

### **Abstract**

The work and history of female Xhosa nurses in the Ciskei region of South Africa's Eastern Cape has largely been ignored by scholars; yet, the region has the longest history of training African professional nurses in South Africa and it is representative of rural or 'homeland' health care. The purpose of this article is to highlight the important role these nurses played in delivering western biomedicine during the dynamic period of the 1960s through the 1980s, by analyzing their successful characteristics and approaches. Based upon archival research and interviews with sixty-seven retired nurses, this article argues that the nurses' dedication, training, and acknowledgment of 'traditional' beliefs contributed to their success. In doing so, the article presents these nurses as an historical example of how women from local communities have been vital to delivering health care and building rural communities.

### **Biography**

**Leslie Anne Hadfield** is an assistant professor in the Department of History at Brigham Young University. She has published journal articles on South Africa's Black Consciousness movement and a book, *Liberation and Development: Black Consciousness Community Programs in South Africa* (Michigan State University Press, 2016). She has also conducted historical research on Xhosa nurses in the Ciskei, South Africa.

## **On the Frontlines of Health Care: Xhosa Nurses in South Africa's Rural Ciskei, 1960s-1980s**

by

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# **On the Frontlines of Health Care: Xhosa Nurses in South Africa's Rural Ciskei, 1960s-1980s**

## **INTRODUCTION**

After transcribing a number of interviews I conducted with retired female Xhosa nurses in South Africa, my research assistant remarked that the Africa she was learning about in her Public Health classes was very different from the Africa she was learning about in her African studies classes. When she started transcribing the interviews, she thought that the descriptions the nurses gave of certain challenges they faced in rural clinics would prove what she believed about the deficiencies of health care in developing countries. As she continued to listen to the nurses, she was surprised to hear that the women had already practiced or knew about certain approaches she was learning about in her Public Health classes. And yet these women had worked decades earlier in rural South Africa.

The work and history of female Xhosa nurses in the Ciskei region of South Africa's Eastern Cape has largely been ignored by scholars; yet the region has much to teach us because it has the longest history of training African professional nurses in South Africa and it is representative of rural or 'homeland' health care.<sup>1</sup> The purpose of this article is to highlight the important role these nurses played in a period of particularly intense change in health care provision, the 1960s through the 1980s, by analyzing the nurses' successful characteristics and approaches. I argue that these nurses serve as an historical example of how women from local communities have been vital to delivering health care and building rural communities. Scholars of health and healing in African history have recently shifted from exploring the opposition between western biomedicine and African medicine to the exchanges between the two (Digby 2006, Flint 2008, Baranov 2008). Other scholars have written about the training of African traditional birth attendants and village health workers (Holden 1984; Maglacas and Simons 1986; Shapiro 1987; Robinson 1990; Rowley 2000). Few have examined the history of African nurses trained in western biomedicine who worked in rural clinics where they constituted the sole biomedical health care providers. Doing so reveals how Africans from similar ethnic groups understood, utilized, and contested various healing systems at different levels while interacting with each other.<sup>2</sup> When we look at Xhosa biomedically trained nurses at work on the ground within Xhosa communities, we see the complexities of the delivery of health care and healing practices and beliefs within African communities on a deeper level than when we focus just on the encounters between Africans and European doctors and nurses. The Xhosa nurses stationed in these communities emerge as central in this history. In particular, the article demonstrates that Xhosa nurses' training, dedication, and acknowledgement of so-called traditional beliefs contributed to their success in delivering biomedicine at a time when material and human resources for biomedicine health care services in black rural areas were minimal.

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<sup>1</sup> Cecilia Makiwane, the first African nurse to be registered in South Africa (1908), trained at Victoria Hospital at the Lovedale Mission in Alice. The hospital continued to train African nurses throughout the early 20<sup>th</sup> century and was later joined by a number of other training hospitals in the region. Ann Digby (2012) also shows how the Ciskei led in the provision of health care among South African 'homelands,' which relied on African nurses.

<sup>2</sup> As Ruth Prince reminds us, Africans have not just been passive recipients of coercive colonial medical campaigns or European visions of health and health care, but have sought out and engaged biomedicine in various ways (Prince 2014).

As a work of history, this article presents practical evidence of the role African women have played in the past which can inform development studies. Historicizing the work of African nurses in rural public health care helps us retain knowledge and experience gained from the past about effective ways of instituting public health initiatives in rural communities, interacting with different healing traditions, and supporting and drawing upon skilled African women. Although the article uses governmental, hospital, and newspaper archival sources, it draws largely upon oral history interviews conducted with sixty-seven retired nurses who were living in the Ciskei region in 2011-2013. Most of the interviewees were members of three retired nurses' associations based in the region. They had various geographical and socioeconomic backgrounds, but most had significant personal ties to rural areas in the broader Eastern Cape and had worked in rural clinics and hospitals in the Ciskei. All but one identified as Xhosa and all were women. There were no male nurses in rural village clinics. Even though men had and would be involved in nursing (especially in predominantly male sectors such as war fronts and mining compounds as discussed in Burns 1998 and Marks 2002), the village clinics were the domain of the female nurse. The gendered nature of the nursing profession in South Africa was influenced by European and Christian notions of women as nurturing, devoted, and passive, and thus particularly suited for the care of sick people in a position submissive to a scientifically-minded male doctor who could provide leadership. It also corresponded to Xhosa roles of women as mothers and healers (particularly diviners, or *amagqirha*).<sup>3</sup> By the 1960s, nursing in South Africa was an overwhelming female profession.

I took a guided life history approach to the interviews, focused on each woman's career. In conducting and analyzing the interviews, I paid attention to issues particular to a woman's experience, emotion and meaning, and interviewer-interviewee cross-cultural, racial, linguistic, and class dynamics. Much of the evidence was presented to me, a foreigner, by nurses who celebrated their careers. This meant that while I gained valuable first-hand and personal accounts of rural nursing that I could not find in the archives, I had to probe interviewees further about certain topics and interrogate the transcripts of their interviews for evidence of bias and silences. The number of interviews I conducted provided various perspectives, and the archival evidence I obtained also helped to flesh out a more accurate bigger picture.<sup>4</sup> How people remember the past is also revealing, further making oral histories valuable sources of evidence despite their limitations.

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<sup>3</sup> Many scholars have pointed out that the development of the profession with Florence Nightingale was highly gendered or based on notions of femininity that women were gentle, devoted, and submissive care givers, but not capable of the kind of scientific understanding and decision making characteristic of male doctors (e.g. Holden and Littlewood 1991, Marks 1994). Racial thinking about the capabilities of Africans and who was suitable for wage labor meant that in many colonial cities and hospitals in Southern Africa, Europeans initially preferred African men in domestic and hospital service; however, at least in the Eastern Cape, concerns about competition between male medical aides and male doctors, plus European gender notions led to a shift to training African women as nurses (Marks 1994). The focus on training African women as nurses was subsequently reinforced by colonial and missionary ideas that African women could most effectively change ideas about health and healing because of their position as mothers (Holden 1984; Egli and Krayner 1997; Rennick 2001; Digby and Sweet 2002). Xhosa *amagqirha* or diviners can be male or female, but by the mid-20<sup>th</sup> century were predominantly female, with a ratio of at least 2:1 (Hirst 1990).

<sup>4</sup> This evidence will also be supplemented by hospital and clinic archival materials as they become available.

## South Africa's Political Economy of Health

The Ciskei was a largely rural region of South Africa's Eastern Cape designated by the apartheid state as a 'homeland' for certain groups of Xhosa people and representative of other black rural areas in the country. Historians have revealed how racial discrimination in state policies and the medical profession resulted in poor health and health care services for South Africa's black populations in these rural areas (Packard 1989; Marks 1994; Wylie 2001; Digby 2006; Flint 2008).<sup>5</sup> With colonial conquest, land dispossession, and the development of migrant labor systems, the majority of black South Africans were placed in a subordinate economic position. When the British claimed South African land, they carved out certain regions as 'Native Reserves' for particular ethnic groups. Many Africans dispossessed of their land in the early 1900s and those subsequently unable to survive on agriculture alone moved to urban areas and mines for work. Urban poverty and poor infrastructure led to malnutrition and the spread of disease in those urban centers. Those left behind on the 'Reserves'—wives, children, and the aged—relied on the wages of absent family members or meager pensions to survive. This rural poverty also led to poor health. Migrant labor further contributed to rural ill-health when migrant laborers failed to adequately support their families and migrations facilitated the spread of disease (Packard 1989; Thomas 1974).<sup>6</sup>

These conditions persisted into the latter part of the twentieth century when the apartheid government began to turn 'Native Reserves' into ten ethnically defined future nations—or 'homelands'—designed to exclude Africans from political participation, but still allow white South Africans to take advantage of black labor. These ten 'homelands' only made up thirteen percent of South Africa's land, although black South Africans constituted around eighty percent of the population. The scattered 'homelands' included the Ciskei as well as the Transkei, KwaZulu, QwaQwa, Bophuthatswana, KwaNdebele, KaNgwana, Lebowa, Gazankulu, and Venda. The process of reorganizing governments and local services into these supposed new nations started in 1959 with the Promotion of Bantu Self-Government Act, and 'homelands' persisted into the early 1990s (though only four gained official independence). As Anne Digby (2012) has demonstrated, the South African government worked with 'homeland' governments to significantly increase government health services during this time, focusing on primary and promotive health care and extending comprehensive community services to rural areas. The 'homelands' saw an increase in health care facilities, particularly clinics, and an increase in the training of health care professionals, particularly nurses who became the "backbone" of 'homeland' health services (Digby 2012, 841). However, while some black people obtained

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<sup>5</sup> In the early 1940s, a radical movement in social medicine had emerged in South Africa and inspired government consideration. For a moment, the medical profession and government seemed poised to significantly extend health care to rural and urban communities all over South Africa. Yet, a lack of political will, hostility from certain medical practitioners and the imposition of apartheid led to the abandonment of these initiatives at that time (Marks 1997, Jeeves 2000, Andersson and Marks 1992).

<sup>6</sup> Packard shows how poor living conditions in cities, where tuberculosis often breeds, led to TB outbreaks in the rural areas where miners' families lived. Dr. Trudi Thomas, a medical officer at the Ciskei's St. Matthews mission hospital in Keiskammahoek, argued that the high prevalence of kwashiorkor and marasmus (diseases of malnutrition among children) was closely related to migrant labor. In a study conducted in the 1970s, she found that 60% of malnourished children had not been born within marriage and 80% had been deserted by their fathers, most of whom were working in the cities. On the other hand, 80% of well-nourished children had been born to married parents and were supported by fathers and 50% of well-nourished children not born to married parents were supported by fathers.

political and economic gains with more attentive local governments, most ‘homelands’ were rural backwaters that continued to suffer from underdevelopment, poor financing, and the negative effects of migrant labor. Furthermore, the apartheid state forcibly relocated thousands of people to these regions, dramatically increasing the population and placing a further burden on local resources.

Available statistics from the time powerfully demonstrate how the disparity in socioeconomic conditions between races affected the quality of health and health care of South Africa’s people. Infant mortality rates for black South Africa for these years are not entirely reliable (African births and deaths were not fully registered); yet the information available is revealing. For example, in the 1960s through the 1980s, there is evidence that the infant mortality rate for white South Africans decreased from 30 per 1,000 births, to around 9 or 13 (South African Institute of Race Relations 1960-1990). In contrast, those classified as Africans suffered a rate of up to six times higher than white South Africans. Estimates for Africans in the 1960s and 1970s ranged from 140 to 180, while other numbers showed the rate remaining steady at 80 through the early 1980s, and dropping to around 63 at the end of the decade. It was much worse in the homelands, with an estimate of 250 in the rural Ciskei in the early 1980s (Switzer 1993, 340). The World Health Organization (WHO) expected that this high rate could be explained by rural poverty and a lack of sanitation. In 1972, it estimated that fifty-eight percent of rural black deaths were caused by malnutrition and gastroenteritis (United Nations Department of Political and Security Council Affairs 1975, 5).

Health challenges in rural areas were compounded by state neglect of social services. Christian mission stations had taken the lead in providing health care facilities in rural South Africa. In 1965, there were 85 mission hospitals in the ‘homelands,’ and 93 in 1973. But in the 1960s and 1970s, many of these hospitals were small and increasingly faced financial trouble (South African Institute of Race Relations 1965, 284; and 1973, 351).<sup>7</sup> In 1965, the 85 hospitals located in the ‘homelands’ had a total of 13,600 beds, as opposed to 21,953 beds available for a much smaller white population. In 1972, the South African Institute of Race Relations reported the ratio of hospital beds as ten beds per 1,000 white people and 5.57 beds per 1,000 people of color. In 1973, the ratio of beds to population in the ‘homelands’ was 3.48 beds per 1,000 people.<sup>8</sup> According to Les Switzer, the Ciskei had half of the minimum number of beds per Africans set by South Africa’s Department of Health and a ratio of one doctor to every 8,707 (Switzer 1993, 339).

Rural black South Africans were further disadvantaged by racial segregation in health care provision. Despite the continued use of Xhosa healers, by the 1960s, Ciskei residents had come to rely on western medical care to treat certain diseases and for surgery. Many western pharmaceuticals and vaccinations proved to be powerfully effective and many Africans relied on western medicine to treat “European” or “white” diseases—diseases such as TB or influenza that

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<sup>7</sup> Many of these hospitals relied on government subsidies. When the national government began to take over provincial hospitals and consolidate ‘homeland’ governments, it took over the mission hospitals in preparation for the establishment of ‘homeland’ departments of health.

<sup>8</sup> The above statistics come from the South African Institute of Race Relations *Survey, 1965* (284) and *1973* (352). See also South African Institute of Race Relations *Survey 1972* (409) which gives these figures: 1:95 whites; 1:184 blacks. In 1980, the Baragwanath hospital in Soweto was short 2,300 beds of the estimated 5,000 needed (de Beer 1986, 36).

spread with the development of industrialization. Legal certification laws that favored white and western-trained medical doctors and Christian mission hospitals also contributed to the growth in African trust in western medicine. Catherine Burns estimated that fifty percent of patients from all of South Africa had shifted from home-based child birth to hospitalized child birth by 1950 (Burns 2002). Thus, there was a demand for western health care, even as people shopped around for other healing therapies. And yet, the number of health care providers for Africans was dismally low in the segregated system. Health practitioners were often restricted to serving people from their own apartheid racial category. With limited opportunities for western medical education for black South Africans, this left black people severely disadvantaged. In 1972, the doctor to population ratio for white people was estimated at 1:400. It was more than double for Indians at 1:900, while for those categorized as Coloured, it was 1:6,200. For Africans, the ratio was 1:44,400—that is 44,000 more people per doctor than the white population (Gwala 1974, 14). That same year, the South African Institute for Race Relations reported that only fifty-four doctors (including nine classified as Africans) worked in the ‘homelands’ (South African Institute of Race Relations 1974). Since almost all of these doctors worked from hospitals, few people in rural villages had easy access to doctors in the region.

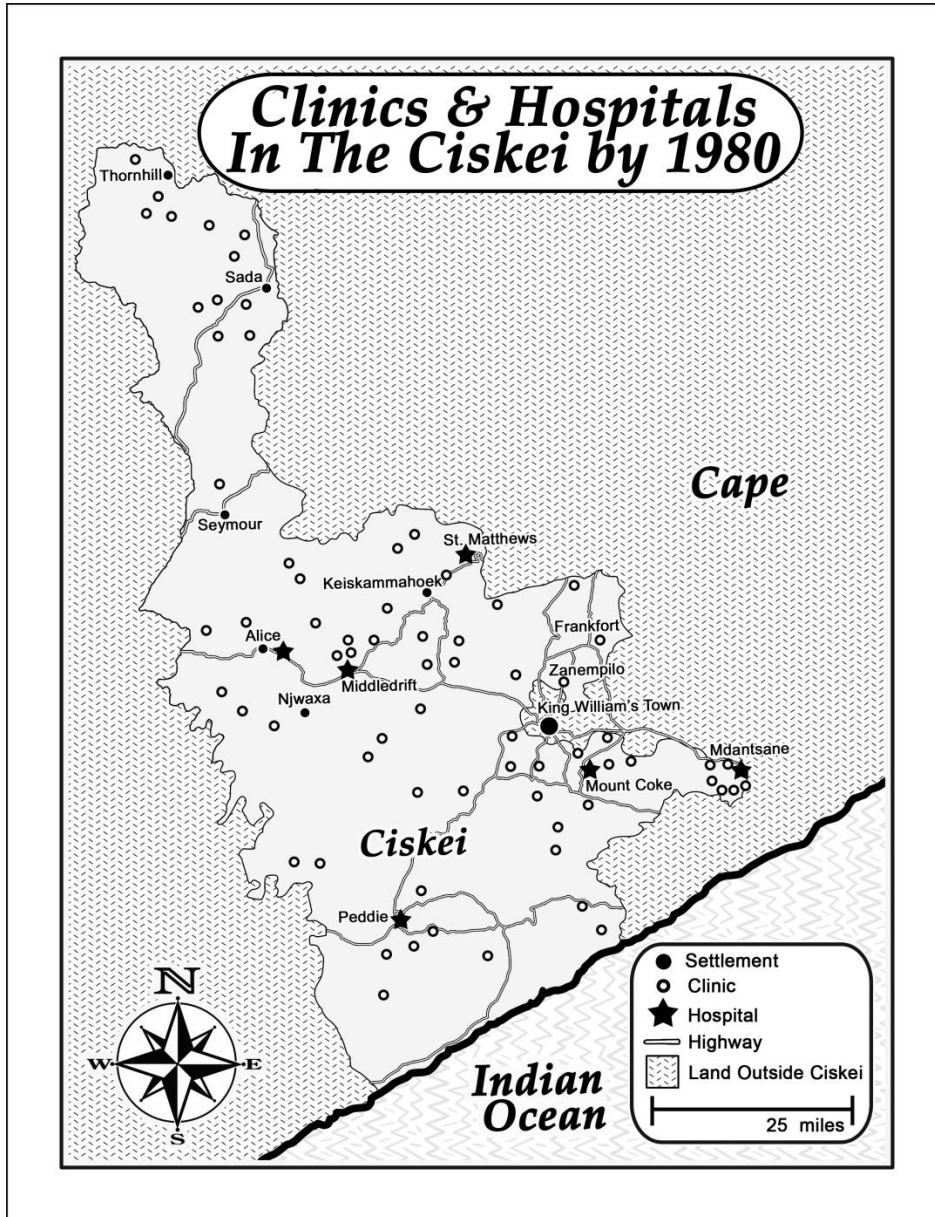
### **Nurses on the Frontlines in the Ciskei**

Although the Ciskei had a few large urban townships, most of the region consisted of a rural population, scattered in numerous villages throughout the country side. Though small and remote, the clinics based out in these villages were extremely important as the first line of western biomedical health care. Mission hospitals that offered services in the rural Ciskei in the 1960s through the 1980s included Mount Coke (at the Mount Coke mission station), St. Matthews (near Keiskammahoek), Nompumelelo (Peddie), and Lovedale (Alice). Like departments of health in the other ‘homelands,’ the Ciskei government sought to improve the services these hospitals provided by taking over the mission hospitals (which had already been heavily subsidized by the government) and improving or rebuilding some such as Mount Coke and St. Matthews, which later became Bhisho Hospital and S.S. Gida respectively. The Ciskei government also built the Cecilia Makiwane Hospital in 1975, in Mdantsane, the largest township of the region located on the periphery of the Ciskei, near East London. These hospitals either sponsored or worked with village clinics, through an extended satellite clinic system wherein the Ciskei government sought to reach remote villages. Yet clinics were generally scattered ten to twenty miles from each other, still requiring some patients to travel long distances for clinic care. In 1980, even after efforts to build more clinics, there were only eighty-one clinics (ninety if mobile clinics and sub-clinics are included) and five hospitals for a population estimated at 635,000 (Saldru 1983, 26). Despite attempts by the Ciskei government to improve health care in the 1980s, these services remained inadequate as thousands of people were forcibly resettled in the Ciskei within a few short years.<sup>9</sup>

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<sup>9</sup> According to Saldru (1983, 6), the population almost doubled in the Ciskei between 1973 and 1983, from 350,000 to 630,000. As Switzer reported, although the Ciskei had increased the number of beds in hospitals and clinics in the 1970s, the proportion of those beds to the population virtually stayed the same, increasing only slightly from 2.1 per 1,000 in 1946 to 2.3 in 1980 (Switzer 1993, 339).

Figure 1: Map of Clinics and Hospitals in the Ciskei by 1980 <sup>10</sup>



The Ciskei Department of Health worked with village leaders to determine the sites of most Ciskei rural clinics. Village leaders either requested or lobbied for clinics to be built in their villages and the Department of Health determined if the location would give the health services an even geographic reach according to the location of other clinics. Clinics were mostly established in order to serve a number of neighboring villages as well as its host village. On average, nurses ran these clinics in four-roomed houses. The front two rooms served as waiting and consulting rooms, while the back two rooms housed the nurses stationed there. Many clinics also had a small yard outside of the clinic and ideally would be fenced to keep thieves or

<sup>10</sup> Figure 1 Source: adapted from Saldru 1983



roaming cattle out of the yard. Bigger clinics may have had up to six consulting rooms and an official pharmacy area.

Patients arriving at the typical Ciskei rural clinics in the 1960s through the 1980s would most likely find only one or two fully-qualified nurses and would rarely see a doctor (Saldrú 1983, 21).<sup>11</sup> The 1960s saw an increase in African nurses, especially as ‘homeland’ governments prepared to take over health services. Fully qualified state-registered African nurses grew from over 5000 in 1960 to about 20,000 in 1980 and nearly 27,000 in 1986 (Marks 1991, 5-6). This accompanied an expansion in rural clinics. However, the deficit of health care facilities and professionals was already so great that even this expansion never reached reasonable numbers set by the WHO, especially with the influx of forcibly relocated people. The WHO regarded a registered nurse to population ratio of 1:500 as reasonable (Mashaba 1995, 136).<sup>12</sup> In all of the homelands in 1972, African nurses and midwives numbered 10,725 (South African Institute of Race Relations 1974). This would have been an ideal number if all of them worked in the Ciskei, with its population in 1973 estimated at 350,000 (for a ratio of 1:33); however, these nurses worked in ten different rural areas.

Besides a lack of personnel, the lack of proper equipment and supplies made the clinic work load difficult, especially when nurses had to handle maternity cases and other emergencies. Like the other ‘homelands,’ the Ciskei’s underdeveloped infrastructure caused significant difficulties (Digby 2012).<sup>13</sup> Most clinics in the Ciskei in the 1960s through the 1980s had no electricity. Nurses commented on the difficulty of using paraffin lamps or candles at night for a baby delivery. A number of clinics also did not have linens. To compensate, nurses would instruct pregnant women who attended the antenatal clinics to start collecting newspapers to serve as a draw sheet for the day they gave birth. Communicating and traveling to the referral hospitals could also pose a major challenge for those stationed at rural clinics. Few clinics had direct telephone lines to the hospitals. Most had radios (affectionately referred to as “overs”) which they would use to call for an ambulance. Some nurses found their referral hospitals responsive and attentive. Other nurses reported they could not rely on the ambulance. Thembisa E. Nkonki worked at Mount Coke Mission Hospital and in various rural clinics before she became a district supervisor for the Ciskei.

“Oh the problems!” she remembered. “No transport to take [sterilized packs at the hospital] straight to you, you have no medicines, there is no transport to take the medicines to you. You phone and phone and phone until sometimes you send a junior nurse or junior somebody to go to the hospital and collect.”  
(Thembisa E. Nkonki, interviewed June 15, 2011)

Waiting on the ambulance was worse when a village was an hour’s drive from the hospital or when the nurse had a difficult pregnancy case. Bad roads and a high demand on the ambulance made matters worse. The ambulance from St. Matthews reportedly was “so unreliable that it is

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<sup>11</sup> Well-resourced clinics might have up to four fully-qualified nurses. Often, clinics had two fully-qualified nurses, with one or two assistant nurses. Doctors visited clinics once-a-month.

<sup>12</sup> Grace Mashaba wrote in 1995 that South Africa needed 72,800 by 2000 to reach that, making the registration of 49,600 necessary.

<sup>13</sup> Others reported similar conditions, for example in rural Tanzania as noted in Holden 1984.

not unusual to wait nine hours for it to arrive, and in bad weather it does not attempt the journey” (Saldru 1983, 28). In urgent cases, sisters may have had to walk to a neighboring village to deliver care or nurses and community members used their own vehicles to transport patients. In the Rabula village, about 7-8 miles from Keiskammahoek, nurses sometimes sent people to the hospital on horseback (Evelyn T.N. Magodla, interviewed June 7, 2012; Constance Nozipho Thoto, interviewed October 18, 2013).

Nurses performed all necessary tasks for running a clinic, ranging from baby clinics and immunizations, to distributing milk powder to combat malnutrition, and sterilizing equipment. Nurses provided primary health care, treating common colds, minor ailments, and cases such as gastroenteritis, hypertension, diabetes, or sexually transmitted infections. They also held weekly child health clinics, antenatal clinics, and TB days. Three of the most common cases nurses dealt with in children in rural clinics and hospitals were gastroenteritis, kwashiorkor, and marasmus. In the nurses’ view, unclean baby bottles and contaminated water supplies contributed to gastroenteritis. Kwashiorkor and marasmus were also linked to the way women fed their children and the state of local food sources. Kwashiorkor is a disease of malnutrition caused by a lack of protein in a person’s diet.<sup>14</sup> Marasmus is a more severe form of malnutrition caused by a general lack of calories that results in a rapid wasting away of muscle and fat. In addition to a lack of food in impoverished families, a number of nurses talked about how mothers or grandmothers feeding babies formula (instead of breastfeeding) would try to make the formula last longer by mixing smaller amounts of the powder to make a bottle, thus chronically depriving their children of nutrition. Nurses used baby clinics and health education days to address these practices and teach nutrition principles to villagers. Nurses embedded in communities, performing home visits and holding weekly clinics, understood the root causes of these diseases and how best to address them.

Nurses stationed at rural clinics emphasized the constant and heavy responsibilities they carried as the sole western biomedical care providers in remote villages. Thembisa E. Nkonki talked about how nurses had to get used to the conditions and “the work that is there...because you stand for yourself, there is no doctor” (Nkonki, interviewed June 15, 2011). Other nurses, such as Feziwe Badi (October 7, 2013), Thandiwe Mkwelo (November 27, 2013), and Victoria Mjikeliso (June 1, 2012), talked about how a nurse had to be independent in the clinics. In the absence of a doctor, she had to use her own discretion—she had to make the decision: do I treat or do I transfer? Nombeko Cecilia Tunyiswa (September 20, 2013) compared working in a hospital to working in the rural clinics: in the hospital, “you treat the patient according to doctor’s instructions and the patient gets well. In the community, the patient comes to *you*...” When talking about being placed alone at the Ann Shaw clinic, she said, “You are a general nurse, you are a midwife, you are a doctor!”<sup>15</sup> As a result, Alecia Phiwo Dubula said, “you must have a big breakfast so you can stand up for the day” (Dubula, interviewed May 4, 2012). In clinics that did not have hired cleaners or gardeners, nurses would also have to perform janitorial tasks after their work was done for the day.

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<sup>14</sup> Nurses described children with Kwashiorkor as being skinny and weak, yet having a bloated stomach and a lighter hair and skin color.

<sup>15</sup> Nonfundo Rulashe summed it up when she said, “And as a general nurse you did everything!” (Rulashe, interviewed June 4, 2012).

In order to ease the burden of the clinics and extend the reach of health services to villages beyond the clinics, ‘homelands’ relied on more low-level professionals and trained community or village health workers. Village health workers were chosen from within communities to monitor patients, keep track of home environment conditions, focus on preventive health care, and provide basic first aid. They had minimal training and little medical authority, but nurses who worked with them praised them for acting as the eyes and ears of nurses in remote villages. They could follow-up with patients on a strict treatment regimen, report sanitation problems, and reinforce health education. These village health workers played a significant role. Indeed, the Ciskei reported that they helped reduce malnutrition, gastroenteritis, and measles (Digby 2012, 842). However, the impact of village health workers was uneven and the program was short-lived whereas the fully-qualified nurses had a more sustained presence and impact in the Ciskei.

Most of the day-to-day work in clinics could be low key, though constant. It was in handling emergencies and maternity cases that nurses felt the high stress of their work. They referred emergencies and surgeries to the clinic’s parent hospital; however, they received these emergencies and dealt with maternity cases at all hours of the day and night. At least one nurse was required to be officially on-call for after-hours emergencies all the time. Most nurses stationed in rural clinics lived in nurses’ quarters near the clinic (whether or not they permanently lived elsewhere), with only two weekends off per month. Living near or attached to the clinic, nurses were easily accessible to communities. People often came for help whether or not a nurse was on call. As Nontsikelelo Biko remarked, “I mean, those days a nurse was just a nurse twenty-four hours around the clock. There was no time you would say, ‘I’m off’” (Biko, interviewed December 2, 2008).<sup>16</sup> For those who served as the only fully-qualified nurse in a clinic, this could be exhausting. One nurse stationed at the Amathole clinic all by herself once became so burned out that she stopped going to work. When her supervisors discovered this, they sent another nurse to relieve her for at least two months. (Thereafter, she felt rejuvenated and recommitted.)

It was ideal to have three professional nurses stationed at a clinic to allow one nurse to rest or take leave when needed. Even then, when it was one nurse’s turn to be on call, it often happened that she would spend the entire night with a patient then be expected to open the clinic at eight o’clock the next morning. Maternity cases were the main culprit.<sup>17</sup> These cases were the most demanding of nurses’ time, energy, and expertise. A woman could deliver any time—a pregnant woman would “just [turn] up when she’s in labor” (Nkonki, interviewed June 15, 2011).<sup>18</sup>

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<sup>16</sup> Mavis Makubalo remarked that the community would not understand when someone was on leave (Makubalo, interviewed December 3, 2013).

<sup>17</sup> Maternal care and midwifery services were an important first focus of extending biomedicine in many African countries and colonies. Often in colonial state systems, maternity care focused first on colonial settlers and then training for African populations followed (especially when colonial governments began to pay more attention to issues of ‘development’ in the interwar period). In mission hospitals and services, childbirth and maternal care were extended to Africans earlier on because of health problems linked to infant and maternal mortality rates (Gelfand 1978; Hunt 1999), maternity care was less challenging to traditional practices (Rowley 2000), missions thought they could make the most effective change by targeting women (Schuster 1981; Holden 1984; Holden 1991, 71-72; Marks 1994; Hunt 1999; Digby and Sweet 2002; Rennick 2001), and missions believed that district nurses would be the most effective in converting people to the clinic and hospital (Holden 1991, 71).

<sup>18</sup> Nombeko Cecilia Tunyiswa mentioned delivering a baby on Christmas day as an example of how demanding the work could be (Tunyiswa, interviewed September 20, 2013). She speculated that her children did not like nursing because their mother was always on-call: “I think they had a bad experience because mama was always busy.”

Nurses attempted to meet with patients to provide prenatal care and watch for problems that may need a doctor's referral. They held antenatal clinics on the same day every week. Still, many mothers did not come for prenatal care. Nkonki explained: "She just comes when she is in labor and she doesn't come the first day. She's allowed to go on at home sometimes because there are *matshoko* [a term for old women] there who think they can help her" (Nkonki, interviewed June 15, 2011). Furthermore, while nurses encouraged women to deliver at the clinic or hospital (especially in high-risk cases, such as first pregnancies or after having multiple pregnancies), many ended up delivering at home. Some nurses remember walking long distances to assist a difficult birth.

Maternity cases required that nurses think quickly and employ all of their training and stamina. These were high-stakes cases with two lives at risk that demanded a nurse's full attention and precision, especially when complications occurred. Evelyn Magodla's memory of her first maternity case at Rabula clinic exemplifies the pressure these nurses felt. It was her first case out in a rural area and she had to go up a mountain to help a woman in labor:

...there came some of the people... that somebody is going to get a baby. "So nurse take your suitcase, there's the horse, go to the mountain." So I took my suitcase, I climbed the horse, go to the mountain. And I was panicking like mad...I phoned St. Matthews... You know, I was so scared...because it was going to be my first experience. But you know—no ambulance came. I have to deliver that woman there, at her house, *ne*? Then when I've already delivered her, only then the ambulance came... I was so scared. When I got [to the hospital] those nurses—those old nurses—they were laughing at me, "Wooh, you're so panicking!" *Ha ra ra* I was just nice and fed up. Because—I'm panicking...if that person died, who's going to be at fault? It's going to be me!  
(Evelyn T.N. Magodla, interviewed June 7, 2012)

Despite the high stress of maternity cases, Nkonki talked about her satisfaction in taking them on. Her skills were sharpened and her confidence boosted: "Nobody is going to help you, that's the thing. Unlike in the hospital... you are using your brains now..." She continued, "you don't depend on anyone there. You know you must do things the right way and do proper findings" (Nkonki, interviewed June 15, 2011). When pregnant women lived far from clinics and hospitals, there was a greater chance that they would deliver in less than ideal situations. These cases demanded that nurses have good technical skills and quick problem-solving strategies. Vuyiswa Sodlulashe remembered delivering twins at the stream below Ann Shaw clinic because the woman could not make it to the clinic. Another time, she delivered a premature baby at the public transportation stop on the way out of her home village of Madubela (Sodlulashe, interviewed September 19, 2013). Nomali Georgina Gwarabe Bangani said maternity cases brought her closer to God because when she was alone and responsible for two lives, she had to ask God for help (Bangani, interviewed October 9, 2013).

### **Training, Dedication, and Xhosa Healing Beliefs**

Because of the responsibility nurses carried in rural clinics, Nkonki and Nomazotsho Mcako, her former colleague in the township clinic in Ginsberg, argued that nurses stationed in village clinics could never be young nurses, fresh from training. They would not have the experience

and “would be stuck with problems.” Nkonki remarked that it was “easy in the hospital. If you find out this is a breach [birth] then you call for a doctor and within minutes he’s there.” In rural villages, there was no doctor and nurses initially received no extra or special training to prepare them for what they would encounter (Nkonki, interviewed June 15, 2011). Some were fortunate enough to be orientated by older, more experienced nurses who had already worked for years in the clinics. Otherwise, as one nurse, Celiwe Elizabeth Mbie, remarked, it was “just experience” that trained them for clinic work (Mbie, interviewed October 7, 2013).

However, the training nurses received during this time period, particularly in midwifery, was a major contributing factor in their success in providing biomedical health care in the rural Ciskei, marked in part by the fact that most nurses reported that they had few if any deaths in child birth. In fact, full-time nurses stationed in rural clinics were required to have midwifery training. Before changes in training in the 1990s, South African nurses had a minimum of three years training for general nursing. Midwifery training took at least one more year as a separate program. Many nurses worked in the Eastern Cape trained at hospitals known for their high standards such as Livingstone Hospital in Port Elizabeth, King Edward the VIII in Durban, McCord’s Zulu Hospital, or Victoria Hospital (the first hospital to train professional black nurses). Mcako trained in midwifery at St. Monica’s in Cape Town, where her instructor took pains to ensure she understood procedures. Looking back, Mcako felt “it was wonderful the way they used to care for us” (Mcako, interviewed June 15, 2011). Others who trained at big urban hospitals like Baragwanath Hospital in Soweto, or who trained in rural mission hospitals remarked that they gained experience in treating a variety of cases or dealing with rural conditions.

Nurses who worked in rural clinics also often added further training to their general nursing and midwifery certificates. Digby described how ‘homeland’ governments and the South African government created various programs and linked with universities to provide the training that was so desperately needed in order to adequately equip health care workers and train more doctors (Digby 2012). Many nurses appreciated that the Ciskeian ‘homeland’ government offered nurses in-service training opportunities on a variety of topics. Many also completed a degree in community health nursing and health administration, either through a new program provided at the Cecilia Makiwane Hospital in Mdantsane or through the University of South Africa. The Ciskeian government also focused for a time on improving psychiatric health services, which led to many completing certificates in psychiatric nursing.<sup>19</sup> Others completed courses in subjects such as family planning. Continuously adding to their skill set with experience and training improved the nurses’ abilities to deliver health care in rural communities.

Even with this training, the lack of resources could have had a crippling effect on the nurses’ work—this was partly why the nurse in the Amathole clinic stopped going to work. Thus, the commitment to nursing in rural communities these nurses had was just as important to helping them persist under strenuous circumstances as their training. The need for a strong commitment was a theme in the interviews I conducted. When asked to give advice to new nurses, Nontsikelelo Mfengqe (November 6, 2013) and Nomathemba Ncukana (October 22, 2013) both asserted that for a nurse to be successful, she had to be dedicated, patient, and diligent. Nombali

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<sup>19</sup> In a town called Fort Beaufort, near Alice, the South African state established a psychiatric hospital named Tower Hospital which took in many psychiatric patients from the Ciskei.

Sara Mbombo remarked that a nurse had to have experience, but also had to care about people enough to motivate her to do further investigations into community health issues (Mbombo, interviewed October 4, 2013). Nozokolo Hono explained that if a nurse liked the community, then she would learn a lot, helping her be a more successful nurse (Hono, interviewed October 23, 2013). When asked what kept them going despite the long hours, lack of equipment, and difficult cases, most nurses talked about their love of nursing and their desire to help their people. When asked why she stayed in the rural clinics, Mjikeliso replied, "I decided to help my people because I knew that there was no other alternative because I was trained and I made a pledge that I will work for my community" (Mjikeliso, interviewed June 1, 2012).

Constance Nozipho Thoto's comment that the community owned their nurse reflected the dedication she had to her work as a nurse as well as the particular demands of working and living within a community. She described why she liked community work: "With the community work, you work in the community. You conduct visits to the homes, you know how they stay at their homes. You happen to know their problems, and so on... In the community, you are involved with them... They own you!" She then went on to describe how a nurse must put her patients first (Thoto, interviewed October 18, 2013). In the first few years of her career, Theresa Nonceba Ntonga worked in three different clinics and then a hospital. Being stationed out in rural clinics was challenging—in the Mgwali clinic near Port Alfred, for example, she had to do everything, including janitorial work. But, she said she was committed to her work and that sustained her (Ntonga, interviewed September 26, 2013). As Penelope Ntshona said, "When you love a thing, when you are there, you wonder why you were afraid [to do it before]" (Ntshona, interviewed October 21, 2013).

Individual personalities, training, and perhaps gendered roles of women as care givers all may have strengthened the commitment these women had to their work. At least twenty-one of the nurses I interviewed told me that they became nurses because they had always enjoyed helping or nursing people, even from a young age. Most emphasized that nursing was a "calling," not simply a job or a career. Those trained in mission hospitals would have been taught that the nature of their work was special or sacred, while others who were already religious may have inscribed this on to their demanding, yet people-centered careers, looking to Florence Nightingale as their noble forerunner (Mashaba 1995; Egli and Krayner 1997; Digby and Sweet 2002; Horwitz 2007). Many scholars have analyzed the gendered nature of nursing as a woman's career and its link to maternal caregiving. A few nurses I interviewed even used the term "mothering" to describe their work, indicating that they also saw nursing linked to their natural role as a mother. For example, when explaining why she loved her career, Pholisa Nombulelo Majiza said when a child came in "helpless, crying in pain and we have to mother that child... and you see the fruit when that child gets better" (Majiza, interviewed October 2, 2013).

Expressions of satisfaction in working with communities reflected the commitment these nurses had to their patients which motivated them to work through difficult circumstances. Majiza told of the joy she felt when she saw her patients improve: "...you look after a patient, looking back at the condition they were in when this patient came in to my hands—I looked after him or her, I did this for this patient, I did that..." and then "you see that patient now becoming a human being again, you do have that feeling inside you that 'I am also a part. I have played a part in this person's health'" (Majiza, interviewed October 2, 2013). Still others talked of the joy of working

with patients in their own environment. This allowed them to really see the cause of ill-health and address it at its root.<sup>20</sup>

Finally, nurses succeeded in spreading health education and delivering biomedical health care because they worked *with* rather than *against* Xhosa healing beliefs. Digby and Karen Flint's recent books have taken an encompassing view of health care in South African history, considering western biomedicine's development along with African healing systems. Their works demonstrate that African health practitioners have continued to thrive in many rural and urban communities (Digby 2006; Flint 2008). Few nurses I interviewed said they interacted closely with Xhosa healers—diviners (*amagqirha* or *isanuse*) or herbalists (*ixwele*)—but they did indicate that their patients often consulted both Xhosa healers and western-trained nurses and doctors. This use of African medicine along with biomedicine was and is quite common. Many scholars have shown that patients, and even some biomedically trained nurses, can view both systems as complimentary as they seek out the most effective treatments. Thus, seeking out biomedicine does not necessarily mean another belief system has been totally displaced (Schuster 1992; Hunt 1999; Digby and Sweet 2002; Digby 2006). Nurses working in rural areas would have dealt with Xhosa healing beliefs more since they were embedded in communities where these beliefs often held more sway. While nurses found certain Xhosa healing practices damaging, they generally did not have a harshly dismissive or hostile view of traditional beliefs. They understood that a sure way to discourage patients from coming to their clinic was to challenge their beliefs. As Nobantu Baleni stated, if you sit down with a patient who has seen a Xhosa healer, “you do not contradict her beliefs because you're not going to get anywhere” (Baleni, interviewed June 6, 2012). Being Xhosa themselves, these nurses had a good understanding of the beliefs of their patients and thus could translate biomedical terms linguistically as well as conceptually. As others have argued, this is a major reason why indigenous nurses are more effective in delivering biomedical community health care (Rogers 1989; Hunt 1999; Rowley 2000; Digby and Sweet 2002).

Most often, nurses motivated their patients to take both Xhosa and clinic medicines. Xhosa and western biomedical treatment for psychiatric cases and TB patients did not seem to clash. Herbal remedies were also known to be effective. For example, many Xhosa used *umhlonyane*, a tea made out of leaves from the herb *Artemisia afra* (or Wild Wormwood), to ease coughs and common colds. Thus, nurses would encourage the patients to take both medicines, saying things such as “go to the traditional healers and take that [drug], that treatment, but don't stop taking our tablets. You can take both together, at the same time, there won't be any harm.”<sup>21</sup> Dubula explained that in doing this, the patient might not know which medicine really healed him or her: “You know when she's healed, she'll say the Xhosa medicine maybe has helped her... Meanwhile it's the tablets.” Yet, for Dubula, “it doesn't matter as long as they're healthy. That is what is important” (Dubula, interviewed May 4, 2012). Nurses who did work with Xhosa healers claimed that Xhosa healers and clinics ended up cooperating in diagnosing and treating cases

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<sup>20</sup> As Mjikeliso said, “It's so interesting to work in the community because they will know everything because you are always there with them and you will see their problems immediately and you will be able to refer...” (Mjikeliso, interviewed June 1, 2012; see also Nomathemba Ncukana, interviewed October 22, 2013 and Alecia Phiwo Dubula, interviewed May 4, 2012).

<sup>21</sup> “But,” Figlan qualified, “we discouraged them to leave the tablets and just concentrate on the traditional healers' treatment” (Ntombentsha Anjelina Figlan, interviewed December 2, 2013).

such as TB, and that some Xhosa healers even came to the clinic to be treated for certain ailments.

Others stressed the importance of health education in the communities, especially for dealing with damaging Xhosa therapies. The more contentious and common clash seems to have occurred in regards to treating diarrhea (Segar 1997; Guma 1998). Many Xhosa healers used enemas to stop diarrhea caused by gastroenteritis. They believed that the diarrhea was caused by a snake that had entered into the body. To cure the ill-person, the snake needed to be expunged. Purging the body, however, often ended up leading to severe dehydration which could even cause death, especially among babies and small children. To combat this practice, nurses educated the community and healers about the negative effects of the enemas and encouraged people to come to the clinic for rehydration kits. In line with the primary and promotive health care emphasized by the 'homelands' (Digby 2012), nurses held health education clinics at the clinic itself, presented information at community meetings held by chiefs and headmen, and educated individual patients as they received care in the clinic or at home. While most did not speak negatively about Xhosa practices and beliefs, the nurses still made it a point to promote biomedicine.

## **Conclusion**

Nurses who worked in rural Ciskei clinics in the 1960s through the 1980s dealt with the effects of apartheid structural violence first hand. Stationed in villages with few other medical personnel, they received those suffering from poverty and a lack of health care largely alone. With no electricity, slow ambulances, and long hours, their work was very challenging. Yet, they found a way to cope and even succeed. They relied on their training to help them do well in high pressure situations that required fast thinking and expertise even beyond what they may have initially qualified for. Their commitment to nursing and serving their people sustained them through long hours and weeks of work in remote villages with few material resources. Their understanding and the respect they paid to Xhosa beliefs about healing helped them to connect with patients and encourage them to seek the most effective healing therapies. Through all of this, they were able to combat the effects of South Africa's structural violence on the ground, a remarkable achievement in the face of the serious lack of biomedical health care at the time. This history serves as a testament to the vital role women from local communities can play in building their communities. It also highlights the need to cultivate commitment among nursing staff, to support that staff with continuous technical and community relations training, and to focus on equipping health care facilities in far flung communities. Hopefully, as we pay more attention to this history, public health students like my research assistant will not be surprised in the future when learning about what people have accomplished in the past.



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