

## **Controlling Birth: Johannesburg, 1920-1960**

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Yes, I knew about something which is like contraception. I had a boyfriend ... but there were strict rules of keeping yourself a virgin in the community ... Well, when we met with these girls who came straight from Johannesburg, well, they fell pregnant. They did this, and we knew it was because they were not doing the right thing that a girl should do. We, from the rural areas, we also had boyfriends, but it was not sexual intercourse. It was *interfemoral*, that is, in-between the thighs. We call it *ukusoma* in Zulu and it is *ukumetsha* in Xhosa ... No intercourse though. No penetration. The two, even the man, well the responsibility was not for the woman alone.<sup>1</sup>

[Sex before marriage in Johannesburg] is equally rife in all classes but ... the better classes are able to protect themselves from the consequences ... [what is to blame] is the new idea in psychology that sex is a natural appetite and should not be restrained.<sup>2</sup>

... European girls and boys of sixteen upwards are ... living together using preventatives and waiting to marry until they have the means. In Johannesburg ... there is an increasing unrest and experimentation in the realm of sex, by both married and unmarried women.<sup>3</sup>

The proprietor of one of the chemist shops in the Western area informed the writer that he encouraged the use of birth control methods for parents of large families. The trade is growing ... A medical man with wide Native practice in Johannesburg stated that many Native women were making use of devices on his recommendation and under his instruction ... Several herbalists and informants declared that herbalists and witch-doctors furnish powders for douches and for internal use. Doctors in charge of location clinics report that women are increasingly asking for information regarding contraceptives and confess having used them.<sup>4</sup>

1. Interview, Patience Tyalimpe, Johannesburg, 22 Nov. 1992 (interview conducted and transcribed by author).
2. Dr Mary Gordon, cited by L.F. Freed to support his own point, in *The Problem of European Prostitution in Johannesburg: A Sociological Survey* (Cape Town, 1949), 316.
3. Gordon's evidence to 'Social Hygiene Committee', 9 June 1926: University of the Witwatersrand, Historical Papers Collection (hereafter HPC), South African Institute of Race Relations Collection, AD 834, my emphasis.
4. R.E. Phillips, *The Bantu in the City: A Study of Cultural Adjustment on the Witwatersrand* (Lovedale, 1938), Section titled 'Health', 131-2.

It seems to the Department that there might be a need in Johannesburg for the development of an Outpatient Gynaecological Clinic where mothers needing advice on physical health matters, both of nature and nurture might be assisted. Under all circumstances the Minister would depreciate the establishment of a clinic having as its sole object the advocacy of artificial contraception ...<sup>5</sup>

### Sex in the City of Johannesburg

The history of individual women and men's attempts to prevent or stimulate the conception of children is one of the most powerful themes in our common humanity. Unravelling this urge, dream, nightmare, duty, fate (shifting with time, place and point of view) from the coils of human sexuality goes to the heart of the study of society and history itself. The study of conception and contraception is bound to the exigencies of money, food, power, war, and death. The demographic patterns that have emerged from the intimacies and individualities making up aggregates of human fertility rates – the amalgamation of millions of moments of conscious and subconscious planning of reproductive lives – is as crucial to the Wealth of Nations at the start of the new millennium as it was in the life and times of Malthus, Smith, Marx, Sanger, and Stopes.

State, civic, and professional leaders in South Africa in the last century who were particularly concerned with sex, conception, birth control and maternal and child health – such as Clara Bridgman, Peter Laidler, Charlotte Maxeke, Hope Trant, Edward Thornton and Alfred Xuma – were well acquainted with the international eugenic and biomedical literature, as well as the contending feminist and religious debates concerning these issues. Social pathologies of every kind were seen to flourish in the rapidly expanding city of Johannesburg, established in the 1880s on the basis of mineral extraction. Accounts as diverse as newspapers in African languages, oral evidence collected at the time and in the mid twentieth century, academic studies, photographic albums, court cases and police records, as well as works of fiction, theatrical and artistic representations all evoke a remarkably similar vision of Johannesburg as the century opened. Into this rough and gritty urban space men greatly outnumbered women until rural poverty pressed greater numbers of women into the city during the Depression of the 1930s. Johannesburg gradually evolved from a tin-and-tent city of men, a place of passing people and economic enrichment or survival, to a city of households and generations.<sup>6</sup> The broad historiography of the city's growth is well developed and

5. Central Archives Depot (hereafter CAD), GES 2281 85/38 Deel 1, E. Thornton, Acting Secretary for Public Health, reply to 'Race Welfare Society', 27 Feb. 1931.
6. See, for example, S. Plaatjie, *Native Life in South Africa* (London: 1916; Johannesburg, 1985); C. van Onselen, *Studies in the Social and Economic History of the Witwatersrand, Vol 1 and Vol 11* (Johannesburg, 1982); C. van Onselen, *The Small Matter of a Horse* (Johannesburg, 1984); and the testimony of Katie Makanya in M. McCord, ed., *The Calling of Katie Makanya* (Cape

well cited, revolutionised by the work of radical historians in the 1970s and 1980s. In the work of this school of 'revisionist historians' (that nomenclature has its own history) the links between the history of Johannesburg and the industrial region surrounding it (the Witwatersrand), as well as the rural hinterlands that fed men, money and later women into the city, were closely examined in relation to the history and existence of the nation state, South Africa. At issue was the impact and nature of the mining industry; the emerging classes and new forms of household and community and lines of conflict; the role and nature of the segregationist state that emerged after the South African War (or 'Anglo Boer', in an older parlance) of 1899-1902; and links between these and the metropoli – particularly that of London, but also of New York.

The historiography of the rise and fall of the apartheid state, the history of the state after the end of the Second World War, is as complex. And Johannesburg plays a central role in this too. In this article these points are crucial. Johannesburg was, by the opening decades of the twentieth century, the region's most populous city, the new Union state's economic hub, and the city with the greatest number of women (African women; settler women – of old and new migrations; women of mixed background; and sojourning women, who would stop and move on). While older labour patterns and legal structures, banking and urban forms of commerce and culture, universities, legal bars and professional academies in the Cape and Durban still dominated, the centrality and power of the Johannesburg Stock Exchange proved a magnet. Soon the social, productive, cultural, scientific (including biomedical), political, juridical, exegetical and reproductive innovations and applications in this city were felt in every corner of South Africa.

While many fine chapters, articles and dissertations on women in Johannesburg (and the links between these women and women in the rest of the region) exist, there is no single monograph on their presence in this city (or the other cities of the region), or their role in the shaping of modern South Africa.<sup>7</sup> And yet in work on the themes that interest me in this paper (birth, sex, health, medicine and particularly contraception), women in Johannesburg have been seen as the centre of state policy regarding women in the country as a whole. A good example of this is the published work on population control and eugenics: state-sponsored programmes designed to increase the fertility rates of white South African women and to decrease that of women of colour, in particular women of African origin. I return to this literature later in the article.

Of course the new energies of settling and building meant that by the 1920s Johannesburg was also the scene of civic upliftment projects, modernising dreams

Town, 1995).

7. The citations for this section would run into pages. A good start is C. Walker, ed., *Women and Gender in Southern Africa to 1945* (Cape Town, 1991). See also the key text on African nurses, many of whom were based in Johannesburg: S. Marks, *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession* (New York, 1994).

and liberal and philanthropic work. The people committed to these endeavours left a considerable archival wake. Their written eloquence and driven commitment to recording their actions left key evidentiary foundations for this study. The memories of people whose lives were structured by wage labour and the establishment of new families and kin networks rather than salaried work, minute taking, fund raising and report writing, also figure heavily in this study.

The broader project, into which this article fits as one section, is a history of the Bridgman Memorial Hospital in Johannesburg; a history of the ideas, motivations, actions and impact of the several complex networks of women and men who worked together for over four decades to establish, develop and utilise this women's hospital and health-care centre, hitherto unknown in southern Africa. Besides the written archives, this project also draws heavily upon insights gathered through formal interviews and informal conversations. These collected memories speak to a considerable newspaper, municipal, state and photographic collection on the Bridgman, as well as to the less tangible, but none the less, crucial legacy of the Bridgman: the shaping of women's reproductive health in the country's largest city for a key period of South African history.

In this article I will focus on the impact of the institution on women's search to control their fertility in the environs of the city and its neighbouring peri-urban regions, from the time of its establishment in 1928 to its closure in the 1960s. Contrary to the assumptions about this earlier era made in the critical population control literature, which researches the years after the 1960s, I will argue that the search to control fertility was largely taken up by women and dominated by women's interests and agendas. This had not always been so. Before the 1920s women and men, especially Africans, worked to some degree together to shape their fertility. The rude and harsh world of Johannesburg's early decades did violence to the intimate lives of men and women and new ideas about sexual propriety, negotiated with haste and in poverty and against difficult odds, left little space for progressive social movements built around control of sexuality and reproductive choices. New gender and sexual roles arose. Some aspects of this were potentially empowering for African women in particular. This article takes up some of these possibilities. In the process, though, men abrogated, and were marginalised in, their responsibility for their own fertility. Why?

Part of the transformation involved the shift in technologies of contraception. 'Natural contraception' was an omnibus term holding a complex of meaning, which could include abortion before quickening (stimulated by purgatives, emetics, herbal concoctions and physical manipulation), inter-thigh sex, external male ejaculation, and post partum and lactation sexual practices. Most of these involved high degrees of male and female co-operation. Lest 'Natural Contraception' seem an unusually wide term, consider how the use of an inter-uterine device or 'IUD', which did not prevent conception but only pregnancy, was marketed as 'contraception' in the later twentieth century. 'Natural contraception' in these senses, was in Johannesburg, as well as other African and world cities, after the

First World War, interpolated with, and at least partially replaced by, mainly women-directed 'artificial contraception': diaphragms, douches, IUDs, injections, surgical sterilisation and later pills. The evidence gathered for this article suggests that male withdrawal before ejaculation, thigh sex, and other forms of non-penetrative lovemaking and petting were in sharp decline as sexual practices were increasingly designed to allow for sexual release and pleasure, as well as the developing of relationships without the concomitant risks of fertility. These practices were increasingly dependent upon female responsibilities, and sexuality was increasingly directed towards full internal ejaculation and male penetration. Male condom use and vasectomies occupied very small compartments in this omnibus of possibilities.

Rather like the huge literature on 'oral' versus 'literate' societies, which when examined shows closer continuum between the two extremes, inspection of the commonly used terms, 'natural' versus 'artificial' contraception, during the 1910s to 1950s in South Africa, reveals a continuum between the two, with lots of admixture on either side. Both contraceptive 'forms' required technologies – of the self, of interest and emotion, of products made and manufactured. Using herbs, skins, rubbers, plastics, and even metals, as well as derivatives of concentrated chemicals, a range of fertility-prevention technologies circulated and were developed, with blurry lines between 'natural' and 'artificial' forms. Both forms predate any *significant* state or scientific interest in 'fertility control' in South Africa. Neo-Malthusian officials from the Departments of Public Health and Social Welfare published their views in medical and scientific journals of the day where they found accord with many medical authorities, as well as many municipal and other officials. Veritable armies of missionaries and charitable institutions (first focused on the rural white and poor and then on the urban black and poor) worried themselves into action, setting up clinics and food banks in South Africa (as in the cities of the United States of America and China).

The main impact of this work was a thicket of services and technologies which grew more out of women's wants and needs, and the out-of-medical service responses to these, more than out of any pre-planned and ubiquitous system of women's reproductive health care. The city of Johannesburg was the centre of this more open-ended response to changing fertility demands. For black women the process originally centred on the Bridgman and for all women in the city these processes only came into their own after 30 years, in the 1960s. Women-centred interventions were vulnerable to rapid changes in biomedical service delivery – some unique to South Africa (such as the combination of market-driven and racial medicine) and to forces at work in the world at large (such as to pressures from northern nation states for fertility reduction in large parts of the developing world and to reproductive health in an age of hormonal contraception). Most particularly they were vulnerable to the exigencies of South African state policies against urban black women after 1960. While the state could hardly boast about the very limited success of its efforts to stimulate white fertility through directed

programmes after 1960, its claims of reducing the fertility of African women were more grandiose. I conclude by arguing that I do not believe that the ‘Depo Provera’ and ‘IUD’ programmes (very well resourced and bracketed with full state bureaucratic and technical support) targeted at African women after 1965 were in themselves the driving force behind the rapid drop in the fertility rates of urban black families. The drive to alter fertility began before, was based on more complex, and even women-centred, impetuses, and lasted through the era of ‘grand apartheid’ fertility programmes. I do however share the view offered by scholars of state fertility programmes in the later 1960s and 1970-1990 era, that the legacy of this set of interventions has been profound. South African women’s relationship to biomedical services and to the discourses and practices of *de facto* rather than *de jure* reproductive health in the country are shot through with their experiences of state reproductive planning. This has been building up since 1965, and has continued, with some new twists since 1994 and the HIV/AIDS pandemic. I will argue therefore that after the 1960s women in South Africa faced a far harder task defining their search for reproductive freedom. This would not change again until after 1994.

#### ‘Gynaecological Needs’ in Johannesburg

Johannesburg is the very pivot upon which the future of the native in South Africa swings.<sup>8</sup>

It took thirteen years to raise the money to open the Bridgman Memorial Hospital, and the driving force behind the campaign was Clara Bridgman, the widow of the American Board Mission (ABM) missionary, who saw Johannesburg as the key to all missionary endeavour in South Africa and indeed the continent. She and her husband moved the fulcrum of ABM activities to that city in the 1910s. When the Bridgman opened its doors in 1928, with a Hospital Board made up of liberal and civic-minded medical authorities (women as well as men, including the prominent USA-trained African physician and district surgeon, Dr Alfred B. Xuma), as well as civic and intellectual leaders such as Charlotte Maxeke, and a host of others known in philanthropic and academic circles, Clara Bridgman was quoted in the leading daily paper of the city at the time saying: ‘As well as doing the ordinary work of a midwifery hospital, it is intended that as time goes on there shall be opportunities given for research, and work and the special study of gynaecology.’<sup>9</sup> In her introduction to the annual report of that year she continued this line of thought: ‘In the original scheme it is stated that “the proposal is to establish a Hospital which will be primarily for maternity work with native women, with

8. Rev. F Bridgman, 23 Jan. 1913, to American Board Mission Headquarters, Boston, cited in P. Rich, *White Power and the Liberal Conscience: Racial Segregation and South African Liberalism, 1921 to 1960* (Manchester, 1984), 11.

9. *Rand Daily Mail*, 28 July 1928.

facilities for gynaecological and children's work".<sup>10</sup> She continued by arguing that the original dream of the founders (including herself) and the mainly female American donors of the original capital sum, would not be satisfied until there was a full service (an out-patients service in the end) for women's gynaecological needs, in addition to services for sexually transmitted diseases (called the 'Venereal Disease Clinic' or 'Syphilitic Clinic'), infant care (which was already being catered for through the expansion of antenatal clinics) and surgical procedures. What 'gynaecological needs' did she mean? Why did Clara Bridgman not use the terms 'birth control' or 'contraception'?

To understand the silence here, we have to take a long detour.

### **Babies and the Bridgman**

The Bridgman was established to provide a space for poor, and particularly black, women (at first designated 'Non European' women, including new immigrants such as Lebanese women, then 'Coloured, Indian and Native' women and then mainly 'Bantu' women, in the shifting nomenclature of the ensuing decades), to receive the best available biomedical reproductive health advice and care.

The Bridgman was forcibly closed by decisions taken at central state level in the early 1960s, through the application of several republic-wide laws, as well as the enforcement of specially promulgated municipal by-laws. Its land and equipment were sold off to a private hospital network. Remnants of the original buildings, the seed beds and many of the mature trees of the extensive original gardens, exist today on the site of the Garden City Clinic. This private Clinic in turn runs a small pricey reproductive Unit from the site, called 'Gynomed'. Specialising in sterilisations, infertility treatments, genetic counselling and *in vitro fertilisation*, the unit advertises its ability to prevent and enhance conception, assuring its customers that in this unit South Africa has a world-class facility. Its existence is almost the complete opposite side of the reproductive health services provided by Bridgman over the 35 years or so of its existence.

The customers of the Gynomed unit at the Garden City Clinic are privately insured professional or entrepreneurial women and men who can afford the high fees and the additional services which are not easily available through the strained public health system. The unit is famous for its 'test tube' conception record.

Of course, until the 1970s, women and men (outside of the realms of divine exception) were unable to conceive at all without engaging in heterosexual intercourse, usually penetrative – although legends about athletic sperm wash through folk and family memories. No child thus conceived had biological parents other than the woman who bore the child, and the man whose sperm mingled *in situ* with the fruit of her ovaries. The trajectory of human reproduction since the

10. HPC, AD 843, 'Annual Report, Year Ending 1928', 2.

1970s has altered the 'natural facts' that many of our ancestors relied upon for all their pasts, and although the great majority of children are still conceived of and born in the same way that their grandparents were, the future of gestation and birth will move our destiny in ways we can hardly anticipate now.<sup>11</sup> The infusion of technology with laboratory science concerning reproduction is at least as old as the century, yet as the work of historians of health, medicine, sexuality, pregnancy and birth, abortion, and more specifically contraception have demonstrated, biomedical means to regulate and control birth are recent and, in the West, occurred after the great demographic transformations that accompanied the development of capitalist agriculture and industrial life. They also occurred after the scientific revolution and secularisation of daily life which accompanied these.

In southern Africa the earliest accounts of indigenous people (oral texts transmitted and then later collected and written down) and eye-witness accounts by travellers, missionaries, traders and researchers contain evidence of the value and attention Africans gave to reproductive controls and associated practices. In the nineteenth and early twentieth century, as Christian missions gathered converts across the region south of the Limpopo, and especially in urban centres such as Johannesburg, cohabitation of various African practices and ideas about heterosexual sexuality, marriage, birth control fertility, and parenthood with late Victorian Christian ideas, teachings and practices, produced new knowledge, and new silences, around controlling birth.<sup>12</sup> As Gaitskell, Campbell and others have been at pains to show, the concomitant tension and suffering, between women and their intimate male partners, between generations of women, between white officials and experts and disenfranchised subjects, was immense. Out of these 'wailings' for purity, arose movements for self assertion: valorising some and abandoning other tenets of Christian moral teaching.

Laura Longmore, a sociologist teaching at the University of the Witwatersrand, understood some of this when she finally found a publisher for her monograph entitled *The Dispossessed: A Study of the Sex Life of Bantu Women in and around Johannesburg* in May 1958. Working and gathering data over two decades in a rapidly growing African city, Longmore chose to write about one aspect of this transformation. She cited inspiration to her thinking in academic literature on the late eighteenth to mid nineteenth-century period of rural capitalisation and urban industrialisation in England, and the impoverishment, the violence of every day life, the urban squalor, disease, and the social chaos emerging from

11. 'More Than One Million Test Tube Babies Born', *Washington Post*, 22 Jan. 2003.

12. D. Gaitskell, "'Wailing for Purity": Prayer Unions, African Mothers and Adolescent Daughters, 1912-1940', in S. Marks and R. Rathbone, eds, *Industrialisation and Social Change in South Africa* (London, 1982); J. Campbell, *Songs of Zion: The African Methodist Episcopal Church in the United States and South Africa* (Oxford, 1995); M. Brandel-Syrier, *Black Women in Search of God* (London, 1962); N. Etherington, *Preachers, Peasants and Politics in Southeast Africa, 1835-1880* (London, 1978).



this. She described the long road towards human betterment, what she often termed ‘civilisation’, emerging from this ‘vortex’. The evidence of England was thus cited in her text as proof of the generality of her study, despite the peculiarities of segregation and the apartheid South African state and society. Her argument was racially predicated throughout. Though she notes, and to some extent analyses, the changes in white gender relations and their sexual dimensions, in urban families and in the cultures and discourses of reproduction, health and moral life around her work, her detailed case study of Eastern Native Township (ENT) is directed in its focus: it is a warning of the impending crisis in the lives of only one group of the city’s inhabitants, ‘Bantu’, or black women of African descent. In the book, women of African descent across the city, and in ENT in particular, are the objects of her analysis and ‘European’ (sometimes ‘white’) women and men, Chinese, Indian and coloured women and men – these demographically described groups of people all living in the city at the time – remain in the background. This makes Longmore’s book unusual, despite its narrow and racist purpose, methodology and objectives.

Longmore argues that the kinds of change and dislocation in Johannesburg in the first eighty years of its life, were producing ‘types’ of people whose sex lives (as she terms all aspects of human interaction and culture involving some aspect of sexual exchange) were the fulcrum of social ill-health. She acknowledges that this was true for many immigrant settler and labouring communities and individuals, and for people of mixed continental descent, but she none the less focuses on women and men with African ancestors. These new types of ‘sex dispossessed women’ embodied these characteristics: they were alienated from their parents’ rural worlds, but not yet born into newer ‘civilisations’ and civic urban roles; they were careless of safety and decorum; immoral; fatalistic; obsessed with rapidly consumed commodities; fetishising of individual sensual pleasures over community integrity; without a saving work ethic and without purchase on the nation state as a whole. Indeed, with few exceptions, they were part of, and producing, a ‘lost generation’.<sup>13</sup> Like anthropologists publishing a decade or more before her study,<sup>14</sup> as well as her colleagues and peers in clinical fields,<sup>15</sup> her study argued that the rural idyll – patriarchal, with ordered and regulated fecundity, community-sanctioned fertility, social rather than individual moral hierarchies – was ending across South Africa and the world at large. While

13. L. Longmore, *The Dispossessed: A Study of the Sex Life of Bantu Women in and around Johannesburg* (London, 1959 and 1966).

14. See, for example, I. Schapera, *Married Life in An African Tribe* (London, 1940) and M. Hunter, *Reaction to Conquest: Effects of Contact with Europeans on the Pondo of South Africa* (London, 1936).

15. For example, L.F. Freed *The Problem of European Prostitution in Johannesburg* (Cape Town, 1949).

capital and labour were important engines, women were the agents of present decay, and the potential heroes of resistance to 'sex dispossession'.

Since the publication of her account, there has been no single study of the history of sex in any city or region of South Africa. In the last five years studies of sex contexts, sex partnering, sexual practices, sex education, and discourses of sex have been undertaken by many groups and individuals – especially those connected with the health sciences (though this is changing now), as part of HIV/AIDS research and planned treatment and intervention.<sup>16</sup> In many monographs and edited collections, journal articles and theses on the social history, sociology and anthropology of the southern African region, in works on health and healing, in poetry and prose, in many works of art and performance, in musical creation and in film, as well as in demographic and economic surveys and works, the themes of fertility and reproduction have played a central role. But these have not been gathered and analysed in relation to one another. In these works pre-colonial migrations, colonial dispossession and the privatisation of property in the hands of a few, waged labour, large-scale migrations and re-arrangements of households and family lineages and ways of life, new tensions in gender and age dynamics, new pressures on human physical capacity and the emergence of new psychological and dialogical selves, have been described and analysed, and in these accounts sexuality has sometimes been alluded to, but seldom discussed as a subject in itself.

A small section of that huge project can only be mapped if the worlds Longmore separated ('Bantu women', off from everyone else in the city and the broader society) are drawn back together in historical analysis. This is the project of 'writing in chords'.<sup>17</sup> The next section of this article attempts to bring together the published work on contraception and the biomedical strides new clinics and services were making among white women, together with an analysis of the world of the Bridgman, to which I return at the end.

16. See the excellent edition of papers edited by Liz Walker and Peter Delius which arose from the workshop 'AIDS in Social Context' in 2000 at the University of the Witwatersrand published in *African Studies*, 61 (July 2002). An excellent recent monograph on sexually transmitted diseases in South Africa, which is country-wide in scope and has many interesting things to say about sexual practices and ideas, though these are not the main focus, is a useful starting point: K. Jochelson, *The Colour of Disease: Syphilis and Racism in South Africa, 1880 to 1950* (London, 2001).
17. For references made to discussion between Shula Marks, David Cohen and others at several anthropology and history 'round table' meetings in the 1980s and early 1990s, see the 'Preface' in D.W. Cohen, *The Combing of History* (Chicago, 1994).

### A Brief History of Contraception in South Africa: 'Natural' and 'Artificial' Contraception

It seems to the Department that there might be a need in Johannesburg for the development of an Outpatient Gynaecological Clinic where mothers needing advice on physical health matters, both of nature and nurture, might be assisted. Such an institution, under ... skilled supervision could receive minor gynaecological cases, deal with some forms of post-natal aftercare, accept responsibility for counseling mothers of subnormal physique or mentality, give advice on contraceptive methods where medically needed ... Under all circumstances the Minister would depreciate the establishment of a clinic having as its sole object *the advocacy of artificial contraception ...*<sup>18</sup>

In his 'Communication of Advice' to the fledgling Race Welfare Society of Johannesburg in 1931, Edward Thornton (Acting, and later, Secretary for Public Health) underlined three key points: artificial birth control *per se* was not yet a unanimously accepted public good; any clinic with this as its intention would have to embed its purpose in a range of other services and advice; and any such venture would have to come under strict medical supervision. The subjects of these early Department of Health endeavours (as described in the work of Jochelson and Klausen in detail) were white working-class women congregating in Johannesburg slums in the period after the Depression.<sup>19</sup>

The past twenty years of historical scholarship on families, gender relations, the history of science and medicine and sexuality in Europe and North America, has moved our attention to the new technologies concerned with the human body which gained currency in the eighteenth and nineteenth centuries.<sup>20</sup> These studies have demonstrated that the professionalising practices and rhetoric associated with these shifts were fraught with inequity, interest and moralising visions. This scholarship has unseated an easy epic of teleological human progress.<sup>21</sup> But these debates about, and questions of, progress fit at best uneasily with questions of the development of different historical actors' understanding and knowledge of improvement. Concerned to demonstrate the objectification of women particularly,

18. CAD, GES 2281 85/38 Deel 1, E Thornton, Acting Secretary for Public Health, Reply to 'Race Welfare Society', 27 Feb. 1931.
19. See Jochelson, *The Colour of Disease* and S. Klausen, 'For the Sake of the Race: Eugenic Discourses of Feeble Mindedness and Motherhood in the South African Medical Record, 1903 to 1920', *Journal of Southern African Studies*, 23, 1 (1997).
20. See L. Jordanova, *Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries* (Wisconsin, 1989); O. Moscucci, *The Science of Women: Gynaecology and Gender in England 1800-1929* (Cambridge, 1993).
21. This field is large, growing and diverse, but certain key texts in my thinking over the last ten years include: E. Fee, 'Science and the Woman Problem: Historical Perspectives', in S. Teitelbaum, ed., *Sex Difference: Social and Biological Perspectives* (New York, 1976); A. Oakley, *The Captured Womb* (Oxford, 1984); C. Gallagher and T. Laqueur, eds, *The Making of the Modern Body* (Berkeley, 1987); E. Martin, *The Women in the Body* (Boston, 1987); M. Poovey, *Uneven Developments* (Chicago, 1988).

in contexts in which their power and social agency was constrained, scholars have often fallen prey to a vision of women as victims of male power, begging questions of contradiction, dialectic and struggle which surely provide the seedbeds of change. Eschewing an approach which describes medical knowledge and technological improvements as closed systems, both totalising and disempowering in their aim and effect, this article argues for an examination of the ambivalence, curiosity, and at times very personal imperatives with which men and women in South Africa approached the study and use of contraceptives.

In early twentieth-century South Africa, neither white nor black women exercised or enjoyed equivalent authority or rights in relation to men-folk from their own households. Even after gaining the vote in 1930, white women were still the focus of decades of social engineering schemes. Black women (with allies who were at times males from their own households, and at times white women and men such as reformers and medics), fought for rights of access to public health care and social services. In this context, the idea of medicine, clinics, and medical professionals as constitutive of 'total institutions', or of the technology of birth control devised as yet another form of oppression designed to control women's socially and biologically reproductive lives, misses several crucial issues this work hopes to address.

The first is that very differently positioned actors took up positions during early contraception debates. The uneasy, and at times contradictory, alliances which formed around these newly available medical technologies of fertility control were not unique to South Africa. In Britain and the USA in the late 1910s and early 1920s, feminists, progressive health professionals, liberal reformers, socialists and conservatives battled against legal and social prohibitions, and often each other, to define their project. Some regarded contraceptive technologies as part of a new liberatory moment for women, others, as a way to halt the degeneration of social stability and maintain the perceived collapsing norms and values of working-class family life.<sup>22</sup>

In South Africa, these alliances were represented in the 1910 to 1930s era by such figures as Olive Schreiner and fellow socialist feminists, as well as liberal segregationists, such as Winifred and R.A. Hoernle.<sup>23</sup> White English-speaking middle-class women made up the ranks of the clinic organisers in the 1930s, but

22. For the history of Sanger and Stopes's contributions to these debates, see J. Rose, *Marie Stopes and the Sexual Revolution* (London, 1992); D.M. Kennedy, *Birth Control in America: The Career of Margaret Sanger* (New Haven, 1970); and N.E. Himes, *Medical History of Contraception* (New York, 1963).

23. For an interesting example of Schreiner's feminist theorising, see O. Schreiner, *Women and Labor* (New York, 1911). This volume became a key document for British and American as well as South African feminists. The complexities of the liberal, and then increasingly segregationist, thinker, R.A. Hoernle, a professor of philosophy, and after 1934, head of the important liberal organisation, the South African Institute of Race Relations, have been examined in Rich, *White Power*.

by the 1940s, many Afrikaans women, after successfully petitioning the organs of the Dutch Reformed Church, began forming clinics and lobbying local governments for aid. Regional differences soon developed. In Natal and the Cape first, and later Johannesburg, women of colour were included in the clientele of clinics originally envisaged as providing for the needs of poor city women. And until the 1930s, black women were not regarded as having substantial permanent presence in cities. At just the time these clinics were being established, local and central state officials expressed increasing alarm over the numbers of black women moving into the cities from the impoverished reserves. At first concerns over the poverty of the reserves prompted anxiety about the detrimental effects this would have on a future male labour force.<sup>24</sup>

By the Second World War, an increasingly common theme, especially in the cities, was the 'overpopulation' of slums and working-class areas, and African men and women became the focus of studies into both 'African family life' and its perceived breakdown, and high rates of illegitimacy and teenage sexuality.<sup>25</sup> These anxieties, in turn, spawned new alliances, including alliances by whites with black men and women in Christian-rooted purity movement. Thus, in order to understand how, by the mid 1960s, we can speak of an official South African state policy of birth control, it is imperative that we take seriously the struggles which Acts of Parliament, cast in the masonry of grand apartheid, attempted to fix, without complete success. As in other regions of the world, local endeavours to control human fertility contained both liberatory and prescriptive agendas. Methods of contraception, and access to them, and the 'population' policies of state and welfare agencies, continue to this day to animate debates, co-operation and struggles between women and men and between individuals and various state and international bodies. My reading of the evidence from the 1900 to 1960 era is that there was at least as much complexity of intent and outcome in this field of human life then as now.

The contraceptive technologies introduced to a wider audience in South Africa from the 1930s onwards were not the earliest attempts of people on the southern tip of the continent to control their fertility, fecundity, progeny and sexual lives. Local knowledge was itself not static. The very context wherein practices such as adolescent interfemural sex had developed, were undergoing massive shifts, as the migratory male labour system, land dispossession, increased taxation

24. F. Fox and B. Back, *A Preliminary Survey of the Agricultural and Nutritional Problems of the Ciskei and Transkei Territories, with Special Reference to their Bearing on the Recruiting of Labourers for the Goldmining Industry* (Pietermaritzburg, 1941); and see A. Jeeves, *Migrant Labour in South Africa's Mining Economy: The Struggle for the Gold Mines' Labour Supply, 1890-1920* (Johannesburg, 1985).
25. Key sources include H. Gluckman, *Report of the National Health Services Commission* (Pretoria, 1944); HPC, Church of the Province of Southern Africa Archives, South African Institute of Race Relations Minutes of the Conference on Urban Native Juvenile Delinquency, Johannesburg, 1938; E. Hellman, *Problems of Urban Bantu Youth* (Johannesburg, 1940).

and the cumulative effects of drought, permanently altered the economic and social landscape of the region.<sup>26</sup> The history, therefore, of the decades before modern contraceptive techniques were available to the majority of women in the region, is complex in itself, and only a brief account will be given here. Helen Bradford has begun to map the history of abortion in South Africa, demonstrating that before the end of the nineteenth century in this region, as in other contexts, illegality was not at issue in relation to induced abortions. These were considered part of the repertoire available to many women in their efforts to control their reproductive lives. Before women detected foetal movement, many utilised menstrual ‘activators’, herbs and douches, as part of a regime of bodily control available within family oral accounts, recipe books, and among local specialists and herbalists. The work of medical anthropologists, chemists and pharmacologists, such as Harriet Ngubane, Christine Varga and D.J. Veale<sup>27</sup> and others has added to the large record of archival (written and physical), oral, commodified, and living evidence of abortifacients, menstruation assistors, lubricants and pessaries, herbal packs and tampons that women and men used along with fecundity and potency assistors, potions and ‘love magic’. Julie Parle<sup>28</sup> among others have begun mapping out these areas of study. My work on the herbalist and midwife Louisa Mvemve has referred to some of these ‘Women’s Helpers’.<sup>29</sup> In the late 1920s new contraceptive techniques designed to prevent pregnancy (although, in the case of certain loops and coils inserted into the cervix, conception could take place, with the intention that the fertilised ovum would not develop beyond this point) were introduced to South Africa, through pharmacies, a handful of gynaecologists and small networks of women who had spent time overseas. Small numbers of women before the Second World War had access to the resources and connections necessary to visit the few private gynaecologists who could provide them with the contraceptive advice of the day, and their story is not addressed in this work. Women who did not have access to private gynaecologists, and for whom the services offered at clinics (which included gynaecological care in some cases, as well as referrals to midwives when women were pregnant, and

26. P. Mayer and I. Mayer, *Townsmen or Tribesmen* (London, 1974), 217, 254, 255 and Chapter 16 ‘Sexual Partnerships’.
27. See the extensive bibliography of this work in C. Varga and D.H. Veale, ‘*Isihlambezo: Utilisation Patterns and Potential Health Effects of Pregnancy Related Traditional Herbal Medicine*’, *Social Science and Medicine*, 44, 7 (1997) and H. Ngubane, *Body and Mind in Zulu Medicine* (London, 1977). See also H. Bradford, ‘Herbs, Knives and Plastic: 150 Years of Abortion in South Africa’, in T. Meade and M. Walker, eds, *Science, Medicine and Cultural Imperialism* (New York, 1991).
28. Julie Parle’s forthcoming PhD thesis deals with the history of mental health and mental healing in Natal between 1860 and 1916.
29. See Bradford, ‘Herbs, Knives and Plastic’, in which she skilfully draws attention to similarities and divergences between southern African and other histories of abortion. See also C. Burns, ‘Louisa Mvemve: A Woman’s Advice to the Public on the Cure of Various Diseases’, *Kronos: Journal of Cape History*, 23 (1996).

to social and charitable agencies) were, in fact, the target of the work of ‘family planning’.

After 1930, when ‘birth control’ devices, such as cervical caps, sponges, foaming tablets, spermicides and their analogues were introduced through clinics, the initial intention was to control the fertility of white working-class, married women, perceived as enfeebled and increasingly regressive in their social profiles. Men were not the subjects of efforts at family rehabilitation, limitation and planning.<sup>30</sup> Even during the Second World War, when international campaigns concerning sexually transmitted diseases had opened spaces in the arguments separating men and women’s mutual contribution to conception, ‘family planning’ was not regarded as the responsibility of the male partner by either social agencies, clinicians or the state.<sup>31</sup> However, many men and women no doubt agreed to mutual strategies and shared responsibility.<sup>32</sup> Furthermore, evidence exists that certain pharmacists and other traders did sell condoms, and they undoubtedly drew on a clientele who found it impossible or difficult to pass as married and monogamous.

#### **A Case Study of Contraceptive Knowledge and Practice: Ideas and Memories of a Family Planning Nurse**

This section could be drawn almost entirely from secondary written sources. Much of what follows can be traced in the ethnographic accounts of anthropologists and authors cited at the start of the article, scholars worked and wrote in the late nineteenth and early twentieth century. However, this analysis traces the forms of and changes in the fertility practices of the indigenous women and men of South Africa over the last century, from the point of view of a highly trained nurse and fertility expert. This approach stresses several unique insights. Patience Tyalimpe, interviewed in the early 1990s on tape, and through letters in the mid 1990s, first in her offices as a Family Planning professional, remembered her first exposure to urban-born women when she started her training as a nurse in the mid 1950s. While she and her friends knew about and practiced ‘sweethearting’,<sup>33</sup> or non-

30. I do not mean to suggest here that white men did not figure at all in reformers’ analyses, prescriptions and campaigns. They were subjects of work-crew plans, protected employment schemes and certain social programmes aimed at recreation and self-improvement. See the suggestions of the *Carnegie Commission Into Poor White Poverty in South Africa* (Stellenbosch, 1932).
31. K. Jochelson, ‘Patterns of Syphilis in South Africa, 1880-1949’ (Paper, South African Research Seminar, Oxford University, 1989) and Jochelson, *The Colour of Disease*.
32. See, for example, testimony about mutual responsibility in Interview, Wilhemina Madiba, Alexandra Township, 2 July 1992 (interview conducted and transcribed by author).
33. This phrase was used by Monica Hunter in her detailed ethnography of Mpondo society, and is a loose translation from the Xhosa into English of the word ‘ukumetsha’. Patience Tyalimpe had read and heard this English term, and used it several times in the interview. See Hunter, *Reaction to Conquest*.

penetrative intercourse with their male lovers, and had done so since their first menstruations, their urban peers did not, and according to Patience Tyalimpe, this was a major cause of the unplanned conceptions among many urban-born women, and their search for abortions and for contraceptive methods which would accord with penetrative heterosexual intercourse.

As a teenager, Patience Tyalimpe had been instructed by her elder sisters, and by her grandmother at the time of her first menstruation, in matters concerning sexuality and the behaviour expected of a grown, but not yet married, young woman. Her first lover had to obtain permission from her aunts and eldest sister to 'sweetheart' with her, as did subsequent partners. But, Patience Tyalimpe recalled, at the age of twenty or so, when she first met up with nurse probationers from towns across the Eastern Cape and Natal and then Johannesburg, her young women peers either had no knowledge of this conception-preventing skill, and its related form of directed sexual expression, or eschewed its practice on the basis that it was unsophisticated and a sign of a rural background. The fact that her urban counterparts did not practice *ukusoma* in the 1950s represented a shift in behaviour and knowledge. These and other compelling assertions by Patience Tyalimpe led me to investigate the themes of fecundity versus fertility and related practices of heterosexual sexuality during my interviews with women who had lived and given birth in Johannesburg between 1920 and 1960.<sup>34</sup>

Tyalimpe's views and analyses remained in my mind as I read the archival and ethnographic record of the early to mid twentieth century. It was clear that her specific and detailed information was a complex mixture of self-generated material, based on her own personal experiences, but also grew out of a conscious effort on her part to glean information from her peers as a young woman and later as a nurse, an interest which led her to specialise in 'Family Planning' in her later career. Her interest also formed the basis of her subsequent reading of anthropological and historical material on the social life of black South Africans in the late nineteenth and early twentieth century. Her reading of several monographs from the 1930s and 1940s when she later studied for her BA degree as a mature adult and well-qualified nurse, confirmed for her that various forms of premarital sexual expression were widely practised and taught among Nguni, Tswana and Sotho-speaking communities across Southern Africa.<sup>35</sup> In her several interviews with me she reflected upon the impact that early missionary, as well as subsequent urban church-based Christian teachings, had on undermining local

34. C. Burns, 'Sex: Lessons from the Past', in *Agenda: A Journal of Women and Gender*, 29 (Autumn 1996), and C. Burns, 'Contraception', in M. Goosen and B. Klugman, eds, *The South African Women's Health Book* (Cape Town, 1996).

35. Patience Tyalimpe had read Monica Hunter's aforementioned monograph, as well as Isaac Schapera's *Married Life in An African Tribe*, in the 1970s, obtaining these texts from the library of Planned Parenthood of South Africa: Interview, Patience Tyalimpe, Johannesburg, 22 Nov. 1992.



practices. In particular, she drew my attention to the impact of prohibitions on sexual expression by unmarried people and the stress on a narrow vision of married sexuality. As far as public health issues were concerned she saw the most negative impact of these new teachings playing themselves out in the undermining of local practices regarding adolescent sexual development and self discipline and the shifting of responsibility to women alone of the domain of married sexuality. The interruption of knowledge of birth spacing, so crucial in her view to maternal and child health, without the provision of viable alternatives, was one cause of huge infant morbidity and mortality in urban townships. One result of this conversion activity shared by both settler and indigenous communities were heightened sexual anxieties, pathologies and repressions, although they were expressed across a range of practices and ideals. This would be a fruitful avenue for further research. Her account, by the written work of Hunter, Schapera, Mayer, Hellman, Longmore, and missionary activists such as Phillips, writing in the 1940s, showed that that by the 1920s town-based women and men were condescending about rural customs and practices. Although many were Christians, when they did engage in sexual relations outside of marriage, this was usually penetrative heterosexual intercourse without contraceptive protection.

In her exegesis, Patience Tyalimpe reported many similar observations to those contained in the ethnographic material of Philip and Iona Mayer, gathered in the late 1950s and 1960s in the Eastern Cape, particularly in the towns of East London and Grahamstown, and the rural hinterland surrounding them.<sup>36</sup> Unlike the Mayers, Schapera and Hunter, Tyalimpe spoke both from personal experience, and from observation and reading of written sources. She ended her interview sessions by calling for a return to many practices of generational and peer-based sexual socialisation of adolescents, and the recognition of the sexual needs of young men and women. Besides making modern contraceptives, especially condoms, more widely available, she advocated teaching young people forms of sexual expression and play other than penetrative intercourse.<sup>37</sup>

Some months after I completed my interviews with Tyalimpe, I interviewed a group of experienced nurses working in the reproductive health field, including Wilhemina Madiba, who described mentors in their lives who had played the kind of role Tyalimpe embodied:

She spoke to us as a mother ... Then she would tell us all the disadvantages of being in love during training, 'No well, some of you started training with boyfriends already. I would like to give you a tip. Never ever go out with your boyfriend at night, because definitely, you are definitely going to be involved in sex, and that's when you go off' ... And the others would say, 'No I am in love', and then left him and told him 'I am going to train'. The

36. Mayer and Mayer, *Townsmen or Tribesmen*, 217, 254, 255.

37. Interview, Patience Tyalimpe, Johannesburg, 22 Nov. 22 1992. She did not, however, suggest any form of homosexual expression.

minute that I tell him I cannot go out with him, he'll think I'm playing tricks'. So, it was then that she taught us about contraception.<sup>38</sup>

The key here for me was 'she spoke to us as a mother'. There was no discourse of respectable fertility control for an African woman that was outside the basket of motherhood, even in 1990s South Africa. I asked Madiba what contraception meant and what practices it entailed. Madiba's replies echoed Thornton's from the 1930s: artificial contraceptives included pessaries, inserted uterine devices, creams, sponges and later hormonal pills and injections. Natural contraception included herbal remedies for bringing back menses; penis withdrawal and external ejaculation; inter-cruial sex and penetrative sex at times of a women's fertile cycle which were least likely to result in conception. Madiba and her peer cohort, whom I interviewed in the 1990s, were all living and making love and practising nursing in Johannesburg when Longmore's study was undertaken. In the interviews, elderly women recalled their sex partners and sex histories alongside histories of birth, waged work and professional careers, and although I focused on the history of childbirth and their role in it in my questions, their interest in 'the problem of contraception' was a recurring theme. They wanted to present nurses in two ways: as exemplars of the best of African womanhood, and as full of the contradictions of being 'in betweeners' and first-generation urban women, lovers, wives and mothers themselves.<sup>39</sup>

Laura Longmore's monograph from the 1950s unconsciously captures these contradictions. In some chapters nurses are portrayed as women who eschewed all forms of artificial contraceptives because they were perceived as abnormal and harmful. On the other hand, and in other places in the text, nurses were the major conduits of illegal abortions and the passing of abortifacants from the stores of biomedical pharmacology. In her own evidence nurses and waged women in factories and in domestic service were amongst the major users of contraception services in city clinics and hospitals.<sup>40</sup> Both directions in her analysis were no doubt based on evidence. As a young black nurse-trainee, Wilhemina Madiba was first counselled about methods of contraception by her Nurse Tutor, herself a married black woman with children. Recalling that no instruction about contraception was included in either general nursing or midwifery instruction in South African training institutions until the late 1960s, and certainly not when she trained, Madiba's recollections were of an informal meeting, initiated by their

38. Interview, Wilhemina Madiba, Alexandra Township, 2 July 1992.

39. See V. Noble, unpublished chapter on 'Nurses' for her forthcoming PhD thesis at the University of Michigan; J. Webber 'Fragmented, Frustrated, and Trapped: Nurses in Post Apartheid Transition at King Edward VIII Hospital in Durban' (PhD thesis, University of Natal, 2000); and C. Burns, 'A Man is a Clumsy Thing Who Does Not Know How to Handle a Sick Person': Aspects of the History of Masculinity and Race in the Shaping of Male Nursing in South Africa, 1900-1950', *Journal of Southern African Studies*, 24, 4 (1998).

40. Longmore, *The Disposessed*, 136-7.

trusted tutor, who was concerned that young unmarried women would lose their chance to qualify if they became pregnant. The tutor recognised that many trainees were engaged in sexual relationships, and offered advice, both moral and pragmatic. Years later, these moments were recalled as part of a discussion about the sexual and reproductive lives of African women before the 1960s.

### **Urban Contexts, Black Women and Contraception in the City**

In cities such as Johannesburg in the 1930s, black men and women as well as white missionaries, social reformers, government officials, religious leaders, physicians and anthropologists began to name a 'crisis' of illegitimate births – specifically represented as the births to young unwed black women – and called for a national response. Often Clara Bridgman and her peers would attend these meetings. Despite the work of Freud and Havelock Ellis and the impact of their theories in the early decades of the century, social activists in cities like Johannesburg continued to employ rigid constructs of 'normal sexuality'. As gatherings of black mothers in prayer groups, black ministers in church meetings, of white missionaries, administrators and philanthropists met to discuss the crisis of illegitimate births, they employed terms such as 'promiscuous' to describe the sexual behaviours they ascribed to city life. To attempt to unravel the web of assertions in the past (echoed repeatedly into the present) about southern African cities as sites of promiscuity, and attempt to understand both real changes in people's organisation of sexual activity, as well as the fears and agendas of policy makers, social activists and ordinary men and women, is a herculean task. If, as Jeffrey Weeks, in his study of sexuality argues, 'sex ... has been a transmission belt for wider social anxieties' then it makes sense that in the context of colonial conquest, massive economic and social change, urban migration and the impoverishment of rural areas, communities in southern Africa experienced and wrought great changes in the most intimate areas of their lives.

In the early 1930s local and central authorities began commissioning expert opinion on the urbanisation of Africans, focusing on women in particular. The reports they elicited and the debates which ensued in government chambers were presented in the language of concern for the effects of 'detribalisation' and the 'breakdown of the traditional family'. Such language was not confined to government-appointed ethnologists and 'Native affairs experts'. Throughout the 1930s and 1940s, there was a mounting production of anthropological research into the 'customs of Southern African tribes'. Academics such as Hunter, Schapera, Krige, Hellmann and later Longmore, bemoaned the desecrated state of family life, focused on the promiscuity of African women in the cities, and in doing so often valorised certain aspects of an idealised African past. Two key anthropological monographs of southern African societies, written in the 1930s by Monica Hunter and Isaac Schapera, as well as research papers published by both authors in the early 1930s, addressed pre-marital sexuality, pregnancy and

socialisation, and the encroaching influences of both missionaries and ‘town life’ on sanctioned adolescent sexual experimentation (especially *ukumetsha*, or non-penetrative heterosexual intercourse between the thighs) as central themes, and provided a vital academic contribution to this debate.<sup>41</sup>

Both Hunter and Schapera went to great lengths to provide detailed definitions of stages of marriage procedures, through bridewealth payments (termed, in Xhosa, ‘*lobola*’, and in Tswana, ‘*bogadi*’) and ceremonies spaced, in many cases, over years. Before their lengthy discussions of marriage and its definitions and changing meanings in the light of missionary influence, both authors spent considerable time developing an analysis of sexuality and its permutations in the societies they studied. What is most fruitful about Schapera’s and especially Hunter’s discussions of sexuality, is the rootedness of their analyses in material life and historical change. Both provided complex insights into the sexual expression of young women, and instead of generalising about the sexuality of their informants, their analyses reflect great range among people, and most importantly, range over the whole spectrum of the life cycles of women in particular. They were both fundamentally interested in the changing meanings and transactions of material, symbolic and emotional capital bound up with forms of bridewealth.

Hunter’s work on pre-marital sexuality and married life is striking in its portrayal of the wider latitude and greater independence younger women enjoyed (despite the overarching constraints of gender differentiation, related especially to household and productive labour) in expressing their sexuality and choosing partners before the actual marriage transactions and ceremonies took place. It is clear that in marriage, with its powerful emphasis on reproduction of the household, especially the bearing of children, ‘sexuality’ was not necessarily the key determinant, nor was marriage necessarily its key site, although Hunter does devote some analysis to the function of *lobola* in stabilising sexual unions, with its economic deterrent to desertion. Sexuality in marriage expected different responsibilities for husbandly and wifely roles. Birth spacing as well as lactation taboos and other communal constraints upon sexual expression were an expected aspect of adult sexual maturity. The emphasis on relative sexual freedom of expression in Hunter’s section on pre-marital sex is juxtaposed with her exegesis on the meaningful transformations expected in a women’s labour, conduct and sexuality after marriage. Her analysis poses useful questions about the impact of the migratory labour of men not only on physical reproduction of the household, but also on the consciousness and identification of married and unmarried women living apart from men and lovers for long periods.<sup>42</sup>

41. See E. Hellman, *Rooiyard: A Sociological Study of an Urban Native Slum Yard* (Rhodes-Livingstone Papers No. 13, Oxford, 1948); Hunter, *Reaction To Conquest*; Schapera, *Married Life in an African Tribe*.

42. Hunter, *Reaction to Conquest*.

Hunter's work, and the oral records of African women and men interviewed in the 1940s, as well as subsequently, novels and literary works by African authors, and in particular autobiographies published in the last ten years in particular, all point to the expectation of long periods of heterosexual continence and constraint for most of adult person fertile lives.<sup>43</sup> In this set of expectations would come advice, support for a range of techniques and practices: avoidance of sexual intercourse; the use of herbal packs and douches before, during and after sex; penis withdrawal before ejaculation; sex between the thighs and other forms of mutual masturbation. Lactation taboos and post partum taboos were socially recreated in successive generations and evidence that their salience has not died is everywhere in contemporary South Africa. However, the privacy, timing, consideration, respect and meaning of these practices was subject to various assaults in the later twentieth century: as we have seen, testimony and written accounts agree that these forms of fertility control were under serious threat even by the 1930s.

Hunter's work suggests that in the 1930s and 1940s, adolescent experiences of sexual experimentation, flirtation, and more equally matched negotiations of opposite-gender sexual satisfaction would have existed in the recent past of many of the women who came to the city at this time, either in their own experiences or those of their mothers and fathers. These episodes might have provided crucial memory resources, skills and potential choices for women living in a rapidly changing social, economic and political world. This information about 'sweet-hearing', the entertainment and pleasure spaces allowed to young people, and the practice of non-penetrative intercourse, provide interesting insights into the adolescent socialisation of boys and girls before the intrusion of missionary influence and the damning of these rites of passage by large numbers of practising Christians.

These contemporaneous sources suggest that pre-marital sexual activity was not a new feature of urban life. Across wide regional differences in language and social life, forms of accepted and sanctioned sexuality outside of marriage were common features of late nineteenth-century southern Africa. Their work suggests that the locus of crisis and change lay in the impact of Christian views about appropriate sexual behaviour and training, and the context of urban life, where maintaining patterns of rural socialisation was untenable. It is also clear that generational and gender patterns were undergoing profound shifts in rural areas as well, and Schapera and Hunter, working in often non-Christian communities, were able to identify similar patterns of 'breakdown'.

Patience Tyalimpe's experiences as a young woman growing up in the Matatiele area, near the border between present-day Lesotho and the Transkei

43. See, for example, E. Kuzwayo, *Call Me Woman* (Johannesburg, 1985); E. Mashinini, *Strikes have Followed Me All My Life* (London, 1989); and S. Magona, *Forced to Grow* (Cape Town, 1992).

region, bear out many of Hunter and Schapera's observations. While she learned and practised sanctioned forms of sexual expression as a young woman, and brought this knowledge with her to Johannesburg, many of her urban-born peers, or women from households of strict Christian converts, did not have any knowledge of either non-penetrative sex, nor of contraceptive use. Her experiences as a young nurse and midwife probationer, especially her recollection of the 'problem of unwanted pregnancy' among many of her peers, and her sense that teenage and youthful pregnancy rates have continued to increase since the 1950s in cities such as Johannesburg, resonate with the fears and worries expressed by black men and women and white authorities and missionaries in the 1930s and 1940s. Remembering the benefits of the sexual and bodily instructions of her grandmother and aunts, Patience Tyalimpe reflected: 'When I look back to my childhood and how I grew up I see great wisdom.'

### **Returning to the Bridgman: Gynaecology and the Work of Out Patients**

Patience Tyalimpe's views concerning contraception were widely shared by the Bridgman-trained midwives interviewed in the 1990s, most of whom were probationers before her in the 1930s and 1940s. None of them had received any official contraception instruction as trainee midwives at the Bridgman, although Wilhemina Madiba and others picked up information through formal and less formal channels, and passed information on about vaginal pessaries, diaphragms and condoms to fellow nurses.

I was puzzled by this and repeatedly questioned them on this point, individually and in groups. One day their responses began to resonate with the written record. Neither Clara Bridgman, nor the seven Hospital Superintendents, from 1928 to 1960 (all but one were women) ever wrote officially in their Reports about their provision of 'contraceptive' services at all. I knew that Bridgman provided these from their extensive out-patient records; the published academic work of the people who worked there, and interviews with women who used their services. The medical officers and nurse tutors at the Bridgman did not teach the trainee nurses and midwives about contraception services either. Why? The necessity that they be unmarried and childless<sup>44</sup> was a requirement of acceptance into training. This rendered them ineligible for the contraceptive work which Bridgman staff pitched at 'mothers' – with the title of 'married', whether this was a marriage that had state legal standing or not. In the context of the debates about the sexual promiscuity of urban African youth there was no way that the missionary-trained Bridgman staff would have been able to cross the boundaries of their own injunctions against sexuality teaching for young people. They were

44. As Shula Marks first argued, and see references to this in my own work: Marks, *Divided Sisterhood* and Burns, 'A Man is a Clumsy Thing'.

fresh from battles against heathen sexual instruction. The contradictions of this did not force them into the open in the niche of the institution and its work. Only after they had graduated, they told me, did they recall being involved with contraceptive work as midwives and clinic nurses. When I looked back at my life histories for each of my interviewees some years later, I realised they were all married within months of graduation.

This muddled issue had plagued me when I read materials nurses were expected to cover for their examinations at Bridgman: why was it that the largest hospital for the maternal and gynaecological care of women of colour in the subcontinent, the Bridgman Memorial Hospital, provided no official curriculum for training in contraceptive or 'family planning' techniques for nurses, midwives or physicians throughout the 1930s, 1940s or 1950s, to the probationer midwives? The answer became clearer in the light of what I learned from Tyalimpe and my secondary reading of the missionary and ethnographic record.

Contraceptive services were bracketed within a wide range of services offered to women, especially women 'as mothers'. From 1928 to 1938 the majority of women patients first came to the Bridgman as maternity patients. This pattern began to shift. By 1939 more than 11 000 women came to seek out-patient services and of these more than half were 'new patients' and were neither referred to the antenatal clinic, nor the infant or child clinic. They received excellent contraceptive advice and service. The move towards what Clara Bridgman had called 'preventative gynaecological work' was gradual. In 1928 she was worried that this work was not yet established. During her furlough year abroad in 1934 the numbers of women seeking pessaries and diaphragms finally began to grow. We do not know this from the reports, where numbers, but not details, are listed. Instead the articles and addresses and published papers of the medical staff have to be read for specifics. An example of this is the report of 1934:

Again, as last year, the chief growth in the Hospital's services has been in the Out-Patient Department, which shows an increase of 1 426 patients over the year 1934, while 1934 showed an increase of 1 241 over 1933. These remarkable figures indicate the very valuable work that the Out-Patient department is doing both in remedial and preventative medicine.

In the same report on the Bridgman's work for 1934, the Chairman of the Board, Dr James Dexter Taylor, reminded his audience that in 1933 Dr Janet Booker began supervising the additional work of the Department and that a permanent 'Native staff-nurse' had to be appointed to assist the existing nursing staff. The Chairman explained that the out-patient figures excluded women coming for treatment at the ante or post-natal clinic (called the 'infant welfare clinic') or patients waiting for gynecological surgery, and also excluded all attendees at the special 'syphilitic clinic' where free courses of 'injections and treatments were being extended to keep up with that demand'.

The context for this written silence in the Hospital's annual reports and in the teaching of probationers is vital. The Bridgman opened its doors just as the contraception debate erupted publicly in South Africa. Edward Thornton, a key state health official whose support for contraceptive services for poor white as well as black women with large urban families,<sup>45</sup> was at pains to distinguish his department's support for 'artificial contraceptives' for poor married couples with numbers of children, to contraceptive knowledge being linked to sexuality outside of marriage or in the absence of other health and moralising services. In this he found support from his medical peers as well as missionaries, social workers and other health activists. The evidence I have gathered indicates that among the registered biomedical practitioners of the city, few respectable doctors would prescribe contraception for women they deemed 'unsuitable'.<sup>46</sup> A few chemist shops as well as herbalists and non-biomedical healers would provide both contraceptive technologies and services to city women, but the numbers suggested in published and unpublished records of the period still seem very low in terms of the numbers of women in the city at the time. This paucity of evidence led me back to the Bridgman records.

When the Bridgman was founded three key principles underlay its purpose and work, and these provide key clues to their policy and practice concerning contraception services: (1) concern about maternal and infant mortality and morbidity, which mitigated against arguments for limiting birth, at a time when the numbers of black children attaining adulthood was seen to be in crisis; and (2) the belief that harnessing the benefits of Western biomedicine to this cause would be a worthy and humane endeavour, and, as crucially, (3) the need to train an army of black nurses and midwives who would carry the torch of Christian-inspired civilisation, and by didactic methods as well as example, train generations of 'new mothers'. Along the way the experimental and scientific work of medicine was to be served as well, not only in the training of medical students, but also through the funding and support of clinical research in the hospital. Two decades later anxieties about the overpopulation of the cities, and the 'masses' of black men and particularly women crowding in from the impoverished reserves, had altered the terms of at least part of the earlier debate about 'population'. On the eve of the National Party's slim parliamentary victory in 1948, which promised the deployment of an array of social engineering measures to halt these and other 'threats' to minority rule, the Bridgman continued to strive for a high level of woman and patient-focused services. At the same time, the Bridgman and other urban hospitals recorded high levels of induced abortions which were 'completed' in the hospital. They recorded these every year without any recorded comment. However, the Medical Officers and Superintendents were not oblivious to the

45. See Klausen, 'For the Sake of the Race'.

46. Phillips, *The Bantu in the City*, 131-2; Burns 'Louisa Mvemve'.



debates raging around them about illegitimacy and the issue of unwanted pregnancies. The tensions and debates which circumscribed a full engagement on the part of the Bridgman Memorial Hospital with the project of birth control, included religious, moral and political considerations, and will be addressed in the final part of this article.

The records of the Johannesburg City Public Health Department indicate that very few black women, and even fewer African women, used their services. Eventually most of these were disestablished. A delegate from Johannesburg at a Conference attended by Race Welfare societies, maternal and child-health groups and city and state officials in 1936 summarised the position:

It was found that now general procedure could be decided upon ... the Johannesburg Centre had tried to establish a Non Europeans in a suitable district, and had done everything necessary to ensure its success. The branch however had not succeeded and was not now functioning.<sup>47</sup>

The next year Ray Phillips collected data from the Non European Clinic in Doornfontein, run under the auspices of the Race Welfare Society, which indicated that 27 women had used the clinic in the first six months after it was opened.<sup>48</sup> In the same monograph Phillips, closely associated with staff of the Hospital, and friends with Clara Bridgman and several Hospital Board members, included this recommendation in his summation section titled 'Health requirements on the Witwatersrand':

Furthermore, in view of the conditions revealed by our study of the use of further control appliances, the writer would urge upon such institutions as the Bridgman Memorial hospital the starting of Birth Control Clinics where the necessary information might be given, and, in addition, sympathetic inquiry be made into family arrangements in the home.<sup>49</sup>

His comments on the matter of 'sympathetic inquiry' were spelt out more fully in the earlier sections referred to in his conclusion. His researchers had reported time and again that 'many Natives are extremely reluctant to go to a hospital. It is due to impersonal treatment.'<sup>50</sup> And his book carries many examples of undignified treatment men and women received in clinical settings for injuries or chest complaints, let alone treatment for sexually transmitted infections or contraception.

Bridgman prided itself on more personal and sensitive treatment for their patients. Few Bridgman patients were ever referred to the municipal contraceptive

47. CAD, GES 2281, Oct. 1936, 6.

48. Phillips, *The Bantu in the City*, 141.

49. *Ibid.*

50. *Ibid.*, 131.

clinic<sup>51</sup> and after the Second World War the number of Bridgman referees dropped markedly. When I asked the Bridgman-trained midwives why women came to Bridgman for contraceptive services but not the clinics in town – often closer to their places of work, and free (the Bridgman charged a small user fee), they provided the following analysis: the Bridgman was a missionary hospital, concerned in the main with the welfare and health (also spiritual health) of women. They were concerned with education and training of midwives, the health of pregnant women, and the birth of healthy babies. To raise money, to gain the trust of their patients and to promote their sincere aims of ‘healthy birth’, they did not publicise contraceptive services. This meant there was no stigma attached to visiting the institution and no sense of its carrying an agenda which was state or municipally motivated or underwritten. The midwives reminded me of the high rates of infant mortality even in the post-Second World War era, and the value all the staff placed on birth spacing rather than reducing fertility.<sup>52</sup> Crucially, this discourse of ‘birth spacing’ dovetailed with the birth spacing fertility controls and practices well established in pre colonial and colonial Southern African societies, and spoken of under the rubric of ‘natural contraception’.

This analysis helps to add another intriguing piece to the puzzle concerning how and when the Bridgman provided contraceptive services. Although, as mentioned, the Bridgman records do not speak about contraception services specifically, or detail any Hospital policy on the matter, in 1935 the Medical Superintendent of the Bridgman, Dr Hope Trant, wrote and then had published, an extensive article, ‘Modern Contraceptive Methods’, on the subject of contraception. This article appeared in the same journal which had published many of P.W. Laidler’s letters and papers on the subject, and which was to publish his address on ‘population problems’ to the 1935 Medical Congress a few months later.<sup>53</sup> In it Trant revealed that in 1933 she had travelled in Europe visiting several birth-control clinics and attended several conferences on the subject in England and Scotland. She then summarised, in minute detail, the physiological and chemical explanations of conception, and followed this with pages summarising and explaining recently published texts on the latest methods of contraceptive techniques. From her work at Bridgman, and that of her successors, it is clear that she took the mission of self education seriously as part of her broader aim of bringing the latest contraceptive techniques and theories into service in her daily work as head of the largest hospital for black women in southern Africa.

51. I can find only 20 cases before 1940, in the letter records: HPC, AD 843, Edith R Jones; and also the HHC 1935, 1939; and only two after that.

52. These comments arose from conversations centred on the Bridgman’s provision of contraceptive services: group interview, Alexandra Clinic, 6 Feb. 1992.

53. See H. Trant, ‘Modern Contraceptive Methods’, *South African Medical Journal* (22 June 1935); and see P. W. Laidler, ‘The Medico-Social Aspects of Population Density’, *South African Medical Journal* (9 May 1936).

With pessaries, vaginal suppositories, douching and diaphragms as the major contraceptives available for women's use in the 1930s to the late 1950s, the dispensing and fitting of appliances, creams and lozenges would usually have taken place at the Bridgman on two afternoons and one morning a week. Patients would sit in the gardens to wait their turn, helping to care for one another's children. Tea would be served twice an afternoon. By the end of the 1940s nearly two thousand women a month incorporated these services into their sexual and reproductive practices. The Bridgman provided a model for a virtually free, women-focused, women-supported clinic adjacent to a tertiary-level hospital, a combination of services only seen again in South Africa, in some centres of excellence, since 1994.

Throughout this long period there were no major breakthroughs in contraceptive technology. At the end of the 1950s, research into hormonal contraceptives resulted in the production of birth control pills and injectable contraceptives became mass-produced for the first time.<sup>54</sup> This new technology became available in South Africa as the Nationalist Government was considering a new package of 'population control' policies, and was not unconnected to the direction of the plan itself.<sup>55</sup> Whereas providing a diaphragm for a woman to insert before intercourse, or a pessary swabbed with a spermicide, required some communication with a woman on the part of the health professional, and often manual demonstration and fitting, the new technologies promised a high-tech approach, which would no longer be dispensable under the sole responsibility of ordinary nurses and midwives because of their chemical and invasive qualities, and which demanded the involvement and authority of physicians, especially gynaecologists. The advent of these new technologies of contraception provided the material basis for the South African state's new didactic policy of population control, which was based on the injectable contraceptive, Depo Provera.<sup>56</sup>

54. See the work of Linda Gordon on the history of these hormonal contraceptives, and the progressive and conservative political agendas that coalesced around these new technologies: L. Gordon, *Woman's Body, Woman's Right: Birth Control in America* (Harmondsworth, 1990).

55. CAD, TES 7240 56/231 6920, 'Family Planning by the Bantu', see correspondence from 1961 to 1966.

56. The Women's Health Project of the University of the Witwatersrand inaugurated in 1992 a massive study of contraceptive use and knowledge among South African women from a wide array of economic, social, ethnic and language groups, with a particular emphasis on use and experience with Depo Provera. This project provides new insights into state contraceptive planning after 1960. See the work of Barbara Klugman on post 1960s state policies: B. Klugman, 'The Politics of Contraception in South Africa', *Women's Studies International Forum*, 13, 3 (1990).

### Conclusion

The complex history of this chemical contraceptive and its continuing legacy in South Africa is addressed in great detail in the work of both Brown and Klugman and the publications from 1995 to 1998 of the Women's Health Project, whose research is focused on the period after 1965.<sup>57</sup> They have detailed how, in the late 1950s, the state began to define 'Bantu birth rates' and the fertility of 'Bantu' women as a serious long-term threat to white national interests, and so began the design of programmes to counter this. New state funding was forthcoming for the South African branch of Planned Parenthood, which had been formed in the mid 1950s from the network of Race Welfare and Mothers' Welfare clinics started in the early 1930s. In a series of reports, memoranda and eventually cabinet meetings between 1962 and 1964, the government decided to allocate a large proportion of health resources for black women to contraceptive services. By the late 1960s, the state, working through the Department of Health, set up its own network of family-planning clinics, and later, through the creation of puppet 'Bantustan' health systems, through these networks as well. The Cabinet in 1964 sponsored a specific programme of action, called *Gesinsbeplanning by die Bantoe*, or 'Family Planning for the Bantu'. By 1966 this plan had received financial authorisation from the Treasury.

Although the Bridgman's records do not provide an insight into how the Hospital adapted to new state policies in their last years of operation (the early 1960s), it is most interesting that there was only a single occasion when one of the Bridgman patient cohort I interviewed recalled receiving contraceptive services. This was Rosina Kotane, who gave birth at the Bridgman four times from the late 1940s to the early 1960s, and who remembered receiving it after her final pregnancy, in 1961, when she was 'confined', in her words, at the new state-run Hospital for black women, Baragwanath. Her recollection of this experience was of a traumatic loss of power over her own body. Although her friends had told her that if she had 'strong blood' the injection would not prevent conception, she blamed her inability to become pregnant again despite her and her lovers' efforts to conceive, on the injectable contraceptive she received from Baragwanath that year.

Unlike Rosina Kotane's descriptions of her treatment at the Bridgman during her antenatal visits, and her memories of her previous successful deliveries, she recalled this experience with a sense of anger:

They give me an injection in hospital! ... Yes. They give me an injection. They say, 'Maybe you will get the child after three years, or after four years'. But if you've got the strong blood you can't stand that. In Baragwanath, that time, whether you want or not, you

57. B. Brown, "'Facing the Black Peril': The Politics of Population Control in South Africa", *Journal of Southern African Studies*, 13, 3 (1987).

given injection! [CB: Did you want that injection?] No, I didn't want that. But if you're strong, with that injection, you are still going to get a babies. I think. [CB: I see, so the nurse gave you the injection?] Mmm, yes. It stopped the blood.

The repeated comments of Patience Tyalimpe gain deeper meaning in the light of her own and other black women's experiences of ill-informed and ill-gotten consent that became the normal practice in many South African Hospitals in the late 1960s and 1970s. The suspicion, anxiety and mistrust that surrounds contemporary contraception debates in South Africa, now powerfully connected to treatment and prevention campaigns around HIV/AIDs, is also the legacy of post-1960s state planning.<sup>58</sup>

But its roots also lie in the silences and were generated by both black and white missionaries, social reformers and authorities in the 1930s and 1940s. These silences enabled some important work to begin, but cloaked this work in such a way that a more progressive debate around controlling fertility was muffled. It will take years of work, on the part of people such as Patience Tyalimpe (who now forms part of a newly re-organised contraception-providing service) and midwives, such as the women at the Alexandra Township Clinic, to re-imagine and rethink practices of fertility control which express the desires and wishes of different South Africans. There is some irony in the fact that as the Bridgman Board began to recognise the imminent fate of the Hospital in the winter of 1962 and 1963, and drew up plans for the future of the funds that would be available after the forced sale of the buildings, and from the capital investments of the institution, they considered the work of Planned Parenthood in South Africa important enough to warrant investment. In the late 1960s and 1970s the money from the Bridgman Memorial Foundation, set up in the wake of the Hospital's closure, was invested and grants were bequeathed annually to a variety of causes, such as foster-care provision and crèches for black children, and fees and tuition for the training of black nurses and black women doctors. As in the 1920s, the people who ran the Bridgman Memorial Foundation overlapped with those who ran the Helping Hand Trust, which had also been created in the wake of the forced closure and sale of that hostel for black women. In the 1980s, both trust funds donated large sums to the Planned Parenthood Association of South Africa.

58. V.H. Erlers, 'Adolescent Mother's Knowledge and Perceptions of Contraceptives in Tshwane, South Africa', *Health South Africa*, 8, 1 (Mar. 2003). My thanks to Rabia Cassimjee for this reference. See also M. Mbali, 'A Long Illness: Towards a History of NGO, Government and Medical Discourse around AIDS Policy-Making in South Africa' (BA Honours thesis, University of Natal, 2000).