

**GENDER AND THE POLITICAL ECONOMY OF HEALTH**  
**AND HEALTH CARE OF WOMEN**  
**WITH REFERENCE TO**  
**AFRICAN WOMEN IN THE NATAL/ZULULAND REGION**

**Claire Dyer**

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## ABSTRACT

The purpose of this thesis is two-fold: it attempts to develop a feminist theory of health and health care of women and moves beyond the political economy theory of health and health care grounded in Marxist principles. Secondly, it attempts to apply these feminist theoretical principles, incorporating the methodology of historical materialism, to a specific historical situation - that of African women in Natal/Zululand in the nineteenth century.

The thesis is divided into three parts. The first provides an overview of the political economy of health and the Marxist theory on which it is based. The second section deals specifically with feminist theoretical concerns: particularly the need to incorporate the concept of gender and the sexual division of labour into analysis of the position of women in society. In addition, it focusses on women's particular health needs and attempts to incorporate these into a feminist theory of health and health care. The third part examines the health and health care of African women in pre-colonial Natal/Zululand by focussing on their role in procreation and production, and changing health patterns and health care under colonial rule.

## PREFACE

Both contemporary and historical patterns of health and health care in South African society have become the subject of considerable academic interest and research in the last two decades. The main thrust has been within the Marxist paradigm, focussing on the political economy of health and health care as a means of explanation of the changing patterns of health and health care and the obvious gross disparities in health and health care in racial and class terms in the society.

This thesis falls within the parameters of Women's Studies and offers a feminist analysis of health and health care, dealing specifically with the problems of women's health and health care and the theoretical issues that surround the issue. Health and health care of women has been the topic of considerable interest of feminists in both the western and Third worlds as it encompasses many of the features which illustrate the specific oppression of women. It is with this in view, that this thesis attempts to make a contribution to feminist studies and organisation of women in South Africa. I acknowledge that the thesis is my own work, unless specifically indicated in the text.

I should like to thank the women who have launched the first interdisciplinary Masters Coursework degree in Women's Studies at the University of Natal for their assistance to me in the past two years. I should like to thank Ros Posel, who, as my supervisor and co-ordinator of the Women's Studies' programme, has given of her time and invaluable insight and discipline, considerable support and encouragement to me in completing this thesis. I should also like to thank my parents, Bob and Jean Vaughan-Evans, Jane Mazibuko, Wilmur Dyer and my children and friends who have egged me on and gave practical and emotional support, and my children particular, who with much forbearance have accommodated the making of this thesis in their lives over the last few years.

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## INTRODUCTION

The inequalities in health and health care in terms of race and class have become a focus of investigation and debate in recent years in South Africa. Links have been drawn between the growing disparities in health and health care in South Africa and the advent of capitalism. Marks and Andersson has argued that

The industrial and agrarian revolution which followed the development of the mining industry, the new concentration of population on the mines and in the rapidly developing towns and the special hazards of the mining, together with increasing impoverishment in the countryside, were to have swift and devastating implications for the physical well-being of workers, both black and white.<sup>1</sup>

Ill health and a paucity of health care facilities in rural areas have been ascribed to the devastating effects of the system of migrant labour, shortage of land and other natural resources and the destructive policies of the apartheid state.<sup>2</sup> Inhabitants in rural areas, particularly the aged, women and children are seen as victims of poverty and disease - victims of the migrant labour system reflected in health statistics. For example, the risk of contracting open pulmonary tuberculosis by Africans in the Transkei in the 1980s is seen as 50 times greater than the risk for whites in South Africa.

Well documented studies have shown how disease contracted by black workers while on the Rand, were spread to an "ideal breeding ground in the reserves when infected workers returned home."<sup>3</sup> However, thus far, there has been little attempt to examine the specific health needs of women, particularly rural women in South Africa. Studies of the political economy of health in South Africa are inadequate from a feminist perspective as they focus on class relationships and fail to explore the consequences of gender relationships on women's health. As Marks and Andersson point out:

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1. S. Marks & N. Andersson, "Issues in the Political Economy of Health in Southern Africa", Journal of Southern African Studies, vol.13, no.2, Jan. 1987, p.178.
  2. See for example, World Health Organisation, Apartheid and Health, Geneva, 1983.
  3. R.M. Packard, "Tuberculosis and the Development of Industrial Health Policies on the Witwatersrand 1902-1932", Journal of Southern African Studies, vol.13, no.2, Jan. 1987, p.187.

(the specific health needs of women)...cannot be deduced simply from class relationships, but have to be related also to women's roles in the political economy and the division of labour in the family, gender relations and the patriarchal forms of dominance, both black and white.<sup>4</sup>

This thesis attempts to place women at the centre of the study and to focus more specifically on issues surrounding women and health from an historical perspective. It aims to reach a more complete explanation of the factors influencing women's health in South Africa within a specific historical time period through an analysis of the interplay of race, class and gender relations on women's health. It draws on recent feminist studies which focus on the lives of rural African women in pre-colonial and colonial societies and which attempt to show that an examination of gender relations and patriarchal forms of control is crucial to an understanding of the ways in which women's lives were transformed by the colonial state. This thesis will attempt to argue that a key factor in the explanation of women's health lies, not only in the analysis of the transformation of their lives with the penetration of capitalism in the colonial period, but in the fundamental gender inequalities which existed in pre-colonial societies and which were altered and, in many ways, strengthened during the colonial period. Moreover, it argues that the historical roots of the disparities in health and health care for women cannot simply be explained in terms of the transformation of the mode of production but must be seen in terms of the reproductive role played by women in society. It moves beyond the concept of reproduction as "natural" or biological and argues that women's role in reproduction must be seen as a site of their oppression.

In order to achieve this, the thesis is divided into three sections. The first chapter focusses on the political economy of health theory and explanation, and establishes the Marxist theoretical framework in which it is grounded. The second chapter examines the specific health needs of women within the context of feminist theory and explores the ways in which political economy of health theory must be challenged in order to develop a more complete analysis of women's health. The final chapter attempts to explore the changing patterns of health and health care of African women within the region of Natal/Zululand in the nineteenth century. This

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4. op. cit., p.185.

chapter examines the ideology of health and health care of women within the specific historical and material conditions of pre-colonial society and attempts to analyse from a feminist theoretical perspective, the changing patterns of health and the effects of western scientific medicine which challenged existing health practices.

The thesis specifically focusses on rural African women in the region, as a preliminary investigation into women's health during the colonial period. It is acknowledged that this study can only give a partial picture of health of women in the region and it is hoped that future research on the health experiences of colonial white and Indian women can be incorporated into a more complete study.

From a feminist perspective, the task of placing women at the centre of the historical stage is particularly difficult. A feminist historiographical tradition is a comparatively recent development, given impetus by developments within social history which extended the frontiers of historical study to include subjects like adolescence, marriage, the family and women and by the demands of the feminist movement of the late 1960s and 1970s. Conventional historiography written largely by men has been criticised by feminists on two levels: firstly, its exclusion of women other than prominent women or deviants and, secondly, the subsumption of women's experiences, under those of class in explanations of the historical processes of transformation of society through industrialisation. As a result, studies of women's activities and contributions in the past have increased.

It is now at least acknowledged that while men were performing the feats, building the institutions, producing the goods and cultures, ruling the peoples and generally busying themselves with those activities we are wont to call history, women were invariably doing something.<sup>5</sup>

However, the task of historians researching women's pasts is both difficult and frustrating. Women have largely been excluded from historical records because of the tendency of male historians to record only masculinist activities.<sup>6</sup> The problem is that "the majority of those activities deemed worthy of the official record have been performed largely by and credited almost exclusively to male members of the

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5. E. Fox-Genovese, "Placing Women's History in History", New Left Review, 133, May/June 1982, p.6.

6. Masculinist activities may be defined as those that have been historically occupied by men.

ruling classes."<sup>7</sup> In order "to lift the veil" on women's historical experiences it is necessary not only to re-examine official records from a different perspective but also to extend research into less commonly consulted sources.

This study exemplifies the problems of feminist research. An attempt has been made to uncover evidence of women's health experiences in the colony of Natal. Of necessity, the research has concentrated on official and missionary records. Official records, particularly the reports of rural district surgeons, are often haphazard and descriptive, offering few statistics and little information concerning women's health experiences. Missionary reports are more detailed and often personalised, focussing on specific individuals. However, both embody nineteenth century male ideological perceptions of women and health, specifically the ideology of procreation as being part of the private sphere and the role of women as biologically determined.<sup>8</sup> It was only with the increasing importance placed on the development of a colonial public health policy that statistics become more accurate, particularly in the growing urban areas with the fear of the spread of infectious diseases.<sup>9</sup> However, as Doyal and Pennell have pointed out, mortality statistics have a limited function:

They tell us what people die of and at what age and can serve as a significant indicator of the varying material circumstances of different social groups....However they can only give a very crude indication of the state of health of those people in the population who remain alive. Thus a falling death rate may not necessarily reflect any overall improvement in basic health and conversely, many kinds of chronic ill-health (including psychiatric illness) will not be reflected.<sup>10</sup>

From a feminist perspective, however, the available sources do throw some light on the white official perceptions of women and health. The annual reports of the Durban Medical Officer of Health and the District Superintendent's Reports in the Blue Books focus largely on the increasing number of sexually transmitted diseases

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7. *op. cit.*, pp.8-9.

8. See Chapter 2.

9. Durban statistics on mortality and notifiable diseases become more accurate in the 1890s. See for example the Annual Reports of the Medical Officer of Health in Mayor's Minutes. This is further highlighted in C. Dyer, "A Case of Money and Life", unpublished BA (Hons) thesis, University of Natal, 1986.

10. L. Doyal & I. Pennell, The Political Economy of Health, 1979, p.58.



in the colony and increasing prostitution.<sup>11</sup> As will be argued later, health problems were often used as means of increasing controls over women, particularly the access of rural African women to urban areas.<sup>12</sup> What is also evident is the patriarchal view that motherhood was a private, "natural" function and children's health problems were often explained as the result of poor mothering.

The researcher's task, in attempting to "lift the veil" on rural women, must also take into account the prevailing racist ideology of white authorities. Perceptions of African women in many ways mirrored the prevailing western perceptions of working class and peasant women in Europe. Missionary reports and biographies tended to reflect the same attitude. Moreover, contemporary anthropological studies written within the colonial milieu equally reflect the perceptions of researchers brought up in an androcentric and imperialist tradition.<sup>13</sup> In this particular case of health and women, attempts to explain African perceptions of health and disease and the treatment of health problems by "traditional healers" reveal more about the attitudes of the researcher than that of the researched.<sup>14</sup>

This raises the issue of whether any researcher of alien culture is able to engage in ideologically neutral or objective research. As Walker argues, the racial (and class and sex) identity of researchers affects their choice and treatment of their subjects but she points out that it does not follow that "only blacks can write about black experience, or women about women's experience - or French people about French history."<sup>15</sup> She argues that "(For one thing), the subjective experience of a condition or experience does not guarantee the ability to reflect critically and analytically upon it, nor does it preclude the problem of bias."<sup>16</sup> It is important that the researcher is conscious of the need to avoid an androcentric view of the status of

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11. See, for example, Mayor's Minutes, Medical Officer of Health Reports.

12. True of most colonial administrations. See L. Doyal & I. Pennell, The Political Economy of Health, pp.108-112.

13. J. Beall, "Class, Race and Gender: The Political Economy of Women in Colonial Natal", unpublished M.A. thesis, Durban, 1982.

14. op. cit., p.8.

15. C. Walker (ed.), Women and Gender in Southern Africa to 1945, 1990, pp.6-7.

16. Ibid.

women or imposing western feminist perceptions of women's oppression on specific women, through the employment of the methodology of historical materialism and the conceptual tools of gender, race and class.<sup>17</sup>

Finally, the question of the value of research that deals primarily with women must be examined. History written exclusively by and for women faces the danger of ghettoisation.<sup>18</sup> The task facing feminist historians is not simply to add the history of women on to existing men's history but instead it is a question of "re-evaluating a whole world of experience - women's experience and using it to describe more accurately the world that men and women shared in the past."<sup>19</sup> The starting point for feminists is the recognition and use of the conceptual tool of gender/sex as a tool of analysis and as the basis of women's oppression in society. Feminist historians challenge mainstream historical practice to incorporate gender analysis along with those of race and class and allied concepts like culture, religion and age, interacting dialectically over time, and in doing so challenges the nature of gender-blind theories.

One cannot bend gender to fit the mould created by existing theories of class and race; issues like sexuality, the ordering and control of female fertility, patriarchal relations within the family, and sexual violence cannot be adequately accommodated in gender-blind theories.<sup>20</sup>

At the same time, women's history challenges the traditional periodisation of history. Events which signal a turning point for men are not those which radically affect women.<sup>21</sup> In the conventional history of colonial Natal, much emphasis has been placed on the imposition of British rule, the Anglo-Zulu War of 1879, the attainment of responsible government in 1893 and the unification of South Africa in 1910. But as Beall argues, while these events

may have impinged on the lives of women as dramatically as on

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17. Also see J. Guy, "Gender Oppression in Pre-capitalist Societies" in C. Walker (ed.), 1990, *op. cit.*, p.46.

18. E. Fox-Genovese, *op. cit.*, p.6.

19. J. Rendall, "What is Women's History?", *History Today*, June 1985, p.47.

20. C. Walker, 1990, *op. cit.*, p.4.

21. J. Beall, 1982, *op. cit.*, p.12.

the lives of men, such political events may not have constituted a change in the status or condition of women sufficiently to justify their use as the basis for periodizing a history of Natal, specifically concerned with the position and role of women.<sup>22</sup>

While wars like the Anglo-Zulu War of 1879 and resistance against colonialism in the form of rebellions, such as the Bambata Rebellion 1905, had severe consequences for women in that their material lives were disrupted and they were displaced, equally crippling for rural African women was the outbreak of locust plague in 1895-1896, periods of drought or floods and the rinderpest epidemic that natural disasters destroyed their subsistence production and enforced their dependency on men for cash, thus strengthening their specific oppression.<sup>23</sup> The outbreaks of infectious disease, such as smallpox or measles, were equally disastrous for women, threatening their own lives, and those of their children, increasing their burden as mothers.

In conclusion, it must be emphasised that the main purpose of the thesis is to focus on the development of a theoretical perspective of women's health and health care that will adequately explain the problems faced by women both in their procreative and productive roles in society. It is an initial attempt to challenge existing political economy of health explanation in the South African context which has focussed primarily on the effects of the transition to capitalism with the mining revolution and the consequences for health and health care of the policy of segregation and apartheid.<sup>24</sup> Through its focus on class, it has failed to consider the specific health issues of women outside of their role in the production process. Further, this is an attempt to explore historically the patterns of health and health care of women embedded in the structural relations of the pre-capitalist economy, relying on recent developments in southern African feminist studies which have highlighted the issue of women's specific oppression.<sup>25</sup> As such, this thesis attempts to contribute to the growing literature on women in southern Africa, and by highlighting the question of women's health attempts to fill partially the gap as indicated by Cherryl Walker:

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22. Ibid.

23. See Chapter 3.

24. See, for example, S. Marks & M. Andersson, 1987, op. cit.

25. See for example B. Bozzoli, "Marxism, Feminism and Southern African Studies", 1983 and C. Walker (ed.) Women and Gender in Southern Africa to 1945, 1990.

Issues warranting more in depth treatment than they receive here include...female health, as well as attitudes towards fertility, child-bearing and female sexuality, including the commoditisation of sex and the development of a market for prostitution.<sup>26</sup>

It is acknowledged, however, that the question of women's health and health care in society is an enormous topic and it is hoped that this thesis will stimulate further research and discussion, particularly on women and health on contemporary South African society.

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26. C. Walker (ed.), 1990, *op. cit.*, p.5.

## CHAPTER 1

### THE CONCEPTUALISATION OF "HEALTH" AND THEORETICAL EXPLANATION

The definition of health is not static: its meaning has changed over time within specific historical conditions. The social meaning of health has particular bearings on the specific form of health care and health practices in a society. This chapter examines the concept of health in its historicity. Moreover, it considers the theoretical implications of the analysis of health and health care in a particular society from a Marxist perspective. Finally, it offers a feminist critique of Marxist analysis in order to set out the theoretical basis for a more adequate explanation of health and health care from a feminist perspective.

Concepts of health and health-care are shaped by the particular worldview<sup>1</sup> held by a group or the majority in a society and must be viewed historically. Pedersen and Baruffati summarise the view that concepts of health and disease are socially constructed:

In every human society, at any point in history, diseases have generated some form of response aimed at interpreting, controlling, preventing, alleviating, repairing, curing or healing injury, illness and disease.

Reactions to disease...can be seen from this perspective as either adaptive and individual responses of a biological nature, largely determined by the genetic code; or they can be a deliberate response of a social nature with varying degrees of complexity, generated by the group, clan or family, or by society as a whole.<sup>2</sup>

As such, the concept of health is difficult to define beyond meanings within specific social and cultural modes of health and disease. Doyal puts it this way:

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1. D. Hammond Tooke, Rituals and Medicine, 1989, p.32. He defines a worldview as "all cognitive ways of conceptualising and classifying the world, including kinship terminology, botanical and zoological ....., the nature and treatment of disease, notions of "good" government, and even such types of knowledge as the geographical and technical."
  2. D. Pedersen, & V. Baruffati, "Healers, Deities, Saints and Doctors: Elements for the Analysis of Medical Systems", Social Science and Medicine, vol.29, no.4, p.487.

Clearly there are certain physiological processes (breathing, eating, excretion and so on) which need to be completed if a person is to remain alive, and their successful execution must therefore be included in any definition of health. There are also certain instances (eg a broken limb) where there would be little disagreement that the person was not healthy in any normally accepted sense of the world. But once we move beyond examples such as these, then health and illness become difficult to define in any absolute way. Yet, the question of how they are defined in a particular society is of utmost importance.<sup>3</sup>

Indeed, the question of definition of health is crucial in that it establishes the framework which shapes the pattern of health care in that society based on beliefs of causation, type of treatment and the apportionment of responsibility for the care of the sick - the health system.<sup>4</sup> Kleinman put forward the notion that medical systems should be defined as cultural systems and that for this reason it would be impossible to understand medical systems without understanding the cultural context of which they are a part.<sup>5</sup> He argues that within each society different explanatory models of disease and illness can exist simultaneously and that these are individual manifestations varying from person to person in the community and changing over time.<sup>6</sup> As Feierman points out, in Africa, hospital medicine is not the only form of healing: African healing churches, Islamic healing, forms of witch-finding and the diffusion of cult of affliction form part of the present picture.<sup>7</sup> The same is true of choices in western societies. Each carries with it its own

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3. L. Doyal & I. Pennell, The Political Economy of Health, 1979, p.34.
  4. D. Pedersen and V. Baruffati, ibid. They define health systems as "the whole array of elements or components of the broader social system which are related to the health and physical, mental and social well being of the population".
  5. A.M. Kleinman, "Some Issues for a comparative study of medical healing", Int. J. Soc. Psychiat., 19, 159-165, 1973, quoted in D. Pedersen and V. Baruffati, op. cit., p.490.
  6. A.M. Kleinman, "Concepts and a model for the comparison of medical systems as cultural systems", Social Science and Medicine, 12B, 85-93, 1978 quoted in D. Pedersen and V. Baruffati, ibid.
  7. S. Feierman, "Struggles for Control: The Social Roots of Health and Healing in Modern Africa", African Studies Review, vol.28, 1985.

formulations of causation, treatment and responsibility for care. Keith Thomas has shown that until the seventeenth century, in western Europe, health and healing was comprised of two main components: a mixture of 'common sensical remedies' combined with 'ritual' healing, in which "prayers, charms and spells accompanied the medicine or even formed the sole means of treatment"<sup>8</sup> derived from practices of the Church and thus had strong religious underpinnings.<sup>9</sup> Thus, the concept of health cannot be abstracted from its particular social and historical context.

It is clear that the concept of health and the health care system/healing system are closely intertwined. However, they must be treated as separate but related phenomena. It can be argued that since the concept of health carries with it many different meanings, particular meanings gain ascendancy at particular historical moments.<sup>10</sup> The social construction of the meaning of health which shapes and reflects a specific mode of healing/health care must thus be understood within the ideational framework of a particular group/groups in society. The concept of health reflects particular social values and beliefs concerning the relationship between the individual and the world, in other words, it forms part of a particular ideology.<sup>11</sup> Based on the Berger and Luckmann theory of the "social construction of reality"<sup>12</sup> de Kadt argues that "ways of thinking, ways of seeing and ways of acting are influenced by the various forces of cultural continuity and discontinuity in society - such as intellectual traditions, the agencies of socialisation and the various structural and organisational factors that crystallise or institutionalise and in some cases, perforce of their "logic" of survival, make "imperative" certain models of action and ways of thinking."<sup>13</sup> The emergence of a particular dominant concept of health at

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8. K. Thomas, Religion and the Decline of Magic, 1971, p.210 quoted by W.D. Hammond-Tooke in Rituals and Medicines, 1989, p.42.
  9. W.D. Hammond-Tooke, 1989, ibid.
  10. Health can be defined negatively and narrowly as the absence of disease or it refers to the physical, mental, spiritual and emotional well being of the individual in society.
  11. Ideologies, in this sense, involve the formulation of a perspective on society in terms of which persons act, give expression to their attitudes and interpret the social context in which they live and their relationship to it.
  12. P. Berger & T. Luckmann, The Social Construction of Reality, 1967.
  13. R. de Kadt, "Ideology and the Social Sciences", unpublished paper, Durban, January 1975, p.4.

any particular time or period is therefore not arbitrary, at the same time, it does not necessarily extinguish other variations.

What, therefore, requires analysis is how do specific concepts of health emerge within particular societies at any one time, how they survive and what interests are served by them? It has been argued by Marxists that ideology is not neutral - from this perspective therefore the definition of health itself is not neutral. Doyal argues that "health" carries with it a functional element, which, in practice, means that "health" is usually defined as "fitness" to undertake whatever would be expected of someone in a particular social position.<sup>14</sup> She argues that the narrow definition of health as the malfunctioning of a mechanical system has two overall consequences: it limits people's own expectations of what it is to be healthy by excluding more subjective illness and secondly, it keeps sickness and the demand for health care under control.<sup>15</sup>

In the explanation of the evolution of different concepts of health and forms of health care over time, in the west, two main approaches have been postulated. The first explanation contains within it the assumption that there is a broad continuum from primitive notions and practices based on rituals and taboos, to the development of a scientific approach to health and health care based on the accumulation of scientific knowledge of the human body and disease. This approach is based on the fundamental premise that the determinants of health and illness are predominantly biological, thus isolating them from the social and economic environment. Further, scientific medicine is seen as the only viable form of health care, viewed as a science producing an unchallengeable and autonomous body of knowledge, untainted by wider social and economic considerations.<sup>16</sup> Thus, until the 1970s, the number of medical histories was limited and the style of the presentation of medical data outwardly atheoretical, as manifested in the chronological documentation of health services, the development of policies of health care and/or the changing patterns of disease.

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14. L. Doyal & I. Pennell, *op. cit.*, p.34.

15. *op. cit.*, p.35.

16. L. Doyal & I. Pennell, *op. cit.*, p.12.



The methodology of historical materialism, on the other hand, attempts to place the development of health and health care firmly within its social formulations. From this perspective, the underlying premise is that observable phenomena are not always as they seem, and this restricting knowledge to the observable aspects of phenomena in question, will inevitably lead to distortion.<sup>17</sup> For example, the consequences of a biologicistic notion of disease effectively obscures the social and economic causes of ill health. Evan Stark has argued:

Disease is understood as a failure in and of the individual, an isolatable 'thing' that attacks the physical machine more or less arbitrarily from 'outside' preventing it from fulfilling its essential 'responsibilities'. Both bourgeois epidemiology and 'medical ecology' consider society only as a relatively passive medium through which 'germs' pass on route to the individual.<sup>18</sup>

In this sense, then, the explanation of changing notions of health and systems as the consequence of progression of ideas alone, is insufficient. Instead, according to Posel what is required in order to explain fully the underlying reality is a radical scientific approach.

A science, a radical version, of any concrete situation, inevitably requires a theoretical abstraction of the structural characteristics from the empirical phenomenon under examination. And this involves a process of progressive removal from the empirical level, to higher and higher levels of abstraction, in each case to isolate the increasingly fundamental determinants of the concrete situation.<sup>19</sup>

Historical materialism is grounded in the Marxist conceptualisation of historical change. Marx's fundamental objective in developing the theory was to provide a scientific critique of capitalism. Historical materialism provided the means of analysis to understand society, within an historical framework, and of understanding

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17. D. Posel, "Radical Science: In the Final Analysis", unpublished paper presented at Arts' Students' Council Conference, 1980, p.1.
18. E. Stark, "Introduction to the special issue on health", Review of Radical Political Economics, vol.9, no.1, Spring 1977, p.v quoted in L. Doyal 1983, p.35.
19. D. Posel, op. cit., p.6.

society in its totality, that is its historical, political, economic and social contexts, based on the premise that human nature, as historical, must be "investigated empirically within specific historical contexts and in particular with regard to the prevailing mode of production."<sup>20</sup>

Engels wrote: "According to the materialist conception of history, the ultimately determining element in history is the production and reproduction of human life."<sup>21</sup>

At the same time, society was seen to be divided into classes - groups "who shared a common relation to the means of production and consequently, shared similar economic conditions, interests and cultural affinities."<sup>22</sup> In reaction to prevailing liberal science, Marx and Engels linked ideology - the framework of beliefs and values generally employed to explain and justify social experience - and its concrete expressions in society to the mode of production in a base/superstructure model, stressing that "the mode of production in a society constitutes the reality finally underlying appearances."<sup>23</sup>

Engels emphasised this: "According to the materialist conception of history, the ultimately determining element in history is the production and reproduction of real life,"<sup>24</sup> establishing that the mode of production is determinant, in the final analysis, in defining political, economic and social structures, i.e. ideological forms, while the superstructure can display a relative autonomy, thus establishing a dialectical relationship between base and superstructure.

History, in the Marxist view, is the history of class struggle; class is defined in terms of its relation to the means of production, and fundamental change can only be achieved through a revolutionary transformation of the mode of production.

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20. Quoted in A. Jaggar, Feminist Politics and Human Nature, 1983, p.52.

21. F. Engels. Letter to J. Bloch (1890) quoted in D. Posel, "Radical Science in the Final Analysis", op. cit., p.3.

22. A. Jaggar (1983), op. cit., p.54.

23. D. Posel, "Radical Science in the Final Analysis", op. cit., p.2.

24. F. Engels, Letter to J. Bloch, quoted in D. Posel op. cit., p.2.

From this perspective, prevailing ideologies are rooted in class formation and reflect the needs and interests of particular classes. Marx explained it in this way:

The ideas of the ruling class are in every epoch the ruling ideas: i.e. the class which is the ruling material force of society, is at the same time its ruling intellectual force. The class which has the means of material production as its disposal has control at the same time over the means of mental production.<sup>25</sup>

However, while the mode of production is ultimately important it is not the dominant instance in the social formation, and the superstructure can itself display a relative autonomy, which is in itself ultimately a function of the mode of production.<sup>26</sup> Ideology, thus can be a site of class struggle, in the final analysis, determined by the mode of production.

This approach suggests then that the dominant ideology of health care at any given historical moment must be seen as functionalist, reflecting the class struggle within a particular mode of production. For example, in explaining the health care system in pre-colonial east-central Africa, Gloria Waite has argued that the definition of disease as illness caused by spirits and sorcery empowered the ruling elite:

The authorities who controlled traditional public health institutions were priestly, chiefly and kingly figures, or they combined both chiefly and priestly roles. These authorities, like the spirits they evoked, were 'guardians of the land' and all that dwelled therein...the control exercised by elites over health care institutions and other resources set them apart from the rest of the population.<sup>27</sup>

For historical materialists, all human existence is ultimately shaped by the material conditions in society. Engels summed up the materialist position:

According to the materialist conception, the determining factor in history is, in the last resort, the production and reproduction of immediate life. But this itself is of a twofold character. On the one hand, the

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25. K. Marx, "The German Ideology" in Selected Works, vol.1, 1962, p.47, Quoted in V. Navarro, Medicine under Capitalism, 1976, p.120.
26. D. Posel, 1980, op. cit., pp.8-9.
27. G. Waite, "Public Health in Pre-Colonial East-Central Africa", Social Science and Medicine, vol.24, no.3, 1987, p.200.

production of the means of subsistence, of food, clothing and shelter and the tools requisite therefore; on the other, the production of human beings themselves, the prorogation of the species. The social institutions under which men of a definite historical epoch and of a definite country live are conditioned by both kinds of production: by the stage of development of labour, on the one hand, and of the family on the other.<sup>28</sup>

From a Marxist perspective, analysis of the concept of health and form of health care rests within the forces and relations of production. Analysis of health and ill health shifts away from the concept of individual, biological malfunction to socio-economic and political causation. In consequence, health and health care are not seen as politically neutral but form part of the class struggle. The achievement of more equitable distribution of health (absence of disease) and health care is seen to be achievable only through the transformation of the mode of production and relations thereof. Arthur Schatzen puts it this way:

Health under capitalism is an integral component of an individual's labour-power or productive capacity. The capitalist's objective interests reside only in the use-value of labour power, that is, how much value the worker produces. A certain level of physical and mental health is thus necessary to maintain the maximum level of productivity. Below that level, the capacity to work falls off, and with it the amount of surplus-value that will be generated. The capitalist is simply not interested in the level of health beyond this, although the worker will be vitally interested from the point of view of quality of life, not of productive capacity.<sup>29</sup>

Health is conceptualised as a form of labour-power in the capitalist system. The reproduction of labour-power (including health) is ensured through the payment of wages which is determined "not by the needs of a 'biological' guaranteed minimum wage...alone but by the needs of a historical minimum...ie a historically variable minimum."<sup>30</sup> The consequences of the extraction of surplus value from labour

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28. F. Engels, The Origin of the Family, Private Property and the State, 1985, p.6.

29. A. Schatzen, "Health and Labour-Power: A Theoretical Investigation", International Journal of Health Services, vol.8, no.2, 1978 quoted in D. Olver, "Poverty, Health and Health Care in South Africa", unpublished Carnegie Conference Paper No.166, April 1984, p.13.

power through the extension of the working-day in terms of workers' health is seen as the absolute expropriation of health.<sup>31</sup> Beyond that, the consequences of increasing productivity of the workers is viewed as a relative expropriation of health.<sup>32</sup> Thus "...it is the conception of health as labour-power that leads us to what primarily determines the level of health and medical care in a capitalist society: the tendency towards maximization of the rate of exploitation."<sup>33</sup>

Within this paradigm, the development of scientific medicine in nineteenth century western Europe and the narrow definition of health and health care formed part of the scientific revolution accompanying the growth of industrial capitalism. Subsequently, western forms of health care took a particular positivist form, focussing on disease and preventative and curative health practices, defining health in terms of the individual and liberal capitalist tenets. Navarro has argued

...it strengthens the basic ethical tenets of bourgeois individualism, the ethical construct of capitalism where one has to be free to do whatever one wants, free to buy and sell, to accumulate wealth or to live in poverty, to work or not, to be healthy or sick.<sup>34</sup>

Doyal argues that

The nineteenth century was a shift from religion to science as the dominant framework used to define and to explain the nature of the existing social order. Medicine and biology were of crucial importance here, providing the basic concepts through which the class and sexual divisions of Victorian society were expressed and ultimately justified.<sup>35</sup>

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30. L. Althusser, "Ideology and Ideological State Apparatuses (Notes towards an investigation)" in Lenin and Philosophy and Other Essays, 1977, quoted in D. Olver op. cit., p.12.
31. D. Olver, op. cit., p.18.
32. op. cit., p.11.
33. A. Schatzen, "Health and Labour-Power: A Theoretical Investigation", International Journal of Health Services, vol.8, no.2, 1978 quoted in D. Olver op. cit., p.12.
34. V. Navarro, 1976, op. cit., p.
35. L. Doyal and I. Pennell, op. cit., p.141.

In the light of the arguments delineated above, a brief overview of the political economy of health approach which views the changing nature of health and health-care within the Marxist paradigm may now be considered. The concept of political economy of health and health-care is rooted in the methodology of historical materialism and Marxist theory. It is based on the fundamental premise that the way health and illness are defined, as well as the material reality of disease and death, will vary according to the social and economic environment in which they occur.<sup>36</sup> Thus, its starting point is the material conditions of society, in Marxist terms, the mode of production and it views health and health-care systems as determined of the social relations of that particular mode in the final analysis.

The political-economy of health approach uses as its starting point the transition of the mode of production from feudalism to industrial capitalism. Doyal argues that it is important not to romanticise pre-capitalist and pre-industrial Britain but that despite a background of extremely high birth and death rates and a short average life expectancy, the transition to capitalism had drastic effects on life and death of the population.<sup>37</sup> With the separation of production from the domestic sphere and the development of factory production, the growing industrial proletariat suffered increasing ill-health on two levels resulting from the nature of work and working conditions within the factories, and at the same time from poor social conditions such as inadequate housing, lack of sanitation and water, and overcrowding. Poor nutrition as a result of inadequate wages made the proletariat more susceptible to infection. Thus, increased morbidity and mortality amongst the working class in nineteenth century Britain is seen to be determined primarily by the demands of industrial capitalism. Moreover, the development of public health policies based on scientific medicine in late nineteenth century Britain and elsewhere is seen as the consequence of the needs of industrial capitalism, through the intervention of the state, to ensure the reproduction of skilled labour. The declining adult mortality rate by the late 1870s is explained, not as a result of curative medical practice but instead of public health legislation and an improvement in wages, achieved partly by the demands of the working class and the growth of trade unionism. At the same

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36. L. Doyal & I. Pennell, *op.cit.*, p.47.

37. L. Doyal and I. Pennell, *op. cit.*, pp.23-27.

time, this improvement was ultimately dependant on a particular mode of economic and social exploitation of the colonised, underdeveloped world.

The disparities in health and health care between the western world and the third world, and within the third world are explained in terms of the impact of colonialism and the concomitant extension of the market economy and penetration of the economy into that world. Doyal argues that

There is always a close relationship between economic and physical health so that the ability of a population to maintain a given standard of health is always directly related to its capacity to maintain and control the material means of production. Colonial expansion in bringing about the destruction of vital social and ecological relationships which enabled people to feed themselves, also destroyed the health of local populations on an unprecedented scale.<sup>38</sup>

Not only did the impact of colonialism have a direct effect on the health of the colonised through the spread of previously unknown infectious diseases, but more fundamentally, the impact of the colonial economy on pre-capitalist societies created the social and economic conditions which primarily shaped the increasing impoverishment of the majority of the colonised, and thus directly contributed to the decline in health of the population. This approach suggests that the alienation of land and the creation of reserves, linked to the need for cheap labour in urban areas and for colonial agriculture, led to overcrowded conditions, decreasing supplies of vital subsistence foods as peasants were forced into the cash economy and experienced increasing malnutrition. The migrant labour force faced increasing ill-health because of poor working and living conditions in urban areas. Workers, suffering from infectious diseases, such as tuberculosis, were dismissed and forced to return to rural areas, thus spreading infection amongst an increasingly impoverished population. Doyal points out that

The structure of the labour system created not only the environmental conditions in which disease proliferates but also the ideal mechanisms for its widespread dissemination beyond the immediate areas.<sup>39</sup>

Moreover, this approach notes that traditional methods of control of some diseases were disrupted by the consolidation of capitalism.<sup>40</sup> Further, the traditional notions

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38. L. Doyal and I. Pennell, *op. cit.*, p.112.

39. L. Doyal and I. Pennell, *op. cit.*, p.111.

of health and healing practices, were challenged and undermined by colonial authorities. Western scientific notions of health and disease and interventionist health policies were used to legitimise colonial expansion and control of the colonised.<sup>41</sup> Thus, for example, segregation policies and removals of the colonised were legitimised in terms of disease control in order to regulate the labour process.<sup>42</sup> At the same time, while the colonial state and local state accepted responsibility for some aspects of health care such as hospitals and public health practices, the distribution of health care facilities was unequal, balanced in favour of urban areas. It is argued within this paradigm that state/local state intervention was primarily focussed on maintaining labour supply and ensuring productivity with the virtual exclusion of non-productive labour. Increasing morbidity and mortality patterns in rural areas are explained in terms of the population's exclusion from the labour process, the effects of the migrant labour system and the consequent disruption of family life leading to increasing impoverishment and ill health.

It is clear that the political economy of health and health-care analysis rests on the theoretical foundations of Marxist analysis. The focus of the analysis is on the changing patterns (of health) and conceptualisation of health determined primarily by the transformation of the mode and relations of production in the transition from pre-capitalist to capitalist formations. It links the ideological thrust of changing notions of health and health-care to the growth of scientific methodology, itself a reflection of the needs of industrial capitalism and imperialism, and the development of public health policies to the changing needs of capital to ensure the maintenance and reproduction of the labour force. It presents the inequalities in health and health care as part of the class struggle and argues that health is itself a site of class struggle. More equitable health and health care will thus only be achieved with a transformation of the mode and relations of production.

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40. L. Doyal and I. Pennell, *op. cit.*, p.108.

41. See, for example, L. Manderson, "Health Services and the Legitimation of the Colonial State, British Malaya 1786-1941", International Journal of Health Services, vol.17, no.1, 1987.

42. See, for example, M.W. Swanson, "The Durban System: Roots of Urban Apartheid in the Colony of Natal", Journal of African Studies, 1976 and M.W. Swanson, "Urban Origins of Separate Development", Race, vol. XI, 1968.



Through the employment of the theoretical approach of historical materialism, the debate on health and society was shifted beyond the narrow confines of medical discourse to a greater understanding of the socio-economic and political foundations of ill-health and disease and the distribution of such in society. The conceptualisation of health and disease as natural/biological and the ideological foundations of the view that health and health care and the role of the state in the provision of health services are politically neutral, have thus been challenged. As such, the political economy of health definitely provides a more complete understanding of the nature of health and health care in society. However, it is arguably incomplete in terms of feminist theory and methodology.

## CHAPTER 2

### **FEMINIST THEORY AND THE CONCEPTUALISATION OF HEALTH AND HEALTH CARE FROM A FEMINIST PERSPECTIVE**

Thus far, the thesis has examined the concept of 'health' and the theoretical attempts to develop it beyond a narrow biological definition as the absence of disease. It has considered 'health' as an ideological construct within a Marxist framework. The Marxist principles, in which the political economy of health explanation is grounded, have been examined. The application of the political economy approach to the question of health and health-care in a given society has been considered specifically within a capitalist mode of production, establishing the social and economic foundations of health. Political economy of health analyses are, however, thus far rooted in Marxist conceptual tools, and have focussed on health as determined by the social relations of production. In consequence, this form of analysis is gender-blind, ignoring the effects of the sexual division of labour and the relations of reproduction on health, particularly the health of women. Moreover, it fails to examine how the system of health-care in capitalist societies, is itself based on the sexual division of labour and that scientific medicine as an ideology of health and health-care reproduces and reinforces unequal gender relations within the society. This chapter presents a feminist critique of Marxist theoretical principles and explores the ways in which gender may be incorporated automatically into analyses. Along these lines, it examines some of the ways in which a gender-blind political economy of health explanation ignores conditions which influence women's health and thus fails to provide an adequate explanation of women's health and health-care. The chapter concludes with a brief examination of the ways in which health and health-care of women may be incorporated into an analysis of health.

In the first instance, Marxist principles must be examined from a feminist perspective in order to assess the extent to which the theory permits an adequate explanation of women's experience. A feminist perspective starts with concrete examples of women's situation. A theoretical analysis must therefore provide conceptual tools of analysis which can specifically explain at an abstract level the oppression of women and provide the means to examine women's lives in the process of change over time, in order to elucidate the ways in which women can end that oppression. As Christine Delphy argues, the feminist movement aims at a

reconstruction of philosophy and the sciences:

Materialist feminism is...an intellectual approach whose coming is crucial, both for social movements, for the feminist struggle and for knowledge. This project would not be - could not be, even if desired - limited to a single population, to the sole oppression of women. It will not leave untouched any aspect of reality, any domain of knowledge, any aspect of the world. As the feminist movement aims at revolution in social reality, the theoretical feminist point of view (and each is indispensable to the other) must also aim at a revolution in knowledge.<sup>1</sup>

A feminist critique of Marxist theory raises the question of the place of women in that theory and its application in explaining the position of and treatment of women in society. Marx's fundamental objective in developing the theory was to provide a scientific critique of capitalism, writing during a period of emerging capitalism and a society in the process of change. Marxism does provide the means of analysis to understand society within an historical framework, and of understanding society in its totality, integrating its political, social and economic spheres into a coherent whole. Historical materialism is based on the assumption that human nature as historical, must be investigated within specific historical contexts and, in particular, with regard to the prevailing mode of production. History, in Marxist theory, is the history of class struggle; class is defined in terms of its relation to the means of production. Fundamental change can therefore only be achieved through a revolutionary transformation of the mode of production. Through its emphasis on class relations, however, Marxist theory provides no separate category for the analysis of the oppression of women. It does provide the means of analysis of women as members of particular classes, and as such, recognises that women, like men, are divided by class, their class positions determined by their relation to the means of production. However, at the final level of analysis, or abstraction, the analytical constructs do not take sex-differences into account, leading to the criticism that: "Marxist categories, like capital itself, are sex-blind."<sup>2</sup> But it must be emphasised, the primary interest of Marxist analysis is the critique of capitalism and the overthrow of the capitalist society.

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1. C. Delphy, "For a materialist feminism", quoted by A.M. Jagger, *op. cit.*, p.22.
  2. H.I. Hartmann, "The Unhappy Marriage of Marxism and Feminism: Towards a More Progressive Union" in Women and Revolution, 1981 quoted in A.M. Jagger *op. cit.*, p.72.

Engels, rather than Marx, focussed on the oppression of women in The Origin of the Family, Private Property and the State, in which he dealt with the oppression of women in pre-capitalist societies, in order to show that patriarchy had its roots outside of the capitalist system. "Women's subordination is a form of oppression, resulting from the institution of class society and maintained into the present because it serves the interests of capital."<sup>3</sup> His premise was that, while there was a 'natural' sex-division of labour in pre-capitalist societies, women were not subordinate until production in the male sphere of labour gave men a chance to accumulate, and thus, in controlling that sphere of production, men were able to acquire social domination and wealth. This sex-specific oppression was the result of women's exclusion from public industry - production - and its fundamental cause rested on women's economic dependency on men as a result of the structure of monogamous marriage which gave men control over the disposal of their wealth to their own biological offspring.

...monogamous marriage comes on the scene as the subjugation of one sex by the other; it announces a struggle between the sexes unknown throughout the previous period....The first class antagonism that appears in history coincides with the development between men and women in monogamous marriage, the first oppression coincides with that of the female sex by the male.<sup>4</sup>

In terms of traditional Marxist analysis and its contemporary extensions, the principal contradiction is ultimately that between capital and labour and not gender oppression. Engels was not concerned with the sex-division of labour, beyond the assumption that under capitalism, the sex-division of labour has been used to divide men and women, dichotomise work into public and private realms and in this way, force women into economic dependence on men in the interests of capitalism. According to Engels, middle class women are more oppressed than working class women who, in working, form part of the working class and therefore share the same class interests as working class men and therefore are not in conflict with men of that class. For Engels, the solution was therefore for women to join the labour market as workers. "...the first condition for the liberation of the wife is to bring the

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3. F. Engels, The Origins of the Family, Private Property and the State, 1972, p.82.

4. F. Engels, op. cit., pp.65-66.

whole female sex back into public industry."<sup>5</sup> Thus, the interests of all women as a sex and the interests of working class men would coincide in overthrowing the system.

The sexual division of labour, of importance to feminists, is assumed as "natural" or biologically determined. In Capital, Marx makes the point:

Within a family...there springs up naturally a division of labour, caused by differences in sex and age, a division that is consequently based on a purely physiological foundation."<sup>6</sup>

Moreover, production in the home, that is the care and physical maintenance and biological reproduction of the working class is peripheralised in Marxist analysis, producing use-value, and not commodities - production for the market, in an analysis that focuses on production and relations of production. Traditional Marxist analysis of women has predominantly followed this direction, that the oppression of women, like that of working class men is linked to the capitalist mode of production. Freedom for both women and working-class men is perceived in the transformation of the mode of production: thus class struggle is primary, both in analysis and organisation.

Feminists have developed a critique of traditional Marxism on several levels. In the first instance, class oppression is not sex-specific. It is assumed that working class women are not oppressed in any different way from men. Engels did not identify any inequality between the sexes in the labour market and thus conflated sex and class, failing to examine male dominance in the labour market. The failure to confront the issue of the sexual division of labour arose from two important assumptions: that on the one hand the sexual division of labour was "natural" - biologically determined - and that women's responsibility for reproduction - both biological and physical maintenance within the home - was a rigid ahistorical process that could not be transformed. Engels' narrow economic determinist definition of women's oppression as exclusion from the labour market prevented his analysis from penetrating beneath the level of appearances. Engels examined the significance of patriarchal ideology, particularly in the later stages of economic

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5. F. Engels, op. cit., p.82.

6. Quoted in A. Jaggar, op. cit., p.70.

development with capitalism.

From a feminist perspective, therefore, Marxist analysis fails to explain adequately the roots of women's oppression. Women are peripheralised in a theory that gives primacy to class-struggle. For many feminists, the narrow conception of freedom through the transformation of the mode of production is insufficient: freedom is identified in the public sphere and women's interests are thus subsumed under class struggle. For male Marxist activists, it has been important to make clear to women that their (women's) interests are primarily class interests and that the liberation of women will take place with the overthrow of capitalism, a standpoint rejected by feminists who argue that the transformation of the mode of production historically has not automatically liberated women from their sex-specific oppression.

Central to a feminist critique of Marxist theory is the dichotomy between public and private spheres of life - the spheres of production and reproduction in Marxist analysis. In this analysis, the distinction separation - between the two spheres occurs with the emergence of accumulation outside the private sphere, and the final separation with the emergence and consolidation of capitalism. Moreover, this view fails to accommodate any real transformation of the private sphere in terms of who does what and how in the home beyond the assumption of socialisation of housework.

These criticisms expose one of the fundamental problems of Marxist analysis for feminists in terms of the public/private dichotomy intrinsic to Marxist theory. The sphere of reproduction is subordinated in that analysis to the sphere of production. It is both within the sphere of reproduction and the sphere of production, that socialist feminists view women's oppression, that is women not just identified within class relations but also women as wives, mothers and housewives. For socialist feminists Marxist analysis fails to explain why women do women's work, thus failing to explain the sexual division of labour, and the sex-specific relations of gender, which transcend class relations. While Engels was able to explain the origins of women's oppression and the changing nature of the family within the transition to capitalism, thus exposing the historical nature of the family, he failed to examine the sexual division of labour within the family itself. It seems, as Jaggar argues, that Marx and Engels "clearly believe that the division of labour within the family is natural because it is biologically determined based on a purely physiological

foundation."<sup>7</sup> Built on this assumption of the sexual division of labour as natural, Marxist analysis, therefore, fails to analyse the historical transformation of the roles and practices identified within the sphere of reproduction - such as sexuality, childbearing and -rearing, and fails to encompass the notion of the transformation of these by women themselves, independent of the class struggle. As a result, it can be argued from a feminist perspective, that Marxists, like liberals, obscure and even justify the subordination of women in the home. Marxist men can argue that the mass entry of women into the public sphere endangers the position of the working class as a whole, and that it deprives working-class men of their refuge and comfort outside the public sphere.

However, while socialist feminists have exposed the deficiencies of Marxist analysis in terms of women's oppression, they have specifically chosen to remain within a historical materialist methodological framework. For socialist feminists, the radical feminist concept of patriarchy as the fundamental/primary explanation of women's oppression is itself insufficient as it is a universal construct, and fails to explain differences in women's experience of oppression in terms of class, race, age and nationality and the underlying material historically specific conditions of women's oppression. Thus, socialist feminists adopt the analytical tools of gender and class in which to explain that oppression.

Thus socialist feminists aim to produce an analytical framework that will permit, not the separate analysis of class on the one hand and gender on the other - or a dual system of oppression, but instead a single system that will incorporate both, as well as race, age and nationality.

A full understanding of women's oppression must examine the sexual division of labour outside as well as within procreation, and between procreation and "production" and "it must examine the endless variety as well as the "monotonous similarity" in women's experience, both the experiences of women in other societies and especially the experience of women as different classes, races and nationalities in contemporary industrial society.<sup>8</sup>

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7. A. Jaggar, *op. cit.*, p.70.

8. A. Jaggar, *op. cit.*, p.139.

By using as their starting point, the sexual division of labour, socialist feminists aim to break down the traditional separation of public and private, "in order to give an historical account of sex and gender",<sup>9</sup> to show that "contemporary masculinity and femininity are not constructed entirely through the social organisation of procreation; these constructs are elaborated and reinforced in non-procreative labor as well."<sup>10</sup> Thus, socialist feminist theory consists "precisely in tracing connections between the sexual division of labour in procreation, the sexual division of labour in the market and the ideological sexism embodied in law, politics, religion, aesthetics and philosophy".<sup>11</sup>

Therefore, the fullest explanation for socialist feminists, of women's oppression must cut through the separation of production and reproduction and must include the analytical concepts of gender, social preference, class, race, age and nationality within a historical materialist framework. In order to produce a single system of analysis of women's oppression within this framework, it is necessary to redefine what is understood in a Marxist sense as production to include or incorporate reproduction as procreation. Jaggar argues that "the economic formulation of society includes a characteristic system of organising procreation which in historical times has been defined in part by a characteristic sexual division of labour."<sup>12</sup> By expanding the base of the base/superstructure model and incorporating the concept of the relative autonomy of superstructural forms, it can be argued that: "This system of procreation is among the most pervasive influences on the culture of a society, understood in the sense of its legal, political, religious, aesthetic and philosophic forms"<sup>13</sup> and its importance "in setting limits to what forms can ultimately exist in society."<sup>14</sup> The conflation of the mode of production to include reproduction allows an exploration of the interrelationship between production and reproduction, rather than the examination of them as discrete spheres, and exposed

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9. op. cit., p.126.

10. op. cit., p.130.

11. op. cit., p.142.

12. op. cit., p.142.

13. ibid.

14. ibid.



the interdependence of them both. By redefining the mode of production to include reproduction, the material nature of women's oppression can be examined. As Michèle Barrett points out the Marxist theory of alienation "is effective as a general theory of oppression and liberation for the reason that it has a strong relational character. It enables us to understand oppression not as an arbitrary imposition but as a process involving the oppressed."<sup>15</sup> Jaggar suggests that "the concept of alienation can provide a theoretical framework for systematising the socialist feminist critique of women's contemporary oppression"<sup>16</sup> and that

(w)ithin this framework, the facts of women's oppression may be reinterpreted and given a new meaning...,(the) use of the theoretical framework of alienation identifies women's contemporary oppression as a phenomenon peculiar to the capitalist form of male dominance....The framework of alienation, moreover, links women's oppression in the home with women's and men's experience in wage labor.<sup>17</sup>

Finally, this collapsing of the division between production and reproduction, enables socialist feminists to broaden the Marxist understanding of freedom. Again, Jaggar points out that

reproductive freedom for women requires a transformation of what has been called traditionally the mode of production. Equally, however, a feminist transformation of the mode of production cannot be achieved without reproductive freedom for women or a transformation of the mode of procreation. Since one cannot precede the other and since both are dialectically related, both must occur together. Procreation and 'production' in the narrow sense are simply two aspects of an integrated capitalist and male-dominated mode of producing and reproducing every aspect of life.<sup>18</sup>

Thus, the expanded conception of the material base opens up for feminists more forms of political activity than conceived in traditional Marxist political theory which subordinates women's struggle under class struggle and which restricts women's political activity to class struggle and enlarges the goal.

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15. M. Barrett, "Marxist Feminism and the Work of Karl Marx" in A. Phillips (ed.), Feminism and Equality, Basil Blackwell, 1987, p.51.

16. op. cit., p.308.

17. op. cit., p.317.

18. op. cit., p.234.

The socialist feminist analysis of women's oppression shows that women's liberation requires totally new modes of organizing all forms of production and the final abolition of 'femininity'....Socialist feminism makes an explicit commitment to the abolition of both class and gender.<sup>19</sup>

Thus far, the chapter has examined Marxist theory from a feminist theoretical perspective. It has argued that Marxist theory, as it stands, does not provide the means for a full understanding of the oppression of women within the spheres of procreation and production. In terms of this argument, the political economy of health analysis, grounded in Marxist theory, does not provide a sufficient explanation of women's health. As discussed previously, radical and socialist feminists have argued for an analysis that takes into account gender relations in the private sphere, the sphere of procreation. It is now necessary to examine the political economy of health explanation from this perspective. The primary aim of this theory is to illustrate the relationship between the mode of production and the distribution of health and disease and health-care in terms of class. The political economy of health approach is an attempt to move beyond a narrow, individualistic biologically-determined definition of health in order to place it within the fundamental historical material conditions that shape health patterns in society. It is correct in arguing that most causes of morbidity and mortality derive from poverty in terms of class relations, and that the distribution of health and disease are largely determined by the distribution of wealth in a society.

However, from a feminist perspective this explanation, based on Marxist principles, does not fulfill the requirements of an adequate explanation of women's health. In the first place, in examining the consequences on health within the labour process, within the narrowly defined terms of production, it fails to examine the sex-specific consequences on health of workers, by using the gender-blind category of class and failing to incorporate the sexual division of labour in its analysis. Thus, it does not examine the specific consequences of the labour process on women's health. Within the capitalist mode of production, women historically have occupied positions in service industries and as the lowest paid workers<sup>20</sup> - for example, female hospital

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19. op. cit., p.317.

20. L. Doyal, 1983, op. cit., pp.382-383.

workers, hairdressers and textile workers. These industries have their own health risks.<sup>21</sup> Moreover, the analysis of occupational diseases is usually addressed in terms of class and is not sex-specific. Fertile or pregnant women face major occupational hazards in certain industries. Exposure to lead or radiation, for example, can damage a growing fetus, produce a miscarriage or lead to permanent sterility. Activists in the women's health movement argue that protective legislation which excludes pregnant women or even fertile women from such jobs, is inadequate, in that it is discriminatory against women. Instead campaigns should be mounted for workplaces to be made safer for both men and women.

Secondly, the Marxist definition of "production" excludes domestic labour as non-productive labour. Political economy of health theory perpetuates the dichotomy between public and private by largely ignoring the sexual division of labour in the domestic sphere and its consequences on the health of "domestic" workers - women. While it is partially correct in analysing the health of the family as linked to the wage earned by the worker (usually assumed as male) and the material conditions created by industrial capitalism, it ignores the effects on the health of women of the historically gender-defined task of home worker. Health hazards such as the type of living conditions, the frequency of accidents and the risk of toxic or carcinogenic chemicals in the home, place women more at risk as they tend to spend more time there.<sup>22</sup> The physical effects of preparing food in the home, in many parts of the world, are largely ignored in this type of analysis. As Kamuzora points out:

It should be remembered that most African women prepare food in deplorable conditions, yet nobody seems to regard their discomfort as a health problem, let alone an occupational health problem.<sup>23</sup>

It is women, too, who face the major health risks, in many rural societies from inadequate supplies of purified water, spending much of their time in performing household chores such as washing clothes and collecting drinking water.

At the same time, by focussing on narrowly defined production relations and the distribution of health and health-care in terms of class, political economy of health

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21. L. Doyal, 1983, *op. cit.*, p.381.

22. L. Doyal, 1983, *op. cit.*, p.382.

23. P. Kamuzora, "Redefining Occupational Health for Tanzania". *ROAPE*, 36, 1986, p.33.

analysis fails to examine all the conditions which mediate in women's health. It fails to examine the consequences of specific gender relations which determine the role that women play in a society and the relationship between gender and health. For example, women's unpaid labour in household production in many underdeveloped countries has been conceptualised as reproduction in terms of capitalist relations, undermining its value and its historically specific social formation in terms of the sexual division of labour. The political economy of health explanation argues that deteriorating health conditions in rural areas in colonial societies can largely be explained in terms of the penetration of capitalist relations into those societies. It argues, for example, that the imposition of systems of taxation, alienation of land and the introduction of migrant labour systems resulted in disruption of family life, through the withdrawal of male labour and the subsequent impoverishment of the family left behind.<sup>24</sup> What it fails to take into account are the existing gender-relations, albeit transformed under capitalism, that rested on the expropriation of women's labour and the effects on women's health.<sup>25</sup>

Women's agricultural labour, along with their other gender-defined roles in subsistence households, have serious consequences on women's health. Feierman has argued:

In rural areas, especially those with a single main rainy season, the amount of labor women devote to agriculture varies widely from one season to another. During the months which demand the heaviest labour the nutrition of women and men suffers.<sup>26</sup>

He argues, moreover, that women themselves often go hungry at this time, during periods when the previous year's food is nearly exhausted and the new year's food has not yet ripened. In consequence, women tend to get fewer calories than they need at the heaviest working time and have to attempt to make up the deficits after harvest.<sup>27</sup>

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24. See for example, F. Wilson and M. Ramphela, Uprooting Poverty: The South African Challenge, 1989.

25. See C. Walker, "Gender and the Migrant Labour System" in C. Walker (ed), Women and Gender in Southern Africa to 1945, pp.168-196.

26. S. Feiermann, "Struggles for Control: The Social Roots of Health and Healing in Modern Africa", p.94.

27. Ibid.

The consequences on women's health are numerous. Maternal malnutrition can lead to fatigue, weakness, susceptibility to infections, insufficient lactation and maternal mortality in childbirth and low infant birthweight. Iron deficiencies can cause fatigue and weakness, and if severe, can predispose maternal death during childbirth.<sup>28</sup>

At the same time, political economy of health analysis fails to take into account the relationship between the "status" of women in the household and health. Feminists have argued that the "status" of women is largely determined by gender-relations and reinforced by ideological constructs in the form of rituals and taboos.<sup>29</sup> MacCormack has argued that in agricultural societies which are largely organised around the labour of men, women and girls have low status. In consequence, relatively little social investment is made in them, specifically in terms of adequate nutrition and care.

Among 45 developing countries for which recent data are available, there are only 2 where mortality rates for girls age 1-4 years are not higher than mortality rates for boys in the same age range, suggesting that less food, health care and other social benefits which enhance survival chances are going to girls in those societies.<sup>30</sup>

Fundamental to an analysis of women's health is the sphere of procreation and the specific relations which shape it. The World Federation of Public Health Associations notes:

Pregnancy and its sequelae are among the five leading causes of death for women aged 15-44. WHO estimates that 500,000 women die each year from causes related to pregnancy. Maternal mortality rates in some less-developed countries are 50 times those in developed countries. These rates are per birth, moreover, and since women in developing countries have higher birth rates, their life time risk of maternity-related death is 150-300 times the risk of developed-country women.<sup>31</sup>

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28. C.P. MacCormack, "Health and the Social Powers of Women", Social Science and Medicine, vol.26, no.7, 1988, p.677.
29. C.P. MacCormack, op. cit., p.681.
30. C.P. MacCormack, op. cit., p.677.
31. World Federation of Public Health Associations, Women and Health, 1986, p.11.

As has been argued above, in Marxist analysis, procreation is obscured under reproduction in terms of capitalist relations, resting on the assumption that procreation is a "natural" biologically determined and historically unchanging process. Feminists have argued that procreation can be viewed as historical, within a specific mode of production that incorporates reproduction within its analysis, illustrating simultaneously how both class relations and gender relations shape the process. For example, Armstrong and Armstrong have argued:

...we do not see biology as fixed and immutable. We do not see childbearing as the same for all women in the same society or in different historical periods. We do not see biological factors as primary or even separate factors. Physical capacities do not exist outside - autonomously from - power structures and productive processes. Nor are they beyond human control and manipulation. Procreation is itself to a large extent socially constructed. It has a history. Its process, its consequences, and its meanings also vary from class to class. Contradictions are created, resolved and transformed. And women, on the basis of these contradictions, struggle to resist, to gain some control over their biological capacities.<sup>32</sup>

Feminist research on the history of women's role in procreation indicates that the general economic situation, the class structure, the development of technology, women's other work, health care and standards and available food supplies affect in part the kind of pregnancies women go through and their chance of survival.<sup>33</sup> For example, Tilly and Scott show how low standards of nutrition and health in early modern England inhibited conception, promoted miscarriages, affected the milk supply of mothers and made women infertile by the age of forty or forty-five.<sup>34</sup> At the same time, menstruation is also dependent in part on changes in economic and social arrangements.<sup>35</sup>

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32. P. Armstrong & H. Armstrong, "Beyond Sexless Class and Classless Sex: Towards Feminist Marxism" in M. Luxon (ed) Marxist-Feminism or Feminist Marxism: A Debate, 1985, p.26.

33. P. Armstrong & H. Armstrong, op. cit., p.27.

34. L. Tilly and J.W. Scott, Women, Work and Family quoted in Armstrong and Armstrong, op. cit., p.27.

35. According to J. Delaney, M.J. Lupton and E. Toth, The Curse, New York, 1977, pp.42-43, first menstruation depends greatly on good food and good health. Figures from Norway show that in 1850 the average girl had her first period at seventeen; by 1950 at thirteen and half. Cited by P. Armstrong and H. Armstrong, op. cit., p.28.

Political economy of health analysis has seen procreation as part of reproduction shaped by economic relations in explaining the consequences on women's health in terms of class relations but it has ignored the analysis of gender-relations and procreation. The specific gender relations controlling women's fertility are not taken into account. Within specific conditions, a women's status and access to land within the household and broader social structure will be determined by her fertility or the sex of her children.<sup>36</sup> Equally, the number of pregnancies, their frequency, the age of first pregnancy or last, can be determined in the immediate instance by the specific gender relations within a wider mode of production. Major health risks are involved for women in many of these instances. The physical act of childbirth can endanger women's lives. Complications such as infections, slow labour, malpresentation, multiple pregnancy, retained placenta among others can lead to maternal and/or infant death. As Shorter has pointed out: "Even though pregnancy is a natural, physiological process and not a pathological one, it can be nonetheless highly dangerous."<sup>37</sup> Moreover, other health problems are aggravated by pregnancy or in turn have serious consequences for the pregnant woman. For example, anemia causes fatigue and weakness and can lead to maternal death during childbirth from heavy bleeding or heart failure. Many chronic diseases such as diabetes, renal disease and hypertension are aggravated by pregnancy. Malaria may lead to maternal death, miscarriages and stillbirths. Sexually transmitted diseases can lead to infertility, increased risk of cervical cancer, ectopic pregnancies and deformities of the fetus.<sup>38</sup>

While political economists of health argue that many of women's health problems related to pregnancy are in a large part determined by their class position, in terms of patterns of disease and health-care, it is argued here that changes in the productive system do not necessarily alter women's experience in procreation.

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36. See Chapter 3.

37. E. Shorter, A History of Women's Bodies, 1984, p.69.

38. World Federation of Public Health Associations, Women and Health, *op. cit.*, p.11.

Possible contradictions between class and gender over women's reproductive freedom are examined by Beneria and Sen. They emphasise the interplay between gender and procreation. They argue that the concept of reproductive freedom includes the right to bear or not to bear children and, by implication, the right to space childbearing, but that women's choice is limited by the extent to which children are potential labourers, or inheritors for the propertied classes. In consequence, decisions about childbearing affect not only the woman but her entire household. But childbearing costs are born in the first instance by women, in terms of health.<sup>39</sup> They sum up the contradictions:

It is true that decisions about childbearing may affect the survival of the entire household over time; still, the most immediate burden of multiple pregnancies falls on the mother. In conditions of severe poverty and malnutrition where women are also overworked, this can and does take a heavy toll on the mother's health and well-being. The poor peasant household may survive off the continuous pregnancy and ill-health of the mother, which are exacerbated by high infant mortality. The mother's class interests and her responsibilities as a woman come into severe conflict.<sup>40</sup>

Thus a woman's reproductive freedom may be severely limited. Beneria and Sen argue that in analysing conditions shaping procreation and contraception research should address several important issues including who makes decisions about childbearing and birth control within rural households, families and communities, and on what basis are the decisions made. Secondly, the extent to which differences of opinion and interest exist between the childbearers and other family members must be examined.<sup>41</sup>

One area that is largely neglected in political economy of health explanation is the physical and emotional consequences of the physical abuse of women by men. The failure to incorporate this aspect into analysis must be seen again in the fundamental concern of this type of analysis to show the relationship between class relations and patterns of ill-health. The effects of sustained domestic violence within the sphere of marriage and family and the wider social question of rape

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39. Beneria and Sen, "Accumulation, Reproduction and Women's Role in Economic Development. Boserup Revisited", *Signs*, vol.7, no.2, 1981, p.296.

40. *Ibid.*

41. Beneria and Sen, *op. cit.*, p.297.



cannot simply be explained in class terms. Both offer stark examples of women's specific oppression by men, and while they need to be examined in terms of the broader social and economic structures, an analysis incorporating gender is fundamental.<sup>42</sup>

Thus far, the chapter has offered a feminist critique of Marxist principles and examined some of the ways in which political economy of health analysis fails to provide a sufficient explanation of women's health. It has argued that failure to analyse health and sex-specific class relations obscures the health problems of women as workers. Moreover, it argues that women's procreative role should be examined as a crucial factor in shaping women's health and that while procreation can be examined in terms of the wider social and economic conditions in a society, it must also be examined in terms of gender relations.

Finally, a major concern for feminist health activists has been a critique of the nature of scientific medicine and its ideological function in the perpetration of the subordination of women. Feminists argue that the ideology of medicine within the context of industrial capitalism has reinforced gender ideology and the sexual division of labour, through its male-biased definitions of women's health as determined by biological sex differences. For example, nineteenth century medical discourse embodied the patriarchal image of the ideal domestic woman based on the assumption of the "natural" reproductive role of women. As Verbrugge has pointed out:

Idealising women as domestic and maternal beings, medical ideologies reinforced the character and implicit values of institutions such as the family which helped glue together the socio-economic system. Furthermore, they provided a gauge for judging women as either 'respectable' or 'deviant' and a rationale for treating them as such.<sup>43</sup>

The emphasis on biological sex-differences between women and men in medical discourse has played a large part in reinforcing the sexual division of labour, based on assumptions of physical, mental and emotional differences. For example, a

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42. L. Doyal, 1983, *op. cit.*, p.380.

43. M. Verbrugge, "Historical Complaints and Political Disorder: A Review of Ehrenreich and English's Study of Medical Ideas About Women", in E. Fee (ed.) Women and Health: The Politics of Sex in Medicine, 1983, pp.323-333.

modern textbook of occupational medicine argues:

In general, women's size and weight are less than men's; the hand is smaller, finer and suppler. Physical force is less developed....From a genital point of view, the [menstrual] periods cause physical and nervous fragility. Pregnancy and lactation get in the way of the accomplishment of industrial tasks....Altogether, except for dexterity, women are physiologically disadvantaged.<sup>44</sup>

Messing argues that these unproven assumptions based on male-biased "scientific" medicine legitimise the exploitation of women in low-paid employment. Feminists have expended a considerable amount of time in research on providing evidence to counter assumptions of women's physical weakness.<sup>45</sup>

Moreover, the contradictions between the advantages of medical intervention in the health-care of women and the loss of control by women in decision-making in terms of their health is explored. It is argued by Doyal that while scientific medical technology has offered women safer and more effective methods of birth control and that childbearing itself is made safer for women who have access to it, the potential for women to control their own fertility is still limited by the power of the medical profession to make decisions on behalf of their patients or to withhold information, thus reinforcing existing gender relations.<sup>46</sup> As a result, particularly in those areas of medical care that most directly impinge on women's lives as women - gynaecologic examination, birth control and abortions, sexuality, childbirth and psychotherapy - feminists have been critical of the nature and quality of medical treatment.<sup>47</sup>

At the same time, feminists have argued that the development of scientific medicine has obscured the historical role that women have played as dispensers of health care.<sup>48</sup> Moreover, the contemporary health system within capitalist societies

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44. H. Desoille, J. Sherrer and R. Truhant, Precis de médecine du travail, p.932 quoted by K. Messing "Do Men and Women Have Different Jobs Because of Their Biological Differences" in E. Fee (ed) Women and Health, 1983, p.140.

45. See, for example, K. Messing op. cit., pp.139-148.

46. L. Doyal, op. cit., p.374.

47. E. Fee, op. cit., p.17.

48. See, for example, E. Shorter op. cit. on how women were displaced as midwives with the development of scientific medicine.

replicates the sexual divisions of labour in the wider society by incorporating women into the system as nurses - performing the caring and comforting duties, while doctors, largely male, perform the scientific and technical tasks. As Doyal points out, in Britain only 25 per cent of doctors are female and most women health workers are to be found lower down the hierarchy, especially in nursing and ancillary work, which involve traditional "female" roles of caring and performing domestic tasks of cooking, cleaning and laundering.<sup>49</sup> Doyal makes the important point that women have been socialised into seeing themselves as care-givers and it is the use of women which has played an important part in maintaining a low-cost health sector in Britain.<sup>50</sup>

In developing a critique of existing health care systems under capitalism, feminists have argued that the system must be seen in context of both capitalist and gender relations. Socialist feminists have argued that alternative health care practices operated for and by women, particularly in the United States, do not challenge the fundamental conditions which shape contemporary health care.<sup>51</sup> Attention has been focussed on the sexist beliefs and practices in the medical profession and on the need for women to gain control of medical knowledge in order to control their own fertility. But as Doyal has argued, feminists need to develop a socialist feminist understanding "of how society makes women sick", through an understanding of the causes of ill-health of women, in particular, the understanding of women's sickness and health in the context of the patriarchal and capitalist nature of society.<sup>52</sup>

This chapter has attempted a critique of the political economy of health explanation from a feminist perspective. It has examined specific areas of women's health that are insufficiently explained simply in terms of class. Ill-health reinforces and perpetuates women's oppression. By failing to incorporate gender analysis, alongside class and race in terms of the disparities in health and health care in contemporary society and historically, political economy of health explanation fails

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49. L. Doyal, *op. cit.*, p.380.

50. *Ibid.*

51. E. Fee, *op. cit.*, p.25.

52. L. Doyal, *op. cit.*, p.381.

to examine all the factors that shape women's health. Socialist feminists must work towards a theory of health that will incorporate as a goal women's specific health needs. Such a definition of health would have to incorporate the fundamental principle for women: the right to control their own bodies.

## CHAPTER 3

**GENDER AND POLITICAL ECONOMY OF HEALTH AND HEALTH CARE OF  
AFRICAN WOMEN IN PRE-COLONIAL AND COLONIAL NATAL/ZULULAND  
IN THE NINETEENTH CENTURY**

This chapter focuses on the changing patterns of health and health care experienced by women in Colonial Natal during the nineteenth century. Its purpose is twofold: in the first place, it attempts to flesh out the lived experiences of African women, mainly in rural areas and to show that those experiences were, in many ways, inherently different from men's. Secondly, it attempts to illustrate the main characteristics of the relationship between health, gender and the broader political economy. In this, it is informed by the theoretical developments of Socialist Feminism, discussed in Chapter 2 and insights into the position of women in colonial society gleaned from recent feminist historical studies of women in pre-capitalist and colonial societies in Southern Africa.<sup>1</sup>

Through the employment of the methodology of historical materialism, it attempts to move beyond the analysis of the universal oppression of women based on female biology.<sup>2</sup> It argues that women's experiences of procreation are not necessarily the same, and are mediated upon by factors other than the individual's physical make-up. It further argues that it is gender relations rather than biology that partly determine the procreation process and that these vary between different classes and within classes at different moments. It also challenges the existing political economy of health explanation that excludes gender as an analytical tool, focussing instead on the relationship between health and the relations of production in terms of class.<sup>3</sup>

Furthermore, it attempts to highlight the role of women in health care in the home, hidden from most analyses by the assumption of it being a part of the domestic, 'natural' and unchanging role of women in reproduction. It examines the issue of

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1. See for example, B. Bozzoli, "Marxism, Feminism and southern African Studies", 1983, C. Walker (ed.), Women and Gender in Southern Africa to 1945, 1990, J. Beall, "Class, Race and Gender: The Political Economy of Women in Colonial Natal", 1982.
  2. See for example, S. Firestone, The Dialectic of Sex, 1970.
  3. See for example, L. Doyal & I. Pennell, op. cit.

whether this role, in specific instances, gives some women power or influence to challenge existing gender relations, and the extent to which it gives them control over other women's lives. Moreover, it attempts to illustrate the extent to which scientific medicine, introduced as part of the colonial political economy, embodied the dominant, patriarchal ruling class ideology and the extent to which it influenced the position of women and their perceptions of themselves in terms of race, class and gender. Finally it examines the question of the availability of scientific-based hospital medicine for women, depending on the needs of the wider political economy in terms of class and race, and poses the question of whether medical intervention, while alleviating women's health problems improved or transformed their position in society, or whether it, in fact, helped to entrench gender relations. However, at the same time the thesis attempts to examine the ways in which women resisted changes which challenged the view of women as passive victims of men or class relations.<sup>4</sup>

An investigation of the position of women in a particular society, within an historical materialist framework, requires an examination of the structural relations embedded in the political economy of a given society and the ideological manifestations emanating from those arrangements. As has been argued above, the conceptualisation of health and health care from a feminist perspective reflects not only the relations of production at any given time, but also the relations of procreation. As suggested in Chapter 2, a more fruitful way of examining women's health and health care within a specific period should attempt to consider the relations of procreation/production simultaneously.

Recent analyses of the contemporary patterns of ill-health and disease in South Africa have focussed on the changing mode and relations of production, using as their starting point the imposition of capitalist relations with increasing imperialist hegemony.<sup>5</sup> It has been stated that patterns of ill-health and disease and maldistribution of health care facilities are best explained in terms of class and race. For example, Marks and Andersson have pointed out:

Part of the story of twentieth century South Africa is

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4. See B. Bozzoli (1983) and C. Walker (1990) for their criticism of traditional Marxist analysis of women and the transition to capitalism.
  5. See for example Special Issue on the Political Economy of Health in Southern Africa, JSAS, 1987.

how the burden of disease has become differentiated according to skin colour, and the role of the state in this outcome. Today, racial and class inequalities are powerfully revealed in infant mortality and TB rates.<sup>6</sup>

and further

The allocation of health care resources and the training of health workers are more than a passive reflection of class and race relationships; however, like welfare in general, these issues played a direct role in the reproduction of class relations at the ideological, socio-political and even economic level, and this is well illustrated in debate around the training of black doctors and the medical aid scheme.<sup>7</sup>

Moreover, the gross disparity of health and health care services between urban and rural communities is explained in terms of the broader political economy. Ill health in rural areas is directly linked to poverty, caused, it is argued, by the alienation of land, the expropriation of male migrant labour and the disruption of 'family' life. Claassens writes that

The poverty of the reserves is a function of the way in which these areas are integrated into the wider South African economy. Neither white farming nor mining would be viable were it not based on the exploitation of cheap labour. The only way to force people to accept the low wages in these sectors has been to destroy their self-sufficiency and alternative sources of livelihood. A study of South African history shows that this has been an expressed aim of successive governments, particularly in the early days when blacks were still subsistence farmers.<sup>8</sup>

Significantly, for the purposes of this study, health problems in rural areas, particularly the relationship between poverty, high birth rates and malnutrition are based on assumptions of the disruption of family life, focussed on the temporary absence of fathers/husbands. For example, in a study of rural KwaZulu, Liz Clarke has stated that in the transition from a subsistence to a cash economy significant changes took place in family organisation.

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6. S. Marks & M. Andersson, "Issues in the Political Economy of Health in Southern Africa", 1987, p.179.
  7. op. cit., p.183.
  8. A. Claassens, "An Assessment of Self-Help Projects in a District of Transkei", in F. Wilson & G. Westcott (eds), Economics of Health in South Africa, vol.II, 1979, p.105.

The end result of this type of change is universally that families are modified in the direction of the nuclear family and that the mutual security functions of the extended family are lost....The migrant labour system in its present form has probably been the most devastating influence, because it fosters an anti-social lifestyle by depriving husbands and wives, parents and children of the opportunity of building sound family relationships based on day to day shared experience of responsibility, respect, trust and affection.<sup>9</sup>

She argues that increased illegitimacy/single parenthood is a major effect of the disruption to family life of the migrant labour system and directly contributes to increasing levels of malnutrition.<sup>10</sup> At the same time, other researchers have argued that the only way to decrease high birth rates amongst the poor is through the provision of employment opportunities and 'settled' family life. Roberts and Rip argue

The motivation needed to decrease family size probably comes best from the settled family life and job opportunities that normally characterise urban life. It may well be that the best contraceptive is stable family life in conjunction with adequate employment opportunities.<sup>11</sup>

Criticism of these assumptions are two-fold: on the one hand, socialist feminists have argued that a change in the mode and relations of production will not necessarily mean a change in the relations of procreation. Gender relations must obviously play a considerable part in decisions concerning contraception and procreation.<sup>12</sup> Secondly, the use of the concept of 'the family' must be historically specific. Walker points out how the use of the concept unhistorically tends to subsume women within the family and to privilege kinship at the expense of other social networks and relationships.<sup>13</sup> Moreover, Walker argues that

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9. L. Clarke, "The Need for a Community Development Approach to Combating Malnutrition" in F. Wilson & G. Westcott (eds), *op. cit.*, p.47.
  10. *op. cit.*, p.49.
  11. M. Roberts & M. Rip, "Black fertility patterns: Cape Town and the Ciskei", Carnegie Conference Paper 254 quoted in F. Wilson & M. Ramphela *Uprooting Poverty: The South African Challenge* (1989), pp.246-7.
  12. See Chapter 2.
  13. C. Walker (1990), *op. cit.*, p.169.



Even while employing terms such as 'the traditional family' or 'the extended family' researchers often unconsciously assume the model of the Christian, nuclear family. This may apply not only to outsiders attempting to reconstruct the history of the family of a particular society but to the members of that society as well; they too are susceptible to viewing their past through the filter of contemporary familial ideology and practice.<sup>14</sup>

The role of women as the primary source of nurturance and health care is emphasised and although the issue of gender relations and the sexual division of labour is hinted at, very little analysis is attempted at this level. For example, Ndaba, in examining the relationship between poverty and family size, argues that in KwaZulu,

For many mothers, often undernourished, the burden of yet another pregnancy and child outweighs any prospective gain from an additional labourer or security for the family. But many women are powerless to make reproductive decisions....<sup>15</sup> Lowering birth rates is not a matter of overcoming ignorance. The poor often know their best interests. Birth rates cannot come down until the poor have overcome their powerlessness, including women's special powerlessness....In the absence of total improvement of living conditions, the birth rate will not come down; and unless the birthrate comes down among the poor, nutritional status will not improve.<sup>16</sup>

Ramphele and Ramalepe found in the northern Transvaal that there was a very high birth rate, with women averaging 6 births but with extremes of up to 18. They argue that the reasons for this "are partly due to the refusal of a lot of men to allow their wives to practise any family planning because of fear of infidelity (whilst they are away as migrants) or some or other irrational reason."<sup>17</sup> However, in an earlier study in KwaZulu, Clarke argued that the mother or mother figure of a malnourished child was likely to have certain characteristics: little or no formal education, unconvinced of the cause of illness, likely to believe in the value of

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14. Ibid.

15. N. Ndaba, "Malnutrition in Children in South Africa", Carnegie Conference Paper 278, p.13 quoted in F. Wilson & M. Ramphele (1989), op. cit., p.246.

16. op. cit., pp.13, 20 in F. Wilson & M. Ramphele (1989), Ibid.

17. M. Ramphele & R. Ramalepe, "Rural health care - the tears and joy", Carnegie Conference Paper 204 quoted in F. Wilson & M. Ramphele (1989) op. cit., p.246.

traditional Zulu health practices, unlikely to be motivated towards family planning and is likely to be unmarried, or if married, the customary lobola obligations not having been met.<sup>18</sup>

These findings are based on the assumption of the "natural", biological role of women as nurturers and places the responsibility for the health of the "family" at their doors, without examining the complex set of structural relations, including the fundamental sexual division of labour that exists in the particular society. It is argued here that the health of the rural population and in particular that of women cannot be understood outside of the relations of procreation/production. A theoretical perspective is necessary in which to understand the particular oppression of women. With this in mind, the chapter will now consider the historical position of women in the region in order to assess their changing position in the society in terms of gender relations and the wider political economy.

Recent research on the changing position of women in rural Natal with the impact of colonialism and penetration of capitalist relations is based on the assumption that

the history of African women in southern Africa is the history of their oppression, and that although this oppression gives women's history a surface continuity the nature of this oppression and the exploitation upon which it is based are dynamic and have undergone qualitative changes over time.<sup>19</sup>

Attempts have been made to look historically at the changing position of women, not simply in terms of class and race but to gender relations and the mode of production that existed prior to the imposition of colonialism. Walker has argued that

gender relations, more specifically the control of women in pre-colonial society and its subsequent restructuring by the colonial state, played a key role in shaping the migrant labour system; further that the impact of the system on the role and status of women was extremely complex, opening up opportunities for increased personal autonomy and mobility at an individual level while radically undermining the security previously accorded women in precolonial society<sup>20</sup>

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18. Lobola - customary Zulu brideswealth. L. Clarke (1980), *op. cit.*, p.64.

19. J. Guy, "Gender Oppression in pre-capitalist societies" in C. Walker (ed.), Women and Gender in Southern Africa to 1945 (1990), *op. cit.*, p.34.

20. C. Walker, "Gender and the Migrant Labour System" in C. Walker (ed.)

which is an attempt to counter "the image of women under the migrant labour system - ...as victims - those left behind, lumped along with children, the old and the sick into the emotive but blurry category of the dispossessed or surplus."<sup>21</sup>

In assessing the effects of colonialism on the status and position of African women in the Natal region, it is important to establish the extent of women's oppression in pre-capitalist society and the relationship between their status and health. In his research on gender oppression in precapitalist societies, Guy argues that the precapitalist economy was founded on women's labour and fertility.<sup>22</sup>

Marriage was so much more than a physical union of men and women, the social institution which allowed the onset of sexual relations, the propagation of children, the transfer of status, property and rights. Marriage, in terms of the above, initiated the productive processes upon which the society was based. These were processes that were predicated upon male control of female productive and reproductive capacity. They were productive processes which had the potential to create and increase value. Women's capacity to create value in marriage was linked with cattle, through the institution of brideswealth. These cattle were in the control of men, and the accumulation of cattle by men was a major social objective. This accumulation was based in the end on fertility - and marriage and infertility were incompatible concepts.<sup>23</sup>

Moreover, he argues, the fertility of the homestead, through the fertility of women was in many cases more important than the potency of its men:

The progenitor of the child was often of little social significance. An absent or impotent or even a dead man could still become a father. In the last case, a man could 'raise seed' for his dead brother, and it was the dead man, the mother and her offspring who were the important social actors. An infertile woman could be joined by her fertile sister, who would bear the children of her sister's house.<sup>24</sup>

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(1990), *op. cit.*, p.169.

21. C. Walker, *op. cit.*, p.168.

22. J. Guy, *op. cit.*, p.117.

23. J. Guy, *op. cit.*, p.41.

24. *Ibid.*

Thus, a woman, on marriage through the transaction of lobola\bridewealth between her husband-to-be's house and her father's, would be responsible for bearing as many children as possible for her husband's house. As Beall has pointed out: "The arrival of a new bride enabled the establishment of a new branch of the household's economy, adding status and prestige to the homestead as well as increasing its overall productive potential and size."<sup>25</sup> It is important to note that both male and female children were important to the strength of the household unit. "Males gave prestige to the homestead, while females meant the accession of cattle in bride-price or lobola."<sup>26</sup>

It must be noted that a woman's access to land which enabled her to develop an independent self-sufficient unit, while under her husband's control, was dependent on her ability to have children. On marriage, she worked under the supervision of her mother-in-law until the birth of her first child. "This period was known as ukokotiza and was a time that she experienced extreme social and economic disadvantage."<sup>27</sup> As Guy has pointed out, the marriage exchange was "conditional on the bride remaining obedient to her husband and proving fertile in the marriage."<sup>28</sup>

This is a very important point in terms of women's health and fertility. Infertility on the part of women, not men, put them at a social and economic disadvantage. In a society, where fertility played a central role in the creation of a surplus, a woman's status was to a large extent dependent on her ability to conceive. Moreover, her material position was directly affected: if infertile, she could be returned to her father's homestead which would necessitate the return of cattle, the bride-price, and an inferior position in her family. If she remained at her husband's homestead, she would be denied access to land in her own right and could remain under her mother-in-law's control or her position could be alleviated through her replacement by a sister. Guy has argued that women also participated in the process as a whole

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25. J. Beall, op. cit., p.59.

26. Ibid.

27. J. Beall, op. cit., p.104.

28. op. cit., p.39.

"and, in fact, supported it as fervently as any other member of these precapitalist societies."<sup>29</sup> He also states that "exploitation through the control of reproductive capacity must of necessity be a qualified form of subordination since it leaves a crucial autonomy and integrity with the possessor of fertility."<sup>30</sup> However, it must be noted that in a society where a woman's status and relative economic dependence rested on her fertility, her "crucial autonomy and integrity" in terms of her right to control her own fertility would be severely limited.

Fertility was strictly controlled through taboos and rituals. Guy has argued that "in societies where fertility created value, and therefore social power, the control of fertility and sexuality by the fathers was essential for their continued dominance"<sup>31</sup> - taking the form of initiation ceremonies as well as in the ideology of deference and obedience imposed by the old on the young.<sup>32</sup> Ear piercing ceremonies and the puberty ceremony occurring at first menstruation were used to impress on girls their subordinate status.<sup>33</sup> These were followed by forms of control through taboos and avoidance associated with menstruation. During the puberty rites and for a week out of every month for the rest of her child-bearing years, a woman was considered unclean.<sup>34</sup> An important role in the control of fertility and sexuality was played by old women,<sup>35</sup> who had reached menopause and were therefore considered pure. For example, on the instructions of the chief or headman, the old women would carry out vaginal examinations on all young girls who had reached puberty as a means of control of sexuality.<sup>36</sup>

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29. J. Guy, op. cit., p.46.

30. Ibid.

31. op. cit., p.42.

32. J. Guy, op. cit., p.42.

33. J. Beall, op. cit., p.63.

34. Ibid.

35. M. Brindley, "The Role of Old Women in Zulu Culture with special reference to three tribes in Nkandla", doctoral thesis, 1982. Brindley makes the point that old age in Zulu culture is fundamentally linked with a physiological change: the attainment of the menopause.

36. M. Brindley, op. cit., p.90.

It is important to emphasise the ideology surrounding fertility and health. On the one hand, women of childbearing years until menopause were regarded as unclean during menstruation and after childbirth. They were not permitted to enter the cattle kraals as their blood would endanger the cattle. Moreover, during menstruation and until they had their first child, they were forbidden to eat amasi, curdled milk, reinforcing the taboo between them and cattle.<sup>37</sup> As has been argued by Brindley, this particular taboo for menstruating women was particularly important in times of food scarcity, as amasi is virtually the only food available during a famine. Thus, "the women of childbearing age experience a degree of hardship by being unable to partake during their menstrual period."<sup>38</sup> On the other hand, in a seeming contradiction, fertility and sexual intercourse is still associated with physical strength but within specific contexts.

There exists a belief that frequent pregnancies are health giving and delay the onset of old age, while old women who have few children will reach the menopause sooner and grow old more rapidly. An old woman who has had children is thought to look healthier than one who has had none because the fertile one had intervals of nine months when she did not menstruate. The woman who has had many children is said to have her blood preserved, whereas the blood of the childless woman is wasted monthly. It is also believed that if people fulfil their sexual desires at the appropriate stage of life they will acquire physical strength. A wife is said to extend her youthfulness if she has frequent sexual intercourse leading to several pregnancies; by contrast, a post-pubescent girl who has not yet selected a lover (itshitshi) or even one who had chosen a lover (iqhikiza) but indulges in full sexual intercourse is said to become weak.<sup>39</sup>

Old women played an important role in the entire process of procreation. As Brindley has suggested:

An examination of the roles enacted by old women reveals a primary concern with fertility and the fostering of life and wellbeing: this is evinced by the distinctive involvement of the old women in childbirth, enculturation, at puberty, the girl's coming-of-age ceremony, marriage and even at death.<sup>40</sup>

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37. op. cit., p.196.

38. M. Brindley, op. cit., p.199.

39. op. cit., p.202.

Old women acted as midwives and took care of sick children. The mother-in-law played an important role in the birth process in order to protect the baby.

Many of the rituals and taboos surrounding procreation itself, were done in the belief that without rituals the physical well-being of the child or mother would be endangered. Mentally deranged children were believed to have suffered because of incomplete rituals.<sup>41</sup> Other abnormalities were associated with sexual intercourse during pregnancy.<sup>42</sup> One of the greatest fears was that of witchcraft; as children gave considerable status and material protection to the women of the household, they and mothers were considered vulnerable.<sup>43</sup> But at the same time, problems in childbirth, for example, prolonged labour, could require the services of an isangoma through the belief that the ancestral shades were causing the problem.<sup>44</sup> Medicines were administered by old women, both to the child and the mother. Most of these medicines were from natural vegetation or animals, although the inyanga also used to supply certain ingredients.<sup>45</sup> However, infanticide was practised. The suffocation of the second twin was a usual occurrence and sometimes when a mother died in childbirth, the infant would be buried with her, unless some substitute could be found.<sup>46</sup> Deformed children were also allowed to die.<sup>47</sup> This can be explained in terms of the intense pressure on women themselves and the nature of a subsistence economy which could not accommodate any person who could not fulfill a function.

A point that needs to be highlighted is the set of relations between women themselves. Old women, after menopause, were empowered within the context of

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40. op. cit., p.271.

41. op. cit., p.58.

42. Ibid.

43. op. cit.

44. op. cit., p.54.

45. op. cit., p.53.

46. Rev. J. Shooter, The Kafirs of Natal and the Zulu Country, 1857, reprint 1969, p.87.

47. Ibid.

specific gender-relations to have direct control over the lives of younger women. A younger woman was always in a subordinate position to older women, particularly mothers-in-law and were expected to fulfill their obligations to them through rituals of respect and obedience and physical service in their fields. Through the ideology surrounding sexuality and fertility, the old women were able to play a large role in controlling, and promoting procreation, a central role in the birth process and the socialisation of young girls. While the birth process was regarded as pollution, it specifically polluted men, endangering their sexual potency and prowess. Men were therefore completely excluded from the birth process, whilst old women, who had had children and had reached menopause, were both pure and safe from pollution themselves. Thus, old women were accorded a specific role in health and health care of children and fertile women which increased their own influence within the household. Any attempt to loosen their control over the birth process - a central focus in Nguni life - would possibly have caused resistance. This will be examined later in the context of colonial scientific medicine.

At the same time, the agricultural labour in domestic production and domestic work was physically taxing for women. It is clear that amongst the Nguni, a distinct sexual division of labour operated. All agricultural work was carried out by women as well as domestic work and childrearing to puberty. On the land apportioned by the homestead head, women and their daughters laboured throughout the agricultural cycle:<sup>48</sup> they prepared the land, sowed, cleaned, reaped, stripped cobs, winnowed or shelled, stored, ground or cooked the various cereals.<sup>49</sup> Women were also responsible for the collection of firewood, water, vegetables consumed in the homestead and made pots, mats and spun fibres. Old women were exempt from agricultural labour - their fields were taken care of by daughters-in-law. A woman thus faced considerable physical tasks in production alongside her role of childbearer. However, her tasks were to an extent alleviated by the presence of other women, and childrearing tasks made easier by the function of the grandmother (mother-in-law) and daughters. Men, on the other hand, were responsible for stock-raising, slaughtering and preparing hides, while boys herded and milked.<sup>50</sup> They were also responsible for the erection and maintenance of the

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48. J. Beall, *op. cit.*, p.60.

49. J. Guy, "Production and Exchange in the Zulu Kingdom" in J.B. Peires (ed.) *Before and After Shaka*, 1981, p.35.

50. *Ibid.*



homestead, the manufacture of certain instruments such as the hoe and spears and the preparation of clothing and shields, as well as military service for the chief.<sup>51</sup>

As Beall has pointed out, pre-colonial life was not static and economic and social patterns were severely disrupted from the first quarter of the nineteenth century, "first by the impact of the Shakan revolution, and later the incursion of the Boers."<sup>52</sup> Moreover, she argues that stock numbers could not be guaranteed in the face of possible Zulu expropriation, and thus greater reliance was placed on cultivation for subsistence needs, and therefore on the labour of women.<sup>53</sup> Furthermore, it can be argued that a women's procreative and productive role made her more physically vulnerable in times of drought or pestilence. As has been mentioned earlier, women during menstruation or childbirth were forbidden amasi, a valuable source of protein, as meat was even in normal circumstances not eaten regularly.

In the political economy of health explanation, considerable attention has been paid to the changes in Zulu diet over time. It has been argued by Liz Clarke that

The Zulu diet included meat from periodic feasts, quantities of amasi (sour milk) and a wide range of vegetables including sorghum, millet, pumpkins, gourds, yams, various tubers akin to the potato, various nuts, and indigenous beans and a wide variety of green herbs and plants.<sup>54</sup>

Without the prior conceptualisation of the sexual division of labour in pre-colonial society, the role played by women in production and the consequences on their health is not explored. As has been discussed in Chapter 2, malnutrition in childhood can result in pelvic deformities in women, which can endanger women's lives in childbirth. Rev. Shooter recorded many maternal deaths in childbirth in the first half of the nineteenth century, suggesting that some women, at least, had suffered from malnutrition.<sup>55</sup> The argument of this thesis is that explanations of

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51. J. Guy (1990), op. cit., p.35 and (1981) op. cit., p.35.

52. J. Beall, op. cit., p.66.

53. op. cit., p.67.

54. L. Clarke, Carnegie Paper 295, p.4.

55. Rev. J. Shooter, 1969, op. cit., p.87.

women's health must take into account both their role in procreation as well as production and the specific changes in both which contribute to health problems for women.

Women played an important role in the health of the household. But a significant role in the health and health care of the community was played by the isangoma.<sup>56</sup> What is interesting here from a feminist perspective is the extent to which the role, within the context of specific gender-relations, allowed certain women a degree of independence from men and status. According to Brindley, one informant suggested that in former times all izangoma were old women, linking the position of old women in the society and the notion of their purity. Bryant maintained that ninety per cent of izangoma were female,<sup>57</sup> while van Nieuwenhuijsen suggested that the role afforded women a means of escaping tensions and conflict situations.<sup>58</sup> Izangoma were excluded from having sexual intercourse and when a married woman became an isangoma, she instructed her husband, if she was the only wife, to take another.<sup>59</sup> Hammond-Tooke has suggested a reason for the importance of the izangomas:

The reason for the importance of diviners, in particular, is clear. If illness and misfortune are caused by a witch and the sanctions for this are, or at least were in the past, a public execution, it is essential that the verdict of guilty be unequivocal and be backed by the fullest authority possible. A charge that carries such dire consequences cannot be left to the vagaries of public opinion. Someone must be clothed with the power and knowledge to point unerringly to the responsible person or persons.<sup>60</sup>

Moreover, he asserts that there is a sexual ambiguity in the role of izangoma:

This carrying of a spear by female diviners, coupled with the fact that the (few) male diviners wear white skirts, would seem to represent sexual ambiguity in the diviner's role, and it is tempting to see this as a symbolic expression of a more general structural ambiguity of

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56. A diviner. See D. Hammond-Tooke (1989), pp.104-107.

57. Bryant (1920), p.48 quoted in M. Brindley, op. cit., p.193.

58. van Nieuwenhuijsen (1960), pp.21-23 quoted in M. Brindley, ibid.

59. M. Brindley, op. cit., p.194.

60. D. Hammond-Tooke, op. cit., p.104.

these people, who, in a very definite sense, mediate between the ancestors and the witches, between life and death.<sup>61</sup>

Another explanation for the symbolic spear suggests that those izangomas carrying spears were mediating through male ancestors, while others, carrying sticks, mediated through female ancestors.<sup>62</sup>

Reverend Joseph Shooter, writing in the 1850s, suggested that the role of isangoma gave a woman economic independence - that she was allowed absolute control of all cattle she received in exercise of her calling.<sup>63</sup> Moreover, the functions of an isangoma gave her a degree of mobility - she was not required to remain within the homestead. But while izangomas played an important and respected role, with some independence, Brindley argues that her ritual status in the umuzi was not more elevated than that of her husband's.<sup>64</sup> The role of isangoma in the community, however, must be explored historically, and while it is briefly discussed in the parameters of this thesis, further research on the relationship between the role of the isangoma and gender relations at specific times, need to be carried out.

Thus far, the focus of the chapter has been on establishing the relationship between women's health and their procreative and productive roles in pre-colonial Nguni society. It has been argued that the roots of women's oppression in that society lay in men's control of their fertility and labour, while this control was mediated through old women who played an important role in reproducing the ideology of female fertility. It has been argued, further, that the health of women was considered important, in a functional sense, in that they should be sufficiently "healthy" to carry out their procreative and productive functions. At the same time, some women, particularly women past menopause, and izangoma were able through their knowledge and skills to empower themselves at the expense of other women, but not men, while at the same time providing an important health care function. Added to this, it has been pointed out that both gender relations and production relations, including the sexual division of labour are not static and that an explanation of women's health and the system of health care need to be historical.

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61. op. cit., p.107.

62. Interview with an isangoma.

63. Rev. J. Shooter, p.352.

64. M. Brindley, op. cit., p.196.

The following section examines the impact of colonialism and the penetration of capitalist relations in Natal in the second half of the nineteenth century on the health and health care of Nguni women focussing specifically on the introduction of scientific medicine and colonial health controls. However, this must be seen within the context of the changing broader political economy and particularly the development of the system of migrant labour and the impact on women's lives. Until recently a view of this impact, which is reflected in political economy of health explanation, ignores the specific gender relations and the sexual division of labour that operated in the pre-capitalist economy and explains the collapse of the rural economy and proletarianisation on the development of the migrant labour system. In part, this collapse is seen as the failure of rural women to cope without men, while at the same time, being drawn into a cash economy with colonial taxation.

As Bozzoli has pointed out:

It was not simply the men's absence that placed the burden of domestic labour and agricultural labour on the women, nor is it just that male tasks had been undermined by the destruction of the African states; it was also that these societies possessed a capacity to subordinate women's labour. Indeed, one might even suggest that the giving up of migrant labour by these societies partly rested upon their capacity to subordinate women's labour; and that it is in this capacity, that the resilience of these systems to "full proletarianisation" may have rested.<sup>65</sup>

Walker has explained how the pre-colonial society could cope with the short-term absence of young men which did not seriously compromise its ability to reproduce itself.<sup>66</sup>

The decline in importance of hunting, as more and more game was shot out, as well as the waning of the military role of young men, contributed to their relative superfluity... Ultimately, however, what allowed these societies to export male labour was the system of homestead production in which women were the primary producers. It is this that explains the violent

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65. B. Bozzoli, "Marxism, Feminism and Southern African Studies" (1983), p.151.

66. C. Walker, *op. cit.*, p.179.

opposition of chiefs and men in general - actual and future homestead heads - to female migration.<sup>67</sup>

What needs to be examined more fully, in the context of this thesis, is how the development of the migrant labour system and the alienation of land with the development of capitalist white agriculture specifically affected women's health. Thus far, the issue of women's health in the pre-capitalist society has concentrated on the role of women in the procreative/productive sphere.

It has been argued by Bundy and Slater among others that until the 1870s Africans had relatively "easy access to land, despite the creation in the 1850s of the reserve system in Natal by Theophilus Shepstone."<sup>68</sup> By 1851, two-thirds of Africans lived outside the locations on Crown and private lands, while in 1882, there were 169,000 living on reserved lands (locations and mission reserve glebe lands). 162,000 were renting privately-owned white land and 43,000 on Crown lands.<sup>69</sup> As a result of this choice, and the growth of peasant agriculture, which "enabled Africans to pay their taxes by selling off their surplus grain or cattle",<sup>70</sup> men were able to resist wage labour for white employers. This choice must be qualified as pointed out by Bundy:

The choice would naturally be affected in every part of Natal by local circumstances: by the prevailing rent levels, population density, soil fertility, market facilities and so on; but in each case the obligations entered into...could be balanced against the prospect of producing an agricultural surplus sufficient to meet the demands of state and/or landlord, and to permit the acquisition of trade goods.<sup>71</sup>

Using Walker's argument that the agricultural production, predicated on female labour formed the basis of the subsistence rural economy in the reserves, and in peasant farming, it would suggest that the physical work of women was intensified, particularly with the introduction of cash crops for the creation of surplus, to be

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67. Ibid.

68. See C. Bundy, The Rise and Fall of the South African Peasantry, 1979, pp.170-171; and H. Slater, "Changing Pattern of Economic Relations in Rural Natal 1838-1914" in S. Marks and A. Atmore (eds), Economy and Society in Pre-Industrial South Africa, London, 1980, pp.38-52.

69. C. Bundy, op. cit., p.170.

70. Ibid.

71. C. Bundy, op. cit., pp.170-171.

expropriated by men and then the state in the form of taxes.<sup>72</sup> This, combined with their domestic roles would have increased the physical vulnerability of women. It is argued here, that the resistance to full capitalist penetration and male wage labour rested essentially on the labour of women, and thus, in one sense, on their physical capability to combine successfully their procreative and productive roles.

Resistance to wage labour and the need to produce a surplus for taxation and trade goods, did challenge the existing sexual division of labour. Men had not, historically, participated in agricultural production.<sup>73</sup> With the growth of successful peasant agriculture and the accumulation of surplus, men purchased ploughs.<sup>74</sup> Because of the traditional exclusion of women from cattle, men began to participate in agriculture. But as Beall has pointed out, ploughs did not take the place of horticulture completely<sup>75</sup> - women continued to produce domestic foods and remained a visible part of peasant agriculture as is attested by the numerous observations of white settlers. Thomas Phipson, for example, complained:

The black man either sets to work the girls and women whom he breeds or buys, or he 'sebenzas' (for work it cannot properly be called) a few months for the white man, and spends his money in cattle and women; or lastly, he ploughs himself...and thus comes into the market as a competitor with his civilized neighbour....If it be right for the Kafirs to have ground given them gratuitously to cultivate, then it would seem right for the colonist to have the same. If it be wrong for the colonist to have slave labour, it is surely wrong for the Kafirs also.<sup>76</sup>

Phipson was one of the white colonists who pressed the colonial government to abolish polygamy arguing that: "By condoning polygamy it provides the African with cheap inefficient female labour and the white with cheap inefficient male labour."<sup>77</sup>

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72. C. Walker, *op. cit.*, *passim*.

73. See prior discussion in Chapter 3.

74. J.D. Beall, *op. cit.*, p.77 and C. Bundy, *op. cit.*, pp.176-179.

75. *op. cit.*, p.77.

76. R.M. Currey (ed.), Letters of a Natal Sherriff, p.131 quoted in D. Welsh, The Roots of Segregation: Native Policy in Natal (1845-1910), p.183.

77. R.M. Currey (ed.), *op. cit.*, p.192.

Moreover, a distinction must be made between the peasant class that owned or rented land and the communities that remained in the reserves. As Beall has pointed out, the payment of taxes in cattle in the reserves could lead "to a reversion to hoe culture if the stock base of such families was not initially large: firstly because there were no cattle to work the ploughs or secondly, because men went into temporary wage labour to replenish their stock."<sup>78</sup>

In the Ixopo District, however, where an African peasant class was developing, a missionary noted:

Civilisation is advancing among the Kafirs in every direction around us. Transport riding or working bullock wagons for hire is the order of the day. And ploughing with oxen instead of women working with hoes is greatly resorted to. On the hills round here natives have purchased from white men plots of land from 50-200 or more acres, on which they build a house and fence a large extent for cultivation.<sup>79</sup>

By the 1880s Bundy has pointed out, however, that crises were developing in both the reserve subsistence economy and in peasant agriculture, the latter due to the growth of white commercial agriculture:

...there is evidence that congestion in the locations was becoming a serious problem, that sales of Crown Land were causing evictions of African tenants and that evictions were taking place in cases of incipient commercialization of agriculture.<sup>80</sup>

In consequence there was a steady increase after the mid-eighties in the number of migrant labourers in Natal.<sup>81</sup> There is evidence to suggest that this gave some women the opportunity to turn to plough agriculture themselves. In the Umsinga district in 1894, the Resident Magistrate described the tasks of African women in domestic agriculture, suggesting the physical arduousness:

Ploughs are now numerous; large numbers of American ploughs are sold by the Arabs to Natives annually during the ploughing season, and every Native

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78. op. cit., p.78.

79. Blue Book for Natal for 1884 (emphasis in the original) quoted in C. Bundy, op. cit., p.181.

80. C. Bundy, op. cit., p.182.

81. C. Bundy, op. cit., p.191.

woman strives to have a plough belonging to her own family household. A large area is cultivated by means of Native picks, about two inches wide, on the rocky sides of the mountains. Good crops are often produced in this manner but much depends upon the nature of the season. The heavy rains of the last summer destroyed many crops and mealies are now scarce....Native women and girls often do the ploughing (my emphasis).<sup>82</sup>

The participation in plough agriculture suggests that there was a loosening of the ideology of fertility and cattle because of the absence of many men, or could possibly suggest a degree of desperation on the part of women and their own resistance to constraints.

Ballard has pointed out that most of the second half of the nineteenth century was a period of increased rainfall and climatic predictability for southern Africa and has suggested that climatic factors may have contributed to the expansion of Natal's African population from an estimated one hundred thousand people in 1850 to nearly seven hundred thousand by 1900.<sup>83</sup> This would suggest an increased population would result in overcrowding in particular areas. Thomas Phipson has estimated that a family of six would require six acres on which to grow sufficient grain a year, besides land for grazing and domestic produce. He argued that if all Africans were forced on to the reserves of which he estimated to carry 350,000 acres of cultivable land, this would lead to gross overcrowding, and "a sort of black dynamite".<sup>84</sup> As Ballard has shown, African peasant farmers concentrated on production of maize and sorghum - "around 90 per cent of the total acreage put into crops by African cultivators".<sup>85</sup> These farmers and their households were thus extremely vulnerable to natural disasters, particularly as they had no political power and therefore received none of the benefits provided to white farmers.<sup>86</sup>

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82. Report of the Resident Magistrate, Umsinga, October 1894.

83. C. Ballard, "The Repercussions of Rinderpest: Cattle Plague and Peasant Decline in Colonial Natal," The International Journal of African Historical Studies, 19, 3, 1986, p.425.

84. R.M. Currey, op. cit., p.201.

85. C. Ballard, 1986, op. cit., p.428.

86. C. Ballard, "A Year of Scarcity: The 1896 Locust Plague in Natal", South African Historical Journal, 13, 1983, pp.8-9.



Between 1894 and 1898, there was not only a drought, but locust plague, followed by the outbreak of the rinderpest epidemic. Production of maize dropped from 667,104 muids to 243,969 and of sorghum from 423,542 to 206,685.<sup>87</sup> Bundy has argued that these disasters, coupled with other pressures, forced many African peasant farmers into labour tenancy on white farms - "all over Natal, but particularly in the Midlands, peasants became serfs."<sup>88</sup> They were forced to sell their livestock or turn to credit.

The immediate consequences for many women and children was to increase their vulnerability. Without the domestic produce to sustain them, they were increasingly dependent on men for money to buy food. The following description in The Times of Natal in 1896 suggests this:

...it appears that a terrible condition of things prevails amongst a large number of natives along the North Coast, both in this Colony and Zululand. It is said that many of these natives are penniless, that women and children are going about the country in a starving condition, begging for food....<sup>89</sup>

Some women tried to alleviate their burden by entering temporary employment with the colonial government through the coercion of the chiefs. "During the purchase of locust eggs by the Government Native women and girls collected them in considerable quantities, with the result that in five weeks, some 13,000 pounds were weighed in and destroyed"<sup>90</sup> - indicating the material need of women in the society for cash for food.

The effects of the rinderpest epidemic were equally devastating. Between 80 and 90 per cent of African owned cattle had died or been destroyed.<sup>91</sup> Plough agriculture

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87. Statistics from Natal Statistical Yearbook 1895, 1896 quoted in J. Lambert, "From Independence to Rebellion: African Society in Crisis c.1880-1910" in A. Duminy and B. Guest (eds) Natal and Zululand. From Earliest Times to 1910, p.384.

88. C. Bundy, op. cit., p.190.

89. Quoted in C. Ballard, 1983, op. cit., p.42.

90. Annual Report of the Magistrate, Weenen District, 1895, Colonial Blue Books.

91. C. Ballard, 1986, op. cit., p.444.

was abandoned, with severe consequences for domestic food production and the continued independence of the peasant farmers. Not only was the physical labour of women intensified as a result, but there are indications of psychological stress amongst women, and girls, particularly the drinking of *isityimiyana* previously forbidden them.<sup>92</sup> As the Resident Magistrate of Nongoma describes, domestic production itself was in crisis.

...owing to the death of cattle from Rinderpest, and the consequent poverty of the people, I fear that little (ploughing) has been done in that way during the past year. The brunt of the work has all along fallen, and now it almost entirely falls upon the women. As, so far as I know, they have always done, the women go out to the fields in the early morning, a Kafir pick over their shoulder, and a bunch of amabele ears or some cobs of mealies in their hand. They dig and plant till about noon, and then return to discharge their domestic duties and rest. The slowness of the process, and the shortness of the time thus given to the work, results in but a small amount of cultivation, and the yield seldom largely exceeds the requirements of the family. The staple crop is mealies and amabele, pumpkins, water-melons, beans, and sweet potatoes being also planted on a small scale.<sup>93</sup>

In this predicament, understandably, women expressed the need for co-wives, believing that many wives would lighten the workload,<sup>94</sup> supporting the argument that while friction and jealousy did occur amongst co-wives, polygamy was supported and encouraged by women for the physical and emotional support the presence of other women gave them.<sup>95</sup>

Moreover, the loss of cattle affected mothers particularly as it created nutritional problems in their children. The District Surgeon of the Umvoti District reported in 1899:

There was a large increase of sickness, and I should think a great many deaths, among Native children

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92. Liquor.

93. Magistrate's Report, Lower Tugela Region, 1896.

94. Magistrate's Report, Nongoma, 1899.

95. See J. Guy's argument on women's tenacious defence of the pre-capitalist system (1990), *op. cit.*, p.47. The need for physical support adds another dimension.

consequent upon errors of diet and privation of milk. The cows, having died of Rinderpest, children who in many cases, were dependent upon their milk for nourishment, had to be fed upon mealies, Kaffir corn or porridge, and being too young to digest this food, gastric disturbances became frequent and in many cases fatal.<sup>96</sup>

In the Mapumulo District in 1899, the Magistrate provides a significant piece of information in connection with the effects of the Rinderpest: he points to the increasing use of bottle feeding by African women in the district. This adoption of supplementary feeding suggests, without confirmation, the increasing physical vulnerability of women and the inability to sustain breastfeeding for the traditional period, or the possible migration of younger women to wage-labour.

In many instances Reports of the Magistrates and/or District Surgeons suggest increasing outbreaks of disease during the 1890s including smallpox, measles and tuberculosis.<sup>97</sup> It may be argued that increasing physical debilitation caused by malnutrition for women and children facilitated the spread of infectious disease, particularly from male migrant labour who had had contact in urban areas with carriers.<sup>98</sup> It has been suggested by Doyal and Pennel that Europeans brought with them infectious disease infecting colonised societies which had adapted to a smaller number of different pathogens, in relative isolation.<sup>99</sup> While attempts to prevent the spread of smallpox, particularly, were undertaken by the colonial state through the district Surgeons, this process itself was a form of control and coercion. The Africans were forced to pay for their vaccinations, even in periods of economic hardship.<sup>100</sup>

Besides the physical and nutritional vulnerability of women and children to infectious disease, they were also at risk from sexually transmitted diseases,

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96. District Surgeon's Report, Umvoti Division, 1899.

97. See Magistrate's Reports.

98. R.M. Packard, "Tuberculosis and the Development of Industrial Health Policies on the Witwatersrand, 1902-1932" in S. Marks & M. Andersson, 1987, *op. cit.*, pp.187-209.

99. L. Doyal and I. Pennel (1979), *op. cit.*, p.102.

100. See District Surgeons Reports.

particularly syphilis.<sup>101</sup> For women, there is great physical risk of infertility and infection of the foetus. In a society which placed such emphasis on women's fertility, the contraction of sexually transmitted diseases from men could indirectly cause social dislocation. With the increase in migrant labour from the region, syphilis became widespread within the subsistence community. Dr McCord also suggests that the smallpox vaccination procedure helped inadvertently to spread syphilis by using the scar from a successful vaccination in vaccinating a second patient.<sup>102</sup> The physical disfigurement from the disease had serious implications for women. Marian Makanya had lost her nose through syphilis and as a result could not find a man to marry her.<sup>103</sup> Another woman had contracted syphilis from her husband and had had nine still births or infant deaths as a result. Her husband thus threatened to leave her in order to have a daughter to sell for cattle from another wife.<sup>104</sup> With medical intervention, this woman was able to bear a child successfully and consequently was able to consolidate her own position.<sup>105</sup>

This raises the question of the type of health care system offered by the colonial authorities and missionaries to women. It must not only be seen in the context of the needs of capital in order to maintain a healthy labour force, or solely in terms of the need to protect colonial settlers from the spread of infectious disease. It must also be examined in terms of the context of women's lives and the extent to which it created tensions for them in the challenge it represented to traditional forms of healing controlled by older women.

As discussed in a previous work, the overriding purpose of the provision of a colonial health service was in order to ensure the successful maintenance of the labour force,<sup>106</sup> while the introduction of a public health policy protected the interests of local capital and protected whites from the spread of disease.<sup>107</sup> As a

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101. Dr McCord and Douglas, My Patients Were Zulus, 1946, p.137.

102. op. cit.

103. op. cit., pp.137-139.

104. op. cit., pp.139-141.

105. Ibid.

106. See C. Dyer, "A Case of Money and Life", 1986, passim.

107. See M. Swanson, "The Durban System: Roots of Urban Apartheid in the

result, hospital facilities were provided by the local state, mainly in urban areas, while small peripheral cottage hospitals and inadequate facilities provided in the rural areas.<sup>108</sup> Konczacki has pointed out that Africans "were forced to pay a higher percentage of their income in taxes" than whites<sup>109</sup> but, because of their lack of political power were powerless in influencing colonial policy and thus gained few of the social benefits. Although hospital admission for Africans was free, few women were able to use the facilities because of the restrictions placed both by the state and the local chiefs and men on their migration to towns.<sup>110</sup> Moreover, the racist attitudes of white nurses, particularly, and the mistrust of "white" medicine, made most Africans reluctant to enter hospitals.<sup>111</sup>

Some of the inhabitants on land in the vicinity of missions or on mission lands availed themselves of the services of mission doctors, despite the need to pay medical fees. Dr McCord charged considerable fees for services in his hospital and for his services at Adams mission.<sup>112</sup> His rationale was that "the Zulus regard free treatment or medicine as worthless",<sup>113</sup> indicating parallels between his services and those of traditional healers. Many of his patients were women, often brought by their husbands, with fertility problems or histories of problematic deliveries.<sup>114</sup> It must be pointed out that medical intervention, particularly Caesarian deliveries, saved the lives of many women which would have been endangered in "traditional" care. Of significance is that men, husbands or fathers, usually accompanied women or girls, indicating the extent of control of women by men<sup>115</sup> and moreover their

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Colony of Natal" (1976), among others.

108. See M.L. O'Reagan, "The Hospital Services of Natal", 1969.

109. Konczacki, Public Finance and Economic Development of Natal, 1893-1970 (1967) quoted by C. Bundy (1979), op. cit., p.190.

110. See C. Walker (1990), op. cit..

111. See C. Dyer, op. cit.

112. op. cit., pp.73, 78, 125.

113. op. cit., p.78.

114. op. cit., pp.141-143.

115. After 1899 no woman was to be issued with a pass unless accompanied by her male guardian. J. Guy, 1982, p.188 quoted in C. Walker (1990), op. cit., p.180.

economic dependence on men. Medical intervention at the same time reinforced gender oppression of women. For example, a girl with sarcoma of the face was unable to marry her suitor as his father would not pay the lobola of ten cattle. Her father then took her to Dr McCord for treatment. The observations of the doctor indicate the economic importance of daughters for fathers, particularly in a cash economy:

He knew I'd operate on his daughter for \$10 or \$15, while the girls would bring cattle worth from \$200 to \$300, so his gain beyond the cost of the operation would be considerable.<sup>116</sup>

It is important to examine the extent to which the discourse of scientific medicine reflected prevailing western attitudes towards women and health and the extent to which it embodied imperialist racist ideology. Vaughan argues that within medical missionary discourse, there was strong criticism of the "evils" of traditional African culture and in particular traditional African healing systems as these formed the basis of resistance to conversion to Christianity.<sup>117</sup> Moreover, as clearly stated by a medical missionary, much of the work of missionaries was seen to be useful in breaking down possible ideological resistance to colonial rule.<sup>118</sup> "The usefulness of the medical arm of the missionary service is indisputable. It breaks down opposition, dissipates prejudice, and wins its way to the hearts and homes of the high and low, the rich and poor."<sup>119</sup>

To an extent, the patriarchal view of womanhood prevailed in the attitudes of colonists and colonial authorities alike. It was argued that women were abused as slaves by men.<sup>120</sup> This attitude towards African female labour and the condemnation of polygamy has been shown by numerous historians to reflect the material interests of the colonists, providing moral justification for the attempts to

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116. Dr. J.B. McCord with J.S. Douglas (1946), *op. cit.*, p.144.

117. M. Vaughan, "Health and Hegemony: Representations of Disease and the Creation of the Colonial Subject in Nyasaland", 1989.

118. L. Doyal & I. Pennell, 1979, p.250.

119. Rev. J.S. Dennis, Christian Missions and Social Progress, 1899 quoted in L. Doyal & I. Pennel, 1979, *op. cit.*, p.250.

120. See Chapter 3, p.30.

erode polygamous practices and the dependence on female labour as a means of forcing men into wage labour.<sup>121</sup> Beyond this, there is little to suggest that there was any real official concern for the health of women engaged in arduous physical labour. It can be argued to a point that the attitude towards African female labour was similar to that regarding the labour of white working class women. Doyal and Pennel have examined the contradictions in the class-based attitudes of women and work, upheld in medical discourse; working class women were regarded as of a different stock from middle class women and thus were able to work without risk to their health and were not incapacitated like middle-class women from menstrual problems, pregnancy or childbirth.<sup>122</sup> Secondly, it was assumed that the type of work was important - physical work was less damaging to women than brain-work, a medical argument reinforcing domestic ideology by perpetuating the view that women were intellectually inferior to men.<sup>123</sup> Moreover, working-class women were regarded as sexually unrestrained, having been exposed, unlike their middle-class sisters, to overcrowded and thus immoral conditions.<sup>124</sup> Doyal and Pennel argue that medical ideology and medical practice thus played an important part in reinforcing both class divisions and the sexual division of labour in Victorian society.<sup>125</sup> In the colonial context, medical discourse carried with it both class and race perceptions and reinforced those divisions. Unhealthiness among the colonised was used as conclusive evidence of their own bad habits - contrasting the supposed moral superiority of the coloniser with "the constitutional depravity of the native".<sup>126</sup> As late as 1948, the Secretary of the Durban Housewives' League wrote to the Town Clerk:

Housewives view with alarm the spread of disease among natives in the cities. The time has come when it is absolutely necessary that native females be registered when entering domestic service. OUR homes and especially our little children must be protected from

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121. See, for example, C. Walker, 1990, *op. cit.*
122. L. Doyal & I. Pennel, 1979, *op. cit.*, p.158.
123. *op. cit.*, p.159.
124. *Ibid.*
125. *op. cit.*, p.160.
126. A. Southall, The Impact of Colonialism in Africa (1971), p.242 quoted by L. Doyal & I. Pennell, *op. cit.*, p.242.

loathsome diseases brought by unclean native servants.<sup>127</sup>

This was not a new idea. In a guide to young white mothers in the colony of Natal in 1906, Dr Lillian Austin Robinson, one of the few women doctors in South Africa stated:

The practice of handing over baby and "comforter" to a small native nurseboy or a dusky maid-of-all-work during the busy hours of the day cannot be too strongly condemned. Well for the infant if his miscalled comforter does not become a medium for the conveyance of germs to his system.<sup>128</sup>

Calls for the restriction of migration of African women on the basis of spread of disease, added to colonial restriction on the mobility of African women.<sup>129</sup>

It is clear that while medical discourse embodied class, race and gender perceptions which were used to legitimise the position of African women in colonial society, medical intervention did improve some women's lives. Feminists have criticised the loss of control over their bodies with the interventionist and patriarchal practices of the medical profession and the commodisation of health care by a male-dominated medical elite.<sup>130</sup> In terms of the region of Natal/Zululand, medical ideology and medical practice was insufficiently powerful to counteract the persistence of traditional health practices, which largely remain the domain of old women in rural society into the present.<sup>131</sup> The resistance of traditional ideology of health and health care should not be seen as static. The question of the role of female sangomas in terms of changing gender relations within the wider political economy needs to be investigated. Some women were, of course, incorporated into western medical health services, particularly as nurses. Dr McCord particularly encouraged the training of African nurses, selecting them from the Inanda mission school. Hughes has examined the roles played by this particular school and other mission schools in Natal, in educating the daughters "of the first generation of converts (and

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127. Quoted by D.J. MacKenzie, "Influx Control, Health Regulations and African Women in Durban c.1917-1959", unpublished paper, October 1982.

128. Dr A.L. Robinson, The Health of Our Children, (1906), p.15.

129. C. Walker, 1990, op. cit., p.180.

130. See E. Fee, 1983, op. cit., pp.17-24.

131. See M. Brindley, op. cit., passim.



of future generations too) for approximately the same kind of roles as those played by missionary wives".<sup>132</sup> The class-base of the mission converts has been clearly demarcated as separate from non-Christians in the reserves; while tensions existed, close family connections remained between the leading members of the Christian community and the tribal elite. One of Dr McCord's first trainee nurses was the daughter of a chief.<sup>133</sup> While the training of nurses at McCord's Hospital provided young women of the African elite a limited independence from gender oppression, they were vulnerable to the prejudice of white nurses and the medical profession, and their training was not recognised in colonial hospitals.<sup>134</sup> One nurse, who had more practical experience than white probationers, was employed at Addington Hospital as a ward maid to care for male African patients, but was called on to help with white patients or confinement cases because of her skills.<sup>135</sup>

In conclusion, the existing evidence thus far suggests that African women in the region of Natal/Zululand in the nineteenth century were vulnerable to health problems not simply because of changing relations of production and the penetration of capitalism into the rural subsistence economy but also because of gender relations within the immediate domestic sphere. The chapter has attempted to focus on women's lives both within the precapitalist society but also in the changing political economy of colonial society. It would seem that women, through their historical roles as both producers and mothers and wives, were vulnerable to changes in production/procreation relations. It can be argued that an analysis of women's health must specifically include the analytical historical concepts of gender and the sexual division of labour in order to reach a more adequate explanation of women's health than one that emphasises the class relations of production. It is acknowledged that a more complete explanation of women's health in the region within the time period would include an examination of the health of both white and Indian women settlers, but that within the parameters of this initial study, the focus on the changing lives of African women through the examination of changing gender

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132. H. Hughes, "A lighthouse for African womanhood": Inanda Seminary, 1869-1945" in C. Walker (ed.), 1990, *op. cit.*, p.203.

133. Dr J.B. McCord with J.S. Douglas, 1946, *op. cit.*, pp.184-185.

134. *op. cit.*, p.198.

135. *Ibid.*

and class relations points to the need expressed within feminist theory for the automatic inclusion of gender and the sexual division of labour in any analysis of health and health care in a society.

## CONCLUSION

This thesis has attempted to accomplish two main tasks: firstly it set out to challenge the existing theoretical framework of the political economy of health and health care analysis and explanation, and to offer a feminist theoretical analysis which incorporates the specific health needs and problems of women into an analysis of health and health care. Secondly, it has attempted, through the employment of the methodology of historical materialism, informed by feminist theory, to examine the health and health care of a specific group of women undergoing material change in their lives in the region of Natal/Zululand in the nineteenth century.

The first part of the thesis focussed on the social construction of the concept of health and examined the question of the type of health and health care in a society as a reflection, in the final analysis, of the material relations of the society. It showed that the conceptualisation of health is historical and its very historicity needs to be explored. Within these parameters, the conceptualisation of health from a Marxist theoretical perspective was examined, particularly the relationship between patterns of health and health care in a society and the class relations of that society. It argued that this analysis of health and health care made a valid contribution to a materialist analysis of health that moved beyond the narrow ideological construct of health as a biologically-determined entity abstracted from the social and material relations of society.

However, it argued in Chapter 2 that, from a feminist perspective, the conceptualisation and analysis of health within the Marxist framework is insufficient explanation of the specific needs and problems of the health and health care of women. It raised the particular issue of the need to incorporate the concepts of gender relations and the sexual division of labour into any theoretical analysis, and in this case, the analysis and explanation of the conceptualisation of health and the patterns of health care in a society, within a historical-materialist framework. It has argued for the automatic inclusion of gender and the sexual division of labour alongside class and race, and other analytical concepts, into the analysis of health and health care.

Finally, in Chapter 3, the thesis attempted an initial investigation of health and

health care of women within a specific society, informed by a feminist theory of health and health care. It showed that health and health care are not static, and that the relationship between health of women and relations of production and procreation must be analysed historically. It illustrated that women's health and health care is not biologically determined and that it is influenced by their particular position in society within specific gender and class relations and moreover that the health needs and experiences of women are not necessarily the same as those of men. Moreover, it has shown that women, in the region of Natal/Zululand bore the brunt of the social costs of production/procreation, and that particular gender relations and an ideology and practice of health and health care, reinforced their gender-specific roles in that society. Moreover, it argued that while scientific medical practice introduced with colonialism alleviated some of the health problems of women, related to their role as mothers in the procreation sphere, that the particular form of health care within the given set of social relations in the society did not necessarily improve their position and instead reinforced their dependence on men.

In conclusion, it is hoped that this initial investigation into the historical nature of the patterns of health and health care of particular women in South Africa will inform both theory and practice of health care in the society. It has proposed that any analysis of health should incorporate the particular needs of women. Women's health issues can be a site around which women can be organised. Moreover, it can be argued that future policies of health and health care should encompass the particular needs of women, and therefore should incorporate an understanding of the relationship between the health needs of women and their position in society. While changes in the relations of production will alleviate some of the health problems in terms of a more equitable distribution of health and health care facilities, women's specific health needs require a transformation at the same time of the gender relations which equally influence their health and access to health care. Ultimately, the goal of feminist practice in terms of health is women's control of their own bodies and control over decisions of procreation, including the decision to bear children and forms of contraception. Without this freedom, women's health will continue to be a part of their oppression by men, despite transformation of class relations.

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