she completed her research, by the Rhodes-Livingston Institute, whose director, Max Gluckman considered that the effect generated by her few published articles on the work merited a complete edition of the study. See Gluckman's "Introductory Note", and Hellman's "Method of Work" in E. Hellman, Rooiyard: A Sociological Study of an Urban Native Slumyard (London: Oxford University Press, 1948).

research.⁴³ Both Hellman and Hunter were deeply interested in health and medical practices, and spoke of the contributions students of the social sciences could make to establishing mutual knowledge and respect between indigenous people of the region and white settlers, and Hellman paid particular attention to the medical treatments and services utilized by the residents of Rooiyard.

Before the establishment of the handful of municipal health clinics in poor areas of the city in the late teens and early 1920s, the only subsidised service available to very poor women in the city, was a clinic run by the Swiss physician Marguerite Crinzos de Cottens, out of a small cottage in Doornfontein, in the same neighbourhood as Rooiyard.⁴⁴ Soon after the American Board Mission couple, Frederick and Clara Bridgman arrived in Johannesburg to begin establishing their missionary and service work, Dr de Cottens approached the couple, and invited them to her clinic to meet her patients and to see first hand the appalling conditions of the poorest ghetto areas of the city. Both Clara and Frederick Bridgman realized that black males had some access to the Johannesburg General Hospital's "non-European section", and the mining hospitals, even though this

⁴³ Monica Hunter, (who subsequently took the married name "Wilson", and whose son, Tim Wilson, became director of Alexandra Health Clinic in the early 1990s), published several articles on women, including "Effects of Contact with Europeans on the Status of Pondo Women" *Africa*, 1 (1933) and the monograph Reaction to Conquest: Effects of Contact with Europeans on the Pondo of South Africa, (1934, London: Oxford University Press, 1961). We will consider the weight of her work in greater detail below.

⁴⁴ HPC/AD 843 B91.32 See the fundraising letters written by Clara Bridgman, especially 18 January 1927. The pioneering work of Dr de Cottens in her Doornfontein clinic was commended in an article on the Bridgman in The Journal of the Medical Association of South Africa (9 May 1931).

treatment was inadequate and largely confined to emergency and curative care. Black women, however, were only admitted to the "Johannesburg Gen" in life threatening circumstances, and no provisions were made until 1925 for even emergency maternity or gynaecological cases. Thus, the first and lasting impression made on the Bridgman's by their visit to the Doornfontein slumyards and the small clinic in their midst was the overwhelming need for health services for women, particularly maternal and infant services, with a focus on preventative and support work, as well as emergency surgical and curative care.

This first apprehension that women in the region needed a hospital site for their birthing labours took hold of Clara Bridgman's imagination, and meshed with her earlier work on Mothercraft and the importance of missionary work with black mothers. Agreeing with Dr de Cottons that the unhygienic and cramped conditions in which most women lived, made safe and comfortable birthing labor nearly impossible to achieve, the need for an institutionalised maternity scheme became a major target of the Bridgmans' fund-raising work. The creation of a Hospital had a crucial added advantage in that it would provide opportunities for the close supervision of midwife trainees in an hygienic and regulated space. The Bridgmans received support for this in North America on their fund-raising trip in the mid 1920s, at a time when hospital birthing labours, especially for the poor, were becoming increasingly acceptable.⁴⁵

⁴⁵ See: J. Walzer Leavitt, Brought to Bed: Childbearing in America, 1750-1950, (Oxford: Oxford University Press, 1986).

A fund raising letter of January 1927 emphasized the impact of Dr de Cottens' clinic on the efforts of the Bridgmans, and outlined the proposed "Scheme" for the Hospital:

When the late Rev. F. B. Bridgman left Johannesburg for a furlough in 1924, after many years of work on behalf of the Natives of the Witwatersrand, it was with the determination to do something to improve the existing facilities for the treatment of sick Natives in this areas, especially Native women. ... on the whole Reef there is no hospital to meet the needs of the large Native female population. The great need for some institution has been further revealed by the experiences of Dr Marguerite Crinsoz de Cottons, who has given her services for the last six years without remuneration, in a clinic in connection with the American Board Mission in New Doornfontein, where she has had coloured and Native patients, the Natives coming from all Reef Locations and Native Townships, and even from Pretoria and Vereeniging. She came to realise the great saving of life that could be effected if there were only adequate facilities for maternity and gynaecological work. Her urgency in this matter was an added spur to Dr Bridgman to do something if possible to meet this need. Soon after reaching America he was overcome by illness, and finally succumbed to the attack which ended his life in August, 1925. The responsibility of the unfinished task rested heavily upon Mrs Bridgman. She could not forget the need, or the challenge presented by Dr de Cottens' sacrificial service. Before leaving America in September 1926, she sought support for the Hospital project. The response, due to the real need, and the influence of Dr Bridgman's life and recent passing, was most encouraging.⁴⁶

It was only in the 1930s that Clara Bridgman began to work with others at the Bridgman and in the Municipality, on planning a district midwifery service for Sophiatown, Alexandra and some of the new segregated black townships in homes that were at least free-standing and had more than one room, as well as access to water and light, facilities considered basic to the adequate birthing work of trained midwives. In the 1940s, physicians and midwives began to question the investment in hospital births that was enshrined in the Bridgman, an approach which set a deep and lasting pattern into the

⁴⁶ HPC/AD 843 B91.32 Filed with Minutes of Meeting, January 25 1927

bedrock of women's health services in South Africa, both in terms of medical planning and administration, and in terms of women and men's perceptions of "good" maternal care.

The latter part of chapter seven, concerned with the period after World War II, will develop this theme further. In the late 1920s, however, available evidence suggests that people such as the Bridgman couple and Dr de Cottons were tapping into an important need, perceived by themselves and by black women in poor parts of the city for comfortable birth spaces. Despite warnings to the contrary on the part of city some officials and many so-called native "experts", after the Bridgman opened its doors in 1928, the numbers of women who came to give birth rapidly increased.⁴⁷

This is not to argue that all black women chose to give birth in a hospital setting. On the contrary, evidence from the early 1930s suggests that many women were cautious in their relationship with biomedical care, (some having experienced alienating and harsh treatment from white physicians with whom they and their male relatives, children and partners had sought treatment), and often paid as much or more to avail themselves of the services of recommended birth assistants.⁴⁸ As we shall see, many women with any

⁴⁷ See especially letters to The Star and Rand Daily Mail in 1927 and 1928 about the fears, caused by 'superstitious' ideas that led to ill-health in black men and women, and which prevented them from seeking hospital assistance. Also see the constant refutations of the inadvisability of creation medical services for black men and women, and particularly, of the incapability of black women to be trained as midwives and nurses, that Edith Rhienallt Jones and Clara Bridgman were having to make in the 1930s before Johannesburg City Council members. See for example HPC/RJ AD843 Aa 12.2.2. Also see the refutations of similar perceptions made by Dr MacVicar of Lovedale Hospital, to health officials, educational authorities and magistrates 22 August 1935 in CAD/GES 1798 29/30.

remaining rural ties, decided to journey to their own, or their in-laws homes in rural regions for the last months of pregnancy and birth.⁴⁹ But even in the early 1930s, among the community of women living in Rooiyard, increasing numbers of women were seeking out hospital births. Few black women arriving in Johannesburg in the late 1920s had established networks of kin or long-standing friends upon whom to rely in matters of such consequence as pregnancy and birth. The lack of privacy and the noise and bustle of township living, or the even greater isolation of backyard domestic worker quarters, combined with women's fears and concerns about childbirth, and their longing for supportive attention during and after their labor, were factors making the shift to the unfamiliar turf of hospital birthing more attractive to black women.

While Clara Bridgman, Ruth Cowles, (Frederick Bridgman's niece, and midwife-nurse with public health training in the United States), and fellow board members all supported the creation of a hospital because of the need for regularized training, a clean and ordered birthing space, and a transformative site for the instilling of Christian motherhood ideas, hospital births were being advocated from within the medical academy itself.

⁴⁸ We will return to this material below. See E. Hellman, Rooiyard, Chapter IV "Birth".

⁴⁹ See the testimony about returning to rural homes for birth labor in: B. Bozzoli, with M. Nkotsoe Women of Phokeng: Consciousness, Life Strategy, and Migrancy in South Africa, 1900-1983 (Johannesburg: Ravan Press, 1991).

Histories of the medicalization of childbirth in European and North America have charted the increasing specialization and professionalisation of medical expertise that propelled this process.⁵⁰ The 1930s were a period of shift away from the perception of hospital births as necessary only for destitute women. To effect this change, and to increase the prestige and acceptability of hospital births for middle class women, physicians stressed the modernity and scientific safety of managed hospital births. In Johannesburg, the appointment of a Professor of Obstetrics at the Wits Medical School led to a flurry of reports and public addresses by the newly hired physician, as well as his colleagues, that South Africa urgently needed specialist obstetric services. In his first major public speech Professor McGibbon argued:

Now the direction in which that help is most needed is unquestionably in the creation of more hospital beds, both for white and native women.⁵¹

At the same time, the laboratory investigations of medical researchers such as Sidney Kark, were finding their way into published papers on the need for scientific management of menstruation, pregnancy, and birthing labor. Kark, who would later champion community health centres, and stress the need for local knowledge and practices to be drawn into the ambit of medical practice, was, in the early and mid 1920s, fascinated by the apparent anomalies within evolutionary explanations of bodily functions, especially

⁵⁰ See for example: J. Barrett Litoff, American Midwives 1860 to the Present (Connecticut: Greenwood Press, 1978); J. Lewis, The Politics of Motherhood (London: Croom Helm, 1980) and J. Walzer Leavitt, Brought to Bed: Childbearing in America, 1750-1950 (Oxford: Oxford University Press, 1986).

⁵¹ J. McGibbon, "The Reduction of Maternal Mortality and Morbidity in its Clinical Aspect" Journal of the Medical Association of South Africa (11 June 1927) 275-6.

women's biological capacities. How could the female of a species had evolved a regime of reproductive organs and processes which seemed so capricious, irrational, dangerous, painful and even pathological? Kark's interventions in this local and international debate opened with an early article on the "Toxaemias of Pregnancy":

Every medical man who practices obstetrics must have been struck with the truth of Mauriceau's dictum: "That pregnancy is a disease of nine month's duration." For although gestation is a physiological function, and as such ought to be a normal process, yet in actual practice we find that the symptoms of pregnancy are very often akin to those of an illness, with a host of other minor complaints... some even fatal. Among authorities the general consensus of opinion is that pregnancy is a pathological condition.⁵²

Kark, under the early tutelage of Raymond Dart--the Anatomy Professor and future leading paleoanthropologist at Wits, recently arrived from studies in Britain and North America with some of the world's leading evolutionary anatomists and craniologist--was interested in coming to grips with the "natural" versus "pathological" discourses of pregnancy and motherhood. He was alive to the long history of literary and cultural perceptions of pregnancy as a natural and innate process, as well as to the tensions within Judaeo-Christian religious teachings on the travail of women in labor as a punishment from God for temptation and original sin.⁵³ Kark's article tracked through the overall

⁵² S. Kark, "The Toxaemias of Pregnancy" in The Medical Journal of South Africa (May 1922) 207.

⁵³ Kark explored a similar question in a detailed investigation of menstruation. See his paper "Menstruation: An evolutionary hypothesis as to its Aetiology and Significance", South African Medical Record (11 October 1924). Also see: E. Kark, "Menarche in South African Bantu Girls" South African Journal of Medical Science 2 (1943). Emily Kark, a fellow academic and partner to Sidney Kark, elaborated on this research, by investigating the timing of menstrual onset among different ethnic groups in South Africa, across high and low lying geographical regions. Emily Kark's work was supported by Dart

arguments postulated in cultural and scientific theories of human gestations, and then

argued that:

... this apparent anomaly in nature, this discord in the "harmonious symbiosis" .. can be explained best by the "Theory of Evolution".

and later, after setting out his findings from case studies of pituitary investigations,

chemical experiments, and bodily and tissue measurements of pregnant women in

Johannesburg:

.. the cause of the frequency of pathological conditions in pregnancy.. is due to the comparative belated appearance of the placental form of reproduction in the process of evolution... pregnancy is a state of more or less hyperpituitarism...hyperpituitarism should have been the state of primitive man...examinations of prehistoric skulls and skeletons their likeness to those of agromegaly.. primitive man was in a condition of hyperpituitarism.⁵⁴

As we shall see in a later chapter on "Bantu Gynaecology" and the science of black women's bodies in South Africa, these more generalised investigations into pregnancy, often led to more specific local research in which discourses around paleoanthropological and archaeological investigations into human origins, and obstetric research into pelvic capacity, coalesced around the bodies of black women. Of course, in the early 1920s when Kark wrote this series of papers, few, if any, black women in Johannesburg and in South Africa as a whole, had experienced birthing labor in hospitals under obstetric or medical specialist care and no research existed, no pool of case studies had been accumulated, to

and other colleagues at Wits, and her findings addressed international debates about the significance and cause for differential rates of fertility and fecundity in young women. Also see the work of her colleagues at Wits: M. Orford, and L. H. Wells, "An Anthropometric Study of a Series of South African Bantu Females" South African Journal of Science vol xxxiii (1937).

⁵⁴ S. Kark, "The Toxaemias of Pregnancy", 207; 210.

provide scientists with data comparable to that which they had begun garnering on white women. Thus another strong interest, on the part of scientists, in the creation of maternal medical settings for black women, was the opportunity these would present for research, employing recognised methods to study local subjects, and enabling local experts to utilize "original" materials to address an international audience.⁵⁵

In 1931 Laidler wrote an paper for the South African Journal of Science based on his investigations as the MOH of East London, a bustling port city in the eastern Cape, on the border of the Ciskei and Transkei regions. His opening comments captured the sense of urgency and purpose with which he and fellow scientists, interested in 'Native Health' for humanitarian and scientific purposes, approached their research in the 1930s:

At present... no detailed account has been published concerning Bantu methods of midwifery, the superstitions connected therewith and the clash between them and the more civilised thought in the form of public health administration. There is no better place for the study of the subject than East London.⁵⁶

Laidler believed that East London provided a key site of "culture clash" between western biomedical and scientific and indigenous practices and conceptions. He was most contemptuous in this paper, and in his other work, of the "interfering" role played by poor whites, especially Afrikaans speakers, in imparting a model of behaviour that did not

⁵⁵ We will return to these themes in chapter nine.

⁵⁶ P. W. Laidler, "Native (Bantu) Beliefs Concerning Pregnancy and Child-Birth, Their Effects on Public Health Administration: And the Effects of Detribalization or Urbanization on Those Ancient Customs and Upon Infantile Mortality Rates", South African Journal of Science Vol xxxviii, (1931) 418.

accord with his version of enlightened Christian family life and he urged that the "best of Europeans" should act as exemplars, particularly to black urban women.

Laidler articulated his reasoning about the centrality of black women, as mothers, to the process of "conversion and civilisation" in language and with metaphors that formed part of a growing script, employed by missionaries and physicians at the time:

Superstitions learned at the mother's breast are the last to be thrown off by any race. In South Africa, Native superstition, whether Hottontot or Bantu, survives even three generations of Christianity... there is little or nothing to show their existence to the superficial observer, whether missionary or layman. This is due in part, in urban locations, to the greater difficulty in obtaining the materials for the visible manifestations of those beliefs... certain charms originally worn around the visible neck, have slipped in Christian households, down to the covered waist... even the professing Christian of years standing retains his belief... In fact he remains mentally a Native, and will remain such, until home life and motherly baby talk have been transformed by education to a more reasonable level.⁵⁷

Laidler's emphasis here, on mothers as vectors of superstition and illness, even though he connected this image to a call for better health services and municipal provisions for black households, was echoed in countless press articles and addresses. This form of argumentation became paradigmatic in the expert literature on "Bantu health" in the 1930s. Before turning to an examination of the way that Johannesburg missionaries and philanthropists, such as the Bridgmans took up and worked with these ideas, it is worth pausing to consider their impact outside of this small cadre of "Native supporters".

In the mid 1930s, the organization spearheading "family planning" and birth control in Johannesburg, the Race Welfare Society, began to respond to the demand for contraceptives among urban black women by extending the services they had originally

⁵⁷ P.W. Laidler, "Native (Bantu) Beliefs Concerning Pregnancy and Child-Birth" 420.

established with poor white women in mind.⁵⁸ The move towards the widespread publicising and provision of techniques for regulating conception took place, at first, outside the purview of the state, although with some financial and tacit support from the Public Health Department in particular. As we shall see in the chapter on birth control, these services and organizations were increasingly refashioned into provincial and municipal services and in the late 1950s almost entirely consumed within state structures set up under the banner of a newly minted Population Planning Program. In the 1930s, however, the absence of central state programs or policies on demography and population reflected the tension between contradictory needs and analyses: on the one hand, the cities were increasingly pressing the state for ways to curb in-migrations of the poor, and attention was drawn to overcrowded slums and ghettos. At the same time, as we have seen, municipal officials worried about the high rates of infant and maternal morbidity and mortality, and the effects of this on the future labor needs of industrialists. Further there were conflicting views among legislators about the responsibilities of the state and objections by some to governmental involvement in any fertility control schemes. But the overwhelming reason for state inaction at this period, at least in the arena of fertility regulation, was the concern of the mining industry that reservoirs of male labor from the rural hinterlands of Southern Africa were being undermined, threatening the future functioning of the country's most vital industry.

⁵⁸ CAD/GES 2281 85/38 Deel 1 for the origins of the Race Welfare Society. See chapter eight.

In 1937 the Gold Producers' Committee of the Chamber of Mines voted to send William Fox of the South African Institute for Medical Research and Douglas Back on a four month tour of the Transkei and Ciskei. The Chamber charged the two researchers with the development of a strategy for "improving the nutrition of Natives, particularly adolescents, and ... reducing infant mortality."⁵⁹ The 400 page report that the two researchers eventually compiled, served as the central text for much of the policy discussion in the mining industry of the conditions of the labor reserves of the eastern Cape, particularly in relation to the health of the families of those who laboured on the mines between the two world wars.⁶⁰

The mining industry's newly developed concern about the conditions in the reserves, and particularly about childbearing and rearing, was not solely prompted by the agrarian crises, severe as they were. The expansion of medical curiosity to the reserves was inspired, on the one hand, by the preoccupation of mine medical officers with the physique and nutrition of migrants within the compounds, and, on the other, by the increasing recruitment crisis of the late 1930s.⁶¹ After 1929, in the wake of the combined

⁵⁹ I am most grateful to Keith Breckenridge for this citation and for providing me with copies of the notes he took while working in the Chamber of Mines Archive. His suggestions concerning the interests of the mining industry at this period, have been invaluable. CMA/ 2095, 1609 "Fox/Back Report", 3 August, 1939.

⁶⁰ Packard has written about the important light the Fox and Back report sheds on tuberculosis among black miners, and the effects of their rates of infection upon rural families. See: R. Packard, "Labor Supplies and Tuberculosis on the Witwatersrand", Chapter VI in White Plague, Black Labor.

⁶¹ Source for these points: K. Breckenridge, K. "The velvet scabbard that holds a sword of steel: the politics of mine medicine on the Witwatersrand in the interwar period",

crises of drought and Depression, recruitment to the mines benefited from surpluses of male labor, until South Africa left the gold standard in 1933. Thereafter the massive expansion of the industry, prompted by the dramatically increased domestic value of gold, required an ever increasing work force. The doubling of the gold workforce between 1929 and 1941 cut deeply into the populations of male migrants forced to leave the reserves by the strains placed on African agriculture. Towards the end of the decade the mines' labor demands were no longer being met. By 1937, for example, the Gold Producers' Committee was placing increasing pressure on the medical officers to accept all possible black male recruits in order to limit the impending shortfall in the labor force.⁶² But when they turned their attention to the long term prospects of the South African portion of the mines' labor force, the General Manager of the Chamber of Mines argued, perhaps for the first time, that:

... any really large addition can only arise through an increase in the population, or rather in the proportion of it which is suitable for mine work. In this connection the two most important desiderata are: (a) a decrease in the exceedingly high infantile mortality; and (b) an improvement in the nutrition of the adolescents.⁶³

Northwestern University, Africa Seminar, May, 1990

⁶² See for example CMA/2211, 1983 General Manager of the C.O.M. to the President of the Mine Medical Officers Association: "In view of the approaching end of the period of plenitude of Native Labour which has prevailed for some years and the continuous expansion of the industry, it has been decided to take steps to ensure that, as far as possible, no Natives offering themselves for mine work in the territories who have a reasonable probability of acceptance for underground work on arrival in Johannesburg shall be rejected."

⁶³ CMA/2211, 1983 "General Manager's Tour of the Transkei, Ciskei and Part of Natal", March 2, 1937.

In the course of the 1930s the mines came to draw heavily on the labor of the Eastern Cape reserves, overwhelmingly Xhosa speaking males. It was, thus, upon the Transkei and the Ciskei that the mines focused their newly stimulated curiosity about the conditions of the reproduction of the rural population.

The massive report that the two researchers compiled on their return to Johannesburg sheds much fascinating light on the medicalization of the recruitment process and on the strategies advocated by agricultural authorities to ameliorate the "incompetence" of African peasant farmers.⁶⁴ But it was in the two areas of infant mortality and adolescent nutrition that the report was most intriguing. For the two scientists, used to the enormous statistical resources of the mine hierarchy, measuring, indeed understanding, infant mortality and childrearing practices proved perplexingly complex, as it did to their peers in Municipal health authorities. Nonetheless, their attempts, however incomplete, were amongst the first of very few efforts to gauge the levels of infant mortality amongst the rural black population of Southern Africa before the World War II.

The researchers early attempts to assess infant mortality were sabotaged by a variety of conflicting medical and popular opinions, and by the complete absence of any

⁶⁴ The suggestions for agrarian reform include an intriguing argument, probably by Douglas Back, that since it was only after the enclosures that agricultural production developed in Britain, the little remaining common land in the reserves should be fenced off and parcelled out to individual farmers.

system of public health visitors, and the absence of any vital statistic counting procedures,

either under the authority of rural magistrates or local chiefly networks. They commented:

We were specially asked to report on this matter, but soon found that there was nothing to go on save the vague estimates of individual doctors. One doctor said that there was hardly any loss of life before the beginning of the second year, whilst another put the infant mortality rate at 60 to 75 per cent!⁶⁵

Fox and Back were thus forced to develop their own ad hoc system for measuring infant mortality. Data was collected from those believed to "hold the confidence" of mothers.

These included, "doctors at mission and other hospitals, district surgeons, private practitioners, the wives of one or two traders, and the wife of the principal of a training college, and several Native teachers working under European supervision".⁶⁶ While the authors claimed that there was a striking correspondence between "the individual records", it remains unclear as to how the information was gathered. It seems highly unlikely that district surgeons and private practitioners would have engaged in field research, which would suggest that Fox and Back gathered their information indirectly. When Laidler initiated the taking of vital statistics in East London, and began enumerating black residents in a miniature census, his efforts were unique, outside of the three largest cities in the country, and there is no indication that medical officers in rural areas followed suit. The categories and qualifications employed by Fox and Back, which stressed the

⁶⁵ F. W. Fox, and D. Back, A preliminary survey of the agricultural and nutritional problems of the Ciskei and Transkeian territories with special reference to their bearing on the recruiting of labourers for the gold mining industry (Johannesburg: Chamber of Mines, 1938).

⁶⁶ F. W. Fox, and D. Back, Preliminary Survey 189.

difficulties of assessing the age of "Red"⁶⁷ mothers and deceased infants and the suspicions levelled at those attempting to count miscarriages, suggest that the data was gathered through direct questioning, possibly by the women married to local traders and the school principle. The completed Report does not provide any sense of just which data Fox and Back commissioned or recorded themselves, and which material had been indirectly gathered. However, they were confident enough of their findings to map out a series of demographic tables.

Three of these tables falling under the category "Infant and Child Mortality Statistics" are worth reproducing below, as they allow a unique vantage point from which to regard the importance of this Report.⁶⁸

⁶⁷ There is a rich literature on the use of the term "Red", to denote non-Christian, non-school educated Xhosa speakers, which conveys the added connotation of a rejection of key aspects of settler and missionary society, and an ethnic conservatism. The term was drawn from Xhosa descriptions of these perceived divisions in society, where the adorning of clothing and bodies with ochre-red clay, (*ibomvu*), was taken as a sign of "Red" affinity. For a sustained analysis of "Red" and "School" divisions, see P. Mayer, and I. Mayer Townsmen or Tribesmen: Conservatism and the Process of Urbanization in a South African City (London: Oxford University Press, 1974).

⁶⁸ These tables have been reproduced from the Preliminary Survey 191- 192.

Infant and Child Mortality in the Transkei and Ciskei: 1937

Numbers of Mothers Questioned:

<u>Numbers of Women:</u>		<u>Age of Women:</u>		<u>Category of Women:</u>	
Ciskei	295	Under "45" years	1,533	"Red" Natives	552
Transkei	1,432	Over "45" years	284	"Dressed" Natives	707
Basutoland	153	Age unspecified	63	Unspecified	621
Totals	1,880		1,880		1,880

Live Births Per Mother:

Age when Questioned	Under "45"	Over "45"	Mean
Ciskei	4.22	7.78	5.25
Transkei	4.29	7.74	4.54
Basutoland	2.82	6.3	3.22
Mean	4.15	7.67	4.55

Surviving Children Per Mother:

	Under "45"	Over "45"	Mean
Ciskei	2.64	4.07	3.06
Transkei	2.24	3.86	2.32
Basutoland	2.02	4.3	3.95
Averages	2.28	3.95	2.45

The full attributes of this table await a more thorough and relational analysis than can be given here. Suffice to say that by the researchers own standards, the rates of child and infant death were extremely high. What they next had to say about the causes of and remedies for infant mortality underscores the interest and prejudice at work in their survey. Having laid out what appeared to be startling evidence of a declining birthright and very high infant mortality rate Fox and Back attempted, first, to calm their readers by comparing their figures with those of eighteenth century England. They did, nonetheless, conclude that "the fact remains that the rate is an exceedingly high one and the enormous wastage of life that occurs needs no emphasis."⁶⁹

It was when they turned to explanations for the massive "wastage of life" that the politics of their scientific endeavour came shining through. Fox and Back blamed the high mortality rate in the reserves on two factors. On the one hand, they cited the doctors as evidence of the ignorance and superstition on the part of black mothers that plagued the

⁶⁹ Preliminary survey 191.

development of "enlightened" medical practices in the reserves. On the other, they pointed to the declining stocks of cow's milk that followed the Native Affairs Department's encouragement of sheep farming in the Transkei and the Ciskei. Far from attempting to assess the impact of migrant labor on rural production, or the increasing burdens on the labor of women, especially younger married women with small children, Fox and Back stressed instead the medicinal benefits of mine work, citing the nutritious food, training in first aid and "many other positive influences" wrought by the mines on male health. Thus, they managed to sidestep the central question as to whether the infant and child mortality of the labor reserves was in some way related to the very high rates of male migrant labor on the Witwatersrand mines. Astonishingly, considering the purported intent of their research, they commented:

It is not within our province to consider the less beneficial effects that are also produced by contact with European civilization....⁷⁰

Finally, almost as if to blind themselves to the reality of rural transformation and structural adult labor migration, Fox and Back chose to extract large segments from Monica Hunter's ethnography of the AmaMpondo, to provide evidence of the poor mothering techniques and superstitions prevalent among "Native" women, strongly suggesting that these "timeless" cultural features of Mpondo life--which they rendered "representative" of family life in the Transkei and "more typical of the Native as he was in his former days"⁷¹--were the root cause of infant mortality and adolescent sickness.⁷² In

⁷⁰ Preliminary Survey 252.

⁷¹ Preliminary Survey 144.

using Hunter's work as a screen behind which to hide the implications of their own findings, they wilfully misread and decontextualized her commentaries, particularly when they utilized material from her work on town life and the effects of Christian missions, cash cropping and tax implementation in rural regions, as if Hunter was describing a timeless template of infant care, maternal health and rearing practices, which she clearly was not. Hunter's nuanced portrait of Western Pondoland did evoke--in the style of the anthropology practised in Britain by Malinowski and Hunter's other mentors of the day--a notion of the enduring structures of kinship and culture as the foundation of Mpondo life, but throughout the monograph Hunter sustains a tension between static ethnographic description and historically contextualized commentary. Principally, Hunter was interested in the social, material and cosmological transformations and adaptations at work in Mpondo society in the 1930s, both in rural homesteads and coastal towns. She took particular care to gather material on childrearing and health practices because the vast number of her informants indicated that worsening material circumstances and vulnerability of younger women in particular, was straining the fabric of social and physiological reproduction. Indeed, so convinced was Hunter that her research pointed to adverse effects on infant and maternal health of the strains on rural women, due to what she termed "contact" with wage labor and commoditization, that she published a separate paper on the subject, titled "Effects of Contact with Europeans on the Status of Pondo

⁷² M. Hunter, Reaction to Conquest.

Women".⁷³ Thus Fox and Back ignored key evidence that directly addressed their purported research, in Hunter's published work. Finally, the Report-- flawed as it was and remains by Fox and Back's reading of the evidence gathered, and indeed by the process of its collection--dramatically underscores the ill-health and poverty of rural women and children in the 1930s.

Although there exists no equivalent to the Carnegie Commission Report, for black men and women in South Africa at this period, the information commissioned by the Chamber of Mines was powerful evidence, no matter how disguised, of the declining material independence and sustainability of rural households. The Report was a harbinger of the migrations of Xhosa speaking women, into small towns and coastal cities in the decade after the Depression, and, increasingly after World War II, to the Witwatersrand.

Juxtaposing these interests and opinions of representatives of the mining industry with those of philanthropists and urban-based missionaries is most instructive. While Clara Bridgman, her niece Ruth Cowles, her philanthropist ally, Edith R. Jones, and other members of the Bridgman board, had very didactic purposes in mind when they tackled the question of Mothercraft for black women, they were committed to religious and ideological philosophies which allowed for pragmatic alliances and the shifting weight of practical experience. Unlike institutions directly connected to the mining industry, they

⁷³ M. Hunter, "Effects of Contact with Europeans on the Status of Pondo Women", Africa 1 (1933).

were not inextricably wedded to the ambitions of accumulation. In their quest for a vehicle for motherhood instruction (through the formation of the Mothercraft League) in their efforts to create a club and hostel for black women in the city (the Helping Hand Club for Native Girls) and in their decision to focus on the building of a hospital in the mid 1920s, Clara Bridgman, Edith R. Jones and their colleagues did not eschew the financial assistance of the mining industry, or large corporations. They attempted to raise funds through every available channel. But they were not bound to the interests of the mines or the municipality. Indeed, the long term consequences of the Bridgmans' fund-raising efforts in North America, provided the fledgling institution with some independence. At the same time, no philanthropic effort in the city could hope to succeed without the support of people or institutions attached to the mining industry.



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Chapter Five

The Founders of the Bridgman: Mothercraft to Maternal Health

On the eve of World War I, soon after arriving in Johannesburg from mission work in Natal, where the bulk of American Board Mission (ABM) work was centered, Frederick and Clara Bridgman began building alliances and networks with other mission societies and welfare-minded residents of the city.¹

... 'Johannesburg', wrote the American Board missionary Frederick Bridgman, soon after arriving on the Witwatersrand in 1913, was 'the very pivot upon which the future of the native in South Africa swings'....²

In his book on the history of twentieth century liberalism in South Africa, Paul Rich traced the cross-Atlantic connections drawing Americans such as the Bridgmans to South Africa at the time. Rich also indicated the way that the Bridgmans brought in fellow Americans to join their Johannesburg mission, notably the public health nurse and midwife, Ruth Cowles, the Bridgmans' niece, and Ray Phillips. Phillips came to the country in 1918 to help Frederick Bridgman establish a network of men's social organizations, and soon became one of the key liberal experts on urban life, completing a dissertation at Yale on black city dwellers, published in 1938, under the title The Bantu in the City.³ But overall,

¹ The Bridgmans were members of the American Board Mission (Congregational), and in South Africa this group was referred to as the "American Board Mission", and the local nomenclature will be followed here.

² P. Rich, White Power and the Liberal Conscience: Racial Segregation and South African Liberalism, 1921-1960 (Manchester: Manchester University Press, 1984) 11. Here Rich is quoting from a letter: F Bridgman to ABM Head Quarters, 23 January, 1913.

there were less than a dozen ABM members in the city during the years when their projects and energies galvanized nearly all work connected with black infant and women's health. One key reason for their influence was that people such as the Bridgmans accepted the presence of black women in the city as a "natural" result of processes of immigration and industrialization, processes which they constantly affirmed having witnessed in the United States of America. Rich argues further, that, unlike the British and Continental missionaries:

The tradition of the social settlement movement in the United States, founded amongst the new communities of immigrants from southern and eastern Europe in the early years of the century, left the American missionaries considerably better placed to confront a situation of multi-ethnic urbanisation than their British counterparts.⁴

Clara and Frederick Bridgman realized that with few resources, and even fewer ABM members, alliances with existing organizations even those unused to urban settings would have to form the basis for any future work. While Frederick Bridgman concentrated on projects with black men in creating moralized leisure spaces in the city, he was drawn into medical work by the Swiss physician Dr de Cottens, and raised money to hire rooms in Doornfontein for her clinic and surgery.⁵ At the same time, Clara Bridgman committed herself to working with organizations focused on women.

³ See the "Preface" in R. Phillips, The Bantu in the City (Cape: Lovedale Press, 1938).

⁴ P. Rich, White Power and the Liberal Conscience 12.

⁵ For more on the connections between American philanthropists, the early Joint Council movements, the founding of the South African Institute of Race Relations and the moral agenda of F. Bridgman and R. Phillips, see: T. Cousins, "'Moralizing leisure time': The transatlantic connection and black Johannesburg, 1918 to 1936", in S. Marks, and R.

On June 16th, 1914, "a meeting to inaugurate the Mothercraft League in Johannesburg, was held at the Nels Rust Dairy.. when about a hundred ladies were present. Some forty joined, and at this meeting ... ladies were asked to form a Committee for Social Work among Natives."⁶ Three months later, a central committee of women, with Bridgman at the core, began discussing the urgent need for supervision of 'young unattached Native females' in the city. Under the heading 'Control and Protection of Native Women and Girls', the committee advocated several immediate steps, including the requirement that women entering Johannesburg should have to register with a central authority, that police should be prevented from detaining women, especially in any prisons or stations where males were present, and finally that some scheme of female officers should be created to direct and supervise incoming women.⁷

This approach supported official conceptions of black women as childlike and in need of guidance, and unquestioningly affirmed that whites, in this case women, should naturally take on supervisory roles. At first Clara Bridgman used the words "female" and "women" to describe black women, but she soon adopted the local white nomenclature which even further infantilized black women. The small group of educated black men in Johannesburg were commonly referred to as "Natives" by most whites, and liberals such as the Bridgmans and Jones' were comfortable employing the term "men" when they initiated

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Rathbone (eds) Industrialisation and Social Change in South Africa (London: Longman, 1982).

⁶ HPC/HHC A2050 Ba.1 "Minutes", 16 June 1914.

⁷ HPC/HHC A2050 Ba.1 "Minutes", 11 September 1914.

their social centres and debating groups. But the anxiety white men and women revealed in their reluctance to recognize the adulthood of black women, underscored both their racism and their insecurity at the close association between the domestic realm of white women, their subordinate social and political position vis a vis white men, and the status and labor of black women. The vast majority of white women possessed greater material and social power than the majority of black women, yet most feared the possibility of sharing more than kitchen and laundry space with them. Indeed the irony of social and welfare work on the part of white women, was that while they set out to work with Christian black mothers, they maintained a set of elaborate distinctions between themselves and even their "successful" converts, often women who themselves expressed a powerful identity as mothers. So ingrained was the colonial and settler use of the word "girl" to describe black women, that it is clear many white women and men no never gave the term a second thought. It is harder to explain why well known black women such as Sibusisiwe Makhanya and Charlotte Maxeke used the term, except that they usually employed it to refer to young unmarried women, without children, and it is possible that their usage stressed youthfulness, without the intention of conveying a deeper level of pejorative meaning. Even more likely, these meanings, ascriptions and useages overlapped upon one another, reinforcing the appearance of normalcy, creating such a prison house of language that many white women, men and children, could call elderly black women "girls" into the 1980s with hardly a pause.⁸

⁸ It is interesting to note, that in the debates around the naming of the Bridgman

While supporting calls for regulation of "Native girls", the new Mothercraft League disavowed the proposed municipal plan to require black women to carry passes, which they would be obliged to show to male officer on demand, facing detention and imprisonment if they were undocumented. Instead, Clara Bridgman and her fellow League members advocated a "motherly" approach to the "problem": strict and firm, yet nurturing and exemplary at the same time. This maternalism was underscored in the name adopted by the League. By coming together as mothers, these white women were able to advocate social policies that addressed a wide range of issues avoiding the shrill reactions of white males towards "feminists and flappers" that raged in the pages of daily newspapers whenever women activists were spotted calling for the extension of the franchise, or involving themselves in "political matters". The professional medical fraternity offered legitimacy to many of these prejudices.

In an article of 1916, the president of the Western South Africa branch of the British Medical Society (to which most physicians belonged, until the South African Branch was accorded its own title) published a paper titled "The Training of Our Girls". In this article he lambasted "feminists and flappers" in the country for the "dangerous and difficult" example they presented to young white South African teenage girls, for their

Hospital, the work "women" was used from the start, although the choice of the designation "European" versus "Native" remained shifted back and forth until in the late 1930s, when the Hospital began receiving more funding from the Native Affairs Department, it began using the term "Native" officially. After World War II, the nomenclature began to shift again, with Board members using the word "African" more frequently.

unchaperoned and libidinous behaviour with men, and for their demands for "freedom" which amounted, according to this physician, to opportunities for "licence". In the same article, he contrasted the behaviour of "feminists and flappers" with dutiful and worthy women: "moral mothers". To corroborate his crusade for correct feminine training, especially before his audience of medical peers, Anderson chose to quote from the widely used text of the eminent American gynaecologist-- based at Johns Hopkins University Medical School, whose textbooks on the subject formed the basis of medical training around the world-- Howard Kelly:

Howard Kelly, in his "Medical Gynaecology", says: "The most important factor in the development of a healthy baby girl into a healthy young women is an intelligent mother, and no more urgent problem calls for solution to-day than that of securing adequate training for the duties of maternity. The care of the health of the growing girl begins with the education of her mother."⁹

Clara Bridgman and her colleagues were fully aware of the care they needed to take with their welfare activities lest they should face the indignation of city notables, and under the umbrella of their Mothercraft League, they began projects that managed to stretch the boundaries of what city fathers regarded as "motherly" activities, without overt criticism.

In November 1914, Bridgman raised the idea of the League becoming involved with the provision of "urgently needed hostels for young women arriving in the city". At a general meeting, she called for the creation of a new social club. Minutes of the meeting summarized her proposal:

Mrs Bridgman then read aloud the outline of a Scheme for a Native Girls' Club, suggesting that a small house should be rented in a suburb or slum district to be in

⁹ C. T. Anderson, "The Training of our Girls", South African Medical Record (27 May 1916) 147-148.

charge of a European lady, and to be used as a resort for native girls, where they could find innocent recreation and helpful instruction in useful arts such as housewifery, singing, etc.¹⁰

A year later, Bridgman was still trying to garner support for her idea, and she called on wealthy Johannesburg women to publicise the effort. During the course of 1915, Bridgman was successful in her efforts to get members to agree to combine plans for a hostel and social club, with other Mothercraft League projects, notably the creation of a register for black domestic workers. In this endeavour, Bridgman had the support of local black women such as the American trained social worker, Charlotte Maxeke.¹¹ But Maxeke and her male peers among the educated African elite of the city warned Bridgman that the black men and women were suspicious of any mention of registration and hostels for young women. Clara Bridgman recognized these fears in an address she delivered in August 1915 before a public meeting of the League, to which the press had been invited. Bridgman argued that her scheme would protect rather than exacerbate the position of black women in the city, pointing to equivalent institutions in British cities as a way to refute charges--which she said she had heard from "leading natives"-- that this was at heart a scheme set up to discriminate against black women. Bridgman announced that, to further allay the fears of "leading natives", her League would not use the name "hostel" for their proposed centre, but had instead adopted the name "Helping Hand Club". The next speaker at the same meeting, Jessie Hertzlet, elaborated on the scope of the scheme and

¹⁰ HPC/HHC A2050 Ba.1 "Minutes", 27 November 1917.

¹¹ See chapter one for details of Maxeke's work, and interest in a domestic workers.

upon the value of the planned domestic training aspect of the Club. Here, poorer black women would be able to learn skills with which to earn a living, and young women planning to marry "educated black men" could learn the skills of housewifery necessary to keep a Christian and modern home. Hertzlet concluded:

The word "club" is used in the modern sense often employed in England, where there were factory girls' clubs, workmens' clubs, and the like. The Helping Hand Club was designed to be a refuge from temptation, where there would be training classes and guidance in the right way of living.¹²

The "right way of living" was of great concern not only to white middle class female Christians, but also to many parents of young women who were loath to let their daughters come to the city gaining notoriety as a site for all of the dangers of immoral life. The language expressed in newspapers articles, written by black and white journalists, and from the pulpits of both black and white church congregations, was of a city rife with sexual liaisons between unmarried men and women; of an epidemic of premarital pregnancies; and of the cheekiness and waywardness of teenagers loosed from either "tribal" or Christian moral codes and parental controls.¹³ This anxiety did not decrease with the passage of time. Indeed in the 1930s, Edith R. Jones received dozens of letters

¹² STAR, 21 August 1915.

¹³ Deborah Gaitskell has written extensively on this theme of adolescent sexuality in Johannesburg. See: D. Gaitskell, "'Wailing for Purity': prayer unions, African mothers and adolescent daughters 1912-1940" in S. Marks, S and R. Rathbone (eds) Industrialisation and Social Change, and D. Gaitskell, "Housewives, Maids or Mothers: Some Contradictions of Domesticity for Christian Women in Johannesburg", Centre for African Studies: University of Cape Town, 1982.

from parents and young women themselves, concerned about conditions in Johannesburg, and imploring her to help secure regulated housing and employment on their behalf.¹⁴

During the following two years, as Bridgman worked to raise money to buy a suitable house for her Club, colleagues worked to establish other Mothercraft Leagues in southern Africa and to produce pamphlets on infant care and feeding for use on mission stations in rural areas. In Johannesburg, cooking and sewing classes were held for small groups of black women in the homes of members. In September 1919, after months of wrangling over the purchasing of a suitable property, the Helping Hand Club for Native Girls was finally opened in a house on Hans street in the small suburb of Fairview, which adjoined the working class, and still racially mixed areas of Jeppe and Troyville.¹⁵ Other missionary societies and religious groups followed suit, setting up two more hostels for black women, and in the next decade the municipality was forced to provide hostel accommodation, although this was very limited before the 1950s. By the late 1930s, the Helping Hand Club could pick and choose its residents, and the Club acquired something of an elite status. Beginning in the 1930s, certain white residents complained about the

¹⁴ HPC/HHC A 2052 Record series from 1914.

¹⁵ Deborah Gaitskell analysed the records of the Helping Hand Club in her dissertation on female missionary work on the Reef, demonstrating the importance of the Club as a site for Christian female networking, as a centre for domestic training, and as a locus for black women seeking respectable status to carve out a space for themselves in an often hostile environment. (In the original, Gaitskell spells Makhanya, 'Makanya'. I have taken the liberty of adding the 'h'.) See D. Gaitskell, "Female Mission Initiatives: Black and White Women in Three Witwatersrand Churches, 1903-1939", PhD diss., University of London, 1981). Her section on "Hostels and Housewifery", Chapter VI, details the work of the Club through twenty years.

presence of the hostel, but they did not manage to have the Club removed from an increasingly white residential area, until after the 1940s, in the wake of the passage of the legislation which would ultimately force the closure of the Bridgman Hospital as well. Gaitskell has examined the records of the Helping Hand Club, and demonstrated that initial suspicion towards the Club was soon superseded by the very pressing need for housing expressed by young women in the city, and by their parents in rural areas. Within a few years, Gaitskell argues:

The hostel ethos found support among those who favoured cooperation with whites, Selby Msimang and Umteteli advocating their encouragement. Social workers, Charlotte Maxeke and Violet Makhanya, cultivated by the Joneses and Mrs Bridgman, likewise warmly advocated hostels like the Helping Hand Club. By contrast, Makhanya criticised the government's hostels in Natal for their frequent lack of distinction between 'raw girls' and 'educated... clean respectable girls'... Hostels clearly had an appeal for 'respectable' African women.¹⁶

The political and social alliances created through the founding of the Helping Hand Club were crucial to Clara Bridgman's efforts to garner support from black men and women in 1927. Selope Thema¹⁷, Charlotte Maxeke, Minnie Soga and Alfred Xuma all lent the considerable weight of their support to the Hospital, helping to publicize its work, speaking at meetings, writing letters to the press, and most crucially, encouraging poorer black women, at church meetings and through networks of pastors and schoolteachers, to

¹⁶ D. Gaitskell, "Female Mission Initiatives", 256. The newspaper Umteteli wa Bantu was owned by the Native Recruiting Corporation, which employed black journalists and editors.

¹⁷ R. V. Selope Thema was a well known political leader in Johannesburg, holding for some time the position of Secretary in the South African Native National Congress, (later the African National Congress). See: A. Odendaal, Vukani Bantu! The Beginnings of Black Protest Politics in South Africa to 1912 (Cape Town: David Philip, 1984).

consider the Bridgman in a positive light.¹⁸ Maxeke, Thema and Xuma each took up positions on the Board of the Bridgman, signalling both their own commitment to the project, and the increasing movement, on the part of people such as Clara Bridgman, towards nonracial, or at least "multiracial" administrative, social and intellectual work.

The records of the Helping Hand Club for Native Girls provide valuable clues to the ages, names, places of origin, health, training records, and even the post-hostel employment history of some of the black women who took up rooms at the Club. Through the 1920s, the women involved with running the Club, began to comment on the need for vocational opportunities for black women with high school mission education, who were coming to Johannesburg to seek work, or who were the daughters of the local educated elite.

It is here that the records of the Helping Hand Club are so useful for an examination of the type of women that were attracted to the Bridgman for midwifery training in the late 1920s and early 1930s. Clara Bridgman read the letters from parents who desired greater tertiary training for their daughters, and participated in discussions with board members and visitors to the Club. When she and Frederick Bridgman left for the United States in 1924, she confidently argued, contrary to many white officials' explanations that there were "not suitable native women available for nurse and midwifery training", that the experience gleaned in running the Helping Hand Club indicated that

¹⁸ See Umteteli wa Bantu for 17 July and 1 September 1928; and for mentions of support from black city notables such as Maxeke, see the Star, January 6 1928.

there were many women who would be eligible for professional training. Further, she argued, the Club provided a needed site where black women arriving in the city from the "Kraals" could gain exposure to the rudiments of urban life, such as cooking methods, cleanliness regimes, sanitation skills. Most of all the Club was a place where they could imbibe from people such as herself, a "will to serve and improve the lives of others", qualities necessary not only for good domestic workers, and respectable wives, but also for the profession of nursing.¹⁹

Thus, by the late 1920s, when Edith R. Jones took on the day to day running of the Club, it had become an important site not only for prospective domestic workers and very young and recent migrants but also a place where mature women, single and increasingly married women, could use as their base.²⁰ This was the place to stay when taking on day-work in white households, when working in a hotel, or as pieceworker or seamstress. The Helping Hand Club was one of very few places a "respectable" women could reside, in a racially segregated city, with few facilities for black women, if they were seeking work, or, after 1928, waiting to gain acceptance into training institutions such as the Bridgman.

Any examination of the records in state, municipal, and missionary archives, of the history of nursing as a profession for black women in South Africa, will reveal the overwhelming contribution of one person to documenting the need for black nurses and

¹⁹ HPC/AD 843 B91.32.

²⁰ HPC/A 2050 Ba. 2: 18 February 1925.

midwives; for coordinating methods of training and compiling material for instruction across Southern Africa, for creating and updating a data base on all existing missionary and state hospitals serving black patients, and for championing the right of black women to equal professional recognition and certification: Edith R. Jones.²¹

Jones was married to John R. Jones-- who along with Ray Phillips had started the South African Institute of Race Relations (SAIRR) in 1929, the year after the Bridgman opened its doors-- coordinated activities and maintained the letters and correspondence of the Helping Hand Club, and from 1931, created a role for herself as "Women's Organiser" of Health and Welfare work for the SAIRR. In this capacity she generated and accumulated a vast store house of information from all over Southern Africa, which she organized into publicity and promotional materials, such as her pamphlet, "Nursing as a Profession for Non-European Women". This text was first published as a feature article in the Health Society Magazine, founded by Dr McVicar of Lovedale Mission Hospital in the eastern Cape for black nurses, health visitors, ministers and 'informed native leaders', and later as a booklet.²² In this publication Jones provided detailed information concerning the requirements for and length of training, as well as an indication of the types of

²¹ HPC/ AD 843/RJ/Kb. See the extensive Nursing files in the SAIRR collection. Also see the correspondence between the Public Health Department and E. R. Jones, in CAD/GES 1798 29/30 "Nursing", in File 1913- 1936; and File 29/30 "a".

²² "Nursing as a Profession for Non-European Women", The Health Magazine (February 1942), which was published at Lovedale; she received requests for off prints of the pamphlet until her death. Also see: HPC/AD 843 RJ Na 13 "Social Services" for letters to E. R. Jones from 1932 to 1942.

remuneration offered to women with nurse and midwifery qualifications. The booklet also carried a series of didactic essays on the history of nursing and on its moral value as a suitable vocation for Christian women. Until she died, Edith R. Jones received weekly requests for off-prints of the booklet, and she replied to each letter, often recalling that women who wrote with questions about midwifery training after qualifying as general nurses, had applied for her booklet as high school students. A typical example arrived at her office in late December 1942:

14th 12th 1942

Dear Madam,
Having read on the Bantu World of the 5th instant about Nursing courses for Non-European women, I wish to have fuller information. May you kindly send me a booklet "Nursing as a Profession for Non-European Women".
Thanking you in anticipation,
R.M. Mogoba.²³

In the 1930s, as word of the Bridgman Hospital's training programme spread through school and missionary networks outside of Johannesburg, Jones received many letters from women who had some training as general nurses, many of them from women working as nurses in isolated rural mission clinics:

Ramakokstad Clinic, via Brits

Transvaal
19 July 1938

Dear Madam,
I kindly implore you to help to furnish me in the following matters.
I have applied for a vacancy as a Probationer nurse in "Pupil Midwifery" in Bridgman Hospital, and have failed on account of the full least. Now Madam, please will you try your best if you can get me a space... I have already handed in

²³

my testimonial. Any further details about my qualifications can be required from the Matron of the City Deep Hospital where I was trained,
I have the Honour to be,
Your faithful Servant,
Alsina Nxumalo.²⁴

Throughout the 1930s and early 1940s, before her early death, she responded to these letters, as well as many from anxious parents, seeking advice on careers in midwifery and nursing, asking for her in securing safe places for their daughters to stay while in Johannesburg. Her reply to Alsina Nxumalo is typical of her brusque yet responsive style:

Dear Nurse,
Has the Bridgman Hospital definitely turned down your application or did they merely say you should wait your turn? If the latter I strongly advise you to do so. But if you have not Std VII at least, you will have little chance of getting in at Bridgman.
If this is so, and from your name I suspect you speak Zulu, I advise you to apply to apply to Kwa Magwaza via Melmoth. They might be able to take you....
Is it a Native Council Clinic at Ramakokstad? I did not know there was a Nurse there!
Yours sincerely,
Edith Rheinallt Jones.²⁵

Edith R. Jones took her campaign for black nurses and midwives on tours of churches, mission institutions, and schools for the secondary education of black women, across the length of the country, which helps to explain why, after her husband, John R. Jones had been elected as one of the Senator's representing "Natives" in the white Parliament, many correspondents addressed her as "Senator Jones", and wished her well in her political work for "our people".²⁶

²⁴ HPC/AD 843 41.4.1 July 1938.

²⁵ HPC/AD 843 41.4.1 July 1938.

²⁶ HPC/AD 843 41.4.1 See especially the letter of 19 July 1943.

Besides their valuable connections with people such as Edith R. Jones and her husband, Ruth Cowles, and the Phillips, when Frederick and Clara Bridgman left South Africa for their American furlough, they had established very close relations with a number of physicians and cultivated connections to the new medical school. Clara Bridgman had connected up with the American born physician, Dora Dart, who was at the time, married to Raymond Dart, Professor of Anatomy at Wits. Dora Dart began working alongside Dr de Cottens in her clinic, and when Clara Bridgman returned to South Africa, Dora Dart and Raymond Dart helped cement the connections between the Medical School and the new Hospital.²⁷ Ten years after arriving in Johannesburg, and on the eve of their departure for a long visit to America, the Bridgman couple were well established in the philanthropic and circles of Johannesburg. The Helping Hand Club and the Mothercraft League, as well as the small Doornfontein clinic were small, but widely publicised institutions, and even as the Bridgmans travelled around the USA, the Doornfontein clinic expanded. When Clara Bridgman returned in late 1926 she was delighted to learn that a zealous public health advocate, Dr Mary Tugman from England, along with her mother, a certified midwife, had begun assisting Dr de Cottens in her Doornfontein centre. The mother and daughter team soon established a set of rooms in Sophiatown, out of which Mary Tugman

²⁷ These connections between the Bridgmans and their allies have been traced through letters and minutes of meetings of the Bridgman Board. See HPC/AD 843 "Minutes".

conducted follow-up visit to de Cottens patients, trying to assist children with chronic illnesses, and maintain contacts with women with Mrs Tugman's help.²⁸

While the American origins of the Bridgmans, may have presented some initial caution on the part of avowedly English health officials such as Charles Porter, soon turned out to be an advantage, especially in their contacts with the influential Alexander Orenstein, a senior mining physician employed by Rand Mines. Orenstein had originally been brought to South Africa by Rand Mines because of his work as the assistant to Colonel William Gorgas, the chief public health official involved with the construction of the Panama Canal.²⁹ The impact of the American-trained Dr Orenstein, on all aspects of health expertise in the city (in the mining industry, on public health, on the Wits Medical School), is yet to receive full treatment, but his interest in Clara Bridgman's scheme for a

²⁸ In 1931 Mary Tugman managed to secure funds for a small nursing home in Sophiatown for women and small children recovering from illnesses and in need of nursing. She managed to gain the patronage of Princess Alice, for whom the home was named. The Home had beds for 5 adults and 6 children, although in its first year of operation, there were often more than ten adults receiving nursing at any one time. After the Tugman's death in an accident in 1932, the Home was unable to function, until "the transfer of a doctor and matron from the Bridgman Hospital... attempted to fill the gap". Taken from: D. Gaitskell, "Women, Religion and Medicine in Johannesburg between the Wars", African History Seminar, Institute of Commonwealth Studies, University of London, (18 May 1983), 8; and see the Obituaries to Mary Tugman and her mother in the South African Medical Journal, August 1933.

²⁹ Gorgas had conducted a survey of mining conditions on the Rand in 1913, on the invitation of the Chamber of Mines, and offered recommendations for ways to lower mortality, (most of which were ignored, such as his recommendation for a phasing out of migrant labor, and the provisions of family accommodation for male workers). As Gorgas' assistant Orenstein had demonstrated his ability to manage the health of large numbers of workers, who laboured in very dangerous and arduous circumstances. See: A.P. Cartwright, Doctors of the Mines (Johannesburg: Purnell, 1971).

maternity hospital after her return from America, provided an important link to the mining industry. Although the Hospital never received but rather modest bequests from private mining companies (and somewhat more from the Chamber of Mines) it did receive various forms of support regarding services and technical advice, for example, the building plans for the Hospital were drawn up by mining architects and engineers with the instigation and aid of Orenstein; the creation and upkeep of an extensive garden surrounding the Hospital was sponsored by mine company nurseries; and expensive surgical equipment was purchased through cheaper mining company Hospital networks.³⁰ More importantly, the presence of Orenstein on the Board of the Hospital, gave the Bridgman access to his web of connections throughout the scientific and medical community in the city, principally the South African Institute for Medical Research and the Wits Medical School. Clara Bridgman could also draw on the connections that Frederick Bridgman had cultivated while alive, with accounting and legal professionals associated with the mining industry. Howard Pim and Walter Webber, who had worked with Frederick Bridgman in setting up the Bantu Men's Social Centre and the Joint Council movement, in the 1918 to 1924 period, agreed to become Bridgman Hospital board members from the start, and provided free financial and administrative services to the Hospital for the remainder of their lives.³¹

³⁰ The original plans for the Bridgman Memorial Hospital are housed in the Barlow Rand Archives. My thanks to Mrs Di Arnott for locating them on my behalf. They were drawn up and completed on 10 October 1927, and remained the property of the Central Mining and Investment Corporation, LTD. Also see the Annual Reports for donations and bequests, HPC/AD 843 Series "Annual Reports".

³¹ For details see HPC/AD 843 "Annual Reports" and see P. Rich, White Power,

The Bridgmans had hosted a number of visiting American philanthropist organizations and missionary visitors to Johannesburg in the early 1920s. They escorted representatives of the Carnegie corporation, the Phelps-Stoke Commission (whose representatives toured South Africa in 1921), and women missionaries connected to such institutions as Mount Holyoke Seminary in Massachusetts, on tours of the city and its slums in Doornfontein and Vrededorp, as well as to churches and recreation halls in Sophiatown and the city centre. In 1925, these connections stood Clara Bridgman in good stead as she petitioned American organizations for financial donations for her hospital project. Since the mid nineteenth century, when the ABM set up a school for African women to receive academic instruction, the Inanda Seminary in Natal, women teachers there had been drawn from a pool of Mount Holyoke graduates, and indeed the school itself was modelled on the American institution.³² These Mount Holyoke and ABM connections survived into the twentieth century, and after Frederick Bridgman died suddenly while on his fund-raising tour in America, women at Mount Holyoke, students as well as alumni, rallied around Clara Bridgman, providing financial and institutional support

"The Joint Councils", for details on the attempts by Bridgman, Phillips and R Jones to garner support from the black elite on the Reef in the midst of increasing resistance to white paternalism and segregation, and increasing radicalization of the black petty bourgeoisie. For an elaboration of this theme, see: P. Bonner, "The Transvaal Native Congress, 1917-1920, the radicalisation on the black petty bourgeoisie on the Rand", in S. Marks, and R. Rathbone (eds) Industrialisation and Social Change.

³² For the history of Inanda Seminary, and its relationship to the ABM project, and to Mount Holyoke Seminary, see: H. Hughes, "'A Lighthouse for African Womanhood': Inanda Seminary, 1869 to 1945" in C. Walker, (ed) Women and Gender 205.

to sustain her campaign. When the Bridgman Hospital opened, it received annual bequests from students at Mount Holyoke, as well as small and large donations of such items as bedding, infant clothing, and funds for the purchase of incubators.³³

On her return from the USA, Clara Bridgman resisted using her husband's name in her early suggestions for a title for the Hospital, arguing that this might make her intention to cooperate with and involve other religious and missionary groups more difficult. In 1927, as the planning for the Hospital got underway, Clara Bridgman wrote to John R. Jones, as well as her supporters in the USA, expressing open concern that the planned hospital should bear her husband's name. She was anxious lest other missionary societies feel slighted, and she was also concerned to maintain the public's connections between the planned hospital, the Helping Hand Club and other missionary work on the Reef. But by December of that year, she had been won over by friends such as Edith R. Jones, who recognised that the high esteem accorded to Frederick Bridgman in the city, as well as the sympathy that could be garnered from the local public by using the name of a man who had died "in service" while raising money in his own country for the people of Johannesburg, would help the fundraising effort. They also argued that Clara Bridgman would become even more effective as a representative of the Hospital, and that this would off-set any anxiety other organizations might have about the use of the name.³⁴

³³ HPC/AD 843 Series "Annual Reports". See the sections on "Bequests and Donations".

³⁴ HPC/AD 843 B91 3.2 See for example the handwritten letters from Clara Bridgman to J D Rheinallt Jones; 3 August 1927 and 6 August 1927.

At meetings in January and February of 1927, twenty-five people were nominated to the Board, with additional members added in later years. The Board included people previously mentioned, such as Clara Bridgman, Margeurite de Cottons, Ruth Cowles, Dora Dart, John R. Jones (Edith became a Board member later, and then resigned when her work load at the SAIRR and the HHC became too heavy), Charlotte Maxeke, Constance Morisse, Alexander Orenstein, Howard Pim (and his accountant partner, H. Hardy), Selope Thema, Mary Tugman and Walter Webber. There were also a host of representatives from religious organisations such as Rev Bovet, Rev Fouche, Rev Bruce Gardiner, Rev T. N. Mahlamvu, and Deaconess Elsie Vigor. A well regarded child specialist, E. P. Baumann, who worked at the Johannesburg Hospital for Children (white children), also joined the Board, and provided valuable access to the municipality with the help of Sister Morisse, the Senior Lady Health Visitor, and Miss B G Alexander, a leading matron, nurse organizer and nurse-trainer, based at the Johannesburg Gen. In later years, the physician Alfred Xuma, and honorary Gynaecologists and Obstetricians, such as John Black and John McGibbon joined. A number of other Johannesburg notables participated intermittently as Board members in the ensuing years, including the Wits Bantu Studies and Anthropology lecturer, Winifred Hoernle. Finally, the Rev James Dexler Taylor, an AMB representative in Johannesburg, who had been promoted after the death of Frederick Bridgman, was also drawn in as a Board member, but his presence was not strongly felt until the Hospital was actually established in 1928, possibly because Clara Bridgman

wanted to avoid any possible hint that the Hospital would be dominated disproportionately by AMB members.³⁵

At the same time that the Hospital Board was being formally constituted, Clara Bridgman provided the initiative for the formation of an auxiliary committee, which she declared would be "devoted to Native Health on the Witwatersrand".³⁶ The "Bridgman Native Health Committee, Auxiliary to the Bridgman", was thus formed, with a smaller number of centrally involved Bridgman Board members. This was Bridgmans' practical way of linking the work around the planning, and later administering the Hospital, with the broader health needs of women and children in the communities surrounding Brixton, and with the satellite connection at Alex Clinic. In every one of their initial meetings Bridgman stressed the need for better preventative public health work, to strengthen family life, and aid mothers and children in need. She drew on new concepts in public health gaining ground in the USA and Britain at the time, which underscored the futility of concentrating upon only one aspect of social reform work. In this regard she was far ahead of many of her peers, but found strong support from people such as Ruth Cowles, Edith R. Jones, Dr de Cottens, Dr Dora Dart and Dr Mary Tugman; prominent black

³⁵ HPC/AD 843 B91.32 "Minutes" from February 1927 to December 1928. Perhaps some of Clara Bridgman's sensitivity to the perceptions other missionaries had of the ABM stemmed from her experiences in Natal, where the ABM influence was much stronger, and the tension between mission societies more evident. The success of the medical missionary, Dr McCord, in establishing an ABM sponsored hospital in Durban during this same period, may have provided her with evidence of the need to cooperate across religious denominations.

³⁶ HPC/AD 843 B91. 32: 25 January 1927.

leaders in Johannesburg, such as Selope Thema and Charlotte Maxeke; and people on the City Council's health staff, such as Sister Constance Morisse. In the minutes of these meetings, Bridgman consistently stressed the need for Health Propaganda and Mothercraft work. Throughout the 1930s the Auxiliary Committee worked to further local Child Welfare initiatives, "Mothers' Unions" (initiated by the Anglican Church), and women's clubs. Furthermore, in the few cases where mothers died at the Bridgman, the staff and Board members often took on the responsibility of finding funding and homes for the children, and keeping in contact with their families over long periods.³⁷

In January 1928, ten years of long-term planning began to bear fruit as brick walls appeared above the veld grasses along the edge of the Brixton hill. The city's most widely read papers, the Star, Rand Daily Mail, and Umteteli wa Bantu, all carried news of the forthcoming event:

Mrs F. B. Bridgman will lay the foundation stone of the Bridgman Memorial Hospital for Native Women, Chiswick Street, Brixton, at 3:30 tomorrow afternoon. The hospital is a memorial to the late Rev. Dr F. B. Bridgman, formerly head of the American Board Mission... Dr. Bridgman died while on a furlough to the United States in 1925, and before her return to Johannesburg at the end of 1926, Mrs Bridgman collected the sum of £5,000 towards the hospital.³⁸

³⁷ HPC/AD 834 B91.32 "Minutes of Auxilliary Committee". Clara Bridgman took special interest in the children born at the Bridgman, and encouraged staff to follow-up on cases of sick and poor mothers. In the famous case of the Bridgman Quads in 1948 (whose mother died after giving birth), the children were kept at the Hospital itself for a year, before arrangements were made for them to enter the care of the Salvation Army. See the Silver Jubilee Pamphlet, 1953.

³⁸ See articles in the Rand Daily Mail, Umteteli wa Bantu and the Star of 6 January 1928. This quotation is taken from the Star of that day.

The money raised in America formed the bedrock upon which the Hospital was founded. Soon after returning at the end of 1926, Clara Bridgman called a series of meetings at the YMCA to set up the Board. An indication of the range of funding raised by Clara Bridgman appeared in the Star newspaper, on the eve of the ceremony marking the laying of a foundation-stone for the Hospital, along with a summary of the work completed by the Bridgman Board in the previous year. Determined to ensure that the Transvaal Provincial Council made its grant to the Hospital, in line with other non-profit health centres in the region, Clara Bridgman publicised the Province's interest in the scheme, even before any funding had been certainly secured. The ceremony was an attempt to utilize the New Year as a symbolic moment before launching a six month drive to raise funding and gain publicity for the Hospital:

Finance naturally plays an important part in a scheme of this kind. As a result of Mrs Bridgman's efforts in the United States, £4,000 became available for the building, and a sum of £300 per annum for maintenance. Since Mrs Bridgman's return to Johannesburg a further sum of £200 per year has been voluntarily contributed by friends. The amount in hand is approximately £5,000, including £1,000 for equipment. With the expected grant from the Provincial Council, the building fund proper will be £6,000. This leaves to be secured approximately £4,000 for building and £1,000 for equipment. For general maintenance, including salaries, £3,000 will be needed every year, and of this probably £500 will be provided by patients' fees. To meet this a financial campaign will soon be launched, and so much interest has already been shown by the public that the committee feel confident that the money required will be forthcoming.³⁹

By the end of July, Bridgman and the Board members had raised nearly £3,000 more, and secured commitments from industrial concerns, local retailers, church and missionary societies and wealthy individuals. All in all, the funds raised in the USA amounted to £6,

³⁹ Star 6 January 1928.

486 and local funds to £4, 162. Clara Bridgman managed to garner double the expected grant from the Transvaal Provincial Council (£2, 000), and the largest remaining local sum of £1, 025, was donated by the Native Recruiting Corporation. The donations of several mining companies amounted to very little, between £20 and £50 each. In her early fund raising attempts in Johannesburg, Clara Bridgman had been convinced that local employers of large numbers of black male and female labourers would be willing to shoulder the bulk of running costs for the Hospital, but she was met with very little success in her endeavour, and only managed to secure donations of between £20 and £100 pounds from the largest secondary industrial corporations. The Rand Daily Mail, in an editorial on the "Vital Need" being filled by the Hospital, commented on the lamentable lack of support from local state sources, juxtaposing the proposed grant from the Province with the income it took in from black workers, and pointing out that:

Self-interest alone should impel the European to help to improve the existing state of affairs, which, in large urban areas, is as bad as it can be, and yet we find that more than half of the cost of the building and equipment of the Bridgman Memorial Hospital is being met by American subscriptions. The Provincial Council takes the best part of £500, 000 per annum in native pass fees, of which the European employer in Johannesburg pays £100, 000. The proceeds of this medieval form of taxation were originally intended by President Kruger to go to the support of a Johannesburg hospital. To-day they are merely a means of augmenting provincial revenue, and we agree with the Mayor... that some part of the money should be refunded to the municipality.⁴⁰

While this liberal newspaper exaggerated the connection between the implementation of a "Native Pass" in the late nineteenth century Transvaal Republic of President Kruger, and the establishment of health services, it did furnish concrete evidence of the gross disparity

⁴⁰ Rand Daily Mail "A Vital Need" 8 January 1928.

between money expropriated in the form of taxes and fees from black men and women, and the amount actually spent by the Province on housing, health and welfare services for these same people.

Meanwhile, Clara Bridgman had also negotiated what she believed would be long term bequests from her friends in America, including an annual grant for the salary of Nurse Cowles (who would oversee the four clinics connected to the Bridgman), and an annual grant for the salary of a black nurse-midwife (Poppy Bud M'belle was appointed). But the USA funds began to dwindle after 1929, when the effects of the Depression began to bite into the resources of even her wealthy friends. Still, for the first two years these added bequests got the Hospital up and running, figuratively as well as literally as it turned out, because the last minute donation from a "connection" in America of a Ford Motor Sedan and a small ambulance, provided Hospital staff with their only on site transport for several years.⁴¹

The six-acre location for the Hospital in Brixton, had been agreed to after weeks of discussion among the Board members, who wanted the best possible site, in terms of access to the townships and freehold areas on the cities western perimeter, as well as to city slums and domestic workers quarters. But they were already aware of segregationist sentiments among white residents of the western areas, and so they chose a site near main roads and a cemetery on an unoccupied strip of land.⁴² The chosen site was deemed

⁴¹ HPC/AD 834 B91.32: 4 April 1927.

⁴² HPC/AD 843 B91. 32: 25 January and 17 February 1927.

"perfect" by the press, and "easily accessible to natives, whose trams and buses pass close to the door"⁴³ The land itself was purchased at a nominal price from Consolidated Langlaagte Estates, with some help from the well-known liberal mining lawyer, Walter Webber. The honorary architect for the buildings was also connected to the mining industry, Mr Goetzche, and he received expert advice concerning the layout of the ward and surgery theatre from Dr Orenstein. The original plan contained ward space for 30 beds, divided into six ward, 2 of which could be used for infectious cases and for isolation treatment. A large, modern operating theatre was built, and bedsides meetings rooms, offices, accommodation for a matron, nurse-midwives and cleaning staff, the plans included a large area for an Outpatients department. The plans were specifically designed to predict future expansion as and when money was raised, and piping and electric lines were laid accordingly, as were the extensive stone foundations.

In the last week of August 1928, the Bridgman Memorial Hospital was finally opened, with grand pomp and ceremony, a few weeks after the first patients had been admitted. Reporters from the daily papers covered the event with photographs of the Hospital buildings and gardens, as well as of the assembled crowd of dignitaries. After a glowing essay on the "proof" that the existence of the new Hospital provided of "the undying spirit of fellowship and humanity which permeated the missionary endeavour", the correspondent from Umteteli wa Bantu quoted extracts from speeches and commented on the large crowd:

⁴³ Star January 6 1928.

The Memorial Hospital, established for the midwifery treatment of Bantu women, was opened by the Administrator (Hon. J. H. Hofmeyr) in the presence of a large gathering of Europeans and Natives. Among those on the platform were the Director of Native Labour, (Major H. S. Cooke, OBE), the Mayor of Johannesburg, (Mr W. H. Port), the Right Rev. the Bishop of Johannesburg, (Dr A. B. Karney). Mr Walter Webber, Dr J. Dexter Taylor, Dr A. B. Xuma and Mrs F. B. Bridgman presided.⁴⁴

After lengthy renditions of the mutual congratulations offered, and details of the financial situation of the Hospital, the journalist from Umteteli wa Bantu quoted from the last section of Clara Bridgman's address, and reporters for the Star and the Rand Daily Mail carried almost the same extract in their text from the same day:

When this ceremony is over, I want you to walk through the ward. I want you to come and see Romulus and Remus, two Native babies. One of them was born in the streets a few days ago, and the other was born in the ambulance on the way to this hospital. You will see them sleeping comfortably together in a cot, and the mother of the two children is also doing well. It is an example of the dire necessity for this hospital.⁴⁵

Clara Bridgman then introduced the Hospital's Medical Superintendent, Dr Ethel Smith; the Matron, Miss M. E. Johnson; the Head Sister, Miss Boulenez; and the Native Nurse-Midwife, Miss Poppy Jane M'belle, to the assembled crowd. She invited the audience to talk with the staff as they toured the wards and admired the sleeping twins. The Roman names of the twin boys, Bridgman explained, had been chosen on their mother's request by Dr Ethel Smith whose specialist care had prevented the death of the mother and at least one of the babies.

⁴⁴ Umteteli wa Bantu 1 September 1928.

⁴⁵ Umteteli wa Bantu 1 September 1928.

Who were these women that occupied the surgery theatre, wards, tea rooms, outpatients department, and midwifery classrooms of the new Bridgman Hospital? Indeed the founding of the Bridgman gave institutional credence to the existence of women in every nook and cranny of Johannesburg, except the male mining compounds and the deep underground tunnels beneath the city in which male miners laboured to extract gold.

A Women's Hospital in a City of Women

Although the number of couples or married partners involved with missionary and philanthropic work on the Reef was perhaps unusually high, the Bridgman, and kindred institutions such as the Helping Hand Club and Alexandra Health Centre, relied very heavily on single, professional medical women to carry the weight of the daily working of these institutions.⁴⁶ Ruth Cowles was a prime example of the type of dedicated woman drawn to health work in Johannesburg at this time. In a preliminary study of her contribution to the Alex Clinic and community, Marcia Wright has traced Cowles work in Doornfontein and Sophiatown before the establishment of the Bridgman and the Alex Clinic, and has demonstrated Cowles' commitment to women and infant health work in the city:

⁴⁶ The Alexandra Clinic was opened in 1934 with the help of the ABM, private donors, the Native Affairs Department and Wits University, and formally absorbed by the University in 1940, as a key site for practical medical training of students and as the chief charity and fundraising project of students. Alex Health Centre and later Clinic sent women with anticipated difficult deliveries to the Bridgman until the 1950s, as well as all patients in need of gynaecological surgery.

In November, 1923, Ruth Cowles, at the age of 31, affirmed that Johannesburg was "the place where my life would count for the most".⁴⁷

Cowles was also instrumental in supporting the development of a professional nurse and midwife association for black women in South Africa, which was inaugurated as the first midwife trainees from the Bridgman began to take their qualifying examinations in 1929. The Bantu Trained Nurses Association, relied heavily on the energy of Ruth Cowles, and Harriet Mbata, one of the first generation of certified black nurses, who together with Cowles established and ran the first district and clinic services in Alex.⁴⁸ Their close partnership survived until Ruth Cowles retired finally left South Africa in 1946.⁴⁹

The matrons and sister tutors hired by the Bridgman were recommended by Edith R. Jones and Ruth Cowles, who sought out and interviewed women with extensive experience working with black women, and who showed a commitment to the nondenominational but Christian ethos of the Hospital. All but one of the Bridgman medical superintendents were women, and the four most long-standing superintendents of the Hospital, namely Doctors Smith, Trant, Roberston and Carlisle, all trained in Britain and came or returned to South Africa as missionary doctors, often after tours of service in British colonies, or other Southern African mission hospitals. Most of these professional women were single, and remained so not only for their terms of service, but for their lives.

⁴⁷ M. Wright, "Urban History and Health: Nurse Cowles and Alexandra Township, 1926-1946", Project on Poverty, Health and the State in Southern Africa, Proceedings of the First Workshop, Columbia University, 1985, 18.

⁴⁸ We will return to discuss the Bantu Trained Nurses Association below. See HPC/AD 843 B89.1.5.6 and HPC/AD 843/RJ/Kb 24 (file 2).

⁴⁹ M. Wright, "Urban History and Health" 18-20.

Gaitskell has written about the contradictions that often surfaced in Church-based women's prayer and mothers' unions, when adult African women, who often drew on their experience and position as mothers to authorise their speech and position, questioned the wisdom and value of white, single, childless women. By 1928 a pattern had been established where single white women would dedicate themselves for decades to missionary work, teaching and medical work, while in supervisory positions over often older women. The Christian message preached by these white women was often centered on the dignity of Christian motherhood and the value of infant life, and not surprisingly the anomalies of station and experience struck many black women very forcefully.⁵⁰ As we shall see, the emphasis in midwifery training--especially in the 1930-1950 period--on accepting unmarried young women, underscored the unease many older black women expressed about the skill and experience of trained midwives.

In the case of white women doctors, it most interesting to note, that black women challenged their position as medical experts infrequently, if at all.⁵¹ There were very few practising female doctors on the Rand in the late 1920s, and most of these women were

⁵⁰ D. Gaitskell, "Devout Christianity? A Century of African Women's Christianity in South Africa", in C. Walker, (ed) Women and Gender, 264.

⁵¹ In the debates over mandatory venereal disease examinations for black women domestic workers and men at labor recruitment sites that raged in the 1920s, the need for women physicians, to "prevent moral danger" (presumably both to black women and to white doctors), was stressed, and indeed it was in this capacity that many of the first women physicians were hired by local state authorities in South Africa, for example, Dr Betsy Goddefroy in Johannesburg. See IAD/JPHD A6153; CAD/NTS 6761 103/315 "Native Women: Medical Examination of in Urban Areas" and HPC/AD 843 RJ Na.10 "Social Services".

drawn to work at the Bridgman and sister institutions. Most white women in the city were accustomed to viewing male physicians in positions of authority, and it was difficult for women physicians to build up private practices.⁵² Most women who entered medical training did so against great odds, and at great personal sacrifice, and many only stayed the course of their training because they had support from missionary groups, or a zealous commitment to public service. It was not unusual then, that many of these women were drawn to the Bridgman, where their expertise was acknowledged, and where they were welcomed *as women*, with specific empathic capacities and worth. The hiring of women physicians arose from the explicit instigations of Clara Bridgman, Dora Dart, M. de Cottens and Mary Tugman, who stated that they wanted the Bridgman Hospital to seek out female physicians to lead the medical work of the Hospital.⁵³ Their appointments greatly legitimized the professional status of women specialists, and crucially, provided a site where women doctors could gain access to research opportunities from which they were excluded in most state and private hospitals. Until the a new cohort of locally trained women graduated from the Wits Medical School in the early 1940s virtually no local women doctors outside of the Bridgman were involved in any academic and scientific research in the fields of obstetrics and gynaecology. The tightly closed, chauvinistically

⁵² For a detailed discussion of the prejudices faced by women physicians in South Africa, both in the part of patients and state health authorities, see the correspondence between Dr Elsa Fristedt, Mrs Margaret Ballinger (who campaign on her behalf), and the Secretary for Public Health in HPC/ AD 843 RJ Na.7.9. This file also contains newspaper cuttings and articles on the same subject.

⁵³ HPC/AD 834 B91.32 "Minutes of Board Meetings".

proud, network of "male midwives", that had sprung up in South Africa in the 1910s, did not relinquish masculine control of the speciality until well into the 1970s.⁵⁴ This was not specific to South Africa, as historians of medicine in Britain and the USA have demonstrated.⁵⁵

In the mid 1930s, however, a new generation of women scientists who worked under the tutelage of Raymond Dart at Wits Medical School, began to challenge the exclusion of females from the "hard science" aspects of medical research. Dart's first marriage to a woman physician, and his contact with women scientists in the United States, may have influenced his unusually energetic encouragement of women scientists at Wits.⁵⁶ Among these women, Margaret Orford was an outstanding example. First registered for a science degree, she later transferred into medicine, and after qualifying, managed to specialize as one of the first women gynaecologist-obstetricians in South Africa.⁵⁷ Besides Margaret Orford, and the help of Dr Rose Ryan in the early years of the

⁵⁴ Interview: Ruth Drubin, Johannesburg, 4 November 1992, Transcript, 1 and 5. by the mid 1980s the number of women medical students equalled or surpassed that of men.

⁵⁵ For example: J. Lewis, The Politics of Motherhood (London: Croom Helm, 1980) and J. Walzer Leavitt, Brought to Bed: Childbearing in America, 1750-1950 (Oxford: Oxford University Press, 1986).

⁵⁶ Interview: Ruth Drubin, Johannesburg, 4 November 1992, Transcript, 3. Dr Drubin recalled that Dart became a close friend long after her days as a medical student in his class, but that he stood out from his male colleagues even when she studied Anatomy with him in 1937, because he tended to abstain from the sexist innuendoes of his male colleagues, and because he referred to the work of many women scientists in his teaching.

⁵⁷ As a young scientist, Orford relied on Bridgman women patients as subjects. Her early research in the field of anthropometry will be referred to again in the next Chapter. See M. Orford, and L. H. Wells "An Anthropometric Study of a series of South African

Bridgman's existence, all the Honorary specialists attached to the Bridgman, who usually held appointments at the Wits Medical School and the Johannesburg Gen as well, were men. It was these men and their advanced students who conducted most of the scientific research of the Hospital, which forms the subject for a separate chapter.

Beginning in the early 1920s, and reaching a fever pitch in the 1930s, politicians, local and central state medical authorities, university professors, magistrates and medical missionaries, debated the lack of local medical training for black doctors. Already, by the mid 1920s, a number of black men had trained as physicians overseas, particularly in Scotland, and had returned to practice in South Africa.⁵⁸ The presence of professional black men with medical degrees from the same institutions as white medical doctors in South Africa, was enormously threatening to many in the medical academy.

In early 1927 one of the first strikes ever by nurses in South Africa broke out at Mafeking Hospital, when a group of white nurses objected to the presence of Dr Molema, a well known physician trained in Glasgow, who attended private patients in the Hospital,

Bantu Females", South African Journal of Science (1937). She died from a genetic blood condition before publishing much of her research, and was memorialized in the Annual Margaret Orford gynaecology Lecture at Wits Medical School. Details of Orford's life from interviews with Geoffrey Charlewood, January and November 1992, and see "Manuscript" of "Questions" from C. Burns and 'Responses' from G. Charlewood, 8 March 1992, page 7 and 8.

⁵⁸ There is a vast collection of sources for these debates, including IAD/JPHD A6153 "Medical Services Native Townships"; HPC/AD B 91.2.1 "Medical Training"; and newspapers and journal articles. For the reminiscences of a black physician in South Africa, see R. J. Xaba, "My Experiences as a Medical Student and as a Practitioner Among my own People", in the South African Medical Journal vol xviii, 22 (1944).

both black and white.⁵⁹ Letters to the press and in the local medical journals, attest to the fact that sentiments among white nationalists and racists in the medical community played an important role in propagating the mood of anxiety about the strike, until it reached the floor of the Cape Parliament later that year. Here, an attempt to create an Ordinance designed to bar black physicians from treating white patients, and to prevent white nurses from having to take orders from a black doctor, was raised for debate, and then quashed. The strike itself was crushed, and the ensuing trial, wherein Molema sought damages from the nurses, resulted in a settlement in his favour, apologies from the nurses, and the award of legal costs and additional compensation which the nurses were forced to pay (although most of the money seems to have been raised by local whites who had supported the strike).⁶⁰

The reasons for the failure of the proposed Ordinance and the strike, were also due to powerful interventions from the medical academy. Seldom united on any issue except the protection of their professional rights and status, the South African chapters of the British Medical Association, the editors of the two leading journals (The Journal of the Medical Association of South Africa B.M.A and the South African Medical Record),

⁵⁹ See the editorials entitled, "The Mafeking Nurses Strike", "The Mafeking Nurses' Trouble" and "The Mafeking Nursing Position" in The Journal of the Medical Association of South Africa B.M.A. (14 May, 11 June and 23 July, 1927); also see A. G. H. Hay-Mitchel, "Native Medical Practitioners and European Patients", The Journal of the Medical Association of South Africa B.M.A. (8 October, 1927).

⁶⁰ "The Mafeking Nurses' Trouble", The Journal of the Medical Association of South Africa B.M.A. (11 June 1927).

published long editorials and feature articles containing grave warnings to fellow doctors who supported race-based prohibitions on the practice of qualified doctors. The reasoning of these leading medical men was not based on a liberal renunciation of racial ideology, although some missionary doctors--notably Dr H. A. Moffatt from Cape Town--and a very small group of medical practitioners who worked alongside the few black doctors in rural practice, wrote impassioned letters testifying to the equality and humanity of their peers.⁶¹ The organised medical establishment eventually succeeded in retaining the *status quo*: no racial language in any legislation connected to physicians; relying on "normal social differences" to ensure most doctors treated their "own kind"; and upholding the right of patients to choose their own doctors, even in a state hospital, thus allowing legal space for a white patient to ask to be treated by a different doctor if one was available. This success was solidly based on their anxiety that differential legislation would delegitimize their position in the world medical community; undermine their ability to centrally control medical fees, licensing and disputes; and, even more dangerously, allow the creation of a class of black doctors who were able to treat people of only one racial designation, thus opening the door for the next step: preventing white doctors from treating black patients. It was very difficult for arch racists to sustain arguments about the inferiority of black doctors and so their attacks on the professional abilities of black doctors were rather feeble and faded quickly. Instead they focused on the great bogey of

⁶¹ H. A. Moffatt, "Native Doctors and European Patients", The Journal of the Medical Association of South Africa B.M.A. (24 December 1927).

"white female flesh" to carry the day. A particularly vitriolic example from the pen of Doctor J. A. du Toit, Victoria West, Cape Province, provides some indication of the line of argumentation used by supporters of racial differentiation. The sexualized imagery of his language, and his revelations about the intimacy he expected from the patients he treated, stood in stark contrast to the call for professional objectivity and scrupulous mutual consideration, in a letter of the previous month by Dr H. A. Moffatt:

It is just as impossible for the native to resist the temptation to treat a European as it is for some of our unfortunate and ignorant Europeans not to go to the native for treatment. The native doctor has attraction for the ignorant European by virtue of their being something mysterious about him, something of the 'toor dokter'. Hence the native will always get a small following, and if allowed to go on unhampered, but encouraged by "his white colleagues", we Europeans will soon be the exploited, and our hopes of a pure white race will be gone... Dr Moffatt... wants equal rights for the native and European doctor. Well, so we all want, but each in his own camp. We have a right to protect our race, and how can we, when we allow our wives and daughters to be attended by native doctors? We all know the status of our profession: if we allow a native as our family doctor, he must enjoy the considerations, etc. And where do we end?⁶²

The fact that there were so few black doctors in South Africa at the time, greatly undermined Dr du Toit's threat of an end to white purity, and most white doctors settled on the idea that the greater threat to their own position would come from allowing any watering down of the certificatory standards that gave medical degrees their power and legitimacy. The doctors who headed the local medical councils and the Public Health Department, felt so strongly about this issue, that they continued to pay black doctors employed as District Surgeons and in state-aided hospitals on the same scale as white

⁶² J. A. du Toit, "Native Doctors and European Patients", The Journal of the Medical Association of South Africa B.M.A. (28 January 1928).

doctors, into the late 1950s, when the creation of a barrage of new health and social laws dramatically reshaped the contours of medical training and practice in South Africa. This material recognition of equality might seem insignificant (and in actuality the numbers of black doctors with state funding of some sort was very small), but can be appreciated more fully when considering the position of black nurses. These same medical authorities had no problems whatsoever with the creation of racially based pay scales for black nurses and midwives, policies which were transferred without debate or argument from the mission established teachers scales established in the Cape and Natal in the nineteenth century. This basic premise of inequality was not successfully challenged in South Africa until the late 1980s.⁶³

In 1927, in the midst of these discussion, an investigative commission, under the direction of Dr Charles Loram, a well known liberal and black education expert, was established to examine the question of the medical training of black doctors. Karen Shapiro has examined the ramifications of the findings of the Loram Commission, and several related official inquiries into hospital care and rural services, charting the uneasy compromise which eventually culminated from among the divergent positions of experts called to present evidence and testimony.⁶⁴ A "medical aid" scheme was created to train

⁶³ S. Marks, "The nursing profession and the paradox of apartheid". Marks details the period from 1957, when new segregated nursing statutes came into force, until the mid 1980s, when a pressing shortage of white nurses in South Africa, the increasing militancy of black nurses, and pressure from international nursing and medical bodies, forced the scrapping of racially based pay and promotion scales. It took until 1990 before hospitals were formally desegregated, and into 1992 for this to be fully effected.

black practitioners for 5 instead of 7 years at Fort Hare University. Those black men (at this stage it was assumed that women would not take up the course), who qualified would have to practice under the supervision of fully qualified physicians in rural areas not served by networks of clinics or hospitals. In the meantime, the state and local bodies (such as the Transkei Bungen, and the Provinces), would pay for bursaries for limited numbers of black students, who had successfully completed three years of initial medical training at such campuses as Wits and the medical school in Cape Town, to travel overseas to complete the practical and more advanced aspects of their training. The contradictions and weaknesses in this plan soon forced its collapse, but the short lived medical aid scheme at Fort Hare set a precedent for segregated medical training, which finally bore fruit in the late 1950s, as the state, in line with its policy to racially and ethnically segregate every aspect of political and social life South Africa, began to plan and build two black medical schools, one in Natal, and one in the northern Transvaal.

At the very same moment as these debates raged in the South African medical community, a young black physician, trained in Scotland, arrived back home from a trip to America (where he met and married an American woman), and registered with the Medical Council. Dr Alfred Xuma (or A. B. Xuma, as he was called) was in Johannesburg as the Board of the Bridgman Hospital was being established, and news of his new practice, his powerful personality, and his outstanding medical qualifications and honours,

⁶⁴ K. Shapiro, "Doctors or Medical Aids--The Debate over the Training of Black Medical Personnel for the Black Population in South Africa in the 1920s and 1930s" Journal of Southern African Studies 11: 41 (1987).

spread throughout the community of missionaries and philanthropists.⁶⁵ There is no record in the Bridgman minutes that A. B. Xuma's name ever came up for consideration as the first Medical Superintendent of the Hospital, but Paul Rich, in his study of liberalism in South Africa, found evidence of just such a discussion, in which C. Loram and H. M. Taberer (Native Labour Advisor, and Superintendent of the Native Labour Recruiting Organisation), "advised" Clara Bridgman:

As chairman of a Commission of Enquiry into the Training of Natives in Medicine and Public Health, Loram championed the idea of welfare work and the training of African doctors being primarily focused in rural areas. Thus, it was not surprising that, when A. B. Xuma returned in 1927... as a qualified medical practitioner, Loram, together with H. M. Taberer, advised the wife of the late F. B. Bridgman not to appoint Xuma as a superintendent of the newly opened Bridgman Memorial home for Africans on the grounds that he would be better employed among 'his own people' in the reserves.⁶⁶

Needless to say, Xuma paid no heed to the patronising advice he too was probably offered. Whether he knew of Bridgman's consideration of his appointment we do not know, but he did not withdraw his support from the institution. Indeed, soon after his arrival he not only took up a position on the Bridgman Board, but was offered the post of Health Officer for Alex, and also established a thriving private practice in Sophiatown as well. His experience of the workings of local and state bureaucracies, and his deep knowledge of the caution, and perhaps cowardice, of white liberals, stood him in excellent

⁶⁵ Dr A. B. Xuma was formally registered as a Doctor in December 1927. Notification appeared in: The Journal of the Medical Association of South Africa B.M.A. (28 January 1928), in the same edition which carried the vitriolic letter from Dr du Toit!

⁶⁶ P. Rich, White Power and the Liberal Conscience, 26 and 27. Rich gleaned this from newspaper reports and extracts from Xuma's autobiography.

stead when he was elected to head the African National Congress in 1940, at the age of 47.⁶⁷ We do not know if Clara Bridgman agreed with Loram and Taberer's advice, but it is evident that she decided in 1928 to push for the appointment of Dr Ethel Smith formerly of the Jane Furse Hospital in the Northern Transvaal, to head the Hospital.

The role of the Bridgman's Superintendents in the intellectual and clinical project of the hospital was extensive, and besides their daily work in administering the Hospital, keeping records and taking on specific projects in outpatients work, infant mortality, and their surgical practice, they ensured that the Bridgman became a valuable resource for academic work and claimed their own, and their colleagues' successes, in the name of progressive and benevolent science. Perhaps their major contribution was to the training and supervision of black women midwives and mainly white male and female medical students from Wits University. From the day it opened in 1928, until it was forced to close over three decades later, the Bridgman Memorial Hospital was the first, and for a long time, the only site for midwifery training of black women in the region. It was also the most important site for the obstetric and gynaecological training of Wits medical school students. Since 1913, the Queen Vic white maternity home had been incorporated into the Johannesburg Gen. At first, when the medical school was founded, students were only accepted for the first three years of a professional degree, which they had to complete overseas, within the system of British medical schools which all accepted the University's training. During the 1920s, as professors such as Dart, McGibbon, Gordon Grant, Watt

⁶⁷ T. Lodge, Black Politics, Chapter One

and others strove to create a full course of local medical training, they drew upon the Johannesburg Gen, its 'Non-European' section, and its attached hospitals as the site for practical work. But the Queen Vic, right from the start, did not admit sufficient patients for both white midwifery and medical student training. While medical students were already spending much of their initial three years in black wards and hospitals, they treated mainly male patients. Thus the opening of the Bridgman was hailed as a necessary step, and necessary for the full medical training of local doctors which was launched in 1927.⁶⁸ The cooperation between the Wits Medical School, the district schemes of the Johannesburg Municipality, and the Bridgman have been alluded to in a previous chapter. It is clear that perhaps the major reason for the Bridgman's success in treating women, attracting honorary staff, and raising funds, was the fertile field it provided for medical training and research.

From her first opening speech at the unveiling of the Bridgman Hospital, until she left South Africa, Clara Bridgman emphasised the importance of the Hospital as a resource for advanced research and scientific investigation into the specific health care needs in obstetrics and gynaecology of black South African women:

As well as doing the ordinary work of a hospital, it is intended that as time goes on there shall be opportunities given for research work and the special study of gynaecology... "We look forward to the day", said Mrs Bridgman, "when we shall have a staff of honorary physicians and surgeons, and become a centre for research and the spread of knowledge."⁶⁹

⁶⁸ F. Daubenton, "Medical Education in Johannesburg, 1903-1975", The Leech, 44:3, (1974).

⁶⁹ Rand Daily Mail 28 July 1928.

Indeed, as we shall see, the work of such medical scientists as O. S. Heyns, J. Black and their students, was undertaken, published and gained world recognition as a direct result of the support of the Bridgman Board and Hospital staff.

From the most broad perspective, the only ambition expressed by Clara Bridgman and the Board before the opening of the Hospital that remained unfulfilled, was the creation of a set of wards for children. In the first Annual Report of the Bridgman, issued in December 1928, the Honorary Secretary explained that it had been decided to create space for twenty additional adult women beds (bringing the total to 50) but at the expense of provisions for children:

In only one particular is there room for disappointment. In the original scheme it is stated, "the proposal is to establish a Hospital which will be primarily for maternity work with native women, with facilities also for gynaecological and children's work." The original purpose of including special provision for children has not been met. Owing to the danger of introducing infectious diseases, it is impossible to include provision for children in the Hospital as it is at present. The Children's Hospital does not take native children... The establishment of a Children's Wing to the Bridgman Memorial Hospital would be the logical way of making provision for native children, and this step should be undertaken when proper support is forthcoming.⁷⁰

The fact that extra funding for such a wing was never forthcoming underscores some of the ironies inherent in the Bridgman's construction. This is where a more sober analysis of the Bridgman than was offered at the time--and in recollections--by either black midwives, women patients, matrons, physicians, Board members and administrators is needed. Clara Bridgman, Mary Tugman, M. de Cottens, Ethel Smith and especially the second

⁷⁰ HPC/AD 843 Annual Report, for the six months ending December 1928, 6 and 7. This series of Bridgman Memorial Hospital Annual Reports, from 1928 to 1964, will from here onwards be referred to as "Annual Reports".

Superintendent, Hope Trant, were all convinced of the need for infant care, child immunization and community health work. Despite this, and Clara Bridgman's attempts from the start to initiate clinic work which would fan out from the Bridgman into the surrounding townships and as far away as Alex, she and her allies could never raise enough money for the vast preventative health work needed to address the mortality and morbidity of women, men and children, even the women who came to the Bridgman for their birthing labor. Neither could the Bridgman and its allied institutions ever attempt to meet the nutritional, housing, water, fuel and educational needs of the majority of Johannesburg's black working people and their children. In the absence of political rights for the majority of South Africans, and in the face of increasing moves towards segregation and the abandonment by the state of any but piecemeal responsibility for black urban provisioning, the Bridgman was never a panacea for more comprehensive services and institutions.

Nevertheless, the Bridgman was fundamentally important to the lives and experiences of women in the city, and it is to the women who trained as midwives, and who came to the Bridgman as patients that we now turn. The story of the midwives--their experiences as part of an emerging African elite in the urban areas; their confrontations with racial and gender discrimination; their work-relationships with white matrons and sister-tutors; and their role in the shaping of this massive project to control and direct the

reproductive labor of African women--form a vital aspect of the complex history of this institution.

Chapter Six

Midwives and Medical Students: The Creation of a Professional Cadre at the Bridgman

The first black professional staff member hired by the Bridgman, was Poppy Jane Bud M'belle, the daughter of an eastern Cape family, whose ancestors had been early converts, seeking education in the best available mission schools from the mid nineteenth century onwards. Poppy M'Belle's father, a great friend of the author, political activist and journalist, Solomon Plaatje, was part of South Africa's small, highly educated, and increasingly radicalized black elite.¹ He had arranged for his daughter to receive training at St Monica's in Cape Town, an Anglican-run maternity home, which had been set up to train "EuroAfrican or Cape Coloured" midwives in 1917.² In 1927, representatives of the Medical Council and the Public Health Department, met with medical missionaries who planned to initiate more extensive nurse training for black women. After persuasive arguments from doctors and matrons at the Victoria Hospital, Lovedale--where the first black nurses had already been trained and had successfully passed the same General Nurse examination as those taken by white women--the Medical Council accepted the position that black women could train for equal qualifications, and would be recognised and registered as full nurses if they passed. However, their salary scales would not be set at the same level, and they could also receive a "half qualification" as Hospital Registered

¹ For details about the M'belle family, see: B. Willan, Sol Plaatje: South African Nationalist, 1876-1932 (Berkeley: University of California Press, 1984).

² CAD/GES 1798 28/30B "St Monica's Home".

Nurses, for which they would not be entered on the country-wide Nurse and Midwife Register. Until 1957, when black and white nurses and midwives were segregated by race in the registers and professional records of the country, black and white nurses and midwives shared at least their qualifications and examinations.³ The massive significance of this proof of equal ability, and the demand for respect and dignity that black women made on the basis of this, cannot be overstressed.⁴

In 1928, Umteteli wa Bantu heralded the appointment of Poppy M'belle to the Bridgman, and announced the acceptance of the first group of midwife-trainees:

It is interesting to note that the Native nurse is Miss Poppy Jane M'belle, daughter of Mr and Mrs I Bud M'belle, Pretoria, who was trained at St Monicas', Cape Town. Miss M'belle enjoys the distinction of being the first Native woman to obtain her full qualifications as a midwife. It is also encouraging to hear that there are to be ten native probationers and to learn that there is a long waiting list of applicants whose ambition it is to qualify as midwives.⁵

The original applicants were accepted on the recommendation of white mission educators, although later, testimonials from black school teachers and ministers, as well as local physicians, notable citizens and so on, were also excepted.⁶ At first the educational

³ See: H. Kuper, "'Nurses'" in L. Kuper, An African Bourgeoisie: Race Class and Politics in South Africa (New Haven: Yale University, 1965); S. Marks, "The nursing profession and the paradox of apartheid"; C. Searle, The History of the Development of Nursing in South Africa.

⁴ We return to this theme below.

⁵ Umteteli wa Bantu, 1 September 1928.

⁶ Material in this section in Midwives is taken from four sources, unless otherwise stated: Interviews with midwives and three documentary sources. Interviews were all conducted by the author with women who had trained at the Bridgman Memorial Hospital from 1932 to 1960. The first three group interviews were all held at the Alexandra Health Centre and University Clinic, in a meeting room off the Maternity Unit. Those interviewed included both retired midwives and women still actively working, namely: Letta Mosikatsana, Mirriam Mphahlane, Wilhemina Madiba, Mirriam Mokoana and Elsina

requirements were a minimum of a Std VI education (eight years of schooling) but by 1931, the new Medical Superintendent, Dr Jane Robertson reported that half the probationers had Std VII or higher and by 1932 the number of applicants who met and surpassed this level was high enough for the Matron to raise the requirement to Std VII, or the Junior Certificate level.⁷ By the late 1930s, the Bridgman was able to select candidates who had passed the highest available school qualification for black women, Std VII (ten years of schooling) and as we shall see, the Bridgman increasingly accepted women who already had some form of Nursing qualification, particularly nurses with the "half-qualification" of Hospital Nurse.

The Bridgman also required excellent character testimonials, many of which Edith R Jones read and checked. Until 1944, whenever a probationer was found 'unsuitable' after arrival, the Bridgman Matron would contact Edith R. Jones, who would then alert the dismissed probationers sponsors.⁸ An age range of twenty to twenty-five was preferred, and the first probationers were all unmarried and childless. The Bridgman matrons and tutors stressed that unmarried women were easier to train, and in line with nurse and

Kabeni. Each women was subsequently interviewed alone, in the case of Letta Mosikatsana, this occurred only once before her death. The remaining women were all interviewed at least twice more on their own, in Alex, Soweto and Atteridgeville. The earlier group interviews, from which I have drawn most of this material, occurred in a much more relaxed and lighthearted atmosphere, than would be the case a few months later when the worst of the 1992 violence and hostel dweller/ community dramas in Alex began to worsen. I have indicated the dates of interviews in the footnotes. The documentary sources are: HPC/AD 843 B91 3.2, "Minutes of Meetings" and "Matron's Memoranda", as well as HPC/AD 843 series, "Nursing" and "Social Services"; and HPC/HHC A2052 E R Jones "Correspondence".

⁷ See HPC/AD 834 B 89.1.2, November 1931; September 1932.

⁸ HPC/AD 843 RJ Na 13 "Social Services", see July 5 1934 for an example.

midwifery training overseas, they accepted that a women with children would not be able to give the needed attention to the training required. This requirement was only relaxed in the late 1940s, when the sheer proportion of single women applicants who already had small children, and who nonetheless met the educational and character requirements of the Bridgman, and even some married women who agreed to remain apart from their husbands and comply with the stiff regime demanded of the midwifery course were increasingly admitted.⁹ Edith R. Jones herself supported the applications of several women married to ministers and teachers in rural areas, arguing that equipped with midwifery skills and formal mothercraft training, these women would be of great service in areas with no clinics hospitals or full-time physicians.

At first the Bridgman intended to admit women who had no previous nurse training, as there were very few fully trained black women General Nurses in the 1920s, and because the midwifery training at the Bridgman was intended to follow the pattern of the British midwifery model. This model viewed midwives as professionals, functioning separately to nurses in the specialist areas of antenatal, postnatal, birthing care, mothercraft training and early infant care. But a massive expansion in nurse training across southern Africa in the early 1930s meant that by 1935, many midwifery applicants had

⁹ The increasing number of applicants who conceived as young women, before or outside of marriage, was the subject of comment in all of the interviews with Bridgman-trained midwives. This process was explained with reference to the collapse of precolonial ethics regarding the strict regulation of full intercourse in adolescence (but not sexuality per se), and the weakness of Christian teachings regarding sexuality in the light of migrant based family life in rural areas, and the confusion and lack of regulation of the young, with concomitant dependence on peer socialization in the urban areas. Also see Interview: Patience Tyalimpe, Johannesburg, 22 November 1992, Transcript, 4.

already obtained some form of Nursing qualification. However, only a handful of hospitals by 1935 had obtained full recognition from the local Medical Council, and set up the necessary facilities and staffing to grant full General Nursing qualifications. The three hospitals which provided full nurse training for black women were: Victoria Hospital, Lovedale, Jane Furse Memorial Hospital, Sekukuniland, and the American Board Mission Hospital, Durban (later called "McCords"). The Johannesburg Gen's Non-European Hospital was capable of providing full nurse training, but resisted this, arguing that full nurse training was unnecessary for most black women, and that a lesser qualification (the "Hospital Certified Nurse"), would ensure that black nurses always worked under the instruction of white Staff Nurses. Edith R. Jones vigorously disagreed with this position, arguing that black women nurses and midwives, who had proved themselves capable of obtaining full training, were needed most in rural areas and urban townships, and that a "half-qualified" person would be unable to carry out the wide range of medical responsibilities and necessary professional tasks demanded of such work. After years of lobbying the Johannesburg Gen, with the active support of the head of Victoria Hospital at Lovedale, which had the longest standing nurse training program, she eventually won the right for black women probationers who entered with Std VIII to obtain full General Nursing qualifications from the Hospital.¹⁰ But the Bridgman from the start provided black women with full qualifications, exactly the same training and examination level as white

¹⁰ HPC/AD 843 RJ Kb 24 "Nursing" 1932-1934; and Aa 12.2.2 and see letters and memorandum from E R Jones and Dr MacVicar in CAD/GES 1798 29/30 "Native and Coloured Nurses and Midwives General", 1932.

candidates, but with an even more rigorous district work and mothercraft certification requirement than that expected of white women.

As early as the mid 1930s the Bridgman began to make some exceptions to their rule of "no married women probationers". Letta Mosikatsana, in her late seventies when interviewed, remembered that in her class at Bridgman in the 1930s:

...we had another one who was married, an elder. I do not remember her name, but she was elderly and even stout. [CB: Was she in her 40s then?] No, I think she was in her 30s. Yah, she had children I'm sure, she was already old, over 30.¹¹

Mirriam Mphahlane, Wilhemina Madiba and Elsina Kabeni, who all trained at Bridgman in the 1940s and 1950s, recalled that increasing numbers of women with children were accepted as midwife probationers. Mirriam Mphahlane herself was already married when she started training at the Bridgman, after having obtained her general nursing qualification the year before, and married in the December after her graduation. She had taken up her first post at the Alex clinic, in the tuberculosis ward, when the matron of Alex clinic, Sister Matthews (who was an old friend of Bridgman's stalwart second matron and longest serving medical staff member, Matron Perrings), insisted that Mirriam Mphahlane obtain her midwifery qualification. The story of her entry to Bridgman accentuates another feature of each midwife interview, namely the powerful role that the matrons played in shaping the experiences and impressions of the young midwife trainees. Matrons were remembered by name and described with great attention to detail, "She was a tall, elegant authoritative woman"; "Yes, and she was a professional, in every sense. She taught me the most about midwifery"; "Perrings was not so old at that time. She was

¹¹ Interview: Letta Mosikatsana, Alexandra Clinic, February 6 1992, Transcript, 6.

active, very active. She had her hair tied always in this way, and she was very neat. She would not take cheek from the doctors or medical students".¹² Nearly every women interviewed experienced encouragement from their matrons, and when questioned about the greatest long-term influence on their careers spoke of their matrons, as their supreme role models.¹³ Mirriam Mphahlane recalled the story of her midwifery training thus:

Sister Matthews came to me and said, "Before you make a dozen of kids, [Laughter] go and do your midwifery". She could see that I wasn't serious. "You are going to do your midwifery". I thought, "But Sister, I haven't applied", she said, "No, we are going to Bridgman Hospital." /.../ She just told me "You go to, whats, Miss Perrings", [Murmurs of agreement from the others.] Yah, she wrote something for me. So I went straight away. She said, "You tell your husband, if he doesn't want, I will talk to him" [Sounds of exclamation and appreciation from the others.] So, at home I told my husband. [CB: Was he angry or supportive?] He was alright. He was not very angry.[Laughter]"Oh well", he said, "Go and do your training". Yet, I was just married. [Wilhemina Madiba: Sister Matthews, she must have thought you had some talent, otherwise she wouldn't have pushed you like that, hey?] Well, ahh, she told me to go. I joined the class which had already started. [CB: So , you were a week or two behind?] Yah, a week or two late. So I continued with my training. We were paid three pounds, which is six rand one cent. [CB: Was that lower than your money at Alex.?] Very, very low. It was just pocket money to buy stockings. Mmm. [CB: What about your husband? Did he have to stay by himself in Alexandra?] Oh yes, but he used to go and 'check my da'! [Great gales of Laughter.] Oh well, what else can you do?¹⁴

¹² These comments are all taken from the first group Interview, Alexandra Clinic, February 6 1992, Transcript pages 2, 5, 11.

¹³ In 1950 there were still no black Matrons in any South African hospitals, and only 9 Sisters, but after 1957, one of the ironies of the new Apartheid legislation, with its policy of 'separate development', was that black Matrons and Nurses were promoted, and black physicians hired in greater numbers into government service in the new state hospital schemes. By 1960, 13 black Matrons and 86 black Sisters had been appointed. C. Searle, The History of the Development of Nursing 227.

¹⁴ Here and for the remainder of the text, the comments in parentheses indicate the atmosphere and interjections from the assembled group; "CB" indicates a question asked by the author; "... " indicates a section of transcript omitted; and ".../..." indicates a question asked by the author has been omitted. Interview: Mirriam Mphahlane, Alexandra Clinic, February 6 1992, Transcript, 5: 'check my da' is a colloquial expression meaning

The concept that midwives and nurses were required to be unmarried when receiving training, and possibly for some time after that if they wanted to secure a job, was startling to many black men and women in South Africa. Every source on the history of nursing in the region, points to the reluctance and amazement expressed by parents of teenage girls educated in mission schools until at least the late 1940s to the idea that their daughters should for any reason delay marriage, and even more oddly, reproduction.¹⁴ Even women who had been educated at mission schools where teacher training after graduating was not unusual, and whose parents had begun to consider that the prospects of an educated, earning daughter could mitigate some of the delay incurred in solidifying family alliances and ensuring fruitful marriages, were reluctant to encourage their daughters to take on nursing and midwifery training.

The story behind Letta Mosikatsana's entry into medical training was strikingly similar to the more elderly women who were interviewed about the process of becoming midwives. Before the 1940s, it seems that few parents themselves considered midwifery or nursing as possible professional choices for their daughters, preferring to stress teaching for their most scholastically achieving daughters and domestic work in a white household for other daughters, who would then, it was hoped, establish worthy marriages. After World War II, the recognition of nursing as a useful, respected and remunerative career for young women became more ubiquitous. This shift was powerfully stimulated by the

'see me there', with the added connotation of a 'date' or rendezvous.

¹⁵ For example: H. Kuper, "Nurses" in L. Kuper, An African Bourgeoisie: Race Class and Politics in South Africa; Marks, S "The nursing profession and the paradox of apartheid" and C. Searle, The History of the Development of Nursing in South Africa.

fact that women from poor families, who had nevertheless managed to obtain eight or more years of schooling, could enter midwifery or nursing without having to pay fees for three to four years. Instead, unlike teaching or any other available vocational training (even domestic science training at institutions such as the Helping Hand Club) nurse and midwifery probationers were provided with uniforms, shoes, food and quarters, and even a small stipend. Every women interviewed stressed that the fact that they and their parents did not have to pay fees enabled them to take up midwifery. Many rural women who applied to the Bridgman were encouraged by Edith R Jones to come for a brief period of "acclimatisation" to the Helping Hand Club, for instruction in cooking, for a brief exposure to some of the "skills of mothercraft, such as correct hygiene and so on" and where "we give the girls a general course at £1 per month, which helps them with their applications to hospitals, etc."

From 1928 to 1958, dozens of women trained at the Bridgman had their first experience of institutional and urban life at the Helping Hand Club.¹⁶ Unfortunately for Edith R. Jones, and the missionaries who zealously supported the training of rural women, most midwives did not return to rural areas after qualifying, but instead obtained jobs in the hospitals, as district midwives and in large institutions and municipalities. Edith and her husband John R. Jones spoke of this as a double-bind situation: on the one hand they supported the full training of nurses for ethical and practical reasons. On the other hand, they recognised that few fully trained women worked in rural areas. In letters to the head

¹⁶ HPC/AD 843 RJ Na 13, see letter of 5 July 1934 and the remainder of the file.

of the health department in Basutoland--Dr Hamilton Dyke, who opposed equal training for black women-- John R. Jones wrote:

But I can't help feeling that in most such cases it is not the fact of taking a registrable certificate which makes the girls disinclined for rural life and work, but rather the fact that they have been trained in urban hospitals and taste the delights and emancipation of urban life.¹⁷

One of the delights of urban life, besides greater freedom over one's choice of partner and, for all but one of the women interviewed, personal independence in deciding whom to marry (and all the women interviewed had married) being a probationer at the Bridgman meant getting access to a small stipend as well.¹⁸ The stipend was recalled as a great luxury by women who were midwife probationers in the 1930s and 1940s, but by the 1950s, the small amounts paid to trainees were described as mere "pocket money". While many of the first probationers had never been in Johannesburg or any large town before they came to Johannesburg, a decade later most of the midwife-trainees had worked for wages in towns before they commenced their training.¹⁹

¹⁷ HPC/AD 843 RJ Na 13, see letter of 3 September 1936.

¹⁸ The subject of courtship and marriage came up in many of the personal interviews. All the women married and borne children of their own; one was divorced and another widowed; all had met their partners as nurse or midwife probationers, (although one woman's parents had played a major role). Three of the women married men who spoke different home languages to their own, and who hailed from different regions of the country. All commented on the great self-control needed to remain either celibate, or very sexually cautious, until their training had been completed, and in some cases, until they had established themselves as nurses. Only Wilhemina Madiba spoke about her knowledge and use of contraception as a young nurse and midwife-trainee, and she indicated that by the late 1950s, midwives and nurses were being instructed by Sister Tutors in evening tea rooms and after hours, in the 'arts of prevention', as she called it. See specifically: Interview: Wilhemina Madiba, Alexandra Clinic, June 17 1992, Transcript, 16-21.

¹⁹ Interview: Mirriam Mokoana, Alexandra Clinic, February 6 1992, Transcript, 6 and July 8 1992, Transcript, 13.

This reflected the widening scope of waged employment for black women as well as a shift in the material position of women applying for midwifery. Whereas in 1927, only women from elite black families were likely to have the qualifications and contacts to apply for nursing and midwifery training, by World War II, many urban-born women, as well as women who had grown up on white-owned farms, and even the rural based daughters of migrant workers, who showed particular aptitude and dedication as students in local schools, could hope for the first time to apply for nurse training. Still, the numbers of black nurses who achieved full General Nursing certification and Registration from 1907, and the numbers of midwives trained and fully registered as Midwives after the 1920s, until 1957--when the nursing regulations were completely transformed-- numbered less than two thousand. In the period before World War II, few black women had full General Nurse certificates, and thus the Bridgman was an exemplary institution where women, who sought a full and recognised qualification, could achieve equal professional status. After 1946, this emphasis on the Bridgman as a rare and special site for career advancement diminished somewhat, as opportunities for General Training and Midwifery Registration opened up in other centres.

One of the most powerful impulses behind the sudden expansion after 1946, in black nurse training, was the massive increase in numbers of hospitals for black patients, which had sprung up in the late 1930s and war years. Each of these new institutions placed fresh demands on the small pool of black nurses. The increasing and acute shortage of white nurses, which was keenly felt during the war, when many went into active service, stimulated this process even further.

Numbers of African Nurses with Professional Nurse and Midwifery Qualifications:

1907-1957

Year	Female General Nurses	Midwives	Total
1907	1		1
1922	2	1	3
1927	2	3	5
1932	4	16	20
1937	8	36	44
1942	89	71	160
1947	217	118	335
1952	289	195	484
1957	433	423	856

In her study of the period, Charlotte Searle estimated that between 1927 and 1947, the numbers of hospital beds reserved for black patients in South African hospitals increased from 14, 873 to 34, 385. The wider ramifications of this growing need for nurses and midwives, were felt in the expansion of high school educational institutions for black teenagers. Whereas in 1937, black teenagers (both girls and boys) who had passed Std VIII numbered less than 1000, by 1946 this had increased four times.²⁰

²⁰ C. Searle, The History of Nursing, 271-275; this Table is adapted from Table 18.1

Like many of the midwives interviewed who trained before the 1940s, Letta Mosikatsana was encouraged to get her Std VII certificate by her head teacher, Mr Myepa, after completing Std VI at her rural school in her home region of Warmbaths in the Northern Transvaal. She travelled, at great expense to her family, to Inanda Seminary in Natal and qualified with the necessary certificate at the end of the next year. She remembered that the influence of the same head teacher and his spouse, as well as her exposure to "the Americans" at Inanda, persuaded her of the merits of nursing. But:

...my mother was deadly against it, she felt that when I became a nurse then I would not marry and I would not get children... she was very much against it. So that teacher and his wife helped me a lot. So I took nursing, because I was very much interested in it.²¹

The same could not be said for why Letta Mosikatsana decided to go to the Bridgman hospital after her Kuruman Mission Hospital training:

You see I had to go to Bridgman, because you know with the Hospital Certificate you don't, you are not paid so much. Its either that you had to go and reregister, and in those days Registered Hospitals were very few. So I decided rather to go to do midwifery to make up. [CB: Were you a good student at Kuruman?] Yes, I went right through, I did not fail anything. [CB: Did you think you had some skill with dealing with pregnant women? Did you feel you would make a good midwife?] No, I did not have very much of an idea of what was going to happen, but I just felt that I should go and do midwifery to make up for this certificate, to get a better qualification, and just to promote myself.²²

By the time Letta Mosikatsana had qualified, she was considered to be one of the Bridgman's top graduates, and Alex Clinic hired her on Matron Mathesson's recommendation. It was soon after she arrived in Alex to stay with her uncle and aunt, from her granny's household in a rural area outside of Rustenberg, that Wilhemina Madiba in Searle's text.

²¹ Interview: Letta Mosikatsana, Alexandra Clinic, February 6 1992, Transcript, 1.

²² Interview: Letta Mosikatsana, Alexandra Clinic, February 6 1992, Transcript, 3.

recalled observing the recently qualified Letta Mosikatsana at work. Wilhemina, who was ten years younger than Letta, remembered seeing Letta working as a midwife when she visited the Clinic with her small cousins, observing Letta visiting women in neighbouring homes for postnatal check-ups, and most importantly, assisting with the birthing labor of Wihemina Madiba's aunt. In the group interview, with Letta present a few weeks before her death, Wilhemina recalled that Letta Mosikatsana was a powerful role model:

She was so smart, you know, with her crisp uniform, and she had a wonderful confidence. I saw her, all the time I was at that School, [the Catholic High School in which Wilhemina Madiba attended], at the Clinic and in the township. She truly inspired me. I thought, "Yes, I am going to be like her".²³

Only one other midwife in the group interviewed recalled having a powerful attraction to midwifery itself. Born in near Idutywa in the Transkei region, Elsina Kabení recalled that a nurse-midwife stationed at the local clinic had a powerful influence upon her decision to train as a nurse and midwife (or "double-qualify" as it was called). Asked whether her parents had encouraged her to become a nurse, she replied:

My father was here, in Johannesburg. He was a worker. He used to come home after a year only. And my mother did not know about nursing. Let me tell you, there was this one lady, she was nice and tall, with a nicely shaped, you know, ah. She was the first nurse-midwife in our area. She used to put on this white nurse uniform you know, with her white doek, so she so impressed me that I said I have got to take nursing!! So, they sent me the form... so I filled them in and sent them. I had to wait for a whole year... [CB: What did you do at home for that year while you waited?] Yes, this was also important. I remember, my mother had a friend, a white lady, so this lady had a small baby. So she said, "Do you mind if she stays with my baby?" So I used to look after her child. It was very nice, and so I got used to babies, and I liked that work. And fortunately for me, the first ward I attended was a baby ward, and then I decided I am just going to try midwifery too.²⁴

²³ Interviews: Wilhemina Madiba, Alexandra Clinic, February 6 1992, Transcript, 10; and see individual interview, Alexandra Clinic, June 17 1992, Transcript, 16-18.

²⁴ Interviews: Elsina Kabení, Alexandra Clinic, February 6 1992, Transcript, 12 and

Younger midwives, notably Wilhemina Madiba and Mirriam Mokoana, were directly encouraged by their parents and relatives to take up midwifery and nursing. Their support was based both on the fact that nurse and midwifery training was sponsored with a mix of private and state funds, once a women was accepted, but also because by the 1940s, the notion of midwifery and nursing as highly worthy careers was gaining currency in very religions Christian families. Unlike Letta Mosikatsana and Elsinä Kabení, Mirriam Mokoana and Wilhemina Madiba explicitly recalled that their decision to enter nursing was seen by their relatives as well as themselves, as an act of service as well as a path to individual accomplishment.²⁵

Some discussion of the smartness of nurse uniforms, and the distinctiveness of the women that wore them, was taken up at the start of every interview, as women were questioned about their reasons for wanting to train as midwives, and about their sense of self-image in their early years as health workers:

I think our uniform then was red and white, yes a dress, with an apron and we had a little cap. ...Yoooh, yooh, very smart! We made ourselves! We had brown shoes, shiny polish, all of that, and we were very proud of that. [CB: Did you get time off?] Oh, we used to get a day off. ...We would go out, to town. We were going by trams then. And it was just starting from Sophiatown. You know we were getting transport right from Sophiatown. People would see us passing by, They knew we were from the Bridgman.²⁶

This powerful theme of dignity and respect was underlined in a several other ways as the discussions developed. In describing their reception as they arrived at the Bridgman for

see individual interview, November 12 1992.

²⁵ Interviews: Wilhemina Madiba, Alexandra Clinic, February 6 1992, Transcript, 10; and see individual interview, Alexandra Clinic, June 17 1992, Transcript, 17.

²⁶ Interview: Letta Mosikatsana, Alexandra Clinic, February 6 1992, Transcript, 7.

first time, midwives recalled the friendliness and cordiality of the Matron, Medical Superintendent and Senior Tutor, and recounted how forcefully they were struck by this treatment and the atmosphere it engendered. Recollections of the neatness of the shared bedrooms, the fresh flowers on the bedside tables, the shiny new shoes, the small watches, the writing paper provided and so on, were narrated with warmth and appreciation. "That is why we make this Maternity Unit here so comfortable too", said Mirriam Mokoana.²⁷

While some might regard the emphasis on appearance and hygiene in these recollections as a sign of the depth of a western domesticated ideal, and its hegemonic power over these groups of successive midwife trainees, this was not the exegesis provided by the women when pressed as to the importance of clothing, interpersonal pleasantries, furnishings, hot baths and clean surrounds. Instead women spoke of the transformative experience signified by these interpersonal communications and commodities in their lives as women, as black women, and as workers. Here, in a respected institution, they too were respected. Their bodies and minds were valued, their labor was noted. This in a city, where black nurses were spat at and taunted by gangs of white bullies, attacked by Amalaita gangs, and harassed by policemen.²⁸

It was my first time in Johannesburg. Yes, I was very scared, but it wasn't so frightening. But the only thing, it was just strange for a person whose from outside. But the people were nice there. The Bridgman people. They were very

²⁷ Interview: Mirriam Mokoana, Alexandra Clinic, July 8 1992, Transcript, 3.

²⁸ See reports of attacks by white men and "Amalaita" gangs in press reports from the *Star*, 19 May 1936; letters and correspondence of E. R. Jones, 1941: HPC/AD 843 41.4.1; for reports of Police harassment, see letters of Ruth Cowles back to the ABM. One important instance is cited in M. Wright, "Urban History and Health: Nurse Cowles and Alexandra Township, 1926-1946", Project on Poverty, Health and the State in Southern Africa, Proceedings of the First Workshop, Columbia University, 1985; also in group interview at Alexandra Clinic, February 6 1992; Transcript, 11 and 20.

nice. They were very friendly, so we didn't feel, I did not feel much out of the way. The Matron at Kuruman had applied for me. She sent a recommendation, everything. So she had prepared the way.²⁹

All of the women spoke at great length of the unusual space that the Bridgman and the hospitals where they had worked before, provided for mutual respect across lines of colour and ethnicity. Repeatedly asked about ethnic and racial tensions at the Bridgman, women testified in group interviews and alone, that they were never treated with condescension by the Matron, senior Sister Tutor or fellow midwife-trainees, who were drawn from different regions of the country: "You see, we were respected as professionals",³⁰ and "We had no tribalism in our day",³¹ were themes constantly stressed by the midwives.

The Bridgman kept records of the ethnicities of probationers and patients, but it is not clear how they established this information. The various Matrons would merely list the number of "tribes" among the staff and patients in their monthly and annual reports, without further comment. Of course, the languages spoken by the midwives, and their places or origin may have aided Matrons in these observations, but many women had attended school and received prior training in places far from their original homes, and so their previous addresses or testimonials may not have provided many clues to their ethnicity. It is likely that Matrons asked midwives and patients their "tribal" designations, but different Matrons had different ideas about what constituted a "tribe". Between 1928 and 1937, "Fingoes", "Xhosa" and "Pondo" women were written up as separate "tribes",

²⁹ Interview: Letta Mosikatsana, Alexandra Clinic, February 6 1992, Transcript, 5.

³⁰ Interview: Mirriam Mokoana, Alexandra Clinic, February 6 1992, Transcript, 10.

³¹ Interview: Wilhemina Madiba, Alexandra Clinic, June 17 1992, Transcript, 1.

but after this only one "Xhosa" category remained. Consistently, these records of midwife trainees and staff, from 1928 to the late 1930s, listed Zulu and Xhosa speaking women, as well as a smaller number of women from the Northern Transvaal (mainly Tswana and Sotho speakers) in the majority. After 1939, with newer training schools opening in northern Natal and Zululand, the number of Zulu speakers seems to have diminished, and a greater number of Sotho speaking women enrolled. A sudden increase in Sotho speaking patients was also recorded.³² That these ethnic and linguistic designations seem to have some legitimacy is borne out by studies of the movements of women into the city after World War II. Sotho women, mainly from Basutoland itself, as well as from border towns, made up an overwhelming majority of the new immigrants.³³ A useful comparison can be made with the records of the Helping Hand Club. There too, Xhosa and Zulu speakers were in the majority, until the 1940s, when Sotho speakers began to equal the Nguni speakers in numbers, and by the late 1940s, increasing numbers of Tswana speakers were recorded.³⁴

Recollections of the ethnicities and places of origin of their fellow probationers among the women interviewed were scanty. As mentioned above, many of these women themselves had married men who spoke different languages and hailed from different

³² HPC/ AD 843 91.32 "Annual Reports" and HPC/HHC A2053 Ba2B89.1.5-6; records of the Johannesburg branch of the Bantu Trained Nurses Association.

³³ See for example P. Bonner, "Desirable or undesirable Basotho women?" Liquor, prostitution and the migration of Basotho women to the Rand, 1920-1945" in C. Walker, (ed) Women and Gender and L. Longmore, The Dispossessed (London: Jonathan Cape, 1959).

³⁴ HPC/A2052 Ba 15.4 to 19.2.

regions of the country. Another reason for their lack of memory on the topic, and it may be added, lack of interest in the subject, may have been their own years of hospital and midwifery work in the Transvaal. An ability to speak English and two or three other African languages, as well as a smattering of Afrikaans, was a skill all women shared and of which they were proud. Language and ethnicity was certainly no barrier to their choice of pre-Bridgman hospital service. Women travelled to Natal, when they were Sotho speakers, learning Zulu from other nurses "on the job", and they all recalled teaching the few Coloured women they met at the Bridgman, who spoke Afrikaans in the main as their home language, to speak some Zulu and Sotho. All of the women could speak some English when they arrived at the Bridgman, although some women from the Northern Transvaal (notably Mirriam Mokoana and Wilhemina Madiba) could speak, besides their vernacular language, more Afrikaans than English when they first started nurse training, and Elsina Kabenjani could not speak fluent English. Her narration of the experience of mutual language assistance and the friendships, both between shared language speakers and with peers from different regions of South Africa with different languages and ethnic identities, is instructive:

The train came from Umtata, via Idutywa then to Amabele station, so at that station I got off, and took a train for East London, and then from there to Johannesburg. It took us two and a half days!!" [Exclamations] Fortunately in the train I met a lady, a lady teacher, who was interested in teaching, so we were together. . . So the next day we had to go to the hospital, and so fortunately I had sort of this friend, so I went with her. Yah, so when there, were welcomed. So what was nice was, I did not know Sotho, and people there were busy talking Sotho, and I didn't know what they were talking about, I was lost! [Laughter] Well in any case, we communicated in English. So I improved in everything, in English and Sotho too. [CB: Did you meet other Xhosa speakers?] There were many, there were many, so we soon spotted each other and said "Mkhaya!", "Mkhaya!", "Home girl!" [CB: Did you find that your friends tended to be Xhosa women?]

No, I was befriended by many. We had nice ladies in our nursing. They used to teach me Sotho. We used to go, ... [Sings Sotho nursery rhyme. Others join in] We got used to it. So they helped me, fingers, body parts, others words, so on. We used to have Indian lady too. She said "Oh you, you are so enjoying yourselves, let me join in" ... It was such fun. [CB: Did you speak English in your classes] Yes. The Sister Tutor, she was Miss Simpson. I think she was from England. She was a tall dignified lady, quiet. Mmm, she was not the talking type.³⁵

These women, throughout all the personal and group interviews, stressed their sense of sistership, based on their professional and work experiences, and their commitment to de-emphasising ethnicity.³⁶ There is no doubt that speaking and working and being tutored in English provided women with a powerful tool for mutual communication, in both specialist vocabulary, and social life. However, their work as midwives constantly developed skills in other languages, and three women specifically described themselves as "multi-lingual" when listing their most valuable personal attributes.³⁷

All the women interviewed were uncomfortable talking about tensions and problems during their years as younger nurses and midwives, although none of them held back from more stinging criticisms of more recent experiences, especially the anger they felt at the disparity between white and black pay scales, which continued up to the late 1980s in legal form.³⁸ As they spoke, they reminded each other that younger nurses and midwives of the future would be spared these problems, and stressed that their own

³⁵ Interview: Elsina Kabeni, Alexandra Clinic, February 6 1992, Transcript, 12 and 13.

³⁶ This was even so when women spoke of the troubles raging in Alex at the time of the interviews, when colloquial wisdom spoke of the 'Zulu Hostel dweller's as enemies of the residents. The Zulu speaking women in the room concurred with this judgement.

³⁷ Letta Mosikatsana, Wilhemina Madiba and Mirriam Mokoana.

³⁸ Interview: Wilhemina Madiba, Alexandra Clinic, June 17 1992, Transcript, 2 and 5.

patience and persistence had been instrumental in winning equal pay, and better working hours for their younger peers. "Benefits, yes I will not see them", remarked Letta Mosikatsana ruefully.³⁹

An explanation for the lack of emphasis on inequity in their recollections of early professional life was articulated by Wilhemina Madiba, who was the most outspoken in her criticism of the slow pace of change in promotion rates for black health professionals in South Africa, even since 1989:

Yah, we were all there as professionals. But, remember we were young then. When we were young nurses we felt so proud that we were earning, we were independent of our parents and could help them now. This made us feel so independent. Yes, and compared to all my fellow South Africans!⁴⁰

Tensions that did emerge, however, and which the midwives discussed at length, were those between white Sisters and certified Midwives employed by the Bridgman full time, and the midwife trainees. Explanations provided for this by the interviewed midwives were also professionally, rather than racially or ethnically based. Every single women interviewed had some form of nursing qualification (although prior to 1950, none had a full General Certificate) before they took up Bridgman training. It appears from an examination of the Bridgman records, that the early groups of probationer nurses were split down the middle between women with no previous training, and those from other hospitals. But by the 1940s, nearly all the women accepted by the Bridgman came with some experience and qualification.⁴¹ This created an imbalance among the probationers

³⁹ Interview: Letta Mosikatsana, Alexandra Clinic, February 6 1992, Transcript, 10.

⁴⁰ Interview: Wilhemina Madiba, Alexandra Clinic, February 6 1992, Transcript, 10-11.

⁴¹ HPC/AD 843 B91 3.2, 1928 to 1938; 1938 to 1944.

and the fully certified, but singly qualified, black and white Midwives (officially called "Nurses"), that was realized in a certain level of tension between them:

The Nurses, they were horrible to us, horrible! You know I think they had that jealousy. If you came in with General Training, even if you did not have the full certificate. Because they just had Midwifery. [Murmurs of agreement from group] Yah, so if you ask a thing, they would say "You are Generally Trained, you ought to know! We do not have time for you now!". I remember one time we even went to the Matron to report it, because I mean we were there to be trained as Midwives. Our General Training did not work for Midwifery. So we had to go and report them, because they did not want to teach us!⁴²

But Letta Mosikatsana pointed out that this division did not fully emerge until years after she had trained, saying:

No, no there was not that tension between us, as it was for these others. In fact our "General" was not registered. And they knew. So it was not so conspicuous after all.⁴³

The written evidence supports the oral testimony in that a sense of cooperation between midwife trainees, the Matron, and the staff seemed to exist until the late 1950s. However, after this period new tensions surfaced. The draconian legislation of the period, including the passage of the Group Areas Act, a new Nursing Act in 1957, and the implementation of requirements that black women carry Passes, altered the interpersonal and institutional terrain at the Bridgman. Towards the end of this chapter we shall examine one immediate effect of this new set of forces.

Throughout the entire period of the Bridgman's existence, the probationers all had far less contact with the Bridgman physicians than with the white Matrons and the white and black qualified Midwives, and even less contact with the medical students from the Wits Medical School. Comments about doctors arose in discussions about the actual

⁴² Interview: Mirriam Mphahlane, Alexandra Clinic, February 6 1992, Transcript, 8.

⁴³ Interview: Letta Mosikatsana, Alexandra Clinic, February 6 1992, Transcript, 9.

midwifery work at the Bridgman, and the manner in which they acquired their skills and knowledge. All the women stressed that although the Bridgman preferred younger women probationers and women without children, patients themselves trusted the older probationers more readily. Alone and in group interviews, midwives agreed that after their training was completed, and especially after they had had children of their own, their efforts to win patients trust, were less strenuous and more effective:

You see, on the line of the patients, when you are elderly, the patients they have faith in you. When you are young, they don't want you because you do not know. Later, it was better.⁴⁴

As the discussion moved to a closer focus on learning the craft of midwifery, it was clear that midwives were mainly instructed by the fully trained midwives and the sister tutors:

[CB: Did you think midwifery was interesting as you began to learn about it?] Oh well, as time went on, it was interesting. Yah. [CB: Did you find that it was difficult?] It was difficult. I mean with midwifery you had to understand, in the first place, if you are just taken to your wards, and then this woman, well you have to know, what does this water come from, and all this. And then as soon as you understand then it, yah, it makes sense. [CB: Who used to teach you the most? Did you have different people? Doctors?] Yah, we had doctors, but the main person was a Sister Tutor always.⁴⁵

Letta Mosikatsana went on to remark that she remembered the influence of a woman doctor at the Bridgman, and how impressed she was with her work, but she could not remember her name. After discussion we all worked out that Letta would have worked with Dr Hope Trant, but no other doctors name were recalled. Yet every single woman interviewed recalled the names of their Matrons and main Sister Tutors.

[CB: Did you have any good doctors helping you learn?] Some were good, and some were bad. There was one which I don't remember his name he was,

⁴⁴ Interview: Letta Mosikatsana, Alexandra Clinic, February 6 1992, Transcript, 7.

⁴⁵ Interview: Mirriam Mphahlane, Alexandra Clinic, February 6 1992, Transcript, 7 and 8.

woowhoa, he used to be so, you know. [Letta Mosikatsana "Irritable?"] Yah, but he used to treat us nurses better than the medical students! Oh, he'll call a nurse, after the medical students had been, from Wits, and he would say, "Nurse, they were talking bullshit today!" [CB: Were they frightened of him?] Yes, they were, they were. [CB: Was he a bad teacher because he was so irritable, and rude?] No, actually he was still ok. But we did not see him that often. [CB: Who was the best teacher you had? Who did you learn the most from?] I think it was our Sister Tutor! Yes. [Others murmur agreement.]⁴⁶

It is interesting to juxtapose Mirriam Mphahlane's insights into student doctor and specialist doctor relations, with comments made by a woman physician, who had undertaken her practicals in gynaecology and obstetrics at the Bridgman from 1938 to 1940. Ruth Drubin recalled that all the woman medical students at Wits (of whom there were still less than 10 per class of 100), served their periods of practical training in these subjects at the Bridgman, whereas male students worked at both the Queen Vic and the Bridgman. The reasons for this were unclear. At first Drubin recalled that no accommodation or facilities for women students existed at the Queen Vic, but she later returned to the topic remembering that:

No, the Bridgman did not have accommodation for us either, but the University hired rooms. Down the road there was a lady in one of those little old houses, probably from when the mining first started. And three of us went together, and I don't know if the room was as big as this one we are in, even. There were three dilapidated beds with mattresses of horsehair, and three of us shared that. /.../ And then if we got a telephone call in the middle of the night we would have to run to get to the Bridgman. [CB: So you would walk there when called to a labor?] It was about a block away. But in those days we were not nervous. Even at night. [CB: So were you and your women co-students disappointed at not being able to go to the Queen Vic at all?] Oh yes, we were all as mad as hell! [CB: Did your male colleagues know that?] I am sure they did, but it was an aloof atmosphere, so we did not talk much.⁴⁷

⁴⁶ Interview: Mirriam Mphahlane, Alexandra Clinic, February 6 1992, Transcript, 8 and 9.

⁴⁷ Interview: Ruth Drubin, Johannesburg, 4 November 1992, Transcript, 5 and 6.

Drubin, along with the midwives interviewed, recalled that she learnt much about uncomplicated birthing labors from observing the qualified Midwives and Sister Tutor with their patients than she ever learned from the Wits connected professors of Obstetrics and Gynaecology. She had this to say about the Bridgman's honorary staff:

[CB: Which professors from Wits were connected to the Bridgman when you were there for your prac.s?] Professor Black, and Heyns, and Krige. Krige was a great character. Black I would not rave about. And Heyns was odd.⁴⁸

Before examining the craft of midwifery as midwives recalled learning it at the Bridgman, it is useful to see the world of obstetrics through the eyes of Ruth Drubin as she arrived for the her first term of training at the Bridgman. Drubin's comments about her own professional status and learning offer a deeply bifurcated vision of the experience. In the first vignette reproduced below, Drubin stressed the heroic quality of the physicians' obstetric assistance (the healthy child is "delivered" safely, and the baby is named after the assistant by a grateful mother) and in this story, Dr Carlisle plays a vital role, which is followed by Drubin's commentary on the sexism of the medical profession at the time:

Vignette I:

[CB: When you arrived on your first day at the Bridgman, had you ever witnessed a birth before, or been in a labor ward? Had you seen a film or other representations of birth before?] It was our first exposure. We had had models, and dummies of pelvises and anatomy, of course. [CB: Did you have the same feeling about going to the Bridgman as you did about other aspects of medical experience?] It was a long time ago, and I don't know. I can't put my finger on it, but I do remember that the first delivery that I was called to. Dr Carlisle was there, the Medical Superintendent, a tall, regal lady. We, at our level, didn't get friendly with her as such, but I always remember her in a floral dressing gown, tall and regal, with her long hair plaited down, because of course we would all come out in the middle of the night, and my first case was a prima, and she climbed the wall! [CB: Can you remember anything about her? Was she a young women?] Very young, very young girl. [CB: Was she nervous of you, do you think?] No, when you are in labor you can't be nervous of anything! [CB: Were you nervous?] No, I

⁴⁸

Interview: Ruth Drubin, Johannesburg, 4 November 1992, Transcript, 3.

don't remember being nervous, just excited. [CB: And was Dr Carlisle there the whole time?] Yes, and then at the end of all of the labor, I remember Dr Carlisle and patients were talking, she was so pleased. She now had a little girl. Then Dr Carlisle left, and I was talking to her. I remember she said, "What's your name?" So I said, "Ruth", so she said I am going to call my baby Ruth. So somewhere out there is a person called Ruth, born in 1939. Dr Carlisle was a brilliant, brilliant teacher. I learnt everything I ever knew about midwifery from her. /.../ [CB: Would Dr Carlisle have had equal status to male doctors in the hospital or equal power?] Today, she would have, but then, you know with that sort of medical politics which... ah well I was never interested in it. [CB: But you saw her as being, say, as important a figure as Doctor Black or Heyns?] Ya, sure. Absolutely. More important, because as least she did things. She was a figure to look up to, absolutely.⁴⁹

Drubin recalled about Dr Carlisle in almost the same works as Mirriam Mokoana and Letta Mosikatsana used to describe their mentors and teachers.

The second vignette, which in the real time of the interview, followed directly after the first, focused instead on the midwives themselves, and Drubin's self description de-emphasises her status as a trainee doctor, and suggests that it was the Midwives who practised with a "calling":

Vignette II:

[CB: How many births did you witness before you actually participated in the delivery?] One or two. [CB: And how many births all in all did you attend that time?] I think our total was thirty... Bridgman was very busy. [CB: Was there always a qualified doctor present?] Oh yes. Or a qualified Midwife. Either. [CB: And what was the relationship like between the young women doctors training, especially a young white women, and perhaps an young African midwife?] I never had any problems. [CB: Was it quite a mutual situation?] Yes indeed, and let me tell you, some Sisters and Midwives have taught me more than the doctors through my life! /.../ The midwives have a mental approach and a temperament that is quite different from other nurses. They are to themselves a profession, over and above, say a Nurse, a Sister, in paediatrics or surgery or medicine. They practice their midwifery, and they have done so since time immemorial. And the midwife has always been through the ages, a professional. A women's profession, long before nursing. [CB: And have you found that, in your experience, that midwives have this attitude?] Oh they still do, they do. When you are with these people that they

⁴⁹ Interview: Ruth Drubin, Johannesburg, 4 November 1992, Transcript, 9 and 10.

have a different relationship to their work. Quite different. [CB: Did you feel that sensibility coming across in both white and black midwives?] Oh yes, yes. No difference.⁵⁰

During interviews with the midwives, all of whom had practised with only brief interruptions (to care for their own children or elderly parents) since they had graduated, the subject of how they came to learn to be midwives came up for detailed discussion. The focus, however, soon shifted away from historical reflection concerning what they remembered being taught at the Bridgman itself, and onto their present convictions, theories and understanding of the work of midwifery. Each woman interviewed provided a sense of her own midwifery knowledge as cumulative, and no woman responded to questions about Bridgman training, with memories specific to that experience. All of the women agreed that midwifery practice involved much more than scientific training, and that deeper knowledge and empathy developed over time. However, neither in individual or group interviews did any woman suggest that they had had "a calling" at a young age to become a midwife. Only Elsina Kabení, as suggested earlier, had a sense from the start of her nurse training, that she wanted to work with babies and women. In the group Mirriam Mokoana offered the most detailed exegesis of midwifery:

Midwifery was a very scientific subject when we learned it. We had, many of us, already done some general nursing before. In our day we focused more upon the moment of delivery, and not the emotional aspects. These days they do everything, psychology, community nursing, and so on. In our day they focused more upon the moment of delivery. [CB: Do you consider birth to be a "medical" or a "natural" experience?] I see my role as a facilitator, as a supporter, of the woman, even of the perineum. The old midwives before, the grannies who did not know about science, yet managed to help women deliver. The only problem is always with medical obstructions and abnormal labors./.../ You see, whether a doctor or midwife is present or not, the processes will begin and delivery will begin, and the baby will come. Also, when the baby is ready to come, it will come!⁵¹

⁵⁰ Interview: Ruth Drubin, Johannesburg, 4 November 1992, Transcript, 12.

Mirriam Mphahlane and the other midwives in the group interview, then discussed at some length the role of the midwife as a "manager of birth". All agreed that the gradual movement toward emotional support during hospital labors was a return to the days of women friends and assistants being present. Mirriam Mokoana and Wilhemina Madiba supported the idea that fathers should be present during labor, but Letta Mosikatsana argued that women family members provided still better support for a woman in childbirth. The conversation then moved to the Alex Clinic pilot project, started in 1991, wherein community birth attendants were being trained and sponsored supported by the Clinic, so that each woman in labor would have someone with her from the moment of admittance until after the birth, to console her, rub her body, comfort her and encourage her. As head of the Maternity Unit at Alex, Mirriam Mokoana was very proud of this new scheme, and the other women present concurred.⁵²

When the conversation returned to the Bridgman, the women recalled that for all the problems of the midwifery practised there when they were probationers, such as women having to lie on their backs throughout the last stage of labor or the absence of family or friends in their labor wards, still:

⁵¹ The pilot project referred to here was initiated in several centres throughout South Africa under a team headed by Prof J. Hofmeyr, Head of Obstetrics and Gynaecology at Coronation Hospital. The programs were constructed to bolster research already conducted in Coronation Hospital which had indicated that birthing labors were less painfully and required less medical intervention, if women were assisted throughout by not only midwives, but also by personal, non-medical attention from empathetic attendants. For a summary of this work see: Alexandra Health Centre and University Clinic, 63 Annual Report, March 1992, 8-9; Interview: Mirriam Mokoana, Alexandra Clinic, February 6 1992, Transcript, 16.

⁵² Interview: Mirriam Mokoana, Alexandra Clinic, February 6 1992, Transcript, 14 and 15; and comments of Wilhemina Madiba and Mirriam Mokoana, 11; 13 and 16.

That was better than what we had outside you know! Even when we did district midwifery in Sophiatown and Alex, we used to be worried. There would be not hot water, and there was a lot of problems coming up. It was better to get to that Hospital, and the woman know that. If they could they would try to get to the Hospital. But the Hospitals were already full up by then. So many times we would deliver 'newspaper babies', that's the baby covered with the prints from the paper, underneath! We were working on the floor in those small shacks at the back of the houses. Then you can see, the Hospital is much better.⁵³

The worst aspects of midwifery work, all agreed, were having to assist in an "sb" or stillborn birth. A long discussion of the best and most empathetic ways to inform a woman about her stillbirth, and also about ways to explaining the story to her "people outside", taking extra care to avoid any sense of "blame", followed. These were aspects of midwifery which only developed with time.⁵⁴ This group of Bridgman midwives therefore saw their roles by the early 1990s as assistants and managers of birth and the birthing process. After years of midwifery service they regarded themselves as skilled if they could work with the latest technologies and facilities, as well as evince great empathy and elicit trust from women patients.

Finally, a commitment to women and to the communities in which women lived, was repeatedly underscored as a hallmark of good midwifery care: antenatal and postnatal work, and a good sense of the context of a woman's life. In reflecting on how this broader aspect of their work was learned or imbibed, all pointed to their religious beliefs and their early teaching at the Bridgman, where they were challenged to become "missionaries for women and children". Elsina Kaben and Letta Mosikatsana recalled that it had been

⁵³ Interview: Letta Mosikatsana, Alexandra Clinic, February 6 1992, Transcript, 16. Comments drawn from 15-19.

⁵⁴ Interview: joint comments of Mosikatsana, Mokoana, Madiba, Kaben, and Mphahlane: Alexandra Clinic, February 6 1992, Transcript, 16. Comments drawn from 18- 19.

strange, after their time at the Bridgman, to work in municipal health centres and in state hospitals where prayer and religious imagery was not a part of their daily routine.⁵⁵ Asked what else they remembered about their life as probationer midwives, they all recalled the affiliation they sought with professional bodies, the meetings and conferences they attended, and their sense of expectation about the life of association and contact with peers which awaited them after graduation.

Outside of the working hours in the Bridgman wards, and the periods of study and examination, many of the older women recalled attending meetings in the 1930s and early 1940s of the Bantu Trained Nurses Association, (which had been formed in the late 1920s by Ruth Cowles with the help of graduate nurses such as Minnie Soga). In Bridgman records from the early 1930s, the only recurring subject of tension discussed, except for a few individual cases of dismissal, focused on the desire by Bridgman staff and students to gain access to the South African Trained Nurses Association. This discussion surfaced in the minutes of meetings, and in letters to and from the Bantu Trained Nurses Association, until the early 1940s, when liberal representatives of the white association persuaded their colleagues to accept co-registration with black peers.⁵⁶

This victory was won, as so many others in South Africa, at the expense of another scheme for which more radical nurses had argued: namely the creation of a nursing trade union. The trade union motion was eventually quashed, but out of the ensuing debate

⁵⁵ Interview: joint comments of Letta Mosikatsana and Elsina Kabenj: Alexandra Clinic, February 6 1992, Transcript, 16. Comments drawn from 19 and 20.

⁵⁶ HPC/HHC A2052 Ba 2; Ba 3 1930-1935; and see C. Searle, The History of Nursing, 271-275.

which had engaged the attention of medical professionals and administrators across the country, a Nursing Act was born and passed into law in 1944. Both nursing associations were disbanded, and all certified and registered nurses became members of the South African Nursing Association, which was constituted under this act as an official body.⁵⁷

The history of this legislation, and of proposed transformations which seemed to hold out possibilities for progressive change in at least some spheres of political and social life in the last years of the war and into 1946, awaits detailed investigation.⁵⁸ Shula Marks has begun the historical examination of the "Gluckman Commission", or National Health Services Commission, whose members met in the last years of the War, to draw up a new, nonracial, community-based comprehensive health scheme for South Africa.⁵⁹ Marks has demonstrated that progressive physicians such as Emily and Sidney Kark, influential missionary doctors and public health officials such as MacVicar and Gale, played a vital role in arguing for a completely new approach to health. Instead of focusing the bulk of health resources on technically sophisticated hospitals and emphasising heroic curative medicine, the new scheme called for networks of primary and comprehensive health care. But, the Commission argued, this could not be achieved on either a piecemeal or race-based foundation. Many of the most active voices in the campaign to reinvent health

⁵⁷ HPC/AD 843 B91 3. 1944; C. Searle, The History of Nursing and H. Kuper, "Nurses" in L. Kuper, An African Bourgeoisie.

⁵⁸ HPC/AD 843 RJ Na 9.3 and Na.11 "Evidence to the National Health Service Commission".

⁵⁹ S. Marks, "The Historical Origins of National Health Services" in C. P. Owen, (ed) Towards a National Health Service: Proceedings of the NAMDA Annual Conference (Johannesburg: 1987).

and medical care in South Africa had served in North Africa together during the War, which was drawing to a close as they met. Swept up in the ideology of world betterment, and less cynically, a more critical sense of the lack of democracy at home, many medics, and a number of other servicemen and women, were persuaded of the need for radical change on their return. The small number of mainly male physicians who spearheaded the new mood, returned to build a constituency across South Africa for a National War Memorial Fund, which would push for tax-based progressive health care for all in a National Health Service, and would concentrate efforts on the poor.⁶⁰ Successfully exploiting the rhetoric of nationalism, the purposefulness and unity which had served the war effort, Gluckman and his allies touted the benefits of two experimental community health centres in Polela, Natal, and the new family centre in Vrededorp, Johannesburg. Part of the incentive for this work came from the hearings which had been held on the eve of the war in 1939, on "free hospitalization" and it was from these beginnings that the new scheme for a national health service sprouted.

In 1939 medical experts from around the world, such as Henry Sigerist the well known Johns Hopkins University public health professor, who was a strong advocate of socialized medicine, toured South Africa lending considerable support to the new effort.⁶¹ Joint communications between South African proponents of the scheme and their British counterparts, resulted in many similar proposals, which, in the case of Britain, led to the formation of the National Health Service. But the revolutionary health plan in South

⁶⁰ HPC/AD 843 Na 12.1 "Springboks Living Memorial" and "National War Memorial Foundation".

⁶¹ Star 15 December 1939.

Africa was shot down in the wave of racist and anti-communist anxiety and fear in the white electorate after the war, which focused on increasing militancy of the African working class, and the danger posed by the unity of white and black radical movements. The Gluckman plan was never passed. The progressive Health Minister behind the scheme, Dr Harry Gluckman, lost his post after the white General Election of 1948 brought the right wing National Party to power on a policy of explicit segregation of the economic, social, intellectual, physical, sexual, psychological and political futures of black and white South Africans.

The outstanding legacy of this election loss on the part of Gluckman and his allies, in the fields of health and welfare, were twofold. First, all health and welfare services, training and institutions were to be overhauled, with racial and ethnic separation constituting the basis for all revenue and provisioning decisions. Secondly, the state was to take over and centralize the network of mission-controlled hospitals and training centres.⁶² One great irony was that the new health authorities used many of the same reasons for the need for state health control, central planning and use of resources that the Gluckman architects had fashioned with very different ends in mind. It took a few years for the new state to oil its legislative machinery, but by 1957, when legislation to further segregate

⁶² Conditions at the Johannesburg Gen's Non-European section deteriorated so much by the early 1940s, that one of the first suggestions of Orenstein (a Brigadier in the Army and head of the medical services), suggested the use of the military barracks at Baragwanath after the war as the site for a new hospital. The SAIRR hired a researcher, Gertrude Kark (a relative of Sidney and Emily Kark), to undertake a detailed survey of conditions at the hospital, which she did. Her findings provided even further ammunition for those calling for an overhaul of health services. See HPC/AD 834 Na.9: Report, 2 September 1944.

nursing and midwifery was introduced, institutions such as the Bridgman were under siege. Hostels, clinics, hospitals, schools and whole residential communities in newly designated white areas were to be destroyed.

Thus, the hard won gains in the Nursing Bill of 1944, although they did not yet equalize the pay and promotion rates of white and black nurses and midwives, were reversed after 1957. In their wake, nurses and midwives at institutions such as the Bridgman were under enormous pressure, and the first recorded labor dispute between the permanent staff and the probationer midwives that is recorded in the Hospital's records occurred in 1959, as the Bridgman entered its final phase of existence.⁶³

⁶³ HPC/A1059:D1.1 April 1959.

Chapter Seven

The Bridgman Mothers

When the Bridgman opened in 1928, the city's small community of experts in "Native" affairs (anthropologists, missionaries, administrators) had little knowledge about black women, their pregnancies and birth labor, their health practices, or their attitudes concerning birth and pregnancy in the city. The small handful of Health Visitors had gathered some information about death and morbidity rates, and had arranged for a white district midwife to be present at the birth labors of hundreds of poor white and black women in the 1920s.¹ As we have seen, authorities, such as the MOH, Charles Porter, had drawn together some available information regarding breastfeeding practices from rural physicians and "native" experts. The 1930s opened with a slew of new research into similar questions in rural parts of the country, and P. W. Laidler was a key figure in that he published his research in the major local medical journals and news of his findings were carried in local newspapers. Physicians and readers from around the country read his remarks on the "taboos and birth customs of Bantu or Native women". In this work, Laidler proceeded on the basis of his research conducted in the black residential areas of East London, and used the census material he had drawn up as well as his own interviews and observations, as the basis for his claims.² But he also drew on the writings of

¹ We cannot know how many of these district midwife assisted births were with black women, because the MOH and Health Visitor records are based on districts; many of these districts before the early 1930s were racially mixed, especially the poorer areas of the city.

missionaries and travellers who wrote on customs and local traditions in very different parts of the region, such as Henri Junod, whose detailed monograph was based on work with the Pedi in the Northern Transvaal.³ Laidler amalgamated his work with the commentaries to arrive at a series of general statements about practices and ideas concerning birthing from around southern Africa. In his paper on "Native (Bantu) Beliefs Concerning Pregnancy and Childbirth", Laidler focused on two patterns observed throughout southern Africa and commented upon in every published work which had something to say about the customs and social life of Africans in the region. First, practices of secluding the expectant mother at the time of birth, and secluding the new mother from full participation in communal and personal life after her birthing labor, were the subject of discussion. In Laidler's work as well as major ethnographic texts from other regions, this seclusion was described both in the short term (until a period of grave vulnerability had passed for her and her new infant) and in a more narrow but longer term sense, the sexual separation of a new mother from any male partner, including the father of the child (until the child was weaned or could walk, a period referred to as the "post

² See for example: P. W. Laidler, "Native (Bantu) Beliefs Concerning Pregnancy and Child-Birth, Their Effects on Public Health Administration: And the Effects of Detribalisation or Urbanisation on Those Ancient Customs and Upon Infantile Mortality Rates", South African Journal of Science Vol xxxviii (1931) 418; "The Influence of the Native on Public Health", South African Medical Journal (October, 1932); "Infant Mortality Amongst Natives", The Blythsworth Review (March 1932); "Modern Public Health Problems", East London Daily Despatch 2 June 1931.

³ H. Junod, Life of a South African Tribe: Volumes 1 and 2 (1926; London: Macmillan and Co.; New York: University Books, 1962).

partum taboo" in most anthropological literature into the present). Second, practices and beliefs concerning the vulnerability of the pregnant woman and the infant from harmful physiological and supernatural forces, and the concomitant efforts at forestalling these, were discussed at some length in Laidler's work. The use of fluids and herbs on the part of pregnant woman was noted, as well as the treatment of new infants, who showed signs of illness, with enemas and purgatives especially during the period when the child's fontanel had not yet closed. During this period when the infant was most vulnerable, thanks and benedictions were offered to ancestors and the child would be protected with bodily ornaments and by a process of "smoking" the infant by holding it above a smouldering fire. In Hunter's ethnography of the Mpondo in rural areas, and of Xhosa speakers (Mpondo, Hlubi, Bhaca, Mpondomise, Mfengu and others) in East London, she commented on the continuing saliency of at least two aspects of these practices amongst Christians and town dwellers: first, the sense of vulnerability of new mothers and infants, and thus the need for seclusion and special attention; second, a grave anxiety about full sexual intercourse after birthing and while the women was breastfeeding, an anxiety which meant that women and men in towns and rural areas would practice some form of post-partum sexual abstinence with one another, even if this tended to last for an abbreviated time period if women and men lived in smaller family units, on white owned farms, or in areas of dense settlement and in towns.⁴ Both Laidler, Hunter and Junod confirmed the presence of women birth

⁴ M. Hunter, Reaction to Conquest. See Chapter III "Growing up" and Chapter IV "Marriage".

assistants, who were regarded as specialists in the community, and recorded that in many cases newly married women would give birth in the homes of their mothers or mothers-in-law, especially on the occasion of their first birth.

These ethnographic texts and reports have to be carefully read, as with all extant records from the period. They were filled with as many prescriptive judgements, prior expectations and didactic ends as official records. Nonetheless some corroborating evidence and testimony from two researchers in the 1930s and 1950s, and from the 1990s recollections of women who had borne children in Johannesburg before the 1950s, concerning features of birthing labor and practice among the ethnically mixed townships and freehold areas of the city, indicates the veracity of the major patterns observed, researched and recorded by Laidler in particular.⁵

Ellen Hellman undertook her detailed ethnography of Rooiyard in Johannesburg, soon after Laidler's research was published, and she was certainly informed by her reading of the current anthropological literature under the tutelage of Winifred Hoernle at Wits. Her research documented the daily lives of 376 residents of Rooiyard in the early 1930s. Of these residents, about 100 were adult women, and most were Tswana, Sotho, Zulu and Xhosa speakers, with a smaller number of people who described themselves as Ndebele,

⁵ In the 1950s, Laura Longmore undertook research for a monograph on black women in the city. Although less richly detailed than Hellman's study, she confirmed many of Hellman's observations about household formations, emerging class divisions and sexuality. However she says very little about hospitals or clinics, except that about 'one third of African women' went to hospitals and clinics, and the rest did 'not believe in clinic services'. She cites no evidence for these statements: L. Longmore, *The Dispossessed* 245.

Shangaan, Swazi, Venda and Nyasa, at least 5 people who described themselves and their children as Coloured, and 2 adults who called themselves Indian.⁶ Most of the women she interviewed had left Johannesburg and travelled to rural homes for the birth of their children, although some of these women had subsequent births in the city. Interestingly, Hellman underscores a feature noted in the Bridgman documents. Working class women from the eastern Cape and eastern Natal, as well as the Orange Free State and Basutoland (present day Lesotho) were far more likely to come to the Bridgman for their births than were equally poor women whose rural relatives were closer by, in the Northern Transvaal for example. The fact that the Bridgman opened its doors on the eve of the depression and the widespread rural drought, meant that the previously more economical and conducive rural surrounds for birthing labor and infant care may have been undermined at just the time that the Bridgman's services became available.⁷ Nevertheless, the Bridgman charged a fee (although it was well below actual costs) for the ten-day labor and post labor stay that was advocated for most patients, and many very poor women could not afford even this low fee. However, as Hellman indicates, most women who did stay in the city for their births, paid as much to get trained midwifery assistance (usually Coloured midwives) or they spent money on bringing rural relatives to the city to help them during and after their birth labor. Her description is so detailed that, it is worth quoting at length:

The majority of Rooiyard women contracted their marriages in the country, and in many cases, bore their first child at their mother's or mother-in-law's homes where

⁶ E. Hellman, Rooiyard 11-12.

⁷ HPC/A1059 D1.1: records of 1932 and 1933.

they felt assured of a degree of help and guidance not procurable in the town environment... It is most common for the first child, and often the first two or three children, to be born at home while subsequent children are born in the urban centre... The reasons for this course of cause are numerous. The isolation of a Native women in a town, deprived of the care and comfort of her relatives, is primarily of importance. The tribal custom that the first child be born at the home of the mother also carries weight... if all goes well in this case a precedent is established, and subsequent confinements take place under similar conditions. If, on the other hand, one or two of the children at the mother's kraal die, the bereaved wife usually decides to bear the next child in town... Economic considerations are, necessarily, also of importance. Many women maintain that it is more inexpensive to bear a child in the country where they need not engage and pay a midwife... It is also occasionally submitted by woman that it is better to be confined in town, as all things are rarer and dearer in the country. Such statements were more common during the drought which lasted till November 1933, at which time the hardship for the rural Native was especially severe. Some women, repelled by the cramped conditions, squalor and general lack of comfort in Rooiyard, prefer to go to the country for their confinements. Distance plays its part in determining whether a women is confined in town or at her home. It requires a greater effort and more money to go to the Cape Colony than to go to Rustenberg... And finally, there is that class of Bantu women, small as yet, who definitely wishes to be confined in a hospital... where she is assured the maximum of care and trained assistance.⁸

That many women from the Rustenberg area and the rural regions to the north of Johannesburg, chose most commonly to return home in the last months of their pregnancies, is borne out in Belinda Bozzoli and Mmantho Nkotsoe's work on the life histories of a group of women from Phokeng, near Rustenberg, many of whom worked and lived in Johannesburg while in their twenties, thirties and forties.⁹ This Bozzoli/Nkotsoe text, as well as the recorded evidence of Hellman, Longmore and others,

⁸ E. Hellman, Rooiyard 54-55.

⁹ B. Bozzoli, with M. Nkotsoe Women of Phokeng: Consciousness, Life Strategy, and Migrancy in South Africa, 1900-1983 (Johannesburg: Ravan Press, 1991), 129, 135-136.

and the testimony of the women midwives trained at the Bridgman, as well as from women such as Rosina Kotane who was a patient at the Bridgman in the 1940s, all emphasise the importance of childbearing to black women at this period. As discussed in chapter two, the valorisation of motherhood by black men and women at this period, forms a dominant thread in the webs of women's self consciousness, a thread binding women to ideas and practices of the late nineteenth century as well as providing new materials for city and migrant life in the twentieth century.¹⁰

Certainly the contexts of birth and reproduction in the city were very different from many women's rural homes. By the 1950s, many of the women who came to the Bridgman were born in and around Johannesburg, but this was not so in the 1930s.¹¹ The details provided by Hellman, and borne out in the recalled experiences of Kotane in particular, stress that most women, no matter how poor, found ways to make sure that they could be secluded for a period after their deliveries, and this meant calling on all their friends, networks and resources in the city to help care for themselves and their children, and to accommodate their male partners and older male relatives in separate rooms. Another feature of birthing practice that women carried with them to the city was the

¹⁰ Interview: Rosina Kotane, Johannesburg, November 2 1992, Transcript, 8.

¹¹ Interview: Bulah Rollnick, Johannesburg, 22 October, 1992; Tape 2, Side One. Rollnick is one of the people most familiar with the registration card records of the Bridgman, having used them as a Black Sash member throughout the 1970s to try and garner permission, for young people threatened with expulsion from the city, under Section 10, to stay, based on their mother's having given birth to them at the Bridgman before the law came into effect. She pointed out that by the late 1940s and early 1950s, many of the children born at the Bridgman were second generation city dwellers.

favoured birthing position which most women had observed or experienced as younger women in rural areas:

Most women are still delivered of their child in a kneeling posture on the floor of the room. They do not make use of their beds... or their good bedding until ten days after the confinement. During those ten days they lie on the floor. A few women, practically only those who have previously been confined in a maternity home, or those women who are assisted by qualified midwives, are delivered lying on their beds. These women also use the beds for the ten days of the seclusion period.¹²

What is most interesting in Hellman's recording of women's testimony and in her observation of their postnatal practices, is the strict observance of the "ten day" rest and seclusion period. None of the works of contemporaneous anthropological evidence suggest that the seclusion period lasted for "ten days", and yet this is precisely the period recorded by Hellman, and precisely the period recommended by the Bridgman, and most European and American maternity institutions. This suggests that by the 1930s, even if many very poor women were not willing or able to shift to hospital birthing they had begun to weld together birth practices from rural areas with the practices of trained city midwives and maternity institutions. Women may not yet have been "brought to bed",¹³ but there existed by 1933 on the Witwatersrand at least, no "pristine", pre-medicalized birth experience, and a dialogue about birth and women's health had been inaugurated which would rage for the remainder of the century.

¹² E. Hellman, Rooiyard 55.

¹³ The term is borrowed from: J. Walzer Leavitt, Brought to Bed: Childbearing in America, 1750-1950 (Oxford: Oxford University Press, 1986).

An examination of the Rooiyard material indicates that by 1934, out of 11 women, who between them bore 34 children, only 3 were born in hospitals and of these only one child was born in the Bridgman, the other two children being born at rural hospitals in the women's home areas.¹⁴ Eight women went into the final stages of pregnancy and birth labor during the period Hellman surveyed the community of Rooiyard, and of these 4 women were assisted by trained midwives, 3 women by relatives, 1 woman by a midwife and doctor called in by the midwife after difficulties presented themselves, and 1 woman by untrained and also unrelated women who charged for their help. However, Hellman indicates that at least 2 of the women had planned to give birth in a local maternity home (presumably the Bridgman) but were anxious lest they be charged the extra money for an extra night's stay, and so waited until the last moment to get to the hospital, but both misjudged their labor time, and were hurriedly helped in their births by the available women of Rooiyard.¹⁵

One of the most extraordinary aspects of the Bridgman as a site in the 1930s, was that women who were poor, living in very cramped accommodation and working more than 16 hours a day to provision families, earn wages and care for children, were able to come to an institution where they would be fussed over, given rest for ten days on average, and lie in beds next to women who were domestic servants, teachers, beer brewers and hawkers from home regions across the country. Why did the first women

¹⁴ E. Hellman, Rooiyard 55.

¹⁵ E. Hellman, Rooiyard 57.

patients of the Bridgman decide to entrust themselves and their birthing labor to such an institution? Before 1928 across the country very few black women had ever given birth in a hospital, and then only under emergency situations, usually requiring surgery. These experiences would have been quite different from the atmosphere of the labor and recovery wards of the Bridgman. The principal reason that women came to the Bridgman in the 1930s, women who were not specifically determined to have a hospital birth, was that many did not have a city "home" in which to give birth. Of course, the working class homes of poorer black families and working class whites were not well equipped and lacked many of the facilities enjoyed by the middle class, including privacy, domestic help and child care, water, electricity and adequate fuel. But the conditions under which domestic workers, beer brewers and the spouses of the lowest paid workers lived, often provided no more than a shared room rented with strangers with no extended household support, or a lean-to room in the backyard of the house of a white employer and their family.

As we have seen, the women whose interests the founders of the Bridgman believed they served, were envisioned from the start as either mothers and potential mothers or as midwife trainees (who in turn, it was anticipated, would become mothers at some time too).¹⁶ In a society where black women were called "girls" by white men and

¹⁶ Although, as we have seen, debates raged throughout the 1930s and 1940s about the advisability or not of married midwife trainees, and even married qualified practising midwives. Pregnancy outside of marriage was considered inimical to the moral ends of the entire project, and women were summarily dismissed if they conceived while in training. Many patients who gave birth at the Hospital were unmarried but they were welcomed at

women and treated as inferiors, where they enjoyed few rights of citizenship, and where they remained perpetual minors in the eyes of both settler and codified customary law, the vision of the black woman as 'mother' on the part of whites required an ability to suspend several levels of objectification simultaneously. A "girl", who was an adult domestic worker, and cared for a white employers children, could herself be a mother. We have also seen that Clara Bridgman and her allies sought to deliver babies along with a regime of "correct methods of mothering", through didactic education programmes, afternoon baby shows and mothercraft classes designed to prescribe changes in behaviour.¹⁷ These Bridgman activities were a powerful means of drawing city women to the Hospital. The women who considered going to the Bridgman for their birthing labor had a variety of ways of finding out about the institution, and besides the on-site activities, the Bridgman was publicised in city papers, in street parades, at dances and recreational meetings. What is more, many women living or working in the western suburbs saw the Bridgman on their way to and from work. Finally, women considering the option of birth at the Bridgman could attend free prenatal classes, where talks on pregnancy, sewing classes, nutritional and cooking advice and free tea and buns would be dispensed on Saturday morning and

the Bridgman, where it was felt they would be exposed to good example and moral influence. For the same reason the Bridgman accepted women prisoners about to give birth, whose period of stay was paid for by the Prisons Department.

¹⁷ HPC/A1059 D1.1 Records from 1930s and 1940s especially; flyers, press cuttings. Also see CAD/NTS 9709 788/400 "Umlindi Illustrated Newspaper for Natives": Photographs, notices of Baby shows and information about the Bridgman.

Thursdays afternoons (the "day off" for laundresses and domestic workers which was becoming ubiquitous in Johannesburg at this time).

Many women had their first experience of the Bridgman not because they were pregnant, but as outpatients. One of the first services introduced by the Bridgman Hospital in 1928 was the testing of and treating of sexually transmitted diseases, with an emphasis on women, and their specific gynaecological needs. Women heard from people at the Johannesburg Gen's Non-European section, and from friends and networks in Sophiatown and the western areas, that the Bridgman offered free venereal disease programmes of treatment in far more private and conducive surrounds than the few municipal clinics and the main Hospital in the city centre.¹⁸

Shula Marks, in her historical work on nursing in South Africa, has commented that a commonly held view of black nurses on the part of other black women by the 1960s, was of "snobbish" and cold women, who were brusque and even cruel in their condescension of women patients.¹⁹ No written records of the Bridgman, of the Matron or any testimony from the Bridgman midwives interviews for this project, supplies any evidence of this as either an accepted or widely-held attitude. However, it is unlikely that this behaviour would have been recorded if it occurred in the many intimate exchanges

¹⁸ In the first six months of the Bridgman's operation, 69 women were treated for sexually transmitted diseases on an outpatients basis, excluding women treated as patients in the maternity or gynaecological wards. The Board was convinced of the value of the service to women's health and saw this as a way to draw younger sexually active women to the Hospital. See Bridgman Memorial Hospital, Annual Report 1928, 3- 4.

¹⁹ S. Marks, "The nursing profession and the paradox of Apartheid".

between midwives and women in small groups. Furthermore, the women interviewed for this project were perhaps extraordinary in their commitment to community service as midwives and work with poorer women, rather than in for profit hospitals, or clinics in wealthier areas. While the written records provide some sense of the reasons women were drawn to the Bridgman, they reveal little if anything about patient-midwife relations, and these records are silent about the opinions and views of the women whose lives were marked in important ways by their connections to the Hospital.

The testimony of Rosina Kotane, who vividly recalled her experiences as a young woman in Johannesburg in the mid and late 1940s, and offered insights into the complex relationship between women patients and midwives at the Bridgman, provides an incomplete yet significant view of the journey that many black women made to and from the Bridgman before the end of the 1950s. Having arrived in the city like so many other young women from a rural area where elderly people held onto small allotments of land, or worked for richer white farmers, and where most younger men and women were forced to leave in order to survive, Rosina Kotane took up work in "the Kitchens" following in the footsteps of her paternal aunt, who helped find her a job, trained her in the requirements of domestic work, and provided her in her first years in the city with free accommodation in her rented house in Sophiatown. Two years later, working in Westdene, Rosina Kotane met her future husband, and although they were married when she was twenty in the western Transvaal at the home of her paternal grandparents, the

young couple lived apart, with Rosina staying on the property of her white employers in a small room adjacent to the main house, while her husband worked for the municipality, and lived in a single sex male hostel. Rosina Kotane recalls that she had not expected to conceive, believing that the infrequent periods of time her husband and her spent together were insufficient for pregnancy to result. Thus when she found herself pregnant at twenty-two, she was shocked, and in fact denied this to herself, until her Aunt came to visit her at her place of work and insisted that Rosina Kotane, now, in her seventh month of pregnancy, should accompany her to the Bridgman. She described the conversation with her aunt one day in late 1948 thus:

My Aunt said, "To the Bridgman." Because why? She said to me "Why are you so light, in your face? I can see, maybe you are pregnant." I said "No, no." I did not want to know what is pregnant! I did not know I could be pregnant from being with my husband so soon! My Aunt told the people in the house she is taking me to the Bridgman.²⁰

Her employers gave her the time off that afternoon, even when, as Rosina Kotane put it, "I did not want to go there!". Once at the Bridgman, which Rosina Kotane had seen at the edge of the Brixton hill almost every week when catching the tram rides to her aunt's house, Rosina Kotane spoke for the first time in her life with a black women midwife:

It was very clean and very nice inside. The paint was white, white. I had to fill a card, a nurse she helped me. She was the first time I had seen a black nurse. She filled out the card. She was wearing black and white stripes, and a cap also. I was not scared of her. You know, she was talking to me. There were plenty of other woman in that room at the front, when you walk in. [CB: So what happened next?

²⁰ Rosina Kotane's first language is Tswana, but her English, although idiomatic, is perfectly intelligible to non-South Africans, I believe. She generously consented to be interviewed in English, her third language. Comments in parentheses have been added by the author. "CB" indicates interjection by Catherine Burns. Interview: Rosina Kotane, Johannesburg, November 2, 1992; Transcript, 5.

Did they check that you were pregnant?] You see, let me tell you. You lie down in a bed, the nurse is coming, and she is talking to you all the time. Then the doctor comes, a white doctor. A man. [CB: How did he treat you?] He was very alright, but not talking so much as the nurse. He said, "You are pregnant here". I asked him "What is a pregnant", because I don't know nothing then. [CB: What did he tell you?] He say to me "You are a pregnant woman." That's all. He did not say nothing else to me. [CB: The nurse, did she say something to you?] Yes, yes. The nurse she was talking to me all the time, she say "Oh, ooh you are so fat, that is the first time of pregnancy", and she laughed, also my Aunty was there. [CB: They were teasing you?] Yes. She didn't tell me what time it was coming on the day, but, she told me, "After three weeks, come here again". She write something that says to me, "You must come back this day". Before, I just thought "You are very fat". But I thought that I was eating too much, that was all. Because I did like the oranges. I did like eating everything. I thought, "I am just getting fat here, no trouble, no what." Aah, you see?²¹

Rosina Kotane then described how scared she felt after leaving that day with her aunt:

"You must come and sleep at this hospital," they said to me. I was so scared, I say, I did see before, when I see other woman, they can get an operation at the hospital, you see. I say, maybe I am going to get that, they are going to cut me. Yes. I did not know then.²²

But her fears were allayed somewhat during the weeks that she visited the Bridgman on her Thursday afternoon breaks, and she had the opportunity to meet and talk with women also preparing for childbirth. Rosina Kotane began noting the movements of the foetus in her uterus, but she could not recall learning anything of about the classes and demonstrations offered on the lawns of the outpatients centre. The days at the Bridgman were mainly a way to rest and consider her future, and meet with other women.²³ The day of her birthing labor, Rosina Kotane was still working in Westdene:

I say to my Madam, "Hhhaaa. I am late. I have got a sore stomach!" She say 'HEY! [Very loud exclamation] "I am going to call the ambulance." I say "No,

²¹ Interview: Rosina Kotane, Johannesburg, November 2, 1992; Transcript, 5.

²² Interview: Rosina Kotane, Johannesburg, November 2, 1992; Transcript, 5 and 6.

²³ Interview: Rosina Kotane, Johannesburg, November 2, 1992; Transcript, 5.

don't call the that. I am not going to the ambulance." So, I just walk myself. To the tram. [CB: By yourself?] Yes, to go to the Bridgman. But I don't carry nothing. Just the money for the tram. Yes, I got a purse, that's all. [CB: What the woman you were working for say?] She say 'Rosie, you go to hospital now?' I say "Yes, I just go now to see". She was telling my Aunty, and that's all. Then I entered in the hospital. I walked in. Yes, Hhm mnn, nothing yet, just my back is sore, [Gestures to her lower back], yes, very sore. The I just walk in, I just go to the toilet, maybe I get a water to drink, or what. I go into the area, to the table, there is the nurse. I just enter in the room. And when I am going to the toilet, she says, "What's going on hey! Hey wena! Don't go to the toilet, I want to take you in", [High pitched nasal enactment of nurse's voice]. But I go past her, and I just walked myself to the back. I know that place now. I had been here before.²⁴

The next portion of testimony focused on the birth experience itself, and was so interrupted with exclamations from both Rosina Kotane and the interviewer, that the coherence of the narrative is broken, but Rosina vividly recalled her sense of expectation and fear. The same midwife who had snapped at her when she arrived, was soon helping her into a bed and talking to her again in a soothing manner. Rosina Kotane was proud that she did not scream in the next few hours, and that she did not require an injection or pain killer:

Very nicely! I did not have even an injection or what! Every one was saying 'Hey Hey', and the doctor come and say, 'Very good, very good'." [CB: Did they come look at the baby and check the baby? Yes they check everythings for the baby. They were washing the baby, and then they bring her to me, they bring the cloth, and put it in a cloth. Then I was sleeping there, just after that, then I get the baby again. Then the nurse takes you, and washes you nice. Takes you, puts you in another bed, for you to sleep there. Then they bring the baby again. She showed me. [Gestures towards her breasts] [CB: Did you have preparation for breastfeeding? Had you seen other women doing that?] I saw another woman, and she, the nurse, she was showing me that. Yah, and that child, she did not drink even a dummy or what, she just sucking on me.

Rosina Kotane's next recollections all revolve around the camaraderie of the days after child birth in the Bridgman, although as she remembers, she left earlier than the usual ten days, because she was well and the baby was well. Her Aunty came to fetch her to take her back to Sophiatown for a few weeks, where the district midwife came to check on the progress of both herself and her baby daughter. Before she left the Bridgman, Rosina Kotane commented that she witnessed other women's birthing labors, which were much more difficult than her own:

No, hey, I did not get that pain of that Shangaan woman. That one was getting very scared because it takes a long time to get that baby. Now, they [she] only get the baby the second day. The woman was on my side, yes, she got that baby, very very late. I was talking to her saying, 'No man, it's nothing man. You are getting alright now, you are getting alright. Now, now, now. "But I was very nice in every one of my babies. I didn't get even an injection or what. No, or stitch or what, nothing."²⁵

After her birth experience, Rosina Kotane recalled that she no longer felt so wary of Hospitals, and she returned for all five except the last of her labors to the Bridgman.

In Sophiatown with her aunt's help, Rosina observed a period of further seclusion. Her aunt obtained leave from Rosina Kotane's employers on her behalf, and relayed messages to and from her husband. Both he, and her husband's family were not allowed to visit Rosina Kotane at first, during the days when the infant was very closely watched by Rosina Kotane and her aunt for any signs of illness:

They are waiting for ten days because it is the law for our people. No, he was staying far away, not even seeing her for ten days. Let me tell you our law. My Aunty, she put the beads on my child first, in the ambulance, when we were coming home. Already, when you enter at home, when it's not your own home, you just take this, [Indicating the picking up of dust from the ground], just next to

²⁵ Interview: Rosina Kotane, Johannesburg, November 2, 1992; Transcript, 8.

the door, or in a car, or in a bus, just put it like this, on the child's neck . [CB You just take-up some dust?] Yes, because you must take, not ah, trust for somebody. Anything, just going inside in the house. [CB: And did you just touch the dust on her neck?] Yes, touch it here and here And her legs also. That's all. [CB: Did you do anything else for your daughter after you arrived in Edwards street?] Yes, we buy a bottle of 'statedruppel', 'hermasdruppel', 'groenemarie', 'wonderkroon', and 'essence of life' anything for that small child. [CB: Where did you buy that from?] My Aunty bought in the chemist. I remember, gripe water too. [CB: Was your baby daughter healthy after you arrived in Sophiatown?] She was not sick, she was very healthy, and the nurse came from the Bridgman, and she was checking her, and the later I did take her to the Bridgman for the injections.²⁶

Rosina Kotane remembered that the next few weeks and months in her life were busy but happy. Her aunt cared for the baby during the week, except for odd days when she kept up with her laundry work, and then a neighbour would help out. In the mean time, Rosina Kotane returned to day work, but would come back to Edwards Street in the evenings. She breast fed her daughter in the evening, and in the day her aunt fed the child with tinned milk formula purchased from the chemist shop a few blocks away. This was the major expense of caring for the new child. Rosina Kotane and her husband, she recalled, "according to the law of our people", did not resume full sexual relations with one another until the baby could walk when she was, Rosina Kotane estimated, about 11 months old:

It is a custom for the Motswana people. The child she must go to one year, with no sleeping with a man. He must wait! They sleep next to you but they can't sleep with you. He cannot say this or be angry, because if he likes his child, he can't sleep with you. [CB: Why is there this rule, this custom?] It is to keep your milk for your baby. He must do that because we don't want to make another baby soon soon also. [CB: Ok, so that is the main reason for this custom of the Tswana people?] Yes, yes. We do it.²⁷

²⁶ Interview: Rosina Kotane, Johannesburg, November 2, 1992; Transcript, 11 and 13.

Rosina Kotane was only one of tens of thousands of women for whom the Bridgman played such an important role in their lives in the city. Richer and poorer black women gave birth and met other women in its wards and gardens. Ellen Kuzwayo, the famous South African social worker and civil rights campaigner gave birth to her first son in 1942 at the Bridgman, and her description of the reasons for giving birth there, add another dimension to the story of the institution. Here, a woman from a family of landed wealthy parents in the Orange Free State, who been educated in Natal, and had tertiary qualifications and a teaching degree from Lovedale College, came to the city "following custom", as this had become the home of her surviving parent, and she needed support from her closest family at this time:

The loophole which allowed my elder son to settle in Johannesburg was that, as custom demanded, I had come to my father's home to have my first child. This custom is both considerate and sensible: black people believe that a young mother must go to her home for the birth of her first child, so that her parents can support and nurse her during the new experience of childbirth. For this reason my son was born at the Bridgman Memorial Hospital, a maternity hospital of repute in those years. (Like many others it disappeared under the heavy wheels of Group Areas legislation.)²⁸

The Bridgman, it seems, had become a space where traditional obligations too could be realized.

²⁷ Interview: Rosina Kotane, Johannesburg, November 2, 1992; Transcript, 13 and 14.

²⁸ E. Kuzwayo, Call Me Woman (San Francisco: Aunt Lute Books, 1985) 18.

The Records of the Bridgman:

At the start, the Bridgman decided to charge a fee to cover not only the hospital stay for the delivery itself, but also for post-natal and out-patient care.²⁹ This was intended, explained the first medical superintendent, Dr Ethel Smith, to inculcate in black women the need to seek treatment before confinement, and to return for treatment at a later stage. Furthermore, she argued, this would allow the medical staff to continue to record the progress of patients, and facilitate the main projects after pregnancy of mothercraft training. She ended the written part of her report by adding:

We would draw attention to the fact that 50 per cent of the births in the Hospital were abnormal; this shows the great need of propaganda work--to teach native women the benefit of the Ante-Natal Clinics and of coming in good time to the Hospital.³⁰

Thus fees were seen as a way of not only contributing to the costs of the institution, but also to the entire health, welfare and Christian project. The percentage of in-patient fees collected, after an initial hovering around the 60% mark, dropped sharply in 1933, and did not rise above 45% until in 1938 they shot up over the 60%, ending up over 70% in 1939. Reasons for these changes emerged in a crucial paragraph in the written record emerged. The 1938 Medical Superintendent's Report, which mentions the reducing of the in-patient fee from that year, from 3 to 2 pounds, commented that:

The increase in the total fees actually paid is the more notable because during the year, the fee for the confinement period of ten days was reduced from £3 to £2. Many Africans have expressed thanks to the hospital for the relief which this reduction has brought to many humble homes. It may be noted that more and more

²⁹ Bridgman Memorial Hospital Annual Report 1929.

³⁰ Bridgman Memorial Hospital, Annual Report 1928, 2. The figures that follow have been calculated from the statistics listed in the Annual Reports.

women are coming to the hospital for pre-natal care, one of the many signs that the African's fear of entering any hospital is being steadily overcome.³¹

Focusing on the numbers of women and babies admitted, an examination of the records reveals that although a small number of women were admitted for gynaecological reasons at first, by 1936 this had almost dissipated, despite the fact that larger numbers of women were being admitted. This was the result of a sharp increase in the numbers of women seeking care through the rapidly expanding outpatients clinic (which went through three stages of extension and rebuilding during this period). This process was twinned to the rise in the number of women visiting the clinics for gynaecological treatment, and this combined with women seeking treatment for their children and babies, made up a large proportion of the cases. It is also interesting to note that whilst the numbers of patients seeking medical treatment for venereal diseases dropped off after 1936, the numbers of babies being brought to the clinic for attention rose steadily. We would need a far more sensitive breakdown of the background of the women attending the clinics to fully understand these changes, however some preliminary comments can be suggested. It is clear from newspaper accounts of the period that the reputation of the Bridgman was becoming extensive by the mid 1930s, and its easy access to Sophiatown, to the inner city, and to white suburbs for women in domestic service was an important factor in its utilisation as a space where women could gather, seek medical care and meet for lectures on Saturday morning and Thursday afternoons. Photographs of the Bridgman 'afternoons',

31

Bridgman Memorial Hospital, Annual Report 1938, 6.

(printed proudly at the end of Annual Reports), show large crowds of women and their babies, in the grassy and flower-filled grounds of the clinic.

In 1932 and 1933 there occurred the only slight drop in the upward curve of patients seeking out-patient treatment in the Bridgman's history . The only possible explanation for this was hinted at in the following terse statement by the newly appointed Medical Superintendent of the year:

The Out-patient Department showed a slight decrease of 190 as compared with 1931. This was probably due to the change of Medical Superintendent, as natives are very susceptible to change in personnel.³²

These small hints of the shifting mood within the Hospital when staff changes were made, are only fragments of a far larger picture of the dynamic, if unequal, relationships which must have developed between nurses and women attending the clinics in particular.

In 1934, funds were collected for the opening of a postnatal clinic, and that very year the numbers of infants and children attending the clinics increased sharply again. This information may seem insignificant, but it contradicts any casual assumptions about the ways black women viewed these services, and it points to a far greater link and sense of communication, albeit on an unequitable basis, between medical staff and people seeking medical treatment. The Bridgman Board explicitly reacted to the welcome reception of the postnatal services in the previous year by trying to increase the number of sessions per week, and the hours devoted by staff to women who came for assistance and questions.³³

³² Bridgman Memorial Hospital, Annual Reports 1932, 4.

³³ HPC/A1059 D1.1 "Minutes of Meetings", 1930 to 1934.

This very close link between the opening of a new facility or the emergence of a new treatment, and the immediate use of this by women in the region, suggests that the Bridgman staff, particularly the Matron and the full-time midwives, kept a close ear out for the services most appreciated by women patients, and the speed with which women heard about new services, suggests that the Bridgman's advertising techniques and word-of-mouth networks were well developed.

In 1937 the Bridgman extended its bed capacity with two new wards, bringing the maternity section to a total of 60 beds, almost double the amount first envisaged a decade before. By 1939, the intake of probationer midwives (all of whom passed their final exams the next year) was recognised as far below the need evinced by the hundreds of applications received by the Matron each year. The Board began drawing up plans to increase the size of the Midwives home, and extend the number of women taken in for training from less than 20, to around forty by the mid 1940s.

In 1939, Clara Bridgman retired from her active role as head of the Board having garnered additional funding for the Hospital from the Native Development Fund and several city charities. The latter grant was hard won, because the Bridgman still admitted women of colour not designated "Native", and for years the Native Affairs Department had wrangled with Clara Bridgman and others on the Board over this "anomaly". But they could do little when there existed no other facilities for women of colour anywhere else in the city boundaries. For example, in 1939, of the 1,597 women admitted for births, the

following ethnic categorizations were recorded (the spellings of the day have been retained): 724 Msutu; 341 Zulu; 201 Nkosa; 69 Swazi; 28 Fingo; 14 Shangaan; 9 Mvenda; 57 Bechuana; 112 Coloured; 1 Malay; 13 Indian; 1 Chinese; 1 Nyassa; 1 Bushman; 3 Griqualand; and 2 Mozambique women.³⁴ Unlike the 1929 to 1934 period, when sometimes "Assyrian" women, and even once a Portuguese woman was admitted to the Bridgman, the racial line drawn between "European" and "Non-European" women was becoming more tightly drawn. It would take until after the war for the Coronation Hospital to be built, catering explicitly for Coloured and Indian women. After the war, the numbers of black women patients not designated African dropped dramatically, but this was more than counterbalanced by the large influx of black women from rural areas into the cities in the early and mid 1940s. In 1944, the number of women admitted for births rose to 3,240 (of whom 122 were listed as Coloured, 15 as Indian, and 4 as European) while the number of women seen in the outpatients department skyrocketed to 22,546 people.³⁵

In 1944, with the Free Hospitalization report of the Penz Commission having argued in favour of such a scheme country wide, the Transvaal Province decided to try and adopt some of the measures in the new year. Instead of financing the Bridgman and other hospitals on a the basis of a single annual grant, the Province would now contribute a basic amount per patient per day. The Bridgman stood to gain enormously from these

³⁴ Bridgman Memorial Hospital, Annual Report 1944.

³⁵ Bridgman Memorial Hospital, Annual Report 1945.

changes, but to do so they would have to expand their facilities and services enormously. The Board realized that the present staff, buildings and equipment would not allow for dramatic expansion. Although they would be subsidised for patient care, the Province was not forthcoming with capital expenditure for new wards, surgeries, Sisters, Midwives and Physicians. A new Nurses Home, planned before the outbreak of war, was eventually erected in 1945 but the Hospital could not afford new ward construction, and thus the same year the Bridgman inaugurated a massive new district midwifery service, where patients were screened in antenatal clinics, and women judged to have "normal" pregnancy forecasts, were waitlisted for hospital beds and assigned midwives. By the end of the 1940s, the Hospital had managed to add on temporary structures and side wards, and had a maximum capacity of 72 beds, yet:

... from the Medical Superintendent's Report we find that the daily in-patient monthly average ranges from 86 to 101. How are these additional patients cared for? On mattresses paced on the floor. As soon as a patient can be safely moved from her bed, she is placed on the floor. Many will say "But how much better accommodation is that than what she would have in her overcrowded home!" That we freely admit, is often true.³⁶

The Bridgman had been designed as small hospital for a minority population of black women in the city in 1928. It was unable to provide the same level of service and care to black women in Johannesburg after the war.

It is also unclear at this point how successful the Bridgman was as a hospital in its mission to improve the health of women and lower infant mortality in the city. By the mid 1940s, the greatest turn-over in patients took place outside of the Bridgman's walls. Inside

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Bridgman Memorial Hospital, Annual Report 1949, 5.

the Hospital, the numbers of live births increased to over 1000 by 1939, and continued to increase exponentially until the early 1960s. However, the percentage of infant deaths (not including stillborns) also increased, after a sharp drop to around 3% in 1936 to its highest level of over 7% in 1939, and they continued to remain high through the 1940s and early 1950s. The reasons for this remain unclear, but it does seem as if a far larger increase in the numbers of women with "abnormal" deliveries were admitted to the hospital in later years. A partial explanation could be that many women with anticipated "normal" births were set-up with birth assistance by a Bridgman district midwife. Despite the puzzling figures, the numbers of maternal deaths recorded at the Bridgman plunged to less than 0.5% by 1939, despite the great increases in the numbers of women admitted, and never rose above this low figure.

In her annual report of 1934, Clara Bridgman commented:

...we take courage in the conviction that slowly but surely ideals are forming and principles of hygiene and order are being instilled... [surely African women would in future be able] ... to withstand the backward pull of ignorance and superstition.³⁷

This quotation serves to turn our attention away from the Bridgman itself and towards the wider social and economic context of women's lives and their health in the city at the time.

The poverty wages, lack of facilities and infrastructure, and the overcrowded shanty towns levied a high toll on the health of the cities most vulnerable members. A report by the Bridgman's Medical Superintendent of 1935, Dr Hope Trant, who conducted her own study on babies seen as outpatients over the year, concluded grimly that:

³⁷ D. Gaitskell, "Housewives, Maids or Mothers..." p 7; words in parentheses drawn from her exposition.

Recently I counted up the number of babies lost by our patients in their first year. It worked out at about 48%. Then others die after their first year, so that the total child mortality during the first four years of life is roughly 64%... this is an appalling state of affairs.³⁸

Her comments were echoed in the Medical Superintendent's Report twenty years later, in 1955.³⁹ This is a salutary reminder of the grave problems of infant mortality in the urban townships of Johannesburg in the 1930s, despite the mothercraft and hygiene programs instituted by the Bridgman, inadequate access to clean water and sufficient food remained the major problem for most black children in the city.

In 1976, Noreen Gruskin, a researcher at Wits Medical School working with Professor Tobias on the Bridgman records, established that one of the most surprising trends traced via computer analysis of the in the bedletter statistics for infants from 1935 to 1962, was the low birth weight of so many Bridgman babies.⁴⁰ The theories she advanced for this finding focused on inadequate maternal nutrition, and the comparison she drew was with a study of Xhosa women in the eastern Cape at the same time, where levels of maternal nutrition in the mid 1960s were higher than those for Johannesburg women.⁴¹ This was in spite of the antenatal care and screening offered by the Hospital.

³⁸ R. Phillips, in The Bantu In the City, 111. Extract from Dr Trant's Report of March 20, 1935.

³⁹ Bridgman Memorial Hospital, Annual Report 1955 and see Silver Jubilee Pamphlet, 1953.

⁴⁰ N. Gruskin, "A Preliminary Study of Maternal and Infant Data from the Bridgman Memorial Maternity Hospital, (1935 to 1965), as evidence of the existence, absence or reversal of a secular growth trend in the South African Negro", University of the Witwatersrand University, Anatomy Department, (1976), 3, 7 and 9.

⁴¹ H. V. F. Jordaan, "Foetal Bipartal Diameter and Birth Weight", South African

Despite the fact that the Bridgman patients were among the few who had access to the meagre health services and medicines available to black women and children, these findings graphically illustrate that the struggle to gain access to adequate medical resources and services could not be separated from the poverty of the majority of people in the biggest city in Sub-Saharan Africa.

Conclusion:

In 1956 a large medical volume was published by the University of the Witwatersrand Press, which brought together a compendium of research on the bodies of African women, undertaken in the main by two key gynaecologist-obstetricians who held joint appointments at Wits University, the Johannesburg Gen. and the Bridgman, Geoffrey Charlewood and Oßsie Heyns. Titled Bantu Gynaecology, this book represented the fruits of more than two decades of research, and was infused with ethnocentric, essentializing visions of African women and their birthing and reproductive "capabilities". In this book, both authors took great pride in the role they and others had played in lifting up heathen African women through their work at the Bridgman.⁴² There were others who were proud of their effort and time at the Bridgman, and indeed Letta Mosikatsana declared, after

Medical Journal 50:30, (1976).

⁴² G. Charlewood, Bantu Gynaecology with O. S. Heyns, (Johannesburg: University of the Witwatersrand Press, 1956).

conducting the author around the Maternity Wing at Alex, that the "spirit of the Bridgman lives here in Alex today, with us!".⁴³

In 1953, writing in the Silver Jubilee Commemoration publication, the Secretary of Native Affairs for the new Nationalist Government complimented the Bridgman thus:

When this institution was founded the Bantu still placed their trust in the witchdoctor and superstition like a thick black curtain prevented many a health-giving ray of light from entering into their lives. Since then many mothers who have received tender care in your maternity wards have in ever-increasing measure spread the gospel of health most effectively. Our sincere hope is that the midwives you have trained will in future devote their lives so zealously to the uplift of their fellow Bantu that their names, and through them your institution, will always be remembered by a grateful Bantu community.⁴⁴

This example serves to illustrate some of the contradictions, and unselfconscious self-congratulation, at the centre of the "ray of light" of medical training, service and knowledge. His salutary comments disguised overwhelming deceit. It was the same government, here represented by Eiselen, that shut the doors of the hospital less than 10 years later.

⁴³ Interview: Letta Mosikatsana, Alexandra Clinic, February 6, 1992, Transcript 1.

⁴⁴ Speech of W. Eiselen, extracted in the Introduction of: Bridgman Memorial Hospital Silver Jubilee Commemoration, 1953, Africana Library, Johannesburg, 4.

Chapter Eight

Controlling Birth: Johannesburg, 1920-1960

It seems to the Department that there might be a need in Johannesburg for the development of an Outpatient Gynaecological Clinic where mothers needing advice on physical health matters, both of nature and nurture might be assisted. Such an institution, under adequate and skilled supervision could receive minor gynaecological cases, deal with some forms of post-natal aftercare, accept responsibility for counselling mothers of subnormal physique or mentality, give advice on contraceptive methods where medically needed and act as a clearing house for appropriate treatment of one sort or another.... Under all circumstances the Minister would depreciate the establishment of a clinic having as its sole object the advocacy of artificial contraception...¹

Yes, I knew about something which is like contraception. I had a boyfriend, very much... even before Nursing.... but there were strict rules in the community... Well, when we met with these girls who came straight from town, well, they fell pregnant. They did, and we knew it was because they were not doing the right thing. We, from the rural areas, we also had boyfriends, but it was not sexual intercourse. It was interfemoral, that is, inbetween the thighs. We call it *ukusoma* in Zulu and it is *ukumetsha* in Xhosa.²

She spoke to us as a mother... Then she would tell us all the disadvantages of being in love during training, "No well, some of you started training with boyfriends already. I would like to give you a tip. Never ever go out with your boyfriend at night, because definitely, you are definitely going to be involved in sex, and that's when you go off"... And the others would say, "No I am in love, and then left him and told him 'I am going to train'. The minute that I tell him I cannot go out with him, he'll think I'm playing tricks". So, it was then that she taught us about contraception.³

¹ CAD/GES 2281 85/38 Deel 1: E Thornton, Acting Secretary for Public Health, reply to the Race Welfare Society, 27 February 1931.

² Interview: Patience Tyalimpe, Johannesburg, November 22 1992, Transcript, 1- 2.

³ Interview: Wilhemina Madiba, Alexandra Township, July 2 1992, Transcript, 3. All interviews were conducted and transcribed by the author unless other wise stated. The use of "..." indicates that a small section of commentary has been left out, while ".../..." indicates that a question asked by the author has been omitted.

Introduction:

In his "Communication of Advice" to the fledgling Race Welfare Society of Johannesburg in 1931, Edward Thornton (Acting, and later, Secretary for Public Health) underlined three key points: birth control per se was not yet a unanimously accepted public good, any clinic with this as its intention would have to embed its purpose in a range of other services and advice, and any such venture would have to come under strict medical supervision. The subjects of these early Department of Health endeavours were white working class women congregating in Johannesburg slums in the period after the Depression.

Patience Tyalimpe, interviewed in 1992 in her offices as a Family Planning professional, remembered her first exposure to urban born women when she started her nurse training in the mid 1950s. While she and her friends knew about and practised "sweethearting"⁴, or non-penetrative intercourse with their male lovers, and had done so since the time of their first menstruations, their urban peers did not, and according to Patience Tyalimpe, this was a major cause of the unplanned conceptions of many urban born women. As a teenager, Patience Tyalimpe had been instructed by her elder sisters, and by her Grandmother at the time of her first menstruation, in matters concerning

⁴ This phrase was used by Monica Hunter in her detailed ethnography of Mpondo society, and is a loose translation from the Xhosa into English of the word "ukumetsha". Patience Tyalimpe had read and heard this English term, and used it several times in the interview. See M. Hunter, Reaction to Conquest: Effects of Contact with Europeans on the Pondo of South Africa (London: Oxford University Press, 1936).

sexuality and the behaviour expected of a grown, but not yet married young woman. Her first lover had to obtain permission from her aunts and eldest sister to "sweetheart" with her, as did subsequent partners. But, Patience Tyalimpe recalled that at the age of twenty or so, when she first met up with nurse probationers from towns across the eastern Cape and Natal, these women either had no knowledge of this conception preventing skill, or eschewed its practice on the basis that this form of sexual expression was unsophisticated and a sign of parochial society. This fact that her urban counterparts did not practice *ukusoma* in the 1950s represented a shift in behaviour and knowledge. This assertion by Patience Tyalimpe was made both on the basis of knowledge gleaned as a younger women, and on the basis of her subsequent reading as a health professional of anthropological and historical material on the social life of black South Africans in the late nineteenth and early twentieth century. Her reading of several monographs from the 1930s and 1940s had confirmed for her that various forms of premarital sexual expression were widely practised and taught among Nguni, Tswana and Sotho speaking communities across Southern Africa.⁵ Christian teachings prohibiting sexual expression by unmarried people had undermined local practices regarding adolescent sexuality, without providing viable alternatives. Town women and men were condescending about rural customs and, although many were Christians, when they did engage in sexual relations outside of

⁵ Patience Tyalimpe had read Monica Hunter's aforementioned monograph, as well as Isaac Schapera's Married Life in An African Tribe (New York: Sheridan House, 1941), in the 1970s, obtaining these text from the library of Planned Parenthood of South Africa. See Interview: Patience Tyalimpe, Johannesburg, November 22 1992, Transcript, 3 and 5.

marriage this was usually penetrative intercourse without contraceptive protection. In her exegesis, Patience Tyalimpe reported many similar observations to those contained in the ethnographic material of Philip and Iona Mayer, material gathered in the late 1950s and 1960s in the eastern Cape, particularly the towns of East London and Grahamstown, and the rural hinterland surrounding them.⁶ Unlike the Mayers, Schapera and Hunter, Tyalimpe spoke both from personal experience, as well as from observation and reading of written sources. She ended her interview by calling for a return to many practices of generational and peer based sexual socialization of adolescents, and a recognition of the sexual needs of young men and women. Besides making modern contraceptives, especially condoms, more widely available, she advocated teaching young people forms of sexual expression and play other than penetrative intercourse.⁷

The third discussion of contraception referred to above, was recalled by a retired midwife in 1992. As a young black nurse-trainee, Wilhemina Madiba was first counselled about methods of contraception by her Nurse Tutor, herself a married black woman with children. Remembering that no instruction about contraception was included in either general nursing or midwifery instruction in South African training institutions of the late 1950s, Wilhemina Madiba recollections were of an informal meeting, initiated by their

⁶ P. Mayer, and I. Mayer Townsmen or Tribesmen (London: Oxford University Press, 1974) 217, 254, 255.

⁷ Interview: Patience Tyalimpe, Johannesburg, November 22 1992, Transcript, 11 and 17. She did not, however, suggest any form of non-heterosexual sexual expression.

trusted tutor, who was concerned that young unmarried woman would lose their chance to qualify if they became pregnant. The tutor recognized that many trainees were engaged in sexual relationships, and offered advice, both moral and pragmatic. Years later, these moments were recalled as part of a discussion about the sexual and reproductive lives of African women before the 1960s. Wilhemina Madiba reported that coming from a very religious Christian family in the Northern Transvaal to Johannesburg for midwifery and nurse training, she had not received any sexual instruction from her family members, and had no prior knowledge of contraception-preventing sexual techniques or practices.⁸

In order to understand the history of Birth Control in South Africa, we need to track back to the period before the 1930s, and through the decades when the subjects of contraceptive provisions were represented as married white poor women, through to the 1950s when the definition of "those in need" shifted to black women, many of them unmarried, and thence into the 1960s, when the South African State devised a formal Family Planning programme, aimed at women of colour, especially urban women.

The history of "birth control" in South Africa suggests fertile questions concerning the wider history of the social and reproductive lives of women in this region. Recent scholarship on this topic in the work of Brown and others has begun to map out the period after 1968, when the South African State developed an explicit "population policy".⁹

⁸ Interview: Wilhemina Madiba, Alexandra Township, July 2 1992, Transcript, 3 and 5.

⁹ B. Brown, "Facing the Black Peril": The Politics of Population Control in South Africa" in Journal of Southern African Studies 13:3 (1987). Recently, the Women's Health

Brown's argument, relying in the main on published works, called attention to the didactic and explicit policies of the State in their attempts to manipulate and bolster the numerical ratio of white South Africans. The state's agenda, she argued, charged as it was by an overarching racial capitalism, contained specific weapons: a history of forced segregation and controls over housing and the movement of people; immigration campaigns designed to attract white settlement; gross inequities in the financing of social and basic primary health care facilities for black people in both rural and urban areas; and most particularly, explicit attempts to manipulate the fertility of black women through state-sponsored "birth control" schemes. Brown's contribution helps re-frame key issues in the history of race and class in South Africa: in what way did the history of Apartheid planning and strategy affect women in particular; and what happened to an understanding of the pillars of segregationist legislation (the Land Act, the Urban and Group Areas Acts, Influx Control Legislation, the Immorality and Mixed Marriages Acts and so on) when these are seen as elements of an evolving "population" control scheme with black women at the centre?

It is the aim of this chapter to approach these questions, through an understanding of the history of a social movement, the actions of local governments, as well as a history of the body of contraceptive knowledge available and utilized in South Africa through the

Project of Wits University, particularly Barbara Klugman, has inaugurated a massive interview survey of contraceptive use and knowledge among South African women from a wide array of economic, social, ethnic and language groups. This project will provide new insights into state contraceptive planning after 1960. See the work of Barbara Klugman on post 1960s state policies: "The politics of Contraception in South Africa", Women's Studies International Forum 13:3 (1990).

first half of the century. The velocity of the state's agenda after 1960, as well as the critiques its actions engendered, cannot be fully understood without this history. Just as importantly, the rich history of late nineteenth century ideas about conception and fertility and how these shifted over time, is crucial to any understanding of ordinary women's ideas about their relationships, their lives as women, mothers, lovers and daughters. Finally, the alliances, movements and institutions which emerged from this history contribute to a wider project interested more broadly in the histories of reproduction and gender in the region.¹⁰

The past fifteen years of historical scholarship in European and North American settings on families, gender relations, the history of science and medicine, and sexuality, has moved our attention to new technologies concerned with the human body which gained currency in the eighteenth and nineteenth centuries.¹¹ These studies have demonstrated that the professionalizing practices and rhetoric associated with these shifts

¹⁰ The arguments and evidence in this section are drawn from materials in the Central Archive Depot (CAD), (including records of the Departments of Public Health, Social Welfare, Native Affairs, and Treasury); Johannesburg Municipality Archives (IAD) (including records of the Public Health Department, the Superintendent of Locations, the records of several townships including Alexandra Township); Records of the Bridgman Memorial Hospital, the Rheinnalt Jones Collection and the Institute of Race Relations at the Historical Papers Collection (HPC) of the University of the Witwatersrand, as well as interviews conducted between January and December, 1992 in Johannesburg, Alexandra, Atteridgeville and in Tabankulu region of Pondoland.

¹¹ See: L. Jordanova, Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries (Wisconsin: University of Wisconsin Press, 1989); O. Moscucci, The Science of Women: Gynaecology and Gender in England 1800-1929 (1990, Cambridge: Cambridge University Press, 1993).

were fraught with inequity, interest and moralising visions. This scholarship has unseated an easy epic of teleological human progress.¹² But questions of 'progress', or questions of the development of different historical actors' understanding and knowledge, and the political struggles which emerged in conversation with these, still remain. Concerned to demonstrate the objectification of women particularly, in contexts wherein their power and social agency was constrained, scholars have often fallen prey to a vision of women as victims of male power, begging questions of contradiction, dialectic and struggle which surely provide the seedbeds of change. Eschewing an approach which describes medical knowledge and technological improvements as closed system--implicated, totalizing and disempowering--this chapter seeks to examine the ambivalence, curiosity and at times imperatives with which men and women in South Africa approached the study and use of contraceptives.

In early twentieth century South Africa, neither white nor black women exercised or enjoyed equivalent authorities or rights in relation to men-folk from their own households, and white women, even after gaining the vote in 1930, were still the focus of decades of social engineering schemes. Black women (with allies that at times included males from their own households, and at times white women and men such as reformers

¹² This field is large, and diverse, but certain key texts include: E. Fee, "Science and the Woman Problem: Historical Perspectives" in S. Teitelbaum (ed) Sex Difference: Social and Biological Perspectives (New York: Doubleday, 1976); A. Oakley, The Captured Womb, (Oxford: Basil Blackwell, 1984); C. Gallagher, and T. Laqueur, (eds) The Making of the Modern Body (Berkeley: University of California Press, 1987); E. Martin, The Women in the Body (Boston: Beacon Press, 1987); M. Poovey, Uneven Developments (Chicago: University of Chicago Press, 1988).

and medics), fought for rights of access to public health care and social services. In this context, the idea of medicine, clinics, and medical professionals as constitutive of "total institutions", or of the technology of birth control devised as yet another form of oppression designed to control women's socially and biologically reproductive lives, misses several crucial issues this work hopes to address.

The first is that very differently positioned actors took their cue during early contraception debates. The uneasy and at times contradictory alliances which formed around these newly available medical technologies of fertility control were not unique to South Africa. In Britain and the USA in the late teens and early 1920s, feminists, progressive health professional, liberal reformers, socialists, and conservatives battled against legal and social prohibitions, and often each other, to define their project. Some regarded contraceptive technologies as part of a new liberatory moment for women, others, as a way to halt the degeneration of social stability and maintain the perceived collapsing norms and values of working class family life.¹³

In South Africa, these alliances were represented in the early teens by such figures as Olive Schreiner and fellow socialist feminists, as well as liberal segregationists such as Winifred and R. A. Hoernle.¹⁴ White English-speaking middle class women made up the

¹³ For the history of Sanger and Stopes's contributions to these debates see: J. Rose, Marie Stopes and the Sexual Revolution (London: Faber and Faber, 1992); D. M. Kennedy, Birth Control in America: the Career of Margaret Sanger (New Haven: Yale University Press, 1970); and N. E. Himes, Medical History of Contraception (New York: Gamut Press, 1963).

¹⁴ For an interesting example of Schreiner's feminist theorising see Women and

ranks of the clinic organisers in the 1930s, but by the 1940s, many Afrikaans women, after successfully petitioning the organs of the Dutch Reformed Church, began forming clinics and lobbying local governments for aid. Regional differences soon developed. In Natal and the Cape first, and later Johannesburg, women of colour were included in the clientele of clinics originally envisaged as provided for the needs of poor city women, and until the 1930s, black women were not regarded as having substantial permanent presence in cities. At just the time that these clinics were being established, local and central state officials expressed increasing alarm over the numbers of black women moving into the cities from the impoverished reserves. At first concerns over the poverty of the reserves prompted anxiety over the detrimental effects this would have on a future male labor force.¹⁵ By the Second World War, a increasingly common theme, especially in the cities, was the "overpopulation" of slums and working class areas, and African men and women became the focus of studies into both "African family life" and its perceived breakdown, and high

Labor, (New York: Frederick Stopes Company, 1911). This volume became a key document for South African as well as British and American feminists. The complexities of the liberal, and then increasingly segregationist, thinker, R A Hoernle, an Afrikaans-speaking philosophy Professor, and after 1934, head of important liberal organization, (the South African Institute of Race Relations), have been examined in P. Rich, White Power and the South African Liberal Conscience: Racial Segregation and South African Liberalism, 1921-1960 (Manchester: Manchester University Press, 1984), see Chapter Three in particular.

¹⁵ F. Fox, and B. Back, A Preliminary Survey of the Agricultural and Nutritional Problems of the Ciskei and Transkei Territories, with Special Reference to their Bearing on the Recruiting of Labourers for the Goldmining Industry, (Pietermaritzburg, 1941) and see A. Jeeves, Migrant Labour in South Africa's Mining Economy: The Struggle for the Gold Mines' Labour Supply, 1890-1920, (Johannesburg: University of the Witwatersrand Press, 1985).

rates of illegitimacy and teenage sexuality.¹⁶ These anxieties, in turn, spawned new alliances, including black men and women who formed part of a local Christian-inspired purity movement, as well as white social workers. Thus, in order to understand how, by the mid-1960s, we can speak of an official South African state policy of birth control, it is imperative that we take seriously the struggles which Acts of Parliament, cast in the masonry of Grand Apartheid, attempted to freeze without complete success. Which is why, as in other regions of the world, local endeavours to control human fertility contained both liberatory and prescriptive agendas. Methods of contraception, and access to them, and the "population" policies of state and welfare agencies, continue to this day to animate debates, cooperations and struggles between women and men.

A Brief History of Contraception:

Contraceptive technologies introduced to a wider audience from the 1930s onwards were not the earliest attempts of people on the southern tip of the continent to control their fertility, fecundity, progeny and sexual lives. Local knowledge was itself not static. The very context wherein practices such as adolescent interfemural sex had developed, were undergoing massive shifts, as the migratory male labor system, land dispossession, increased taxation and the cumulative effects of droughts, permanently

¹⁶ Key texts included: Gluckman, H Report of the National Health Services Commission, (Pretoria: Government Printer, 1944); South African Institute of Race Relations, Minutes of the Conference on Urban Native Juvenile Delinquency 1938, Johannesburg: Church of the Province Archives; and E. Hellman, Problems of Urban Bantu Youth (Johannesburg: South African Institute of Race Relations, 1940).

altered the economic and social landscape of the region.¹⁷ The history, therefore, of the decades before modern contraceptive techniques were available to the majority of women in the region, is complex in itself, and only a brief account will be evinced here. Helen Bradford has begun to map-out the history of abortion in South Africa, demonstrating that before the end of the nineteenth century in this region, as in other contexts, illegality was not at issue in relation to induced abortions. These were considered part of the repertoire available to many women in their efforts to control their reproductive lives. Before women detected foetal movement, many utilized menstrual "activators", herbs and douches, as part of a regime of bodily control available within family oral accounts, recipe books, and among local specialists and herbalists. The chapter on Louisa Mvemve has referred to some of these "Women's Helpers".¹⁸

In the late 1920s new contraceptive techniques designed to prevent pregnancy (although, in the case of certain loops and coils inserted into the cervix, conception could take place, with the intention that the fertilized ovum would not develop beyond this point) were introduced to South Africa, through chemist shops, a handful of gynaecologists and small networks of women who had spent time overseas. Small numbers of women before the Second World War, had access to the resources and

¹⁷ P. Mayer, and I. Mayer Townsmen or Tribesmen (London: Oxford University Press, 1974), 217, 254, 255 and Chapter 16 "Sexual Partnerships" in particular.

¹⁸ H. Bradford, "Herbs, Knives and Plastic: 150 Years of Abortion in South Africa" in T. Meade, and M. Walker, (eds) Science, Medicine and Cultural Imperialism (New York: St Martin's Press, 1991). Here Bradford skilfully draws attention to similarities and divergences between Southern African and other histories of abortion.

connections necessary to visit the few private gynaecologists who could provide them with both the contraceptive advice of the day, and their story is not addressed in this work. This chapter focuses on women who did not have access to private gynaecologists, and for whom the services offered at clinics (which included gynaecological care in some cases, as well as referrals to midwives when women were pregnant, and to social and charitable agencies) were often important aspects of the work of "family planning".

After 1930, when "birth control" devices such as cervical caps, sponges, foaming tablets, spermicides and their analogues were introduced through clinics, the initial intention was to control the fertility of white working class, married women, perceived as enfeebled and increasingly regressive in their social profiles. Men were not the subjects of efforts at family rehabilitation, limitation and planning.¹⁹ Even during World War II, when international campaigns concerning sexually transmitted diseases had opened chinks in the arguments walling-off men and women's mutual contribution to conception, "family planning" was not regarded as the responsibility of the male partner by either social agencies, clinicians or the state.²⁰ However, many men and women no doubt agreed to mutual strategies and shared responsibility.²¹ Furthermore, evidence exists that certain

¹⁹ I do not mean to suggest here that white men did not figure at all in reformers analysis, prescriptions and campaigns. They were subjects of work-crew plans, protected employment schemes and certain social programs aimed at recreation and self-improvement. See the suggestions of the Carnegie Report cited below.

²⁰ K. Jochelson, "Patterns of Syphilis in South Africa, 1880-1949", South African Research Seminar, Oxford University, 1989.

²¹ See for example testimony about mutual responsibility in Interview: Wilhemina Madiba, Alexandra Township, July 2 1992, Transcript, 3-11.

pharmacists and other traders did sell condoms in particular, and they undoubtedly drew on a clientele who found it impossible or difficult to pass as married and monogamous.²²

On the other hand, despite a constant mantra on the part of clinics, that they provided for married women's genuine and respectable needs, very little evidence exists in clinic records or reports for any "checking" mechanisms, such as requiring marriage certificates. This point is crucial: as black women began to seek out contraceptive advice, particularly in urban centres such as Cape Town, Pietermaritzburg, Port Elizabeth and Johannesburg, it was increasingly difficult to argue that 'only married women' were receiving contraceptive advice. Many women were either married under jurisdiction designated "customary", some under both customary and civil writ, others under religious licence, and many others not married under any of these descriptions. At the same time debates, centred upon the "illegitimacy rate" and the sexuality of young women in particular, occupied great attention, a point addressed later in the argument. Thus the contradictions encoded in the parallel tracks of Customary and Civil Law not only undermined African women's claims for equality with their men-folk before the an increasingly iniquitous law, they also had the less unhappy result of frustrating the efforts of many local authorities and administrators in enforcing Housing and Urban Areas Acts,

²² See R. Philips, The Bantu in the City, (Cape: Lovedale, 1938) and see the references to the sale of condoms to 'Natives' by chemists in: Report of the Commission of Inquiry into Advertisements of Proprietary Medicines and Medical Appliances (Pretoria: Government Printer, U.G No 19, 1936).

and later Pass and Influx Control legislation.²³ However, before black women began presenting themselves at local clinics for advice and contraceptives--clinics which if not hostile to their presence (and many of them were)--at least initially did not regard them as appropriate clients, other women of colour paved the way. Particularly in the Cape Town and Pietermaritzburg, there was a greater ambiguity from the start about the potential patient. Here an early recognition that the "poor white" problem could be named the "coloured problem" reoriented the work of the Cape clinics. Among these women were many who were non-Christians and whose Hindu or Muslim marriages were not accorded equal treatment to Judaeo-Christian or civil marriages. Here too the notion of marriage as a black box of rights and duties, and that which accorded legality and sanctity, was undermined. Thus, except in the few rare cases which occasionally appear in the files of the Health Department marked "Sterilization of the Unfit", where questions were raised about sterilizing both men and women deemed insane or retarded, there seems to be no evidence before the 1960s for contraception aimed at male subjects.²⁴

²³ H. J. Simons, African Women: Their Legal Status in South Africa (Evanston: Northwestern University Press, 1968); D. Shropshire, "Report of an Investigation Concerning Bantu Marital Unions" presented to the South African Institute of Race Relations, (1940); E. Hellman, Rooiyard: A Sociological Study of an Urban Slumyard (Oxford: Oxford University, 1948); M. Brandel-Syrier, African Women in Search of God (London: Lutterworth Press, 1962) and "The Needs of African Women" manuscript held by the Church of the Province Archive, University of the Witwatersrand L. Longmore, The Dispossessed: A Study of the Sex Life of Bantu Women in and Around Johannesburg (London: Jonathan Cape, 1959).

²⁴ See "Sterilization of the Unfit, Genetics and Birth Control, 1929 - 1939" CAD/GES 2281 85/38 Deel 1.

The experts and social reformers spearheading these campaigns were drawn from an uneasy alliance of progressive and profoundly reactionary actors. To make a case for either the necessity for contraception (from either a eugenic, malthusian, social-control, preservation-of-the-family, or feminist viewpoint) involved convincing legislators, clergy, journalists and other public interlocutors, as well as "the moral public" that social order would be served. This often centred around reinforcing testimony that the sanctity and legal bonds of marriage would be upheld, with sexuality contained by writ if not by deed within this relationship. A great deal of ink was spilt, and a great many voices hoarsened by 1940, to these ends, despite their complete lack of salience for many women. The same vigilance was not maintained in the daily operations of the newly opened clinics. Originally begun with private moneys, once established and able to provide evidence that their existence had not confounded social order, these clinics gradually received support from Municipalities and local institutions. That these clinics gradually began passing on contraceptive advice more to a category they deemed "needy", and bothered less with the category "respectable", is not surprising.

A more muddled issue, and one requiring careful explanation, concerns why it was that the largest hospital for the maternal and gynaecological care of women of colour in the subcontinent, the Bridgman Memorial Hospital, provided no training in contraceptive techniques for nurses, midwives or physicians throughout the 1930s, sending women who did specifically ask for this advice to the clinics in the centre of Johannesburg as late as the

1940s. According to midwives trained in that institution, right up to its forced closure in the early 1960s, no provisions were made for teaching contraceptive techniques, or any theory or practice of "birth control", to the probationer midwives.²⁵ However, it is less clear to what extent women who came to the Bridgman as maternity patients, or the tens of thousands of women outpatients who attended the Hospital for ante and post natal care, and also for child immunization programs, treatment of sexually transmitted diseases, gynaecological complaints, and motherhood and hygiene training classes, received contraceptive advice. The Bridgman opened its doors just as the contraception debate was to erupt into public life in South Africa. The founding of this institution, as indicated in earlier chapters, focused on two key principles: (1) concern about maternal and infant mortality and morbidity, which mitigated against arguments for limiting birth, at a time when the numbers of black children attaining adulthood was seen to be in crisis; and (2) the perception that harnessing the benefits of western biomedicine to this cause would not only be a worthy and human endeavour, but also, and as crucially, train-up an army of black nurses and midwives who would carry the torch of Christian-inspired civilisation, and by didactic methods as well as example, train in turn generations of "new mothers". Along the way the experimental and scientific work of medicine was to be served as well, not only in the training of medical students, but also through the funding and support of clinical research in the hospital. Two decades later anxieties about the overpopulation of

²⁵ Group Interview, M. Mokoana, M. Mphahlane, W. Madiaba, E. Kaben, and L. Mosikatsana, Alexandra Clinic, February 6 1992, Transcript 11-18.

the cities, and the "masses" of black men and particularly women crowding in from the impoverished reserves had altered the terms of at least part of the earlier debate about "population". On the eve of the National Party's slim parliamentary victory in 1948, which promised the deployment of an armoury of social engineering to halt these and other "threats" to minority rule, the Bridgman and other missionary hospitals and training institutions do not seem to have altered their curricula or training. At the same time, the Bridgman and other urban hospitals recorded high levels of induced abortions (illegal then and now, unless authorised according to narrow constraints) and could not have been oblivious to the debates raging around them about illegitimacy and the issue of unwanted pregnancies. The tensions and debates which circumscribed a full engagement on the part of the Bridgman Memorial Hospital with the project of 'birth control', included religious, moral and political considerations, and will be addressed in the final part of this chapter. Here consideration will be given to the debates and events which preceded a decision by the Cabinet in 1964 to sponsor a specific program of action, *Gesinsbeplanning by die Bantoe*, or "Family Planning for the Bantu", which by 1966 received financial authorization from the Treasury.²⁶

Race Welfare:

...the Race Welfare Society is eugenic in its intention... its main purpose is to secure the physical and mental betterment of the race. To achieve this aim the most practical course appears to lie in the wise direction of the birth control movement.

²⁶ CAD/TES 7240: 56/231 Transcribed on the cover of the file as "Family Planning by the Bantu".

In the past birth control has been mainly practised by the relatively well-to-do. ... the inevitable result has been that the natural growth of the Union's population has come increasingly from the sections least capable of providing their children with healthy bodies, proper nourishment and suitable homes. The recognition of this unnatural condition of affairs was responsible in 1931 for the formation of birth control clinics in the two chief centres of the Union.... designed to give instruction to the very poorest, and especially to discourage births among the physically or mentally unfit.²⁷

The subjects of this extracted paragraph, "the very poorest", and "the physically or mentally unfit", were white women and their families in South Africa in the early 1930s. Excerpted from the Annual Report of the Race Welfare Society of Johannesburg, these lines point to the complex and layered history surrounding the definitions of race, gender and class, emerging in South Africa in a moment of international and local crisis. At the opening of the 1930s, South Africa began to feel the pinch of the world-wide depression. The early confidence of Prime Minister Barry Hertzog who boasted that South Africa would not "feel the slump", was soon overshadowed by falling wool and maize prices, and by 1931, wage-rates across the country plunged.²⁸ The severe drought of 1932-3, kindled the already besieged rural reserves and both African peasant farmers, and hundreds of thousands of people, black and white, who laboured with varying degrees of security within relationships of sharecropping and tenancy on richer capitalised farms, faced unprecedented hardship, many forced to migrate to the nearest towns, and then larger cities in search of wages and work.²⁹ In the early 1930s, a new juncture was achieved in

²⁷ CAD/GES 2281, June 20 1935: excerpts of the Annual Report of the Race Welfare Society of 1934.

²⁸ Evidence before the South African Native Economic Commission (Pretoria: Government Printer, U.G. 22-732, 1932).

the complex politics of class, race, ethnicity and region. With malthusian energy, a reform movement, led by urban Afrikaans and English-speaking white middle class women and men and aided and abetted by a cast of influential supporters from the ranks of professionals (academics, physicians, nurses, social workers, lawyers and even magistrates), burst onto the South African stage in 1931. Under the banners of racial welfare and race-purity, and employing the language of eugenics and social darwinism, these societies held meetings, produced pamphlets and articles and established clinics aimed at poor, respectable married white women. Their particular zeal was kindled by the developing classification and analysis of what was termed "the poor white problem" in South Africa in the mid 1920s and 1930s, which culminated in five volumes of research, sponsored in part of the Dutch Reformed Church of South Africa and the Carnegie Corporation of New York.³⁰ This was also a moment when middle class women, long active in social, religious and missionary movements, had achieved adult suffrage for white women, and their entry into the echelons of legislative power was on the basis of social issues such as women's health and support for family-life.³¹

²⁹ See Chapters two and four for greater detail on the 1930s.

³⁰ Carnegie Commission Report (Stellenbosch: Pro Ecclesia, 1932) 5 volumes. The chief researchers and authors were Professors Grosskopf, Wilcocks and Malherbe; a Department of Health physician, Dr Murray; a Dutch Reformed minister, Reverend Albetyn; and a social worker influential in Afrikaans women's movements, Mrs Rothman. Their reports, which drew together interviews and expert testimony from witnesses countrywide, included material on economic conditions, education, the health and welfare of women and children in particular, and a psychological profile of "poor whites". See chapter four.

³¹ Walker, in her pioneering study of this history, details the growth of a suffrage

In the late nineteenth century the small organized medical profession in South Africa, still tied by an umbilical cord to its parent societies in Britain, set itself up in opposition to the realm of home-remedies, women's cures and herbalists which continued to provide the mainstay for people's everyday health needs into the twentieth century. Earlier chapters have indicated the complexity of this professionalising history, which in certain measures mimicked the trajectory of medicine and health care in Britain and the USA. Local physicians had not only to counter the pervasive knowledge and utilization of cures carried on within families or communities, they also competed with established healers whose knowledge of the herbatoria of southern Africa, as well as indigenous languages and local customs, underwrote their remedies and prescriptions. Bradford and Berman have begun trace the hostility of the medical profession in the late nineteenth century to abortifacients and contraceptive technologies which circulated among and between women in particular.³² But their work does not indicate the presence of

movement out of both the Women's Temperance Unions' Franchise Department of the late nineteenth century and several small splinter societies established in the early years of the twentieth century, which amalgamated in 1911 into the Women's Enfranchisement Association of the Union. Her work analyses the complex history of public debates on male superiority, legal battles, propaganda and petitioning, the growth of Afrikaner nationalism, and the gradual relinquishing of certain key women suffragettes of their original ideal of non-racial women's voting rights. At the same time as the State debated the disenfranchisement of an elite group of African men in the Cape, votes for white women seemed acceptable to men who had eschewed the idea 10 years before. In 1930, white adult women were admitted to the franchise. See C. Walker, Women and Resistance in South Africa (Cape Town: David Philip, 1991) Part One.

³² S. Berman, and M. Naude, "Bearing a Bastard: The Social Consequences of Illegitimacy in Cape Town, 1896 - 1939" Journal of Southern African Studies 17:3 (1991) and Bradford, H "Herbs, Knives and Plastic: 150 Years of Abortion in Southern Africa".

contemporary opposition to these positions on contraception among prominent publicly employed physicians such as J. A. Mitchell and E. R. Thornton, who later became Secretary for Public Health and Chief Health Officer for the Union, respectively. In the late nineteenth century, as medical knowledge about conception developed, reactions on the part of physicians to this were contradictory. The main body of physicians regarded the language of "prevention" as gross, irreligious and unnatural, and consequently led campaigns to banish it from public access.³³ As early as the 1780s, European physicians wrote accounts of contraceptives, linking their use to prostitution and unnatural acts.³⁴ Commercial advertising for condoms grew from the 1860s, along with religious and legal opposition, and the passage of the 1873 Comstock Law in the USA, designed to prevent the dissemination of birth control information was an example of this. It took until the First World War for the work of Margaret Sanger in the USA and Marie Stopes in the UK, among others, to challenge the notion of "unnaturalness" and "debauchery" associated with contraception. But physicians in Southern Africa, as well as elsewhere, were also founder-members of organizations designed to demolish anti-contraceptive legislation.

³³ To contextualize this with respect to the wider history of feminism see N. Cott, The Grounding of Modern Feminism (New Haven: Yale University Press, 1987). The literature on efforts to eliminate and then regulate the dissemination of birth control information is vast, but see D. Kennedy, Birth Control in America: The Career of Margaret Sanger (New Haven: Yale University Press, 1971); L. Gordon, Woman's Body, Woman's Right: Birth Control in America (Harmondsworth: Penguin, 1990).

³⁴ N. E. Himes, Medical History Of Contraception (1936; New York: Gamut Press, 1963).

The impact of Darwinian-inspired theories on the origin of the human species, combined with the genetic investigations of scientists such as Dalton, Mendel and Weismann cannot be overemphasised in terms of their invigorative effect on debates concerning human fertility. The Race Welfare Society, formed in Johannesburg in 1931, was explicit in its references to eugenic science as a useful tool for social ills. To try and understand the resonance of these theories in 1930s South Africa, and we need first to examine their antecedents in the history of eugenics in Europe and the USA. In South Africa the strands of explicitly eugenic thought were undermined by the late 1930s, as in the west. However the rhetoric of social engineering gained widespread salience in race-based political discourse, and extended many familiar arguments of religious and anthropological accounts of human development produced in Southern Africa in the early decades of the century. This body of social theory contributed to the state's legitimization of its moves in the 1950s and 1960s to control the landscape of human reproduction in South Africa.

Recent scholarship on the history of genetics and its relationship with the eugenics movement has revealed the dangers of summarizing and homogenizing complex political positions and scientific investigations and theories. In a recent study, these complexities were illuminated:

Historians of science have been struck by the coincidence of the rise of genetics and eugenics after 1900. Genetics underpinned techniques of family reconstruction, which were deployed for the screening of population groups. Areas of social policy, such as the prediction of potential criminals and other types of social deviancy relied on eugenic rationales. This poses intriguing problems

concerning the extent to which genetic research was motivated by eugenic ideals, particularly in the field of human genetics. At the same time it is important to recognize that eugenics was a heterogeneous agglomeration of sciences: in addition to genetics, a prominent place was taken by anthropology, clinical medicine, statistics, and psychology. These diverse constituents were welded together by cultural and social movements peculiar to respective national contexts.³⁵

With this caveat in mind, we can nevertheless approach an understanding of key elements in this movement by the beginning of the twentieth century, which impacted on Southern African debates. The work of Harwood, Ludmerer, Barker, Rafter and others has shown that by the 1920s many geneticists were distancing themselves from the radical formulations of eugenics, and returning to questions of socialization and social context as key indicators of, for example, personality formation.³⁶ Nevertheless, despite six years of explicitly Nazi eugenic theories, by 1939 delegates at the Edinburgh Seventh International Congress of Genetics, signed a Manifesto which did not renounce eugenics, but instead attacked "Nazi racist hygiene, while endorsing a version of reform eugenics".³⁷ Larson has traced the close association between Eugenics and Genetics, in a explicit form until the late 1920s, and demonstrated that a "reformed" strand of eugenic theory emerged in competition with the older form, in the 1930s. His arguments about the importance of the status of scientific arguments in different settings links up with research working on

³⁵ P. Weindling, "The 'Sonderweg' of German Eugenics: Nationalism and Scientific Internationalism" British Journal for the History of Science 22 (1989) 321.

³⁶ This is a vast field. Works referred to here include the special edition of the British Journal for the History of Science 22 (1989) with articles by Harwood, Weindling, Roll-Hansen and Barker.

³⁷ J. Harwood, "Genetics, Eugenics and Evolution" Editors' Introduction to the Special Edition of the BJHS 22 (1989), 262.

histories of North America and other European countries. Of great interest to historians of this branch of science has been the genealogy of theories of racial purity behind National Socialist ideologies and practices in Germany in the 1930s and early 1940s. Here the work of Weindling and Procter has been instructive.³⁸ The history of eugenics in the USA is also particularly relevant for an understanding of the South Africa eugenic movement. In the late nineteenth-century, research conducted in pine regions of rural America, on 'hillbilly' families, established the family-study approach which was influential in eugenic studies into the twentieth century. Two better known texts, which classified family-based communities as eugenically impaired, were the 1877 study by R. L. Dugdale, titled The Jukes, and the 1912 study by H. Goddard, The Kallikak Family.³⁹ Arguing that the language used to describe these rural families, as "tribes" and "bestial" was part of a process of racializing class, Rafter calls attention to conceptions of "the other" (black ex-slaves in the Americas, the Irish, Highlanders, native Americans etc.) and categories of deviancy and normal, based on social darwinist theories of race and ethnicity.

In South Africa in the early 1930s, both strands of the eugenics movement, the radical view (advocating the state's involvement in restrictive measures focusing on degenerate families, particularly 'poor whites'), and the more limited form (concentrating on both environmental and hereditary factors), were apparent at the end of the 1920s. In

³⁸ J. Harwood, "Editorial", BJHS 22 (1989) and R. N. Procter, Racial Hygiene: Medicine Under the Nazis (Cambridge: Harvard University, 1988).

³⁹ See N. H. Rafter, (ed) White Trash: The Eugenic Family Studies, 1877 - 1919 (Boston: Northeastern University Press, 1988).

late 1930, when the Race Welfare Society came together in Johannesburg, its explicit eugenic aims were at first more obvious than its interest in setting-up birth control clinics. Here the "race welfare" aims were more obvious than in Cape Town, Port Elizabeth, East London, or Pietermaritzburg, where eugenics movements were from the start encompassed by a focus on birth control. The reasons for this Transvaal emphasis were complex: firstly, and most crucially, it was the cities of the Transvaal, such as Johannesburg, which had experienced the first effects of the movement of indigent whites off the land. Secondly, the powerful mix of liberal reform movements in this city, combined with the growing organization of Afrikaner Nationalists (women's organizations, the rising cohesiveness of the covert Afrikaner Broederbond, and the efforts among poor whites of the Arme Blanke Verbond or Poor White Alliance), produced sort periods of alliance around issues such as this "threatened population".

A key figure in the Johannesburg group seems to have been the philosophy professor at the University of the Witwatersrand, R. A. Hoernle. He embodied some of these uneasy contradictions between naming and focusing on "poor whites", and also working to secure certain reforms for black urban dwellers. During this period he became head of South African Institute of Race Relations, whose chief concerns were with the country's black majority, and later he headed a Committee supervising and advising residents of the black freehold area of Alexandra Township, arguing for its continued existence. By the late 1930s, Hoernle was thinking through his own liberal affiliations. In

his study, Rich traces some of the strands of "trusteeship", "segregation" and "native self rule", ideas debated by members of the Institute during this period, and demonstrates that by the close of the decade certain individuals such as Hoernle were turning away from the notion of an integrated society. Rich describes this as a move towards "cultural idealism". Examining his thinking in relation to black South Africans, Rich misses perhaps the full importance of Hoernle's comments about segregation, which increasingly tied the "Native question" to his perception of the poor white problem by the late 1930s. Rich quotes

Hoernle in a letter of April 1937:

'...what I have criticised is the incomplete segregation, which is to me a mere sham.'

and adds in his own words

Heaton Nicholls idea of 'keeping the Bantu race in its own reserves' had an attraction to Hoernle who was prepared to support it in its full 'literalness', especially if by total segregation there would be ensured the ending of 'the disruption of Native social and economic life' Hoernle undertook his rethinking of liberal ideology in his Phelps-Stokes lectures of 1939, 'South African Native Policy and the Liberal Spirit'. Here the cultural idealist arguments on the value of social communities as the essential basis of social control became linked, in Hoernle's analysis, with an interpretation of liberalism.... The static notion of a 'liberal spirit' thus became bound up with the preservation of 'culture' in the group-oriented sense of the cultural idealists...⁴⁰

The full ramifications of the Carnegie Commission's Report need further investigation, but their emphasis on the cultural, moral as well as physical atrophy of this group underwrote much of the thinking of social theorists such as Hoernle. The commission calculated that out of a population of 1,8 million whites in 1931 (a million being Afrikaans-speaking)

⁴⁰ P. Rich, White Power and the Liberal Conscience (Manchester: Manchester University Press, 1984) 66-68.

more than 300 000 were paupers. It gave some space to the high birthrate among whites, which it calculated had doubled in the period between 1904 and 1936, and pointed to this factor alone as having greatly contributed to overcrowding, disease and death. In sections on school children, it concluded that 'thousands were classified as retarded'. In the final Volume, devoted to the welfare of women and children, authored by the social worker and only woman on the commission, Mrs Rothman painted a scene of "race-degeneracy". To make her case, she felt it compelling enough to juxtapose images of poor white family life with that of rural black households. Her descriptions of Afrikaner women giving birth with the help of women of colour, on mats on mud floors, with children running naked outside with black playmates, relied for their power on the assumption that black women embodied, through their birth processes and mothering, primitive social formations.⁴¹ In this volume Rothman reveals much about the racial darwinism of her perceived readership, and she introduces oblique references to the population problem, not fully envisioned by her Dutch Reformed Church colleagues. Through the early 1930s, Rothman and fellow Afrikaner women crafted an ultimately victorious strategy within the Dutch Church, ultimately winning the support of clergy for birth control methods for poor women, "in the case of threats to the mothers' health".⁴²

⁴¹ See chapter 4.

⁴² Carnegie Commission Report; also see C. Bundy, "Vagabond Hollanders and Runaway Englishmen: White Poverty in the Cape Before Poor Whitism" in W. Beinart, P. Delius, and C. Bundy, Putting a Plough to the Ground (Johannesburg: Ravan Press, 1986); and D. O'Meara, Volkskapitalisme: Class, Capital and Ideology in the Development of Afrikaner Nationalism 1934-1948 (Johannesburg: Ravan Press, 1983).

Women physicians and social workers, English and Afrikaans-speaking, were also key players in the formation of the Race Welfare Society. In 1930, before the investigations of the commission were even complete, the Society met and drafted a constitution and their first letter to the Union Health Department and other health authorities outlining their cause:

This Society owes its inception largely to considerations of the appalling nature of children born in the Union into conditions which doom them from the day of birth....The Society believes the time has come to tackle those evils at their origin. It proposes, in the first place, to collect and collate as much information on the subject as possible. Secondly, to secure the support of public opinion for the application of Eugenic measures. Thirdly, to convey education in "Birth Control" to those sections of the population where it is most urgently required and least practised.⁴³

Thus, in its first inception, the Race Welfare Society was most explicitly eugenic in character, relegating contraception to a third level of priority. The final draft of the "objects" of the society, formalised in the Constitution, which was sent to the Union Health Department in December of 1930, did not even mention "Birth Control" at all. Instead, each clause referred to the eugenic intentions of the organization and its mission to "keep the subject of Eugenics, before the general public".⁴⁴ Attention to the topic of "sterilization of the unfit" did produce articles in the South African Medical Journal through this period, and occasioned debates at medical congresses, but the emphasis in South African medical circles seems to have devolved onto "voluntary" sterilization. By 1931, less than a year after its inception, and possibly prompted by the stony silence with

⁴³ CAD/GES 2281 85/38 Deel 1: Race Welfare Society, 29 November 1930.

⁴⁴ CAD/GES 2281 85/38 Deel 1: Race Welfare Society, December 1930, 1.

which its first letters to Health authorities were received, the Race Welfare Society began to turn its attention to the establishment of a birth control Clinic in the centre of Johannesburg. Never again did the Society (which dissolved into the Planned Parenthood Association and Municipal Birth Control clinics of the 1960s) offer explicitly eugenic principles as its chief reason for existence.

Contraception Clinics and the Origins of Planned Parenthood:

E. H. Cluver (Assistant Health Officer, Union Health Department) and E. Thornton (Acting and later Secretary for Health), received the 1931 letters from the Race Welfare Society with more interest, but evinced grave caution at its expressed intention to start a Birth Control clinic, having as its sole intention "artificial contraception".⁴⁵ Thornton's reply, which he composed on behalf of the Minister of Public Health, was the first in a series exchanges with the Race Welfare Society and the Cape Town Mothers' Clinic.

In the opinion of the Department it is doubtful whether at present there is a sufficient degree of unanimity in the medical profession or public opinion to warrant the establishment of a clinic for systematic instruction in artificial contraception and its application. Experience elsewhere has shown that birth control clinics are attended by many who are in need of the medical or surgical treatment of disease or discomfort rather than the application of contraceptive methods./ It seems to the Department that there might be a need in Johannesburg

⁴⁵ For the sake of clarity, throughout the remainder of this chapter, the words 'contraception' and 'birth control' will refer to practices and technologies such as barrier methods, spermicides and later hormonal drugs, rather than *coitus interruptus*, home remedies, and abortifacients based on local knowledge. By the 1950s in South Africa these terms had come to refer to commoditized forms of pregnancy prevention, however women and men continued to practice a variety of other methods of fertility control.

for the development of an Outpatient Gynaecological Clinic where mothers needing advice on physical health matters, both of nature and nurture might be assisted. Such an institution, under adequate and skilled supervision could receive minor gynaecological cases, deal with some forms of post-natal aftercare, accept responsibility for counselling mothers of subnormal physique or mentality, give advice on contraceptive methods where medically needed and act as a clearing house for appropriate treatment of one sort or another.... Under all circumstances the Minister would depreciate the establishment of a clinic having as its sole object the advocacy of artificial contraception even on the lines suggested by your Committee.⁴⁶

Despite his officious reply, and although he did not initiate these initial exchanges, by 1936 Thornton was the most powerful non-member of birth control organizations, shaping their unified constitution in 1936, suggesting fund-raising strategies, petitioning on their behalf within the Department for greater state and municipal funding, and lobbying religious leaders for their support, or at least not active opposition to the organization. His last act before retirement in 1938 was the preparation of a memorandum empowering and directing local authorities to support existing birth control clinics, and suggesting the establishment of clinics in areas without any services. In 1937 the clinics came together to form a National Council for Birth Control, inviting Thornton to their first Conference, where his suggestion to rename the group the National Council for Maternal and Family Welfare was resoundingly adopted.⁴⁷

With Thornton's support, "Mothers' Welfare" clinics were established in Johannesburg, Cape Town and Pietermaritzburg in particular, and by the late 1930s and

⁴⁶ CAD/GES 2281 85/38 Deel 1: E Thornton, Acting Secretary for Public Health, reply to the Race Welfare Society, 27 February 1931.

⁴⁷ CAD/GES 2281 85/38 Deel 1, May to August 1937.

early 1940s, the clinics in these three towns began remarking on the increasing numbers of "Indian, Coloured and Native" women seeking birth control advice and devices. From 1933 to 1938 the birth control movement gradually gained wider acceptance, and received increasingly positive publicity in major news papers.⁴⁸ With the key support and advice of Thornton, the movement managed to attract Municipal and finally central state-aid by the eve of World War II. The notion of "race welfare" continued to be stressed, but the meaning of these terms began to shift: now contraception was spoken about in this period, in contradistinction to "abortion", which was termed "race suicide".⁴⁹ While the local and central state was increasingly convinced of the need to control the fertility of working class and unemployed white men and women, they were less unanimous in their approach to the physical reproduction of black men and women. As we have seen in chapter four, the mining industry in particular was gravely concerned about the high infant and maternal mortality rates of the rural reserves, and they did not lend their support to

⁴⁸ CAD/GES 2281 85/38 Deel 1 and 11, 1931 to 1947.

⁴⁹ In the period between 1915 to the late 1920s, influential medical journals in South Africa did not offer support to contraception or birth control, but this altered radically after 1930s. In a series of articles and Editorials in the South African Medical Record of 1916, it was argued that women who sought contraception (and the target for these discussions was always women), were not truly committed mothers and tainted in some form by their unwillingness to shoulder their responsibilities (see for example 27 May 1916 and 11 November 1916). But in the 1930s, the South African Medical Journal (which had absorbed the SAMR), began publishing articles and papers in support of contraception; for example E. Woodrow, "Contraception: Its Justification and Practice", South African Medical Journal (22 October 1932). However, they continued to publish articles lambasting abortion proponents, for example: C. C. Jarvis, "The Crime of Abortion" South African Medical Journal (8 August 1936).

any country wide movement to lower fertility rates among black men and women.

However, municipal officials were increasingly anxious about the numbers of black women moving into the cities, and so when the Johannesburg City Council voted to provide grants to the locals "Mother's Welfare" clinics, they noted approvingly that black 'mothers' were also given contraceptive advice.⁵⁰

Throughout the 1940s and early 1950s no systematic attempts were made to create a national campaign or program to address population increase. Instead, local and central initiatives in the 1930s and 1940s, and country wide initiatives in the 1950s and 1960s after the passage of the Group Areas and Bantu Authorities Legislation, concentrated on a plan of population control through forced removals, racial classification and labor bureaux. The objective of these measures was to control the influx of black men and women into cities and towns, and to carve out designated Bantu Homelands where the elderly, young and those deemed economically unproductive from the point of view of the white state, could be partitioned off.⁵¹ This was social engineering on a vast scale, but it did not yet contain a didactic contraception or fertility policy.

⁵⁰ CAD/GES 2281 85/38 Deel 1 and 11, "Minutes of Meeting", March, 1937

⁵¹ Of course the state was not completely successful in any of these endeavours, many communities resisted these policies, many individuals managed to manoeuvre between the cracks of bureaucratic procedures, and there were internal contradictions at the heart of many policies, which further undermined their full application. For example, the needs of secondary industrialists for skilled and semiskilled categories of labor often prompted the relaxation of certain labor influx laws. See for example L. Platzky, and C. Walker, for the Surplus People Project, The Surplus People: Forced Removals in South Africa (Johannesburg: Ravan Press, 1985) and D. Posel, The Making of Apartheid, 1948 to 1961: Conflict and Compromise, (Oxford: Oxford University Press, 1991).

The seeds for just such a policy were being sewn, however, in the 1930s. In 1935 and 1936, the MOH from East London, P. W. Laidler, began writing a series of articles on fertility and "the population problem" in South Africa. A highly influential public health official, Laidler was keenly aware of the debates in the Race Welfare movement and had supported the creation of a Mothers' Welfare Clinic in East London.⁵² However, his expertise was in "Native Health", and using his access to newspapers and scientific journals (cultivated after more than two decades of published research), and drawing on his own observations as well as the work of anthropologists such as Hunter and Schapera, he began making a series of arguments linking the need for population planning and public health, for the first time stressing the need to include urban "Natives" in any discussion of contraception. The target of his analysis was the pathology of poverty in dense urban settlements, and he advocated measures including redistribution of rural and urban people, the decentralisation of jobs and industries, as well as public education, health and contraception services as the only rational panacea for a looming national crisis. His remarks were picked up by the major newspapers, and occasioned a storm of letters and articles that raged into the next year.⁵³

Urban contexts, black women and contraception:

⁵² P. W. Laidler, "The Medico-Social Aspects of Population Density" South African Medical Journal (9 May 1936).

⁵³ See Rand Daily Mail, 1 October 1935; Daily Dispatch 8 July 1935; and Star 27 October 1936.

In cities such as Johannesburg at the same time, black men and women as well as white missionaries, social reformers, government officials, religious leaders, physicians and anthropologists began to name a "crisis" of illegitimate births, specifically represented as the births of young unwed black women, and called for a national response. Despite the work of Freud and Havelock Ellis and the impact of their theories in the early decades of the century, social activists in cities like Johannesburg continued to employ rigid constructs of "normal sexuality". As gatherings of black mothers in prayer groups, black ministers in church meetings, of white missionaries, administrators and philanthropists met to discuss the crisis of illegitimate births, they employed terms such as "promiscuous" to describe the sexual behaviours they ascribed to city life.⁴ To attempt to unravel the web of assertions in the past (echoed repeatedly into the present) about southern African cities as sites of promiscuity, and attempt to understand both real changes in people's organisation of sexual activity, as well as the fears and agendas of policy makers, social activists and ordinary men and women, is a herculean task. If, as Jeffrey Weeks, in his seminal book on sexuality argues, "sex... has been a transmission belt for wider social anxieties" then it makes sense that in the context of colonial conquest, massive economic and social change,

⁴ The most important and useful material on this subject is in the work of Gaitskell. Her research has tracked the history of black women's prayer groups and Social Hygiene movements. See D. Gaitskell, "'Wailing for Purity': prayer unions, African mothers and adolescent daughters, 1912-1940" in S. Marks, and R. Rathbone (eds) Industrialisation and Social Change in South Africa (London: Longman, 1982).

urban migration and the impoverishment of the rural areas, communities in southern Africa experienced and wrought great changes in the most intimate areas of their lives.⁵⁵

In the early 1930s local and central authorities began commissioning expert opinion on the urbanization of Africans, focusing on women in particular. The reports they elicited, and the debates which ensued in government chambers were presented in the language of concern for the effects of "detribalization" and the "breakdown of the traditional family". The language of family breakdown and detribalization was not confined to government-appointed ethnologists and "Native affairs experts". Throughout the 1930s and 1940s, there was a mounting production of anthropological research into the "customs of Southern African tribes". Academics such as Hunter, Schapera, Krige, Hellmann and later Longmore, bemoaned the desecrated state of family life, focused on the promiscuity of African women in the cities, and in doing so often valorized certain aspects of an idealised African past.⁵⁶ Two key anthropological monographs of southern African societies, written in the early decades of this century by Monica Hunter and Isaac Schapera, as well as research papers published by both authors in the early 1930s, addressed pre-marital sexuality, pregnancy and socialization, and the encroaching

⁵⁵ J. Weeks, Sexuality and its Discontents (London: Verso, 1989) 16.

⁵⁶ M. Hunter, Reaction to Conquest: Effects of Contact with Europeans on the Pondo of South Africa (London: Oxford University Press, 1936); Chapters by Eileen Krige and Ellen Hellmann and Isaac Schapera in I. Schapera, (ed) The Bantu Speaking Peoples of South Africa: An Ethnological Survey (London: G. Routledge and Sons, 1937) and Isaac Schapera Married Life in an African Tribe (New York: Sheridan House, 1941); and the entire collection of papers in Schapera's edition entitled Western Civilisation and the Natives of South Africa (New York: Humanities Press, 1967) are emblematic.

influences of both missionaries and 'town life' on sanctioned adolescent sexual experimentation (especially *ukumetsha*, or non-penetrative heterosexual intercourse between the thighs) as central themes, and provided a vital academic contribution to this debate.⁵⁷

Both Hunter and Schapera went to great lengths to provide detailed definitions of stages of marriage procedures, through bridewealth payments (termed, in Xhosa, "*lobola*", and in Tswana, "*hogadi*!") and ceremonies spaced, in many cases, over years. Before their sections on marriage and its definitions and changing meanings in the light of missionary influence, both authors spent considerable time developing an analysis of sexuality and its permutations in the societies they studied. What is most fruitful about Schapera and especially Hunter's discussions of sexuality, is the rootedness of their analyses in material life and historical change. Both of them provided complex insights into the sexual expression of young women, and instead of generalising about the sexuality of their informants, their analyses reflect great range between people, and most importantly, range over the whole spectrum of the life cycles of women in particular. They were both fundamentally interested in the changing meanings and transactions of material, symbolic and emotional capital bound up with forms of bridewealth, namely *lobola* and *hogadi*.

Hunter's work on pre-marital sexuality and married life is striking in its portrayal of the wider latitude and greater independence younger women enjoyed (despite the

⁵⁷ See for example how the missionary activist and moral reformer, Ray Phillips uses their research to describe the pathology of the urban world of black Johannesburg dwellers in *The Bantu in the City* (Cape: Lovedale Press, 1938).

overarching constraints of gender differentiation, related especially to household and productive labor) in expressing their sexuality and choosing partners before the actual marriage transactions and ceremonies took place.⁵⁸ It is clear that in marriage, with its powerful emphasis on reproduction of the household, especially the birthing of children, "sexuality" was not necessarily the key determinant, nor was marriage necessarily its key site, although Hunter does devote some analysis to the function of *lobola* in stabilising sexual unions, with its economic deterrent to desertion.⁵⁹ The emphasis on relative sexual freedom of expression in Hunter's section on pre-marital is juxtaposed with her exegesis on the meaningful transformations expected in a women's labor, conduct and sexuality after marriage. Her analysis poses useful questions about the impact of the migratory labor of men not only on physical reproduction of the household, but also on the consciousness and identification of married and unmarried women living apart from men and lovers for long periods.

Hunter's work in particular suggests that in the 1930s and 1940s, adolescent experiences of sexual experimentation, flirtation, and more equally matched negotiations of opposite-gender sexual satisfaction would have existed in the recent past of many of the women who came to the city at this time, either in their own experiences or those of their mothers and fathers. These episodes might have provided crucial memory resources, skills and potentials choices for women living in a rapidly changing social, economic and

⁵⁸ M.Hunter, Reaction to Conquest 181.

⁵⁹ M. Hunter, Reaction to Conquest 212.

political world. This information about "sweethearting", the entertainment and pleasure spaces allowed to young people and the practice of non-penetrative intercourse, provide interesting insights into the adolescent socialization of boys and girls before the intrusion of missionary influence and the debarring of these rites of passage by large numbers of practising Christians.

These contemporaneous sources suggest that pre-marital sexual activity was not a new birthmark of urban life. Across wide regional differences in language and social life, forms of accepted and sanctioned sexuality outside of marriage were common features of late nineteenth century southern Africa. Their work suggests that in fact the locus of crisis and change lay in the impact of Christian views about appropriate sexual behaviour and training, and the context of urban life, where maintaining patterns of rural socialisation was untenable. Finally it is also clear that generational and gender patterns were undergoing profound shifts in the rural areas as well, and Schapera and Hunter, working in often non-Christian communities, were able to identify similar patterns of "breakdown".

Patience Tyalimpe's experiences as a young woman growing up in the Matatiele areas, near the border between present day Lesotho and the Transkei region, bear out many of the observations of Hunter and Schapera. While she learned and practised sanctioned forms of sexual expression as a young woman, and brought this knowledge with her to Johannesburg, many of her urban born peers, or women from households of strict Christian converts, did not have any knowledge either of non-penetrative sex, nor of

contraceptive use. Her experiences as a young nurse and midwife probationer, especially her recollection of the 'problem of unwanted pregnancy' among many of her peers, and her sense that teenage and youthful pregnancy rates have continued to increase since the 1950s in cities like Johannesburg, resonate with the fears and worries expressed by black men and women and white authorities and missionaries in the 1930s and 1940s.

Remembering the benefits of her Granny and Aunts' sexual and bodily instructions,

Patience Tyalimpe reflected:

When I look back to my childhood and how I grew up I see great wisdom.⁶⁰

After several years working as a midwife, Patience decided to enrol for a diploma in public health nursing, and it was while she studied for this in the mid 1960s, that she first learned about chemical and barrier methods of contraception in any detail:

[CB: As your ideas about contraception developed, did you think to yourself that this was excellent, and that new contraceptives would help people? Or did you have a mixed feeling about the new technology?] No, I didn't have a mixed feeling at all. I thought immediately this is good. But, my strong BUT, was that it's only good if people are properly educated. They must be properly informed. Because they came here because they knew there must be something. There's something to help them, and long ago it was the interfemural sex, even when you are married if you got a small child. Yes, in those days of separate bedrooms and so on, the mothers could control the sex while they were breastfeeding, and not having full sexual experience 'til such time. But now here is a method, I thought. Here we are in this situation where there aren't many rondavels. You will have to share your bed with your husband. I thought that contraception was an excellent idea, but it should be explained fully.⁶¹

Patience Tyalimpe's views concerning contraception were widely shared by the

Bridgman-trained midwives interviewed in Alexandra Township in 1992, most of whom

⁶⁰ Interview: Patience Tyalimpe, Johannesburg, November 22 1992, Transcript, 3.

⁶¹ Interview: Patience Tyalimpe, Johannesburg, November 22 1992, Transcript, 3- 4.

were probationers before her in the 1930s and 1940s. None of them had received any official contraception instruction as trainee midwives, although Wilhemina Madiba and others had picked up information through formal and less formal channels, and passed information about vaginal pessaries, diaphragms and condoms onto fellow nurses.⁶² It was only after they had graduated that any of them recall being involved with contraceptive work as midwives and clinic nurses. All of them, by the late 1960s, had had some experience with dispensing contraceptive birth control pills, and many had witnessed the administration of injectable contraceptives. All of these women, and Patience Tyalimpe herself, informed the author that they had used contraceptives themselves as married women, and several of the midwives testified to using contraceptives bought in chemist shops before they married or graduated in the 1940s and early 1950s.⁶³ However, unlike Patience Tyalimpe, none of the other women midwives interviewed had practised intercrural sex, although several of them had heard about this form of sexual expression. Letta Mosikatsana explained that her family was very religious and eschewed many practices which they considered to be heathen and immoral.⁶⁴

Why was it that the Bridgman did not provide the midwives they trained, especially after the mid 1930s when it is clear that many black urban women were beginning to seek

⁶² Interview: Wilhemina Madiba, Alexandra Township, July 2 1992, Transcript, 11.

⁶³ These comments are drawn from individual interviews conducted from February 1992 to September 1992; and from the Group Interview: Alexandra Clinic, February 6 1992, Transcript, 5, 8 and 17.

⁶⁴ Interview: Letta Mosikatsana, Alexandra Township, February 6 1992, Transcript, 18.

contraceptive advice, with contraceptive instruction?⁶⁵ The records of the Johannesburg City Public Health Department indicate that many Bridgman patients were referred to the municipal contraceptive clinic, cosponsored by the Race Welfare society, in the late 1930s.⁶⁶ But after World War II, the number of Bridgman referees dropped markedly. When this was anomaly was put to the Bridgman-trained midwives, they provided the following analysis: the Bridgman was a missionary hospital, concerned in the main with the training of midwives, the health of pregnant women, and the birth of healthy babies. To raise money, to gain the trust of their patients and to promote their sincere aims of "healthy birth", they did not publicise any contraceptive services, nor did they provide any contraception teaching to the trainee midwives. But, with their huge outpatients department, where they treated many women for sexually transmitted diseases and where they examined women for their post-natal check-up, there was ample opportunity for the dispensing of contraceptives once this policy became widespread. After the War, they surmised, most women who requested contraceptive advice would probably been advised at the Bridgman itself. Finally, the Bridgman would have been wary about appearing to support in any way a decrease in the fertility of black women, especially because, as these midwives remembered, infant mortality and deaths under one year remained major issues throughout their periods of training and beyond.⁶⁷

⁶⁵ Another useful source, indicating the increasing numbers of black women seeking contraceptive advice and services is: C. P. Anning, "Sterility and the Falling Birth Rate: The Public Health Aspect", in the South African Medical Journal (24 July 1937).

⁶⁶ IAD/ JPHD 35 2/25/2 "Birth Control", 1931 to 1960.

This analysis helps to add another intriguing piece to the puzzle concerning how and when the Bridgman provided contraceptive services. Although, as mentioned, the Bridgman records do not speak about contraception services, or specify any Hospital policy on the matter, in 1935 the Medical Superintendent of the Bridgman, Dr Hope Trant, wrote an extensive article on the subject of contraception. This article was published in the same journal which had published many of P. W. Laidler's letters and papers on the subject, and which was to publish his address on 'population problems' to the 1935 Medical Congress a few months later.⁶⁸ In it Trant reveals that in 1933 she travelled in Europe visiting several birth-control clinics, and attended several conferences on the subject in England and Scotland. She then summarizes, in minute detail, the physiological and chemical explanations for conception, and follows this with pages summarizing and explaining recently published texts on the latest methods of contraceptive techniques. It would be very startling if someone so interested in, committed to and informed about the latest contraceptive techniques and theories did not put this knowledge to service in her daily work as head of the largest hospital for black women in southern Africa.

⁶⁷ These comments arose out of a fifteen minute conversation centred on the questions asked by the author about whether or not the Bridgman had provided contraceptive services, something never explicitly referred to in the otherwise extensive outpatients records. Group Interview: Alexandra Clinic, February 6 1992, Transcript, 20-21.

⁶⁸ See H. Trant, "Modern Contraceptive Methods" South African Medical Journal (22 June 1935); and see P. W. Laidler, "The Medico-Social Aspects of Population Density", South African Medical Journal (9 May 1936).

With pessaries, vaginal suppositories, douching, and diaphragms as the major contraceptives available for women's use in the 1930s to late 1950s period, any dispensing of appliances, creams and lozenges could have taken place on an outpatient basis. Throughout this long period there were no major breakthroughs in contraceptive technology. At the end of the 1950s, research into hormonal contraceptives resulted in the production of birth control pills and injectable contraceptives being mass produced for the first time.⁶⁹ This new technology became available in South Africa as the Nationalist Government was considering a new package of "population control" policies, and was not unconnected to the direction of the plan itself.⁷⁰ Whereas providing a diaphragm for a woman to insert before intercourse, or a pessary swapped with a spermicide, required some communication with a woman on the part of the health professional, and often manual demonstration and fitting, the new technologies promised a high-tech approach, which would no longer be dispensable under the sole responsibility ordinary nurses and midwives because of their chemical and invasive qualities, and which demanded the involvement and authority of physicians, especially gynaecologists. The advent of these new technologies of contraception provided the material basis for the South African state's

⁶⁹ See the work of Linda Gordon on the history of these hormonal contraceptives, and the progressive and conservative political agendas that coalesced around these new technologies: L. Gordon, Woman's Body, Woman's Right: Birth Control in America (Harmondsworth: Penguin, 1990).

⁷⁰ CAD/TES 7240 56/231 6920 "Family Planning by the Bantu", see correspondence from 1961 to 1966.

new didactic policy of population control, which was based on the injectable contraceptive, Depo Provera.⁷¹

The complex history of this chemical contraceptive and its continuing legacy in South Africa is addressed in great detail in the work of both Brown and Klugman, whose research begins its focus on the period after 1965.⁷² They have detailed how, in the late 1950s, the state began to define "Bantu birth rates" and the fertility of "Bantu" women as a serious long-term threat to white national interests, and so began designing programs to counter this. New state funding for the South African branch of Planned Parenthood, which had been formed in the mid 1950s out of the network of Race Welfare and Mothers' Welfare clinics started in the early 1930s, was forthcoming.⁷³ In a series of reports, memoranda and eventually cabinet meetings, the government in the 1962 to 1964 period decided to allocate a large proportion of health resources for black women to contraceptive services. By the late 1960s, the state, working through the Department of Health, set up its own network of family planning clinics, and later, through the creation of puppet "Bantustan" health systems, through these networks as well.

⁷¹ Recently, the Women's Health Project of Wits University, has inaugurated a massive study of contraceptive use and knowledge among South African women from a wide array of economic, social, ethnic and language groups, with a particular emphasis on use and experience with Depo Provera. This project will provide new insights into state contraceptive planning after 1960. See the work of Barbara Klugman on post 1960s state policies: "The politics of Contraception in South Africa", Women's Studies International Forum 13:3 (1990).

⁷² B. Brown, "Facing the Black Peril".

⁷³ CAD/TES 7240 56/231 6920 "Family Planning by the Bantu", see correspondence from 1961 to 1966.

Although the Bridgman's records do not provide insights into how the Hospital adapted to new state policies in their last years of operation (the early 1960s) it is most interesting that the only occasion in which Rosina Kotane, who gave birth at the Bridgman four times from the late 1940s to the early 1960s, recalled receiving contraceptive services, was after her final pregnancy, in 1961. Her recollection of this experience was of a traumatic loss of power over her own body. Although her friends had told her that if she had "strong blood" the injection would not prevent conception, she blamed her inability to become pregnant again despite her efforts to conceive, on the injectable contraceptive she received from the Bridgman that year, just a few years before it was forced to close. Unlike Rosina Kotane's descriptions of her treatment at the Bridgman during her antenatal visits, and her memories of her successful birthing labors, she recalled this experience with a sense of anger:

They give me an injection in hospital! [CB: At the Bridgman?] Yes. They give me an injection. They say, "Maybe you will get the child after three years, or after four years". But if you've got the strong blood you can't stand that. In Bridgman, that time, whether you want or not, you given injection! [CB: Did you want that injection?] No, I didn't want that. But if you're strong, with that injection, you are still going to get a babies. I think. [CB: I see, so the nurse gave you the injection?] Mmm, yes. It stopped the blood.⁷⁴

The repeated comment of Patience Tyalimpe gains deeper meaning in the light of her own and other black women's experiences of ill-informed and ill-gotten consent that became the normal practice in many South African Hospitals in the late 1960s and 1970s. She said:

I thought that contraception was an excellent idea, but it should be explained fully.⁷⁵

⁷⁴ Interview: Rosina Kotane, Johannesburg, November 2 1992, Transcript, 10.

The suspicion, anxiety and mistrust that surrounds contemporary contraception debates in South Africa is powerfully connected to the legacy of the post 1960s state planning. But its roots lie in the language and analysis generated by both black and white missionaries, social reformers and authorities in the 1930s, around such issues as the race degeneracy of poor whites, borne in the bodies of white women, and the promiscuity of urban life, borne in the bodies of black women. It will take years of work, on the part of people such as Patience Tyalimpe (who now forms part of a newly reorganised contraception-providing service) and midwives such as the women at Alex Clinic, to reimagine and rethink practices of fertility control which express the desires and wishes of different South Africans.

There is some irony in the fact that as the Bridgman Board began to recognise the imminent fate of the Hospital in the winter of 1962 and 1963, and drew up plans for the future of the funds that would be available after the forced sale of the buildings, and from the capital investments of the institution, they considered the work of Planned Parenthood in South Africa important enough to warrant investment consideration.⁷⁵ In the late 1960s and 1970s the money from the Bridgman Memorial Foundation, set up in the wake of the Hospital's closure, was invested and grants were bequeathed annually to a variety of causes, such as foster care provision and crèches for black children, and fees and tuition for the training of black nurses and black women doctors. As in the 1920s, the people who

⁷⁵ Interview: Patience Tyalimpe, Johannesburg, November 22 1992, Transcript, 3- 4.

⁷⁶ HPC/A1059 D1.1, see 3 July 1962.

ran the Bridgman Memorial Foundation overlapped with those who ran the Helping Hand Trust, which had also been created in the wake of the forced closure and sale of that hostel for black women. In the 1980s, both trust funds donated large sums to the Planned Parenthood Association of South Africa.⁷⁷

⁷⁷ HPC/HHC A2052/Oa2, see 13 April 1977 and 7 November 1988.

Chapter Nine

"Bantu Gynaecology" and The Science of Women in South Africa, 1920 - 1960¹

Less than twenty years ago the Bantu were an exotic growth to the gynaecologist. Now this branch of the human race has been received in orthodox gynaecological circles, and its womanhood forms for the observer an entity.²

Introduction

Black women, in southern Africa during the first half of this century, became the objects and, indeed, subjects of wide-ranging and influential research which opened, investigated and scrutinised their bodies, and particularly their reproductive processes. This attempt on the part of the medical and scientific academy in southern Africa, to appropriate, penetrate, and classify, women's bodies, formed part of a wider process wherein local and central state authorities, especially in urban areas, sought increasingly to control the movement, settlement, productive and reproductive labor of black women, particularly women designated as "Native" and later "Bantu" women. This web of intersecting scrutinies and controls was, however, not a closed or tightly bound system.

¹ This title draws upon two works discussed below. The first is the Medical Textbook, edited by G. P. Charlewood, and O. S. Heyns, Bantu Gynaecology (Johannesburg: Witwatersrand University Press, 1956); and the second, the recently published book on the history of gynaecology and obstetrics in England by Ornella Moscucci, The Science of Women: Gynaecology and Gender in England, 1800-1929 (Cambridge: Cambridge University Press, 1993).

² O. S. Heyns, "Chapter One" in Bantu Gynaecology 1.

There were two main reasons for this. Firstly, before World War II, missionaries, individual local and central state officials, physicians, nurses, and black and white social activists, created alliances around specific projects, such as the provision of maternity care for black women, without also creating hegemonic institutions. As contradictions emerged and became points of contestation, many of these alliances broke apart. After the 1940s, however, the role of the central state was far more omnipresent in these conflicts, and increasingly the victor in battles over the movement and rights of African women in particular. Secondly, the inter-war period was marked by tremendous change and struggle. Black women found many ways to subvert, reinterpret, and avoid controls over their movement, employment, housing and household relationships, forging vibrant and creative networks of support. After the 1950s, however, the spaces open to black women in cities were increasingly circumscribed.

The history of the movement of black women into the towns, the economic odds they faced, and the occupations such as beer-brewing and domestic service that they made their own, in order to survive, has begun to receive serious attention. But very little recent scholarly attention has been paid to practices and ideas concerning sexuality, conception, birthing and child-rearing, which were part of the intimate fabric of women's lives in the developing metropolis of Johannesburg. Women arrived in the city as mothers, workers, wives, lovers and daughters, bringing with them many conceptions and experiences forged out of the conversation between regionally specific bodies of knowledge and more recent

experiences of colonialism, dispossession and conversion. Thus, nineteenth century technologies of diagnosis and healing, developed in different regions of the sub-continent, intermingled with the knowledge and skills of specialists: herbalists, diviners and increasingly, practitioners of western biomedicine. Within a few decades, this latter group grew to include a large contingent of black nurses and midwives.³

This chapter will attempt to address only one of the many aspects of this complex history of reproduction, namely: the science and practice of "Bantu Gynaecology". This specialized branch of gynaecology developed in South Africa, particularly the city of Johannesburg, after the First World War. It developed in close conversation with similar movements in the social sciences, particularly Anthropology, and within the University of the Witwatersrand Medical School, with the Anatomy Department headed by Professor Raymond Dart.⁴ The first part of this paper will attempt to sketch the links between these topics of scientific inquiry. The Bridgman Memorial Hospital, opened in 1928, was the production site of much of the knowledge and research forming the basis for the interconnected branches of anatomy and gynaecology whose experts were increasingly interested in black women. A volume of collected material on the physiology and gynaecology of black women was published in 1956 in textbook form, under the auspices of the Wits Medical School, the teaching and research institution connected to

³ See chapter three on the life and work of the herbalist and midwife, Louisa Mvemve.

⁴ For the remainder of the chapter, this University will be referred to by its colloquial name, "Wits".

the Bridgman. This moment of publication formed the apex of over two decades of research in the formation of a specialization. This chapter will sketch-out the research of Professor O. S. Heyns and his assistants, first tracing the history of widespread scientific interest in genital organs of African women, and then, in more detail, the theme of "Bantu women's pelvic capacity". Certain aspects of "Bantu Gynaecology", such as the development of expertise in repairing vaginal fistulae, will not receive detailed attention in this paper, despite their presence in the literature. This is because it was particularly in the attempts to establish the connection between scientific measurements and the analysis of the birthing potential of women, that the sub-discipline concentrated its attention, and staked its claim. After 1960, with the forced closure of the Bridgman Memorial Hospital, research on the part of one of the leading progenitors of "Bantu Gynaecology", O. S. Heyns, turned increasingly to utilizing methods and technologies developed at the Bridgman on the bodies of black women, to wider application on all women, particularly pregnant women. In 1972 an updated and substantially altered edition of Bantu Gynaecology, was published under the same editor. Titled Gynaecology in Southern Africa, this volume focused on black women in the main, but all chapters contained references to white women and women of Asian descent. The Foreword in this case described not the peculiar characteristics of the "Bantu Patient", as the earlier volume had done, but instead emphasized that:

Gynaecological conditions in southern Africa vary so considerably from those overseas that a book such as this has been long overdue.⁵

Thus the idea that the practice of gynaecology in southern Africa continued to require specific knowledge did not diminish after 1960, but the characterization of black women's innate corporeal, eugenic, and emotional qualities did shift. Local gatekeepers of the profession turned their attention outwards rather than inwards in the ensuing decades. This chapter will end with a brief discussion of the way local practitioners such as O. S. Heyns began to lay claim to international expertise, with the invention of the "Birthsuit" in Johannesburg in the late 1950s.

A central idea underpinning the main focus of this chapter is that very intimate interconnections existed between the creation of segregated cities, passes for women, the setting up of rural Bantustans and expert ideas about and attempts to control black women's sexuality and reproductive labor. Research into the creation of different bodies of ethnographic, paleoanthropological and especially medical knowledge concerned with black women's bodies is part of the wider work from which this paper is drawn. Three parallel and mutually influencing spirals of inquiry informed the thinking of clinicians and technicians who invented "Bantu Gynaecology". First, perceived characteristics of African women's bodies became diacritica in anatomical and physical anthropological research dedicated to the categorization and hypothesizing of the evolution of African peoples in southern Africa.⁶ Second, African women became the subject of research concerning the

⁵ G. P. Charlewood, (ed) Gynaecology in Southern Africa (Johannesburg: Witwatersrand University Press, 1972) from the Foreword by Dr C. De Wet .

⁶ The term 'African' women will be used in this chapter to indicate the specific interest of local scientists in the bodies of women designated as having 'native' or

measurement of their labia minora, buttocks and particularly, pelvic passages, and significance was attached to these measurements. And third, African women found their birthing practices and experiences the focus of close examination on the part of medical and anthropological authorities. The motors for this research lay in the emergence, within Europe and the United States, as well as in the academic environment of South African universities and hospitals, of scientific thought and practice obsessed with physical, cultural and behavioural difference. The particular racial and tribal lexicons under construction in southern Africa in this period, both by liberal anthropologists who saw a potential in the 'progression' of all humanity, and state ethnographers, concerned increasingly with the need for systematic segregation, provided a fertile soil for these scientific discourses. In the southern African context an overriding concern about the laboring and reproductive potential of black men and women, remained a recurrent theme of state authorities and as well as the initiatives and company reports of mining and manufacturing capital.⁷ A close reading of the written work of anthropologists, such as Isaac Schapera, anatomists, such as Raymond Dart, and gynaecologist-obstetricians, such as O. S. Heyns and G. P. Charlewood, suggests that a number of ambiguities forced their way into the discourse of official knowledge of and about African women. The bony passages of African women could be measured, but what of the unquantifiable laboring indigenous origins. Researchers at this time claimed that the capacities and physiology of 'negroid' and 'bush' people in southern Africa was distinctive, and it was women from these categories, or African women, who were the targets of research.

⁷ See R. Packard, White Plague, Black Labor.

power, fortitude and control over their bodies during birth labor that African women again and again exhibited in the face of medical disbelief and indeed, at times reverent incredulity? The affront that African women posed to medical experts when they 'triumphed' during labours deemed impossible by virtue of their measured anatomical capabilities, could not be hidden in the pages of statistical gynaecological and obstetrical reports. Black women's own changing self conception, the impact of their presence and the challenge of their body-control, is a major theme of the last section of this chapter.⁸

'Expert Opinion' on the movement of black women into Johannesburg:

By the turn of the century most independent African communities in South Africa had been forcibly drawn into the colonial political economy. Previous chapters have sketched out the increasing vulnerability by the 1920s of rural subsistence for black women and their households. The movement of women into towns and cities in search of work and sustenance, which took on greater momentum in the late 1920s and early 1930s in the context of widespread droughts and the far-reaching effects of the depression, alarmed local authorities.⁹ As we have seen, white officials regarded the urban settlements

⁸ The work of Mary Poovey and Emily Martin on medicine and women has suggested ways to read medical texts subversively, see: M. Poovey, "'Scenes of an Indelicate Character': The Medical 'Treatment' of Victorian Women" *Representations* 14, (1986) and E. Martin, *The Woman in the Body* (Boston: Beacon Press, 1987).

⁹ The records of the central state, which cannot be regarded as accurate for this period, document the increase of 'Native' women in urban areas as follows: from 1921 to 1936 the numbers of women increased 142.3%, (147,293 to 356,874); and from 1936 to 1946 increased again to 642,190. These figures no doubt represent a very conservative

of black women as more permanent, and more threatening to their plans for white segregated cities offering almost no infrastructure and few amenities for male workers. Thus, within the context of an increasingly industrial South Africa, the central state in 1930s made the first in a series of specific moves towards restricting the mobility of women through influx-control legislation, which tied their rights of entry into towns and cities to the length of time their husbands' and fathers' had been employed in a particular urban area.¹⁰ However, women in the cities were able in many instances to carve out greater independence, and control over their own income and their sexuality, than their sisters in rural areas, who lived under the watchful eye of elder kinswomen and men, and as Gaitskell and Eales have demonstrated, these legislative attempts and measures were received ambivalently, and sometimes supported by black men.¹¹

estimate, as women who were in urban areas illegally no doubt attempted to avoid being counted. See chapter two.

¹⁰ See chapter three. There is a growing body of revisionist literature on this theme and period. For a particular focus upon women see especially C. Kros "Urban African Women's Organisations: 1935-1936" *Africa Perspective* 3 (1984); I. Matsepe, "African Women's Labour in the Political Economy of South Africa, 1880-1970", PhD diss., Rutgers University 1984 and K. Eales "Patriarchs, Passes and Privilege: Johannesburg's African Middle Classes and the Question of Night Passes for African Women, 1920-1931", University of the Witwatersrand, History Workshop, 1987.

¹¹ D. Gaitskell, "Wailing for Purity; Prayer Unions, African Mothers and Adolescent Daughters, 1912-1940" and "Housewives, Maids or Mothers: Some Contradictions of Domesticity for Christian Women in Johannesburg", University of Cape Town, African Studies Seminar, 1982; and P. Bonner, "'Desirable or undesirable Basotho women?': Liquor, prostitution and the migration of Basotho women to the Rand, 1920-1945" in C. Walker, (ed) *Women and Gender in Southern Africa to 1945* (Cape Town: David Phillip, 1990).

There was little waged employment open to black women in the cities and towns into which they migrated. Industrial work was dominated by white and black men, and except for a tenuous presence in the garment industry, the major wage earning opportunities available to black women were in domestic service of some sort, often as live-in maids, cooks and child-minders in the homes of middle class whites, alternatively as laundry workers and part-time house cleaners. Women who could not obtain even this low-paid work, or who could not survive on the income it brought in, engaged instead in the brewing and sale of beer and sex-work of various forms, (both short-lived arrangements and longer-term relationships which could involve joint housing and shared living expenses).¹²

The potentialities of women's greater independence in the cities was thus ambiguous. Women were highly vulnerable to low wages, the absence of any labor contacts with employers, to the violence and harassment of sex work, to police raids on beer-brewing operations. Women entered the cities from regions throughout southern Africa. They brought with them ideas about productive and reproductive labor, which did not necessarily translate easily into a capitalist division of labor between household and

¹² See the work of Ellen Hellmann in this regard, especially Rooiyard: a Sociological Study of an Urban Native Slumyard (London: Oxford University Press, 1948), and also Laura Longmore The Dispossessed: A Study of the Sex-life of Bantu Women in Urban Areas in and around Johannesburg (London: Jonathan Cape, 1959). Beer-brewing has received great attention lately from social historians of southern Africa, but for a specific focus on women and the construction of gender see K. Eales "'Good Girls' vs 'Bad Girls'" in Agenda (1989) and J. Mackenzie "African Women and the Urbanization process in Durban, 1920-1949" History Workshop, University of Natal, Durban, 1983.

waged work. They brought with them ideas and practices concerning sexuality, birthing labor, the care of children, and importantly, gender relations. These different, and changing, ideas and practices shaped, and were in turn shaped by, the urban setting of shanty-towns, slums and locations. The records of the Bridgman and of the physicians, midwives and patients who congregated around its wards, laboratories, clinics and lawns, provide a crucial site for the examination of some of these questions.¹³

Much of what we do know of the household arrangements and provisioning networks of women migrants to port cities, and towns along the Rand, is lodged in the detailed anthropological texts written during this period, texts which resonate with overarching themes of academic and state discourse of the day, particularly "detrribalization and the impact of western civilization". Recently the work of Gaitskell and Eales on Johannesburg and Mackenzie's work on Durban has begun to focus upon the complex debates around black women's bodies and sexuality in the early decades of the century. These took place between local authorities, but also among Christian Africans, among an aspirant petty-bourgeoisie in the towns, and among women and men who were involved in church networks, fund-raising campaigns and education schemes. One emerging theme amongst these intersecting voices of authority, was the whole question of "sex-hygiene" or Christian purity education, in an environment described as fraught with promiscuous temptation and unbounded by self-regulating practices. Amongst a broad and

¹³ See chapter four.

varied segment of urban society, these questions were connected to fears about women as vectors of venereal disease through sex work; sexualised and possibly diseased women as domestic servants, and therefore intimately connected to white households; and women as the mothers and socializers of future generations, and thus the need to concentrate on the training, hygiene and control of their bodies.¹⁴

In the early 1930's local and central authorities began commissioning expert opinion on the urbanization of Africans, focusing on women in particular. The language of family breakdown and detribalization was not confined to government-appointed ethnologists and "Native affairs" experts. Indeed liberal reformers and the organisations set up to lobby for their cause (such as J D Rheinallt Jones) and academics such as Hunter, Schapera, and Hellmann and medical doctors with a reforming and policy-making agenda, such as Laidler, built their many of their research topics in this period around the themes of the impact of conquest on "tribal life" and the harmful effects of the urban environments such as the Witwatersrand and East London, upon the character of black people. Central to their enquiry was the position of black women in "tribal" versus urban life.¹⁵ Although these academics, as individuals and as a group, did not necessarily hold agendas mirroring that of the state, their work formed part of a developing genre around

¹⁴ These themes have been addressed in more detail in preceding chapters.

¹⁵ M. Hunter, Reaction to Conquest; chapters by Eileen Krige and Ellen Hellmann and Isaac Schapera in I. Schapera, (ed) The Bantu Speaking Peoples of South Africa: An Ethnological Survey, and Isaac Schapera Married Life in an African Tribe, the entire collection of papers in Schapera's edition entitled Western Civilisation and the Natives of South Africa, 1934 are emblematic.

the need to plan for and control the movement and livelihoods of black people. Anthropologists such as Eiselen, who contributed to many of the same academic publications in the 1930s, was appointed to an official post, and in the 1950s and 1960s became a leading ideologue of separate development, or Apartheid.¹⁶ As indicated in Chapter Eight, the 1930s and 1940s saw the mushrooming of anthropological research into the social life of different Southern African ethnic communities, especially practices relating to sexuality, puberty, marriage and childbirth. These texts are a rich testimony to the wide-ranging research of this energetic group of anthropologists, and their insights have often conferred upon them the status of primary sources in the writings of revisionist historians. Indeed their work deserves to be taken seriously. But to do this, and to appreciate the ramifications of their writing and fieldwork, we need to investigate the linkages between their work and that of their colleagues who read, commented upon and influenced their research, with their peers in related academic disciplines, whose papers appeared side by side with theirs in academic journals.

During this same period, a parallel literature in anatomical research into southern African women's bodies developed, with the University of the Witwatersrand at its centre. Academics such as Raymond Dart, fascinated by the indigenous people of southern Africa and the "secrets" to human origins that they believed lay in the pasts of indigenous black

¹⁶ Appointed to a Native Affairs Department post in the late 1930's, Eiselen continued nonetheless to collaborate with Schapera and other ethnographers holding academic posts, and he continued to contribute to collections of southern African anthropological work.

South Africans, set out to study, classify and interpret local Africans' bodies, their beliefs and their behaviours. For Dart and those who dealt with dead bones and skin tissue, their aim was to provide objective markers of racial difference and posit theories of evolutionary and genetic heritage. And for anthropologists, the purposes of their research were often remarkably similar: to record objective markers of difference, to preserve traditions (at least through the recording processes of their work), to represent people within structural categories, such as "tribe", and to reveal and interpret the mythical beliefs and customs of their subjects for their expert audience and for posterity. Indeed, Dart and the coterie of brilliant students of science that he gathered around him in his laboratories at Wits, did not draw a clear disciplinary line between the work of paleoanthropology and the work of people in the "Bantu Studies Department".¹⁷ Dart's close allies were people such as P. W. Laidler, the Medical Officer of Health for East London, an expert on "Native" health, and an amateur but widely published anthropologist, as well as fellow scientists in the medical school and Wits anthropologists, such as Winifred Hoernle, who supervised the work of Ellen Hellmann.¹⁸

"Bantu Female Bodies": the creation of an iconography of black women's body parts.

¹⁷ Dart provides detailed insights into his early years at Wits in the 1920s and 1930s in his intellectual autobiography. See R. Dart, Adventures with the Missing Link (Philadelphia: The Institutes Press, 1967).

¹⁸ Dart himself makes these connections clear. See: R. Dart, "Recent Advances in Anthropology in Africa" The Leech (April 1938) 55.

Isaac Schapera, in his well regarded study of a Kgatla community on the border of present day South Africa and Botswana, Married Life in an African Tribe, devoted a section to "Sexual Relations between Husband and Wife". His discussion of women's sexuality and sexual anatomy in this book provides an anthropological parallel to the work of Dart, Laidler and prominent gynaecologists and obstetricians at Wits who, after 1928, initiated new research projects at the Bridgman Memorial Hospital. These researchers shared an interest in codifying the particular nature of 'the Bantu female body'. One significant example is Schapera's focus on the vaginal tissues of the women he observed and described in his study of the Bakgatla Reserve, in what was then the Bechuanaland Protectorate (present day Botswana). This interest in the sexual organs of African women, was part of a widespread and sanctioned scientific interest in a transatlantic and colonial academic community. In specific discussions of the elongated labia minora common among these women, Schapera emphasised, unlike many of his colleagues in the Anatomy Department, the created rather than genetic qualities of local women's sexual organs. He quotes an informant's mother as saying:

The labia adorn a woman. If a woman hasn't got long labia, we don't call her a woman at all, but a child. When you hear husband and wife quarrel at home, this is the main cause of their quarrel, because this is the place where the husband plays every day, and if his wife has not got them, there is no peace at home, for then he has nowhere to play, while other men boast to him about how they play with their wives.

Schapera then offers this analysis:

These statements indicate clearly enough the high erotic value attached by the Kgatla to the labia. Women say also that it adds greatly to their own enjoyment when the penis rubs against the labia during intercourse.¹⁹

Much more research awaits future southern Africanists scholars in exploring the histories of sexuality and ideas about corporeality in different communities throughout this century. However, it is clear that the sexualized representation of Tsawana and Sotho women's genital organs was not confined to the scientific discourses of white ethnologists and researchers. Sotho and Tswana women in cities such as Johannesburg in the 1940s and 1950s, have been represented in autobiographical novels, performances, musical lyrics and in interviews conducted since the late 1970s, as highly sexualized, promiscuous, and sought after, both by black men and women as well.²⁰ It is not unlikely that in Schapera's case, his attention to genital organs of women was directed not only by his wide reading of late nineteenth century travellers accounts, but also by the commentaries of his informants. Schapera was generally more skilful than his fellow anthropologists, at involuting his own agenda and authority, in the process of developing and claiming a silent ethnographic presence. Nevertheless we can track the legacy of writing about the genitalia of black

¹⁹ I. Schapera Married Life of an African Tribe 188.

²⁰ In interviews with elderly women in Isiyaya in the Transkei region, the sexual organs of Sotho and Tswana women were spoken of in very objectified ways. For example, in one interview in which the conversation turned to the ethnic differences between women, the informant exclaimed: "These women try to catch our men by stretching their organs with warm cow dung!", and followed this with a stinging commentary on the avarice and promiscuity of such women. See Interview: Nora Mdlamza, Isiyaya, 17 October 1992. Translation assistance in this interview was provided by Nokhatazeka Mzayifani. The interview was transcribed by Nontobeko Lugqola. Transcript, 4. Also see: D. Mattera, Sophiatown: Coming of Age in South Africa (Boston: Beacon Press, 1989); E. Kuzwayo, Call Me Woman; D. Coplan, In Township Tonight (Johannesburg: Ravan Press, 1985); and A. S. Mopeli-Paulus, and P. Lanham, Blanket Boy (New York: Crowell, 1953).

women through his scientific interest in the bodies of the women who formed key subjects of his research.²¹

This fascination with, and ultimately iconographic representation of African women's sexual organs (as exotic, highly sexualised and problematic sites of study), echoes an important theme of early travellers' accounts of African, and especially Khoisan women's sexual organs, which evolved in the nineteenth century into a highly developed discourse.²² Sander Gilman's study reveals the links between the obsessions of travel narratives with the voracious sexual appetite of African women and the categorization of these women as "primitive". Measured on the basis of the hierarchical scale devised by late nineteenth and early twentieth century social darwinists and eugenicists, to delineate the level of civilisation of different "races" of people, "Hottentots" and particularly "Hottentot" women were seen as representing the least advanced living human life form. Schapera's work on this theme amongst people who were considered to be "part Hottentot" was intimately connected to that of his nineteenth century antecedents, and the contemporary academic community in which he worked and wrote.

²¹ He pays no such careful attention to the penises or testicles of the male subjects in his study.

²² For an intriguing investigation into the history of these representations in the nineteenth century discourse, and the power these iconographies took on, see Sander Gilman's "Black Bodies, White Bodies: Towards an Iconography of Female Sexuality in Late Nineteenth-Century Art, Medicine, and Literature" in *Critical Inquiry* 12: 1(1985). For South African scientific literature on the topic see: J. Drury, and J. R. Drennon, "The Pudendal Parts of the South African Bush Race" *Medical Journal of South Africa* 22 (1926).

Saul Dubow, in his research on the links between state policy, anthropological research, segregationist and reformist discourse, provides us with a vital missing link in the interconnected web of racial (and as argued here, explicitly gendered) capitalism that developed in South Africa.²³ In providing a backdrop to liberal reformers and their connections to the projects of racial anatomy, Dubow points to the:

... paranoia about civilization's retrogressive tendencies and its vulnerability in the face of a 'vigorous' and 'virile' mass of 'barbarians' who were flooding into the cities... The question of the capacity of African races to rise in the level of civilisation became an integral part of any discussion on segregation. Rheinallt Jones... called upon scientists, psychologists and anthropologists to establish the data upon which a sound social policy could be formulated.²⁴

Less than a decade later this research agenda was being vigorously pursued by Raymond Dart, eminent anatomist and colleague of Schapera's at the University of the Witwatersrand.²⁵ Soon after his appointment in 1922, Raymond Dart, a medical-trained

²³ S. Dubow, Racial Segregation and the Origins of Apartheid in South Africa (Hampshire: MacMillan in Association with St Anthony's College, Oxford, 1989); and "Race, Civilization and Culture: The Elaboration of Segregationist Discourse in the inter-war years" in S. Marks, and S. Trapido, (eds) The Politics of Race, Class and Nationalism (London: Longman, 1987).

²⁴ Saul Dubow "Race, Civilisation and Culture" 77; John Rheinallt Jones, a famous liberal reformer, and an important figure in the establishment of the South African Institute of Race Relations, was also a key figure with the aid of his spouse, Edith R. Jones, in the establishment of the Bridgman Memorial Hospital. See previous chapters.

²⁵ His fame arises from his "discovery" in 1924 of the Taung skull, which he argued provided the "missing link" between "primitive humans" and "humans", between "ape-man" and "man". Named "*Australopithecus africanus*", the discovery of this specimen was Dart's first reward for pioneering efforts at tracing the ancestry, and establishing a classification for the different indigenous "races" of southern Africa. This work was sustained after his retirement in the late 1940's, by a group of young students trained under his guardianship, notably Phillip Tobias.

anatomist, began developing a the Anatomy department and a school of paleoanthropology at the University of the Witwatersrand. While it may be an exaggeration to argue that Dart "virtually created the University's international reputation for the study of the peoples of Southern Africa",²⁶ this was certainly his aim, and in 1937, when Isaac Schapera asked him to pen the first chapter in the weighty collection, The Bantu Speaking Tribes of South Africa, Dart's labours were recognised alongside the writing of Eiselen, Hellmann, Hoernle, Hunter, Krige, Schapera and Van Warmelo.

Under Dart's direction, a series of investigations of the genitalia of black women was inaugurated. Besides the measurements of dead bones, Dart was interested in living tissue, and he initiated what he and colleagues called "Field Studies on Living People", a project which expanded in the after the 1940s and continued into the 1970s, after Dart's retirement. Besides chemical and genetic investigations of "isolated racial groups" and physiologically "unusual" groups of people (investigations which were intended to unearth patterns and connections between human origins research and human race classification), these projects continued to seek out women with elongated labia minora.²⁷ As late as the 1970s, a new coterie of graduate students under Dart's successor, the equally famous Philip Tobias, were publishing papers of the "Hottontot's Apron", except by this time they

²⁶ B. K. Murray, Wits, The Early Years 1896-1939 (Johannesburg: University of Witwatersrand Press, 1982) 126.

²⁷ See P. V. Tobias, "Raymond Dart: Biographical Sketch and Appreciation", The Leech (November 1959).

were conducting research among Griqua communities in the Knysna district of the eastern Cape.²⁸

"Bantu Gynaecology"

The outstanding advances that have taken place in clinical medicine, surgery, gynaecology and obstetrics during the last decade have been those arising out of the application of physical and chemical science to the study of the human body.²⁹

In 1937 two graduate students working in Dart's laboratory, Margaret Orford and Lawrence Wells, conducted an investigation into the measuring and classification of African women's bodies, with a particular emphasis on "racial typing" (skin colour gradations, facial features, height and weight measurements, pelvic and arm measurements) including two sections concerned with the observation of and physical measurement of their subjects labia minora and buttocks. Entitled "An Anthropometric Study of a Series of South African Bantu Females",³⁰ this text self-consciously brings together all of the paleoanthropological themes briefly traced in the above section. The assembled data for the paper was based upon research conducted on 98 adult, "Bantu" women, of different "racial" groups³¹ (that is women identified in the text as Sotho, Xhosa,

²⁸ See C. Orkin, "The Tablier in Griqua Women", *The Leech* (July 1970) and P. Tobias, "Human Biological research in the Anatomy Department, University of the Witwatersrand, 1959-1969" *The Leech* (July 1970).

²⁹ R. A. Dart, "The Central Clinical Laboratory", *The Leech* (September 1934) 13.

³⁰ M. Orford, and L. H. Wells, "An Anthropometric Study of a Series of South African Bantu Females" in *South African Journal of Science* Vol. xxxiii (March 1937).

³¹ Clearly, even amongst the scientists creating the racial schemas, there was slippage and confusion about the use of the terms "race" and "tribe".

Zulu, Tswana, Fingo, Swazi, Shangaan and Hlubi), who were examined at Bridgman Memorial Hospital in Johannesburg. Orford and Wells did not indicate how they gained access to the women patients and whether they informed these women about the purposes of the interventions undertaken upon their bodies, the paper states only that "the subjects examined" were outpatients of the Hospital.

In October 1934, at a meeting of the House Committee of the Bridgman Board, Clara Bridgman who was presiding as the Chair, informed the gathering about research being conducted under the auspices of the Medical Superintendent, Dr Hope Trant. The Minutes of the Meeting recorded the moment thus:

The Chairman called attention to the fact that measurements of patients were being made by medical students in the Out-Patient Department in furtherance of certain investigations which Dr Trant is carrying out on her own initiative, and that certain patients had complained against this practice. It was AGREED that Dr Trant be asked to discontinue the taking of such measurements by the students until the matter had been discussed by the full Committee.³²

Dr Trant was at the meeting, and no record was taken of her explanation or comments, nor do we have a sense of how Clara Bridgman found out about the patient complaints. The records do indicate, however, that all future research conducted at the Bridgman had first to be cleared through the full Board, and this would have included the Matron and Sister Tutors. It is also clear, from the published results of Wells and Orford's work, that they were allowed to continue with some aspects of their work. However, as we shall see,

³² HPC/AD 843 B91.32. "Minutes of Meeting: House Committee", 8 October 1934.

the objections of some patients to their invasive research found its way into the final published paper.

The depth and extent of the measurements taken, the descriptions of skin colour and facial features would seemingly have occasioned a long and particularly invasive examination. As students of Dart, their work was seen as a critical contribution to the work of anatomists and obstetricians of the day.³³ Orford and Wells state in the opening paragraph of the published paper:

The investigation was undertaken with a two-fold object: (1) To obtain pelvic measurements of normal Bantu Females for use as standards in obstetrical practice; (2) to test the applicability of the Mills classification of bodily habitus in the Bantu... In the process of these studies, however, a number of standard anthropometric determinations were made, and the object of this paper is to place these on record.³⁴

In their introduction the authors point to the classifications and measurements accomplished successfully through this work, and then they pause to add a note concerning the incompleteness of their measurements of these women's labia minora:

Observations were also made on the incidence of steatopygia, and in certain of the individuals on the form of the labia minora; owing to objections raised by the women this latter investigation was later abandoned.³⁵

³³ After qualifying, Orford was connected for a number of years to the Bridgman, one of very few women gynaecologists who were. But she soon opened a private practice, and this was also very rare. "... in the 1950s, the largest practice was run by a woman, Margaret Orford. She was a good looking, charming and brilliant woman, who suffered from high blood pressure... she died from a stroke at the height of her career. Her memory is honoured by the annual Margaret Orford Memorial Lecture..." Interview: Durban, G. P. Charlewood, December 9 1992, 7.

³⁴ M. Orford, and L. H. Wells, "An Anthropometric Study" 1010.

³⁵ M. Orford, and L. H. Wells, "An Anthropometric Study" 1010.

Despite stating that they were forced to abandon this part of their research, within in the body of the text the results of their findings are nonetheless recorded alongside their classification of facial type and their outline drawings of steatopygia (of which they found "only 14 strong cases"). The results of their findings (in the text, placed above a table of "types" of labia minora in relation to "Facial Type") underscore the invasive and extensive nature of this examination, despite the opposition of many among the group:

As explained above it was possible to examine this feature in only 59 of the 98 individuals. The labia minora have been classified into two main types: the so-called "European" type, in which they do not project beyond the labia majora, and the elongated type in which they project to a greater or lesser degree... two main forms (are distinguished) among these elongated labia. In the one, termed ... the "butterfly" type, the elongation effects evenly the whole of the organ: in the other, or "wattle" type, only the anterior part of the labium is prolonged... of the 59 individuals examined, 17, or less than one-third, showed no elongation of the labia; of the 42 cases of elongation, only four were of the "wattle" type. Elongation of the "butterfly" type thus appears to be the rule in this series. It was not possible in any of the cases to ascertain whether artificial elongation of the labia had been practised.³⁶

This paper, bringing together as it does, commentary on the "tribal" divisions of southern Africa, on the hierarchy of development of different races, on the very particular sexualizing of African women, focusing on the so-called "Bush" (meaning Khoisan) features of elongated labia minora, is a central text, revealing with startling clarity the powerful links between the networks of experts assembled around the University of the Witwatersrand and Bridgman in the 1930s and 1940s. The obsession with genitalia

³⁶ M. Orford, and L. H. Wells, "An Anthropometric Study" 1015.

continued, and both Wells and Orford continued their investigations in northern Natal in the late 1930s.³⁷

The Orford and Wells paper is important for two additional reasons. First, it provides a rare example in the southern African scientific literature of explicit, if fleeting, reference to the objections of a group of black women to a medical examination. Second, the paper introduces a genre of anthropometric research on the body of African women, which was to develop and flourish during the 1940's: namely the measurement of pelvic size. After extended discussion of Cephalic, Facial, Stature, Limb, and Trunk measurements, the paper continues with a long section on the pelvis of the South African Bantu Female, concluding that the majority of the "98 Bantu females examined" had smaller "expandable pelvic potentials" than white women measured in the using similar methods in a series of influential studies in England.³⁸

In her extensive study of the history of gynaecology in England in the period between 1800 and 1920, Ornella Moscucci provides an incisive analysis of the links between the science of physiology and ideas about social roles, through the inscription of a particular feminine mental, imaginative and social character in the bones of women. It is worth quoting her summary of the European literature at some length:

While craniometry has long attracted the interests of historians, the study of pelvimetry remains to date totally unexplored. Anthropologists had elaborated it in the first half of the nineteenth century to complement craniometry, as a means of

³⁷ P. Tobias, "Human Biological research in the Anatomy Department, University of the Witwatersrand, 1959-1969" *The Leech* (July 1970) 89.

³⁸ M. Orford, and L. H. Wells, "An Anthropometric Study" 1033.

classifying races on the basis of pelvic and cranial capacity respectively... But while craniometry was believed to be applicable to the classification of men, in the female the dimensions of the pelvis were deemed to be more appropriate. Thus the cranial index was paralleled by the pelvic index, a parameter devised by combining together the different diameters of the pelvis. According to the cranial index, the white European male was found to occupy the highest place in the order of races. The European women for her part was also thought to be more highly developed than her 'primitive' sister, but her superiority was indicated by the greater capacity of her pelvis.³⁹

In South Africa by the 1930s, it was this branch of anatomical research that came to form the foundation for "Bantu Gynaecology". As in North America and Great Britain, obstetrics and gynaecology were still umbilically tied, but nonetheless, also seeking separate identities in this period. The emphasis on surgical intervention, and thus the need for surgical rather than medical skills in the work of gynaecology, underlined these research initiatives.

In 1927, as John McGibbon took up his new post as the head of the recently established Department of Obstetrics and Gynaecology at Wits, he addressed the organised medical community by lamenting the low regard that many "medical men" in South Africa had for the science of gynaecology and obstetrics or midwifery (and here he explicitly meant the midwifery of male physicians). He argued:

The days in which midwifery was regarded as an inferior sort of art, as compared with medicine or surgery should be gone, and midwifery in South Africa must... take a seat in the front row of clinical education in our medical curriculum, with clinical medicine and clinical surgery on either side of it, for the privilege of which, however, it has had a long and historical struggle. That position cannot be better expressed than in the words of Sir George Newman, "The obstetrician and gynaecologist is the great example of the unity of Medicine and Surgery in actual

³⁹ O. Moscucci, The Science of Woman, 183

practice. Here is the full integration." ... it shall no longer be the Cinderella of medicine, as it was formerly known.⁴⁰

Although anaesthetic drugs had been developed and used in obstetrical surgery since the late nineteenth century, referred to as "twilight" sleep into the 1920s, no major new chemical discoveries in obstetrics or gynaecological work emerged until the mid 1930s, when the company Bayer developed and patented "Prontosil", the first sulpha drug to come on the market. In his autobiography, the South African gynaecologist-obstetrician C. F. Krige, who worked at the Bridgman and the Queen Vic from the late 1930s to the late 1950s, and taught at Wits Medical School, remembered his first exposure to "Prontosil" in London where he was specializing at Queen Charlotte's Hospital in 1935:

The firm of Bayer had sent the hospital a supply of this drug for trial on puerperal sepsis cases, and doctors were beginning to find a distinct improvement in their results... Recoveries were occurring in cases that previously would have been considered hopeless... Improved sulpha drugs, followed by antibiotics in the first half of the twentieth century, revolutionized the treatment of sepsis and saved innumerable lives. Their success was the greatest event in therapeutics in this country.⁴¹

When he returned to South Africa to take up work in Johannesburg the next year, there were still so few gynaecologists and obstetricians in practice, that he decided to have the name plate above his offices read: "Dr C. F. Krige (with degrees etc.) Diseases of Women".⁴² Just before O. S. Heyns was appointed to Wits Medical School, Krige began

⁴⁰ J. McGibbon, J. "The Reduction of Maternal Mortality and Morbidity in its Clinical Aspect", The Journal of the Medical Association of South Africa, (B.M.A.) (11 June 1927) 275.

⁴¹ C. F. Krige, To Cure Sometimes: a doctor's autobiography (Johannesburg: Da Gama Publishers, 1967) 164.

⁴² C. F. Krige, To Cure Sometimes 166.

working at the Queen Vic and the Bridgman. It was while working in the latter hospital, he recalled, that he was first exposed to such a great volume of unusual obstetric and gynaecological cases, and the newly available drugs were of great service:

At the Bridgman Memorial Mission Hospital my willing availability was responsible for my doing most of its abnormal obstetrics. The work there also entailed a university appointment, requiring ward rounds and instruction for non-european students, which was a pleasant source of mutual benefit to both student and teacher. Many cases of grossly neglected labour were admitted, including ruptured uteri. Before antibiotics, only those cases in which the uterine wound was sewn up recovered.. Full-time ectopic pregnancies presented themselves not infrequently...⁴³

The Bridgman was, to gynaecologist-obstetricians such as Krige and Heyns, not only a place where women with usual birthing labours could receive treatments and care for ten days--indeed neither physician had much to do with "normal patients" who were tended by the trained Midwives--instead for these skilled physicians, the Bridgman was a site for "medical miracles", as Krige put it, for heroic last-minute surgery and for exposure to a wide variety of pathological and life-threatening birthing dramas. As we have seen in Chapter Seven, the Bridgman was the only maternity hospital for black women in the region, and it was therefore not unusual that women with anticipated obstetric difficulties were directed to, or sought out the facilities of the Hospital. In comparison with the Queen Vic and other maternity homes for white women, the proportions of "difficult labours" at the Bridgman were very high. But even taking these factors into account, specialists such as Krige and Heyns began observing by the late 1930s that a key reason

⁴³ C. F. Krige, To Cure Sometimes 167.

for the difficult and obstructed birthing labours under their supervision, was the apparently small pelvic size of many black women.

Thus, in the decade after McGibbon issued his missive, research on pelvic capacity in South Africa brought together the interests and knowledge of the gynaecologist and the techniques of research science and surgery. Physicians such as Heyns saw intimate connection between the measured capacity of the pelvis, its role in foetal development, and its crucial function in the obstetrical drama of birthing itself.⁴⁴ The focal point for this new research were the pelvises of black women, because their small size, in comparison with white women's pelvises, had been repeatedly noted in the commentaries of Dart and other anatomists. Interestingly, instead of underwriting an easy assertion of the superiority of white women (as the studies of white women's pelvic size in England earlier in the century had suggested) the research initiated by experts in South Africa, led its chief proponent, O. S. Heyns, to question the mental and physical stamina of white women, and even the role and worth of gynaecologist obstetricians in the clinical treatment of black women.⁴⁵

⁴⁴ Moscucci traces the gradual, although never complete, separation of gynaecology and obstetrics. She points to the increasing use of episiotomies in the 1930s, and the greater demand of gynaecologists by the interwar period that they be recognised as surgeons. See *The Science of Woman* 180-183. In the post World War Two period, G. P. Charlewood one of South Africa's most respected gynaecologist-obstetricians applied for a post as a surgeon as well, and was denied this appointment. Interview: G. P. Charlewood, Durban, December 9 1992, and written answers to authors' questions by G. P. Charlewood, Letter: March 8 1992, 15.

⁴⁵ We shall return to a discussion of this theme in greater detail below. For a summary of the work on the pelvic measurements of skeletons from the 1930s to the

Before turning to an examination of this theme (the challenge that living black women's birthing labor posed to pelvic measurements and ascriptions), we must pause to note something of the particularity of medical knowledge and research. Orford and Wells' examinations of live women, as opposed to Dart's research on bones and cadavers, were surely in a much more immediate and direct relationship of power and authority in relation to the African women who formed the subject of their research. The breadth and power invested within the "medical examination" was so much more sweeping than the academic texts that an anthropologist would produce out of visit to, for instance, an urban slumyard. Women patients were usually examined alone, on cold tables, in situations of physical and emotional stress, and often in pain, by people in white coats, usually men, speaking English, and using cold implements and devices. These scenarios bear little resemblance to even the rather authorial practices of a respected anthropologist such as Schapera in Bechuanaland of the 1920s.

The social history of medicine and health in southern Africa has been defined during the past five years, as a neglected topic, worthy of the attention of the revisionist school. Social scientists and historians, and in some cases medical practitioners themselves, have begun to engage questions of the intimate links between the development and practice of medicine and colonial intrusion, the growing power and strength and demands of capital, and the extension of the post-1910 segregationalist state.⁴⁶ These

1960s, see: H. De Villiers, The Skull of the South African Negro: A Biometrical and Morphological Study (Johannesburg: University of the Witwatersrand Press, 1968).

researchers have, in describing vastly unequal medical provisioning and institutions throughout the region, discovered a powerful thematic and empirical base from which to analyze the broader ramifications of class and racial inequalities. But, despite being invested with authority and power by their institutions, by their learning and by the state, medical doctors were often challenged and refuted, by the living evidence and actions of their patients and case studies. During the late 1920s, 1930s and 1940s in particular a growing swell of papers and studies appeared in the trade journals of southern African medicine and science. Their pages are filled with a gaping ambiguity: a constant subtext being the power and authority of the doctor, versus the power, knowledge and even courage of "the patient".

There was a great deal of commonly proffered "wisdom" about the ease with which black women gave birth in South Africa at the time, even amongst members of the medical community.⁴⁷ These cliched images of the black woman in such and such a

⁴⁶ Examples of this emerging body of work include: S. Marks, "Race, Class and Gender in the South African Nursing Profession", presented at the University of Chicago, May 1987; "Women's health in South Africa" in M. Wright, et al (eds) Women's Health and Apartheid, Columbia University Workshop, 1988; S. Marks, and Andersson, N "Epidemics and Social Control in Twentieth Century South Africa" Bulletin of the Society of the Social History of Medicine 34 (1984); S. Marks, "Women and health in South Africa" Canadian Woman Studies, 7, 1986; "Issues in the Political Economy of Health in South Africa" in Journal of Southern African Studies 13.2 (1987) and S. Marks "The State, Class and the allocation of Health Resources", Social Science and Medicine 28 (1989), Special Edition on the Political Economy of Health in Africa and Latin America; and R. Packard, White Plague, Black Labor.

⁴⁷ In a brief popular study of birth customs in South Africa, the psychologist Dr Beverly Chalmers drew together the medical opinions which insisted that African women gave birth without the need for assistance and refuted this by summarising post 1940s

field, giving birth, tying the baby to her back, and continuing to work, crop up again and again on the literature of the period, and even into the present. Perhaps the first recorded evidence of this image, and certainly a template for recurring references, was captured in the Journal of one of the first licensed "surgeons" at the Cape, Jan van Riebeeck, who was also the first Governor installed by the Dutch East India Company in 1652:

Yesterday a Hottentot woman was delivered of a child close to the fort, on the bank of the river beneath the branches which were pulled up, without the assistance from man or woman, just as if she were an irrational animal. She immediately cleaned the child herself, and rubbed it well with cow-dung all over, making it black... immediately afterwards she put it to the breast while holding it on a small skin.⁴⁸

Confusions raged in the medical literature and amateur anthropological commentaries by magistrates and contributors to local scientific journals ruminated about whether black women were attended in their birthing labours by other women.⁴⁹ Just as many texts railed against the "meddlesome midwifery" of grannies and community midwives, and pointed to

evidence from anthropological texts. See B. Chalmers, African Birth: ChildBirth in Cultural Transition (River Club: Berev Publications, 1990). However, despite intentionally dispelling many of the myths and stereotypes around the primitivity of black women, Chalmers unintentionally reinscribes many of her own, speaking constantly of the innate qualities in all black women, and, simultaneously underscoring the vast differences between different black South African women's "cultural experience of birth", depending on their ethnicity. This combination of liberal refutation of racial inferiority combined with a culturalist assertion of difference, is an outstanding feature of much contemporary popular psychological literature in South Africa.

⁴⁸ Johann van Riebeeck's Journal, 1652-1655, Volume One, edited by H. B. Thom, (Cape Town 1952), 236; quoted by Charlotte Searle in The History and Development of Nursing in South Africa (Cape Town: Struik, 1965).

⁴⁹ For example: F. P. Grobbelaar, "Random Jottings of a Country Practitioner" in The Leech (September 1934).

the absence of birthing assistance as a sign of the primitivity of black women.⁵⁰ It took until the 1930s for the first referenced major texts on black women and birth customs to be published by people such as Laidler, Hunter and Schapera, and much longer before these clichés were questioned on a wider scale.

These stereotypes had two long-term consequences for the image of the birthing labours of black women, one intentional, and one perhaps less clearly anticipated. First, this image of the ease of birth created a fiction about the physicality of black women and the primitivity of their 'natural state'. Whereas white women, in this same lexicon, suffered like Eve in their birthing labor, black women, who were closer to the earth and its fruits, bore children with no difficulty. Of course this type of explanation could be and was used by some of the most racist officials as an excuse for the lack of maternity facilities for black women, and Clara Bridgman herself argued with Johannesburg City Councillors in numerous meetings in the late 1920s and 1930s not only about the suitability of black women for midwifery training, but also for the need for a maternity hospital for black women at all.⁵¹ But these arguments were in the minority. A second and less expected

⁵⁰ For example: P. W. Laidler, "Native (Bantu) Beliefs Concerning Pregnancy and Child-Birth, Their Effects on Public Health Administration: And the Effects of Detribalisation or Urbanisation on Those Ancient Customs and Upon Infantile Mortality Rates", South African Journal of Science Vol xxxviii, (1931); and J. McGibbon, "The Reduction of Maternal Mortality and Morbidity in its Clinical Aspect", The Journal of the Medical Association of South Africa, (B.M.A.) (11 June 1927).

⁵¹ HPC/AD 843/RJ/Kb and HPC/AD 843 B91.32. See the extensive Nursing files in the SAIRR collection. Also see the correspondence between the Public Health Department, C. Bridgman and E. R. Jones.

consequence of this stereotype was that it enabled a vision of black women as having greater fortitude and resilience than white women. Those who adopted a more measured version of the cliché of "birth without fuss", could envisage that black women experienced pain, but argued that they could bear this birthing pain with greater ease than their white sisters.

This latter theory gained great prevalence in the 1940s through the work of Grantly Dick-Read, a British gynaecologists-obstetrician who wrote extensively on "childbirth without pain". While many of his observations about the connections between actual physiological experiences of pain, and fear, unsympathetic treatment and strange surrounds, have been borne out in recent medical and psychological research, Dick-Read based the central assumption in his 1940s work on a series of images he had absorbed through pre-1930s writings on African women.⁵² in The Principles and Practices of Natural Childbirth, he expounded on these theories about "natural women".⁵³ In the early 1950s, he finally decided to visit the African continent to investigate first hand his assumptions about the ease with which African women gave birth, and the reasons for this:

For over forty years I had suspected the beliefs of my medical colleagues; I suspected them of misinterpreting the laws of nature, and implementing modern scientific methods to hide not only the pain of childbirth but their failure to understand their cause.... But still one vulnerable chink in my armour of defence caused me constant irritation and dissatisfaction. I taught the natural way to have a

⁵² There has been a growing literature on this subject since the late 1960s. For a widely read example: S. Kitzinger, The Experience of Childbirth (Harmondsworth: Penguin Books, 1978).

⁵³ G. Dick-Read, Childbirth Without Fear: The Principles and Practice of Natural Childbirth (New York: Harper, 1953, Revised and Enlarged Edition).

child and, from experience among 'unnatural' women, had formulated the methods and procedures to remove the impediments of culture... These methods and procedures had never been compared with the childbirth customs of the people who lived closest to nature and furthest from both the advantages and disadvantages of modern science.⁵⁴

After months planning this great safari to Africa, Dick-Read and his family arrived in South Africa to begin their long journey north. He was disappointed with his investigations in Johannesburg itself and throughout his journey through the densely settled areas of the Transvaal, where missionary hospitals and the presence of nurses and doctors precluded Dick-Read's search for women in their "natural" state. He decided he would have to go beyond the borders of South Africa to find such women. The story of his year long odyssey cannot be examined here, suffice to say that Dick-Read's original question was answered equivocally at best, and negatively at worst, by the evidence of his own account. He had set out from the start to see whether "the tenets upon which my theories stand or fall" were sustainable. His central question was this:

Do African women have their babies in the manner we believe all women should, or do they have a high percentage of trouble because the laws of natural reproduction are not adequate?.... After forty years I might discover that there is no foundation for the principles in which I had believed from my youth.⁵⁵

Despite finding that many African women experienced similar and worse problems of obstructed labor and physiological complication, Dick-Read did, not surprisingly also find much evidence of the self-control, lack of physical inhibition and corporeal fear as well as the fortitude he had anticipated. The notion that different "races" of women were endowed

⁵⁴ G. Dick-Read, No Time for Fear (London: Heinemann, 1955), x.

⁵⁵ G. Dick-Read, No Time for Fear ix.

with different innate qualities was the starting point for Heyns as well.⁵⁶ But his work led him to a realization, in the face of much anthropometric, genetic and paleoanthropological research of the day, that the context of a living consciousness could provide an even more powerful hold over reproductive labor than the "story of the bones".⁵⁷ Still, like Krige, Charlewood and other prominent gynaecologist obstetricians, Heyns maintained his self-identification as a heroic scientist, whose labours were often of more significance than the women he assisted and studied, and so it is to this prevalent theme in the corpus of "Bantu Gynaecology", of the labours of white male gynaecologist-obstetricians that we now turn.

The Labours of Doctors:

In 1932, an obstetrician from Stutterheim in the eastern Cape delivered a paper at the South African Medical Congress to great acclaim, and was asked to publish his address in the South African Medical Journal.⁵⁸ Dr. L. Marchand's subsequent article was

⁵⁶ Recent work on the history of the body and on the changing corporeal conceptions of humans over time, has stressed the malleable rather than immutable qualities of physiological conceptions, the experience of pain and pleasure and the interconnections between mind and body. See T. Laqueur, Making Sex: Body and Gender from the Greeks to Freud (Cambridge, Massachusetts: Harvard, 1990); D. Arnold, Colonizing the Body: State Medicine and Epidemics in Nineteenth Century India (Berkeley: University of California Press, 1993) and B. Duden, The woman beneath the skin, translated by T. Dunlap (Cambridge, Massachusetts: Harvard University Press, 1991).

⁵⁷ This was Dart's expression. See R. Dart, Adventures with the Missing Link (Philadelphia: The Institutes Press, 1967), Chapter 11, "The Bones Tell Their Story".

⁵⁸ Anonymous, "Diary of a Congress Delegate", Journal of the South African Medical Association (10 October 1931) 639.

framed in intensely personal terms, with Marchand, the valiant doctor struggling, it would seem alone, against the ignorance, and unhygienic living-conditions of black women "patients". His paper is treated at some length here, because in its personalization and claim to generality (on the basis of "field work" and examination), was echoed in subsequent papers and medical texts for the next two decades. Indeed, this is an exemplary rather than unique text.⁵⁹ The theme of the "examination" itself is woven into the text, and it is in the fissures that reveal themselves between the cracks of his expert narrative, and the bodies of the women he is examining, that we can begin to read into his paper challenges to his expertise and explanations. His piece opened with a paragraph common to many medical papers of the day: a series of references to black women's superstitions and living conditions and to their duplicity, emphasizing the difficulties of a doctor in his position. Through a close reading of this article, certain themes emerge: black women's refusal to present themselves voluntarily to him for examination, and their refusal to participate in his regime of questioning and the taking of a "case-history". These contestations are represented as part of a much wider struggle.

In the first place one has to deal with a race which is ignorant (often unintelligent), very superstitious, and still very much under the influence of the witch-doctor. Consider also the unhygienic and unsanitary state of their dwellings... and add to

⁵⁹ See for example: G. Gale, "The Rural Hospital as an Agent in Native Health Education", South African Medical Journal (8 August 1936); B. Morris, "The Squatting Position During Labour" South African Medical Journal (10 December 1938); W. Robertson, "Africa, But Not So Dark", The Central African Journal of Medicine (July 1955); J. Manson, "Obstetrical Problems in Bechuanaland", The Central African Journal of Medicine (June 1956).

that the struggle with an unknown language, and one has difficulties enough to start with. The disappointing part of the work lies in the entire absence of antenatal examination and supervision. The native only calls in the medical man when in despair, as a last resort, often when the patient is in extremis. Thus one is confronted with a position requiring a quick decision. In one's enquiries as to the length of labour, and other necessary information, one is struck by the native's capacity for withholding the truth. One woman, in labour for at least three days, was brought to the surgery, and I was told that she had a pain in her stomach, and they wanted to know what was wrong, knowing full well what was the matter with her.⁶⁰

The thrust of these passages underscores the burden and responsibility that fell upon Marchand's shoulders to "deliver a live birth", and the live "woman in the body", instead of being seen at the very least as the vessel of the child working under the guidance of the expert, is represented instead as the "enemy" of the doctor. What is particularly interesting is how Marchand begins to take up the language of labor, attributing "work" and effort to himself, yet the constant laboring of the woman ("...in labor for at least three days") finds its way into the text despite his intentions.

The fatiguing part of the work arises from the appalling conditions under which the work has to be done. The hut may be large or small, but always has a fire burning in the centre, from which acrid smoke makes things unpleasant for both eyes and lungs. The patient lies on the mud floor, on sacks or straw mats, and one has to work kneeling on the ground or squatting beside her. It is a position not to be recommended to anyone suffering from lumbago, especially in a protracted case...⁶¹

Believing that he had established in the minds of his medical audience the arduous task to which his expertise had been called, Marchand attempted next to draw the reader into a

⁶⁰ L. Marchand, "Obstetrics Amongst South African Natives" South African Medical Journal (May 1932) 329.

⁶¹ L. Marchand, "Obstetrics Amongst South African Natives" 329.

vicarious experience of the difficulty of his work, and into a collegiate objectification of the "Native women":

Picture the floor when all is over --blood, faeces, liq. amnii, soiled clothes. In the daytime it is draughty with door and air-holes open, and at night-time the light is poor ... warm water is usually obtainable, but of doubtful purity, and coming from a nearby river or well, and very seldom boiled.... As to the patient, it is most rather an unsavoury situation that awaits one. ... The umbilical cord or a limb of the child may be presenting. Anaesthesia must now be induced, the mess cleaned up, and all this on a patient whose pulse may be anywhere up to 140.⁶²

But it is precisely at this point that his narrative began to crack open, and a host of unintended side shows and main characters in the drama are revealed to us, though Marchand clearly saw himself as the protagonist. We find out that other women were present. We find out that there is a designated "attendant", who may have interloped upon Marchand's territory by examining the woman, and we recognise in the next clause his unease at this possibility of prior trespass. In a series of concluding passages Marchand's paper lost its ironic and expert tone. Black women managed to recover from these experiences, but something about their recovery, came from themselves and not from Marchand. We find out that despite his depreciating references in the previous excerpt to the interfering attendants, his knowledge was challenged, and indeed bettered by a woman and her attendant, after she had delivered a child. This throws into disrepute the claims he made throughout the article about "Native" midwifery and medical knowledge:

But here, in contrast to the disappointments, is just where the encouraging part comes in. Considering the length of labor, shock of instrumentation or version, exhaustion of the patient, perhaps manual removal of the placenta, dirty vulva and scant asepsis, one is surprised at the good results obtained. The native's vitality and

⁶²

L. Marchand, "Obstetrics Amongst South African Natives" 330.

power of recovery are somewhat phenomenal... The native women often sit up within a short while after the child has been born. In one case, after forceps, manual expression of the placenta failed. The attendant woman said that was not the proper way to do it. She made the patient sit up and bear down, and with one big heave, out flopped the placenta.⁶³

Just as it seems that Marchand might concede at least powers of resilience to black women, he undercuts this:

One comes to the conclusion, thus, that if they would call the doctor sooner, very little assistance would be required to give them very good results, and encourage one to do better. As it is now, one has to work hard for doubtful results, and in addition there is no comparison between the amount of time and energy spent and the fee charged, still less received.⁶⁴

In this light, the work of O. S. Heyns and his group of researchers and medical staff, in acknowledging not only the heroics of physicians, but also black women, is even more remarkable.

Writing a decade later, with the authority of a prestigious research and consulting position inside the medical academy (as Professor of Gynaecology and Obstetrics at Witwatersrand University, and as the Chief Gynaecologist Obstetrician at Bridgman Memorial Hospital) Heyns' thesis, summarised in an article titled, "The Superiority of the South African Negro or Bantu as a Parturient", carried a substantial weight. Filled with cross-referencing, laboratory data, conversant with American and European literature, supported by large grants for research and numerous assistants, and based on examinations upon thousands of "sample cases" in a major hospital, the conclusions of

⁶³ L. Marchand, "Obstetrics Amongst South African Natives" 330.

⁶⁴ L. Marchand, "Obstetrics Amongst South African Natives" 330.

Heyns' research elicited widespread debate among various sections of the medical academy and its practitioners.⁶⁵ Commentary centred on Heyns' suggestion that the basis for the skeletal differences between white and black women's pelvises could be differences in maternal nutrition, rather than evolutionary delayed development, as suggested by anthropometrical research. Further, his suggestion that small pelvic diameter in the pelvises of live "Bantu" women he examined, and in the collection of skeletal pelvises in Dart's collection, could be smaller than the pelvises of black women born in the mid nineteenth century, elicited notice.⁶⁶ Instead of the smaller pelvis being a long term feature of "Bantu" women:

Bantu Living in the towns are subjected to low standards of living, while those living in the native territories have to withstand occasional periods of great privation.⁶⁷

The first part of his later detailed paper, "The Superiority of the South African Negro or Bantu as a Parturient", was a minute reiteration of research concerning the potential pelvic expansion of African women, and the relative size of African foetal heads.⁶⁸ After exhaustive relaying of numerical measurements and calculations, diagrams

⁶⁵ See the Reports of discussions at the South African Medical Congress of 1947, in the South African Medical Journal November, 1947.

⁶⁶ This in turn drew on an earlier published paper in a prestigious international journal, O. S. Heyns, "A Study of the Bantu Female Pelvis" Journal of Anatomy, 78: 5 (1944).

⁶⁷ O. S. Heyns, "A Study of the Bantu Female Pelvis" 164.

⁶⁸ O. S. Heyns, "The Superiority of the South African Negro or Bantu as a Parturient" in The Journal of Obstetrics and Gynaecology of the British Empire (October 1946).

and charts, Heyns concluded that the differences between "Bantu and European foetal heads at term is not considerable".⁶⁹ He then moved onto a detailed examination of the pelvic structure of African women, classifying women at first according to differing "tribal taxonomies", and drawing general conclusions from this approach. His evidence supported an already large body of data which asserted that a high proportion of black women measured had a pelvic area capable of only limited expansion. But, substantiating his investigations through the use of X-ray and "dry-pelvis" measurements, Heyns contested the findings of British and American doctors that women with a pelvic area of less than 80 sq. cm. would not be able to "deliver successfully", arguing:

It must be admitted that there is no incalculable virtue inherent in the Bantu women. Successful labour depends on three main factors: the passenger ...; the bony passages which exhibit pronounced contraction more frequently in the Bantu; and the powers of expulsion. It is the quality of the powers that offers an explanation. There can be no doubt that fundamentally the white women can accomplish as much as the Bantu. ... It is submitted that in the European there is an unfavourable emotional background which has an inhibitory effect on efficient uterine action. ... The most urgent thing in Obstetrics, in my opinion, is to discover how the gift of physiological labour may be made to the woman of caucasian stock. This priceless gift, I am sure, can be obtained most readily from the Bantu.⁷⁰

This passage, from a lengthy journal article summarizing a decade of research might have surprised some of his local colleagues in other centres. They were making similar observations about the resilience of black women during childlabour, but only as a sideline

⁶⁹ O. S. Heyns, "The Superiority of the South African Negro or Bantu as a Parturient", 408.

⁷⁰ O. S. Heyns, "Obstetrics in the Bantu", The Leech (January 1950) 46.

to their main case, which was to argue that black women's resilience was born from ignorance and stubbornness, a resilience that they forced upon themselves by refusing to call a doctor to supervise the birth of their child. During this period, the a major project of many obstetricians and gynaecologists writing in journals abroad and in South Africa was to detail the need for more doctors, the extension of antenatal and postnatal observation, and most importantly, more hospital births for African women. Their aim was to bring African women into the regime of "confinement care" laid out and practised extensively among white middle class women, increasingly among white rural and poor women, and occasionally among urban black women.

Heyns' research during the 1940's, took a tangential route. He set out with the same baggage, but found, to his "great surprise", as he often reminded his readers, that the bodies, and what he calls "emotions" of black women, defied, and even contradicted his expert knowledge. The passage above makes explicit Heyns' view of black women's conduct during childbirth. His thesis was that they represented a "resource" to be studied, by experts such as him, and once understood, this resource--in the form of the gift of knowledge--was to be passed on to white women, by himself and others trained to understand the complex science of obstetrics.

Let us examine this passage in more detail. Heyns set out three factors essential to any successful parturition: the passenger (once he decided the foetal head was comparable in size to white babies, his interest in the foetus wanes sharply); the bony passages (the

pelvis etc); and the powers of expulsion (a more shaded area containing it would seem, both physiological powers -perhaps involuntary- and great powers of will and of the mind working with the body).⁷¹ After a long summation of medical expertise on "Bantu" women's uterine and vaginal structure, and on "the bony passages", in which he concluded "Bantu" women often had a much smaller area of potential pelvic expansion than white women, his article focused on the last of the three "essentials". And it is here that his work seems to eclipse the previous debates in medical texts epitomizing this period. This study by Heyns, laced with internal tension, reflects many contradictions embedded in debates about doctors and their powers, women and their bodies, science and experiments and the creation of, and investigation into a defined "other". Crucially, it reflects a deep tension within the debates around black women in South Africa, debates onto which the rhetoric of racial taxonomies and ideologies were grafted.

It is to the theme of "successful delivery" that the remainder of Heyn's paper turns its attention. Employing many of the discursive conventions found in the earlier work of Marchand, Heyns revealed his familiarity with ethnographic material in long passages about tribal customs and lore regarding health and pregnancy. Another powerful metaphor of his argument, echoed Marchand's view of the doctor "in combat" with the patient. On one occasion, when a 13 year old patient gave birth without the aid of the caesarean

⁷¹ For an example of a text that interrogates these false divides of instinct and will, and which explores instead the various and ambiguous experiences of childbirth that may be at its very heart, for example the study by E. Martin, The Woman in the Body (Boston: Beacon Press, 1987).

Heyns had determined was vital, according his measurements of her "tissues and bony passages", Heyns described the event as follows:

The test of labour of the patient of 13 ended in defeat for myself,
we might expect because the patient died, but no:

for labour terminated in undramatic fashion, the infant was alive, weighed 7
pounds...⁷²

Scores of case studies of women followed; actual deliveries were described and testimonies of deliveries at which Heyns was not present, were collected and recorded. All these empirical cases build towards a thesis in which Heyns argued that, despite limited antenatal care and despite smaller bony pelvic passages on the part of many "Bantu" women, their birthing labours seemed to proceed without the aid of doctors far better than the labours of white women in hospitals. Finally, Heyns assembled an argument which departed from his forbears. Testing and examining black women who gave birth in hospitals he found that the rates of "success" and methods of delivery (that is, with forceps, by caesarean, under anaesthesia) were comparable with white women, whom he viewed as relinquishing their own will and power into the hands of doctors they expected would engineer the delivery of their child. His explanation for black women's passive behaviour in the hospitals, so different to home deliveries, was that they too expected the doctor to enact the procedure, to take charge. In his conclusion Heyns observed:

⁷² O. S. Heyns, "The Superiority of the South African Negro or Bantu as a Parturient", 410.

It has been shown that the size of the new-born bantu baby head is in no respect different from that found in higher races.... It has been shown, secondly, that the necessity for operative assistance in the Bantu parturient is exceptional... No further argument is required to confirm the claim that the South African Negro parturient is superior functionally to her European counterpart.⁷³

This passage opens up one last contradiction within Heyns' work, which was pivotal to attempts to create the specialization of "Bantu Gynaecology". Heyns had arrived at an impossible impasse for an expert gynaecologist-obstetrician: based on the anatomical features he and his colleagues had noted, he could not understand how it was that the majority of black women who gave birth outside of hospital settings managed without the aid of experts such as himself. Yet, black women reacted the same way as white women when they too were studied in the context of a hospital birthing situation. Arriving at this point, Heyns skated on the very thin ice of his own expertise. What "culpability" did he share with his peers in the process he described, where the "gift of physiological labor" was lost by women, when in the "care" of experts such as himself? Exploring this question in a roundabout manner, Heyns went so far as to say:

There is evidence in the cases quoted that the Bantu woman in many instances does not even entertain the idea that modern trained assistance is available... This is a disadvantage, but her tradition must be compared with that of the European who considers that she has engaged on obstetrician who knows more about parturition than she does, and whom she intends giving abundant opportunity of exercising his ability.⁷⁴

⁷³ O. S. Heyns, "The Superiority of the South African Negro or Bantu as a Parturient" 424.

⁷⁴ O. S. Heyns, "The Superiority of the South African Negro or Bantu as a Parturient" 424-425.

These challenges to medical authority and knowledge that Heyns was in certain senses addressing in his 1946 paper, found their way into his extensive introductory chapter for the 1956 text, Bantu Gynaecology co-edited with his junior colleague at the time, G. P. Charlewood. Titled, "Some Ethnic Relations of the Bantu in South Africa", it opened:

Less than twenty years ago the Bantu were an exotic growth to the gynaecologist. Now this branch of the human race has been received in orthodox gynaecological circles, and its womanhood forms for the observer an entity. The present work has been written on the problems presented by this subfield of endeavour.⁷⁵

Ensuing chapters, dealing with congenital abnormalities, carcinomas, sexually transmitted diseases, fibromyomata and genital prolapse, were premised upon the work of Heyns and his students and colleagues who had spent the period from 1946 to 1955 researching aspects of the medical and surgical problems presented during the clinical experiences of women who attended Bridgman Memorial Hospital. The anxiety expressed a decade earlier, that black women were less in need of the aid of gynaecologists and obstetricians, had been muted by the increasing numbers of women who booked into Bridgman for the birth of their children, and who attended antenatal and post-natal clinics, immunization sessions, venereal disease clinics, and mothercraft classes in their thousands by the mid-1950s. These women and their obstetrical needs presented Heyns and his colleagues with many objects for scientific query, and provided subjects for scientific experimentation on devices to lower abdominal pressure in pregnant women, suction devices to aid the

⁷⁵ O. S. Heyns, "Chapter One", in G. P. Charlewood, Bantu Gynaecology I.

withdrawal of the foetus, and breathing devices to help both the women in birth labor and newly born babies.⁷⁶

Hospital Births and Birth Suits:

In interviews with midwives trained at the Bridgman the subject of O. S. Heyns' investigations came up in a lively group discussion about the benefits of medical research and the advantages and disadvantages of hospital births.⁷⁷ After a brief discussion of Heyns' research into Pelvic size (about which Letta Mosikatsana and Wilhemina Madiba recalled the most) the midwives were asked whether they agreed with the conclusions arrived at by Heyns, that black women who had had less experience with hospital and medicalized births were more likely to give birth unassisted even if they had small pelvises, but that as black women became "urbanised", and experienced hospital births as the norm, their "birth labor profiles" resembled those of white women. Their immediate responses echoed many widely held ideas about the fortitude of black rural women, and the "accepting behaviour" as Mirriam Mokoana described it, of rural women. This stoicism of rural women was a matter of comment on the part of midwives in everyday work at Alex. Wilhemina Madiba explained that in the years since the relaxation of the strict Influx

⁷⁶ Besides the papers and theses referred to below, see O. S. Heyns, "Classifications of the Human Pelvis, with a Preliminary Note on the Evolution of the Anthropoid or Ultra-dolichopellic Type of Pelvis", Journal of Obstetrics and Gynaecology of the British Empire 53 (1946), O. S. Heyns and E. C. Halliday, "Progress in the Study of the Modes of Action of the Human Uterus During Pregnancy and Labour", Proceedings of the 37th Medical Congress of South Africa (1950).

⁷⁷ See chapter six for a more detailed discussion of these interviews with Bridgman trained midwives.

Control measures (abandoned by the Botha regime in 1986), greater numbers of rural born and raised women had been coming to Alex Clinic for their birthing labours:

Miriam Mokoana: I think we have spotted this too, amongst ourselves. Because we always say in this clinic "Shangaan women have an easy labour, they deliver easily, they do not tear." And we always wonder why. [Murmurs of agreement from the others] Amongst the blacks, I would say that Shangaans have got an easy labour. And they do not have tears or require stitching. Hardly ever in fact. But we do not even know why. [CB: Would you say that Shangaan women who come here are mainly rural women, or women from a rural area?] Letta Mosikatsana: I should think so, because it seems even those who have an easy labour who are not Shangaan are the ones from the rural areas, not from town. When the Shangaan women is from here, then it is just the same as an Alex woman. Miriam Mokoana: I have experience with a rural hospital. I have seen women delivering, or those who came and waited in the hospital for delivery, at Jane Furse Hospital in the northern Transvaal. You know, they can stand pain, they were not screaming like our patients here. And one thing the midwives would say, "You know, they just come voluntarily on their own, saying 'I am now going to deliver now', without anyone." They live far from the hospital, so they come and wait at the hospital. So some of them will just come when they are ready to deliver, without screaming, without crying, without doing anything. So I don't know why they sort of have that accepting behaviour that much. Unlike our mothers here in town. [Murmurs of agreement from the others] Letta Mosikatsana: Let us not forget we have also said on many a time that women from the Transkei do not scream either, or show signs of pain. Yes, and sometime if you are not careful, she can get the child right here. She can get the baby underneath the clothing. [Lots of agreement and counter examples and voices over one another]. Yah, you've got to be very careful, they do not demonstrate!⁷⁸

Wilhemina Madiba commented that none of the assembled midwives had ever assisted at the birth of a white woman, and we all reflected on the ironies and bitter reasons for this.

Especially, as Letta Mosikatsana pointed out, "We have trained the medical students who

⁷⁸ Interview: Group included Letta Mosikatsana, Wilhemina Madiba, Elsina Kabeni, Mirriam Mphahlane and Mirriam Mokoana, Alexandra Clinic, 6 February 1992, Transcript, 15 and 16. "CB" refers to the author, who conducted and transcribed the interview.

have been the doctors for the whites all the years here!"⁷⁹ Then Wilhemina Madiba

continued:

Wilhemina Madiba: Maybe we can say one day, yes this is so and so with white woman and this with black women. We do not have experience with white women. Now, with black women, even the ones who do notice the pain more, it is true, I think, it is the matter of pride, with our women, to deliver normally. She says 'I am a woman'.⁸⁰

In contradistinction to the pathological view of pregnancy and birthing labor articulated by obstetricians and gynaecologists in the earlier part of the century, Wilhemina Madiba suggested that both rural and urban women needed to be assured with both the best support and care, and aided by the best scientific techniques.⁸¹ In her final comment she drew together some of the aspirations of Grantly Dick-Read and his obstetric successors, with reference to the pilot work being conducted at Alex on the usefulness of birth companions in hospital births:

Wilhemina Madiba: My view is that, I think our women need education. If we could encourage our birth companions to be able to tell our women, that "Labor, you know, is not a disease, it is something natural." We have magazines by Johnson and Johnson, from the word go, from the beginning of labor, showing this is what happens when. Because that thing, when they show them this is what happening, when the pains get strong, they tell them that the passage opens, and then the patient becomes relaxed, and then they deliver normally. Very often. We must give patients hope.⁸²

⁷⁹ Interview: Letta Mosikatsana, Alexandra Clinic, 6 February 1992, Transcript 17.

⁸⁰ Interview: Wilhemina Madiba, Alexandra Clinic, 6 February 1992, Transcript 17.

⁸¹ S. Kark, "The Toxaemias of Pregnancy" in The Medical Journal of South Africa (May 1922).

⁸² Interview: Wilhemina Madiba, Alexandra Clinic, 6 February 1992, Transcript, 18.

Mirriam Mokoana, referring to an earlier conversation about the role of the midwife,

agreed, and said:

Mirriam Mokoana: That is why I said, we are trying to say to the patient something she is not experiencing. When the patient wants to push, you say 'Don't push' ["That's right", chorus the others], whereas we forget that it is her body, she feels that she wants to push. We must be very careful to listen to her.⁸³

But the final word that day went to Letta Mosikatsana who reminded us all that the whole point of hospital births was to enable better and less painful birth labor experiences. She cautioned:

Letta Mosikatsana: By the way, we are trying to avoid complications here! Because, I mean, if you allow a woman to push at the wrong time automatically, the *uterine os* just comes out in a tear and then you'll have complications. That's why we are trying hard to help her, to guide her. But if she wants to she does, and you won't ever stop it. She does. There is no way!⁸⁴

Thus, the testimony of black women patients and midwives support at least one line of the earlier conclusion of Heyns: once black women began giving birth in clinical settings similar to white women, the treatments they received and the interventions deemed necessary by physicians and midwives during their labor, increasingly resembled the birth profiles of other women in Southern Africa and the rest of the world.⁸⁵

Perhaps this is why in the last decade of his active career, Heyns and his colleagues turned to the invention of devices and techniques which would be applicable "even to the Queen of England", resulting in the invention of the infamous decompression "Birthsuit",

⁸³ Interview: Mirriam Mokoana, Alexandra Clinic, 6 February 1992, Transcript, 18.

⁸⁴ Interview: Letta Mosikatsana, Alexandra Clinic, 6 February 1992, Transcript, 18.

⁸⁵ See chapters six and seven.

tested on the women of Bridgman first. In the late 1940s, Heyns' research on pelvis size and capacity led him to craft a new series of research questions. Could the birthing labours of women, particularly women with smaller pelvic girdles and lower back pain, be assisted if the pressure on the lower portion of the spine and abdomen was alleviated? Most gynaecologists and obstetricians in South Africa at the time were very interested in the early findings of Heyns and the coterie of medical graduates and specialists in training under his direction. The Bridgman Board was so delighted with his work and rising prestige that they appointed him head "Academic head and Chief Consultant" to the Hospital in November 1955.⁸⁶ The local press picked up on the general excitement around the new "invention" by Heyns, and took photographs at the Bridgman of women encapsulated in large rubberized body suits, attached to an "Electrolux" vacuum machine, which in turn was plugged into an electric outlet.⁸⁷ Within four years the research of Heyns and his two senior aids, W. A. Roberts and J. A. Blecher at the Bridgman, had amassed enough evidence to convince many members of the local and international medical community of the positive effects on foetal stress and maternal pain, that the Birthsuit delivered.⁸⁸ The white Queen Vic Hospital set up a Decompression Unit, and several

⁸⁶ HPC/A1059 D5.01 18 November 1955.

⁸⁷ See the press releases in the Star, Sunday Times, and Rand Daily Mail from 1956 to 1976, which are clipped and contained in HPC/A1059 D5.01.

⁸⁸ See: J. A. Blecher, "Aspects of Physiology of Abdominal Decompression and its Usages in the Toxaemias of Pregnancy and in Foetal Distress in Labour" M. D. Thesis, University of the Witwatersrand Medical School, (1963) and W. A. Roberts, "Facilitation of Vaginal Delivery by Pelvic Outlet Decompression", South African Journal of Obstetrics

private clinics in Johannesburg followed suit.⁸⁹ In 1962, the South African Broadcasting Corporation (S.A.B.C.) recorded a series of radio interviews with Heyns, his staff and the first group of white women to use the suit, and played these on the "Women's World" programme for a week starting from the 14th November 1962.⁹⁰ The "Dramatic and Moving Birthsuit Story" was so well received that the S.A.B.C. decided to market the recordings, making phonograph records of the series, and selling these overseas in 1963. The same year the B.B.C. sent a camera team to South Africa to film women in suits at the Queen Vic (but they studiously avoided any filming at the Bridgman).⁹¹ By 1964, the Queen of England's personal physician, Sir Peel, was curious enough to communicate with Heyns, and arrange for a demonstration. Indeed so impressed was he with Heyns, the device and the evidence before him that he recommended that Elizabeth II use the suit for her final birth, which she did the following year. Prince Edward was born in the suit, with Heyns in attendance along with Peel.⁹²

The claims made on behalf of the Birthsuit were extended with each passing year.

and Gynaecology (6 June 1964).

⁸⁹ See: South African Medical Journal (4 September 1965).

⁹⁰ "Birthsuit: A Dramatic and Moving Human Document" SABC Bulletin, 3 December, (1962), 8-9.

⁹¹ Sunday Express, "S.A. Birthsuit to go on T.V." 10 May 1964. This was 13 years before television was available in South Africa.

⁹² HPC/A1059 D5.01 Correspondence with Heyns and Bridgman Board, 1955 to 1967. For details of Heyns trip to England see: Interview: Mary Lucas, Johannesburg, 6 September 1990, Transcript, 6.

In his autobiography of 1967, which was published just at the peak of the Birthsuit fever,

Krige, the retired former colleague of Heyns at the Bridgman mused:

Then Professor Heyns' birth suits came on the scene. As to its efficacy in labour I have no knowledge, and opinions may differ about it, but I do feel that it came at a psychological time, when the average women was less fussy in labour. Psychologically it must be very helpful with its constant application during antenatal visits. My own personal experience with it for sciatica was disappointing.⁹³

Krige's humorous caution sounded a warning bell that was being heard across the city of Johannesburg, and later the international medical community. At first, in the mid 1950s when the testing at the Bridgman was still underway, Heyns claimed only that the Birthsuits helped women with small pelvic size, and women in distress in the final stages of birthing labor. By 1962 he was claiming that the greater exposure to oxygen and the increased flow of nutrients to the foetus occasioned by the use of the suit in the last stage of labor, had a promotive effect on the mental capacities of the infant after birth. It was these latter claims that generated such enthusiasm for the suit in 1965 and 1966, but also raised suspicions in the medical community. Many in the local medical academy began expressing a sense of outrage at Heyns' meteoric rise to fame and intellectual prominence, after all, here was man whose major work had been on black women and their bodies.⁹⁴ So professional jealousy may have initiated the official enquiry into the Birthsuit at the end of 1967. But more than this sustained the investigations over the next ten years.

⁹³ C. J. Krige, *To Cure Sometimes* 215.

⁹⁴ This was drawn to my attention by G.P. Charlewood. Interview: G. P. Charlewood, Cape Town, February 8 1992, Transcript 11.

The following year, in 1968, Heyns mysteriously took early retirement from Wits Medical School, disappeared from the editorial board of the South African Journal of Gynaecology and Obstetrics, and retired to the coast at Hermanus. He died a few years later, still not vindicated by his colleagues. It took until the late 1970s before some aspects of his work on the Birthsuit were exonerated.⁹⁵ But the decompression qualities of the suit had, by that time, been reproduced via other technologies, and Heyns claims to infant mental enhancement were completely discredited. The local press followed these dramas with some interest, but the sudden wane in interest just as the investigations drew to a close suggests that the well organized local medical community sought to downplay any adverse findings to avoid civil suits from wealthy parents and patients.⁹⁶

O. S. Heyns was recalled later not for his work for over three decades with thousands of women as a surgeon and obstetrician of note, but for the flamboyance of his final project. Ruth Drubin, who trained under Heyns as a medical student in the late 1930s and early 1940s, recalled:

Yes! Heyns and his Birth Suit made out of vacuum cleaners, you know! It became a craze, but then he was odd you know! And they were discredited after time, I believe.⁹⁷

Wilhemina Madiba, who worked at the Bridgman in the mid 1950s, remembered the Birthsuit and recalled that at least one woman with severe problems of threatened

⁹⁵ Star 26 April 1967; Sunday Times 7 June 1970 and Star 26 July 1976.

⁹⁶ Unlike the U.S.A. at the time South African civil litigation did not have a lengthy record of claims won against Hospitals or doctors in any case.

⁹⁷ Interview: Ruth Drubin, Johannesburg, 4 November, 1992, Transcript 3.

miscarriage had used the suit with success. But Wilhemina Madiba and the midwives interviewed agreed that the claims made for the Birthsuit by the late 1950s were exaggerated, and that it was no surprise that it had disappeared without a trace.⁹⁸

Heyns' movement towards wider applications for his research and away from specific attention to differences between white and black women under his care signified a new moment in the history of southern African gynaecology, and spelled the demise once and for all of the separate field of "Bantu Gynaecology" so heralded in the mid 1950s. His early success, in this international arena, although it was not an unqualified, did open the way for other South African gynaecologists and obstetricians to make their mark in the international academy by the late 1960s and early 1970s.

The revolution in the work of Heyns and his junior colleagues in turn meant the demise of the subfield itself, and by the 1990s, one of the few living experts in the speciality of "Bantu Gynaecology" was impatient with this authors' continuing curiosity about its history.⁹⁹

⁹⁸ Interview: Wilhemina Madiba, Alexandra Clinic, 6 February 1992, Transcript 19.

⁹⁹ Interviews: G. P. Charlewood, Cape Town, 8 February, 1992 and Durban, December 9, 1992, and written answers to authors' questions by Charlewood, G P, Letter: March 8 1992, 11 to 17.

Conclusion

In 1953 the Bridgman celebrated its Silver Jubilee to great acclaim, and the presence of the Administrator of the Transvaal, the Principle of Wits University, and the Secretary for Native Affairs, besides a host of local notables seemed to assure its continued thriving existence. Clara Bridgman was honoured in her retirement for all the work she had put into the Hospital since 1928. The professional staff of Physicians, Sister Tutors, Matron and Midwives, black and white women, were similarly eulogized. Three years later, while in America with her family, Clara Bridgman died. She could not have dreamt what was to become of her "House of Friendship".¹

In 1962 the recently retired Director of Hospital Services for the Transvaal, Dr. H. G. Hugo, delivered an address to the Annual General Meeting of the Bridgman Memorial Hospital's Board of Management. In it he commented on the great work being done by the Hospital, both in the previous year and indeed in the years since its opening in 1928. Hugo pointed to the changed circumstances in health and welfare funding since the end of World War II and the world wide realization that service projects of the nature and scope of the Bridgman could no longer be supported by philanthropy. Thus, in this respect, he argued that the greater involvement of the State in the running of medical and social institutions was a positive benefit:

One can, therefore, in all sincerity thank the various people from Overseas who have contributed towards the Bridgman Memorial Hospital, one can also thank the

¹ HPC/A1059 Bridgman Memorial Hospital Silver Jubilee Pamphlet.

civic authorities and the Government authorities for their contributions in the past, one can also thank the people of Johannesburg and the Transvaal for their support... There was a time when this kind of support was looked upon as a philanthropic gesture, but I maintain that no institution can exist on a philanthropic contribution. The advancement in science, the costly medical bills for medical and surgical dressings and drugs is making it imperative... for the State to take more responsibility for the health of its peoples.²

The reasoning at work behind Hugo's consoling remarks lay in the fact that throughout the late 1950s and early 1960s, institutions such as the Bridgman had been increasingly threatened as the National Party Government instituted its plans to segregate all facilities and regions of cities and take control of the vast network of missionary-founded social, welfare and health centres. The social engineering plans of Grand Apartheid directly impinged upon the day to day existence of the Bridgman. In the late 1950s, the forced removal of the mixed urban communities and "black spots"³ adjacent to the Hospital, and especially the destruction of Sophiatown, as well as a host of laws addressing the administration and financing of hospitals, schools, and training centres, alarmed the community of midwives, physicians, administrators and patients drawn together by the work of the Hospital.

The seeds for greater state control over institutions such as the Bridgman had been sewn in the period after the War, when liberal health officials such as Sidney Kark and Harry Gluckman began to devise a new and comprehensive health system for South

² HPC/A1059 D1.1: "Address to the Board of Management, Annual General Meeting", by H. Hugo, 16 October 1962 (2).

³ Areas of dense residential settlement in regions deemed "white" under the Group Areas Act of 1950.

Africa, on a non-racial and equitable basis. The authors of the Gluckman Commission's Report had pointed out the grave imperfections at the core of South African health systems, including these features: facilities without common policies, co-operative work or ground rules for funding; division on the basis of race and ethnicity; over-concentration in some urban areas; and a focus on curative rather than preventative medicine. While acknowledging the work of missions and philanthropic bodies in poor and black communities, these planners asserted that a new post war state in South Africa should acknowledge its responsibilities to all its citizens and move ahead to create needed facilities and services, drawing on the existing provincial and university connected hospitals, as well as municipal clinics and mission hospitals and centres.⁴

Earlier chapters have indicated the erratic manner in which local public health schemes developed in the 1920s and 1930s, and the inability of an institution such as the Bridgman to fulfil the lofty goals it set for itself in 1928. Clara Bridgman's attempts to initiate a comprehensive health scheme fanning out from the Bridgman into the surrounding townships and as far away as Alex, was never realized on any large scale. In the absence of political rights for the majority of South Africans, and in the face of increasing moves towards segregation and the abandonment by the state of any but piecemeal responsibility for black urban provisioning, the Bridgman was never a panacea

⁴ See: S. Marks, "The Historical Origins of National Health Services" in C. P. Owne, (ed) Towards a National Health Service: Proceedings of the NAMDA Annual Conference Johannesburg (1987); HPC/AD 843 RJ Na 9.3 and Na.11 "Evidence to the National Health Service Commission".

for more comprehensive services and institutions. With first hand experience of the wide gaps in public health service, many medical missionaries gave their support to the proposed National Health scheme in 1944 and 1945 and backed its proposals for equitable resource distribution. But both the plans, and their architects, were defeated by the end of the 1940s.

The new state, however, adopted many of the policies suggested by their briefly empowered predecessors. Except, in the new scheme, the very foundation for all health and welfare plans was to be separation on the basis of "race". Any group of people seen to disagree with this tenet of State policy were regarded with suspicion. Many missionary institutions and hospitals, already operating along segregated lines in the main, awaited their fate with bated breath. Others directly opposed new policies, and either closed after the provincial grants upon which they depended were halted, were absorbed into state hospitals, or were forced to shut because they were deemed to be operating illegally in "white areas".

Still, administrators and missionaries at institutions such as the Bridgman continued hoping that they would be spared. After all, throughout the late 1940s and until 1961, the Bridgman continued to offer the only midwifery training school for black women on any scale in the region, and it remained the only maternity hospital for black women. In 1957, after the passage of the new Nursing Act, and in the wake of the violent destruction of Sophiatown, representatives from the Bridgman Board approached the

Provincial authorities, arguing their case for continued existence.⁵ They were assured that "until" provisions were finalized for the new Maternity wing and midwifery training school at the Baragwanath Non-European Hospital on the edge of Soweto (the consolidated areas now set aside for black urban residents, an acronym for the "south western native townships") the Bridgman was under no immediate threat.⁶ By August 1961 Baragwanath had begun accepting its first probationer midwives, and had begun planning a new maternity section.

It was in this context that Hugo made his speech. Referring to the threat of the Group Areas Act and new arguments being made by Provincial health authorities that all women currently served by Bridgman could be catered for at Baragwanath on the opposite side of the city, he focused on the needs of black women who would be legally allowed to remain in the eastern and northern areas of the city as domestic workers in white homes, hotels and restaurants. The weakness of his counter-argument, in the face of such strong state machinations, provides a rather pathetic sign of the lack of resistance that liberals such as himself were able to muster at the time. He commented:

⁵ HPC/A1059 D1.4: "Minutes of the Board of Management, 1956-1965".

⁶ In 1948, the Baragwanath Hospital was opened on the site of a military hospital. Patients were moved from the old "Non-European" section of the Johannesburg Gen. and a new chapter in the history of South African medicine was opened. The Hospital was to become the biggest in the southern hemisphere and a premier research and training centre for the country. In the 1980s it was the site of great tension, taking in the greatest numbers of casualties from the daily violence and becoming a locus for progressive nurse and physician opposition to repressive state actions. See Shula Marks, "The Nursing Profession and The Paradox of Apartheid", paper presented at: Women on the Frontline, Northwestern University, June (1991).

I have been asked whether I thought that this Institution may one day have to close... I am no longer speaking as Director of Hospital Services for the Transvaal, having relinquished that post some months ago, but I can now say as an ordinary citizen that I hope that will not eventuate. I know that it will not be lack of money that will cause its closure--some people have said "But you will be having a big maternity hospital at Baragwanath"-- I can just imagine the fleet of ambulances that will have to be in operation carrying married and unmarried women having babies from the centre and thickly populated European areas of Johannesburg where female domestic labor is now employed, on their way to Baragwanath hospital...⁷

The ramifications of the opening of the Baragwanath were more severe than Hugo admitted. In 1963 the long standing Matron of the Bridgman, Mrs Perring, wrote a lengthy Memorandum to the Board, indicating that for the first time in the history of the Bridgman there were not enough women coming forward with suitable qualifications for midwifery training:

The Bridgman is still highly thought of by would-be trainees, but preference is given to Provincial Hospitals who pay their pupils higher salaries... and they are more likely to be placed in Provincial posts after qualifying.⁸

She was concerned that the Hospital would run out of qualified applicants if the new Provincial hospitals continued to attract the best probationers, and indeed the number of applicants dropped again the next year.

Midwives trained at the Bridgman in the 1930s, 1940s and 1950s, remembered the closure of the Hospital with great regret. Although all agreed that the Baragwanath was, in many respects, a good nurse training institution, they commented that the demise of the

⁷ HPC/A1059 D1.1: "Address to the Board of Management, Annual General Meeting", by H. Hugo, 16 October 1962, 3.

⁸ HPC/A1059 D1.2 "Memorandum: Report to the Board of Management on the Difficulty in Obtaining Suitable Candidates for Midwifery Training" 1963:1.

Bridgman marked the beginning of the end of a stage of professional midwifery in South Africa when its status was special and apart from general nursing.⁹ Mirriam Mokoana commented in an individual interview:

After Baragwanath, midwifery is now seen as one speciality within nursing. We still regard it as something very special, but that is not all the way through anymore.¹⁰

A woman who had experienced four birthing labors at the Bridgman, Rosina Kotane, recalled the closure of the Bridgman in the same conversation in which she recounted the destruction of her home of over a decade, Sophiatown, and the removal of her and her family to Meadowlands, Soweto :

We were cross, because it was no good, because the people was shouting and shouting. We were still living there because we were still young and we had small children, we could just walk everywhere. They take our things on the truck. Yes, it was very far away because we go to Meadowlands, we had to take a train. I don't know the year, but I hear that the Bridgman was closed. Because I was not staying there, I was staying in the farms with my Granny, when the last child was sick. I did not see the day it was closed. [CB: Did anybody say why the Bridgman was closed?] They did say "They take the Bridgman to Baragwanath, they make the hospital one, they make the Bridgman there, at Baragwanath". [CB: When you went to Baragwanath for the first time, was it the same as the Bridgman?] No, was not the same, because they got the rooms for the other sick people, and then a place for, ah what they called the Bridgman, Maternity Hospital. Well, it was nice Baragwanath also. Yes, it was just nice. But it was not the same.¹¹

The Bridgman was the most important single site for the black women of Johannesburg and indeed the Witwatersrand women for over thirty years. When it was closed many of

⁹ Interview: Group included Letta Mosikatsana, Wilhemina Madiba, Elsina Kabeni, Mirriam Mphahlane and Mirriam Mokoana, Alexandra Clinic, 6 February 1992, Transcript, 19.

¹⁰ Interview: Mirriam Mokoana, Alexandra Clinic, July 8 1992, Transcript, 5.

¹¹ Interview: Rosina Kotane, Johannesburg, November 2 1992, Transcript, 11-12.

its functions were taken over by Baragwanath, but the new hospital was no longer the "house of friendship" that Clara Bridgman had envisioned. It could no longer exist alone in mainly white suburbs, adjacent to the new residential complex called "Triomf" (or triumph) that was being constructed in the ruins of Sophiatown. Its district midwifery schemes, baby clinics, outpatients department and even its mothercraft classes, the special creation of Clara Bridgman, were forced to close down.

In 1962, just two months after Hugo's speech before the Board, the Star newspaper, which had been printing daily articles about forced removals and Group Areas relocations, commented:

Many people who have put in years of hard work to keep the Bridgman Memorial Hospital at Brixton on its feet for 34 years will one day see their efforts reduced to rubble. The decision to close the African maternity hospital because it is in a white area has caused considerable reaction in medical circles. The mission hospital subsidized by the Province is to be replaced by a new maternity hospital at Baragwanath, 12 miles away. It is understood however that the 330 bed Baragwanath hospital may not be able to offer the same extensive facilities as those available at the Bridgman. Ironically enough, Dr H. Hugo, until recently Director of Hospitals in the Transvaal, recently said about this hospital... "I hope there will be no evil. Brutus to stab this hospital to its death I hope that it will survive for many long time".¹²

After detailing the years of fund raising, and the varieties of people in Johannesburg connected to the Hospital, the article continued by stressing the loss which the closure of the Bridgman would mean for the women it served:

Yet this hospital ... which has an average of 280 admissions every month, will have to close when the Baragwanath is finished in about two years time. The Bridgman is a large hospital. Every day it has an average of 75 women and 55 children in its wards. There are seven full time doctors, 10 senior European Sisters, 17 African

¹² This, and the following two quotes are from the Star 12 December 1962.

Staff Nurses, and 60 African probationers. Last year 2, 500 babies were born in the hospital, including 65 sets of twins.

Finally the Star underlined one of the major changes in the quality of maternal health services that were already being planned by the administrators of the new Maternity Wing of Baragwanath:

In terms of the South African Nursing Council Regulations a maternity hospital must provide for a maternity patient for eight days. It is understood that the planned turnover at Baragwanath will be much quicker.

On November 7 1965 a small advertisement appeared in the Star, a few days after the Bridgman Board was given notice by the Province that the Hospital had to close and that Baragwanath had opened its maternity section. The advertizement offered the site, "with its beautiful gardens and trees", buildings and equipment for sale. Four days later a consortium of private health businesses purchased the six acre site and well maintained buildings, and began planning its transformation into the "Garden City Clinic", a private nursing home for whites which exists into the present, although since the mid 1980s it has served all patients able to afford its rates.¹³ Two weeks later, after a huge auction of furniture on the front lawn, the midwives sang a farewell song for the staff and assembled Bridgman Board. "The largest training ground for hundreds of black midwives", the site where 93 000 women came for maternity and gynaecological care, and the birthing place of over 50 000 babies, shut its doors for the last time.¹⁴

¹³ Star 7 November 1965, and see HPC/ A1059 D4 "Final Memoranda and Notices".

¹⁴ Star 22 November 1965.

Our mother, the late Letta Mosikatsana, has been a true disciple of nursing and midwifery... She was never off duty... She was a missionary for women and children's lives.¹⁵

At the funeral service for Letta Mosikatsana in 1992, held in the main Anglican Church in Alexander Township, the mourners, many of them from families whose children and children's children had been born with the help of Bridgman midwives, memorialized her for her work in words that hearken to the rhetoric articulated by Clara Bridgman and the Christian founders of the Hospital. Letta Mosikatsana was described as an exemplary mother, a woman never "off duty" in her community, as a "missionary for women and children's lives". It is clear that Clara Bridgman and her closest allies would have derived deep satisfaction from knowing that a midwife and mother trained under the auspices of their institution should have lived a life remembered in this way. It is also clear that the life and work of Letta Mosikatsana and others like her transformed the concept of "mission" in ways not anticipated by Clara Bridgman and her allies. Instead of focusing their lives on rewards offered by the slim possibilities of social mobility, a feature ascribed to many black nurses by Shula Marks and Hilda Kuper who have argued that many black nurses in South Africa after the 1960s formed part of a growing new petty bourgeois class, many of the Bridgman trained midwives were notorious for their continued involvement in

¹⁵ Tribute to Letta Mosikatsana from an Alexandra Clinic Midwife, on the occasion of her funeral; Anglican Church, Alexandra Township, May 2 1992. Notes of Speeches made by C. Burns; Copy of printed Memorial Pamphlet, 3.

community programmes and commitment to public health work.¹⁶ In the testimony of women who had given birth at the Bridgman in the 1940s, their memories of the Bridgman were juxtaposed with later biomedical and hospital experiences which they described as depersonalized and brusque.¹⁷

Perhaps this Bridgman legacy of public health and community service was a feature of the exposure of nurses and patients to the ethics of the missionary project of the Hospital. Perhaps, as Mirriam Mokoana indicated, the status of Bridgman staff as highly trained professional Midwives, women with a craft and calling as well as skill, set them apart among the growing community of black nurses. "It is something to be a Bridgman midwife!", said Mirriam Mphahlane in a tea room off the main birthing ward of Alex Clinic in 1992, a clinic where Bridgman midwives had congregated to continue the mission of "saving women's and children's lives" that they took on as their own decades before.¹⁸ Thus, the legacy of the Bridgman lived on particularly in the lives of the women who had trained there, such as Letta Mosikatsana, whose funeral orations spoke of her as one of the women were at the centre of the ambitious "dream" of building the Bridgman.

¹⁶ Shula Marks, "The Nursing Profession and The Paradox of Apartheid", paper presented at: Women on the Frontline, Northwestern University, June (1991) and see her forthcoming book; and Hilda Kuper "Nurses" in Leo Kuper An African Bourgeoisie: Race Class and Politics in South Africa (New Haven: Yale University Press, 1965).

¹⁷ See the testimony about the Bridgman and then about her treatment in other South African hospitals by Ellen Kuzwayo in Call Me Woman (San Francisco: Aunt Lute Books, 1985); and see similar statements by Ellen Mashinini in Strikes Have Followed Me all My Life (New York: Routledge, 1991) 8-9.

¹⁸ Interview: Mirriam Mphahlane, Alexandra Clinic, 19 March, 1992, Transcript, 4.

This dissertation has suggested that women in Southern Africa have been at the very centre of health and welfare efforts of the part of armies of experts and professionals, and that the health work undertaken at a site such as the Bridgman was shaped very obviously by the agendas of missionary physicians and philanthropists. It had been argued, in the chapter on "Bantu Gynaecology" that many of the claims of medical and social science articulated in the 1920 to 1960 period, are highly fallible and problematic when scrutinised today, infused as they were by very particular racialized visions, often plainly stated by individuals who employed an objectifying and gendered discourse as a matter of course, and who naturalized even relatively novel ideas about black women and their capabilities through their daily communicative acts. However the intentions and the efforts of physicians, nurses, missionaries, welfare workers and anthropologists were accompanied by genuine empathy and lives of hard labor. Nor were all of their efforts co-ordinated towards one totalizing aim, one colonial or neo-colonial project. Furthermore, very often it was the responses of ordinary people, very often black women, to the health needs of their communities ravaged by hunger, poor housing and facilities and ill-health, that secured the attention of health and mission officials.¹⁹ Throughout this dissertation it has been argued that black women's responses to biomedical therapies and technologies were vital to the building and maintenance of the Bridgman in the first place.

¹⁹ See S. Feierman, S "Struggles for Control: The Social Roots of Health and Healing in Modern Africa", African Studies Review (1985) 28 2/3.

The labors of these women, both the midwives and the mothers of the Bridgman, formed the basis for the social and physiological reproduction of twentieth century Johannesburg.

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IAD: Intermediary Archive Depot, Johannesburg; containing these Municipal collections:

JPHD: Johannesburg Public Health Department, 1904 to 1960.

WRAB: West Rand Administration Board, 1930 to 1960.

CAD: Central Archives Depot, Pretoria; which houses the following collections of State Departments for the 1915 to 1960 period:

ARB: Labour

GES: Health

GG: Governor General

JUS: Justice

MNW: Mines and Works

NAD: Native Affairs

UG: Executive Branch

VWN: Social Welfare

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5. Oral Interviews:

The following interviews were conducted and transcribed by Catherine Burns except in the case of interviews in the Transkei region, and these are additionally annotated below. The

interviews were conducted and taped between August 1990 and December 1992. All tape cassettes and transcripts in the possession of the author. Copies to be housed at the Oral History Collection, African Studies Institute, University of the Witwatersrand, Johannesburg, South Africa.

Midwives:

Interviews with women who had trained at the Bridgman Memorial Hospital from 1932 to 1960.

The first three group interviews were all held at the Alexandra Health Centre and University Clinic, in a meeting room off the Maternity Unit. Those interviewed included both retired midwives and women still actively working. Each woman was subsequently interviewed alone, in the case of Letta Mosikatsana, this occurred only once before her death. The remaining women were all interviewed at least twice more on their own, in Alexandra, Soweto, Johannesburg and Atteridgeville.

Interviews cited in the dissertation:

Interview: **Mirriam Mokoana**, Alexandra Clinic, July 8 1992.

Interview: **Wilhemina Madiba**, Alexandra Clinic, June 17 1992.

Interview: **Wilhemina Madiba**, Alexandra Township, July 2 1992.

Interview: **Letta Mosikatsana, Wilhemina Madiba, Mirriam Mokoana, Elsina Kabeni and Mirriam Mphahlane**, Alexandra Clinic, February 6 1992.

Other Interviews Cited in the Dissertation:

Family Planning Specialist and Nurse:

Interview: **Patience Tyalimpe**, Johannesburg, 22 November 1992.

University of the Witwatersrand Medical School Archivist and Librarian:

Interview: **Mary Lucas**, Johannesburg, 6 September 1990.

Office Service and Cleaning Worker:

Interview: **Rosina Kotane**, Johannesburg, 2 November 1992.

Black Sash Legal Advice Centre Advisor, (retired): Used Bridgman Memorial Hospital Records to fight cases on behalf of women ordered to leave the city under Group Areas Acts:

Interview: **Bulah Rollnick**, Johannesburg, 22 October, 1992.

Community Worker and Social Activist:

Interview: **Clare Rheinnalt Jones**, February 14 1992; May 11 1992; August 12 1992.

Physician and Health Administrator:

Interview: **Ruth Drubin**, Johannesburg, 4 November 1992.

Physician, and Specialists Gynaecologist and Obstetrician:

Interview: **Geoffrey Charlewood**, January 13 1992, March 8 1992, December 9 1992.

Herbalist and Community Midwife:

Interview: **Mamtolo Dubazana**, Isiyaya, 22 August 1992. My thanks to Nokhatazeka Mzayifani for her assistance with translating during this interview and to Nontobeko Luggola for producing the translated transcript of the cassette tapes.

Agriculturist and Rural Homesteader:

Interview: **Nora Mdlamza**, Isiyaya, 17 October 1992. My thanks to Nokhatazeka Mzayifani for her assistance with translating during this interview and to Nontobeko Luggola for producing the translated transcript of the cassette tapes.

