Towards a History of Hospitalised Childbirth in South Africa: A Case Study.

Introduction

By 1960 women of *all* backgrounds in South Africa gave birth in hospital settings and relied upon some aspect of biomedical structuring of their reproductive capacities and practices to a greater degree than any people living anywhere else on this continent. By 1989 women in South Africa were more likely to give birth in high tech hospital settings, with doctors rather than professional midwives managing their labour, and they were more likely to experience birth through a cesarean section than any other group of women in the world. South African children continued to suffer high infant and maternal mortality and morbidity rates into the 1980s, and then in the 1990s maternal and infant mortality again shot up the scales as the ravages of HIV and related illnesses took hold over pregnant, lactating, and sexually active women. South African women were the first to receive *en masse* a hormonal contraceptive banned for use in most countries of the world until modifications in treatment and administration had been radically modified, namely Depo Pravera. African women in South Africa trained in biomedical midwifery and nursing formed the largest cadre of professional women on the continent (over 300 000 in 1998), finding ready employment outside of South Africa in large numbers after political change opened world opportunities to them in 1990s. By the late 20th century South Africa's medical schools produced some of the world's most renowned specialists in obstetrics and gynaecology. In 2001 women in South Africa, facing the worlds highest infection rates of HIV/AIDS, are even more likely (75% of c-section rate in several hospitals) to experience biomedical birthing interventions at their fullest. Lactation has become a major source of infant HIV/AIDs infection, creating a crisis in childhood mortality and morbidity not seen in the history of this region, with huge implications for motherhood and its meanings and practices. The country faces a crisis in the practices and definitions of healthy sexuality and contraceptive as well as abortion practices and ideologies. The biomedical professions struggle to make substantial interventions at a time when its ascendancy is as high as in any other industrial country in the world and tunes in for the first time in any sustained fashion to the work of historians, anthropologists and sociologists of science, sexuality, women's health, and the intertwinings of gender identity and lived experience.

The pages you are about to read form my initial plan of a Chapter for book I am writing based on my PhD dissertation *Reproductive Labors: The Politics of Women's Health in South Africa from 1900 to 1960*[1].

The overall aim of this work will be to write a critical history of the emergence and significance of medicalised reproduction in South Africa from the 1850s colonial period into the early Apartheid era of the 1950s. The book will suggest that nowhere else in Africa, and with few counterparts in the rest of the Southern hemisphere, medicalised reproduction has been a singular feature of modernity with specific ramifications for the lives and practices of women. As this is a vast subject and no single work could provide detailed evidence for the entire region south of the Limpopo, the book begins with broader chapters drawing out patterns and arguments across South Africa, comparing and contrasting South African colonial and Union experiences from other African colonies, as well as white settler colonies, in the 1850 to 1950s period. The study then moves onto a case study of South Africa's single city, the largest in sub-saharan Africa, and within the city, the largest hospital designed explicitly for women in the Southern hemisphere before the 1960s: the Bridgman Memorial Hospital, located on the western edge of Johannesburg. Since this Hospital was designated one for "Non-European Women"[2] the book also takes account of differences and similarities embedded in the systems and practices of reproductive work and ideology from and for white Afrikaans and English settler women and newly arrived European women immigrants to the region in the early 20th century.

The book explores the dense tissue of practices, discourses, interventions and naturalizations around interrelated strands of medicalised reproduction. The views, decisions, choices, reactions of

[1] Note the USA spelling as in the original, Northweatern University, Evanston, Illinois 1995.
[2] At times this bracketing also included "Malay, Coloured, Indian, Lebanese and Assyrian" women.

Johannesburg's different classes and groupings of women is played against and alongside those of the armies of reproductive experts, reformers, service providers, and educators of the day. Oral histories (many based on distant memories and recall in the 1990s); early ethnographies; private letters and accounts; published medical treatise and articles; religious and church papers; material lodged in archives from religious and reforming groupings; state (local and central) papers and archives—some of them very substantial in volume and detail indeed; as well as newspapers and photographs collections; and finally and most vitally—hospital records—form the evidentiary basis of the text.

The dense tissue of medicalised reproduction is examined through in chapter divisions and their areas of focus include: contraception and population control; pregnancy and its meanings and management; breastfeeding and infant care; mothercraft and motherhood institutions; women-centred midwifery in indigenous and settler society and then the origins of professional midwifery and biomedical training around reproduction—and the statutory history of this as well as of public health regulation in general as a part of state work; and finally the emergence of South African gynaecology and obstetrics with its roots in European and North American institutions, but radically shaped by local contexts after 1930.

An insurgent argument throughout is a debate with the rich scholarship of sociologists, anthropologists and historians of science, medicine, sexuality, and women about the challenges, limits and possibilities of intertwining material, intellectual, social and representational approaches to the past and producing an imaginative, yet grounded and convincing contribution to the history of women, particularly African women, in South Africa, and to the social and intellectual history of medicine and health in the region.

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Mapping Medicalised Birth: The early years

> 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*[i]

> 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.*[3]

> I knew the Bridgman because I was working near Brixton. I could see it every day when I went passed. /.../ I did get the first child when I was 22 years old. I did not know I was pregnant. My aunt took me to the hospital, to the Bridgman., because she say, "Why are you so light in your face? I can see, maybe you are pregnant!" /.../ There I had to fill out a card, and a nurse helped me, she was a black nurse. She filled out that card. She was wearing black and white stripes, and a very white cap. But I was not scared of her, there were plenty of other women.
> *Rosina Kotane, Office Cleaner and Domestic Worker; two of her children were born at the Bridgman.*[4]

> People all knew about the Bridgman. It was well known. It had a reputation.
> *Ruth Drubin; Obstetric and Gynaecological training at the Bridgman.*[5]

> When this institution was founded the Bantu still placed their trust in the witchdoctor and

[3]Interview: Letta Mosikatsana, Alexandra Township, 6 February 1992, Transcript, 2.
[4]Interview: Rosina Kotane, Johannesburg, 2 November, 1992, Transcript, 3.
[5]Interview: Ruth Drubin, Johannesburg, 4 November 1992 , Transcript 3.

> 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: Minster of Native Affairs, former Chief Government Ethnologist*[6]

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 labour; 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 increasingly severely proscribed black women's access to material, 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 labours of black women. Publications, dissertations, surveys and the gathering of statistics were supported and enabled by the labours 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

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[6]Eiselen, W Bridgman Memorial Hospital Silver Jubilee Commemoration, 1953, Africana Library, Johannesburg, 4.

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".[7] Within this corpus of published texts, the production of a genre of heroic narratives, authored by 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,[8] while analogous studies in colonial contexts have explored the constructions of race and the violence of colonial representations more fully.[9] In her 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.[10] After recording her indebtedness to many of his insights on stereotypes and human psychology, Vaughan comments:

> 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 onto stress, 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.[11]

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

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[7]Hansen, K T Distant Companions: Servants and Employers in Zambia, (Ithaca: Cornell University, 1989), and see Fraser, N Unruly Practices (Minneapolis: University of Minnesota 1989).

[8]For example: Jordanova, L Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries, University of Wisconsin Press, 1989; Walzer Leavitt, J (ed) Women and Health in America, University of Wisconsin Press, 1984; Martin, E The Woman in the Body, Beacon Press, 1987; Moscucci, O The Science of Women: Gynaecology and Gender in England, 1800-1929, Cambridge University Press, 1993; Oakley, A The Captured Womb: A History of the Medical Care of Pregnant Women; Rabinbach, A The Human Motor , University of California Press: Berkley, 1992; Showalter, E The Female Malady, Pantheon Books, 1985; Sontag, S Illness as Metaphor, New York, 1977, amongst others.

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

[10]Vaughan refers here to: Gilman, S Difference and Pathology: Stereotypes of Sexuality, Race and Madness, Ithaca, 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: Gilman, S "Black Bodies, White Bodies: Toward an Iconography of Female Sexuality in Late Nineteenth Century Art, Medicine, and Literature." Critical Inquiry, 12, 1985

[11]Vaughan, M Curing Their Ills: Colonial Power and African Illness, Stanford University Press, 1991, p 3 and 4

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 vital 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 knowledge and analyses of the revolutions in thought and practice which have reshaped human society since the Enlightenment.[12] 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 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 woven into 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.[13] By the early 1940s, a mosaic of positions had emerged, spurred on by the hot-house of 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.[14] But the competing visions of public health in the 1940s were barely hinted at in 1910.

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 labour. 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 labour and gynaecological history in South Africa, a history connected to industrial labour and migrancy but also distinct from the direct control

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[12]See especially Foucault, M The Birth of the Clinic: An Archaeology of Medical Perception, Tavistock: London (Translated edition), 1973; The Archaeology of Knowledge, Tavistock: London, (Translated edition), 1972; The History of Sexuality: An Introduction, Pelican:Harmmonsworth, 1981

[13]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.

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

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 labourers 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 cliched, 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 labour, 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.[15]

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 and kin, community and herbal medical treatments and systems.[16]

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[15]This "measure of dignity" is intended to stand as a qualified statement: some 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.

[16]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 cesearean section techniques; dramatic inventions in suction and aspiration devices for women with difficult labours, 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 their impact on other registers of human experience, for example, the easing or not of physical pain and mental anxiety and to appraise 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 the USA, 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.[17] 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 "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 outcomes were feared and predicted by white missionaries, anthropologists and other experts, 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

[17]Here the work of Elsabe Brink is key. See "Man-made women: Gender, class and the ideology of the *volksmoeder*" in Walker, C (ed) Women and Gender in Southern Africa to 1945, David Philip: Cape Town, 1990. We shall return to this theme below. See also Marijke du Toit's reworked manuscript for her book based on her Uct PhD … title…

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.[18] 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 objectified the vast epistemological disjunctures between these different practices and theories of healing.[19] 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*[20], who practised in both rural areas and in Johannesburg, and cities and towns along the Rand, and indeed in the rural reserves as well.[21] In order to address this terrain, a discussion of women healers, midwives, fertility specialists and entrepreneurial chemists.[22]

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 labour 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

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[18]Interview: Rosina Kotane, Johannesburg, November 2 1992

[19]See references to these romantic visions of indigenous healing systems in the Lousia Mvemve chapter.

[20]IsiXhosa, isiZulu and seSotho words for "healer" and "doctor".

[21] and the municipalities and settlements to the east and west of it, is located.

[22]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.

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 Medicalised 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 ...[23]

In his work on the history of Bubonic Plague and urban segregationist policies in the decade after the South African War of 1899-1902[24]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 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".[25] 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.[26]

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 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.[27] 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

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[23]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.

[24]Until recently this war was referred to as the "Anglo Boer War" or the "Boer War". Several historian 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.

[25]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.

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

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

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 two Boer Republics of the interior, health authorities and sanitation committees were formed, especially 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 year 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 laws[28]

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.[29] 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 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 labour 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.[30] 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.[31] In a series of 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

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

[29]White, L The Comforts of Home: Prostitution in Colonial Nairobi, University of Chicago Press, 1990

[30]Jochelson, K "Patterns of Syphilis in South Africa, 1880-1940", South African Research Seminar, Oxford, 1989

[31]See for example: Eales, K "'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

the status of black women in Johannesburg.[32] 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 labour" 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.

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 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.[33]

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.[34] Umbilically tied to imperial expansion; wars of conquest and rebellion, land 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

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

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

[34]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. 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 to 1945 (Cape Town: David Philip, 1990).

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 seldom 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.[35]

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 reply mainly on indirect controls, in the form of a reinforced patriarchal tradition, to achieve this.[36]

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 labour, 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 labour with the labour 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

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[35]Bozzoli, B "Marxism, Feminism, and South African Studies", Journal of Southern African Studies, 9, 2, 1983, p 151

[36]Walker, C "Gender and the development of the migrant labour system" in Walker, C (ed) Women and Gender, p 186

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 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.[37] 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 labour 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".[38]
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:
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.[39] 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 is 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.[40]

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 permanently. The literature supporting this observation is formidable: missionary, sociological, anthropological and official surveys and inquiries from around 1911 through the early

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[37]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).

[38]Star, 17 October, 1923 and see NTS 7601 9/328.

[39]Rand Daily Mail, 14, July, 1924

[40]Star, 19 August, 1923

1940s, proffered evidence that women's moves to the city were more permanent than many men's, and advanced reasons for this.[41]

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.[42] 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 and the 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 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.[43] 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...

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

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

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

[43] The starkest examples of this pattern have been drawn for Basutoland, (Lesotho). See the work of Bonner, P "'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; Kimble, J "'Runaway Wives': Basotho Women, Chiefs, and the Colonial State, c. 1890-1920", Women in Africa Seminar, (School of Oriental and African Studies, June 1983). Murray, C Families Divided, Cambridge University Press, 1981. For the Transkei and Eastern Cape see Mayer, P and I Mayer Townsmen or Tribesmen, (Oxford University Press, 1974)

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.[44] 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.[45] 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.[46] Black women numbered less than 10, 000 in 1910, but by 1928, the year that the Bridgman opened, official statistics recognized just under 30, 000 women.[47] The same city records recorded the presence of 120, 000 white women by 1928, almost the same figure as white males.[48] 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-[49]1931) 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 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 USA. 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

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[44]Union Statistics For Fifty Years, (Bureau of Statistics: Pretoria, 1961)

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

[46]Unterhalter, B "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, p 618)

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

[48]Brink, E "The Afrikaner Women of the Garment Workers Union, 1918-939" (M.A. University of the Witwatersrand, 1986, p 191)

[49]Bonner, P "'Desirable or undesirable Basotho women?'" in Walker, C (ed) Women and Gender, (p 230)

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 statues concerning midwifery registration and training, as well as the implementation of labour 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.