

WOMEN AND HEALTH IN SOUTH AFRICA

Shula Marks and Neil Andersson

En Afrique du Sud, l'oppression des femmes a croisé le chemin suivi par l'industrialisation et le racisme dans la région. Ceci a produit certains dangers psychologiques et physiques pour les femmes. Quoique, à l'origine, les femmes blanches ressentaient le poids du développement industriel de l'Afrique du Sud, se sont les femmes africaines qui souffrent de plus en plus, à mesure que l'agriculture des noirs décline et que le système de la main d'oeuvre saisonnière mine la famille noire.

Pour les femmes noires, les grossesses sont risquées en l'absence de sécurité d'emploi ou de congés de maternité. Les tentatives de résoudre les problèmes d'indigence, au moyen de la planification familiale, n'ont souvent servi qu'à augmenter les pressions sur les femmes noires en Afrique du Sud, où l'avortement demeure en grande partie illégal. Malgré l'immensité des épreuves confrontant les femmes noires en Afrique du Sud, elles continuent de mener une lutte pour leur survie.

If the pervasive destructiveness of apartheid has a point of fine focus, it is women's health. As workers, black women are the most exploited of the workforce. As citizens, they have the least rights, being bound not only by apartheid legislation and practices but also by the oppressive traditions that are fostered by the government. The pivotal role of women in households makes child care, management of scarce resources, shortages of food, fuel and shelter all immediate and personal burdens. Yet women are not simply victims of apartheid. Through collective coping strategies, women may also provide the basis for future social transformations. Women produce or purchase food, they determine infant feeding practices, and

they usually have a controlling hand in household hygiene. Women make up the majority of traditional healers and certainly the majority of hospital workers.

It is widely recognised by sociologists of medicine that disease patterns cannot be separated from social, economic or political power, while health care systems form part and parcel of the totality of social and productive relations, and 'mirror' society's class structure. Much disease is socially produced, while resource allocation for health needs is dependent on forms of class domination and class alliance. Yet disease patterns and conflicts over the allocation of health resources are not simply a reflection of class society. Age and gender are reflected in a variety of ways, both in disease and mortality patterns and within the health apparatus and in the allocation of health resources.

The health needs of women cannot be deduced simply either from class relationships or their specific reproductive role, but have to be related also to their roles in the political economy and the division of labour in the family, gender relations and patriarchal forms of dominance. There

can be little doubt that specific forms of female oppression exist for women of all racial groups in South Africa and, like other forms of subordination, have specific health effects in, for example, maternal mortality, VD and rape, or the differential toll taken by diseases of poverty.

Quite apart from the specific health needs associated with the biological reproductive role which women have, in South Africa the oppression of women has intersected with the path that industrialization (for which the short-hand term is apartheid) has taken in the region. This has produced particular psychological and physical conditions for women.

In South Africa, women's political participation is overridingly determined, like men's, by the colour of their skins. This in turn has its ramifications in legislation, family policy, education and employment opportunities. There are in addition specific/different forms of gender oppression within each group, which are reinforced by the overarching 'patriarchy' of the South African state. On all social indicators the differences between these racially defined groups is stark, with 24

Women

constitute **half** the world's
population,

perform nearly **two-thirds**

of its work hours,

receive **one-tenth** of the world's income

and own less than **one-hundredth**

of the world's property.

United Nations Report, 1980



Winnie Mandela

Credit: International Defence and Aid (London)

million Africans at the bottom, 4.8 million whites at the top, and some 3.5 million Asians and 'Coloureds' occupying an intermediate position.

South Africa's contemporary health pattern is rooted in the social changes which began with the discovery of minerals in the first third of the nineteenth century: diamonds in Kimberley in 1868, vast seams of gold at very deep levels underground on the Witwatersrand in 1886. The industrial and agrarian revolution that followed the development of the mining industry, the new concentrations of population on the mines and in the rapidly developing towns, the special hazards of mining operations, and the growing impoverishment of the countryside were all to have swift and devastating implications for the health of workers, both black and white.

The first to feel the impact were migrant men and white women. The effects on men, both white and black, were dramatic, although in the long run the toll paid by black men was far higher. To some extent the majority of African women were temporarily sheltered from the effects of industrialization because of access to agricultural production. Unlike African women, however, white Afrikaner women rarely played the same role in agriculture: they were employed in childrearing and domestic work around the farm. The commercialization of agriculture – and especially the tremendous increase in the value of land which came with the mineral discoveries in the last third of the century – had a significant impact on these women, who were the first to be pushed off the land and into the

towns in search of employment.

By the 1920s increased white rural impoverishment meant that large numbers of Afrikaner women were being forced into factory employment, often under highly exploitative conditions. By the 1930s they dominated in the garment, sweet-making, confectionary and textile industries, which were traditionally associated with women's labour in European society and thus regarded as peculiarly 'suitable for white women.' Impoverished Afrikaner women forced to seek work in the cities were taken on as semi-skilled operatives at very low wages, often undercutting and deskilling the jobs of white men. The view that women's place was in the home and that even women workers were partly supported by male earnings, justified their being paid very low wages – between one-half and one-third of those of male workers. The health implications were profound. White women did not initially receive unemployment or sickness benefits, and were reluctant to take time off work to attend to their own illnesses, so that ill-health was compounded. Some unions provided their own benefits, but funds were limited and, by and large until just before World War II, health and welfare were left to the Dutch Reform Church and the Afrikaner National Party. After that time, the health problems of white women, in contrast to black, became increasingly the concern of the state. In time, white women were themselves to be ousted from the production line by proletarianised black – first Colored¹ and then African – women, who entered the cities in increasing numbers from the 1940s.

An eye-witness recorded the impact of proletarianisation and urbanization on white women in the Transvaal in the 1930s:

The most saddening stories are those one hears at the Mothers' Clinics in the large towns where these women come for relief, for the lactogen to feed their recurrent babies and the free meals that the municipality provides. A women of twenty-six with nine children, four alive; one of twenty-one with three children and carrying a fourth; one of thirty-two who had endured twelve pregnancies – these are among the supplicants seen recently at one of the Clinics. There is a movement, fostered by the women themselves, to introduce birth control, but the Church frowns at it . . . and the mere suggestion that it should be applied is as yet regarded as an affront and an insult.²

At least until the 1940s medical services for white women were poor. A general practitioner in the countryside at the time wrote of the "astounding" number of men who "have been or are widowers" and claimed that the maternal mortality as a result of "sheer preventable ignorance" was two percent of all childbirths in many rural areas:

Obstetrics in the country districts is today a crying disgrace . . . The Government has it in its power to put a stop to the terrible toll of women's lives, if it could be induced to divert its attention for one brief moment from a consideration of locusts, veterinary diseases, boll weevil and foot-and-mouth disease.³

Economic change and, in particular, the transformation of the position of 'poor whites' through the expansion of secondary industry and the movement of white women into white collar employment meant that in the 1940s the position of white women also improved dramatically. Not only were they able to earn better wages, but they also had access to medical and welfare facilities, many of them for the first time.

Thus, the registered white maternal mortality in the Union as a whole between the 1920s and 1937 was between 4 and 6 per thousand, with no systematic decrease. This was considered high: in early Victorian England, the rate was 6 per thousand, though this is possibly a considerable underestimate given the nature of registration procedures. In 1935 the regulations governing unqualified midwives were tightened up and the problem of white maternal mortality received increasing attention just as the improvement in the economy made welfare for whites a possibility. In 1938 the white maternal mortality rate dropped below the 4 mark for the first time, and saw a steady decline thereafter, with the most marked advances being made in the war years with the development and widespread use of antibiotics.

The decline in maternal mortality for whites was not matched by an equal decline for women in other population groups in South Africa, although it is difficult to know the precise situation for black women as there is no statistical data for maternal mortality amongst Africans. Amongst Asians and Coloureds, the rates of maternal mortality in the 1940s were not dissimilar to those of white women in the 1930s. The files of the Department of

Health suggest a fatalistic attitude in the face of abundant evidence of the unhygienic and dangerous conditions in which many black women were forced to give birth, quite unlike their solicitous enquiries into every case of puerperal sepsis amongst whites. Although doctors had to report all cases of puerperal sepsis to the Department of Health, relatively few of the cases of maternal mortality amongst urban Africans would have come to their attention, and virtually none in the countryside.

Whereas in the inter-war years Afrikaner women were increasingly drawn into the urban workforce, 'African' women were left alone in the 'reserves' (the 13 per cent of the land in South Africa set aside for African occupation) to reproduce and subsidise the welfare needs of the migrant labour force. This was not a painless process. The division of labour within the family was changed, increasing women's workload and giving rise to new forms of stress and ill-health. Although it was the men who first experienced the brunt of South Africa's mineral revolution, increasingly the burden of disease was felt amongst the women in the rural areas. Paradoxically, as the mining industry began to improve conditions for men in the compounds, providing a more balanced diet and up-to-date hospital facilities, so the ravages of TB and VD took their toll in the countryside.

For African women the decline of agriculture in the reserves was particularly grim. From about the 1920s (though the process was chronologically uneven), people who had been able to produce an adequate subsistence and a surplus for the colonial markets, were now having to purchase their food. By the early 1930s, falling yields, scarce resources and a heavy dependence on labour migration, were almost universally evident in the reserves.

By the late 1930s, when 40 per cent of their mine labour force came from the reserves of the Eastern Cape, the Chamber of Mines was sufficiently alarmed by the evidence of rural decline to send its own nutrition survey to the region. It was paralleled by a Department of Health Survey. Their findings were uniformly pessimistic: 25 per cent of children in the 'Territories' died during their first year, 33 per cent before reaching two years, and about 50 per cent before reaching eighteen. Deficiency diseases



*Lilian Ngoyi, ANC activist (died in 1980, while still under a five year ban)
Credit: International Defence and Aid (London)*

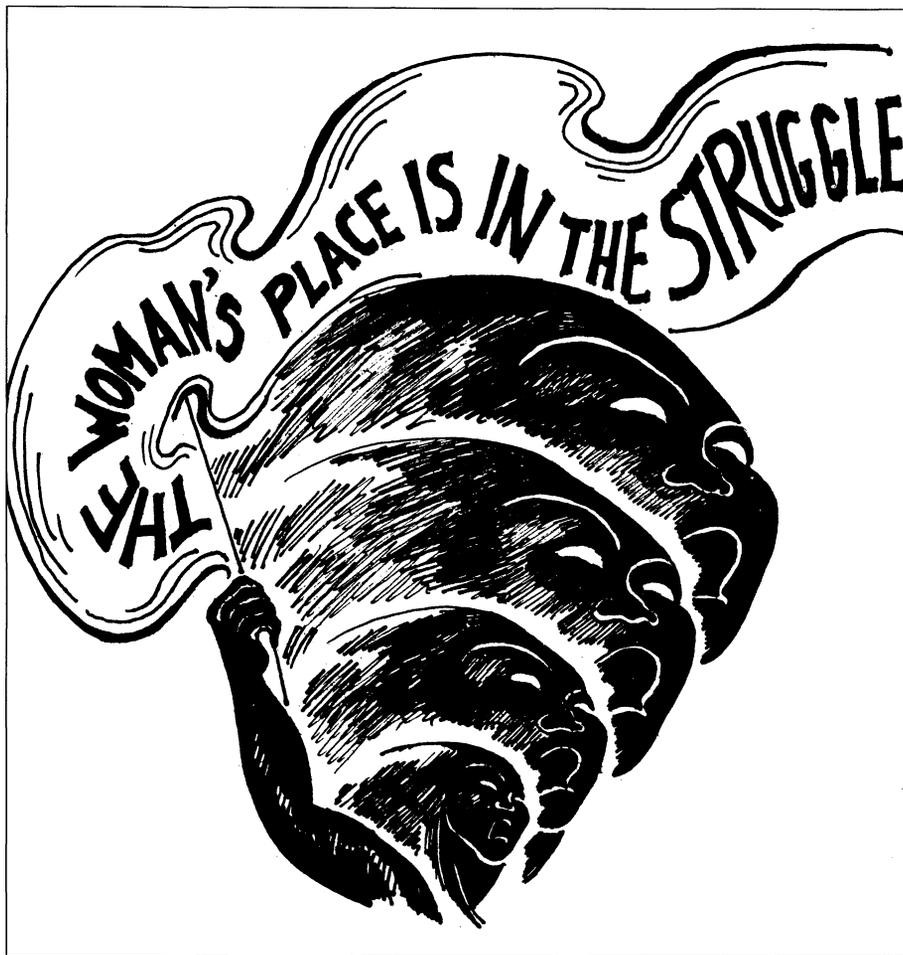
were not uncommon amongst small children. The impact on women responsible for nourishing and nurturing children is immeasurable. Conditions in the urban areas were as deplorable, with very high rates of infant mortality, tuberculosis and malnutrition reported from every city.

In the post-war years the deleterious effects of migrant labour on the lives of women and children intensified under the impact of the Nationalist government's apartheid policies. One of the main casualties has been the black family. The impact of the migrant labour system, influx control and resettlement on physical well-being has been profound. The psychological stresses have been no less disruptive. A detailed recent assessment of the effects of migrant labour on the rural periphery of South Africa has pointed out that virtually every adult male in the Bantustans is faced with the contradiction that "his absence is a condition of his family's survival.⁴ But his absence also undermines the conjugal stability from which his family derives its identity."⁵

Since the 1940s postponed and broken marriages and the distorted sex ratios in the rural areas have led to a high proportion of children being born outside of marriage. The lengthy absence of hus-

bands and fathers creates problems in the socialisation of children and leads to high rates of widowhood. Without men around, women have to take care of the day-to-day management of the household, but often they have very little control over the necessary resources. With their dependence on the erratically remitted earnings of their husbands, they suffer constant anxiety and insecurity. There is frequently a disjuncture between the economic power and overall authority which the husband expects to exert and the daily demands and responsibility for rearing the family which the women have to carry alone. A woman whose husband was a migrant worker in Cape Town put it graphically in an interview in 1978:

Marriage is not worthwhile for us black women. It traps us. Men are having it all right in town with their girl friends and the money, while we must keep home on empty pockets and empty promises. We feel deserted. We feel lonely in this desolate place where so many of our husbands must leave to find work, and stay away all year, sometimes many years . . . I do not hear from my husbands for many months. The money has stopped coming, even when I cry for it, it does not come. My children are hungry. I am hungry. No food. No money.⁶



Credit: Gabriela (Philippines)

Migrant labour earnings account for between 70 and 80 percent of household income in the Bantustans and only those who send out adult wage-earners can survive. This system breaks up the family and ensures continued low wages in the urban areas. Initially, low wages were rationalized by the employers on the grounds that they were supplemented by the subsistence production of women in the reserves. This is clearly not true any more and has not been so for several decades since the Bantustans are heavily overpopulated in relation to their food production. The large numbers of workers thus available sustains the low wages in the urban areas and on the white-owned farms. Moreover, the constant absence of the majority of able-bodied men from the countryside has further decreased the already low agricultural output in the Bantustans.

The migrant labour system has also led to a very high percentage of births to single mothers. A study in the Ciskei emphasized how this disruption of family relationships promotes malnutrition and

puts thousands of children at risk. In both urban and rural groups studies, 60 per cent of malnourished children were born of single mothers, whereas 80 percent of well-nourished children were born to married mothers. It is a popular misconception that in the case of unmarried mothers the traditional extended family can still automatically care for the child. As one observer pointed out:

The fabled extended family now usually consists of one old woman on a hut on a hill, too decrepit to work, who is forced to carry on the back breaking struggle of caring for small children. If granny sickens or dies, the children must go to even more unsuitable relatives.⁷

These realities lie behind the increasing number of women making their way into the urban areas, where by the late 1930s the expansion of manufacturing created a new demand for semi-skilled operatives. Since World War II, the numbers of African women entering the urban labour force have climbed dramatically. In 1946 only 2 per cent of African women employed outside agriculture were in the

industrial labour force; by 1970, this had risen to 10 per cent. Between 1973 and 1981 the proportion of women in the black workforce increased from 14 to 22 per cent. The vast majority of women were and are still employed in the service sector (mostly as domestic servants) and as farm workers: in 1970 85,000 black women were employed in factories, with twenty times this number working on white farms and as domestic servants. Increasingly African women in towns are having to face the problems of being poorly paid workers with a double shift and are the targets of resentment from men that they are breaking traditional roles; they are also subject to the relentless violence of town life under apartheid.

A widely held belief among white South Africans is that if the black population growth were slowed down, under-nutrition would not be so widespread and resources could be used more effectively. This is, however, the view of a particular interest group. Resources are concentrated at present in the hands of small groups of people, and it is these who would benefit most from a decrease in population growth. When too many impoverished people have to subsist off too little, strain is put on the system from which the minority benefit. For these, the logical way of easing the strain is to slow down the population growth of the majority.

Immediately after a series of major strikes in 1973, and as the problems of black unemployment began to impinge on white consciousness, the state launched a massive family programme: "At clinics, in adverts, even at work, Africans are told 'A small family for a big future' - while whites are encouraged to have large families for the Republic."⁸ By 1978 the Health Department boasted that its family planning programme was the eighth biggest in the world, and when population size was taken into account, it was surpassed only by China. Over the next five years expenditure on family planning increased three-fold. In 1983-84 approximately 6 Rand (equivalent at that time to c.\$6) was allocated for every woman aged 15 to 45 years. At that time the total health budget for the Bantustans of Transkei, Ciskei, Bophutatswana and Venda amounted to 24 Rand per person.

The state emphasis on family planning is a predictable 'solution' which leaves the situation unchanged. The widespread

availability of contraception is undoubtedly beneficial where it increases the control people have over their own destinies. But in South Africa the majority of blacks hardly have control over their daily food – let alone their destinies.

For many black women at work pregnancy is a nightmare. A high premium is set up on having many children who are still seen as a security for the future. At the same time, there is no statutory provision for maternity leave for black women, few if any maternity benefits, and no right to reemployment. A major preoccupation of employers is to avoid engaging potential mothers. A family planning poster aimed at employers explained the benefits of advocating birth control:

The establishment of a stable and productive workforce to increase overall profitability; the stabilising effect it has on the economy of the country resulting in bigger investment possibilities for overseas investors; without planning the service period of women is often interrupted due to unplanned pregnancy; . . . the costs relating to the recruitment and retraining of workers can be drastically decreased.

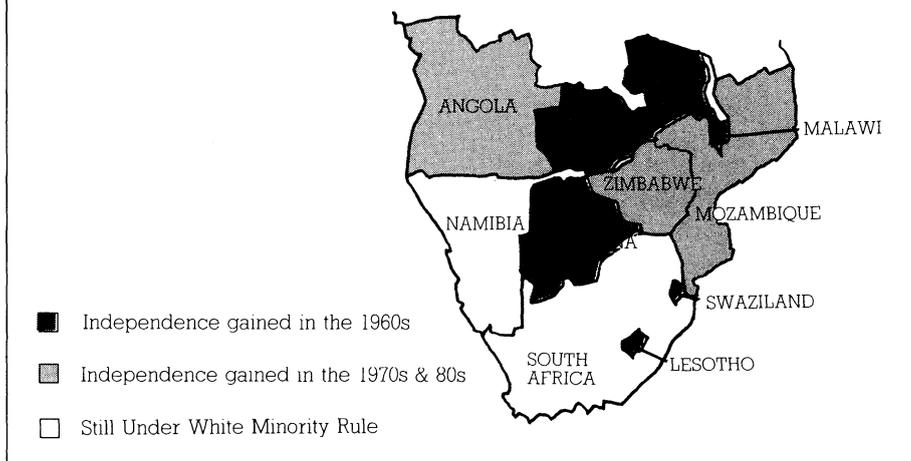
The employers were not slow in taking up the initiative to the extent that the bulk of activities in many factory clinics is family planning.

For those blacks who are interested in family planning the options are limited. Certain methods like progesterone depot injections, which are considered unsuitable and even banned in some western countries, are the only methods available to black women in some areas. According to local official data, 80 per cent of white women use oral contraceptives, whereas 70 per cent and 50 per cent of Africans and Coloured respectively are given progesterone depot injections.

Maternal mortality not only reflects the level of health care available for childbirth and pregnancy, but also the anti-abortion laws. These forbid the ending of pregnancy, irrespective of the woman's wishes. Women who want control over their lives have to appeal for abortion on medical or psychiatric grounds, after which the decision is out of their hands, or risk illegal abortion. In the country as a whole in the first eleven months of 1980, according to official statistics (which are undoubtedly an underestimate) the number of septic abortions treated were: white 124; coloured 312; Asian 144; and African 1060. During the same time period

SOUTHERN AFRICA TODAY

Showing changes with independence



the number of legal abortions were: white 304; coloured 82; Asian 8; and African 51. Two years later, in 1982-83, the numbers of legal abortions increased for whites and Asians (359 and 72 respectively), but decreased for coloureds and Africans (18 and 25 respectively).⁹

The risks from illegal abortions are only one aspect of the state induced violence against blacks in South Africa. Arbitrary arrests and detentions, floggings and torture, shootings, political assassinations and executions are the state's contribution to the climate of violence. Blacks – and especially black women – do not suffer only from the violence of the state, however; apartheid breeds anti-social and criminal behaviour, which manifests as drunkenness, robbery, assault, rape and murder. The deliberate manipulation by the state of ethnic identity has exacerbated the tensions between people already forced to compete along ethnic lines for scarce resources. All these forms of violence impinge directly on the lives of women. In 1983 over 15,000 rapes were reported; the actual incidence was probably far higher.

Despite the enormous hardships faced by black women in South Africa they have not simply become victims of apartheid. In the churches, in community self-help groups and, more recently, in the trade unions, women have struggled for survival and have shown quite remarkable resilience. It would be wrong, however, to underestimate the price paid, or the problems that will confront an independent South Africa.

¹The official term for the people, mainly in the Western Cape, who were the first to come into contact with the settlers and were South Africa's first proletariat.

²Louis C. Leipoldt, *Bushveld Doctor* (London: Jonathan Cape, 1937), p.307.

³Isidore Frack, *A South African Doctor Looks Backwards – and Forward* (South Africa: Central News Agency Ltd., 1943), pp. 29-30.

⁴In the 1950s the former 'reserves' came to be known euphemistically as 'Bantu homelands' or 'Bantustans' as the government developed its policies of granting 'independence' to collaborating groups in these areas.

⁵Colin Murray, "Migrant Labour and Changing Family Structure in the Rural Periphery of Southern Africa," *Journal of Southern African Studies*, Vol. 6, No. 2 (April, 1980), p.150.

⁶Interviewed in *South African Outlook* (May, 1978).

⁷Trudi Thomas, *Their Doctor Speaks* (Cape Town: Kegan Paul, 1973).

⁸Catholic Institute for International Relations, *Vukani Makhosikazi South African Women Speak* (London: CIIR, 1985), p. 169.

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