An epistemological study of the power of women as nurses

A phenomenological approach

by

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Doctor of Philosophy

Dissertation supervisor: Professor Leana R Uys

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Declaration:

I declare that this thesis is my own, unaided work. It is being submitted for the degree of Doctorate Social Science at the University of Natal, Durban, South Africa. It has not been submitted before for any other degree or examination at any other university.

Anita Serdyn van der Merwe

1996/03/19

Date

Dedication:

To all the women as NURSES and nurses as WOMEN who moulded the reality of power into more than just a phenomenon worth studying; sharing and caring about ...

acknowledging ...[1]

clara; euphemia; fortunate; grace; joy; lee; lorraine; lucy; lulu; marilyn; norma; nikitha; peggy; pretty; treasure; vicky; zodwa; and zoleka - for moulding meaning in your own unique way and sharing it with anita ...

the managers of the different health services in kwazulu-natal and the university of natal - you allowed a caring space for this to happen ...

the scientists who have written down their meaningful thoughts and experiences through all the ages ...

my very special family, colleagues and friends who pulled and pushed; walked and ran; pleaded and structured; laughed and cried; but who never lost their true concern and commitment ...

anne - who transcribed most of the interviews - for such quality support I will remain your friendly servant ...

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[1] ... the order is not important; the people are ...

professor leana r uys - who somehow believed in me through these many years and who mentored me with such skill and vigour ... and

my Creator: who was there once again ... as from the beginning.

ABSTRACT

Aim:

The aim of the study was to do an epistemological analysis of the power of women as nurses working in one of the larger and more deprived regions of South Africa, namely KwaZulu-Natal. This research was based on the premises of the Standpoint theory. Concurrent to the collection of data, a literature review and a concept analysis of power, powerfulness, powerlessness and empowerment were done and incorporated where applicable in the final theoretical framework.

Methodology:

A phenomenological approach was used. This incorporated two to three in depth interviews with each participant, lasting an average of thirty minutes each, was used. Women, relating to the gender factor, as nurses were also marginalised in terms of class, as they belonged to the enrolled category of nurses, and race, being African. A fourth selection criterium was added to analyse the reality of **locality** [2], called **rurality**. The researcher applied the principle of theoretical saturation and a total number of nine women, who belonged to the enrolled category of nurses and who worked in a distinct rural health care setting, were interviewed. A second group consisting of five women enrolled nurses and working in an urban setting were interviewed, as were a third relatively contrasting group of four women registered nurses. All forty four interviews were audio taped and transcribed, and a qualitative software package called NUD*IST was used to identify and refine experiential themes.

Findings:

The relationship between power and rights was often layered in contradiction during the interviews and the participants portrayed a picture of being oppressed or marginalised and powerless. The women as nurses belonging to the enrolled category were alienated as women and as nurses in terms of

2. Bold indicates concepts developed by researcher.

being **severed** from the nursing profession and from the ruling gender of men, of being lost in an ever present **routinization** of activities, of being **misused, maternalised** and **domesticated** at home and at work. These phenomena were quantitatively more voiced by the rural group of women and these participants strongly emphasized the limiting influence of their prescribed scope of practice, the approach of the senior category of nurses and they conveyed a traditionalist and altruistic view of nursing and nurses.

The women as registered nurses created their own freedom often away from their men as in divorce. They also sought for solutions concerning powerlessness in more global and distant terms, for example in relation to cultural practices. They communicated a sense of empowerment in terms of for example education, personal qualities and increased job satisfaction. Culture rather than race was emphasized as an essence of womens' oppression.

An epistemological framework of the power of women as nurses developed by the researcher constructed the totality of empowerment in terms of fifteen transformational and hierarchial actions incorporating and adapting Dooyeweerd's theory of modalities and the surfaces of class (**categorial divide**), gender (**the eternal carer**), race (**culture**) and **locality** (**rurality**). These actions and reformulated concepts could be used for the development of specific strategies to facilitate the empowerment of individuals, groups and communities of women as nurses and nurses as women.

Further collaborative research into the phenomenon of power, a re-conceptualization of nursing education and levels of expertise and hierarchies within nursing were some of the suggestions for the way forward.

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Prologue

In preparing for the study, the researcher realized that the approach might be different or new to some readers; and thus felt the need to emphasize the following:

* Accepting the researcher as a woman and the woman as a researcher - thus creating and advocating space for a sincere sensitivity for and involvement with women's issues; and particular the issues of women as nurses ...
* "Re-search" being interpreted as exploring:

  - And re-affirming or dis-affirming what is perceived to be known;
  - What is not well known;
  - What might not be known; and
  - Suggesting and advocating involvement and possible changes to the benefit of women in general and women as nurses in Kwazulu-Natal and South Africa as a whole.
* A refraining from traditionalist structure and division - allowing meaning to shape methodological contentment and content and not the other way round ...
* Accepting a constant movement between sections of the report and stages of the research - nothing being complete till the end and the end not (ever) complete ...

* Allowing space and movement for, and being comfortable with *more than just what is presented to the researcher and to the reader* - the important but often hidden nuances and depths ...
* Allowing a sensitive union and expression of research and aesthetic skills to try and do (more) justice to the complex meaning and inherent beauty of human beings interacting ...
* Accepting that gazing long at and deep into a moment in time in the lives of women holds both specifics and a generalizations; both what is true and what is false; but above all *what it means to be human* ...

The research report consists of the following sections (adapted from Munhall, 1994, p.261-271):

1. Aim of and rationale for study - Including a historical and experiential perspective and justification for doing the study; as well as justification for the theoretical framework and methodology chosen;
2. Theoretical frameworks applicable to women and power - Providing a guide for the planning and the implementation of the research; and (partially) for reflecting on and analysis of the findings;
3. Methodology: General (philosophical and theoretical substantiation for using the phenomenological and thus qualitative approach) and applied (for and within the actual research study in terms of for example aim, selection of participants and conducting of interviews);
4. Exploration of data from the literature - focussing on a discursive overview and a conceptual analysis of power; as well as dealing with empowerment; women, feminism and nursing (international and in South Africa); and
5. Description of the realization of the interaction process between researcher, the setting and the participants:
    * Describing the setting and the participants;
    * Two comparisons of the three groups - firstly of nurses of the

enrolled category working in a rural setting with nurses of the enrolled category working in urban settings and secondly the nurses from the enrolled category with the nurses belonging to the registered or professional category; and

- Studying a key concepts and metaphors used by participants, reporting on the realization of criteria evaluating qualitative research;

Finding meaning, relevance, implication and significance: Reflecting on the findings to understand; to build bridges with the literature review and concept analysis; to describe limitations and to suggest helpful changes and future research possibilities; and to constitute a situated conceptual framework of the power (powerfulness, powerlessness and empowerment) based on the knowledge of these women as nurses in KwaZulu-Natal, South Africa.

BRIGHT BLUE ROSE (excerpt)

I skimmed across black water, without once submerging onto the banks of an urban morning that hungers the first light, much more than mountains ever do

And she like a ghost beside me, goes down with the ease of a dolphin and emerges unlearned, unshamed, unharmed

For she is perfect in every feature and I am the gig with the alchemist's stone

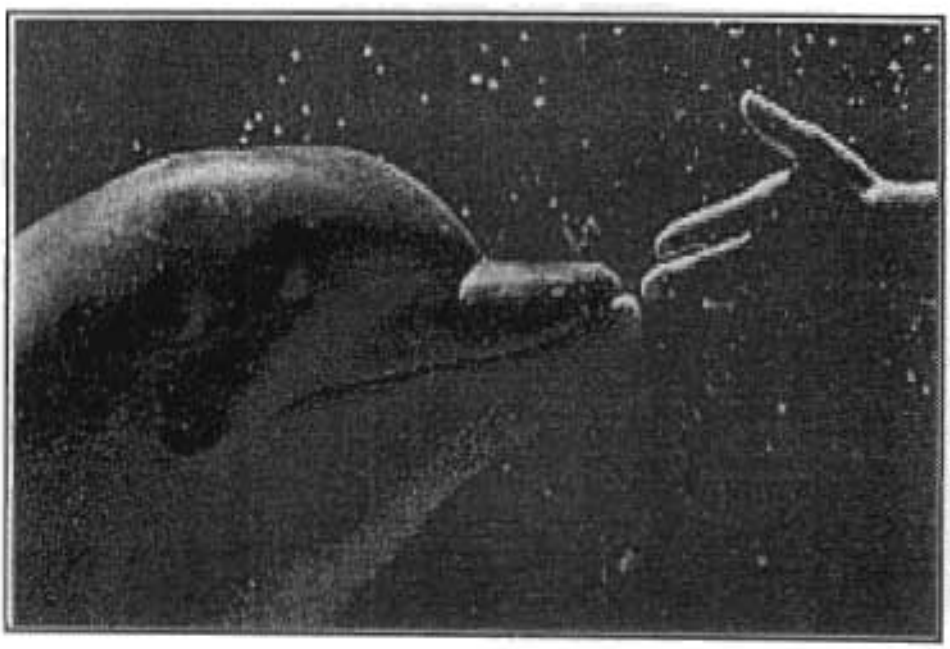
For all of you who must discover

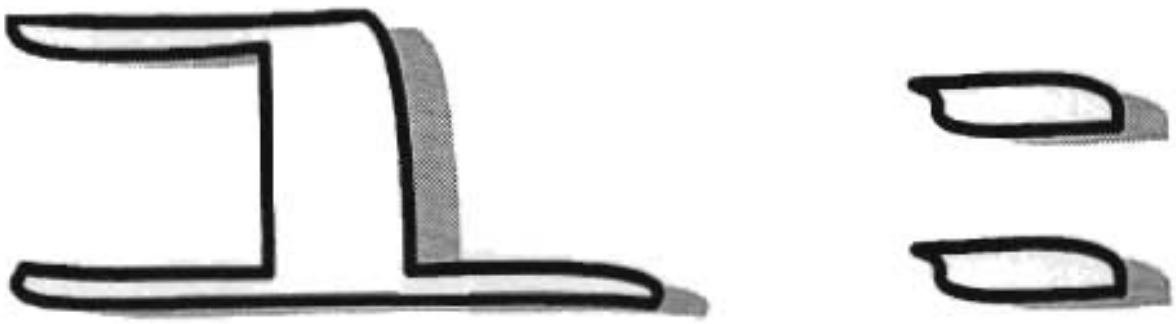
For all who seek to understand

For having left the path of others you'll find a very special hand

And it is a holy thing and it is a precious time and it is the only way...

(J McCarthy / Mary Black; sang by Mary Black)





AIM OF AND RATIONALE FOR STUDY

1.1 AIM OF STUDY

The aim of the study was to present **an epistemological analysis of the power of women as nurses** who live and work in South Africa. In preparing the researcher accepted the following suppositions derived from a **feminist (women's) epistemology**:

- All knowledge is socially and politically situated and open to constant reinterpretation (Harding, 1991);
- Women are perceived to be oppressed by typical male dominated and patriarchal knowledge and practices - feminist theories study these asymmetrical **relations of power as imbedded in class, gender, & race** (Alexander, 1991; Bhavnani, 1993; Harding, 1991; & Tong, 1989);
- A person's reality (and thus knowledge) is always structured by a trilogy of race, class and gender (Standpoint theory);
- The *Standpoint* of the oppressed is epistemologically meaningful in that it can give a comprehensive representation of the interests of the community,

society and of the universe as a whole;

- Women's social and economic desires are often exploited; and nurses are often seen as part of the so-called, maintenance and reproducer roles in the health services (Fogel & Woods, 1981; Witz, 1993);

- Nurses are predominantly women who are spending their working lives in a patriarchal and male-dominated health system; and this domination is often continued in their *'after-hours;'* lives; and

- The lives of women as nurses need to be understood and studied within both the context of work (nursing) and of being a woman.

Nursing science thus needs to analyse the realities of power in the lives of women as nurses and identify the resultant need(s) for empowerment strategies for nurses as women; and to develop a clear epistemological framework of power, powerlessness, powerfulness and empowerment as perceived by nurses, as women, in their daily lives.

1.2 PHENOMENON OF INTEREST

The phenomenon of interest was nurses as women and their perceptions and lived experiences of power; including powerfulness, powerlessness and empowerment. The women were selected on the basic premises of the Standpoint Theory. The theory states for example that actual and everyday lived situations of women need to be analysed and understood - women's lives being a meaningful, epistemological and objective starting point (Harding, 1992 & Wetzel, 1993). The standpoint of women who are meaningful strangers to the established social order,

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[1] For explanations see end of chapter.

needs to be discovered through a systematic political and scientific struggle as portrayed by the distinctive social experiences and insights of women; and by the overthrow of male domination - women need to take the authority to speak. The theory recognizes the distinct power relationships between the ruler and the oppressed and accepts that marginal lives refer to those lives necessarily outside the centre of power and prestige (Harding, 1992).

It is also accepted that knowledge is always mediated by a multiplicity of factors related to the woman's situation at a certain moment in time, within an actual historical setting, and within a set of social relations. Women's knowing is enabled and limited by what they are doing. Womens' everyday experiences as well as the variety of experiences are accepted as meaningful and can make a valuable contribution to theory building (Harding, 1991; Harding, 1992 & Smith, 1987).

1.3 JUSTIFICATION FOR STUDYING THIS PHENOMENON

The perceived justification for studying this phenomenon was thus based on the following stated and perceived realities concerning women and nursing:

1.3.1 THE INTERNATIONAL REALITY

Nursing has a rich but often very sad history in terms of discrimination on the basis of gender, race and class. Nurses were and are often caught between the patriarchal powers of the medical profession and the powers of the bureaucratic hospital system

(Bunting & Campbell, 1990); and also had to face the two conflicting "ideologies" of professionalism and domesticity (Hughes, 1990). Nursing slowly developed other and often opposing views regarding knowledge; for example contextual and phenomena-centred knowing emphasizing the humanness of relationships and caring as experienced within these relationships. These views and approaches were often seen in opposition to the traditional empiricist and positivistic approaches of for example, the medical profession.

Nurses need to question the historical power relationship between medicine and nursing and need to develop their own knowledge within a social and institutional context. According to Chinn and Wheeler (1985), Clifford (1992), Kilkus (1990), and Roberts (1983), nurses are an oppressed group who has long experienced subordination. Nurses have internalized the values of the medical profession, and have often been rewarded for being marginal. Nurses are also inclined to exhibit divisiveness, self-hatred, lack of pride, passivity, horizontal violence, denial of own culture and fear of success; while also suffering from the so-called submissive-aggressive syndrome - all described by the above mentioned authors as traits of oppressed groups.

1.3.2 NATIONAL PERSPECTIVE

1.3.2.1 Placing Nursing in South Africa in perspective:

A historical background

South Africa did not escape the afore-mentioned tensions - nursing here had been consistently plagued with an inherent dialectic tension between the drive for professionalism (and thus elitism) and on the other hand, the many day-to-day activities related to the traditional domestic work of women. Marks (1994) felt that this tension was historically aggravated in South Africa by the need to develop a

distinct middle and white class of women as nurses who would be lifted above the level of such traditional domestic work. This drive for professionalism in Nursing was mirrored by the promulgation of the Nursing Act no. 45 in 1944 which made provision for a nursing council (S.A.N.C.) and a nursing association (S.A.N.A.); the membership of and appointment to the management structure open in terms of colour and gender; but not in terms of category.

The 1957 Nursing Amendment Act, however, was a victory for the advocates of *Apartheid* (separate development) *and Nationalist party* ideology, but an ever-present symbol and degradation and pain for "non-white" women as nurses. The Act made provision for only white nurses to elect and serve on both the S.A.N.C. and S.A.N.A. Separate nursing rolls were to be kept for the different racial groups; and a clause in the Act also made clear provision for giving race preference to rank and for supporting the male status of doctors: "... *black nurses could not give orders to white nurses of an inferior rank except in an emergency, black doctors could"* (Marks, 1994, p. 141). This act also made provision for the enrollment of nurses (enrolled nurses); and in 1972 a roll was created for nursing auxiliaries. These groups also became associate members of the South African Nursing Association (S.A.N.A.), with no voting powers.

A continuous shortage of *white* nurses developed and the black nurses of South Africa were increasing in numbers. In the late 1970's the majority of registered and enrolled nurses were black [2]. These nurses became distinctly and justly politically active and unionized; with ever growing international support. In 1973 South Africa was forced to withdraw from the International Council of Nurses. The Nursing Act no. 50 of 1978 made superficial provision for less racial discrimination by stating racial quotas for elected members of the S.A.N.C.; but, both voters for and appointees to the council should have South African citizenship - thus excluding nurses from the so-called "*homelands*". Enrolled and nursing auxiliaries remained excluded.

Historically, black enrolled and especially, nursing auxiliaries were used to tend to mostly white patients in old age homes and private hospitals: they had to attend to

the basic health needs of the patients with limited if any incentives except the small salary. In the late 1970's urban white hospitals and clinics had to employ qualified black nursing staff to alleviate the shortage of nurses in these services. Charlotte Searle, who was historically involved in setting up apartheid structures in nursing, now became active in removing discriminatory legislation in nursing in South Africa (Marks, 1994). At the same time a marked national and international shift towards nursing education for registered nurses at colleges and universities took place; with little if any concern for the enrolled and nursing auxiliaries.

During the period 1992 to 1995 a new era in the history of Nursing in South Africa dawned; these changes taking place within the wider reality of the first democratically elected Government of National Unity and the Reconstruction and Development Plan of the leading party in government, the African National Congress (A.N.C.). An interim nursing council (I.S.A.N.C.) came into being in 1995 - and hopefully one of their tasks would be to investigate the representation of all categories of nurses on the Council. The restructuring of professional organizations was also taking place to represent all their members (all categories). Enrolled and nursing auxiliaries in South Africa actively participated in the struggle for this fair and humane representation (Nursing Amendment Act No. 5 of 1995).

1.3.2.2 The reality of race ...

The reality of race is imbedded in South Africa's history with ample examples of discrimination on the basis of race. As indicated above, black nurses were historically deprived of voting powers within the profession and of equal opportunities of exchange within the profession - *"notions of black inferiority and white superiority were both commonplace and commonsense"* (Marks, 1994, p. 147). Black nurses were misused by many health services to provide underpaid and low skilled health care services; or had to function in poorly equipped and segregated health and nursing education facilities. Black nurses had to historically accept lower salaries, often stayed far from work, and were also subjected to the country's discriminatory laws for example the influx control laws. The nurses also belonged to and lived in a traditionalist society where men were considered very powerful and

above or free from household duties.

During the difficult period of violence in South Africa (during the 1980's), black women as nurses played a major role in stabilizing their communities. But not all black registered nurses escaped the elitism and class awareness which tended to lead them to look down on and to distance themselves from fellow blacks; while placing the black female patient at the bottom end of the scale (Marks, 1994). The inherent dualism between health care for the poor which makes up the majority of the community (primary health care); and specialized and privatisized health care for the economically advantaged members of a community might not contribute positively to eliminate this gulf - the black community historically the poorest and the white community the wealthiest.

Since the 1970's some black nurses played a prominent role in activating the political changes that finally took place in the country; and were rewarded with prominent positions in government at national and regional level, the health services and in their own profession. This study focussed on the African (black) woman as a nurse - thus referring to the black women who were historically from and part of the African continent (indigenous) and who belonged to a distinct cultural group such as the Zulu tradition [3]. These women often came from or grew up in severely deprived rural and urban areas (such as townships), and suffered extensively in terms of quality of life, ethnic and political realities and experiential opportunities.

1.3.2.3 The reality of gender ...

The 1991 census data (which excluded the former homelands of Bophuthatswana, Ciskei, Venda and Transkei), indicated that for all age groups, there were slightly more females than males in South Africa, with 51,2 % of the African population being female. Concerning income, a proven direct relationship between women and low income existed: *"The percentage of women earners drops as income rises, and male-oriented professions have higher starting salaries than female-oriented professions, regardless of the length of training time for the profession"* (South African Health Review, 1995, p. 18). Women were disproportionately represented in the so-called domestic work and in the informal sector where little health and

safety precautions and regulations existed.

In 1993/1994, Kwazulu-Natal also had the second highest number of poor people of all the provinces (21 % of the total country); as well as the largest household size for Africans in South Africa: 6,2 in 1990 (the second highest being Northern Province with 5,4).

In South Africa, the development of Feminism and even womens' movements were slowed down by the stark reality of racial inequalities. Women joined men in the struggle for liberation; and in 1994 the democratic and non-racial elections hallmarked a new era in the history of South Africa. The debate on issues of feminism and women are still, however, in their infancy. Some of the reasons according to Sorour (1995) were:

- Feminism in South Africa was often associated with the privileged white middle class women;
- Women in South Africa have not yet established their own and unique feminist identity;
- Black and white feminists in South Africa were often experiencing tensions; with black feminists being traditionally more marginalised in terms of for example opportunities and access routes to voice their concerns and feelings;
- The difficulty in establishing supportive and cooperative relationships with men and / or husbands brought up in traditional cultural practices that emphasized the stereotype of a chauvinistic and powerful ruling man and husband; and
- The stigma attached to the concept "feminism" were still operational in South Africa with some women strongly resisting the concept as being full of negative connotations: "... *a hairy man-eater burning her bra*" (Sorour, 1995, p. 54).

In focussing on women and work, nursing and teaching remained very important professions for women; with women dominating and leading in Nursing. On the

contrary, the medical profession was male dominated and powerfully dominated nursing and nurses: *"In South Africa, these power relationships have been made more complex by racial, ethnic and class divisions within the profession while the form that professionalization has taken both reinforced racial and class cleavages, and has ultimately subverted them" (Marks, 1994, p. 4).*

At the end of 1994 in South Africa, the gender representation in Nursing clearly indicated a very strong majority of women in nursing; with the strongest representation in the categories of registered and enrolled nurses (See table 1:1).

Table 1.1: Gender representation in the nursing profession in South Africa: Dec. 1994

CATEGORY	Registered	Enrolled	Nursing Auxiliary
Male	3 183 (4%)	1 774 (5.6%)	4 601 (9.4%)
Female	76 471 (96%)	29 777 (94.4%)	44 250 (90.6%)
Total	79 654	31 551	48 851
TOTAL	160 056		

1.3.2.4 The reality of class ...

In South Africa, the regulatory body of nursing, the South African Nursing Council (S.A.N.C.), regulated the development of two distinct classes or categories of nurses. At the end of 1994, professional or registered nurses and midwives made up slightly less than 50% (79 654) of the nursing population; and the enrolled category of nurses slightly more than 50% (80 402). The enrolled category of nurses consists of two hierarchial subclasses; the lowest class being the enrolled nursing auxiliaries who represented 61% (48 851) and enrolled nurses who represented 39 % (31 551) of the enrolled population. The region of KwaZulu-Natal had more nurses in the enrolled category: a total of 14 672 (48%) registered nurses and midwives compared to 16 164 (52%) enrolled nurses and enrolled nursing auxiliaries (1994, S.A.N.C.).

a) Registered nurses:

Registered nurses had, compared to the enrolled categories, significantly more opportunities for career advancement and professional development. A career ladder which incorporated positions ranging from a professional nurse to the Deputy-Director of Nursing Services was usually available in the government services - with a total of eight (8) different hierarchial progressive positions. There were also a significant number of post-registration and post basic programmes available to professional nurses, for example post-secondary education in Nursing Management and Nursing Education. Apart from doing their basic training or undergraduate training at a nursing college (since 1985 affiliated to a university) or at a university, professional nurses also had the opportunity to specialize in advanced clinical programmes such as Intensive Care Nursing, Advanced Midwifery and others.

Continuing Education programmes traditionally focussed on the needs of the professional nurse and those of the employer in relation to the activities and responsibilities of professional nurses in different positions. Registered nurses had the right and were compelled to wear symbols of their professional qualifications in the form of distinguishing devices regulated by the S.A.N.C. These devices were bold and colourful. Apart from the badge of the Council, registered nurses wore for example the maroon (described as *"dull cherry"*) epaulette representing their qualification in General Nursing with additional bars indicating other qualifications such as Psychiatric Nursing (navy blue bar), Community Health Nursing (yellow), Midwifery (green), Nursing Education (white), and Nursing Management (silver) (S.A.N.C., 1970). Through her twenty years of experience as a nurse clinician, nurse manager and educationist, the researcher was exposed to many different view points concerning theses devices.

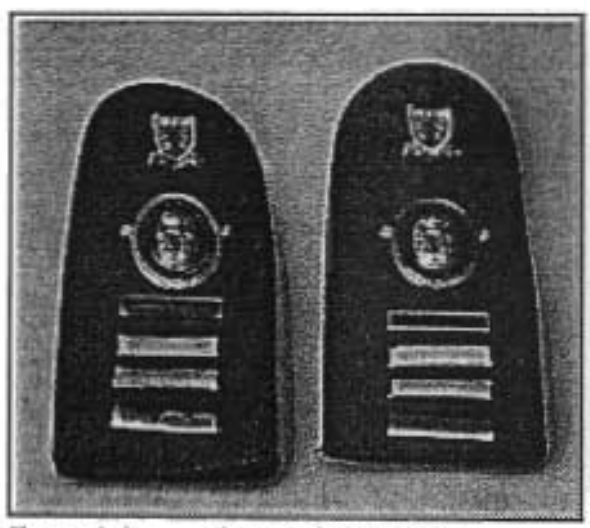


Figure 1.1: The epaulettes of the registered nurse

Some nurses would humoristically refer to these devices as a "fruit salad"; "bar-ones"or "it is not inside, but on top". Some individuals questioned the need for such an elaborate and visible system of symbols. Other nurses felt that they had worked hard for these symbols and that it inherently strengthened their feelings of power(fulness).

b) Nursing auxiliaries:

The Nursing Amendment Act of 1995 made provision for a South African Interim Nursing Council who would be responsible to the Minister of Health for constituting a new council and the abolition of the different nursing councils that were in place during the *Apartheid* years. In formalizing a name change, this act made provision for the consolidation of *"laws relating to the professions of registered or enrolled nurses, nursing [**assistants**] auxiliaries and midwives ..."* - the bold in square brackets indicating an omission from the existing enactment (Republic of South Africa, 1995; Nursing Amendment Act, No. 5 of 1995). Nursing assistants would thus now be known as nursing auxiliaries.

Nursing (assistants) auxiliaries were at the bottom of the nursing career ladder in South Africa and usually underwent two hundred days (one academic year) of training at an accredited nursing school. The nursing schools were usually based in and under control of the hospital or old age home. Entrance requirements for this programme was a junior certificate (10 years of schooling); and the training consisted of mastering basic skills in supporting the patients' "Activities of Daily Living" or the patient's basic needs. Their Scope of Practice as defined by the S.A.N.C. referred to acts and procedures that were planned and initiated by a registered nurse or registered midwife and being carried out under their direct or indirect supervision (S.A.N.C., 1984). The distinguishing device that was issued by the S.A.N.C. was in the form of a big, round black badge with silver lettering to be worn on their uniform (S.A.N.C., 1972b). The researcher observed that this badge was not popular amongst these nurses and they often opted not to wear it.

Nursing auxiliaries had limited, if any, career advancement opportunities in terms of promotion and further education. Current promotional opportunities in the

government health services and in most private institutions were in the form of a so-called "rank promotion" (coming into effect after a number of years of service and usually initiated by the manager of the respective health service) to the level of senior nursing auxiliaries (only one promotional opportunity with no real change in terms of responsibilities or tasks).there were two options available for further education: One option was the Enrolled Nurses' programme presented at a few schools of Nursing. The other route for formal education was the four-year programme in General, Psychiatric and Community Health Nursing and Midwifery usually presented at relatively centralized Nursing Colleges and Universities; a route that was difficult in terms of logistics and academic requirements for entry.

c) Enrolled nurses:

Enrolled nurses were exposed to two years of training at a nursing school. The course consisted of a common core and an elective course, for example General Nursing Care, Nursing Care of the Aged and Community Nursing Care (S.A.N.C., 1979b). According to their so-called Scope of Practice, they were supposed to consistently work under the direct or indirect supervision of a registered nurse or registered midwife. They would thus do acts or procedures that were "*planned and initiated*" by a registered person (S.A.N.C., 1984, R. 2598 as amended). The distinguishing device was a white epaulette with a bold oval badge of dull cherry colour with a blue edge and white lettering (S.A.N.C., 1972a). A bridging programme allowing enrolled nurses to upgrade their qualification to that of a registered nurse (General Nursing) was implemented by the S.A.N.C. to counteract the drive in the health services to exploit the enrolled category of nurses as cheap labour. This drive also meant the phasing out of the opportunity to do the enrolled nurse training programme.

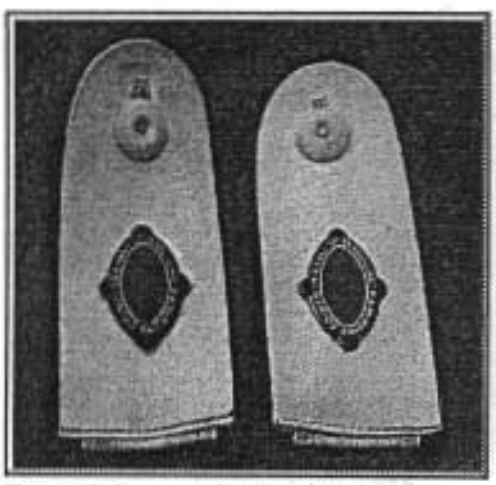


Figure 1.2: The epaulettes of enrolled nurses.

Enrolled nurses thus formed a "middle group" in the nursing hierarchies of health institutions and in the profession in South Africa with limited power (always to be supervised) in terms of the execution of nursing tasks. They were able to give guidance to and to supervise nursing auxiliaries; at times they were requested to perform duties traditionally seen as part of the Scope of Practice of registered nurses.

1.3.2.5 The reality of locality ...

In critically reviewing the context and situation of women as nurses, the researcher was of the opinion that marginalization would be influenced profoundly by the locality of the participants. The general conditions of and for a meaningful existence in remote and rural areas differ significantly from urban areas. According to the South African Health Review (1995), these areas had limited access to electricity and water, with the collection of wood and water traditionally the duty of women. Telecommunications were poor in the deep rural areas, which housed 17% of the population in 1993, having only 2 % of the telephone lines. Three-quarters of rural households lived below the minimum standard of living; and female headed households were found to be poorer than those headed by men - especially in the rural areas of former KwaZulu. The Review also stated that a relatively high number of poor aged people live in the rural areas; women generally had a low level of education, limited access to employment and career development.

In relation to tribal custom, women had to get married and had to tend to their husbands' wishes who had paid *lobola* [4] for them. These duties included caring for the husband, their family, the extended family, the household and managing an occupation in the case of a working woman. According to Prekel (1994), the lebola system also made successful women very expensive to "buy".

According to Yach (1995) the health status of rural South Africans were far worse than those of urban South Africans; especially in terms of for example infectious diseases (such as malaria in KwaZulu-Natal), trauma (often violence related) and nutritional status (South African Health Review, 1995). Health care in many of the rural areas were totally in the hands of black nurses due to the virtual absence of

for example medical practitioners who often preferred to practice in the urban areas. Registered nurses in the rural areas were also given explicit power to take responsibilities traditionally associated with doctors, for example the prescription of certain kinds of medicine. The tasks and responsibilities of the enrolled category of nurses might have expanded without formal sanctioning and appreciation.

1.3.2.6 The researcher's perceived reality ...

The researcher took a quiet moment to record her own experiences and perceptions that played a role in the choice of the target group and key focus of the research project:

Based on my experiences as a Nurse Executive of a large urban academic hospital that was based in a historically black township, I became aware of the plight of the enrolled nurse category who seemed often to be neglected and misused. Many members of this group made a positive impression on me in terms of, for example their spontaneity, caring attitude and skills in specialized aspects of nursing care. In spontaneous conversations with them it also seemed that many of them became enrolled or nursing auxiliaries because of lack of opportunities to further their education or because of a schooling system that influenced their ability to achieve. Their frustration and suffering in the traditional positional power structure of Nursing in South Africa; as well as their need (longing) for upliftment and empowerment were often in the forefront.

It also seemed true that very few registered nurses (be it nurse clinicians, nurse managers or nurse educators) were interested in the trials and tribulations of these two groups; and very limited if any research was published that addressed the specific issues of the enrolled category as a group. Nurse academics at

universities in the country very seldom if ever related to this group's needs and aspirations. I was historically inclined to view the S.A.N.C.'s concern as often being insensitive to the needs of the enrolled category: Traditionally, the S.A.N.C. was more concerned about the proliferation in numbers and misuse of this group as cheap labour (hands) for health services which was also perceived to be to the detriment of the registered category.

1.4 QUALITATIVE RESEARCH METHODOLOGY CHOSEN AND RATIONALE

The researcher decided to use an inductive and phenomenological approach as a method of inquiry. This approach aided the researcher to concentrate on the lived, everyday and subjective experiences of participants and also to try to understand the deeper essence and meaning of the phenomenon of the power of women as nurses. Data were in the form of words shared and verified during two or three successive interviews; and the outcome the development of a theoretical framework of power, powerfulness, powerlessness and empowerment of women as nurses. The broad objectives stated at the beginning of the research were the following:

TO:

1.4.1 Define and analyse the attributes and realities of power, powerlessness and powerfulness as verbalized by nurses as women [5].

1.4.2 Analyse the experiences of, and dealing with powerlessness and powerfulness of women as nurses in their daily lives.

1.4.3 Identify the behaviours indicative of a need of and/or readiness to engage in empowerment behaviour.

1.4.4 Identify the perceived consequences of empowerment for nurses as women in their daily lives.

1.4.5 Analyse the concept power as found in the scientific writings of primarily philosophy and the social sciences.

1.4.6 Develop a theoretical epistemological framework of power of women as nurses in South Africa.

In applying the premises of the Standpoint theory, the researcher identified the enrolled nurse category *(class)* to be most marginalised in the nursing community in South Africa; and sought to interview African *(race)* women *(gender)* nurses from this category (both enrolled nurses and nursing auxiliaries) - both from a relatively deep rural and of an urban setting. The researcher decided to use in-depth interviews to gain access to the lives of the participants; and to conduct an average of three interviews per participant. A preliminary guideline (which was open to adaptation) was developed to focus the interviews in terms of goal, content and process. Participants were also requested to share any other form of communication with her, for example an essay, story, song, poem or drawing if they feel comfortable with the medium. The researcher accepted that the number of participants and thus interviews will depend on the moment of data saturation.

The researcher planned to interview a relatively contrasting group of nurses: urban African professional nurses (thus professional nurses at the lower or entrance level of the professional nurse category). This was done to be able to compare the data for example across class and geographic location.

The researcher intended to follow at least five steps during data collection and analysis which incorporated investigating the related phenomena of powerlessness,

power, powerfulness and empowerment during interviews, reducing the obtained data, developing different kinds of data displays to condense outcomes, developing essential and meaningful relationships and generalizations and developing a meaningful epistemological framework of the power of women as nurses in South Africa (Burns, & Grove, 1987; Oiler, 1986; Polit & Hungler, 1993) (see chapter 3).

Data collection and data analysis occurred simultaneously and the researcher redirected her research on the basis of new insights. Findings were described from the orientation of the participants (for example their own words). The researcher used member checks to refine the themes identified and used three other nurses with expertise in different fields to independently search data for meaning and to code the data. The researcher finally developed an integrated and overall structure and a theoretical framework.

1.5 RELEVANCE TO NURSING

In a time of tremendous changes affecting South Africa's political society, and its national and health services, nurses played a pivotal role in enacting these changes; for example in delivering a primary health care service. The nurse in being fully human, was exposed to the explicit and implicit realities of being a woman, and of being a nurse. Imbedded in this reality was the concept of power and power relations in all their dimensions; and nurses as women were historically exposed to power relations in all its "fullnesses or could it be emptynesses".

A careful analysis of the power of women as nurses in South Africa which takes cognisance of race, class and gender had not been done at the time of this study; and the researcher was of the opinion that a study of this nature could contribute to a better understanding of power; and would provide a meaningful epistemological framework of the power of women in South Africa. The researcher also hoped to

advocate an increased and sensitive understanding of the reality (and plight) of being a woman and an African enrolled nurse or a nursing auxiliary in South Africa - this would hopefully lead to increased support and development of this precious group of women.

1.6 DEFINING KEY CONCEPTS

The researcher consciously refrained from defining key concepts such as power, powerlessness, powerfulness and empowerment at the very beginning of the study to try and counteract the influence of pre-conceived ideas and notions during the actual data collection process. These concepts were thus defined from the perspective of the respondents and the researcher at the end of the study (Section 6).

1.6.1 EPISTEMOLOGY:

Epistemology is traditionally a branch of the science of philosophy, and refers to the study of knowledge (Allen, 1991). In this study of the knowledge of women as nurses concerning the phenomenon of power: powerlessness, powerfulness, empowerment and related concepts and nuances were explored.

Knowledge is a comprehensive and abstract concept which refers, amongst others, to a sensitive blend of intellect (cognition), experience, affect and intuition. It has the ability to change over time and signals a relationship between the knower and the known, and what is claimed to be known, becomes the property of the knower. The knower has the power to uniquely reason and judge what is known: to indicate

certainty and probability; truth and falsitivity; right and wrong. Knowledge is and the knower becomes socially and politically structured; especially with-in the realms of class, gender and race (Crowley & Himmelweit, 1992; Doering, 1992; Harding, 1991; Hartsock, 1983; & Jaggar, 1983).

In this study, the researcher accepted the women as nurses as knowers: their ability to relate to what is known and thus real to them concerning the phenomenon of power and related concepts.

1.6.2 CLASS

Class refers to the effect of the historical categorization of nurses in the nursing profession in South Africa in terms of their level of training and scope of practice as regulated by the South African Nursing Council. Two distinct hierarchial classes were sanctioned at the time of the study: the "lower" enrolled category of nurses and the "higher" registered category of nurses. The focus of the research was the enrolled category of nurses who consisted of nursing auxiliaries and enrolled nurses, and who underwent from one to two years of training. The registered nurses were popularly called professional nurses or "sisters"; and underwent several years of training (currently four years) and formed a comparative group for the study.

1.6.3 GENDER

The reductionist biological category of female was rejected by the researcher as a sexist and unfortunately fixed approach, and accepted gender as a socially constructed phenomenon. Women, in comparison to men, were considered the most marginalised because of their appropriation in many power relations. Examples of

appropriation could be objectification (the Other), division of labour, domination, and sexual usage. It was accepted that from the oppressed

> *"comes the knowledge that nothing happens that is not historical, that nothing is ever impervious to change, that no one is the bearer (or expression) of a 'being' or an eternal fate, and ultimately, that practice makes history" (Guillaumin, 1995, p.168)*

1.6.4 RACE

Race referred to a concept historically created by the social system to classify human beings according to naturalist and socialist criteria. Society then placed certain race groups in weaker positions of power and often degraded the very essence and human worth of such groups. In this study, the researcher interviewed black women as nurses. These women were of African descent - thus part and from Africa. Most of the women spoke Zulu as a first language and were imbedded in the Zulu heritage.

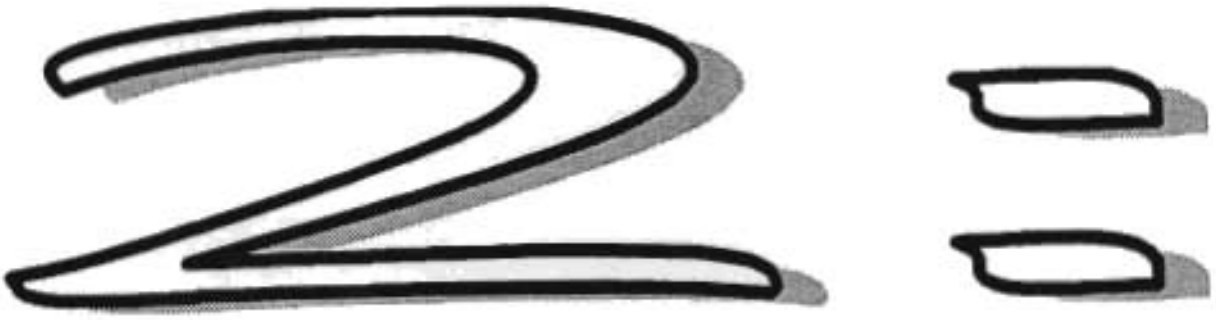
1. The concept "after-hours" refers to the informal and often unrecognized responsibilities and activities of women before going to and after coming from work - "work" relating to their formal and often recognized occupation (such as being an enrolled nurse in a specific health setting).

2. The concept "black" here refers to nurses belonging to the historically "non-white" racial categories; and would thus have included the so-called Coloured, Indian (Asian) and African nurses.

3. The majority of women as nurses in Kwazulu-Natal belong to the Zulu cultural group; with a smaller representation from for example, the Xhosa and Sotho groups.

4. *Lobola* refers to a traditional cultural practice where the prospective husband pays a certain amount of money or goods (for example cattle) to the parents of the prospective wife to obtain the right to take their daughter as his wife. Some men might interpret this right as exclusive ownership. Prekel (1994) was of the opinion that a successful black career woman became very expensive in terms of the lobola demanded by her parents; and her future new family might also oppose some of her career decisions.

5. Women as nurses refer to women who were marginalised on the basis of race (being African), gender (women) and class (the enrolled nursing category in Nursing in South Africa).



THEORETICAL FRAMEWORKS APPLICABLE TO WOMEN AND POWER

The researcher decided to do a preliminary and focussed literature review dealing with theoretical frameworks primarily used in research and other activities dealing with womens' issues. This review was especially necessary and useful to guide the researcher in the development of criteria for the inclusion of participants in the study. The researcher realized that this preliminary review would influence her thoughts, ideas and activities to a certain extent, but was of the opinion that a meaningful framework would strengthen the study's theoretical basis and provide the necessary guidance.

According to Glaser and Strauss (1967) library material also allows the keen reader to cross boundaries, space and even life to "listen to" authors, speakers, and groups who have been documented. Library material is very useful as a stimulus to develop a deepened awareness of existing theory and

for potential theory generation. After studying a number of theories related to women and power in the different subject disciplines, the researcher summarized the Feminist Identity Development (2.1), the Feminist Therapy (2.2), the Identity Empowerment model (2.3); and the Standpoint Theory (2.4).

The researcher decided to use the Standpoint Theory for the following reasons:

1) The Standpoint Theory is grounded in and uses an explicit philosophical (specifically an epistemological) approach that was seen to be very applicable to the initial and original research approach and research aim.

2) The Theory was very compatible with the researcher's inherent academic and personal approach and skills.

3) Black women as nurses who were part of the so-called enrolled nurse category in South Africa were historically marginalized in terms of the right and ability to exert power in their different situations and contexts. This reality of perceived powerlessness fitted well with the key premises of the Standpoint Theory.

4) The researcher also had the privilege to attend two seminars presented by Sandra Harding, one of the key developers of the Standpoint Theory (South Africa: Pretoria and Durban, 1994). These real-life opportunities were meaningful and instrumental in focussing and deepening the researcher's knowledge and attitude.

2.1 FEMINIST IDENTITY DEVELOPMENT MODEL

The development of a feminist identity is a difficult process. Research done on the development of a feminist identity in women found that it coincides with the stages of Black identity development (Cross, 1980; Downing & Rouch, 1984; Worell & Remer, 1992). This model does not take into account individual differences (for example age and socio-economic class); as well as the unique position of men. Women might also "fluctuate" between the different stages.

The stages are:

I) Passive acceptance

Here the woman either denies or is unaware of any prejudice and discrimination and actually accepts and / or enjoys the historically and biologically (sexually) determined role expectations and behaviour.

ii) Revelation

After a consciousness-raising experience (crises) or coming into contact with feminist issues she realizes the oppression, feels guilty for her own involvement in the patriarchal system, and values all women to the detriment of all men (dualistic thinking).

iii) Embeddedness-Emanation

She now immerses herself in womens' culture, connects herself with other selected women, and strengthens her new identity.

iv) Synthesis

The woman is now able to transcend traditional sex roles and to positively and individually value her female self. Men are evaluated on an individual basis and no longer collectively.

v) **Active commitment to social change**

Men are equal but not the same (sex-role transcendence); and her actions become personalized and rational.

2.2 FEMINIST THERAPY MODEL

Feminist therapy acknowledges that the personal is political and that the source of an individual woman's issues or pathology is often more social and political; and not personal. Feminist counselling would concentrate on being or becoming aware of the sex-role socialization process and to develop more free and flexible personal and social skills.

The development of an egalitarian relationship between the client and the counsellor is of paramount importance to minimize social control and to strengthen collaboration between the counsellor and the client. Sharing of values, self-disclosure and self-involvement of both client and therapist is of paramount importance.

Appreciating and trusting a female value system and perspective of life are emphasized; and qualities such as empathy, nurturance, intuition, cooperation, interdependence and relationship focus (which are often devalued and suppressed) are seen as important and legitimate (Worrell & Remer, 1992).

2.3 IDENTITY EMPOWERMENT THEORY

The Identity Empowerment Theory was developed by Hall (1992) as a clinical sociological theory comprising of ten sociological concepts derived from research over a 20-year period. She analysed about 500 detailed life stories, mainly of white middle-class women. The theory emphasizes the need for women to understand and increase their knowledge of their personal and collective past ; as well as their strengths and weaknesses.

The concepts identified are the self (including self-awareness and self-knowledge), dyad (intrinsically unstable relationship between two persons), triad (including a third party or outsider), family, religion, definition of (own) situation, reference group, class, culture, and society. One needs to acknowledge that the theory needs considerable substantiation (Hall, 1992).

2.4 FEMINIST STANDPOINT THEORY

Feminist theory is both scientific and political. In constituting knowledge, traditional Marxist, radical and socialist feminists state that knowledge is and needs to be socially and practically constructed. Modern feminists argue that objectivity, rationality and the scientific method needs to be redefined. They also state that science (and feminism):

- Are politics plus knowledge generation.
- Are both progressively and regressively inclined (thus not value-neutral or inherently good).

- Are imbedded in a social context (socially situated and construed; observer and subject matter are on the same social level or plane).
- Should also decentre white, middle-class, heterosexual, Western women (gender being in essence a relation between men and women).
- Needs to challenge the current relationship between social and natural sciences (natural sciences to be "illuminatingly conceptualized as part of the social sciences") (Harding, 1991, pp.9-116).
- Needs to challenge the ideal of objectivity being equal to neutrality, and needs to emphasize fairness, honesty and a kind of detachment (this detachment referring to a distancing from the researcher's own perceptions and convictions)

(Harding, 1992; Harding, 1991).

2.4.1 EPISTEMOLOGY AND STANDPOINT

Feminists tried to develop a distinct theory of knowledge or epistemology since the 1970s. Traditionally an epistemology:

- Is a branch of philosophy.
- Concentrates on the nature and scope of knowledge (including presuppositions and basis) and whether knowledge is at all possible (scepticism).
- Tries to establish whether claims of knowledge and truth are justified.
- Determines the criteria for beliefs to be considered knowledge.
- Guides methodology - what can be known and who can be a knower.

(Campbell & Bunting, 1991; Hamlyn, 1970; Harding, 1991;)

According to Campbell and Bunting (1991) it is politically necessary to differentiate between critical theory (primarily developed by men such as Adorno, Habermas and Freire) and feminist theory. The epistemology of the critical theory emphasizes that knowledge is created; that it should be used for political aims; and that "all meaning and truth are interpreted within the context of history" - "all standards of truth are always social" (Campbell & Bunting, 1991, p. 5). Feminist theory, on the other hand, focuses on gender issues and idealistically places the woman central in their reflection on the nature of knowledge. Feminist theory emphasizes unity and relatedness (tends to disregard boundaries), contextual orientation (emphasizes the power of the whole and not division) and the subjective (accepts and values feelings and intuition).

At least three distinct feminist epistemologies developed: feminist empiricism (trying to eliminate sexist and androcentric biases by strictly adhering to conventional methodological rules and scientific enquiry), feminist standpoint (equal to woman's perspective) theory, and the postmodernist approach (Harding, 1991).

Feminist epistemologists generally agree on the need to monitor conventional male-centred and positivistic approaches to science. "Women and men, then, grow up with personalities affected by different boundary experiences, different constructed and experienced inner and outer worlds, and preoccupations with different relational issues" (Hartsock, 1983, p.295). In society historically, the standpoint of the so-called western, white and economically stable "ruling" men or the "ruling" class is usually accepted as relevant, meaningful, authoritive, universal and neutral. The ruling becomes rationally organized in complexes of practices, for example in government, business and the professions. (Harding, 1991; Smith, 1987).

According to Harding (1991) all knowledge is in essence socially situated. Scientific rationality is however relatively flexible and versatile and allows for constant reinterpretation. Women of every class, race and culture can use scientific endeavour to establish and to increase control over their lives. Women (being exploited and oppressed) can thus transform science agendas and develop a more comprehensive view of reality.

Socialist feminists paved the way for a unique epistemology for women by revaluing

female experiences and by striving to give a complete account of womens' unique social or class position and oppression - as opposed to the universally accepted historical standpoint of men. They emphasized that the interests, thoughts, choices and actions of men are usually clearly heard while womens' are "brutally" silent - invisible and unhearable (Chinn, 1991; Smith, 1987; Wetzel, 1993).

An epistemology in feminist theory would thus emphasize:

- Womens' experience as a legitimate source of knowledge and basis for research;
- The validity of subjective data;
- Informants as being the experts of their own lives;
- The relationality and contextuality of knowledge; and that
- Boundaries between theory and practice; and personal and public are artificial (so-called boundaries need to be scrutinized)

(Campbell & Bunting, 1991).

Haraway (1988, p.589) argues for "politics and epistemologies of location, positioning, and situating, where partiality and not universality is the condition of being heard to make rational knowledge claims". Pearson (1992) also emphasizes situation and context; but adds the need for an epistemology to be transformational (incorporating action).

2.4.2 DEFINING STANDPOINT

"*In order to arrive at an adequate representation of reality, it is important to begin from the proper standpoint*" - this standpoint does not refer to a so-called world view, but is defined as "*a position in society from which certain features of reality come into*

prominence and from which others are obscured" (Jaggar, 1983, p. 370 & p. 382). Feminist standpoint epistemologists emphasize in essence the Marxist vision that science can reflect the world as it is (Harding, 1986).

The actualities of womens' everyday worlds in a particular, local and historical setting have been ignored; womens' lives have often been deleted, ignored or misconstructed in many a science, for example historical studies, ethnology, psychology and moral philosophy. Now is the right time in history to enter this arena where conflicting gender and social agendas are prominent (Harding, 1991; Smith, 1987).

The standpoint theory was developed by amongst others, Dorothy Smith, Nancy Hartsock, Hillary Rose and Sandra Harding - adhering in varying degrees to the principles of historical materialism (Harding, 1992; Hartsock, 1983; Jaggar, 1983; & Smith, 1987). The actual and everyday lived situations of women need to be analysed and understood - in the process being faithful to the "actualities and organization" - research needs to be initiate from outside the traditional institutions, practices and conceptual schemes (Harding, 1992; Wetzel, 1988, p.73). The standpoint of women needs to be discovered through a systematic political and scientific struggle as portrayed by the distinctive social experiences and insights of women; and by the overthrow of male domination - women need to take the authority to speak.

This theory requires a "strong objectivity" which needs to take cognisance of different belief formations and legitimation in social order; it needs to investigate the relation between subject and object (and not control it). Researchers need to take cognisance of the historical character of every belief. Both the objects of enquiry and the researcher are involved in the multiplicity and particularity of culture - research projects use the historical location as a resource for gaining objectivity (Harding, 1991).

2.4.3 BASIC PREMISES OF THE STANDPOINT THEORY

The basic premises of the Standpoint Theory can be summarized in the following twenty-one points:

- The theory recognizes power relationships (between the ruler and the oppressed);
- Knowledge is always mediated by a multiplicity of factors related to the woman's situation at a certain moment in time, within a actual historical setting, and within a set of social relations;
- The usefulness of knowledge is constructed within the realms of womens' interests not being subordinate to men's interests;
- The theory focuses on gender differences - womens' lives being in essence different (and not inferior);
- Women are valuable strangers to the social order and can more easily distance themselves from the social order (have less to loose);
- Women are from the other side; are "outsiders from within" (especially woman researchers);
- Womens' perspective is from everyday life - the "dailiness" of womens' lives; the "everyday as problematic" (Smith, 1987, p.88-97);
- *Marginal lives* refers to those lives necessarily outside the centre of power and prestige (usually marginalized by the or a institution);
- The marginal lives are "*determinate, objective, locations in the social structure*" - in this process gaining stronger objective accounts of power relations in the social order (Harding, 1992, p.581);
- Womens' perspective is rooted in the ideological dualism of nature (manual or

emotional) versus culture (intellectual);

- A person's reality and understanding of reality is always structured by class, race, and gender;
- The oppressed is able to attain a more correct and comprehensive understanding of the world than the oppressor;
- The standpoint of the oppressed is epistemologically meaningful in that it comprehensively represents the interests of the society and the universe as a whole (and not just of the ruling class);
- The oppressed's standpoint incorporates both the ruler's as well as those being ruled;
- Womens' position in society provides an adequate epistemological point of departure or standpoint (adequate and not easily accessible to men);
- Womens' standpoint creates an ontology of relations and continuing processes
- Womens' oppression changes constantly;
- Woman's lives is an objective location and starting point;
- The variety of womens' experiences can be a meaningful contribution to theory building;
- The dominant ideology restricts what everybody is permitted to see; and
- What women do, enables and limits what women (can) know

(Hartsock, 1983; Hawkesworth, 1989; Jaggar, 1983; Smith, 1987; & Wetzel, 1988).

The acceptance and application of the above mentioned premises, and not the methods (for example observation, listening, questioning or examining historical records) give gestalt to feminist theory and feminist research (Hall, & Stevens, 1991).

2.4.4 CRITIQUE OF THE THEORY

Criticism of this theory focused on the inherent difficulties of women to be able to differentiate and to develop a true self against the very real background of oppression and subordination in a male-dominated society. Another critical issue deals with the question of accepting that all women will occupy the same or common distinct standpoint. An acceptance and a consideration of differences is thus important (Jaggar, 1983).

Greene (1995, p.151 - 152) criticizes the Standpoint theory when it relies on Freudian psycho-analysis (which underlines for example the notion that men and women see and experience the world differently); and she feels that a more independent way of clarifying ideological beliefs and notions is needed. Greene advocates an approach which leaves room for the complimentary; and not opposition.

According to Rouse (1987) the standpoint theorists still need to develop a distinctive programme to guide researchers. Feminist researchers, on the other hand, have developed a number of distinct principles and criteria to be used when doing research with women. It is the opinion of the researcher that these principles and criteria are meaningful and applicable when and in using the Standpoint Theory as a broad epistemological framework.

Some of the principles guiding feminist research are that the principal investigator should be a woman and that the research should answer questions that women would like to be answered. The research should have and establish a positive view of women and should focus on womens' needs, actual experiences (for example oppression) and their interpretations of these needs and experiences. The context in which the research takes place needs to be sensitively accounted for.

Feminist research emphasizes shared interaction with the sharing of values, feelings and concerns. The researcher should also be aware of and record their own biases, background, ethnic and social class as part of the data (the researcher's history,

assumptions, motives and interpretations need to be exposed). The researcher should validate her observations with the participants, and the relationship between researcher and participant should be nonhierarchial and reciprocal. The use of sexist language is generally not acceptable.

The research should have the potential to help both participants and the researcher (empowering) and the researcher should share insights with all women - thus breaking the silence (Campbell & Bunting, 1991; Hall & Stevens, 1991; Parker & McFarlane, 1991; Webb, 1993; & White, 1991).

METHODOLOGY

3.1 METHOD OF INQUIRY: GENERAL

"Phenomenological research is the attentive practice of thoughtfulness - a minding, a heeding, a caring attunement, a wondering about the project of living. When the language of a lived experience awakens a person to the meaning of the experience, he or she gains a fuller understanding of what it means to be human"

(Munhall, 1994, p.17)

3.1.1 PHILOSOPHICAL FOUNDATIONS

The social sciences have a tradition of focusing on the lived experiences of people and the meaning attached to these experiences. Qualitative research methodology tries to improve our comprehension of a complex and dynamic reality and flows out of an epistemology that accepts for example uncertainty, mental perception, holism (related to the concept gestalt), interpretation, patterns-qualification, subjectivity, human values and context integration (Burns & Grove, 1987; Munhall & Oiler, 1986).

Phenomenology as a philosophy and as a method of inquiry was first mentioned by Brentano and Strumpf in the last half of the nineteenth century as a critique of the insensitivity of the positivistic approach to human and humanistic concerns. Edmund Husserl and Martin Heidegger founded phenomenology as a distinct philosophy and a scientific method of inquiry. These philosophers advocated the study of human experience and subjectivity. Their philosophy concentrates on the human being's presence or existence in (being-in) the world and the ways in which the human being is conscious of this world, and expressing and interpreting this consciousness through their bodies (embodiment) (Heidegger, 1978; Hindess, 1977; Oiler, 1986; Parker, 19994; &Mezquita, 1994).

Heidegger states that phenomenology means "*apophainesthai ta phainomena - to let what shows itself be seen from itself, just as it shows itself from itself*" (Heidegger, 1978, p. 82). According to Robertson (1994) Heidegger has a holistic view of humankind and believes that the human being is constrained by their particular language, culture and history - thus a situated freedom. He also sees the lived experience as a moment of interaction between past, present and future, with the human being concerned and thus involved with time, things and persons. This approach also links to Dooyeweerd's theory of Modalities which identifies the relation between the dimensions of time, and "things" (individuality structures). Dooyeweerd, however, adds the dimensions of religion and of modalities (the how). The french philosophers Gabriel Marcel (1889 -1973), Jean Paul Sartre (1905 - 1980) and Maurice Merleau-Ponty (1908 -1961) made a significant contribution to the establishment of phenomenology (Parker, 1994).

According to Hickman (1995) nursing theorists such as Parse, Paterson and Zderad developed nursing theories that hinge heavily on the phenomenological-existentialistic philosophies. Parse emphasizes the themes of a multidimensional meaning (which interrelates the concepts of imaging, valuing and languaging), rhythmicity (dealing with revealing versus concealing, enabling versus limiting, and connecting versus separating) and cotranscendence (interrelating the concepts of powering, originating and transforming) (Parse, 1992).

Paterson and Zderad developed a so-called "humanistic practice" theory which takes the lived and existential experiences of nurses and those receiving care as the basis for theory development. They advocate a well developed and interactive methodology called "Phenomenological nursology" which consists of the following five phases:

1) The preparation of the nurse to become and to be open and caring (for coming to know);

2) Becoming to know the other intuitively - to get inside the other and to develop a special knowledge of the other;

3) To reflect critically on while being immersed in the experience - to know the other scientifically;

4) To synthesize multiple realities and to come to an expanded view of reality; and

5) Developing a descriptive and theoretical construct of nursing which has a personal and universal meaning

(Paterson & Zderad, 1988; Praeger, 1995).

Phenomenological research emphasizes the lived and subjective experience - what is perceived to be (being the essence and the focus); and not so much the processes. Phenomenological research thoughtfully concentrates on the essence of a "subject's experience" or perceived (interpreted) reality. This everyday reality is studied as it is lived by people and within the complexities of their own context - always within relationships with things, people, events and situations (Munhall & Oiler, 1986, p. 57-58). The meaning or the essence of the phenomenon is thus sought within the personal knowledge realm - what it means to be human (Burns & Grove, 1987; Munhall, 1994).

A controversial procedural step or phase of phenomenological reduction (as Husserl calls it) is the bracketing or epoché of the researcher's presuppositions. According to Merleau-Ponty, the human scientist should apply the epoché only to "cognitively

held or theoretical views" (and not to experiential beliefs as well) - the scientist thus securing a less dogmatic and unbiased approach (Fouche, 1990, p.378).

3.1.2 PHENOMENOLOGICAL RESEARCHERS

Phenomenological research is often ill-understood or discouraged by educational institutions because of a lack of expertise. The aim of phenomenological research is in essence humanistically inclined: to understand the essence of experience in its fullness (Burns & Grove, 1987; Munhall, 1994; Munhall, & Oiler, 1986). The phenomenon studied could be an emotion or a relationship or a culture; and the assumption of an essence always present (Patton, 1990). The researcher tries to enter the lived reality of the participant and thus becomes the "instrument" (the "self-as-instrument") (Rew, Bechtel & Sapp, 1993, p. 300).

The researcher's personality is a key factor in qualitative research; and empathy and intuition are used deliberately (Burns & Grove, 1987). The researcher passionately tries to understand the phenomenon and in the process tries to maintain an emphatic neutrality. Researchers attempt to recover an original awareness ("reduction") and to bracket their suppositions or assumptions (exposing the link between the researcher's suppositions and the lived experience) in describing experience - the researcher tries to become "unknowing" (Munhall, 1994, p.23). Bracketing also entails that the researcher deals with the data in very pure forms - securing a very open context. Intuiting refers to the researcher remaining open to the meanings as stated by those who have experienced it; and absolutely concentrating on and absorption with the phenomenon. The researcher usually asks the participants to describe their experiences; or to write it down. The researcher can also try to experience the phenomenon in the same way (for example participant observation or introspective reflection) (Burns, & Grove, 1987; Oiler, 1986; Patton, 1990; Polit & Hungler, 1993).

According to Rew, Bechtel and Sapp (1993) the researcher also needs to be aware

and use the attributes of

- **appropriateness** (clear about the purpose and the use of the self);
- **authenticity** (the researcher's behaviour is congruent with her attitudes, beliefs and values);
- **credibility** (trusted by participants and a necessary development of rapport);
- **intuitiveness** (involves the researcher an empathic reflection and meaning subtraction);
- **receptivity** (the researcher is open and willing to receive);
- **reciprocity** (the participant and the researcher are on equal footing and to see the experiences and perceptions of participants as they are); and
- **sensitivity** (to see and to hear accurately).

3.1.3 PROCESS FOLLOWED WHEN DOING PHENOMENOLOGICAL RESEARCH:

The phenomenologist researcher usually uses at least the following four steps:

i) Investigating the essence and meaning of the phenomenon as related by the participants (requiring the utmost of concentration);

ii) Reducing data (for example by using contact summary sheets, codes and coding, reflective remarks, memoing and developing propositions);

iii) Displaying the data (condensed versions of outcomes; for example matrices, critical incidents or mapping, and causal networks); and

iv) Developing essential and meaningful relationships and limited

generalizations (using for example tactics like counting, identifying themes, clustering, factoring and making metaphors)

(Burns & Grove, 1987; Oiler, 1986; Polit & Hungler, 1993).

Data collection and data analysis occurs simultaneously in qualitative studies; and researchers might redirect their research if they gain some new insights. The search for themes (recurring regularities) as well as the patterning of the themes are important. The use of member checks is crucial to refine these themes; and a second researcher can be used to independently code and analyse the data. Finally, an integrated and overall structure needs to be developed; where for example cross-tabulation can be used. Findings are often described from the orientation of the subjects (for example their own words) (Burns & Grove, 1987; Polit & Hungler, 1993).

3.1.4 CRITERIA FOR EVALUATING PHENOMENOLOGICAL RESEARCH

Scientists accept that any research needs to be critically appraised and justified. Parse (1985) and Leininger (1990) explicitly states that the criteria for evaluating qualitative research is essentially different from those traditionally used to evaluate quantitative research - the reason being the different paradigms from which they function. Quantitative research tries to measure "discrete variables"; and thus underlines criteria such as internal and external validity, reliability and objectivity. Qualitative research, on the other hand, tries to "establish the existence and nature of phenomena with its meanings, attributes, and contextual features" (Leininger, 1990, p.1; Klopper, 1995).

Qualitative research is in essence an inductive research approach (different from the deductive positivist approach) that gives sincere attention to the social context in which the research takes place and which tries to discover, describe and understand

the social reality with and from the perspective of the participants - verification usually being done with the participants. The data gathering process is flexible and might be constantly revised during the data gathering process. The data are in the form of words and the analysis is mainly done in the same or equal narrative form. The analysis will transform and abstract ideas; the outcome should be theory construction and development (Burns, 1988; Cobb, & Hagemaster, 1987). The cyclic nature of qualitative analysis is underlined by Peters and Wester (date unknown) - "*reflection - observation - analysis - reflection*".

Examples of criteria or standards subtracted from the literature are discussed in table 3.1

Table 3.1: Criteria for the evaluation of qualitative research

CRITERIUM	*EXPLANATION*	*SOURCE(S)*
Truth value; also called credibility (as opposed to internal validity)	• To authentically and faithfully represent the truth and reality of experiences as lived by participants in context (the truth lies with and in the subject and not the researcher) • Researcher to truthfully record her own experiences, interpretations and biases (for example the dilemma of being involved with participants versus maintaining a distance to reflect on findings). Credibility can be established by using for example prolonged engagement, persistent observation, triangulation (comparing multiple data sources, methods and theoretical schemes) and member checks.	**Klopper, 1995; Leininger, 1990; Lincoln & Guba, 1985; Sandelowski, 1986**

Table 3.1: Criteria for the evaluation of qualitative research		
CRITERIUM	*EXPLANATION*	*SOURCE(S)*
Fittingness (also called transferability as opposed to generalizability or external validity)	• Findings can fit (comparable) and are applicable to "outside-the-study-contexts" and experiences; findings and theoretical framework also fit real life data from which they are derived. Fittingness can be established by monitoring categories with the participants and verifying the categories with persons outside the study but in a similar context	**Burns, 1988; Klopper, 1995; Leininger, 1990; Sandelowski, 1986**
Descriptive vividness and clarity	• The in-depth description of the researcher gives the reader a real and "alive" or "being-there" sense of the context and social reality	**Burns, 1988; Sandelowski, 1986**
Auditability	• Another researcher can clearly follow the decisions taken by the researcher and can arrive at the same decisions and conclusions in the same situation (decision trail). According to Klopper (1995, p. 27) this relates to Lincoln and Guba's confirmability concept - whether the data are confirmable.	**Burns, 1988; Klopper, 1995; Leininger, 1990; Sandelowski, 1986**
Rigor in documentation	• To represent (write down), explain and logically motivate all the steps and decisions taken; all the activities during the study (also called procedural rigor) - for example the rationale for decisions taken concerning sampling, data collection and analysis. Primary documents provide direct evidence or substantiate what was found.	**Burns, 1988; Leininger, 1990; Sandelowski, 1986**

Table 3.1: Criteria for the evaluation of qualitative research		
CRITERIUM	*EXPLANATION*	*SOURCE(S)*
A realization of human existence, time, space and context (also called meaning in context) in an integrated manner	• An in depth study of a unique interaction between human beings, in a moment in time, in a specific setting and frame of reference - providing a logical flow of ideas in and elements of the study. This can be achieved by constantly giving and explaining the data in context; and to relate to the context constantly.	**Aamodt, 1983; Leininger, 1990; Parse, 1985**
Exhibits and communicates preciseness in analytical thinking and theorizing	The processes of transformation and discovery are logically and consistently described, discussed, prioritized and linked - a picture or conceptual map of the phenomena studied emerges meaningfully	**Burns, 1988**
Making a contribution to knowledge in general and nursing knowledge specifically (also referred to as heuristic relevance)	Enhances the understanding of the phenomenon under study and ultimately contributes to the health of those participating in and to those exposed to the study and its findings.	**Parse, 1985.**
Mastery of methodology	**Researcher needs to provide supporting evidence of her mastery in as well as willingness to learn the approach of choice (for example phenomenological approach) and the use of the self as a research instrument. Researcher needs to demonstrate an ability to rigorously marry methodology, documentation, procedure and ethical principles.**	**Burns, 1988; Cobb & Hagemaster, 1987; Good, 1993**

According to Munhall (1994) and as adapted by the researcher, additional criteria

for evaluating phenomenological research could be:

- **The phenomenological nod** (from participants and readers of the findings) indicating an agreement with the description and interpretation of the researcher;

- **Rigor**: Criteria for rigor would include

  Resonancy - where the written interpretation resonates with the individual's feelings and thoughts;

  Reasonableness - the rationale (answering the "why" question) is clearly articulated throughout study;

  Representativeness - the study needs to represent all the relevant dimensions and modalities of the lived experiences of the participants;

  Recognizability and raised consciousness - the reader recognizes certain aspects and they ring true to her / him; and the reader becomes aware of this new experience. The reader should also be moved to act or respond to the research results (also called responsiveness);

  Readability - "your study should read like an interesting conversation ... the writing should be understandable" (Munhall, 1994, p.191);

  Relevance - referring to relevance for the researcher and for the community to which the researcher turned to serve;

  Responsibility - the researcher needs to remain and be true to all four chambers of the heart of the study: the participants, their lived experiences, the researcher as a human being and the phenomenological approach; and

  Richness - to relate a sensitive, passionate and "in-tune" description and analysis of the participants, their experiences and feelings.

3.1.5 QUALITATIVE DATA ANALYSIS

Qualitative data refers to data in the form of words - word(s) being the unit of analysis. The researcher searches for meaning in context and aims at discovering certain patterns or themes that "repeat across data" (Tesch, 1990, p. 63) - the commonalities and uniqueness are explored and compared carefully. Participants or informants are requested to provide thick, intense and detailed descriptions which are then analysed by the researcher in a fairly eclectic way; the result being the development of a higher level structure or theory.

From the literature the following principles were accepted for application by the researcher:

- Although the data was broken down into meaningful units, the researcher endeavoured to maintain the whole (a holistic approach);
- An elementary conceptual plan initially guided the interview process and the formation of some categories; but usually the data itself provided the categories and themes;
- Data collection and analysis were integrated and co-dependent processes;
- The phases (or steps) followed and categories developed were logical and meaningful but not rigid - they remained flexible and open to creativeness throughout the research experience;
- "The analysis ends only after new data no longer generate new insights; the process 'exhausts' the data" (Tesch, 1990, p. 95); and
- Analytical or reflective notes or memos were kept right through the data gathering and data analysis processes for guidance and to establish accountability.

3.1.6 RATIONALE FOR USING THE PHENOMENOLOGICAL METHOD FOR ENQUIRY AND ANALYSIS

The researcher embarked on making a contribution to an epistemological framework for women as nurses. **Traditionally an epistemology is a branch of philosophy** that:

- Concentrates on the nature and scope of knowledge (including presuppositions and basis) and whether knowledge is at all possible (scepticism);
- Tries to establish whether claims of knowledge and truth are justified;
- Determines the criteria for beliefs to be considered knowledge; and
- Guides methodology - what can be known and who can be a knower

(Campbell & Bunting, 1991; Hamlyn, 1970; Harding, 1991).

According to Hamlyn (1970, p.284) there

> "*are all kinds of sources of knowledge. The question of the sources of knowledge is unimportant and irrelevant; the proper epistemological question is whether what we claim to know is true, and we try to find out the truth by examining and testing such assertions as are made, by, in other words, critical inquiry*".

The epistemology of the critical theory emphasizes that knowledge is created; that it should be used for political aims; and that "all meaning and truth are interpreted within the context of history" - "all standards of truth are always social" (Campbell & Bunting, 1991, p. 5).

Feminist theory as a critical theory, focuses on gender issues and idealistically places the woman central in their reflection on the nature of knowledge. Feminist theory emphasizes unity and relatedness (tend to disregard boundaries), contextual

orientation (emphasizes the power of the whole and not division) and the subjective (accepts and values feelings and intuition).

At least three distinct feminist epistemologies developed: feminist empiricism (trying to eliminate sexist and androcentric biases by strictly adhering to conventional methodological rules and scientific enquiry), feminist standpoint (equal to woman's perspective) theory, and the postmodernist approach (Harding, 1991).

In this research the Standpoint theory was used. This theory underlines that in society historically, the standpoint of the so-called western, white and economically stable "ruling" men or the "ruling" class is usually accepted as relevant, meaningful, authoritive, universal and neutral. The ruling becomes rationally organized in complexes of practices, for example in government, business and the professions (Harding, 1991; Smith, 1987). According to feminists, women of every class, race and culture can use scientific endeavour to establish and to increase control over their lives, and can thus transform agendas of science and develop a more comprehensive view of reality.

Socialist feminists paved the way for a unique epistemology for women by revaluing female experiences and by striving to give a complete account of women's unique social or class position and oppression - as opposed to the universally accepted historical standpoint of men. They emphasized that the interests, thoughts, choices and actions of men are usually clearly heard while women's are "brutally" silent - invisible and unhearable (Chinn, 1991; Smith, 1987; & Wetzel, 1993).

The researcher thus accepted that an epistemology located in feminist theory would emphasize:

- Women's experience as a legitimate source of knowledge and basis for research;
- The validity of subjective data;
- Informants as being the experts of their own lives;
- The relationality and contextuality of knowledge; and

- That boundaries between theory and practice; and personal and public are artificial (so-called boundaries need to be scrutinized)

(Campbell & Bunting, 1991).

The standpoint theory provided the researcher with a coherent framework to use as the basic premises for her research. This theory focuses on gender differences - women's lives being in essence different (and not inferior). The standpoint theorists accept that women's perspective is rooted in the ideological dualism of nature (=manual or emotional) versus culture (=intellectual) and that the women's standpoint creates an ontology of relations and continuing processes.

The key premises of the theory (as summarized by the researcher) are stated in column 1 of Table 3.2 and the application or realization in the research project in column 2.

Table 3.2: The application of the Standpoint theory's key premises in the research planning and implementation

KEY PREMISES OF THE STANDPOINT THEORY	*APPLICATIONS OR REALIZATION OF THE BASIC PREMISES OF THE STANDPOINT THEORY*
CONCERNING SITUATED KNOWLEDGE:	
* *Knowledge is always mediated by a multiplicity of factors related to the woman's situation at a certain moment in time, within a actual historical setting, and within a set of social relations - a reality that constantly changes* * *Women's position in society provides an adequate epistemological point of departure or standpoint* *(Haraway, 1988; Harding, 1991; & Jaggar, 1983)*	**The participants were situated in meaningful historical, geographical and social settings and relations: South Africa and Kwa-Zulu Natal in an important transitional period concerning major political (for example the first non-racist local government elections) and health care (for example the move towards primary health care) issues. The rural settings assumed to be disadvantaged because of a lack of basic infrastructures and poor quality of life. The strong influence of cultural values and practices were assumed to be quite evident.**
CONCERNING THE USEFULNESS OF WOMEN'S KNOWLEDGE	
* *The usefulness of knowledge is constructed within the realms of women's interests not being subordinate to men's interests - women are valuable strangers to the social order and can more easily distance themselves from the social order (have less to loose)* *(Harding, 1992)*	**Women as nurses were interviewed and their perceptions and experiences of power and related concepts were accepted as useful, independent and unique to women. The women could utilize a unique opportunity to talk about their daily realities as women and as (enrolled) nurses.**

Table 3.2: The application of the Standpoint theory's key premises in the research planning and implementation

KEY PREMISES OF THE STANDPOINT THEORY	APPLICATIONS OR REALIZATION OF THE BASIC PREMISES OF THE STANDPOINT THEORY
CONCERNING POWER:	
• *The recognition of power relationships (between the ruler and the oppressed) - marginal lives refers to those lives necessarily outside the centre of power and prestige (usually marginalized by the or a institution).*	• Women as nurses traditionally placed in an inferior and relatively powerless position to the (male) doctor.
• *The marginal lives are strongly located in the social structure - in this process gaining an objective, comprehensive and correct account of power relations in the social order. This account is perceived to be stronger than that of the oppressor.*	• The traditional hierarchial patterns in the nursing profession itself may lead to "oppressors" and the "oppressed". The enrolled category of nurses are perceived to be marginalized by having limited career advancement, a limited and restricted Scope of Practice, and being at the lower and or lowest levels of the nursing hierarchy in an institution and the profession.
(Harding, 1991; & Harding , 1992)	

Table 3.2: The application of the Standpoint theory's key premises in the research planning and implementation

KEY PREMISES OF THE STANDPOINT THEORY	*APPLICATIONS OR REALIZATION OF THE BASIC PREMISES OF THE STANDPOINT THEORY*
CONCERNING THE IMPORTANCE OF EVERYDAY LIFE	
* *Women's perspective is from everyday life - the "dailiness" of women's lives; the "everyday as problematic" (Smith, 1987, p.88-97)* * *What women do, also enables and limits what they (can) know* *(Harding, 1992; Hartsock, 1983; Smith, 1987)*	Enrolled nurses were requested and given the freedom to talk freely about and relate to their daily working lives; inclusive of the realities of home and communities - the influence of these daily lives on what they (can) know was evident

Table 3.2: The application of the Standpoint theory's key premises in the research planning and implementation

KEY PREMISES OF THE STANDPOINT THEORY	*APPLICATIONS OR REALIZATION OF THE BASIC PREMISES OF THE STANDPOINT THEORY*
CONCERNING THE "TRIPLE JEOPARDY"	
* *A person's reality and understanding of reality is always structured by class, race, and gender*	* The participants were purposively selected on the bases of class (enrolled nurse category which is seen as the lowest category in the community of nurses), race (black), and gender (women).
* *The dominant ideology also restricts what everybody is permitted to see*	* The influence or not of (a) the dominating ideology might (was) be visible and identifiable - probably linked to the traditional practices and ethos of the nursing profession
(Hawkesworth, 1989; Harding, 1992; Harding, 1992; & Jaggar, 1983)	
Concerning a contribution to theory building	
* *The variety of women's experiences can contribute meaningfully to the representation of the interests of the community and society as a whole; as well as to theory building* *(Harding, 1992; Harding, 1991; & Hartsock, 1983).*	* The researcher endeavoured to develop a consistent and meaningful epistemological framework of the power of women as nurses based on the analysis of the qualitative data.

(Harding, 1992; Harding, 1991; Hartsock, 1983; Hawkesworth, 1989; Jaggar, 1983; Smith, 1987; & Wetzel, 1988).

3.2 METHOD OF INQUIRY: APPLIED

3.2.1 AIM OF STUDY

The aim of the study was to develop a clear epistemological framework of power, powerlessness, powerfulness and empowerment as perceived by nurses in their daily working lives. The research questions asked were:

3.2.1.1 What are the defining attributes and realities of power, powerlessness and powerfulness as stated by women as nurses?

3.2.1.2 How is this powerlessness or powerfulness experienced and dealt with by nurses as women in their daily working lives?

3.2.1.3 What are the behaviours indicative of a need and readiness to be engaged in empowerment activities by women as nurses?

3.2.1.4 What are the perceived consequences of empowerment for nurses as women?

3.2.2 SELECTION OF PARTICIPANTS (SAMPLING)

The researcher made use of a scientific purposive or judgmental selection or

sampling where the researcher consciously selected participants based on the guidance provided by the Standpoint theory. Participants were thus selected on the basis of gender (woman), race (African) and class (enrolled category of nurses). The researcher's increased involvement and awareness played an important role in the selection of participants. An additional geographical criterium of spending their working lives in rural health care settings were for example added to strengthen the perceived degree of "marginalization". The selection approach and application was monitored by an experienced researcher to strengthen its logical and scientific basis. This approach is often, however, criticised for its perceived lack of precision in judgment (Burns & Grove, 1987).

After obtaining permission from the regional health authority the researcher negotiated entry with the Head of Nursing Services of a rural health service in the region of KwaZulu-Natal. She received permission to discuss the project with a group of nurses belonging to the enrolled category at a small hospital which was situated in a traditional rural setting and which rendered health services on a secondary level. The group were first fully briefed concerning the purpose, approach and ethical guidelines followed. The nurses who were willing to participate and share in the project were enrolled with the South African Nursing Council as either enrolled or auxiliary nurses A total of ten (10) nurses who were practising in a health care setting in a rural area were proposed (the researcher accepted the principle that the interview process will continue until no new information becomes available). These nurses were not directly involved in health or nursing management, nor in management or executive positions.

The researcher then endeavoured to interview a second group of five nurses belonging to the enrolled category and working in an urban health setting - these nurses thus adhered to the criteria of class, gender and race; but not explicitly to the fourth, the researcher developed the criterium of locality (rurality) - permission was granted by the Head of the specific health service.

A third and relatively contrasting group in terms of class was proposed; Five (5) urban based registered nurses who were involved in clinical health care (and not

explicit management or education) - again permission was granted.

The data and findings from the interviews with the different groups were to be compared to identify similarities and differences meaningful to the groups, context and project.

3.2.3 THE SETTING AND GAINING OF ACCESS

The researcher requested permission from the Secretary, Department of Health, Kwazulu-Natal, which was approved in principle (see Annexure A). The request to interview the different categories of nurses in rural and urban health care settings was negotiated with the respective Head of Nursing Services for that setting as well as with the participants who were willing to participate.

The interviews were scheduled to take place at a time and place convenient to the health service and the participant. The length of time requested per interview was approximately thirty minutes. The researcher endeavoured to obtain a private area (for example an unoccupied office or room with at least two chairs) where disturbances would be minimized and where the participants would feel safe to express their experiences and feelings.

3.2.4 GENERAL STEPS

The researcher intended to follow the following five steps:

1. Investigating the related phenomena of powerlessness, power, powerfulness and empowerment (using the utmost of concentration and so-called "strong objectivity");

2 Reducing data (for example by using contact summary sheets, codes and coding, reflective remarks, memoing and developing propositions);

3 Developing data displays (condensed versions of outcomes; for example matrices, critical incidents or mapping, and causal networks);

4 Developing essential and meaningful relationships and generalizations (using for example tactics like counting, identifying themes, clustering, factoring and making metaphors); and

5 Developing a meaningful epistemological framework of the power of women as nurses in South Africa

(Burns & Grove, 1987; Oiler, 1986; & Polit & Hungler, 1993).

Data collection and data analysis occurred simultaneously and the researcher had the freedom to redirect her research if she gained some new insights. Findings were described from the orientation of the subjects (for example their own words). The researcher searched for themes (recurring regularities). She used member checks to refine these themes; and a second researcher to independently code and analyse a sample of the data. Finally, an integrated and overall structure was developed; where for example, cross-tabulation could be used (Burns & Grove, 1987; & Polit & Hungler, 1993).

3.2.5 CONDUCTING INTERVIEWS

The researcher accepted and adopted a direct contact approach which meant close involvement with the participants - each participant being and becoming special and unique (Patton, 1990). The situated context of a woman who is *(am), was, have, work, interact, give, create, perceive, reflect, choose, know, understand and change* was accepted by the researcher without the researcher assuming to be knowing or to know (Munhall, 1994). Discovery, understanding and interpretation of what was

said was reflected by the researcher during the interviews where possible and applicable; and validated in successive interviews (the "phenomenological nod", affirmative statements and utterances of agreement being closely observed).

A conceptual and rudimentary outline was developed prior to the interviews to underline the key focus of the research and to guide the series of interviews with each participant. The researcher tried to formulate the guidelines to be non-prescriptive and to counteract inbuilt biases, expectations and values. Simplistic terminology was used to facilitate discussion. The guidelines were not seen as a locking device, but left open and subject to change. The changes were for example based on the development of the interaction process, the progress made, the needs of the participant and researcher.

The proposed guidelines were:

First interview:

- Entrance process - to discuss purpose, procedure and ethical guidelines; to obtain informed consent and elementary biographical data; and to develop a climate of sharing and commitment;
- Participants are requested to "take us through a working day" - from waking up to going to bed at night - this was done to obtain a picture of and to gain insight into the participants' everyday lives as a woman and as a nurse;
- Participants to contrast their daily lives and responsibilities with those of the (a) male partner that they share their life with (if applicable) - this was meant to more clearly outline the woman's daily experiences and responsibilities; and to foster a sensitive awareness for the realities of being a woman;
- Participants to relate whether they have any choices and related decisions in their daily lives - choices and decisions being considered as an indication of opportunities and an ability to exert influence and to exercise power in some form;

- Participants to relate to their "freedom" to make choices and decisions - linked to their perceived opportunities to exercise power or exert influence and
- Participants to indicate whether they feel that they make a difference to the lives and experiences of those around them (to have an effect); whether they are important in and for other people's lives - to gain understanding as to whether the participant feels that she is of value and meaningful to others and to herself.

Second interview:

- Discuss major themes from the first interview;
- Clarify obscurities;
- Power
  - To relate to the meaning and the experience of (the concept) power
  - In their daily working lives:
  - Perceptions and examples (realities) of
  - Having power

    (what does that mean to them / how do they exercise it / how does it feel to have power)
  - Not having power

    (what does that mean to them / how do they experience this powerlessness / how does it feel to be powerless);
- Discussing the relationship between the powerfulness and powerlessness and being woman; and
- To refer to and discuss the following whom they perceive to have the most power

- A (any) single person
- A nurse belonging to the enrolled category / a professional nurse
- A group of people within the nursing profession

- Elaborate on power, powerfulness, and powerlessness of women as nurses.

Third interview:

- Discuss major themes from (first and second) interview;
- Clarify obscurities;
- Deal with behaviour and actions that can be empowering (how, by whom, what will it mean, what will be the effect - personally and collectively);
- Clarifying concepts, perceptions and themes identified by the researcher and the participant; and
- Suggestions for the future and exit process.

Throughout the interviews the researcher endeavoured to use only open ended and reflective questions, for example

> *"What is it like..." / "Give me an example..." / "What do you think is the meaning of..." / "Can you share with me..." / "What are you thinking when we talk of all these things?"*

The participants were encouraged to fully describe and express their personal experiences, views, and feelings; and to use own concepts and metaphors.

The interviews were all audio-taped after the need for this technical and, perceived by the researcher to be initially intrusive procedure, was clearly explained. The use of only pseudonyms (which was chosen by each participant themselves) while tape recording, the commitment that only the researcher and a research assistant (who was a typist that did not know the true identity of the respondents) would have access to the recordings, and that the audio recordings would be deleted after

completion of the project, were explained to the participants. The participants also had the opportunity to listen to their "own voices" before, during or after the interview when requested.

All interviews were transcribed verbatim by the researcher and a field worker using a compact cassette transcribing system. The researcher developed guidelines for the field worker to transcribe the taped interviews (see Annexure B). Interviews were identified by pseudonym and number (for example Peggy1.urb). The researcher's question(s) and remarks were typed in upper-case; and non-words such as laugh(s), silences and sighs were noted (in parentheses) to aid data description and to facilitate the capturing of meaning.

3.2.6 PRELIMINARY OR PILOT INTERVIEWS

The researcher requested the permission of the Head of Nursing Services at an urban hospital to conduct a pilot study at her hospital (See Appendix C). Permission was granted and the researcher interviewed two nurses who met the other inclusion criteria and who were willing to participate in the project. The data was analysed and was to become part of the final documentation and description.

This opportunity was also utilized to explore the guidelines for the interviews as developed by the researcher (see 3.2.5); and to evaluate the feasibility in terms of time and number of interviews planned. The pilot study also enabled the researcher to further develop skills in the phenomenological approach to in-depth interviewing and to explore the capabilities of the software system utilized. The process of and data from this phase was shared and discussed with an experienced researcher.

During and after the pilot interviews the researcher made minor changes to the interview guidelines. These consisted of the following:

Interview 1:

- Requesting the participants to compare their daily lives with those of the (a) male partner with whom they share their lives with (if applicable). The researcher enacted this change to help the participant and the researcher to focus more clearly on and to optimize sensitivity to the realities of womens' everyday lives

- The researcher initially thought that she would like the participants to link their freedom to make choices and decisions to whether these choices and decisions made a difference to their and other people's lives. From the first preliminary interviews the researcher got the distinct impression that this linkage or cause - effect relationship was not easily understood and probably abstract to grasp. The guideline was thus broadened to whether they feel that they make a difference to or are important in and for other people's lives. The guideline was thus now trying to focus more on the participant's sense of self-value and meaning within her own situated context - her own subjective experience valued and accepted.

Interview 2:

- The researcher felt the need to create more opportunities for the participant to relate to experiences of power as a woman to be able to have a deeper understanding of her interaction with the realities of power. The participant was thus requested to refer to and discuss examples of individuals and groups whom she perceived to have power or who are powerful.

The researcher also realized that a richer collection of qualitative data would be phenomenologically meaningful to discover, understand, interpret and illustrate the meaning of the experiences of the participants and the researcher. The researcher thus requested participants to create a data document in any form that they will feel comfortable with. The form could be for example an essay, a picture with her own

notes added, a drawing, a poem or a song. The participants were also free to use their own home language and could do it in their own time. The theme and contents were to relate to power and women and nursing and was discussed with the participants at the end of the second interview (The second interview focussing on the phenomenon of power). The participants were requested to bring it to the third interview where the researcher and the participant could share the document; permission was also requested to use the document in the research report.

3.2.7 OUTLINE OF PHASES FOLLOWED DURING DATA ANALYSIS

The following phases were developed before analysis to give structure to the data analysis:

Phase 1: Before working on the data, the researcher needs to reflect on and identify her own preconception(s) of the phenomenon under study and to suspend or set aside these preconceptions - this process is called bracketing. Munhall (1994) refers to an "attitude of unknowing" - which will help the researcher to be more open and less inclined to validate her own beliefs and concerns (being decentred). Preconceptions might hinder the researcher in fully understanding the lived experiences of the participants or may impose a priori hypotheses. Listing these presuppositions is helpful but perspectives and biases can not be controlled fully;

Phase 2: The researcher reads the entire document carefully and becomes fully involved and immersed in the contents - a sense of the whole is developed;

Phase 3: The researcher organizes the data by looking for, for example, material that relates to the phenomenon under study. Meaning units (which are parts of the description that together form a specific

meaning, idea, piece of information or moment) are identified (Tesch, 1990). These meaning units will still be meaningful outside their context. Software analysis programs call these units text segments;

Phase 4: The content of the meaning unit is then interpreted by summarizing or restating it in more abstract language. Meaning units that show similarities, are clustered (condensed) together and will be identifiable in an organizing or category system. These categories (and sub-categories) are in essence data management tools. The categories represent data and will form part of the research results in theory building activities (Tesch, 1990);

Phase 5: Each meaning unit is categorized within the organizing system - this is called coding or data sorting;

Phase 6: All data within the same category are assembled and studied by the researcher. The researcher constantly moves to and fro between raw and extracted data (for example meaning units) and themes to fully understand and to validate. The researcher finally develops specific and exhaustive statement(s) and descriptions related to the respondent(s)'s experiences. Actual words used by subjects will be used extensively (examples) to illustrate themes and categories; and

Phase 7: Data documents are compared across cases to determine common as well as unique (variating) themes, as well as the patterns amongst these themes. An exhaustive description of the phenomenon under study will lay bare the essential and integrated structure of the phenomenon.

(Burns & Grove, 1987; Munhall, 1994; Munhall & Oiler, 1986; Polit & Hungler, 1993; Tesch, 1990).

The researcher used the multi-functional software system NUD*IST [1] to aid the understanding of nonnumerical unstructured data. The package was used for example to:

- Collect and manage transcribed interviews (created and filed in a word processor) and imported to the programme's data base as on-line documents;
- Create and manage categories to facilitate thinking about the data and to find patterns in the data;
- Make and store factual information about the participants as well as notes and memos about the documents and categories as understanding and insight develops; and to
- Test the understanding against the data

(Qualitative Solutions and Research [QSR] Pty Ltd, 1995).

The researcher also made use of the electronic Internet forum on computational qualitative analysis managed by QSR at La Trobe University (Melbourne, Australia) for ideas, further information and help.

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1 Non-numerical Unstructured Data: Indexing, Seraching and Theorizing.

3.2.8 ETHICAL CONSIDERATIONS

3.2.8.1 Feminist research

The researcher defined and adhered to ethical guidelines related to qualitative and feminist research:

- The principal investigator was a woman.
- The research endeavoured to answer questions that women as nurses would like to be answered - focusing on women as nurses and their actual experiences related to power (for example oppression and patriarchy); and their interpretations of these experiences.
- The researcher had a positive view of women and women as nurses; had a specific and caring interest and commitment to the realities of women as enrolled nurses who spend their working lives in rural areas.
- The researcher took great care to be aware of the context in which the research takes place - human beings perceived to be marginalized on the basis of race, gender, and class.
- The researcher strove to be aware of and record her own biases, background, ethnic and social class as part of the data (the researcher's history, assumptions, motives and interpretations need to be exposed).
- The researcher validated her observations with the participants. The first stage of validation took place during the interview process by reflecting on the responses of the participant and determining their agreement or disagreement with the understanding of the researcher - the "phenomenological nod" played a crucial role in the validation process. The second stage of validation took place at the beginning of interviews two and three where the researcher took the participant back to what was discussed

in the previous interview and summarizing the central thoughts, ideas, experiences and feelings that were expressed. The third stage of validation was optional and referred to going back to the participant(s) after the completion of the analysis of the data and of the development of a theoretical framework to establish congruency, to verify problematic aspects of the data in general, and to share the researcher's insight and experiences.

- The participants were considered and perceived to be on equal footing with the researcher (nonhierarchial and reciprocal). The researcher tried to eliminate barriers related to for example academic and professional standing. She spontaneously requested the participants to use her first name (Anita) in discussions, by being open to any prompts, suggestions, feelings and actions (verbal and non-verbal) from the participants and from herself. The researcher also did not hesitate to enact, facilitate or return spontaneous physical and psychosocial interaction for example touching, hugging, smiling, laughing, conveying empathy, caring and attunement.

- The researcher used the concepts "feminist" and women and constantly tried to remind the participants of this focus.

- The researcher cited feminist literature (for example Standpoint theory and related literature).

- The researcher tried not to use sexist language except where necessary to illustrate or convey a specific point. It was important to note that some participants were inclined to refer to "she" when meaning "he" - this might be related to English being the second language - there is no "he" or "she" in the Zulu language).

- The research had the potential to help both participants and the researcher. The sharing of thoughts, experiences and feelings as well as the sensitization of the participant, the researcher and the reader to the phenomenon under study was seen to be meaningful and potentially contributing to social change.

- The researcher would share insights with all women in the nursing profession - "breaking the silence" concerning the realities of enrolled nurses as women in South Africa and the phenomenon of power.

- The findings were considered for social change and not just for individual change within the nursing profession. This might seem to be contradictory to the phenomenological approach which traditionally focuses stronger on discovering, understanding and interpreting. The researcher is of the opinion that change is an inevitable part of human existence and that any study in some way enacts change - within the participant, the researcher, the reader(s) and the community (ies) to which the findings is conveyed. It is thus the task and the ethical responsibility of the researcher to foster positive change; to think, feel, speak and act meaningfully and passionately.

(Campbell & Bunting, 1991; Hall & Stevens, 1991; Parker & McFarlane, 1991; Webb, 1993; & White, 1991).

3.2.8.2 The protection of the participants

The participants as human beings were protected in the research project and afterwards by the following ethical guidelines:

Faithfulness — The researcher undertook to describe experiences faithfully (as were expressed or stated);

Informed consent — The participating were free to exercise their power to participate after being informed of the title, purpose, nature and procedures to be followed;

Entry and departure — These events were carefully discussed and negotiated to prevent feelings of disappointment and desertion;

Confidentiality — The researcher explained that precise quotations will be used; but anonymity will be guaranteed;

Secrets — All data obtained would form part of study;

Process consent The researcher strove to encourage mutual participation and input; and

Risks The researcher explained risks involved, for example the possible invasion of the personal space and the psyche of respondent and/or researcher; and that the dialogue might trigger emotional responses that will have to be dealt with adequately

(Munhall, 1994).

3.3 BRACKETING AS UNKNOWING

According to Munhall (1994) the unique self of the researcher is an essential and critical part of the phenomenological research approach - the self that needs to understand, accept and appreciate differences and similarities in human experiences. Unknowing becomes a decentering process which then leads to more openness for the world of others. When the worlds, views, verbal and non-verbal behaviour of two human beings meet, interact and share, intersubjectivity and sharing of perceptual space takes place. Patton (1990) emphasizes the necessity to become aware and to minimize personal bias and judgement - the processes of *Epochè* and phenomenological reduction being instrumental in minimizing these preconceptions.

The researcher accepted that biases can never be completely described and controlled; but opened a quiet moment to unravel some of her own pre-conceived thoughts, interpretations, meanings and ideas concerning being a woman, being a nurse and power:

BEING WOMAN:

When I think about myself as a woman I accept that I am part of a group of privileged white women in South Africa who had ample and pre-structured opportunities to develop in a safe environment. My exposure to other human beings, cultures and contexts lead me to appreciate the innate potential, power and ability to endure. I perceive women to be unique in their ability to care and to consolidate; and in their ability to appreciate and tolerate differences. On the other hand, women and their ability to handle acquired status, conflict, and opposition has always been worrying to me.

BEING A NURSE:

Nursing for me is in essence a caring activity contributing to the health of human beings. Being a nurse is not easy: to be often exposed to pain and suffering; and to often say and to do uncomfortable things to and with people is very draining and takes a lot of inner strength. In the past I also had great difficulty in marrying my deep interest in art and aesthetics with the realities of health care delivery; especially at the traditional curative level.

ON POWER:

When I think about power I am inclined to see it as a male oriented and dominated concept; and often feel the need to develop another or new concept that will relate to womens' unique abilities to "enable" and affect change. I am also more fond of the concept "empowerment"; empowerment more strongly emphasizes the process of giving and sharing power.

3.4 STRENGTHS AND LIMITATIONS

Qualitative research approaches are often criticized for their "subjective" and unstructured approach. It is also difficult to defend in qualitative research approaches for example sample selection, generalizability, reliability and validity as is stipulated and accepted for traditional quantitative approaches. It needs to be remembered that qualitative research methodology operates in a different paradigm (phenomenological paradigm) and inductive research tradition that emphasizes for example depth, totality, context and so-called "subjectivity". It is a naturalistic, non-manipulative and unobtrusive approach that forms a stark contrast to the empirical-analytical or logical-positivistic paradigm (Mouton & Marais, 1988; Munhall, 1994; Munhall & Oiler, 1986; Patton, 1990).

The acceptance of a paradigm of choices where the need, place and value of both approaches is accepted and advocated. According to Patton (1990) a paradigm of choices states that the appropriateness of the methodology should be the key criterium for evaluating the quality of the methodology. Qualitative research methods are often described as a first level of inductive and logical discovery and exploration.

This study focused on a fundamental phenomenon (power and related concepts) in human existence and specifically in nursing, and tried to link this phenomenon with the reality of being a marginalized woman. The standpoint(s) of some of these perceived to be marginalized women in South Africa (Kwazulu-Natal) concerning power and related concepts were documented and made known to the sciences, the profession and the communities - breaking and voicing the silence.

The fact that the researcher was a white woman from an advantaged and "middle class" background who was not able to speak the mother language of the participants would influence the research process, content and findings. It also

needs to be debated whether the researcher could "speak for" or "on behalf of" the participants. It was hoped that the researcher's integrity, honesty and commitment would build some of the bridges needed.

The involvement of nurse managers in the recruitment of respondents might have influenced the participants' freedom of choice to participate initially. The interviews usually took place when the nurses were on duty because of logistical problems to stay after work or come to work earlier. It was also difficult for the researcher to intrude on the womens' limited time at home. The homes in the rural settings were also not readily accessible to the researcher.

The setting in which the interviews took place might not have been ideal in terms of creating a relaxed and comfortable atmosphere with enough privacy. Usually an available office was used. The researcher placed the chairs away from the desk or table to eliminate a feeling of a typical "behind the desk" interview; and to facilitate eye and any other contact. After explaining the purpose, use and handling, the compact cassette machine and microphone was usually placed on the table or desk - out of direct sight. Controlling noise outside the office (for example patients, clients and staff) was difficult as the researcher did not want to interfere with the normal setting of the health service and the natural setting of the interview. The scheduling of two to three interviews in succession where the researcher and participant could strengthen their "being-together" also counter-acted and alleviated these limitations to a certain extent.

To close:

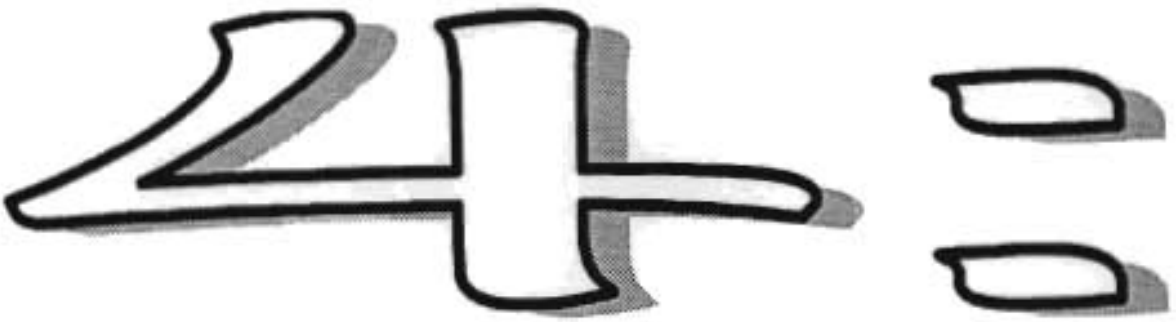
While sharing with the women or when reading what was said - sometimes in broken English; sometimes in a language of tentativeness - the following became so appropriate and meaningful:

" *Her* power came from some great reservoir of spiritual life;

else it could not have been so universal and so potent,

but the majesty and beauty of the language with which *she* clothed it were all *her* own"

(Claude Bragdon; italics mine)



LITERATURE REVIEW & CONCEPT ANALYSIS

Many phenomenological researchers see the literature review as part of the method of inquiry - an applied method; and thus part of the data collection. This is done in order to limit the biasing effect of a literature review (Munhall, 1994; & Patton, 1990). A literature review can also help to focus the study and if done simultaneously with the data collection, can be meaningful in facilitating the interaction between data collection, literature review and the researcher's analytical and introspective thought processes (Patton,1990).

The literature review for this study turned out to be a "powerful" undertaking for the researcher. It needed to deal with key concepts related to women as nurses within the epistemology of power. It endeavoured to view power, powerfulness, powerlessness and empowerment within the arenas of selected philosophy, social sciences, feminism, educational theory and professionalism. The researcher also decided to present a concept

analysis of empowerment as part of the applied data collection to summarize the literature data and to place the concept of empowerment in a strong theoretical and philosophical framework.

An applicable feminist oriented epistemological framework which was used to guide the selection of participants was discussed in Section 2; and the applicable research methodology in Section 3.

4.1 POWER

4.1.1 DEFINING POWER

4.1.1.1 Introduction

There is limited agreement on the definition of power as a hypothetical construct; as well as on the essential attributes of power. This is mainly because of the explicit and implicit contradictions embedded in the theoretical and practical construction of the concept. A lay and traditional view of power as a noun places the concept on equal footing with mightiness (greatness) and authority, as well as an ability (competency) and energy. All of the above mentioned strengthen the influential and / or controlling character of power; of power being exercised rather than possessed. Power exercised is linked to the ability or capacity to get what one wants, to accomplish something or to bring about consequences - usually within a certain context or situation (Covey, 1989; Donley, 1983; Kirkpatrick, 1987; Lukes, 1977; Parenti, 1978; & Reading, 1977). According to Rappaport (1984), powerlessness needs to be seen within the context of the absence of empowerment. Powerlessness would relate to the inability to exert such influences; and is usually accompanied by

experiences such as pain, frustration, alienation and helplessness (Pinderhughes, 1983). According to Kieffer (1984, p. 15-16) the sense of powerlessness *"is viewed as a construction of continuous interaction between the person and his/her environment"*. Lerner (1986, p. 2) states that powerlessness *"changes, transforms and distorts us"*.

The powerless or oppressed tend to

- Feel humiliated, overpowered, unable and defeated;
- Retribute and comply with power system's expectations to avoid punishment or to obtain rewards;
- Convert to accepting dependency as good, and inflict oppressor's values as own;
- Invalidate own thoughts and experiences and accept survival skills and non-punishable behaviour; and
- Accept and present subordinate roles and status as a proper choice

(Gabalac, Ballou, & Kelley; as cited by Wetzel, 1993).

Power relations are present in all the micro and macro spheres of life - every human being individually or collectively exercises power, but is also subjected to it (then placed in a "powerless" position). The implicit and explicit advantages available to people when they become aware of their own powerlessness and begin to define and work toward their own objectives are well accepted by for example political activists and health care professionals. The assumption that individuals and groups possess the power to "achieve goals which are unforeseeable at any moment in time" is emphasized by Darvill & Smile (1990, p. 13).

4.1.1.2 Power and authority

Differentiating between power and authority over the conduct of others has always been a thorny issue. According to Bayles (1976) a person in authority's behaviour is determined and defined by the purpose or goals (for example to the benefit of

those subjected to it), rules (for example directives should be in writing) and conditions (for example being elected or appointed); and does not usually intend to harm or reward. Authority thus refers to a legitimate use of power, an authority that is open to challenge from those striving for freedom and emancipation. This healthy tension between authority and freedom should be kept alive (Degenaar, 1994).

The current emphasis on the goals of justice and welfare in political authority was awakened by the French Revolution; and is currently embedded in different constitutions and Bills of Rights. An in-depth analysis of the purposes of authority for the group, community and / or country it serves is crucial to determine whether authority and the persons placed in authority positions actually hinder or promote the purposes they are serving.

4.1.1.3 Power and knowledge

The relationship between knowledge and power has been intensively analysed by philosophers; knowledge is currently not conceived as being innocent in its origin, content and purpose. The historical thesis stating that there can be no knowledge without power or the thesis that suggesting that knowledge is independent of power is actively contested by, for example Foucault. He emphatically states that power produces knowledge; and that power and knowledge directly imply one another - knowledge is immanent in power relations (Sheridan, 1980). Foucault also suggests that knowledge is not only always innocent in its origins; but *"he suggests also that knowledge can never be innocent in its origins or effects"* (Forrester, 1994, p. 3).

According to Doering (1992, p. 25) power *"limits what is acceptable to be known, and knowledge develops in response and sometimes in resistance to the limits set by power relations"*. The relationship between power and knowledge is not fixed - and this delicate balance makes change possible. Power is thus capable of both repressing (negative) and producing (creative, positive) knowledge (Sheridan, 1980).

The intricate relationship between language (*langue* - referring to traditional culturally linked languages, for example French or German), the formation of a discursive practice and a body of revolutionary knowledge, and behaviour and

strategies gave rise to Foucault's theory of society (Foucault, 1972).

According to Rouse (1987, p.24) power relations *"permeate the most ordinary activities in scientific research"* - power and knowledge being internally related. An inherent difference between the natural and social sciences relates to the difficulty and (actual unacceptibilty to) of the social sciences to deploy power in their scientific activities. In dealing with liberated criticisms of science with a political emphasis, he mentions that a feminist standpoint theory as advocated by Harding and Keller might be a useful, less power orientated and less androcentric approach to develop scientific knowledge.

Feminist theories of knowledge tries to find the theoretical connections between gender and knowing. Feminist empiricism (in essence adhering to the framework of philosophical realism and the primacy of the senses) believes that misogynist bias can be eradicated through a rigorously controlled process of knowledge development. Feminist standpoint theory emphasizes the role of class, gender and race in formulating an individual's understanding of reality and thus knowledge - emphasizing the realities of the oppressed or marginalized. Feminist postmodernist epistemology upholds a scepticism embedded in the plurality and differences of every situation and context (Hawkesworth, 1989).

4.1.1.4 Power and politics

Politics is often defined as the practice of power relationships, and the male-created concept of politics usually denotes the exercise of power and authority in the public realm (the establishment of government) - an area of traditional male activity. More contemporary definitions emphasize the comprehensive view where the collective will and strife of the people to control their own destiny is prominent (Pablos, 1992). According to Davis (1984, p. 53) *"politics do not stand in polar opposition to our lives. Whether we desire it or not, they permeate our existence, insinuating themselves into the most private spaces of our lives"*. According to Rendel (1981) political science has erred seriously by failing to include women when dealing with the totality of political systems.

Studies concentrating on women in issues of public concern, found that women in public offices were generally more inclined toward global peace, anti-militarism and genuine responsiveness to the needs of the people. Women were usually more willing than their male counterparts to take radical stands on public policy issues (Bystydzienski, 1992; Ling, Matsumo & Bystydzienski, 1992).

In Norway (where the cabinet consisted of 44% women in 1989), womens' unique experiences in certain spheres of life as well as their emphasis on cooperation and expressive relationships brought changes to the political agenda; as well as a flexible and people's touch to traditional public politics (Bystydzienski, 1992). According to Carroll (1992) women legislators in the U.S.A. were significantly more involved in health care, women and child's issues and were substantially (73%; N = 605) involved with certain womens' organizations.

Feminists redefined politics to include *"people's everyday experiences of oppressive conditions, the recognition of injustice of power differences, and the many and varied attempts to change power relationships at all societal levels"* (in essence an **empowering** focus and concentrating on local revolutions) - the reality of politics thus embedded in every sphere of everyday life (Bystydzienski, 1992; p. 4). Women also became increasingly involved in less traditional politics, for example less structured community movements, kinship and local networks; as well as agitating for quality of life projects.

4.1.1.5 Power and Philosophy

Foucault (1972, p.22) refers to the power of life, with its *"adaptations, its capacity for innovation, the incessant correlation of its different elements, its systems of assimilation and change"*. He sees power as seeping into the very essence of existence - it is induced in the body and is brought to the forefront of every social interaction. Power is neither positive nor negative, but is seen as producing reality's knowledge, meaning and value (Crowley & Himmelweit, 1992; Hollway, 1992; & Martin, 1992).

The defining and use of the concept power is based on and linked to the user's

religious inclination in the heart (an exhausted but not easily replaceable metaphor), value systems, philosophical perspective, skills framework and life experiences. Moral philosophy's task to investigate the consistencies, inconsistencies and assumptions embedded in these judgements of right and wrong concerning power and power relationships needs to be emphasized. The motivation for this necessity is related to the assumption that most of the above-mentioned contradictions are intrinsically linked to the four basic moral values of non-maleficence, beneficence, justice and non-deception identified by Strawson & Warnock, as cited by Stofberg (1994). The survival of any group or society depends on the *"minimum adherence to these principles by the majority of the group, for most of the time"* (Stofberg, 1994, p. 5).

Foucault, a social poststructuralist philosopher, specifically analyses power in term of its effect ("does what"). He moves from a negative conceptualization of power *"as something that establishes lines of division and exclusion"* to that which *"enjoins an interminable seeing, saying and doing"* (Williams, 1981, p. 122). Power for him becomes mainly a strategy that needs to be analysed throughout history (Foucault, 1972). Power relations in a society maintain the social hierarchy through the day-to-day activities of individuals in the society (Foucault, 1976).

Historically, philosophy voiced an anti-feminism (for example Emile Rousseau, Hegel and Comte) and delegated the realms of feeling, passion and nature to women a *"power of disorder"* (Le Doeuff, 1987, p.193). Le Doeuff argues that women should refrain from entering a discourse which tries to adopt a feminism of difference or a discourse trying to change or nullify the long oppression of women. She advocates a practical approach to philosophy and the adoption of a collective effort to the philosophical:

> *"In this kind of practice, at every moment I encounter the fact that the other's discourse being the origin of mine, as well as an unforeseeable future, gives it a continuing sense of its own limits. Here, one has the impression of experiencing a new rationality, in which a relationship to the unknown and to the unthought is at every moment reintroduced"*

(Le Doeuff, 1987, pp. 208-209).

4.1.1.6 Power and Political Sociology

Male political sociologists' thoughts and research have been fascinated with the concept and reality of power (and authority) ever since the mammoth writings of Machiavelli, Hobbes, Weber and Parsons. Apart from the ability of the powerful to exercise power despite resistance, the legitimacy of power is also to be found in societal values, for example custom and rational legality. According to Smelser (1988, p. 402) power represents *"the social capacity to make binding decisions that have major consequences over the directions in which a society moves"*.

Marxist sociologists see the existence of power as a consequence of class structures, and will thus give rise to class struggles; originating from the so-called dominance of ruling classes who hold key positions in, for example government and corporate directorates (Smelser, 1988). This view point links up with Parenti (1978) who sees power as a pattern of relations inherent in the social system itself which persists over long periods of time.

4.1.1.7 Power and Psychology

Individual psychology often refers to locus of control as a psychological variable when dealing with the concept power. An internal locus of control reinforcement (being related to their own behaviour or relatively permanent characteristics) is a desired and positive capability to control personal outcomes and indirectly psychological health. The external locus of control can, on the other hand, be linked to a strong blame factor in the systems and result in powerlessness or alienation.

Community psychology focuses on community problems of living which they see as a function of denial of or access to resources which are created by social and political systems that withhold either money or power (the powerful). The approach is thus either "blaming" the system or adapting an external locus of control. The resultant absence of power can lead to general uninvolvement, negativism and fatalistic views. Community psychology thus moves from mere public analysis of

social policy and its effects to direct social and active intervention and evaluation of social change (Rappaport, 1977).

The research of Dahl in 1961 and Clark in 1971 in diverse urban communities, demonstrated that many individuals are participating in political decision-making at different levels; the so-called de-centralized centres of power. The dynamic relationship of and between the "parts" is in essence the power to create a synergistic culture inside an organization or structure (Covey, 1989).

The traditional psychological theories with their strong male-typed traits as norm which reflect the inequalities in social status and interpersonal power between men and women were challenged by some psychologists, psychotherapists and counsellors which motivated for the development of a Psychology of Women (Feminist Psychology).

This psychology should:

- Acknowledge the reality of the politics of gender as it is reflected in the lower social status and oppression of women in many societies;
- Strive for the empowerment and equal status of women and any other oppressed group;
- Appreciate knowledge about womens' experiences and the value-laden reality of science and practice; and
- Be committed to social and political change

(Worell & Remer, 1992).

4.1.2 POWER, FEMINISTS AND WOMENS' MOVEMENTS

Feminists became interested in relations which were traditionally based on strong

patterns of dominance and subordination, and initially defined power as sexual politics. Later they located the source of power in consciousness and language - language that shapes and that is being shaped by experiences. Radical feminists tried to challenge traditional myths and to identify womens' potential power (for example as mother).

The reality of womens' inherent abilities as well as the development of anti-domination patterns became strong themes; mainly because of men's perceived focus on the securing and expanding of power (Humm, 1989). However, Thürmer-Rohr (1991, p. 11) stated emphatically that *" 'future' no longer meant a transfer of power and a new beginning. What has been done here cannot be undone or unlearned. The dreams of dismantling patriarchy are drawing to an end"*.

For many women participation in a womens' or feminist movement is the first step toward empowerment and the struggle against oppression; especially in very poor and / or rural communities. A distinction needs to be made between the struggle of women for women (to gain for example equal rights); and the situation where women join men in resistance to onslaughts on humans' freedom, equality and dignity, as well as striving for democracy and national liberation as a prerequisite for peace. The strategies of political activism, resistance, and finally an armed struggle are used to reach such goals. The political histories of for example, Uganda, Palestinia, Nicaragua, Poland and South Africa sketch such strategies very clearly. Here women fought side by side with men; and this became an opportunity and a rationale to gain political power (Byanima, 1992; Najjar, 1992; Regulska, 1992; & Seitz, 1992).

A womens' movement can be defined as collective and active effort to effect change (mobilization and / or conversion) in womens' situation(s). Although movements are not always homogenous and contain both groups and individuals; they share certain broad beliefs and values (for example economical, social and political empowerment), and are committed and able to disseminate these beliefs and values which usually challenge the status quo. The experience of women in different countries was that formal political parties promised definite attention to womens' problems; but that these promises were not effectively kept in the political arena -

women thus had to resort to additional strategies (Ling, Matsumo & Bystydzienski, 1992; & Papageorgiou-Limberes, 1992).

According to Bystydzienski (1992), and Najjar (1992), the key strategies used by women to empower themselves collectively are:

- The development of a distinct womens' culture, value system and a ever present feminist agenda;
- To have more women present in the formal political system where they can make definite contributions from a woman's perspective and participate in decision-making (the avenues being for example through the voting system, left-wing party involvement and the development of a strong national belief in equality and the rights of individual groups);
- The mass recruitment of women and the establishment of strong womens' groups and movements which speak out on and act for the benefit of women - the concepts of unity (a united front or coalition) and agreement on major issues between different womens' movements are very important here - without losing a healthy diversity;
- The creation of a strong public awareness of womens' issues;
- Intense lobbying of legislators and other important political figures, as well as good timing and presented within a relevant or meaningful context;
- To build international links with meaningful and influential individuals and groups;
- To mass educate women (formally and informally);
- To financially empower women through vocational training and employment - the goal being increased independence, quality of life and control of their lives;
- The provision of essential and other support services for women, for example child care and health services; as well as solidarity groups who provide other

forms of support (for example material, emotional and social);

- To publish womens' experiences and contributions; and to foster discussion in the public realm of the media and the literature; and
- Joining men in major or national struggles without losing sight of their own interests and agendas.

Womens' movements usually form the link between and entrance (access) to the power of society (grass roots) and the power of the state (where women usually strive for equality and specific rights). Movements can also serve as a mechanism to develop alternative and new support systems apart and separate from the state. Movement participation and activities also serve as a vehicle to empower women on a personal and collective (group) level in different aspects of their lives; for example confidence, self-esteem and economical gain. According to Davis (1984, p. 5) women need to "lift as they climb" - referred to as the "essential dynamic of our quest for power". Davis also states emphatically that racially oppressed women should be given priority, and that professional women should also accept the leadership of women who are actively involved in the labour movements.

The successes and failures of womens' movements in several countries have been well documented - for example Japan, Greece, India, Nicaragua, Uganda, Poland and Palestine. These successes and failures are not only measured in term of political power, but also economically, psychologically and socially (Bystydzienski, 1992; Calman, 1992). Haussman (1992) also stresses not only endogenous factors (for example resources possessed and strategies developed), but also exogenous factors such as timing and cultural context.

Tarrow's political process model states that the openness of state elitists as well as the stability of these alignments are very important variables in determining the success of social movements. It seems that the timing factor (or moment of opportunity) is very important but not solely responsible for success or failure. Another important variable is the power of beliefs about the spectrum and capabilities of politics to solve social problems - thus a value construct (Haussmann;

1992).

4.1.3 EXAMPLES OF POSSIBLE KEY CONTRADICTIONS EMBEDDED IN THE CONCEPT POWER:

The innate contradictions in the literature of different sciences dealing with the power concept and the reality of practical or applied power needs to be further addressed:

- Power is exercised by both individuals **and** groups; and can thus involve **opposing** intentions, choices and agency; thus creating competition (Parenti, 1978);
- Power is both **creative** (productive, for example giving to or sharing with the powerless) and **destructive** (repressive, for example depriving those subjected to the powerful);
- Thrives in, needs, is exercised in **resistance** and can lead to **conflict**; but also nurtures **joy in achievement;**
- Leads to or is **controlling** (dominating and forceful) in nature (with a strong emphasis on (political) leadership and so called power elite who came to share a similar world view) - these elitists can thus **limit other's freedom** of choices (Smelzer, 1988);
- Is a state of **energy and dynamism** (Curtin, 1989), but also seeking **stability and order;**
- Has the ability to **remove** obstacles hindering the attainment of goals; or of **creating** obstacles, for example deprivation and inequality (Parenti, 1978);
- Is in essence **subjectively interpreted** by those **having power** or by those

striving towards attaining power (is perceived and relative);

- Power is crucial in **defining, as well as pursuing** immediate and long-term personal, interpersonal and global interests (Parenti, 1978);
- Power might be **differently perceived** by the powerful and by the powerless;
- The subjection to power by the powerless might **give freedom** (autonomy) to the powerful and at the same time it might **deny** it to the powerless (Smelser, 1988);
- Power is exercised within the **ever present possibility** of or **potential** for revolt or refusal (King, 1992);
- The **abuse of power leads to oppression**; and oppression can be defined as humanly imposed unjust restrictions on people's freedom. Oppression will inevitably lead to a strive towards liberation (Jaggar, 1983);
- "*The **power of the powerful** rests, after all, on the **powerlessness of the powerless***" (Rendel, 1981);
- The so-called powerless **give in anticipation of receiving** some kind of reward, the power relationship is defined by the interests of participants (Parenti, 1978);
- Power is **neither** visible nor invisible ;
- A given context (for example time and structure) usually **limits** the agents and exercise of power - thus a dialectic tension between power and structure (Lucas, 1977);
- The powerless are **never totally without** power (Rendel, 1981);
- Change is possible as the **relationship between power and resistance can be altered** (Doering, 1992); and
- In looking and striving forward and towards for example power, "clearly what

was hoped for was always the wrong thing" (Thürmer-Rohr, 1991, p. 26).

To summarize:

Power in an elementary sense refers to a social relationship between individuals and / or groups that determines access to, use of, and control over basic material, social and ideological resources in society. Power is primarily viewed as a positive social capacity to achieve common goals (Abercrombie, Hill, & Turner, 1984; Bookman & Morgan, 1988); a capacity that can be strengthened or developed.

4.2 EMPOWERMENT

Empowerment as a noun and empower as a verb stems from the Latin *"potere"* and *"posse"*, literally meaning to make able (enable) or possible (*"possibilis"*), to provide with means, or to give power to (Allen, 1991; Chandler, 1992; Hawks, 1992; Partridge, 1958; & Randall, 1992). Although empowerment is a popular term, nursing literature and nursing research addressing the concept of empowerment is still limited.

4.2.1 DEFINING EMPOWERMENT

Authors from different professions do not agree on or do not state consistent definitions of empowerment. Some authors view empowerment as a process (Bookman & Morgan, 1988; Bystydzienski, 1992; Clifford, 1989; Hawks, 1992; & Simmons & Parsons, 1983); as an outcome (Gibson, 1991); or as a goal

(Rosenwasser, 1992; & Browning, 1989). While Hawks (1992) mentions three themes in the definition of empowerment (namely sharing of power, enablement [to make possible] and empowerment as professionalization); Randall (1992) emphasizes two approaches to empowerment: the one to conscientize and mobilize (oppressed) women and the second approach focussing on providing an opportunity to make their own choices.

Empowerment is also defined in terms of an individual (personal) and / or a collective perspective; with these two perspectives usually being mutually dependent on one another. Daily personal concerns and individual strategies of resistance can be linked to collective forms of action (Bookman & Morgen, 1988).

A wide-ranging definition of empowerment stated by Bookman & Morgan (1988, p.4) is that empowerment is in essence a process aimed at consolidating, maintaining and / or changing the distribution of power in a particular context. Empowerment includes a wide range political activities; from *"individual resistance to mass political mobilizations that challenge the basic power relations in our society"*. Empowerment is in essence not domineering, authoritarian or controlling (Chandler, 1992); and it is the transactional nature of empowerment that is emphasized, a sharing of costs, benefits and risks.

4.2.2 THE AIMS OF EMPOWERMENT

The main aims of empowerment in political terms would be the sharing of power, the breaking down of social barriers (Browning, 1989), and the creating of equal opportunities and wealth, especially for the so called *"marginalized or disadvantaged"* individual, group or community (also called social justice). According to Labonte (1989), no one can empower anybody, they can only empower themselves.

This view seemingly contradicts the view of Parenti (1978, p. 7) which states that

others empower the then so-called powerful; *"social - political power is not self-generated but acquired through the attachments of many individual energies, strengths, and talents".*

This links with the essence of the educational perspective which emphasizes enablement: the interactive process between two or more people to develop or build their abilities to set and reach goals (Hawks, 1992).The educational perspective also highlights the assumption that empowerment implies "*ownership of information - the key to learning*" (Thomas Johnson, 1992; p.x).

The normative nature of empowerment cannot be ignored: the process of empowerment for example deals with what is acceptable (right) or not acceptable (wrong) within a given situation. Linked to this complicating "normative" reality is the generally accepted assumption that empowerment cannot be directly measured; data from qualitative analyses might however unravel some of the complexities of empowerment.

4.2.3 WOMEN AND EMPOWERMENT

The study of the dynamics of power in nursing might have been propelled by the international womens' movements where feminism is stated to be about *"the empowerment of all women and change in the conditions of all womens' lives"* (Russo, 1991, p. 298); and if we take into consideration that nursing is predominantly a female profession (Clifford, 1992) with the historical and traditional medicine (male) and nursing (female) power relationship.

According to Wheeler and Chinn (1989) feminists formulated "alternatives" to the traditional patriarchal power model. They see these alternatives not necessarily as opposites, but as contrasts, and emphasize a commitment to these alternatives in a united and consensus-seeking way. The contrasting features of power by Wheeler and Chinn (1989, p. 6-8) are summarized in table 4.1.

Table 4.1: The contrasting features of patriarchal versus feminist power	
PATRIARCHAL POWER	*FEMINIST ALTERNATIVE*
Power of Results *(policies, goals, programs)*	Power of Process (freedom from rigidity)
Power of Prescription *(authority)*	Power of Letting Go (cooperation, consensus)
Power of Division *(centralization to privileged few)*	Power of The Whole (mutual help networks)
Power of Force *(negative sanctioning)*	Power of Collectivity (participating in reaching consensus)
Power of Hierarchy *(linear chain of commands)*	Power of Unity (shared laterally)
Power of Command *(aggressive leader and passive followers)*	Power of Sharing (leadership according to potential, talents, expertise)
Power of Opposites *(polarizes issues)*	Power of Integration (acknowledging context)
Power of Use *(exploitation of resources)*	Power of Nurturing (cherish and respect life and experience)
Power of Accumulation *(for self-interest)*	Power of distribution (share resources equitably and according to need)
Power of Causality *("technology of the conqueror")*	Power of Intuition (totality of human experience)
Power of Expediency *(immediate reward and easiest solution)*	Power of Consciousness (long-range outcomes and ethical behavior)
Power of Xenophobia *(fear of strangers; conformity is rewarded)*	Power of Diversity (alternatives, flexibility)

Table 4.1: The contrasting features of patriarchal versus feminist power

PATRIARCHAL POWER	FEMINIST ALTERNATIVE
Power of Secrets *(mystifies processes, agents and line of command)*	**Power of Responsibility** **(demystifying; naming and being the agent; open criticism)**

4.2.4 EMPOWERMENT: CONCEPT ANALYSIS

When dealing with the abstract and complicated concept of empowerment, it is necessary to analyse the concept in order to clarify relevant knowledge - this is especially crucial where nurses borrow or adopt concepts from other disciplines (Matteson, & Hawkins, 1990). According to Walker and Avant (1983) the identification of defining attributes, antecedents, consequences, and empirical referents are needed, as well as the construction of model and additional cases.

4.2.4.1 The defining attributes of empowerment

In trying to understand reality, one can focus on the things (entities; the what) that we experience or one can focus on the properties or **attributes** that one discerns (the how); or on the relationship between these attributes (Hart, 1984). According to Strauss (1991) these properties normally refer to particular functions or aspects (also called modalities to emphasize their concern with fundamental modes of reality) of those entities.

The theoretical view of the relationship between the different fundamental aspects or modalities of reality form the core of "every theory of reality" (Strauss, 1991:61); and the cosmology or ontology of power is no less richly diverse. The framework used by the researcher was developed by the Dutch lawyer Dooyeweerd (1894 - 1977) and the philosopher Vollenhoven (1892-1978).

The basic premises of the Modality Theory:

- Every modality is unique, irreducible and indefinable;
- Every modality indicates coherence between all the various aspects - intermodal coherence (sphere universality);
- Earlier modalities form the foundation for all the later modalities;
- Each modality has a nucleus of meaning that can't be defined any further;
- A modality can indicate a field of special science, for example the psychical or psychological aspect is the home of psychology;
- Retrocipatory and anticipatory moments of a modality remains qualified by the nucleus of the modal meaning; and
- Modal spheres are founded in the cosmic time order and are determined and limited by it.

The numerical modality

Increasing power by increasing numbers and (ordinal) position

According to Dooyeweerd (1955, p.83) the numerical modality is the *"first modal terminal sphere of our cosmos"*. This (least complex) aspect which is always present, deals with discrete quantity (numbers), either from a cardinal or an ordinal position. It is the home of concepts such as unity, uniqueness and the individual.

Sufficient power (strength) can be derived from different sources; for example the numerical size of the group (Rahman, 1993) - compare the concept "masses" as used in political (and power language). The use of numbers in democratic elections is a concrete force to gain access to power. Nurses, because of their numbers in the health workers' setting, can be very powerful (Gibson, 1991).

The role of the change agent as an individual or as part of a group is often described

as catalytic, participatory, and not as primary or first (Burkey, 1993; Rahman, 1993). It is thus clear that the change agent takes no ordinal "first" position, but is on equal footing with the other individual(s), group(s) or community(ies).

The invisibility of women as political actors is traditionally linked to a conventional definition of politics as being out of the reach of ordinary people and linked to governmental structures and officials (Bookman & Morgan, 1988) -thus a pluralistic perspective. These structures which are traditionally male dominated are pluralistic in character; and are in contrast to the individual or person power of the individual voter.

The spatial modality:

- ***Increasing power by standing together***

The spatial aspect implies the numerical aspect and deals with continuous extension. To transfer the original meaning of continuity to number leads to antinomy (Dooyeweerd, 1955).

The lively debate concerning the whole versus the parts relation with its emphasis on coherence (continuity) finds its origin in the spatial aspect of reality (Strauss, 1989; 1991). The "power" of coherence (standing together) is thus empowering; with five settings of interactive empowerment identified, namely the dyad, small group, organization, community and society (Vogt & Murrell, 1990, as cited by Hawks, 1992).

The modality of perpetual motion or extensive movement:

- ***Increasing power by facilitating positive change***

According to Dooyeweerd (1955) movement is an irreducible aspect of human experience but can not be conceived without referring to the original meaning of space. This aspect finds its meaning in Newton's laws of constant movement (law of inertion) (Strauss, 1989); but can only exist on the basis of the spatial aspect. One also needs to remember that without the basis of constancy (perpetual motion), there

will be no **dynamics** of change (which refers to the following physical aspect [IV]). The unique nature of constancy forms the foundation of change (Strauss, 1991).

Oppression and liberation as political concepts (which are fundamentally linked to freedom, justice and equality) construes a very **dynamic** view of society (Jaggar, 1983). Empowerment (being instrumental in liberation), cannot be a static phenomenon by its very nature as a process, thus continuously moving. One view in line with this argument states that change can become the norm (everything is forever changing) while the opposite view states that change is actually very difficult to effect; that there is a strong resistance to change (Parenti, 1978).

The physical modality:

- ***Increasing power by increasing energy***

In this modality or aspect the core deals with acceleration and energy (potential and actual); thus change and dynamics are of fundamental importance. This aspect is the original home of the cause-effect relationship (Strauss 1978). According to Jones and Meleis (1993) a synonym for power is energy, strength, and effectiveness. Increased and increasing energy will thus be empowering.

The biotic modality:

- ***Increasing power by growth and development***

Life is a fundamental modality, and not a concrete phenomenon according to Dooyeweerd (1955, vol. 2). The biotic aspect deals with the typical life or vital processes, for example, growth, adaptation (acclimitation), self-regulation and self-organization. These concepts were frequently used by system theorists (for example in the social sciences), creating an impression of ecological simplicity.

Sexuality can be seen as essentialist (a natural instinct which needs to be fulfilled by the sexual act and thus part of our **biological** composition) or as a socially, culturally and historically constructed entity (Bhavnani, 1993). Power and powerlessness is however, historically embedded in the biological (sexual)

differences between man and woman where the male is powerful and good, and the woman powerless and bad - sexuality became a powerful way to exert control in society (Chancer, 1992). Sexual differences are imbedded in "nature", but gender in "culture" (Grimshaw, 1986).

According to Accad (1991), sexuality is however, of vital importance to women and a central issue for women of the so-called third world. She notes that the silences concerning for example virginity, masturbation and sexual pleasure are kept out of discoursive reach by autocensorship.

Women often experience their bodies as belonging to and at the disposal of someone else (the male); the womens' health movements thus advocate awareness and ownership of womens' own bodies. Sex-role stereotyping further limited womens' choices in society and often lead to self-defeating behaviours (Fogel & Woods, 1981).

According to Thürmer-Rohr (1991) both men and women suffer from a bodily and biologically based envy: the man from birth envy (the ability to give birth symbolizes woman's power) and the woman from penis envy (the penis symbolizing man's power). According to Foucault the relationship between power and sex is not in essence repressive, but rather *"productive of a ever-proliferating discourse on sexuality"*. The body becomes an instrument and an effect of power; and the superficial concept sex disguises the embedded power relations (Butler, 1992; Sheridan, 1980, p. 165-166).

Growing or development would link to the educational theories of Freire where the experiencing, understanding and creation of one's own (individual and collective) cognitive powers takes preference (Rahman, 1993). Understanding what is happening can in itself be liberating (freeing) and empowering - it frees the learner from belief that they are subject to the capriciousness of fate or personal adequacies (Wilmot, 1993).

According to Keiffer as cited by Chavasse (1992) and Gibson (1991), the development of empowerment can be described in four stages as a long-term and

labour-intensive process of becoming.

1 **Era of entry:** Here the individual's participation is of an exploratory nature; power structures are still demystified.

2 **Era of advancement:** This era is characterized by mentoring and supportive peer relationships which facilitates the understanding of the situation. Here the individual will have opportunities to collaborate and do mutually supportive problem-solving; and in the process develop rudimentary political skills.

3 **Era of incorporation:** Here the individual confronts and overcome the barriers to self-determination. The individual needs to accept the painful constraints or barriers to self-determination.

4 **Era of commitment:** The final stage of maturity where the individual integrates new personal knowledge and skills into the reality of every day.

vi The psychical modality:

- ***Increasing power by increasing feelings of being powerfull***

The psychical aspect focuses on human experience and deals explicitly with feelings (emotions). Psychology as a special science would then study phenomena such as instincts, desires, and emotions - within the conscious or sub-conscious layers of human behavior (Dooyeweerd, 1955; & Strauss, 1978).

Although the feeling of powerfulness is usually gratifying and thus iniates a drive for more power; the result of powerlessness is usually different escaping behaviours; for example alcoholism, crime, hedonism and drug addiction (Parenti, 1978). The

anger of for example, the "Black women" in South Africa is a reality and needs to be recognized and dealt with: *"...we have the problem of a lack of sensitivity or blindness to how race affects us all"* (Gender Research Group, 1991; p. 26).

Another interesting view dealing with the relationship between the powerful (sadist) and the powerless (masochist), also called dominance and subordination,, and which is using the personal experience as the subject at hand, is stated by Chancer (1992, p.1-5). She believes that it aids understanding in terms of an internally transformable dynamic. She thus refers to the so-called *"sadomasochistic dynamic"* meeting the following four criteria:

- The existence of an excessive attachment between the parties.
- A symbiotic type of dependence where both feel the critical need for both physical and psychic connection to the other. The interaction is also in essence repetitive and ritualistic.
- The presence of constant change and movement, with action and reaction. The potential for transformation and thus the reversing of roles is always present (and threatening).
- Individuals and /or groups *"face severe consequences if they should question, talk about or challenge the power of those individuals (or groups) who are structurally more powerful"* (p. 5).

A sadist takes pleasure in the position of power, authority and inequality - they experience or long for confidence and self-assurance, but also paradoxically yearn for recognition, legitimizing, resistance and challenge. Unfortunately, sadism and masochism never resolve the dilemma actually responsible for the development of this relationship or sadomasochism dynamic (Chancer, 1992).

Empowerment in a more individual and personal context refers to a personal positive and gradual process of self-discovery, individual self-assertion and the releasing of creative potential (Gunden & Crissman, 1992). Empowerment leads to upward mobility as well as the affective experiences of *"feeling powerful"* (Bookman &

Morgan, 1988, p. 4). Some feminists refer to the power to be, and to become, a reclaiming of a woman's power (Rosenwasser, 1992; Wetzel, 1993); valuing empowerment as a co-operative and just mode of achieving aims (Chavasse 1992).

The feminist psychologists Worell and Remer (1992; p. 22-23) conceptualize empowerment in two ways:

i) Empowering the woman to deal with her life-situations through flexible problem-solving and the development of a complete range of interpersonal and life-skills; and

ii) Encouraging women to identify and challenge the "external conditions of their lives that devalue and subordinate them as women or as members of minority groups, and that deny equality of opportunity and access to valued resources".

The logical modality:

- *Increasing power by obtaining legitimate power*

Also referred to as the analytical aspect or analytical mode of distinction, and appeals on only the human being's ability to identify and to differentiate. This aspect and all the following aspects are structured normatively, meaning that the human being can behave normatively ("correct") or anti-normatively ("wrong") in a given situation according to stated personal and other societal norms.

The need for empowerment implies that inequalities in power relationships exist, or that, different attributes are identifiable when comparing the powerful and the powerless. This relates to the differences and similarities between powerfulness and powerlessness which requires differentiation.

For women to accept equality with men, they also accept to behave according to patriarchally defined logic and power; not developing a unique female counterforce and identity (Thürmer-Rohr, 1991).

The historical modality:

- ***Increasing power by taking control of the created reality***

Human beings transcend the things of nature; this modality refers to the ability of the human being to create and control culture. Culture forms the power base of controlled creation for humankind (Ouweneel, 1984). Dooyeweerd (1955, Vol. 2, pp. 119-120) states that power, mastery, control and command have different meanings. He is of the opinion that the "fundamental signification appears to be cultural authority over persons or things corresponding to a controlling manner of form-giving according to a free project". Real power over people is always consolidated in cultural forms, and can not be reduced to only the feeling aspect of reality (psychical).

The historical aspect is related to the development of human mastery, command, control or power. The unique ability of human beings to freely control material (persons and things) and to deal with it in a reflective and productive way denotes the essence of culture. Tradition's task is to guarantee the continuity of cultural development; *"the struggle for power between tradition and progress is inherent in the shaping of history"* (Dooyeweerd, 1955, Vol. 2, p. 243).

According to Foucault (1972, p. 13) history is embedded in a theme of continuity, openness and development - not a system, but an *"effort of consciousness turned upon itself, trying to grasp itself in its deepest conditions"*.

The creation and development of major institutions as well as their ultimate authoritarian frameworks (both legally and traditional) gave rise to structures imbedded in power and control - often through the monopolization of privileged positions (Parenti, 1978).

Most patriarchal societies have reinforced the idea of associating women (femineity) with nature and the domestic realm (as not essential); and with qualities such as empathy, understanding, love, concern and patience. Men (masculinity) were seen

as the projects of culture (as essential), symbolizing strength (power) and rationality (Chancer, 1992; Thürmer-Rohr, 1991).

The growth of womens' history since the 1970s was linked to the development of womens' liberation movements as well as the emphasis on the neglected and marginalized by the human sciences, for example Anthropology. The revival of womens' movements led to the revival of the writing down of womens' history - women being traditionally absent or invisible in major historical books. Feminist historians had the mammoth task of restoring womens' contributions to the development of humankind and to develop a distinct woman-centred approach to history. Concepts such as patriarchy, inequality and oppression are used to contextualize womens' experiences (Hannam, 1993).

The earlier years of womens' history focused on a more functionalist approach to female physiology, body, sexuality and motherhood; but then moved to analysing the imbedded tensions between, and contradictions in, the masculine and the feminine - thus radicalizing female consciousness and demanding a new language (Farge, 1987; Foster, 1989).

ix The modality of symbolic signification:

□ *Increasing power by using the language of power*

According to Thompson (1984) symbolic forms include a variety of images, texts, actions and utterances which can be linguistic or non-linguistic in nature. Language and the meaningfulness of language are of paramount importance in the development of humankind and culture - but concrete entities also exhibit meaning; for example status symbols. Language controls our perceptions, defines the meaning of our experiences, influences the ease of communication and provides an instrument to exert social influence.

The models of discourse, for example a structuralist (where language is a symbolic system or code) versus a more pragmatic approach (where language is seen as sets of historically institutionalized practices and where the social context and practice

of communication is emphasized) all in essence, refers or acknowledges the power of language. These discourses illuminate the processes whereby for example power, authority, inequality and oppression are formed and transferred (Fraser, 1992).

The role of language in the production of meaning was re-emphasized by the philosopher Jacques Lacan; language pre-exists the birth of an infant and thus identifies and orders masculinity and femininity. Everyday language stipulates boundaries and privileges; for example regarding power relationships (Alexander, 1991). Foucault (1972) also emphasizes the conscious and unconscious activities that take place; for example the intention of the speaker, the invisible text.

Feminists are quite concerned about the inherent sexism of language where the male is taken as the norm, as well as the absence of certain words to describe womens' experiences (especially womens' sexuality). The definition of the concept "woman" and "man" often portrays a distinct sexual stereotyping, and womens' speech is often described as more uncertain and hesitant, and lacking authority. Research has however, pointed out that womens' speech is more supportive and co-operative than men's (which are traditionally more of a competitive nature) (United Nations, 1991).

Women writers, for example Rich, Wittig, Grahn and Walker have developed the metaphor of lesbian as a new, independent (from men) and powerful concept to redefine female creativity. The concept is not necessarily used in sexual terms only, but depicts the tender presence and attention of women to women - of a common language of honesty, trust and truth spoken together (Farwell, 1989).

Some women criticize the use of a so-called academic or intellectual language and prefer accessible language that will actually facilitate the reader's and / or listener's insight into the material at hand (Gender Research Group, 1991).

The modality of social intercourse:

- ***Increasing power by sharing and using networks***

This aspect deals with the human being in a multitude of relationships with other

beings, for example, social involvement and community structures. The individual is involved in a multitude of social relationships at a particular moment in time, for example family member, church member and employee. Within these relations the individual will experience different degrees of power (and powerlessness).

The traditional subject - object relationship relates to a relationship where the (a) object is under the power of subject (so-called power-subject); and where sharing and / or delegation of authority of specified scope is conferred on the object according to the discretion of the subject. The power base of the subject is, according to Reading's Freudian terminology (1977), based on the alter's belief of the ego's skills.

According to Cliff (1992) a person is turned into an object in the mind of the oppressor in the process of objectification - the person becomes dehumanized and the "Other". This person then loses her or his self-identity and culture and values become part of a so-called sub-culture. In racist situations the black woman became a double-object: - as a black and as a woman. According to Thürmer-Rohr (1991) the so-called "feminization of society" is misleading and a product of men's creativity to control women.

Power can be derived from social awareness; from a collective self-enquiry and reflection (Rahman, 1993, p.206), which is placed on an equal footing with the so called *"formally 'educated' classes of society".*

Although the sharing of power among equals is a well-known socialistic principle, the legitimation of classes and accompanying characteristics is a thorny issue in the social sciences (Parenti, 1978). According to Rahman (1993) empowerment deals with enabling the people to articulate and to assert their thinking and urges concerning the dimensions of social development, which is definitely not a top-down approach. This "powerful", but delicate process might create a dialectical tension between people's participation and people's organization; confronting but needing one another!

According to Clifford (1992, p.1) empowerment is a process *"which grows from the*

grass roots up", and will thus come into being when the individual and / or group re-evaluate and change their perceptions concerning the causes of powerlessness; recognize the systemic forces that oppress them, and act to change the condition(s) of their lives (Bookman & Morgan, 1988). According to Burkey (1993) meaningful participation is a key characteristic of empowerment; the major effort is to be concentrated upon this process of participation.

Kieffer (1984, pp.18-25) described four distinct phases of empowerment as a developmental process in analysing citizen empowerment:

i) Era of entry (de-mythification of power and mobilizing of the self);

ii) Era of advancement (increased engagement in and understanding of political activities);

iii) Era of incorporation (overcoming obstacles and sharpening political competence); and

iv) Era of commitment (restructure own involvement and commitment to continuous mobilization).

The economical modality:

□ *Increasing power by obtaining and sharing rewards*

The economic aspect deals not with only the cost of things or activities; but also with the utilization of scarce resources. In dealing with scarce resources the relationship between those who have or sell and those who have not or buy come into play. When dealing with the process of actual sharing (giving and receiving) or "sale" (selling and buying) - often called the "(only) moment of truth", the relationship orientation versus the transaction orientation come to the fore. The relationship orientation or customer focus is seen as empowering both parties or groups involved; the business of management thus being people, and not finance (Thomas Johnson, 1992).

In traditional class-dominated societies the economic power would be in the hands

of a small group of people; - this economic power gives a vast amount of political power to this group. Institutions would then try to serve the interests of those with power and entrench the status quo (Lerner, 1986).

When considering the equal distribution of scarce resources, the conflict of **needs versus power** as primary consideration, needs attention - the so-called profit and financial interest as purpose in capitalist, versus the needs as purpose in philanthropical societies (Parenti, 1978). The traditional powerless group(s), for example women, will often lack access to certain power resources and participatory roles (Parenti, 1978).

Political freedom without economic power might be empty; especially if one accepts the assumption that economic empowerment is complementary to the political process. Economic empowerment is not a substitute or an alternative to the political process, but can accelerate political change (Browning, 1989).

According to Rahman (1993, p. 206) a quantitative element of empowerment is control over economic resources, but "*progress in this matter is by itself no indication of enhanced social power of the underprivileged*". The quest for control (for example profit, money and wealth) can also symbolize a desire for (em)power(ment). The so-called "bottom-up" approach which emphasizes the sharing of information, empowers workers to adapt to and to initiate change in, for example, the workplace. This approach implies amongst others:

- The continuous removement of constraints;
- Creating an environment conducive to learning;
- Building and incorporating flexibility;
- Building loyalty; and
- Increasing shared ownership

(Thomas Johnson, 1992).

The aesthetic modality:

□ *Increasing power by being creative*

The essence of the aesthetic modality deals with harmony and beauty; the purpose and meaning of artistic creation is not clearly defined in terms of power relationships. Art has been seen as instrumental in the struggle for justice (instrumental in obtaining or keeping of power); as an expression of that which already was, is existing, or is still to come (power to portray reality); or as a pure aesthetic and / or emotional experience (power to instill feelings or emotions).

Feminists are especially interested in how women of different cultures and their work are presented, or how women present themselves in the different forms of art and the media. The written word, which can be seen as an indication of imbedded social attitudes, generally portrayed women as characterless, inferior and irrational - this phenomenon was present in for example classical, Hebraic and Christian writings. Samuel Butler in the seventeenth century stated that womens' souls are so small that some believe that they have none at all; while the Spectator in the eighteenth century stated that the souls of women were made out of different materials, for example a fox, canine particles, earth, sea, a beast of burden, an ape and a cat (Atallah, 1987).

The well known "to-be-looked-at-ness" (also referred to as the "gaze") of women as opposed to, for example men and this phenomenon's relationship to pornography is well documented (Bonner, Goodman, Allen, Janes, & King; 1992). In the film industry, women were often made into passive objects with limited expression; men often possessing the desire and women receiving the punishment (Modleski, 1988). The popular image of women as nurses has also not reflected changes that took place in the profession, and stereotypes such as "the ministering angel" (emphasizing caring and dedication), the "battleaxe" (focussing on the overweight and authoritarian nurse), "the naughty nurse" (so-called "sexual mascots"), and "the doctor's handmaiden" (supporting the power and superiority of the medical profession) are still portrayed and communicated in television programmes and other

media (Bridges, 1990).

In South African art, a call to study and portray not only the external conditions of apartheid, but also to explore the minds of South Africans to determine how apartheid has settled internally in their consciousness was done at the Zabalaza festival in London during June 1990 (Levy, 1993).

> *"We have begun to assert ourselves;*
> *to mobilise our consciousness*
> *to banish the strictures of ignorance*
> *and the hideous mythologies of fear.*
> *Together we must sculpt and pare*
> *the forms of our various lives*
> *and in all ways possible*
> *urge and celebrate our thoughts*
> *to move in this cycle*
> *of ever-renewing cycles of life*
> *and to finally create*
> *a vibrant aesthetic of our being*
> *so that we may hold*
> *our lives in our hearts* *(Espin, 1993, p. 226)*

Most women in South Africa historically suffer from oppression because of their race, class and gender; the traditional portrayal of women as weak often made room for the portrayal of women as strong and bold (a Mother Africa image) which was politically acceptable - portraying the liberation of women. According to Mabie (1993) both these portrayals were unrealistic and not a true reflection of women.

xiii The juridical modality:

- ***Increasing power by distributing power fairly***

This modality deals with justice and fairness - usually enacted by law. The international history of womens' struggle to gain equality before the law is well documented. The Norwegian juridical reality of actually stating (in the Equal Status

Act of 1978) that it will *"improve the position of women"* and that women may acquire special rights in connection with, for example pregnancy, childbirth and nursing is however, an exception which can be viewed as not being gender-neutral (Bystydzienski, 1992, p. 19-21).

According to Maynard (1993), the law has major power in that legal definitions stipulate and outline the activities of for example, the police and social services. Legal definitions tend to be narrow and authoritative, and do not often include womens' perspectives and/or experiences. Examples of such problematic areas would be violence against women, sexual rights, sexual abuse and pornography. In studying the most frequent arrests for women in 1985 in the United States of America, it was clear that arrests for larceny-theft (20.5%) and driving under the influence (10.5%) occurred most frequently. These were in essence non-violent crimes. An increase in womens' arrests indicated not increased violence, but an increase in economic crimes (Diaz-Cotto, 1991).

The Reproductive Health Caucus (1995, p. 1) strongly advocates the implementation of measures to ensure the sexual and reproductive rights of women all over the world and states that because of *"womens' inferior status in many societies and lack of information, women are powerless to protect themselves"*. Stevens (1995) urges women to protest against religious lobbying groups such as the Holy See (representing the Vatican and thus Catholics worldwide) who tries to block issues such as the expansion of sexual rights and the use of concepts such as gender, and womens' and men's equality at the United Nations.

Rawls' well known conceptualizations of fairness or justice emphasizes the proper distribution of the benefits and burdens of power; certainly appropriate to the situation of oppressed or disadvantaged women (Wetzel, 1993). Women commonly demand equity, protection, respect democracy and no discrimination. These demands and the "legal concept of gender equality are enshrined in the 1948 *Universal Declaration of Human Rights*, as well as in the 1979 United Nations *Convention on the elimination of All Forms of Discrimination against Women*" (United Nations, 1991, p. 6).

xiv The ethical modality:

☐ *Increasing power by caring*

"*Love, as the moral modality of human experience, cannot exist apart from its immediate foundation in the retributive meaning of the juridical aspect*"; and love implies a relationship with fellow human beings (Dooyeweerd, 1955, p. 152). This aspect deals with love and to do good (to care).

According to Greer (1990, p. 12) the "*proper subject for love is one's equal, seeing as the essence of love is to be mutual, and the lesser cannot produce anything greater than itself ... it is love that forms communities, from the smallest groups to the highest*", and men and women do love differently.

Grimshaw (1986) states that there is limited agreement on ethical priorities for women; the "different" moral reasoning of women are often questioned; and notions considered to be associated with women, can be used oppressively.

Morality and love is often engineered and (mis)used by those in power - emphasizing conformity and exploitation. The masculine is now recognized as the determiner, destroyer and threat to humanity, leaving women in a moral empty space (Thürmer-Rohr, 1991).

According to Lind, Wilbur and Pate (1986) moral and ethical issues are essentially about power - and feminism seeks to change the power structure of ethics. The power-from-within (rather than power over) which relates to a horizontal sharing of information and decision-making, and emphasizes connectedness. Feminist ethicists might rather feel that fairness (an ethics of rights or justice; treating everyone the same) is not the only moral value. Individuals and groups may and would often like to make a different, contextual and caring choice from within the situation (an ethics of care).

Some feminists were reluctant and or cautious to emphasize the concept of caring in their work because they feared that this attempt would be used against women and force the duty of caring back to women only; caring then defined as needed by

patriarchal institutions. Other feminists, such as Carol Gilligan and Nel Noddings, placed caring in a very central position when exploring feminist ethics (Cole & Coultrap-McQuin, 1992; Gordon, 1991).

According to Aroskar (1987) politics (which refers to power relations between leaders and followers) and ethics interface at three different levels:

- **Micro political:** The relationship between the nurse, patient and physician with conflicting needs and choices;
- **Intermediate political:** Functions within institutions or organizations to develop policies (for example ethics committees); and
- **Macro political:** Referring to public policy and the distribution of scarce resources (for example acute and long term health care facilities).

The modality of faith or belief:

- *Increasing power by believing*

This aspect is found in all human beings and should not be confused with religion. According to Dooyeweerd (1955) it is the only modal meaning-nucleus that transcends or points above time and is thus linked to the root or origin of temporal existence. An example of such faith would be man's faith in the sovereignty of natural-scientific thought as characterized by the Humanistic science-ideal.

Carol Christ differentiates womens' spiritual needs (for example their deepest longings and fundamental beliefs) from their psychological needs. Judith Plaskow argues that womens' central mistake can be described as the deep belief that women must deny the development of the self, while men are criticized for the strong belief in themselves (egocentricity) (Yates, 1983).

A different individualistic and personal approach to empowerment is in dealing with the human being's inherent and perceived powerful ability to transcend reality and

to access nonordinary reality by using different practices; for example sonic driving (drumming), isolation, fasting, concentrating on a regular breathing pattern, dancing and singing. The psychophysical process of *entrainment* (referring to the induction of a changed state of consciousness) is used to gain access to this nonordinary reality. The ecstatic state of being generates and is powerful tools for healing and transformation (Doore, 1988).

> *"When we get together in the healing circles, we begin to drum, we begin to pray I suppose you'd say, asking the healing power to be with us. And it immediately begins to come forth through the body ... it's very* ***empowering****, and it's hot. It's literally hot"* (Vicki Noble in an interview with Rosenwasser, 1992).

The shamanic world view emphasizes the interconnectedness of all parts of the world, everything in the whole universe is alive and sacred, and the objects that we can see are just as important as those that we cannot see (they are just manifestations of larger patterns of energy (Doore, 1988; Kremer, 1988 & Mehl, 1988).

The defining attributes of empowerment using the modality theory are summarized in table 4.2.

Table 4.2: The defining attributes of empowerment using the modality theory

MODALITY		DEFINING ATTRIBUTE
I	Numerical	**Increase numbers and position**
II	Spatial	**Stand together**
III	Extensive movement	**Facilitate positive change**
IV	Physical	**Increase energy**
V	Biotic	**Facilitate growth and development**
VI	Psychical	**Facilitate feelings of powerfulness**
VII	Logical	**Obtain and foster legitimate power**
VIII	Historical	**Taking control of created reality**

Table 4.2: The defining attributes of empowerment using the modality theory	
MODALITY	DEFINING ATTRIBUTE
IX Symbolic	**Use a language of power**
X Social	**Build and utilize networks**
XI Economical	**Obtain and distribute rewards**
XII Aesthetic	**Be creative**
XIII Juridical	**Be fair**
XIV Ethical	**Be caring**
XV Faith	**Believe**

4.2.4.2 Antecedents to empowerment

Antecedents are *"those events which must occur prior to the occurrence of the concept"* (Walker & Avant, 1983, p. 33). When identifying the antecedents to empowerment, the antecedents can usually be placed into the following key categories:

I) Actual or potential powerlessness;

II) Affective aspects of powerlessness; and

III) A readiness to be engaged.

Table 4.3 summarizes the categories of powerlessness and the related antecedents.

Table 4.3: The categories of powerlessness and related antecedents

CATEGORY LABEL	ANTECEDENT
I) **ACTUAL OR POTENTIAL POWERLESS-NESS**	Being powerless (perceived to have no power in a specific situation)
	Having power; but there is an actual or potential threat of losing power within a specific situation
	Not having enough power or weakening of power; for example individual or collective loss or weakening of negotiation position in relation to the negotiating position of other people
	Belonging to a disempowered group which creates the perception and / or belief of being powerless
II) **AFFECTIVE ASPECTS OF POWERLESS-NESS**	Hopelessness
	Distrust / fear
	Hostility / anger
	Alienation

Table 4.3: The categories of powerlessness and related antecedents	
CATEGORY LABEL	ANTECEDENT
III) PRESENCE OF A READINESS TO BE ENGAGED	A willingness to participate and to assume responsibility
	A belief or trust in the capabilities and capacity for growth and development which is seated in the individual or group themselves
	A willingness to take risks
	The existence (or the possibility) of competencies needed if given the opportunity to apply
	Acceptance of behaviours that encourage empowerment
	Value the symbolic significance of the situation or happening
	Loyalty - willingness and ability to stand behind, beside and for the stated cause(s)

The antecedents of the category of actual or potential powerlessness can be placed on a continuum - see table 4.4.

Table 4.4: The continuum of actual or potential powerlessness			
Being power-less in a specific situation	Having power, but not enough	Having power but might loose it (real or perceived threat)	Belonging to a disempowered group

4.2.4.3 Consequences of empowerment

The consequences of empowerment refer to the events or incidents which occur as a result of the occurrence of the concept (Walker & Avant, 1983).

The literature states the following consequences or outcomes:

- A sense of power, control, hope and satisfaction (Gibson, 1991; Mason, Costello-Nickitas, Scanlan, & Magnuson, date unknown);
- An increased ability to set and reach goals (Hawks, 1992);
- Increased knowledge, information, understanding and connectedness or involvement;
- Increased intellectual reflection and ethically acceptable behaviour; and
- Openness to the possibility of becoming the victimizers (the oppressors), and later the victimized (oppressed) again - a cyclic phenomenon (Chancer, 1992) - this might not be perceived to be an essential consequence.

4.2.4.4 A model and contradictory case of empowerment

A model case of empowerment might be portrayed in the following scenario:

Unafungwase's (Zulu: meaning the second oldest child and the first born daughter) parents were poor and living in a small coastal village. She was the second eldest of eight children. Her mother, who was a strong

minded and dedicated women, motivated Unafungwase to go to school and to study hard. Unafungwase persevered, even in difficult circumstances (for example no electricity or water in the house, and walking seven kilometres to school every day), to complete high school and to obtain good results in the final year. Unafungwase decided that she will not allow the constraints of her personal circumstances (including the political situation that placed Africans at an historic disadvantaged position) to hamper her growth and the reaching of her goals.

Unafungwase was fond of participating in the local community youth club and eventually became the chairperson. She and her friends initiated projects such as a local drum majorette and choir competition. Unafungwase's older brother left school at an early age and went to work in the local clothing factory.

Unafungwase applied to read for a degree in law at a university about two hundred kilometres from home. With the help of her older brother and with a small bursary from the owner of a local supermarket (where she worked over week-ends), she managed to meet the financial obligations of the programme. She also joined a peer discussion group where they together studied and discussed the objectives and the literature of the different courses. During weekends she worked long hours at a local take-away food outlet to strengthen her poor financial position. She also attended voluntary classes to strengthen her command of the English language; as her mother tongue was Zulu.

She met an attractive young guy who was also studying law. The two of them together (still as students) decided to become partners in a project to provide a free legal advice service to her local community. After completing their practical requirements (article years) at an urban law firm, they decided to get married and to open a small legal practice. They soon became well known and accepted by the people in their neighbourhood and community; Unafungwase initiated community legal aid projects such as the "Young Legal Eagles Club" for street children and the "ABC of the Law" course for different age groups.

Many of her community members described Unafungwase as a happy person; a person of strong character and conviction - someone who used her inner power to reach meaningful objectives. They felt that she was willing to share what she had, with her fellow human beings. They soon called her "Unkozikazi ohloniphekile obambisene nomphakathi: The woman who has and shares power".

A contradictory case of empowerment might be:

Inkosazana's (Zulu: meaning the only daughter and the youngest child) family was rich and an important member of the community. Her father was the mayor and the owner of the local shopping complex. Inkosazana was the only daughter and the youngest of four children. She was sent to a private school in the local town at a very young age. She made friends

with Sue and Donna who invited her to work with them in the local night club as a 'waiter'. Inkosazana soon became disinterested in her school work and spent many hours at the night club: drinking, singing and enjoying any sexual attention. She often did not attend school and refused to make regular contact with her parents.

Inkosazana felt a deep awareness inside of her that she could not adequately cope with the realities and expectations of life and survival; she often voiced a raw anger towards and helplessness to deal with what she called the "system of politics in the country".

Inkosazana eventually became involved with a group of casual acquaintances who introduced her to the use of habit forming drugs. While writing her standard eight examinations Inkosazana disappeared. She was apparently admitted in the local hospital with the diagnosis of "drug overdose" - she was found in a dark alley in the centre of town - a fragile, deserted and desperate young woman. At the health care setting it was also determined that she was pregnant. The health personnel contacted her family telephonically; the old and tired voice on the other side just said that he could not remember having a daughter and then put the receiver down ...

The old women of the community where she came from, who sat everyday in the shade of the Big Tree next to the shopping centre made soft and continuous clicking sounds when someone mentioned her or her

parents' names, saying: "Unkosikazi obengahlonipheka kodwa kwam lahleka - The young woman who lost the power that could have been".

4.3 PHILOSOPHICAL FOUNDATIONS OF POWER

4.3.1 IDEOLOGY AND POWER

Social scientists make frequent use of the concept ideology, which is historically a politically charged concept denoting a symbol system with traditional negative or positive connotations. The negative connotation refers *to a "false consciousness or deception"* which negatively influences man's insight into social reality, and a positive connotation which is usually linked to a mere expression of world-views (Larrain, 1979, p.13-16).

Thompson (1984, p. 4) calls the second possibility a *"neutral conception"* of ideology; but he refers to a *"critical conception of ideology"* where it preserves its negative edge in the study of asymmetrical relations of power and the study of relations of domination - especially in class societies - Thompson thus moved away from the more negative conception of an ideology, to using it as an analytical tool to theorize about human societies (Van Niekerk, 1993). Thompson refers to three ways in which an ideology operates, namely by presenting itself as legitimate, as something other than what it really is (dissimulation), and by presenting a state of affairs as permanent and outside the realms of time (reification).

The emergence of new theories of ideology during the last twenty years signified new ways of dealing with the "lived" and conscious realities of social life and social reconstruction - of breaking with traditional and historical approaches.

Language (as an instrument of meaning and power) is generally recognized as vital

in understanding a social or cultural reality. An ideology, which is usually a hidden and not necessarily a conscious structure in any discourse, needs to be decodified and analysed. An ideology will sustain itself by being presented through language and meaning as legitimate and permanent, and by trying to conceal relations of dominance. An ideology thus defines what should be publicly discussed and what should not; it infuses meaning with power (Thompson, 1984).

A satisfactory analysis of relations of dominance (power and powerlessness) in contemporary society needs to recognize the interrelatedness of phenomena such as *"racism, sexism and the system of nation-states"* (Thompson, 1984, p. 130). Feminism as a critical ideology analyses asymmetrical relationships of power in modern society and tries to define and guide public and private discourse. Feminism explicitly studies knowledge, language, relationships and meaning as it is infused with power. According to Delphy (1987) feminists in their struggle with ideology and ideologies, need to explain womens' oppression and subordination on the one hand, and on the other hand give women a fresh understanding of themselves.

The concept women is not static and given; but is used in discourse (especially of the post-structuralist) as a constantly changing and evolving category with a multiplicity of meanings across "*time, place and context*" (Bhavnani, 1993, p. 64-65).

Bhavnani (1993) states that Womens' Studies are using four key concepts to describe and to challenge the processes fundamental to feminist critiques:

- **Erasure** — Womens' contributions often being erased from academic work.
- **Denial** — Writers are denying the unique way in which women can contribute to and challenge the current social order.
- **Invisible** — Women are absent from most of social theory.
- **Tokenism** — Women are acknowledged, but the power imbalances between men and women are not acknowledged and analysed.

Black feminist ideology is traditionally faced with the so-called "triple jeopardy" of racism, classism, and sexism. Unfortunately, black women are often excluded from

many feminists' writing - thus **erasing** or excluding black women and creating an image of **invisibility** of black women. It is the whiteness that often signals *"power and privilege"* (Bhavnani, 1993, p. 33). According to Russo (1991) white feminists need to be honest about their perceived privileges and need to respond to the challenges of social and political alliance with women of colour.

Racial solidarity and race liberation usually takes precedence for black women in a racist society; and these women play powerful roles in liberation politics. According to King (1989) black womens' feminist ideology is rooted in their reality - and emphasizes both being black and being woman. Black feminists challenges the interrelated oppressing nature of sexism, racism and classism. The black woman needs to be portrayed as powerful and self-determining; able and willing to define her (their) own reality and aims.

In referring to so-called third world womens' writings, Mohanty, Russo and Torres (1991) states that these women consistently analyse the complex relationships between feminist, antiracist and nationalist struggle. She emphasizes the necessity to view race and gender as relational terms; and the imbedded relations of power within these concepts. Walker (1983) coins and prefers the concept *womanist* as referring to a broader struggle and a deep longing for an interconnectedness amongst people irrespective of gender, race and exploitation.

4.3.2 WOMEN AND FEMINISM

According to Flax (1983, as cited by Grimshaw, 1986) classical and traditional philosophical theories seem to reflect male experiences by denying the interactive character of human development; by separating the knower from what is known; by emphasizing opposition between for example mind and body and reason and passion, by emphasizing themes of mastery and dominance; by expressing fear of women and sexuality; and by devaluating all that is associated with women. A

feminist philosophy on the other hand, values womens' contribution as related to their unique nature, qualities, behaviour and experience.

The meaning of the concept "feminism" (originally from the Latin *femina* and the French *féminisme*) is constantly changing; and feminist authors actually find unity in their attention to differences (Tong, 1989). The core concept in any theory dealing with feminism is "woman" - which immediately highlights the ever-present and contrasting "other" (or male). All knowledge concerning women is in essence contaminated with misogyny and sexism; and feminists are faced with the difficult task of either exclusively describing and evaluating women, or to deconstruct all concepts of women and replace gender with a plurality of difference (Alcoff, 1989). Feminists also tend to appreciate a more social constructionistic approach dealing with change, discontinuity and contradiction (Stacey, 1993).

According to Nichols (1982) definitions of feminism fall into two categories: the first category dealing with the social, political and economic equality with men, while the second category emphasises equal "*rights*" with men. Nichols (1982, p. 209) defines feminism as a "political philosophy which recognizes and upholds the human rights of the individual woman"; it refers to all those individuals and / or groups who want to end woman's subordination (also referred to as oppression) - the so-called womens' liberation. Feminism thus becomes a conscious political movement when women with their distinctive needs and perceptions of themselves and their status distinguish themselves from their male counterparts to fulfil their own demands and aspirations (Alexander, 1991; Bhavnani, 1993; Jaggar, 1983). Developing stark male or female viewpoints might, however, lead to a false universalism (which disregards individual differences), idealisation (of for example womens' powerlessness or men's powerfulness) and exclusiveness of a particular group (Grimshaw, 1986).

It needs to be realized that the concepts "feminism" and "feminist" encroach on every facet of womens' (and men's to a certain extent) lives and are therefore inclined to be or to become very emotionally laden. The concepts are often disliked by many women because of its perceived radical and political undertones. Some women feel that feminists tend to be aggressive and militant; that women should remain wholly

women (retaining their so-called femininity), that feminism is old-fashioned and that women should take advantage of the differences between men and women (Atallah, 1987).

The concepts are also questioned by many so called third world women, and by black women, mainly because of its historical links with cultural imperialism. The meaning of gender in terms of western, middle-class (bourgeois), white experiences, as well as internal racism, classism and homophobia are usually unacceptable (Bonner, Goodman, Allen, Janes & King, 1992; Bhavnani, 1993; Bookman & Morgen, 1988; Mohanty, Russo & Torres, 1991; Russell, 1989).

According to Bhavnani (1993) feminist thought and theory is in essence epistemological in nature; emphasizing situated knowledge and limited location. It is also difficult to categorize feminist thought - feminist theorists tend to ignore the so-called logical and "male-invented" artificial boundaries; but the following main streams can be and are traditionally identified:

4.3.2.1 Liberal feminism

Although feminism dates from the early 1830's and abolitionism (a radical anti-slavery movement), the early 19th century saw the awakening of the struggle for womens' liberalization (McElroy, 1982).

Liberal political thought concerns itself with the essential, unique and equal capacity and potential of humans as individuals to think rationally, either morally or prudentially. Liberalism tried to identify the essence of rationality either in the ability to grasp moral principles or as a mere (instrumental) capacity to develop the best way(s) to reach certain aims - in essence an egoism (Jaggar, 1983). Liberalists endeavoured to identify timeless and universal principles and the upholding of basic egalitarian and human values became a key issue. The State became instrumental in guaranteeing these fundamental values. Classic liberals (which were more linked to the capitalist economic ideal) concentrated on protecting civil liberties and provide equal opportunities; while the welfare liberals (more sympathetic to socialist ideals) more strongly focused on economic justice, and on intervention where differences

were too great (Jaggar, 1983; Tong, 1989).

Womens' capacity to think rationally was apparently doubted by prominent philosophers, for example Hume, Rouseau, Kant and Hegel. The democratic ideals of equality and liberty embedded in the woman's capability to reason, thus formed the essence and motivation for nineteenth-century feminists. The primary issue was suffrage and related issues included freedom of speech, property rights, educational parity and reciprocal responsibilities. The primary advocates of feminist liberalism were Mary Wollstonecraft (1759 - 1799), John Stuart Mill, and Harriet Taylor Mill. Through the using the principle of utility (the greatest happiness of the greatest number) they emphasized the woman's equal ability to reason, to accept and handle moral responsibility, as well as the ability to make autonomous decisions. They argued that the lack of educational opportunities embedded in society's customs and traditions was responsible for womens' underdeveloped rational capacities and her non-participation in the free (capitalist) market (Jaggar,1983; Nye, 1988; Tong, 1989).

"Modern" feminist liberalists (twentieth century) fought against for example, discriminatory laws, unequal employment opportunities and insufficient maternity benefits. They strive towards the humanistic ideal of an "androgynous society" where individuals, irrespective of gender, will fully develop their own unique potential and interests (Jaggar, 1983). The most important and uniting goal of modern liberal feminists like Betty Friedan, Elizabeth Holtzman and Pat Schroeder still is **sexual equality** or gender justice (Tong, 1989).

Examples of problematic issues that feminist liberalism needs to face are:

- The strong emphasis placed on intellect (rationality); traditionally linked to men and maleness (culture) versus women and their body (nature) (Jaggar, 1983);
- The absence of context or situation in liberalism with its strong emphasis on "formal" and abstract equality (Jaggar, 1983);
- The social barriers which fall outside the scope of the law (de facto) still limit

womens' progression and foster the upholding of discrimination and the development of stereotypes, for example in the mass media and low status professions (Nye, 1988);

- The conflict concerning the "rational marriage" of different or even opposing rights, for example in the discussions concerning womens' pornography, and the woman's right to abortion versus the foetus's right to live (Nye, 1988); and
- The dialectic tension between the so-called "rational behaviour of men" and the "irrational behaviour of women" - they are not conceptually separable and the one actually needs the other to exist.

4.3.2.2 Marxist feminism

Marxism as a political theory came to the forefront in the middle of the nineteenth century, basically as a revolt against a capitalist and industry-based society; and was a major contrast to liberalism. In contrast to the liberalists' upliftment of rational thought as the key human activity, Marxism acknowledges the importance of the human's physical and biological needs. These needs are important determinants of social life; and human activity (*praxis*) is in essence social, conscious, definite and purposeful (Jaggar, 1983). Marx (1976, p. 13) stated very clearly that *"social life is essentially* ***practical****. All mysteries which mislead theory to mysticism find their rational solution in human practice and in the comprehension of this practice"*.

Eventually, human nature becomes the product of the society that it is embedded in, thus emphasizing the historical context which is determined by the mode of production (in essence means of existence) of that particular society.

The method of historical materialism investigates human nature empirically within a historical context by focussing on the prevailing method{s} of production, explaining *"man's 'knowing' by his 'being', instead of, as heretofore, his 'being' by his 'knowing'"* (Engels, 1976; p. 180). A historical materialist analysis of society will have to take account of classes and class struggles in a given society (Jaggar, 1983; Marx & Engels, 1976). Class became the determining social experience and the key to understand all social phenomena. Marxist thinking also found meaning in a system

of ideologies; ideologies which outlined the beliefs and values used to account for and justify social behaviour. The bourgeoisie as the so-called dominant class with their strong focus on self-interest and the development of instruments of production, historically played the most revolutionary role in controlling (has the power over) the production of these ideologies. The only perceived cure for this situation was the abolition of capitalism and the development of socialism where every human being in a society has an equal share of control and ownership -the so-called proletarian revolution (Engels, 1976; Jaggar, 1983).

Socialist feminists tried to secure some key elements of Marxist thought; for example political economy, and historical and dialectical materialism. Socialists however, avoided sexual antagonism and relayed all historical differences to class struggles (Alexander, 1991).

Clara Zetkin (a German Marxist feminist) and Alexandra Kollontai (Russian), valued Marxism as the starting point of liberation and a new womens' movement; a way to understand the struggles of women and the contradictions embedded in womens' lives. Zetkin tried to understand womens' oppression within the broader context of socioeconomic evolution and analysed womens' unique conditions of living and especially working. She explored the interconnections between class exploitation, racist oppression and male supremacy, but always advocated the importance of peace within the struggle (Davis, 1984).

A gulf developed however, between Marxist political leadership and these feminists; especially concerning questions of sexuality. Lenin as a conservative regarding sexual matters, saw all the discussions on sexuality as dangerous and unnecessary (sex being beyond the scope of politics; having nothing to do with production, being something private and not to be spoken about). Women were however, not willing to keep silent.

According to Zetkin and Goldman, socialist women had to work out new relationships and sexual practices as members of the proletariat. Women were now independent ("single") and working; purposeful and self-affirmative - with the built-in freedom to love and to develop relationships (which is more vital to emancipation than the right

to vote). Women also had no known property which can corrupt them and thus should lead the way in dealing with socialistic issues.

Efforts for example, to acknowledge housework as productive labour, to voice dissatisfaction with their domestic lives and to change the representation and exploitation of women in popular culture, science and philosophy, were carried out by marxist feminists; but the sexist emphasis on man's work and production remained fundamentally part of Marxist theory - the woman supposed to be struggling with (and not against) her husband (Jaggar, 1983; Nye, 1988).

4.3.2.3 Radical feminism

The radical feminist movement (initiated in the late 1960s) overtly opposed the tyranny of men and male power - womens' oppression being the most fundamental, deepest, widest and most difficult to eradicate form of oppression; and thus leading to rage, grief and a deep evaluation of the value and worth of women. Radical feminists tried to remove the blinkers used by a male-dominated society by gaining a thorough theoretical understanding of the ways in which men and patriarchy (rule by the fathers) try to control (having power over) womens' lives and bodies. Examples of these established "controls" are marriage, heterosexuality, contraception, contracted motherhood, rape and prostitution. The political aim of radical feminists are to end this oppression of women and to unite all women (the so-called sisterhood) (Bhavnani, 1993; Doering, 1992; Jaggar, 1983; Tong, 1989).

Sex is seen as political because of the male-female power relationship and the imbedded patriarchal ideology (which was analysed in detail by the feminists Millet and French). French advocated for a "power-to" (constructive) rather than a "power-over" (destructive). Women therefore had to re-define sex class (as a class struggle of women), sexuality (discovering their own sexual expression and pleasure), and power, and women had to advocate for a separist rather than an androgynous society.

Eminent radical feminists such as Shulamith, Firestone and Piercy, advocated the abandonment of capitalist production and patriarchal reproduction (procreation) -

"biological motherhood being the root of all evils"; while other radical feminists (for example O'Brien and Rich) believe that men are fearful of womens' reproductive powers. (Tong, 1987, p. 76).

Daly (with strong "re-interpreted" Nietzschean undertones) rejects femininity as a concept created by men; and went a step further by advocating a move beyond androgyny where women became free and their natural self. Women can then develop and identify themselves as radical lesbian feminist separatists and even develop masculine traits if they feel to do so (Nye, 1988; Tong, 1987). According to Tong (1989, p. 122), most radical feminists don't see lesbian sexuality (as an alternative to heterosexuality) as a *"paradigm for female sexuality"* - although they usually agree that it is a sign of rejecting patriarchal sexuality.

Radical feminism for example emphasizes:

- The woman's body (woman's biology and psychology);
- Biological determinism;
- The culture of rebellion and conflict;
- Generalizations about men (and women);
- The "glorifying" of women (superiority of female thinking and virtues) and womens' values; and
- The over-emphasizing of an utopian woman's culture and separatism (and its perceived power).

These emphases were often criticized by eminent feminists and philosophers (Jaggar, 1983; Nye, 1988; Tong, 1989). Cultural feminism, on the other hand, strongly proposes a re-focus on the essence of femaleness and the creative expression of bonds with other women in a womens' culture and world.

4.3.2.4 Psychoanalytical feminism

The psychoanalytic theory of Sigmund Freud in essence describes how social

beings emerge from mere biological ones; how patriarchal society forms sexuality - sexuality can thus not be perceived as innate or biological. Freud's universalistic and deterministic theory described the process of how instincts become drives through and in culture. Adult sexuality and identity is thus the product of a long development process that is dominated by the problem of how to regulate sexual instincts - the self being always and fundamentally divided.

Freud relied mostly on men's lives to understand human growth; and finds it thus difficult to apply his theory to understand womens' experiences. Freud makes various skewed assumptions about gender and women in particular. He generally describes women as emotional, irrational, passive and masochistic, and ignores female characteristics such as sensitivity, caring, openness and flexibility (Jaggar, 1983).

In describing female development towards sexual identity, he mentions amongst others, the phenomena of penis envy, sexual (which is in essence a masculine sexuality) repression and threat of castration - all negative and unresolved and leading to a socially imposed inferiority and an increased proneness to mental ill-health (Gilligan, 1982; Meyers, 1992; Nye, 1988).

According to Gatens (1991), Meyers (1992), and Tong (1989) psychoanalytic theory helped to shed light on the social meaning of womens' bodies and biology - of how social and historical practices and institutions "form" or create and uphold masculinity and femininity; but, it does not give a complete explanation of womens' oppression and powerlessness - feminists thus tried to correct Freud's misconceptions (for example misogyny); and to use psychoanalysis as a tool to free femininity from masculinity. Psychoanalytic feminism however, struggles to escape the divisions of gender and biological determinism instilled by Freud, and mainly reflects the barriers and obstacles to womens' agency; the main purpose being consciousness raising and breaking down the power of the patriarchy (Leland, 1992).

Karen Horney agreed with Freud concerning the physical reality of womens' sexual organs and that women are symbolically castrated (not having the power of the

penis); she emphasized the woman's productive power and the man's resultant envy or jealousy of this power. The a-symmetrical patriarchal culture creates women as passive, masochistic and narchistic) (Horney, 1973).

According to Dinnerstein, society's destructive and unequal gender relationships and arrangements are because of womens' control (monopoly) over child rearing.

These arrangements are:

- Men's accepted sexual possessiveness;
- The muting of female erotic impulsivity;
- The combination of sexual excitement and personal sentiment for only women;
- The denial of women personhood;
- A general ambivalence towards the flesh; and
- The agreement that men should go out (in the public sphere) and that women should stay behind (in the private sphere) (Tong, 1989).

Both Dinnerstein and Chodorow agree that the solution to female monopoly over child rearing is that men and women take equal responsibility for parenting (dual or coparenting); Chodorow also emphasized a change of quality in parenting (for example challenging the father's position as head of the family). They were, however, criticized for this solution as it might for example, exacerbate womens' oppression and that it is based on limited white middle class perceptions and experiences. Juliet Mitchell suggests no family at all (Nye, 1988; Tong, 1989).

Freud's statement that men have a well developed sense of justice versus womens' underdeveloped sense of justice was severely criticized by Carol Gilligan. She found the traditional male notions of justice biased and concentrated on womens' perceptions of the self and their ways of making moral decisions.

"The failure to see the different reality of womens' lives and to hear the

differences in their voices stems in part from the assumption that there is a single mode of social experience and interpretation"

(Gilligan, 1982, p. 173).

Gilligan therefore also rejected Kohlberg's theory and scale of moral development.

She stated that women generally:

- Accentuate continuing and imbedded (connected) relationships;
- Foster interdependence of self and other;
- Value and calculate the effects of moral action and take this calculation into account when taking a moral decision;
- Accept excuses for moral behaviour (mitigating circumstances);
- Interpret moral choices within the historical context and circumstances; and
- Apply an ethic of care (and not of justice)

(Gilligan, 1982; Tong, 1989)

Gilligan was criticized for not being sensitive enough to racial, class and individual differences in her research, and for not always recognizing that her ethics of caring can be enslaving and oppressing; and not liberating (Tong, 1989).

4.3.2.5 Socialist feminism

Socialist feminism which developed in the 1970s combines influences form Marxist, radical and psychoanalytical feminism, and developed a dual-systems theory (where the intersection of patriarchy and capitalism oppress women) and unified-systems (where capitalism and patriarchy are combined to give one unified view) theory to explain womens' oppression.

Socialist feminists concentrate on the structuring effect of gender; gender being socially imposed in a systematic and historically defined system of production. Socialist feminism conceives procreation and male dominance as part of the

economic fibre of society - this *"requires the a transformation of the economic foundation of society as a whole"* (Jaggar, 1983, p. 147). These feminists do also not agree with the traditional and Marxist division of private and public life which they believe exploit women.

Juliet Mitchell describes the necessity to overturn both the patriarchal ideology (by using psychoanalytical strategies) and capitalism (by using marxist strategies). Heidi Hartmann views patriarchy not ideologically, but as part of a relation structure where man has the historical control over womens' labour power - thus operating in the material realm. Men had an equally strong desire to control women as capitalists had a desire to control workers (Tong, 1989).

Dual-systems theories were criticized for their instillation of hopelessness in women, and their eventual acceptance of capitalism being the main cause of womens' oppression - a unified-systems approach which was not gender-blind was advocated as a solution. Here the focus was on analysing division of labour (*gender division of labour as unifying concept*) and paying attention to individuals (for example women) involved. The marginalization of women as secondary work force became the main area of study; capitalism was accused of committing this crime - womens' work being often less prestigious, poorer paid and perceived to be less skilled (Jaggar, 1983; Tong, 1989). Jaggar suggests the concept of *alienation* as a unifying concept - referring to woman's fragmented life as an intellectual (made unsure of herself), a mother and a sexual being (to-be-looked-at; to be owned). A woman is alienated from her body - which is the product on which she works.

Socialist feminists recognizes the reality that a psychological theory (for example psychoanalysis) to explain male domination is not adequate; but struggles to realize the problems inherent in the dichotomous basis of combining radical (of a more capitalist nature) and the marxist (with the more patriarchal and domestic nature). They do suggest however, strategies to transform sexuality and procreation, for example genuine reproductive freedom, abolition of the wage system, organizational independence, and changing not only material conditions, but also perceptions, feelings and ideas. These women would like to responsibly affirm themselves,

appreciate their own intelligence, and live naturally with both reason and feeling (Bono & Kemp, 1991; Jaggar, 1983).

4.3.2.6 Existentialist feminism

The well-known existentialist philosophy emphasizes the *"I am"* or rather "*exist*" as a revolt against the idealism of for example Hegel. It emphasizes the value and freedom of the individual and concentrates on the dynamic here and now of reality. Existentialists accentuate the human being as a mode of being between being and nothingness. They emphasize the concept of ambiguity as stated by Simone de Beauvoir:

> *" From the beginning, existentialism defined itself as a philosophy of ambiguity. It was by affirming the irreducible character of ambiguity that Kierkegaard opposed himself to Hegel, and it is by ambiguity that, in our own generation, Sartre in Being and Nothingness, fundamentally defined man, that being whose being is not to be, that subjectivity which realizes itself only as a presence in the world, that engaged freedom, that surging for-oneself which is immediately given to others"*
>
> (De Beauvoir, 1964, p. 9-10).

Sartre's "Being-for-others" entrenched for him the ever present conflict and disharmony between human beings; where (mystic as well as physical) love is essentially masochistic and hate (desire, indifference) is sadistic. De Beauvoir emphasizes that man named himself the Self (the subject) and woman the (perpetual) Other (the object); the Other lacking power but a threat to man. This relationship is thus filled with tension (Gatens, 1991).

The social value of biological and physiological "facts" are determined social beings (needs to be interpreted); a woman is definitely more than her body. Womens' freedom is blocked (she is enslaved and being made miserable) by the role of being a wife and a mother; but also by being a career woman. She describes narcissists, mystics and prostitutes: prostitutes being viewed as women getting something for yielding their bodies; men thus appreciates their otherness.

De Beauvoir agitates for women to transcend this immanence (of being the Other or second sex) by going to work (economic independence), by becoming intellectuals; and by trying to socially transform society (Tong, 1989).

The existentialistic feminist theories are extremely individualistic theories of human existence which do not usually value economic and ideological considerations; the ideal of transcendence can be interpreted to be paradoxical and self-destructive. Transcendence also differs within male and female perspectives (Gatens, 1991; Tong, 1989).

2.3.2.7 Postmodern feminism

Postmodernism tries to remove the reader from traditional and (western) cultural beliefs concerning for example the nature of power, language and knowledge; and exhibits the following characteristics (according to Degenaar, 1994):

i) Language (as a fabric of differences) and not reason, constitutes the relationship between the human being and reality;

ii) A profound scepticism against a fixed point of reference;

iii) Acceptance of a plurality of narratives and thus meaning;

iv) A contextualization of meaning where context cannot be ignored and can never be saturated;

v) Meaning can not be divorced from the process that brings it forth; and

vi) An awareness of the relationships of power; and that every discourse is ideological and concepts are value-laden. Feminists tend to add that power is always exercised in relation to resistance; power is served and generated by knowledge (Doering, 1992).

Postmodern feminists (initially many were French feminists) are very diverse in their thinking and reject traditional assumptions of truth and reality. They proclaim the concept of Otherness as being a positive phenomenon; a way of being, thinking and

speaking. (Tong, 1989).

According to Whitford (1991), Luce Irigaray's work should be viewed as feminist philosophy; she borrowed significant themes from for example, Lacan, Derrida and German philosophy. Lacan, who often adopts a psychoanalytical approach, emphasizes the Symbolic Order (signs, roles and rituals) of society and which then becomes society and which then needs to be internalized by the child through language. These rules will then be inscribed in the child's unconscious (internalized). Lacan places the Oedipus complex in a central and universal position when dealing with the development of sexual identity. **The child goes through different phases:**

- The **Imaginary phase**; consisting of the pre-Oedipal phase where the child is not aware of his ego boundaries; and the mirror phase where the child recognizes himself as a self that first corresponds with the mother and then with the object of the mother's desire. During this phase the child is in a diadic relationship with the mother; and
- The **Symbolic** (Oedipal phase and post-Oedipal phases) where the child can individuate him- or herself (psychic castration). The child becomes estranged from the mother and view her as the Other (Leland, 1992).

Irigaray is in essence a (psycho) analyst; but also speaks as a woman (parler femme). She seeks for the (own) female imaginary; and sees the Imaginary phase of Lacan as a prison; girls stay behind in this (not necessarily negative) prison because they never complete the Oedipal phase. Womens' bodies become in essence "matter" to be acted upon. In resisting masculine socialization, she theorizes female pleasure (and rejects Lacan's notion that women have nothing to say on the subject of pleasure). A female imaginary for her is articulated by the "two lips" ("both at once") - also symbolizing womens' autoeroticism. Other interpretations which are less literal and essential, refers to a plurality of being in touch, a mutuality and continuity, and of a speaking together (Fuss, 1992; Leland, 1992; Whitford, 1991).

Irigaray stated that *"superimposed, moreover, these lips adopt a cross-like shape that is the prototype of the crossroads, thus representing both inter and enter, for the lips of the mouth and of the female sex do not point in the same direction"* (Iragaray, 1987, p.128).

To liberate women, women need to pay attention to the nature of language; to explore the multifaceted female body (with its extended forms in human expression and even social structures); to mime back at men the image that they have in magnified proportions. She advocates a global as well as a local feminist politics (in each woman's situation) - women are simultaneously constructing and destructing their essences and identities (Fuss, 1992; Tong, 1989). Bono and Kemp (1991) also sees Irigaray as a deep political thinker who advocates the exposure of the exploitation of every woman right where she is and in what she experiences. According to Leland (1992) the theories of Irigaray (and Kristeva) do not qualify as feminist political psychology because they do not acknowledge the cultural and historical embeddedness of womens' internalized oppression and they do not acknowledge the possibility that such oppression can be overcome.

Helene Cixous is a french novelist who contrasted feminine with masculine writing and viewed the dichotomies she found to be imbedded in the fundamental dichotomous couple of man (the Self) and woman (the Other). She optimistically motivated women to change their writing style, for example jotting down, scribbling and marking - ever changing and flowing (Tong, 1989).

Thürmer-Rohr (1991) states the following typical traditional obligations of women as the powerless: To be sweet, good and happy, to endure, obey, and to be grateful and proud. She underlines the indivisibility of love and lies; the "being used by the one who loves you, not apart from his other actions, but for the sake of them (p. 90).

4.3.3 POLITICAL THEORY

According to Jaggar (1983) the aim of political theory is a normative and empirical endeavour to analyse (a good) society with special reference to concepts such as freedom, equality and justice, as well as the means that are socially justifiable to effect social change. The ideals of political theory should however be applicable to the real life situation and build on an informative relationship with other sciences, for example psychology, anthropology and economics.

Every political theory has a certain conception of human nature and can thus not ignore the relative positions of men and women in society. Feminist theories investigated these relationships and challenged *"traditional androcentric paradigms of human nature and traditional androcentric definitions of political philosophy"* (Jaggar, 1983, p. 22).

4.3.4 EDUCATIONAL THEORY

Critical theory emphasizes that knowledge should be used for political emancipatory political aims - to release the individual from domination and to foster responsibility and autonomy (Campbell & Bunting, 1991).

4.3.4.1 The educational theory of Paulo Freire

Paulo Freire was a Brazilian educator who made a profound impact in the field of education and in the overall struggle for national development. Freire's main goal was to accomplish literacy for the Brazilian masses (for example the shantytown dwellers of Brazil) and to increase political consciousness and participation. He thought that education could enact these changes gradually. He advocates revolution based on religious principles and might be criticized for a rather naive

theory of revolution. Freire's work was also based on limited if any, experiences of revolutionary movements, and has been criticized for his lack of concreteness and specificity. He also advised educators to work "within the system" (Elias, 1975).

According to Freire (1972), there exists a "culture of silence" of the dispossessed. The educational system became one of the major instruments for the maintenance of this culture of silence. Freire's work is a process of reflection set in a historical context of struggle to create a new social order and thus represent new unity of theory and *praxis.*

Freire's basic assumption is that man's ontological vocation (as he calls it) is to be the subject who acts upon and transforms his world, and in so doing moves towards ever new possibilities of fuller and richer life individually and collectively. This *world* to which he relates is not static or a closed order or a *given* reality which man must accept and adjust to but *is* a problem to be worked on and solved. If man is provided with the proper tools for dialogical encounter, every person, no matter how "ignorant" or submerged in the "culture of silence", is capable of looking critically at his world, the contradictions of social reality and to become conscious of his own perception of that reality.

Humans will no longer be willing to be mere objects and will struggle to change the structures of society, which until now, has served to oppressed them. There is no such thing as a *neutral* educational process; it either functions as an instrument which is used to facilitate the integration of the younger generation into the logic of the system (conformity) *or* it becomes "the practice of freedom", the means by which men and women deal critically and creatively with reality and discover how to participate in the transformation of their world. Freedom is thwarted by injustice, exploitation, oppression, and the violence of the oppressors; it is affirmed by the yearning of the oppressed for freedom and justice, and by their struggle to recover their lost humanity. The great humanistic and historical task of the oppressed is to liberate themselves and their oppressors as well. The oppressors cannot find the power or strength to liberate either the oppressed or themselves.

Almost always, during the initial stages of the struggle, the oppressed, instead of

striving for liberation, tend themselves to become the oppressors, or "sub-oppressors". The very structure of their thought has been conditioned by the contradictions of the concrete, existential situation by which they are shaped. Their model of humanity is to be oppressors and to adopt an attitude of adhesion to the oppressor - under these circumstances they cannot consider him sufficiently to clearly to objectivise him - to discover him outside themselves. The perception of themselves as opposites of the oppressor does not yet signify engagement in a struggle to overcome the contradiction; the one pole aspires not to liberation, but to identification with its opposite pole.

The oppressor, who is himself dehumanised because he dehumanises others, is unable to lead this struggle - the oppressed internalise the consciousness of the oppressor. Reflection of oppression and its causes will (instigate) necessary engagement in the struggle for liberation. Liberation is a painful childbirth, but a new man is born: no longer oppressor or oppressed but man in the process of achieving freedom.

Education is not neutral but takes place within a specific context. Unfortunately, the teacher-student relationship is fundamentally of a narrative character - the narrating subject (teacher) and patient, listening objects (students). The contents tend, in the process of being narrated, to become lifeless and petrified. Education is suffering from narration sickness with the contents detached from reality, disconnected from the totality that engendered them and could give them significance. The words become empty, hollow, and alienated. The teacher becomes the depositor and the student depositories (the so-called "banking" concept of education).

The banking concept states that knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider know nothing. Projecting absolute ignorance onto others, a characteristic of the ideology of oppression, negates education and knowledge as processes of inquiry. The teacher justifies his own existence by considering the students' ignorance absolute.

The *raison d'être* of libertarian education, lies in its drive towards reconciliation. Education must begin with the solution of the teacher-student contradiction, by

reconciling the poles of the contradiction so that both are simultaneously teachers and students. The individual, marginal cases (outsiders or deviants) need to be 'integrated', 'incorporated' into a healthy society (of the oppressed); the solution being to transform the structure of oppression so that oppressed individuals can achieve conscientization. *Conscientización* can be described as educating for critical consciousness where the oppressed reflect on their reality (what they see and feel; and sharing experiences), look behind these immediate problems for the root causes (the many levels of the problems), examining the implications of these issues, and developing an action plan to deal with these issues (Freire, 1972; Minkler, & Cox, 1980; & Wallerstein & Bernstein, 1988).

The humanist and revolutionary educator's efforts must be in partnership with the students to engage in critical thinking and the quest for mutual humanisation. Problem-posing education affirms men as beings in the process of becoming - as unfinished, uncompleted beings within and in a likewise unfinished reality. Men are aware of their incompletion. In this awareness lies the very root of education as an exclusively human manifestation - this necessitates that education be an ongoing activity.

In order for education *"to be"* it must *"become"*. Problem-posing education is a humanist and liberating praxis which posits as fundamental that men subjected to domination must fight for their emancipation. Teachers and students become subjects of the education process by overcoming authoritarianism and an alienating intellectualism. The world becomes the object of the transforming action by men which results in men's humanisation. Problem-posing education cannot serve the interests of the oppressor.

Those who have been denied the right to speak must reclaim this right and prevent the continuation of this dehumanising aggression - dialogue is an existential necessity as it is the way men achieve significance as men. Dialogue cannot exist without humility, the naming of the world through which men constantly re-create that world, cannot be an act of arrogance. Someone who cannot acknowledge himself to be as mortal as everyone else still has a long way to go before he can reach the

point of encounter. Faith in man is an *a priori* requirement for dialogue, the belief in man even before meeting face to face. Man must develop trust in dialogue as a horizontal relationship. Hopelessness is a form of silence; as long as I fight, I am moved by hope. Hope does not consist in crossing one's arms and waiting.

Critical thinking discerns an indivisible solidarity between the world and men and admits of no dichotomy between them; it perceives reality as process, as transformation rather than as static entity - which does not separate itself from action, but constantly immerses itself in temporality without fear of the risks involved. Critical thinking contrasts with naive thinking. Naive thinking has as its goal the clutching to guaranteed space and to adapt to it. In doing so, it denies itself by denying the temporality of space (which is a domain that should take shape as man acts upon it). Dialogue requires critical thinking and generates it.

The object of the truly humanist educator and the authentic revolutionary is the reality to be transformed by political and educational programs together with other men - not other men themselves. The oppressors are the ones who act upon men to indoctrinate them and adjust them to a reality which must remain untouched. Revolutionary leaders do not bring a message of "salvation", but in order to introduce the people to their **objective situation** and their **awareness** of that situation (through dialogue), they must come to know the various levels of perception of themselves and of the world in which and with which they exist.

Many programmes used Freire's philosophy and approach to education, for example in literacy, health education, adult education and community development (Wallerstein, & Bernstein, 1988). Feminists in their strive to free women of oppression, often utilized Freire's principles. Feminists added concepts such as cooperation, mutual respect and interdependence - the sharing of power and ideas regenerate and expand themselves (Faunce, 1985).

4.3.4.2 Education and women

According to Skelton (1993) the educational experiences of males and females are different and often unequal. Science is often seen and portrayed as a "macho

business" (p.327) and traditional aspects of teaching such as teacher-pupil interaction and teacher attitudes have an important influence on gender differentiation and gender discrimination. Men (boys) tend to make more use of verbal and non-verbal language, take up more time in the class room and are inclined to harass women (girls). The reinforcement of the active role for boys versus the passive role for girls is emphasized by differential feedback and exposure to different tasks (Rosser, 1988).

In South Africa under the apartheid regime, white south Africans had relatively easy and structured access to quality education, while the so-called black education was deliberately designed to prepare those who undergo it for their pre-determined place in life and society (Browning, 1989). Apart from equal education for all citizens of South Africa, educational policies need to limit sexist and biased language, fairly distribute research funds and assistance, and strive to eradicate the sexual harassment of women students and faculty (Worell & Remer, 1992). According to Davis (1984), education alone is not the cure for the political injustices that took place - employment opportunities need to be created.

According to the United Nations (1991) more than 40% of young women in Africa and Southern and Western Asia are still illiterate; with the women from rural societies being the hardest hit. The value of education to empower women is stressed by this publication - education facilitates the woman's ability to

- Financially earn;
- Foster her own health and fertility;
- Foster the health of her children and family;
- Participate more fully in the public activities of her community; and to
- Live a full, expanded and meaningful life.

4.3.4.3 Nursing education

Historically, nursing education was linked to the patriarchal power relationship

between the powerless student and powerful teacher - described by Chally (1992, p.118) as *"military training"*. The nursing uniform and insignia pins are still remnants of this era; as well as curricula that emphasize prescribed outcomes and "teacher-defined products" (behaviourist model).

Nurse educators can make use of the Murrell-Armstrong Empowerment Matrix which identifies five settings of interactive empowerment (dyad, small group, organization, community and society); as well as six categories of empowering methods: education (share information and helping to learn), leading (involving in decision-making), mentoring/supporting, providing (resources for success), structuring (promoting organizational arrangements to facilitate or hinder activities) and actualizing (to perform as best as the person could) (Hawks, 1991). Some of these methods are relatively similar to Chally's "tools of empowerment". The author discusses a positive self-concept (of both facilitator and student), creativity, resources, information (which includes political intelligence) and support. Political intelligence would also incorporate that nurses should be prepared to be political activists for health care and health promotion (Williams, 1989).

Nurse educators should also focus on using a feminist framework for education, for example developing concepts such as feminist consciousness, the liberation of women, the "personal is political" and womens' health. The development of women related research questions and the use of qualitative research methods should be advocated (Andrist, 1988). Welch (1987) also advocates a rich and diverse liberal art and sciences foundation for future nurses.

For empowerment to take place, a nurturing and caring environment is necessary, for example community, trust, openness, mutual respect and the recognition that both student and facilitator is human. The actualization of a shared vision and the integration of cognitive and affective learning, as well as the need for action (praxis) must be emphasized (Chally, 1992; Hawks, 1992; & Hezekiah, 1993).

4.4 AFRICA: FEMINISM, WOMEN AND GENDER

4.4.1 AFRICA

According to Steady (1990), the economic and social conditions of women in Africa have worsened and can be described as retrogressive development. Economic chaos is reigning in many African countries with women occupying subordinate and subsidizing roles in the work force. Women became the cheap labour force in export-oriented electronics, agricultural and food processing industries; and were mostly found in the informal labour market (women constituting only 10-15% of the formal labour market in Africa). Womens' bodies were perceived to be exploited by the mass usage of drugs such as Depo-Provera. In Zimbabwe for example, women were of crucial importance in providing food and shelter for freedom fighters during the country's liberation war (Chinemana, 1991).

The Nairobi conference of 1985 addressed several issues regarding inequalities; as well as inequalities amongst women (for example women under apartheid in South Africa). Womens' issues were now correlated and accepted as life and political issues. Womens' health became a critical political issue; for example maternal and child health care. The participation of women from the grass-roots level in primary health care and preventive health care programmes is accepted as being crucial to the success of these programmes (Steady, 1990).

The relationship between education and health is broadly acknowledged, and according to Steady (1990), the access to education for African women is still problematic. Factors like poverty, neo-colonial values, cultural stereotypes and teenage pregnancy hinder womens' access and performance in education.

4.4.2 SOUTH AFRICA

According to Smit (1992) national development in South Africa has a history of so-called "homelands", industrial decentralization policies and "separate development". These policies aggravated poverty and left development in the hands of the church and non governmental organizations (NGOs). These NGOs usually adapted policies that were "anti-apartheid" and not viewed favourably by the previous government.

Since the 1970s women, especially black women, participated in mass actions against the policies of apartheid and the realities of racial oppression, for example forced removals and incorporation into Bantustans. Women also participated in trade union activities and went on to become key role players in policy formulation (Dubel, 1991; Van Niekerk, 1991).

The oppression of women in South Africa was especially clear when observing the marginalized lives of women of the working class and women in the rural areas where a capitalist economy created disrupted family lives and exploited women as cheap labour (Horn, 1991; Van Niekerk, 1991). Horn emphasized that South Africa's women need to identify the key tasks to establish emancipation, for example by dismantling patriarchy, to change the marginal role that women play in the labour market to a central role, and to establish gender sensitivity and interests on a national level (in the constitution, laws, policies and services). Hassim (1991) argues for the need to see both men and women as gendered beings and both group's behaviours need to be publicly discussed.

The appointment of women as delegates based on a quota system at the first Multi-party Negotiations Council in South Africa was a progressive step for politics, and according to Finnemore (1994) most of the women were from the caring professions, for example education, social work and nursing. 87 % of the delegates (n = 46) felt that it was successful; 91 % felt that women were doing everything in their power to address gender issues in the council.

The Malibongwe conference that was held in Amsterdam in January 1990 was important to legitimize gender issues as part of the political struggle. According to Charman, De Swardt and Simons (1991, p. 2) the papers delivered there made the following theoretical and methodological assertions:

- An explanation of apartheid and capitalism also explains gender oppression and gender exploitation;
- The defining of women within patriarchal roles within the family: mothers, wives, daughters and sisters; and
- The appropriateness of using a marxist-Leninist analysis to explain gender oppression and exploitation in South Africa.

The first academic conference in South Africa to focus on women and gender issues took place in Durban at the beginning of 1991. during this conference the debates focused mainly on racism and academic accountability, with the problematic relationship between black and white women and the questionability of intellectuals' analyses of the nature of the struggle of masses of women constantly under discussion. Questions were asked concerning the autonomy of intellectuals, the right of making black women the subjects of academic research, and the labelization of so-called activists. The necessity for women to become involved in policy formation in the "new South Africa" was acknowledged (Gender Research Group, 1991). The Womens' Health Project is for example active in disseminating policy proposals developed at the Womens' Health Conference in December 1994 for lobbying and debating at all levels (Klugman, 1995).

The Womens' Health Project is a non-governmental organization which was initiated in January 1991 at the Department of Community Health at the University of the Witwatersrand. The main objectives of the organization are networking, interaction with womens' organizations, lobbying at different levels (including government), disseminating information, providing education and training, research, and the development of policy proposals to the benefit of women and womens' health in South Africa (Womens' Health Project, 1995).

According to Bozzoli (1986, p.171), South African women need to develop a general (feminist) theory which includes the historical reality of South Africa and which considers the places of "*gender in the system as a whole*". South Africa's historians, on the other hand, need to pay tribute to the South Africans who struggled against the white minority government and policies of apartheid. Women who have strived for freedom, for example Nomzomo Winnie Mandela, Teresa Ramashamola, Marion Sparg, Nontsikelelo Albertina Sisulu and Helen Suzman should not be forgotten (Davis, 1984; Gilliam, 1991; & Goodwin, 1984) - *"... the Women of South Africa who are risking their lives to give birth to a new South Africa"* (Russell, 1989, p. vi).

Women comprised 53 % of the voters in South Africa's historic first democratic selection. Women also represented themselves in the multiparty constitutional negotiations prior to this selection (Baker, 1994). Women immediately moved to formalize a charter for effective equality for women.

The first draft of the Womens' Charter for Effective Equality was endorsed by 92 organizations affiliated to the Womens' National Coalition (WNC) in 1994. The participants seized the historic moment of dramatic change in South Africa. They agreed that women have been exploited and marginalized for too long; and decided to break the silence of women. These women underline the subordination of women that has taken various forms, for example patriarchy, tradition, colonialism, racism and apartheid. South African women stated the need to redefine democracy and human rights; and emphasized the concept of effective equality for women in all spheres of life; and the recognition of womens' dignity (Unified charter for equality, 1994).

Twelve articles with elaboration on specific aspects, were developed. The charter's articles deal with (1) equality, (2) law and the administration of justice, (3) economy, (4) education and training, (5) development, infrastructure and the environment, (6) social services, (7) political and civic life, (8) family life and partnerships, (9) custom, culture and religion, (10) violence against women, (11) health and (12) the media (Negotiation News, 1994).

The Womens' Lobby (TWL) has been primarily involved in promoting women into the government (national, provincial and local) and other decision-making positions. The organization is also in favour of South Africa taking a leading role in the debate concerning and application of gender quotas (Kabak and Ravenhill, 1995).

4.5 PROFESSIONALISM FROM A FEMINIST PERSPECTIVE

An occupation is usually clearly demarcated and separate from domestic or social lives. It entails a large part of the human being's sense of self and usually holds some form of reward. The historical evolution of men's and womens' work clearly emphasizes gender and class differences (McDowell, & Pringle, 1992). Womens' roles were traditionally seen as only that of mothers and domestic work; with working women facing the "double bind" of being viewed as less effective mothers and less effective workers ((White, 1991).

Womens' social and economic desires are often exploited; waged work traditional carries definite scars of womens' oppression and gender segregation both vertically (different grades of occupations) and horizontally (across occupations). In Great Britain in 1990, women were horizontally over-represented in the occupational groups of personal services (for example hairdressing, catering and cleaning), selling, clerical and related occupational groups in health, education and welfare. Men tend to be traditionally found in the vertically higher levels of occupations such as management and exclusive professions. Men thus consistently control the board- and the bedroom (Weaver, J.L. & Garrett, S.D., 1982; Witz, 1993)!

4.5.1 PROFESSIONALISM

The concept profession is derived from the Latin meaning "*to profess*" - and referred to vows taken when entering a religious order. Modern day professions are inclined to become elitist groups who operate as communities within larger societies and control the selection, education and activities of its members (Labonte, 1989; Kronenfeld, 1988).

The professions symbolize a "knowledge is power" as well as certain priveleges; and emphasize the ideals of rationality, objectivity and standardization. According to Zander, Cohen and Stotland's classical work in 1959, a profession's perceived relative power is embedded in variables such as status, the nature and value of functions included in their role, and the responsibilities to others or others to them.

Watts (1990) emphasizes the fact that the values, cognitive styles and language of professionals and clients are often very different and that professionals often find it difficult to accept that clients are capable of identifying their own needs and making their own choices. The democratization, as well as the redistribution and the sharing of power with individuals, groups and communities as is advocated by, for example, a primary health care approach is thus often easier said than done.

Since the mid-nineteenth century more women started entering traditionally male dominated professions. This was due to womens' rights movements and their demands for the balancing of so-called sexual, academic, economic and professional power.

According to Cott (1987) historical research revealed the presence of male professionals' convictions of female inferiority and unsuitability for leadership positions. Women had to prove their value and work very hard to actually offer more than men and were inclined not to associate themselves with feminism initially - mainly because of loyalty to the predominant (male) ethos and the development of a community of so-called professionals.

Women are traditionally placed in the so-called maintenance and reproducer roles in the health services where men (for example the male dominated medical profession) are placed in positions of power and resultant decision-making. The health profession, however, is dominated numerically by women as members of the nursing profession (Fogel & Woods, 1981). Unfortunately, males hijacked even traditional womens' health care activities. According to Versluysen's research, the male medical profession took over the control of childbirth from traditional female midwives by developing maternity hospitals in the nineteenth century. Women as nurses also need to accept part of the blame by historically advocating and accepting a subordinate role - for example as promoted by Florence Nightingale (Hockey, 1993).

4.5.2 THE NURSING PROFESSION

Nursing and teaching are often seen as status professions in the African community in South Africa. Women teachers are predominantly in primary schools, and a *"strong culture of male dominance pervades and persists in schools"* as expressed in the typical hierarchy of most schools and the division of labour (Kotecha, 1994).

Although feminism concentrated on many of the issues dealing with womens' health, it is unfortunate that nursing as a profession is often not well understood and ignored by those who fight for the cause and rights of women - the womens' movement in the early 1970's actually questioned the value of nursing as a profession (Fitzpatrick, 1977; Parker & McFarlane, 1991). According to Skeet (1988) the "nursing culture is heavy with subordination without influence. It is burdened with obligation without power - even in directing, heading and controlling its own education, practice, research and management". Nurses were and are often caught between the patriarchal powers of the medical profession and the powers of the bureaucratic hospital system (Bunting & Campbell, 1990); and also had to face the two conflicting "ideologies" of professionalism and domesticity (Hughes, 1990).

The power of the medical profession over, for example, nursing education is well described in the literature. Doering (1992) emphasizes the disparity between medical and nursing students in America where medical students were historically not part of a hospital setting while nurses were used as "unpaid" labour by these hospitals. Degree programmes for and the professional status of nurses were also traditionally opposed by the medical profession.

It also needs to be mentioned that the traditional university community also resisted and challenged nursing education at universities; primarily because of the suspicion against vocationalism at these institutions. Nurses had to concentrate on the development of a unique science relevant to the profession of nursing - a feminist framework can support and enhance such an endeavour (Baumgart, & Kirkwood, 1990).

Nursing's claim to a unique and own body of knowledge was thus often questioned. Medical knowledge with its typical male, logical, positivistic and empirical approach often overpowered and dominated nursing knowledge. Nursing scientists need to recognize that existing knowledge was created by humans and can thus be changed by humans (Dickson, 1990; as cited by Doering, 1992).

Nursing slowly developed other and often opposing views regarding knowledge, for example, contextual and phenomena-centred knowing emphasizing the humanness of relationships and caring as experienced within these relationships - according to Doering (1992) this orientation finds a definite home within a feminist poststructuralist framework. Nurses need to question the historical power relationship between medicine and nursing and need to develop its own knowledge within a social and institutional context.

Examples of analyses of the health care professions would be to:

- View the medical profession's position of power (paternal or authoritarian) as just another mirror of womens' social subordination (liberal feminism); or to
- Identify just another patriarchal family where the doctor is the father, the nurse is the mother and the patient is the child (radical feminism) - the

medical practitioner having the scientific and technical skills and the nurse the caring and comforting skills; or to

- Accept that the predominant pattern between the medical practitioner and the nurse has been one of authority, dominance and deference; in essence a stereotyping of roles and responsibilities

(Fee, 1982; Fogel & Woods, 1981; Ondeck, 1990).

The nursing profession often looses power by not uniting or reaching agreement on fundamental issues:

- Women as nurses often disagree concerning the essentials of practice, borders and control (also referred to as territoriality) of nursing as a profession;
- Nursing tends to remain divided into distinct clinical (at-the- bedside), managerial and educational "sub-professions" with an inherent presence of real or possible conflict and division;
- Nurses tend to often disagree on fundamental health issues, for example primary, promotive and preventive health care;
- Nurses are often reluctant to take action to achieve their goals, for example legal action;
- Nurses often hesitate to accept non-traditional ways of knowing, for example intuitive knowing; and
- Nursing still struggles to formulate an encompassing theory of caring unique and to successfully incorporate caring into nursing curricula

(Doering, 1992; Fogel & Woods, 1981; Kilkus, 1990).

Modern day nursing strives to develop egalitarian and collaborative relationships amongst themselves, with other professions and with their clients (Woods, 1981); but, nurses as women often suffer from the unique problems of a primarily female

work force. According to Davison-Crews (1990) many professional women have suffered from betrayal and back stabbing (about eighty women out of every hundred); place (too) a high level of trust in their relationships with other women; and experience a whole range of deep emotions when being hurt. Another behavior pattern identified in nurses, is a codependency which relates to an addicted selfless care of others, a sense of responsibility that is more than is expected, and a fear of authority (Clifford, 1992).

Nurses need to accept and practice emancipatory actions that will change the power relationships in the health sciences, for example taking gender, race and class seriously; challenging prevailing ideologies; upholding continual dialogue; organizing groups and communities; questioning standard practices and breaking barriers. Nurses thus need to enact a synergy paradigm (human activities and intentions are intrinsically available and expanding) instead of a scarcity paradigm (human activities are scarce and one needs to compete for them) (Kendall, 1992).

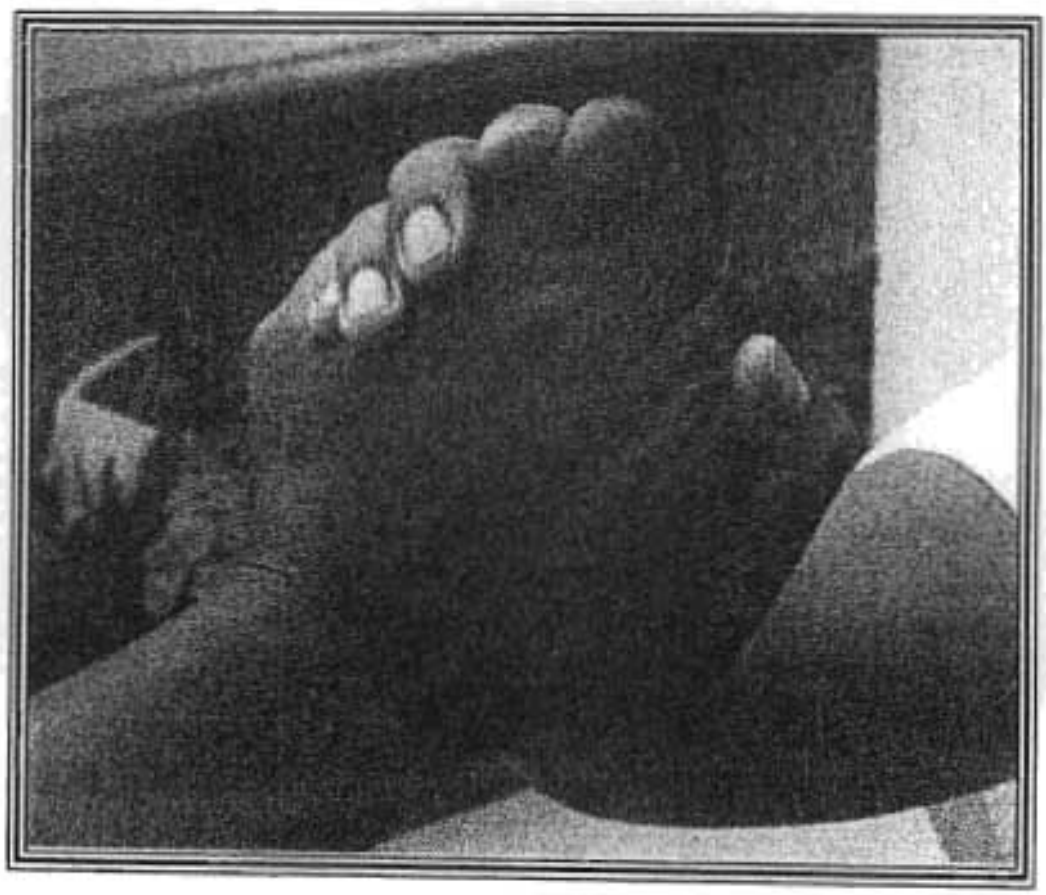
According to Chinn and Wheeler (1985), Clifford (1992), Critical Health (1988), Kilkus (1990), Roberts (1983) and The Boston's Womens' Health Collective (1984), nurses are an oppressed group and have a long history of subordination. Nurses have internalized the values of the medical profession, and have often been rewarded for being marginal. Nurses are also inclined to exhibit divisiveness, self-hatred, lack of pride, passivity, horizontal violence, denial of own culture and fear of success; while also suffering from the so-called submissive-aggressive syndrome - all traits of oppressed groups.

In South Africa, the discrimination against black nurses during the Apartheid era aggravated the already volatile situation of women as nurses, and some nurses felt that the *"apartheid policy went against the underlying philosophy of the nursing oath"* (Rispel & Motsei, 1988, p.20).

Nurse managers also became marginalized as they seem to be not incorporated in either the medical or nursing profession and tend to view themselves as an elite group. Nursing leaders will have to demonstrate the ability and willingness to empower the nurses that they work with; for example, by believing in the worth of

every individual, to develop leadership from the grass roots, and by focussing on successful leadership behaviours (for example consensus building, mentoring, facilitation, dialogue and communication) (Glendon, & Ulrich, 1992; Gunden, & Crissman, 1992; Hotter, 1992; Roberts, 1983).

The challenges affecting the nursing profession and practice within an uncertain future can not be ignored, for example the growing cost of education, growth of biotechnology and information technology, changes in population demographics and restructuring of the health care systems. Nursing needs to secure its respect and power base and to develop leadership in womens' issues, for example womens' health (Aydelotte, 1987; Goertzen, 1987; McBride, 1987). Felton (1987) emphasizes the realization of concepts such as excellence, equity and affirmative action policies, but plead for the commodities that go with the realization of these concepts: the necessary information, resources and support.

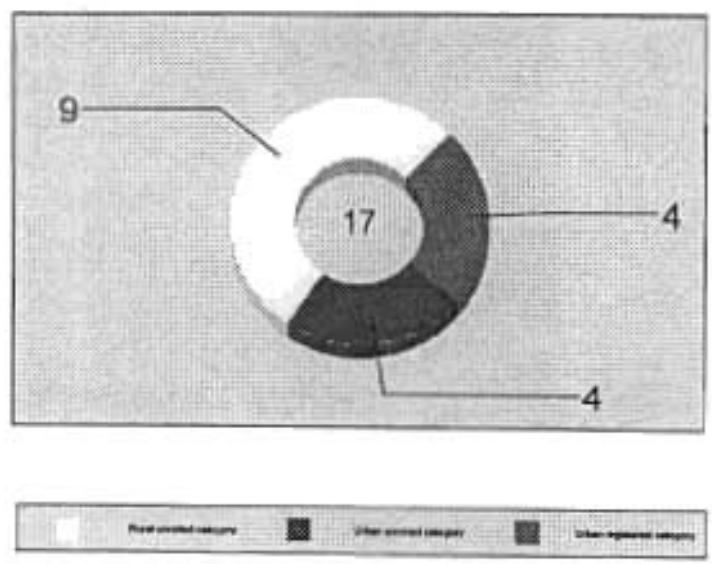


5

DATA DESCRIPTION : REFLECTING ON PARTICIPANTS AND INTERVIEWS

THE PARTICIPANTS

Illustrating the three groups



5.1 INTRODUCTION

The researcher decided to approach the description of data in the following way: Section 5 would be divided into five parts. **The first part** (5.2) gave a description of the settings and the participants. An example of the interview process and content using women as nurses belonging to the enrolled category [1] and working in an urban setting was placed in **Annexure D**. These six interviews with FORTUNATE and PEGGY were conducted first and formed a baseline from which to proceed.

The second part of this section (5.3) consisted of an analysis of the experiential themes identified during the interviews and from the data. This analysis would compare the urban and enrolled category; and the registered category of women as nurses. **The third part** (5.4) of this section analysed the use and meaning of key concepts by the participants, followed by some classical moments of expressive wisdom and humour (**part 4**, 5.5). The **last part** (5.5) reported on the realization of criteria for evaluating qualitative research.

The data collection had three distinct foci and the selection of participants was based on the key premises of the Standpoint theory in terms of class, gender and race, with the added premise of geographical location (now called rurality). In accepting the principles of theoretical sampling, the researcher consciously identified the three groups of participants for the data collection process. The description of the data of the different groups did not necessarily follow the same order as during the research, but were described in a way that would facilitate understanding.

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1 The reason for consistently using the concepts "women as nurses belonging to the enrolled category" was to emphasize the intertwined reality of being a woman and a nurse.

According to the researcher, the first participant group met all three criteria of the Standpoint theory, and worked in a distinctively rural setting - thus meeting the added criterium of locality in terms of rurality. The second group of participants met all three criteria of the Standpoint theory and worked in two different urban health settings. In the third group the respondents had enough features in common with the first two groups (gender, race, and to a lesser extent class), and were chosen on the basis of theoretical relevance - to further the process of analysing similarities and differences and to foster the development of meaningful categories. The differences between the first two groups were minimized to an extent; while with the third group differences were more maximized.

The **first participant group** consisted of black (race) women (gender) as nurses of the enrolled category (class) who were working in a distinct rural health setting (rurality). The **second participant group** consisted of black (race) women (gender) as nurses who belonged to the enrolled category (class) and working in distinct urban health settings. The data from the preliminary study were combined with this data as the researcher accepted the principle that all data was meaningful; that the nurses met the stated inclusion criteria; worked in relatively similar health care settings in an urban area and the structure and flow was minimally adapted after these first interviews. The **third participant group** consisted of a relatively contrasting group of black (race) women (gender) as nurses belonging to the registered category (class) and working in an urban health setting.

The researcher conducted a total of 44 interviews with 18 women as nurses with an average of 2,5 interviews per participant. The principle of theoretical saturation was applied. When the researcher became aware that no new data was found that lead to the development of new categories, the researcher moved to a new group in terms of conducting interviews and/or analysis. The members of the different groups were summarized in Tables 5.1, 5.2, and 5.3.

5.2 DESCRIBING THE SETTINGS, PARTICIPANTS AND INTERVIEW PROCESS

5.2.1 MACRO SETTING

Figure 5.1 KwaZulu-Natal

All the interviews took place in health care settings in the second largest of the nine regions of South Africa, namely KwaZulu-Natal. This region with its subtropical climate, was known for its diversity in terms of for example its natural beauty (which ranged from coastal resorts and wild life sanctuaries to beautiful mountain scenery), technological development, cultures, and political realities. The cosmopolitan city of Durban, where the University of Natal was situated, had the largest harbour in Southern hemisphere. The stark contrast of informal settlements (in and close to cities and large towns) and rudimentary rural dwellings versus for example some urban and peri-urban mansions and estates made one aware of some of the painful differences between and amongst human beings. The rural areas of KwaZulu-Natal with its rolling hills, traditional Zulu culture, lack of development, low level of literacy and severe poverty formed a suitable setting in terms of the objectives of this research.

At the end of 1994, the region had the largest population in South Africa with an estimated population of 8 966 860, which formed 21,2 % of the national total population. An estimated 82 % of the population was classified as African. The population density was 92,3 per km^2; with only 38,2 % of the population classified as urban (Health Review, 1995).

The ratio of one nurse for every 291 members of the population was also the poorest

for the country (S.A.N.C., 1994). The health services of KwaZulu-Natal consisted of a provincial health service serving the eight different regions of KwaZulu-Natal, and several private health care facilities. The implementation of the National Government's Reconstruction and Development Plan (R.D.P.) was a strong priority in the regional Health Services with the emphasis on Primary Health Care. The major causes of death in KwaZulu-Natal were violence and poverty-related diseases; while the major health problems in the rural areas related to HIV/AIDS (which were more common amongst women than men), parasite and worm infestation, nutritional deficiency, malaria, tuberculosis and diarrhoeal diseases.

The only medical school of the region was situated in Durban as a faculty of the University of Natal and was known for its stance against *Apartheid* and for the training of black doctors during the *Apartheid* years. At the time of the study, the region had two universities who trained nurses at the undergraduate and postgraduate level; as well as presenting various formal programmes leading to additional qualifications in nursing. A number of nursing colleges affiliated to the two universities presented diploma programmes at the basic and advanced level; while Hospital schools mainly trained the enrolled category of nurses.

5.2.2 THE PARTICIPANTS AND THEIR MICRO SETTINGS

The researcher decided to combine the discussion of a particular setting with the discussion of the participants from that setting to obtain a clear and coherent picture of the participants themselves and their environmental realities.

5.2.2.1 Women as nurses belonging to the enrolled category and working in a rural health setting

a) Getting to know the participants

The first focus group eventually consisted of nine nurses who were willing to participate and who belonged to the enrolled category. Of these nine nurses, five were nursing auxiliaries and four were enrolled nurses - see Table 5.1. All nine participants chose their own pseudonym which was used consistently during the interviews. Seven of the nine names chosen, could be viewed as well known western names; while one participant opted to be linked to her religious conviction - the name referring to a maiden martyr probably persecuted by Diocletian for her faith. She was tortured and eventually thrown to the wild beasts - she died at Chalcedon on the 16th of September, 307 (Attwater, 1976). The only Zulu name chosen was "*Zoleka*" - meaning or referring to a quiet disposition or a quiet person.

Table 5.1: Members of rural group (enrolled category)

Pseudo-nym	*Sub-category*	*No of inter-views*	*How long qualified (+-, in years)*	*Brief description and remarks (gathered during spontaneous discussions during interviews)*
LORRAINE	E/N[2]	Two	**Ten**	**50s; working for one year in current health setting; chose to withdraw after two deaths occurred in her family.**
LUCY	E/N	Three	**Ten**	**40s; working for three years at current health setting; has three children.**

[2] E/N indicates an enrolled nurse

Table 5.1: Members of rural group (enrolled category)				
Pseudo-nym	*Sub-category*	*No of inter-views*	*How long qualified (+-, in years)*	*Brief description and remarks (gathered during spontaneous discussions during interviews)*
LULU	N/A[3]	One	Eight	50s; working for six years in current health setting; three children; developed health problem.
MARILYN	E/N	Three	Twelve	40s; working for three years in current health setting; has two children.
NORMA	N/A	Three	Fifteen	30s; working for six years in current health setting; has one child.
NIKITHA	N/A	Three	Fourteen	40s; working for three years in current health setting; has four children.
EUPHEMIA	N/A	Two	Six	30s; working for six years in current health setting; no children; preferred to write down her thoughts instead of last interview.
VICKY	N/A	Two	five	Working for five years in current health setting; has two children; Went on leave after second interview.

[3] N/A indicates nursing auxiliary.

Table 5.1: Members of rural group (enrolled category)				
Pseudo-nym	*Sub-cate-gory*	*No of inter-views*	*How long qualified (+-, in years)*	*Brief description and remarks (gathered during spontaneous discussions during interviews)*
ZOLEKA	E/N	Three	**Nineteen**	**40s; working 14 years at current health setting; has five children.**
TOTAL RURAL	**E/N=4; N/A=5**	**Twenty-two (22)**	**Mean = 11 years**	

The nurses who participated, worked in the different sections of the hospital, and were bound to traditional nurses' duty hours to provide a 24-hour service. Their different schedules (for example day-off), involvement in ward activities and sometimes personal circumstances, often made it difficult for the researcher to meet with them as planned.

The participants were generally soft spoken and friendly, and accepted the researcher within the boundaries set by themselves. Most of the participants initially did express some discomfort with the research; especially in terms of knowing what would be "right" or "acceptable". This concern was usually voiced while explaining the purpose of the research and gaining permission, as well as just after the recording of the first and even the second interview. The researcher had to repeatedly explain to them that there was no right or wrong; that she did not try to test their knowledge; but was interested in their own thoughts, ideas and feelings about the issue at hand. The researcher expected a greater concern from the participants in terms of the recording of the interviews, but the participants generally accepted the procedure well - two even requested the researcher to play back a section of the tape to hear their own recorded voice.

The researcher observed that the participants sometimes had difficulty to express themselves adequately in the English language and often used facial expressions (for example frowning, laughing or smiling), hands (seeking for words]), or even the

body to convey a certain message or meaning. This was more often seen with nursing auxiliaries. In expressing emotion, concepts such as "happy", and "sad" were most often used. The reason for this phenomenon might have been that within the Zulu language a limited range of concepts to describe emotions were available. One of the participants actually requested to rather write down her thoughts than having a third interview; and also at one stage had a discussion with the researcher concerning a matter close to her heart - requesting the researcher beforehand not to audio tape the interview.

b) Getting to know the setting

The health service where the participants worked was located in a relatively remote rural area between the mountains and sugar plantations. The health setting was about twenty kilometres from the nearest small coastal town; and about 130 kilometres from the nearest city. The hospital based service had less than a hundred beds and linked to the hospital were also ten rural clinics. The hospital services provided ranged from primary medical care, maternity care for uncomplicated cases and caring for chronically ill and bedridden patients. The hospital catered primarily for the local (African) community.

All the interviews took place in an office usually used by the deputy matron or deputy charge nurse - she kindly made the office available to me - she then had to share an office with the local head of Nursing Services. The office was painted in a shining cream colour and was sparsely furnished. The windows overlooked a traditional stoep where the patients usually sat to have their daily conversations; at times they sang songs in Zulu beautifully - songs that sounded like hymns. The sounds from the kitchen close by

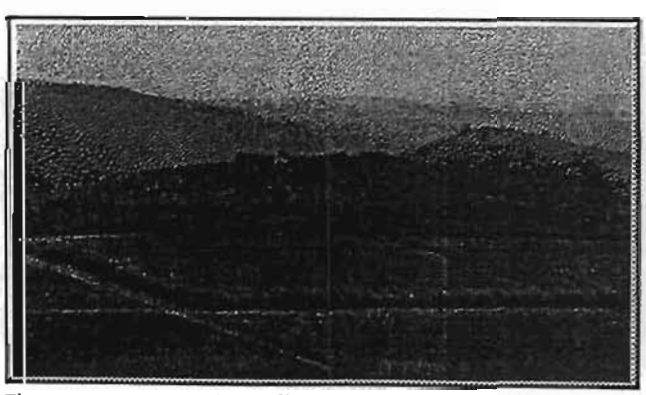

Figure 5.2 The rolling hills ...

often penetrated the discussions and the recordings made; and outside across the corridor I could often hear the sounds of babies crying and of babies being born ...

The interviews were frequently interrupted by a staff member looking for the deputy matron, and once a strange looking man with tattered clothes and a heavy alcohol breath shuffled in and aimlessly took a seat next to the participant. After a lengthy discussion between the two in the Zulu language, the participant gently helped him out of the office and called a colleague to take over. She came back, smiled, and while shaking her head said: "So, where are we ?"

5.2.2.2 Women as nurses belonging to the enrolled category and working in urban health settings

a) Getting to know the participants

The second focus group consisted of five nurses belonging to the enrolled category and who spent their daily working lives in urban settings. All the nurses who were willing to participate were enrolled nurses - see Table 5.2. The participants also chose their own pseudonyms - also more western names that might have some meaning to the participants, for example when the researcher asked FORTUNATE why she chose that name, she said that she considered herself fortunate, strong and happy! The researcher found this remark to be consistent with FORTUNATE's approach to and ways of expressing herself during the interviews: *"and there are still more stars and bright things that are coming ..."*

FORTUNATE had been an enrolled nurse for two years. She had no children and was staying with her family which consisted of the grandmother, mother, and six brothers and sisters. Fortunate was the main breadwinner at home; and was actually on night duty at the time of the interviews. I was willing to come and see her before she went on duty or when she came off duty; but she insisted to come on her days off for the

interviews. She thus travelled by bus from her home each time and considered it a pleasure to come: *"It's a pleasure my dear"*; and usually came in full uniform; except for the last day.. On this day she was dressed in a special navy blue dress with a bright red jacket *"to say good-bye"*. At this interview we shared special moments: I asked her how did she feel when we talked about all these things? She said smilingly and taking my hand:

> *"I feel very much comfortable, Anita. I don't want to tell lies. Feel free, whatever I had within me, it has been worrying me so much. But you were there for me to give me an opportunity to cough it out. This is wonderful. So as I am talking, I have the confidence, the power and you have been basically asking me about the power. It feel so great. Such a wonderful blessing to come to me at this time"*

And I was thinking; what a pleasure and privilege for me to be there and to share in such a powerful blessing; to get to know such a strong woman ...

Table 5.2: Members of urban group (enrolled category)

Pseudo-nym	*Cate-gory*	*Number of interviews*	*How long qualified (+-, in years)*	*Brief description and remarks (gathered during spontaneous discussions and during interviews)*
CLARA	E / N	Two	20	40's; working 13 years in current health setting; one child; went on night duty after second interview.
JOY	E / N	One	24	50's; working 15 years in current health setting; one child; went on night duty after first interview.

Table 5.2: Members of urban group (enrolled category)				
Pseudo-nym	*Cate-gory*	*Number of interviews*	*How long qualified (+-, in years)*	*Brief description and remarks (gathered during spontaneous discussions and during interviews)*
PRETTY	E / N	Three	29	**50's; working two years in current health setting; three children.**
FORTUNATE	E / N	Three	2	**20's; working years in current health setting; no children; staying with family.**
PEGGY	E / N	Three	6	**20's; working six years in current health setting; two children.**
	FOUR E / N	**12; Mean = 2,5**	**Mean =**	

b) Getting to know the settings

Both the health care settings served mainly the historically black community and participated in providing a comprehensive health care within the greater Durban metropolitan area.

Two women as nurses (FORTUNATE and PEGGY) worked in an urban regional hospital that was partly subsidized by the government. This relatively modern hospital was situated in a well-known suburb of Durban; a large cosmopolitan city. Ambulances and delivery trucks were often obstructing the road; while visitors and patients were using the narrow sidewalk to go up the steep hill to the hospital. The entrance to the hospital created an impression of efficiency and accommodation; with a helpful secretary at the front desk. In the absence of the Superintendent or the head nurses the secretary assisted the researcher to find a vacant office. One interview was conducted in committee room.

The other three women (CLARA; JOY and PRETTY) spent their daily working lives

in another urban health setting. This setting was a community health centre which provided a comprehensive health service to a mainly African community. The services provided ranged from promotive, preventive, and primary medical care; as well as a maternity service for uncomplicated pregnancies and deliveries. The very busy centre was situated on the outskirts of Durban in a historically African suburb with a relatively poor infra-structure. Many of the houses were shacks, one or two roomed dwellings; and many houses did not have their own running water. The access roads to the township and leading to the clinic, though tarred, were often strewn with refuse. Battered taxi's provided the local transport.

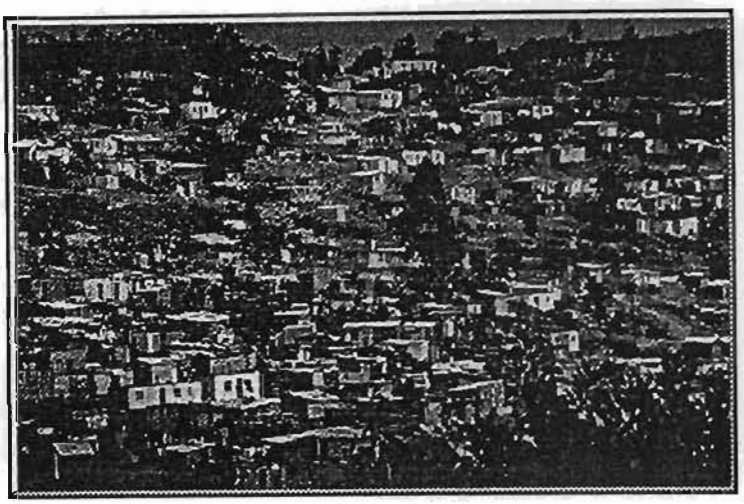

Figure 5.2 Surrounding the clinic ...

The clinic itself was surrounded by walls, barbed wire and a strong presence of security personnel at the large grey iron gate. The centre was apparently situated in an area that was known for its high violence and crime rate which often spilled over into the clinic with gun battles sometimes completed in the clinic where the combatants were brought for medical attention.

As the clinic had no vacant offices - even the deputy charge nurse had to share an office with the head nurse - the researcher had to find an office with the help of the different participants. The interviews took place in for example a doctor's office, a duty room, a so-called examination room and even a cubicle used for patients awaiting treatment. The conditions were far from ideal with frequent interruptions, for example telephone calls and attending to the need of patients and other health personnel. The researcher and the participant often had to sit next to one another on a wooden bench - with the tape recorder often situated too low to make a quality recording. During one interview about three or more babies started crying just outside the door. The typist who transcribed the audio tapes noted: *"Lots of babies*

crying ... I can't hear a thing ... must have been 'happy hour' ..."

5.2.2.3 Women as nurses belonging to the professional or registered category and working in an urban health setting:

a) Getting to know the participants

The third focus group consisted of four registered nurses working in the same urban setting as the three respondents named CLARA, JOY and PRETTY - see table 5.3. They chose names such as GRACE, LEE, TREASURE and ZODWA; and the interviews took place in the same conditions as discussed for CLARA, JOY and PRETTY. The registered nurses were apparently very busy and the times for interviews thus limited. They were all very active in the actual day-to-day direct care to clients and patients; and were not part of the management structure of the service. In observing the day-to-day functioning of the clinic while waiting for opportunities to see the participants, the researcher could sense that the registered nurses worked under difficult conditions with little support from medical practitioners. The patient attendance report underlined these observations. During the first half of 1995, the clinic had an average attendance of 16 000 people per month, with for example an average of 141 deliveries, 1 464 ante natal visits and 3 580 babies and children attending the child health clinic per month (Personal communication with, and a health services computer print-out from the Head of Nursing Services, 31/10/1995).

Table 5.3: Members of urban group - Registered category				
Pseudo-nym	*Cate-gory*	*Number of interviews*	*How long qualified (+-, in years)*	*Brief description and remarks (gathered during spontaneous discussions and during interviews)*
GRACE	SR/N [4]	Three	40	60s; working 24 years in current health setting; two children; divorced; lived alone during week; goes to real home during weekends.
LEE	R / N [5]	Three	14	40s; working 13 years in current health setting; 2 children; happily married to a Sotho man.
TREASURE	R / N	Three	15	40s; working three years in current health setting; 3 children; stays with husband but is in essence separated from him.
ZODWA	R / N	Two	10	40s; working two years in current health setting; two children; divorced; staying alone; goes to parents (where children were) over weekends.
	FOUR R / N	11; Mean = 2,75	Mean = 20	

We were sitting next to each other on a long wooden bench in the doctor's office - between us the black tape recorder with the little red light glowing. On the table in the corner were signs of someone who had just left - without closing the MIMS directory

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[4] S/RN indicated a senior registered nurse.

[5] RN indicated a registered nurse.

or a pad of prescription forms or seeing that the equipment was safely put away ... At times it looked as if LEE (my participant) was staring at the table, but she did not refer to it. She was concentrating on giving me, a stranger, an insight into a normal working day in her life; focussing on the details of getting up and preparing for work ... Outside I could hear the sound of passing cars and of car doors slamming. Suddenly an oldish woman dressed in a blueish uniform walked in. She passed us as if we did not exist and went straight to the table. She methodically started cleaning and tidying the table - LEE spoke to her softly but urgently in Zulu; and the other woman replied. I switched off the tape recorder; and after some conversation between the two of them, the woman in the blue uniform left. LEE just said quietly: " I'm sorry, she is used to tidy the table at this time ..."

5.3 REFLECTING ON THE LIVED EXPERIENCES OF PARTICIPANTS: THE EMERGING OF EXPERIENTIAL THEMES

In musical terminology, a theme is a "*musical idea that is the point of departure for a composition*" - these theme(s) are often contained in the first section or exposition of for example a sonata and in the first and subsequent sections of a fugue (Apel, 1970, p. 843 & 301). For the purpose of this phenomenological study, experiential themes would thus relate to ideas [1] that consistently, recurringly and even progressively expose themselves explicitly and implicitly during the actual interviews and during data analysis. These themes would thus establish themselves as being meaningfully part of the participant(s) and the researcher's lived experience(s).

These themes then form the point of departure for a deeper search, understanding and analysis of meaning - for example thematic parts of the theme were identified; and an epistemological framework of the power of women as nurses were developed (see Section 6).

The initial analysis of these themes sought to find the imbedded similarities and differences between the groups in terms of the experiential themes. Such an analysis also could lead to the exploration of possible overt and covert moments of identity and contradiction and of the universal and particular. Although a few options of analysis were open, the researcher decided to compare and contrast the

- **Urban and rural groups of women as nurses belonging to the enrolled category** (5.3.1); and the
- **Women as nurses belonging to the enrolled category to the women as nurses belonging to the registered or professional category** (5.3.2).

Rationale: Apart from establishing the similarities and differences in terms of the themes, the first analysis (5.3.1) was also done to describe the possible, if any, effect of rurality - rurality being added by the researcher as a fourth premise to the Standpoint theory. The second comparison (5.3.2) was done to seek and highlight the similarities and differences between a perceived more marginalized group (enrolled category of nurses) and a less marginalized group (the professional or registered nurses) which in essence formed a relatively contrasting group.

The experiential themes and their sub-themes identified, were listed and defined by the researcher in table 5.4. The perceived experiences of the participants as related to and understood by the researcher were used as a departure point for these definitions; the researcher tried to capture the essence of the women's "standpoints" in the sections that follow the definitions.

Table 5.4: Experiential themes and their sub-themes	
SUB-THEME	*DEFINITION*
THEME 1 : "ONE DAY IN OUR LIVES" (5.3.1.1)	
Referred to the perceived day-to-day realities of the participants being a woman and being a nurse; including the presence and/or absence of significant others.	
The carer at home	The historical responsibilities of being a woman and mother; and the reality of significant others in her life:
	Early morning carer;
	Late afternoon and late night carer (attending to the children; domestic duties; re-creation & religion; going to bed); &
	Man's presence (passiveness; delay; being served).
The commuter	Depending on public transport:
	(Dis)comfort of transport; &
	Stress of being dependent on transport.
Caring to be and caring on duty	Being a nurse and being able to work highly valued by the participants - the tasks on duty related to people and to things; and to the relationships with and between these:
	Routine;
	Attending to needs of others;
	Administrative duties;
	"Domestic" tasks;
	Communicating & communication; &
	Being a messenger.

Table 5.4: Experiential themes and their sub-themes	
SUB-THEME	*DEFINITION*
THEME 2 : SIGNIFIERS OF POWERLESSNESS OR POWERFULNESS (5.3.1.2) *A signifier indicated or signalled the possible presence of powerlessness or powerfulness in the participants' lives.*	
Signifier 1: ***Choices***	The perceived presence or absence of the will, ability and right to make choices at home and at work: Selective permitted choice;
	Essence of choice;
	Rationale for accepting limited choice; &
	Negotiating choice.
Signifier 2: ***Being needed and/or being important***	Related to an inner awareness of being valuable and meaningful to others - at home and at work.
Signifier 3: ***Perceptions of own freedom***	Being able to create and/or control your own destiny, the route leading you there, and the vehicle to take you there - in essence normative.
Signifier 4: ***Experiences of and with men***	Comparing (their) women's way and meaning of existence with those of (the) men in their lives; as well as related and imbedded feelings: Way and meaning of existence;
	Essence of being a hu-man being; &
	Imbedded feelings.
Signifier 5: ***Relating to medical practitioners***	Perceptions of the relationship between women being nurses and the medical practitioner(s).

Table 5.4: Experiential themes and their sub-themes	
SUB-THEME	*DEFINITION*
Signifier 6: ***Perspectives on nursing and nurses***	The deeper meaning and essence of nursing and the rationale for being a nurse:
	To support;
	To do for;
	To feel;
	To be altruistic; &
	To be available.
Signifier 7: ***Rights versus power***	The complex and embedded relationship between power (an ability) and rights (indicating what belongs to you):
	The right to refuse;
	the right to go to higher authority;
	the right to be respected;
	The right to ask when you don't know; &
	The right to be equal.
THEME 3 : AFFECTIVITY (5.3.1.3) *Indicating the participant's perceived broad or general emotional or affective reality at home and at work.*	
Being valued at home & being valued as a nurse	
THEME 4 : POWER (5.3.1.4) *Seeking to understand the reality and the deeper meaning of the phenomenon of power as related and experienced by the participants.*	
1: Defining POWER	A description of power in the own words of the participant:
	As an ability;
	As a right;

Table 5.4: Experiential themes and their sub-themes	
SUB-THEME	*DEFINITION*
	As authority;
	As strength; &
	As achievement.
2: The power of nurses as WOMEN	Illuminating the perceived reality concerning the unique power(s) of being a woman - from the standpoint of these women:
	Maintaining a family;
	Being a peacemaker;
	Being able to provide;
	Being able to endure / conquer; &
	Being able to love.
3: The power of MEN	Illuminating the perceived reality concerning the unique power(s) of being a man - her standpoint ...
4: The power of women as NURSES	Illuminating the perceived reality concerning the unique power(s) of woman being a nurse and belonging to a certain category or class - her standpoint ....:
	To comfort patients;
	To say no;
	Of not being proud;
	To differentiate right from wrong;
	To handle with insight;
	To teach or educate; &
	To delegate.
5: Being the most powerful at home	Indicating the person perceived to be the most powerful at home.

Table 5.4: Experiential themes and their sub-themes	
SUB-THEME	*DEFINITION*
6: Being the most powerful at work	Indicating the person perceived to be the most powerful at work.
7: The woman and powerlessness at home	Reflecting on the reality of the women's powerlessness at home.
8: The powerlessness of women as NURSES	Reflecting on the reality of women being nurses and belonging to a certain category or class - their powerlessness at work:
	Constraints of hierarchial framework and education;
	Characteristics of work situation;
	Approach of senior category;
	Having to do more than one category's work;
	Threat to registered category;
	Women working together;
	Lack of educational opportunities;
	Symbols of powerlessness;
	Struggle to obtain rights;
	Absence or presence of doctors;
	Effect of violence;
	Luke warm religion; &
	Associated emotional effect.

Table 5.4: Experiential themes and their sub-themes	
SUB-THEME	*DEFINITION*
THEME 5: THE EMPOWERMENT OF WOMEN (5.3.1.5)	
Seeking ways and means to make a meaningful difference to the lives of these women in a way that would come from, find acceptance, foster growth and would ensure fairness and harmony within and amongst themselves.	
1: At home	Empowering the woman at home:
	Forming support groups;
	Negotiation;
	(Re-)Education of men and children; &
	Stronger financial position.
2: At work	Empowering the women being nurses and belonging to a distinct category and a distinct profession:
	Eliminating categories;
	Revise strict rules;
	Increase renumeration;
	Provide educational / developmental opportunities;
	Increase communication;
	Involve in management;
	Uplift working conditions; &
	Remove stigma.

5.3.1 ANALYSING THE ENROLLED CATEGORY OF NURSES:

RURAL VERSUS URBAN

...the photographs of the reality of women as nurses scanned onto these pages; with the researcher using accentuating brush strokes; the brushes sensitively covered with "Thoughts and Ideas Paint" in the colours of the self (the researcher) and others such as those conversing meaningfully through the written word...

5.3.1.1 *Experiential theme 1:* "One day in our lives"

This theme dealt with the day-to-day realities of being a working woman for these nurses participating in the study; and the researcher found that the women generally had a very strong awareness and application of time frames, structure and routine. These were evident in both their descriptions of their activities at home and at work. At home activities were usually spelt out in terms of times for getting up and going to bed, typical domestic responsibilities and activities, and a very few leisure activities such as watching television.

The being at work was structured in terms of going on duty, activities before tea, after tea and before lunch, lunch time and after lunch. The nurses gave exact times for going to tea and lunch; and often even the different tea and lunch times depending on your shift. The researcher got the impression that these moments were very important and meaningful to them - it became like high points in their routine days.

Sub-theme 1: The carer at home (before and after work)

Here the participants related to the traditional responsibilities of being a woman; the complicating factors being the expectations of their men and children and the expectations of the local nursing service in terms of for example duty hours and physical input. The poor services infrastructure of especially the rural setting did not make matters easier; as well as the reality of poor transport services that made them to leave quite early from home. In the urban setting, two of the nurses stayed relatively close to the health setting; but the one was staying alone in a one room dwelling - away from her husband because he was working in another town, about 130 kilometres away.

Table 5.5 : Sub-theme 1: The carer at home

RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
EARLY MORNING CARER:	
Early waking up (0430 to 0530); ***Personal hygiene; and*** ***Preparing food (breakfast and lunch boxes); preparing the children and man (if present) of the house.*** ***"I have these children and a husband too, who is also like a child" (MARILYN)*** ***One participant: Prepared self; prayed.***	**Early waking up (0500 - 0530), personal hygiene, preparing breakfast, children and husband (where applicable)** **(JOY, PEGGY, PRETTY, FORTUNATE, CLARA)** **Clara had a young baby of eleven months old which she still had to breastfeed before and after work:*"I offer the little one breast"***

Table 5.5 : Sub-theme 1: The carer at home	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
LATE AFTERNOON AND LATE NIGHT CARER:	
Attending to the children:	
"How was the day at school, one by one I must listen. I sort the problems, where there are problems; I reassure where I must re-assure" (ZOLEKA); bathing the children.	*"The little one needs mother's love at that time, I am tired - it's night now. So they don't get that love they need from the mother"* (PEGGY)
Domestic duties - a continuation of nursing duties(?):	
Fetch water (LUCY and NORMA); Prepare supper; do household chores.	*"I do the housework, washing and ironing, plus the other things a woman does" (FORTUNATE)* *"My granny she is a pensioner; so she is always complaining ... I have been nursing on duty ... I have to practice it ... so I take care of my granny" (FORTUNATE)* *"I wash my clothes and do all those things ..." (CLARA)*
Recreation and religion:	
Watch television; Do an evening prayer.	*"Then we watch the TV, thereafter, supper and then go to sleep"* (PRETTY)
To bed again:	
Go to bed very tired and early (2000 to 2100) to prepare for following day...	*"When I come home I am usually so tired, I just sit down there, making tea and relaxing"* (PRETTY) Go to bed very tired (PEGGY)

Table 5.5 : Sub-theme 1: The carer at home	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
MAN'S PRESENCE:	
Passiveness:	
"When he comes home there is nothing he does" (LORAINE); "If something happens, you must go and collect, how tired I am coming off duty - does he know I am working also?" (NORMA)	*"He comes home at seven ... he takes his paper and relaxes ... there is nothing that he does"* (PRETTY) *"There is nothing he does because he does not stay with me; he stays in ..."* (CLARA)
Delay:	
"We can't eat if he does not come yet" "He is not expecting me to say I am tired" (MARILYN)	
Being served:	
"Because when he is at home, he asks everything from me" (NIKITHA); After he went to his friend, "He woke me up" (VICKY).	

Sub-theme 2: The commuter

It seemed to me as if transportation was a major issue and a powerful force in the lives of these nurses. Because of not having their own transport, they mostly had to rely on a "privatized" taxis often owned and driven by local businessmen who were very interested in making profit; but did not always make sure that the taxi's were in a roadworthy condition - some of them desperately needs some panel beating; or at least rear brake lights. Violence often broke out amongst

the different taxi drivers and associations with passengers amidst the gun fire.

The passengers often had to stand in long queues and had to just accept the actions and rules of the drivers. These taxi's often travelled at high speed to reach the next group of customers as soon as possible; and often played very loud and booming mostly African reggae music during the trip.

Many nurses in the rural area actually had to catch two taxi's; and the taxi's schedules then had a influence on their going on and off duty times. I felt that the nurses were in essence powerless in terms of this phenomenon.

Table 5.6 : Commuting to and from work

RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
(DIS)COMFORT OF TRANSPORT:	
Leaving home early (at 0600); *Travelling time often an hour or more; often need to take two taxi's* *"The drivers are not happy to come here because it is not safe - they had the business of shooting each other" (VICKY).* *"I just wake up everybody in the house to escort me to the bus stop" because of no street lights (ZOLEKA);*	*"Stays very far"*, used the bus (taxi's unreliable; bus cheaper) (FORTUNATE; PRETTY) Transport costly (PRETTY) *"Yes I walk, part of the exercise"* (JOY) (CLARA) *"The taxi's they are old; they are not safe for my children"* (CLARA)
STRESS OF BEING DEPENDENT ON PUBLIC TRANSPORT:	
"So by the time it is five, half past five (in the evening) for me who stay far, I am very much panicking, so at quarter to six I have got to leave for the transport" (ZOLEKA)	Went back with the same transport (bus or taxi); Hospital transport provided to go home in evening (FORTUNATE)

Sub-theme 3: Caring to be and caring ON DUTY

Some of the women gave a detailed description of their daily responsibilities at work; one could experience the presence of traditional or historical task oriented nursing which needed to fit into neat time boxes of before tea, after tea and before lunch; and after lunch before going off duty. The tasks ranged from early morning prayer, roll call, reading of policies and report taking (*"So when we take the report, you just sense if the day if it is going to be tough"*- ZOLEKA, rural enrolled nurse) - *"and after that we are dismissed and start our work as usual"* (FORTUNATE), to *"checking equipment and blood pressures and patients' conditions"* (CLARA); to providing in and for the basic needs of the patient.

Table 5.7: Caring to be on duty

RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
ROUTINE:	
"When I am on duty I do the routine work" "I do the daily routine" "So we start the routine" (LORAINE, LULU and MARILYN)	***"We do the ward routine"*** **(FORTUNATE)** ***"Then I discharge my patients, carry on with the routine ..."*** **(JOY)** ***"We attend the report; what has happened last; then we check the patients; a routine ..."*** **(CLARA)**

Table 5.7: Caring to be on duty	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
ATTENDING TO THE NEEDS OF PATIENTS:	
Doing bed baths, feeding (supper being at 1700); *Providing physical exercise and change of position,* *"After lunch we have to make the patients to sleep" (NORMA),* *Handing out medicine,* *"Make a bedpan round" (MARILYN) and* *Observing vital signs.*	*"I am responsible for the dressings, giving of medication ... check that the babies are immunised; which is very important in preventing those communicable diseases"* (FORTUNATE) *"Then we start the STD's. I take blood and give injection. Sisters they examine the patient and then give the orders. The STD's we do them twice a day. We do the first lot in the morning, then we go for tea ..."* (PRETTY)
ADMINISTRATIVE DUTIES:	
"Writing papers" (LULU): discharging patients, update prescription charts, writing the diet sheet and "matron's report (MARILYN).	*"I discharge my patients ..."* (JOY)
"DOMESTIC" TASKS:	
For example dishing up food, carbolising and making up beds, and doing damp dusting	*"The first thing I have to do is the cleaning, dusting"* (PRETTY) *" ... tidying the ward"* (JOY)
COMMUNICATING:	
Translating and interpreting for the medical practitioner; contacting relatives of discharged patients - which seemed to be quite problematic and time consuming in terms of for example a lack of telephones and transport, staff meetings in the ward.	

Table 5.7: Caring to be on duty	
RURAL ENROLLED CATEGORY	URBAN ENROLLED CATEGORY
BEING MESSENGER:	
	"Up and down, going to CSD, collecting what ever is not in the wards ... so you find yourself getting very much exhausted" (FORTUNATE)

5.3.1.2 *Experiential theme 2:* Signifying power-lessness or -fulness

The concept signifier related to an indicator, sign or suggester of the possible presence of powerlessness or powerfulness; the researcher was of the opinion that these would eventually be indicative of and meaningful to the phenomenon of power. The researcher identified the following signifiers whilst analysing the data:

Signifier 1: Choices

According to the Concise Oxford Dictionary (1991) choice indicates the power or opportunity to choose. In rethinking the concept, the researcher was of the opinion that the power to choose (choice) was dependent on the existence of three distinct pre-requisites. These were the will - for example the need, awareness, and/or motivation (often thus seen as a voluntary act); the ability - for example on a cognitive, affective and/or psychomotor level; the right - accepted by the majority of the concerned community as legitimate. Choice would be present and active in:

1. Identifying alternatives;
2. Selecting the most appropriate and meaningful alternative;
3. Applying the selected alternative;
4. Monitoring the effect or outcome of applying the alternative; and
5. In re-considering and adapting either or 1, 2, 3, and 4.

The ability, will, right and applying of the concept choice could thus be indicative of a real powerlessness or powerfulness. Many of the rural participants found it difficult to express themselves during this part of the interview; it was as if the concept "choice" was strange and foreign: "Have a choice, where what?" (LORAINE).

The women who were enrolled nurses and who worked in urban settings also indicated that their choices were limited if any, mainly because of their Scope of Practice and the need to treat everybody the same. According to JOY, they did not make any decisions - that was left to the seniors and the Head of the Nursing Services; while PRETTY indicated that she had to do what she was told and what was right.

Table 5.8 : Signifier 1- Choices	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
SELECTIVE PERMITTED CHOICE:	
Under the supervision or absence of the professional nurse - needed to be affirmed with her:	
In times of need or crises, for example when short staffed: "And there is this question in my mind which says at first why were we not allowed to do these jobs? Was it because we are stupidity, yes. Sometimes you feel because they are desperate, they always take us to do those things which they say is beyond our practice. But when the work is right for them, you all of a sudden is not allowed" (ZOLEKA).	
In moments of perceived unfairness:	
	"Not to be overworked when others are sitting ... yes ... I say it in their presence, not go behind ... but if you make me do your job and you are sitting, I won't do it ..." (JOY)
ESSENCE OF CHOICE:	
Needs to provide what is needed by the consumer(s). In the hospital the patient within the constraints of the doctor's "orders" or what sister (professional nurse's) says (LUCY); and at home the man and/or children (LULU). *At home:* *Apparently nothing more or nothing less than those embedded in routine activities at work and at home: "There is not really a choice, it is a routine" (NIKITHA)*	*"I must do what I am told and I must do what I know is right. It is my scope"* (PRETTY) *"No, so and so must say ..."* (CLARA) At home: *"O yes at home I do ... when I feel that is right, I do it"* (PRETTY) *"If I go home I can decide ... I like change ..."* (CLARA) *"it is only laziness, if I don't feel like washing today I won't wash ... that is your choice"* (JOY)

Table 5.8 : Signifier 1- Choices	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
RATIONALE FOR ACCEPTING OF LIMITED CHOICE:	
Accepting an ethical and/or pistic mission	
"Because the patient is waiting for me" (EUPHEMIA).	
To avoid confrontation:	
"I am that person that does not like to argue" "I just do my thing" (NORMA)	
Prevented by Scope of Practice:	
	"As an enrolled nurse I have no choice. If my Scope says you must do this and this, I go according to the guidelines of my scope" (FORTUNATE)
Related to the absence of a subordinate:	
	You get to adjust yourself and do all the work, make sure you do all, because I have no subordinate" (FORTUNATE)
Because of equality:	
	"When nursing care must just be equal, we don't have any choices by treating this one in a better way than another one" (FORTUNATE)
NEGOTIATING CHOICE:	
Discusses issue with husband at home and come to a agreed choice (LORAINE), or just become "a bit stubborn - I just buy what I feel like" (MARILYN)	*"I talk to my husband and say I feel this is what I must do and I do it"* (PRETTY)

Signifier 2: Perceptions of being needed and/or of being important

This signifier tried to grasp the participants' perceptions concerning their inner awareness or not of being valuable and meaningful to others at work and at home. The researcher tried to formulate this signifier in different ways, for example relating to making a difference when present or absent to the people staying behind, being important and being needed by others. It became clear that participants from the rural area found it difficult to relate to this request - as if they did not know or had not thought about it that deeply. In relating to patients in the ward, LULU said for example: *I can't tell. (Laughing). I don't know how they feel. I come in the morning, they are all laughing, they are all happy*". LUCY felt that it was difficult for patients to indicate their appreciation of nurses, especially in the nurse's presence.

The urban group of nurses belonging to the enrolled category were able to relate more freely to this request and indicated that they felt that they were important to their patients, clients and fellow nursing staff. FORTUNATE stated that she felt that the patients were dependent on her for their most basic needs; while PRETTY said "*when I am not here, there is a gap*".

Signifier 3: Perceptions of own freedom

When reading Mill's view on the only `"freedom that deserves the name, is that of pursuing our own good in our own way, so long as we do not deprive others of theirs, or impede on their efforts to obtain it", for, " in proportion to the development of his individuality, each person becomes more valuable to himself, and is therefore capable

of being more valuable to others. There is a greater fullness of life about his own existence, and when there is more life in the units there is more in the mass which is composed of them" ' (Adler, 1952, p. 999). I could tentatively argue the link between being valued and freedom. It seemed as if freedom pursued and exercised was necessary to become more valuable to yourself and others. A lack of freedom or excessively constrained freedom would thus signify a powerlessness to be valuable to yourself and to be valued by others.

In relating to freedom, nurses belonging to the enrolled category found it relatively easy to make a distinction between home and work. In the rural group LORAINE, MARILYN, EUPHEMIA, and ZOLEKA explicitly stated that they have more freedom at home than at work; freedom being "*a choice what we like to do*" (EUPHEMIA). At work the freedom was limited in terms of "*because I can't do what I feel doing. Most of the time I must report first*" (LORAINE). The other freedom limiter was not having a choice in terms of ward allocation: "*If you work in a ward that you don't like, you don't perform well there, you work with your heart broken every day*" (MARILYN).

Concerning at home, ZOLEKA, who had decided to divorce her husband and to stay alone with the children on her own property, voiced her freedom at home as a weak point . She felt that "*people does not take it as something good - more especially if you are not married. You have got to go by somebody*" (usually a man) *"can I do this, can I do that?"*

The urban group of women belonging to the enrolled category also stated clearly that they had more freedom at home than at work, PEGGY in essence stated that the Scope of Practice does not allow you *"talk about it and work it through"*; but at home there was no Scope of Practice! JOY felt that because of her experience at work she was free "*since I know everything*". She did mention that she had to however run away from "*all sickness, like BP's and worries, just to forget about all those*" to be free. PRETTY also was of the opinion that because of her skills and the fact that she was the one who had to do it, she was free at work.

Signifier 4: Perceptions related to and of men

The researcher requested the participants at various moments during most of the interviews to compare and contrast their essence as a human being, their way and meaning existence; as well as imbedded feelings with those of their male counterparts. The participants related relatively freely to these requests, and later spontaneously related to their views as and when they felt they needed to.

Table 5.9: Signifier 4 - Experiences of and with men

RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
WAY AND MEANING OF EXISTENCE:	
Intermittent presence of men:	
"If he comes he just stays for one night and then he goes ... he doesn't provide me with anything, he doesn't work, he doesn't give me any money" (LUCY).	***"There is no man, I am by myself in one room. My home is with my husband at ... I go there when I am four days off ... we don't know each other ... we don't see each other often; so when we see each other we are glad ..."*** (CLARA)

Table 5.9: Signifier 4 - Experiences of and with men	
RURAL ENROLLED CATEGORY	***URBAN ENROLLED CATEGORY***
Men's expectations:	
"Because I sometimes ask him why are you always tired and you are sitting down expecting me to do everything. Yet I am also tired, I am also from work. So he say, oh, you are tired, I know you are tired because you are from work, but as you are my wife, you should do it for me and Must sit down, regardless that you are also from work" (MARILYN). ***"I was coming home at seven o' clock, but he was not at the house. He came at about nine o' clock. UMM. Demanding food" "Look, the husband doesn't like the woman above him" (VICKY).*** ***"Because fathers are always saying that oh, this is not my job, you must do that as a woman" (NIKITHA).***	
Specifies the need for and demands control of the number of children - leaves woman limited choice:	
	".. He will say I am going to take another wife ... OHH ... to give more babies ... then you will say OK just to maintain his marriage, you want to stay here ... so with blacks, some of the things need to be cleared out, really (sigh)" (PEGGY)

Table 5.9: Signifier 4 - Experiences of and with men	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
ESSENCE OF BEING A HU-MAN BEING:	
Men's freedom:	
"They do what like in their own time" (LULU) *"The man is himself. But the woman is not" (NKITHA)* *"... but he has no responsibilities" (NORMA)*	*"They are irresponsible ... our men don't, they don't care about their families. They don't care at all"* (FORTUNATE) *"But he doesn't like that* (to share responsibilities) *... well all of them are like that, but there are those few who are responsible"* (PRETTY) " ... they can not adjust themselves, they just think about themselves" (FORTUNATE)
Men are to be respected:	
"He has got the time to go and booze whenever he wants to. At the same time he has got the time here in the house to be respected, to be catered for you know. So it is almost 80% of my time, I give to him and his freedom ... And when he comes home he is drunk. I must take care of his drunkenness too" (ZOLEKA) *"Some of them are useless" (NIKITHA)*	*"He does sometime say I am the man here..."* (CLARA)

Table 5.9: Signifier 4 - Experiences of and with men	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
IMBEDDED FEELINGS:	
Pain of being a woman:	
"It is difficult to be a woman. UMM. But it is alright to be a human being" (EUPHEMIA). *"He is my husband, but I don't know him" (LUCY)* *"Mine comes weekends ... He don't even says what happened to him during the week" (NORMA)*	*"You know that in life it is so difficult for something that is painful. It has been there for along time and it won't go over. But when the night time comes, you forget about it. But by that time it comes ..."* (nodding head) (PEGGY) *"They are cruel most of the time. Somebody who doesn't care hurting somebody is cruel"* (PEGGY)
Someone to love and share with me as a woman:	
"Sometimes he distracts me from all these things, they go in my head, so if he is there I know. There is somebody to love with, There is somebody to pour in some of my problems" (ZOLEKA)	*"... and I talk to him; and he understands the point why I chose that. So you can work it through"* (PEGGY)

Signifier 5: Relationship to medical practitioners

The researcher was interested whether the above-mentioned tension between men and women were continued between women as nurses and mainly men as medical practitioners.

Signifier 5 a): Rural setting: Enrolled category

Although international nursing literature often referred to the reality of the patriarchal relationship between men as doctors and women as nurses, it seemed as if these nurses working in the rural setting did not really experience this tension. The reasons for this might be the limited exposure or contact with medical practitioners in the rural areas or an unquestioned or conditioned acceptance of the doctor's power and authority. Only one participant related to the phenomenon and more in terms of the equal sharing of this form of "empowerment": *"If there could be more women doctors to at least neutralise the doctors that are more learned* (thus more empowered) *than nurses ... So I think if there are more female doctors the empowerment can be shared" (ZOLEKA).*

Signifier 5b): Urban setting: Enrolled category

Two of the nurses belonging to the enrolled category and who were working in an urban hospital based health setting indicated that in their experience *"that bossy character still remains. He can be educated, he can be white, but that bossy thing remains the same"* (PEGGY). FORTUNATE also related to the phenomenon that they overuse their power - *"even in the working situation the big man they know that we are the subordinates"*. Enrolled nurses needed to wait on the presence and/or orders of the doctor and even their opinion was being discarded because of their position; sometimes to the detriment of the patient (FORTUNATE and PEGGY). The three nurses working in the other urban health setting had very limited contact with medical practitioners probably also, because of the unavailability of medical practitioners in many of the primary health care services.

Signifier 6: Perspectives on nursing and nurses

The researcher found that many nurses spontaneously referred to or aired what was for them, the deeper meaning and rationale for being a nurse. These statements were perceived to be significant in terms of the reality of nursing and nurses for these women. It could also be linked to the participants' perceived placement on the powerless - powerful continuum; which included empowerment as vehicle to move from powerlessness to powerfulness. Some of the nurses expressed the satisfaction derived from nursing, for example, *"I feel so wonderful being able to help the patient"* (FORTUNATE).

Table 5.10 : Signifier 6 - Perspectives on nursing and nurses

RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
TO SUPPORT:	
To help the needy; to give loving care; to be kind to them (LORAINE; MARILYN, NORMA) ***"Because the patient has come to you to nurse the patient because she can no longer nurse herself. So then she has come to seek help. But when you give help, you don't impose power, but you give her in a way that one who needs help, must accept it" (ZOLEKA)***	
TO DO FOR:	
To do everything for the patient (LORAINE). ***"You have got those things that you made an oath, you swear that you do this and that on behalf of the patients" (MARILYN)***	

Table 5.10 : Signifier 6 - Perspectives on nursing and nurses	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
TO FEEL:	
"Well with the patients that is why we are working, because we feel for them" (MARILYN)	
TO BE ALTRUISTIC:	
"One must be very dedicated to nursing, rather than doing it for the money. It demands a lot from you (ZOLEKA).	*"we are here for the patients ... when they are in the ward we give them perfect nursing care" (FORTUNATE); "as I took this profession of serving the community..." (PEGGY)*
TO BE AVAILABLE:	
"You even apply nursing in the street, you even apply it at home" (ZOLEKA).	

Signifier 7: Rights versus power

While conducting these interviews, the researcher contacted an academic and colleague who was proud to be part and from the African culture and who had a deep understanding of the reality of the African women. She explained to the researcher that the concepts AMANDLA (power) and AMALUNGELO (rights) were very close to one another in the Zulu language. To understand and to expose this relationship, the researcher decided to incorporate these two concepts in her discussions with participants where possible and meaningful.

In the rural group of women as nurses belonging to the enrolled category, NIKITHA and VICKY felt that they were one and the same thing while MARILYN felt that one needed power to get your rights. ZOLEKA formulated the difference in similar but clearer terminology: She explained that rights needed to be exercised, and power

must be *"given"* to somebody to exercise his or her rights. Power would thus be necessary to exercise or apply rights.

In the urban group of women as nurses belonging to the enrolled category CLARA was of the opinion that a person's right was based on who he or she was, for example, the woman being a mother gave her the right over her child and the child had certain rights, being a child.

Table 5.11: Signifier 7 - RIGHTS

RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
THE RIGHT TO REFUSE:	
"We are given, what can I say, work that is beyond our scope. We have the right to tell the sister in charge that it is not our duty" (LUCY)	
THE RIGHT TO GO TO HIGHER AUTHORITY:	
"We have the right to see the one who is superior" (LUCY)	
THE RIGHT TO BE RESPECTED:	
"Patients must know that I am a nurse too, they mustn't do as if I am at home"; "they don't give us the dignity of nurses" (NORMA)	
THE RIGHT TO ASK WHEN I DON'T KNOW:	
	***"I have the right to ask the sister if I don't know"* (CLARA)**
TO BE EQUAL:	
	***"We are the same* (human), *so we must be given equal rights"* (PEGGY)**

5.3.1.3 *Experiential theme 3:* Affectivity

The researcher tried to get an indication or an understanding of the participants' emotional or affective experiences both at home and at work. Participants used limited but meaningful words to describe these, such as "happy" and "; and easier related to their feelings at home - especially as a mother. Although CLARA, who worked in the urban setting, was happy at work, she indicated that she was often worried about her little baby.

Table 5.12: Affectivity

RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
At home:	
Being needed and loved: ***"I am very happy at home ... it's warm and I am, always needed at home" (LORAINE)*** ***"Eh, at home they (the children) like me, they love their mother ... Yes. Life is fine" (LULU)*** ***"Oh, sometimes I feel, like what you mean, relaxing, watching TV, but I can't do that, I must do that, I must cook food for my children, I must clean the house, you see" (NIKITHA)***	***"Ya am happy because the children are grown up now. So here is a lot of work for me to do ... I am very important at home ..."*** (PRETTY)
Being valued as a nurse:	
	"they sometimes come to me as a nurse and ask some questions related to nursing" (FORTUNATE)

5.3.1.4 *Experiential theme 4:* Power

This theme usually formed the main thrust of the second and third interviews with participants and tried to relate to, for example their thoughts, feelings, perceptions, experiences and ideas concerning powerlessness, powerfulness and empowerment. For purposes of clarification the researcher had to constantly request participants to elaborate or to provide examples. She also had to return to the participants to validate the essential parts of the experiential theme of power. During the first interview, participants were prepared to discuss the phenomenon of power at the following and successive interviews. This might have given the participants an opportunity to clarify or discuss with others, but on the other hand, the researcher felt compelled to give the participants an opportunity to prepare themselves - especially as many indicated that they felt unsure whether they would know what to say. The spontaneous nature of the interviews and the rapport developed between the two participants also aided free and open discussion.

It was clear to the researcher that many of the participants thought about the phenomenon before the interview; the researcher spontaneously indicated her appreciation for their thoughtfulness and involvement.

Sub-theme 1: Defining POWER

The researcher requested the participants to describe the concept power in their own words - the participants did not find this request easy and they often pondered a while before venturing an answer.

Table 5.13: Sub-theme 1- Defining power	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
AS AN ABILITY:	
"It is the ability to do things" (LORAINE); "I can do things that make people feel better" (NIKITHA); "... to be able to do whatever you think is right; and at the same time to do it freely" (ZOLEKA)	*"to me I can analyse it as something that sometimes are given and it sometimes comes on its* own. Ability *to initiate something ..."* (PEGGY)
AS A RIGHT:	
"Power I think is your right" (LUCY); "...power is the right given to somebody or to certain people, to do things on their own, without depending on somebody else" (MARILYN)	*"For me power is also the right over other people, for example over my kids ..."* (CLARA)
AS AUTHORITY:	
"Power means that if you are something is greater than, like a father at home. The father is the head of the family, it means that he has got all the power" (NORMA); "In the church, the power is the authorities" (EUPHEMIA)	
AS STRENGTH:	
".. Somebody has strength" (VICKY)	*"Power means to be strong ... like lifting up something ..."* (CLARA)
AS ACHIEVEMENT:	
	"When I think of power I think of the best results; of the good outcomes which can happen through the power that I have" (FORTUNATE)

Sub-theme 2: The power of nurses as WOMEN

In relating to the powerfulness of women, many of the nurses belonging to the enrolled category referred to the power of a woman to construct and maintain families and to provide. The ability to endure, to love and to make and maintain peace were also mentioned.

Table 5.14: Sub-theme 2 - The power of women as nurses

RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
MAINTAINING A FAMILY:	
"As a woman, I have the power for constructing my family (LORAINE) ***"We are bringing children"; "I look after the children" (NIKITHA);*** ***"(the mother) - her voice must be listened to" (VICKY);*** ***" ... and look after the children, and everything in the house depends on me" (MARILYN)*** ***"I am the one to say, hey kids, you must do this now" (ZOLEKA)***	***"Like caring the children and caring for others. Cooking for them, washing for them, giving love"*** (PEGGY)
BEING A PEACEMAKER:	
"... and we are even giving peace ... we don't use weapons" (ZOLEKA)	
BEING ABLE TO PROVIDE:	
"So I get tired to ask money ... sick and tired of asking ... so OK I am working, I will do it for myself" (NKITHA)	***"Even if the mother is not working, but she can do everything for the child. She try by all her means to do everything ..."*** (PEGGY)

Table 5.14: Sub-theme 2 - The power of women as nurses	
RURAL ENROLLED CATEGORY	URBAN ENROLLED CATEGORY
BEING ABLE TO ENDURE / CONQUER:	
	"I can make an example ... being a pregnant woman means that particular woman has power to have strength to stand all the bad things that can happen to her ..." (FORTUNATE) *"I got the power to face two years studies ... because I conquered that examination"* (FORTUNATE)
TO LOVE:	
	"I think about power lies mostly on love ... as women; ... and the love she must also give to the family" (FORTUNATE)

Sub-theme 3: The power of MEN

> *"The men who are given power, they say they were given power by God. They were great at first which means they are the first ones. So we came after them. It even goes as far as the land. They are the people who govern the land. If you are a woman, you cannot get it if you haven't got a man. If you are not married, they even say at least if you have a got eh, eh, a boy, OK they can give you through that boy; which means even he* (the child) *has more power than myself"* (ZOLEKA; belonging to the rural group of nurses).

In the rural setting, land and other resources were traditionally controlled by the chief and the elders. The priorities for development and improvement of conditions, were also set and decided by this group. An example quoted was the decision to install telephones before developing the provision of water to the houses: *"The reason is*

that they don't see the need of it, because they are not the one to bring water in the house. It is for us women to go to the river, to carry the bucket of water" (ZOLEKA).

The women as nurses belonging to the enrolled category and working in an urban setting also indicated that the power of men was strongly established and acknowledged within their perceived reality; this lead to discomfort amongst the women. They did not however, feel that they could control it (CLARA, PRETTY).

Sub-theme 4: The power of the women as NURSES

The essence of the power of women as nurses as related to the researcher, indicated an for example an awareness of power to comfort, to refuse, to differentiate between right and wrong and to handle with insight. These powers could indicate an inherent ability to choose and to decide and could thus be seen as contradicting the previous stated inability to choose. The researcher, however, felt that these powers as listed below; stemmed more from professional and social conditioning. It also stemmed from an effort to make the reality of nursing more comfortable and acceptable to, and for, themselves.

Table 5.15: Sub-theme 4 - The power of women being nurses

RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
TO COMFORT PATIENTS:	
"I can make the patient comfortable without my seniors' help" (NIKITHA); "to save the patient" (LUCY); Yes, the patient must listen to me. If he is refusing to take the medicine, the treatment, I need the power to scold him" (VICKY)	

Table 5.15: Sub-theme 4 - The power of women being nurses	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
TO SAY NO:	
"... we must have the power to say this must not be done by us" (VICKY)	
OF NOT BEING PROUD:	
"They are the people who are not proud. They can nurse the patients, all types of work. Not like others who say tell so and so to do that thing" (LORAINE)	
TO DIFFERENTIATE RIGHT FROM WRONG:	
"I have the power to do right or wrong .. What to do to the patient .. I have to agree with what is right and disapprove what is wrong. That is my right" (LORAINE)	
TO HANDLE WITH INSIGHT:	
	"... but through the power that she has within you, can set the tray properly and assist the doctor properly, having a good insight that you want to achieve to save this patient" (FORTUNATE)
TO TEACH / EDUCATE:	
	"Alright, (because I have done the courses) I have the power to call those students to come together and listen to me and give out whatever I have to give ... I will have the power to the junior students" (FORTUNATE) *"...the power I have to give health education to him (a diabetic patient) will make his life more ..."* (PEGGY)

Table 5.15: Sub-theme 4 - The power of women being nurses	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
TO DELEGATE:	
	***"I have power over those below me ... I can delegate ... like to the assistants and the general assistants ..."* (CLARA)**

Sub-theme part 5: Being the most POWERFUL person at HOME

In indicating the most powerful person at home, the rural participants often gave two responses: referring to the mother (themselves) and/or to the man (father) in the house. The participants who referred to the mother, primarily mentioned the powerful ability of the woman to look after the family and the house (NIKITHA, EUPHEMIA, VICKY, and ZOLEKA). In referring to the man, they linked his powerfulness with culture, tradition and religion: *"According to black culture, something that makes me feel I don't have power, because our husbands have more power than women"* (NIKITHA); even the Bible underlined that they are the boss (LORAINE). ZOLEKA questioned the real meaning from the bible: *"To think God made us to be a doormat. They even said in the Bible' he took a rib, we are equal, we are all created by God"*. In the urban group of women belonging to the enrolled category, FORTUNATE referred to her own mother who was a divorcee and single, but who was able to raise them very well under these difficult conditions. The inherent reality of being a career woman and a mother was also underlined by Fortunate.

Although CLARA (from the urban enrolled category of nurses) indicated that the man (her husband) was the most powerful person at home, she did add that she respected him and could tell him that she did not want to do this or that. She also mentioned that he did not always like this.

Sub-theme 6: Being the most POWERFUL at WORK

Eight of the nurses belonging to the enrolled category and working in a rural setting indicated that the most powerful person in their health setting was the Head of the Nursing Services, while three added other officials such as the hospital administrator and the medical superintendent. The reasons stated mostly related to positional and knowledge power; and ranged from *"because of the position and qualification", "they are the most learned", "she is on top","she is the chief", "they are taking the upper chairs"*, and *"whatever she says, there is nobody against it - she tells you what to do, you are not allowed to say your opinions or what"*.

In the urban group of nurses belonging to the enrolled category, CLARA, FORTUNATE and PEGGY indicated the Head of Nursing Services. The reasons stated also related to clearly to the woman's experience, information base, position and education. An added dimension was however, the person power of the Head of Nursing Services: *"she has got a power, it is not easy to be in charge of the people, in charge of the other women who also got degrees, to stand in front of them ..."* (FORTUNATE).

CLARA, PEGGY and FORTUNATE also indicated that the person who is next to the bed of the patient, for example, the junior nurse who admitted the patient and did the first observations is very powerful. The nurse with considerable experience was also perceived to be powerful. CLARA said that *"I have power over the patients, I can tell them go there, do this, sit here - they must listen to me"*. In the nursing profession, FORTUNATE added the S.A.N.C.: *"... because they are the ones that offer rules and regulations about the practising of nursing, the guidelines that you must go under, all the scope of practice and whatever"*.

Sub-theme 7: The woman and POWERLESSNESS AT HOME

LUCY, a nurse belonging to the enrolled category and staying in the rural area, shared her pain of having to leave her home and her husband because of violence in the area. She now made use of temporary shelter and *"we are just hanging around here. The kids you know, will get confused because we stay here and there. Even at school they won't cope. So that is why I have no power at home"*. Both LUCY and MARILYN also indicated that a lack of communication and presence of misunderstanding made them feel powerless at home, although MARILYN indicated that she had managed to work on it. The behaviour of men (for example drunkenness) (MARILYN) and the lack of financial resources to iniate projects at home such as farming (ZOLEKA) was also mentioned.

Both FORTUNATE and PEGGY indicated that the men at home did try and control them: *"even as a woman you have the power, but whatever the man is next to you, he always want to have more power"* (FORTUNATE); "... just because I am a female, I must just agree with everything, whereas he can't as a male" (PEGGY). Clara felt that there was not anything in particular at home that made her feel powerless, while PRETTY indicated an awareness of powerlessness in the presence of and in relation to men.

Sub-theme 8: The powerlessness of a woman as a NURSE

The nurses who belong to the enrolled category and worked in a rural setting voiced a strong sense of powerlessness, especially in terms of the relationship between the different hierarchial categories; and the "misuse" of the enrolled category. Both LORAINE and NIKITHA also identified this category of nurses as the most powerless in the health care setting; with the auxiliary nurse at the bottom of the scale.

"Because oh, I am an assistant, I am under the enrolled nurse. Sometimes she is dirty and if the problem becomes worse, if I look these things, I think I have a chance to do this, I do it faster than her. My problem is I am not, I am under her" (EUPHEMIA).

In the health setting itself, the general assistants (for example the cleaners) were considered the least powerful (rural group): "*They've got no voice. I think they have something to say. I think everybody must have something to say*" (CLARA).

Table 5.16: Sub-theme 8 - The powerlessness of women as NURSES	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
CONSTRAINTS OF HIERARCHIAL QUALIFICATION FRAMEWORK AND EDUCATION:	
"Sometimes you know what to do, but you can't because of your qualification" (LORAINE) *"Oh, this is a professional nurse, so she is above, she has got power. So she can say whatever she likes. And I will follow that instructions" (LUCY)* *"... if I can do this for the patient maybe it will do, but then you have to ask permission from the sister superior" (MARILYN)* *"I got no power, because I am not well educated" (NIKITHA)* *"Many things it is not allowed to do. Because I am smaller than them" (EUPHEMIA)* *"we have to do what is written down" (MARILYN)* *"eh, you just let your senior ride you, because you are the junior. Umm. And that somebody has been empowered upon you .."; "She is the one to delegate, you have got to ACCEPT THAT, yes accept that" (ZOLEKA)*	*"I have no power over the sisters, because they are higher than me"* (CLARA) *"I might have the feeling, might have the power to assist the doctor, but due to the certain scope and some regulations I can become powerless"* (FORTUNATE) *"There are things that you want to do but you can't, so those you can say you are disempowered by them. Like giving of drugs, the scheduled drugs ... - well you tell the patient, you are waiting for the keys, the patients tell him that no, this one, why she can't have the keys ... at home I do keep the keys anyhow you know ... that leads people in nursing updating themselves, not for improving the standard, but just for the sake of being a superior somebody, you see"* (PEGGY)

Table 5.16: Sub-theme 8 - The powerlessness of women as NURSES	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
CHARACTERISTICS OF WORKING SITUATION:	
"And if we are short staffed, so I think that can also take your power away" (LUCY) *"But at times we are left alone on the wards, and we do all the jobs that are supposed to be done by the sisters" (MARILYN)* *"People have lost their conscience at work - they are merely working ... patients are not satisfied with the nursing care" (EUPHEMIA, written)*	
APPROACH OF SENIOR CATEGORY:	
"Since we are working with sisters they are harsh" (LUCY) *"... because they (the sisters) are always top level. When she is sitting down she asks us to do this and that" (MARILYN)* *Newly qualified professional nurses were taught by the enrolled category, but as soon as they felt competent they forget the assistance they had (EUPHEMIA, written)*	The subordinates listened and tried to understand the professional nurse, but *"when somebody under her who is having the same problem, she doesn't take it as her subordinates have taken it ... she doesn't understand the world we are living in"* (PEGGY)
HAVING TO DO MORE THAN ONE CATEGORY'S WORK:	
"... because at times we do the work that is supposed to be done by sisters. And those duties that are also supposed to be done by ENA's; because we know both the job descriptions"; "You see at the end of the day you are the only one with painful feet (MARILYN)	*"We are in that in between situation ... we are doing most of the sister's work, suturing, plaster of Paris ... we are the stand-in person ... this makes me feel I must go and train, but I can't with the small baby and the husband"* (CLARA)

Table 5.16: Sub-theme 8 - The powerlessness of women as NURSES	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
THREAT TO REGISTERED CATEGORY:	
"May be they feel you are just lowering them" (LORAINE) *"Low level of co-operation at work causes poor relations and ill feelings at work" (EUPHEMIA, written)*	
WOMEN WORKING TOGETHER:	
	"...that attitude in nursing profession being led by the females; because they have that attitude of not loving one another" (PEGGY)
LACK OF EDUCATIONAL OPPORTUNITIES:	
"They (we) are always make application to go and do (bridging course) .. But one person in two years (can go) and how long will that take" (MARILYN)	
SYMBOLS OF POWER OR POWERLESSNESS:	
	"Sometimes you find the patient was dissatisfied by the dressing because it was done by someone without epaulettes ... UMM *... Because he thinks those people with epaulettes, maroon or white, they are the people who know very well.* UMM *... Irrespective of their experience"* (PEGGY)

Table 5.16: Sub-theme 8 - The powerlessness of women as NURSES	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
STRUGGLE TO OBTAIN RIGHTS:	
"When we hear from the others that are working in an urban area, and have all the rights ... they are all put in the bridging course, every staff nurse ... So they are getting their rights. But here in the bundus, we have got to talk a lot before we get what we want" (MARILYN)	
ABSENCE OR PRESENCE OF DOCTORS:	
"Doctors here they are few and work on a part time basis - in most cases nurses work independently (EUPHEMIA, written)	
EFFECT OF VIOLENCE:	
"Violence interferes with the quality of life because many people loose their residential areas and are forced to stay in shack houses which are very cold and predispose them to flue and other conditions" (EUPHEMIA, written)	
LUKE WARM RELIGION:	
"We have put God behind all our activities" (EUPHEMIA, written)	

Table 5.16: Sub-theme 8 - The powerlessness of women as NURSES	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
ASSOCIATED EMOTIONAL EFFECT:	
"Sometimes it is problem because we just accept it, because it is at work" ;"So it makes you unhappy at work" (LUCY) *"Oh, it does not make me feel good" "I just put it inside ..."(NIKITHA);* *"I have accepted it" (LORAINE)* *"Emotionally you become depressed. Become frustrated" "I wish I could one day beat (In terms of education) those seniors so that she feels what she is doing to me" (ZOLEKA)*	*"You are finding that you are having that inferior complex"* (PEGGY) *" ... it makes me feel inferior; I don't feel free"* (CLARA)

5.3.1.5 Experiential theme 5: The empowerment of women

Women were requested to identify and discuss possible ways to make a difference to and to change their lives in the areas they feel were important. The concept of empowerment was phrased in terms of "giving more power or "make more powerful" where necessary to facilitate understanding.

Sub-theme 1: At HOME

The researcher got the impression that it was difficult for these nurses to relate to

the possibilities of, and for, empowerment. It seemed as if most of the responses of the nurses belonging to the enrolled category and working in the rural setting centred around opportunities for education or development, negotiation, support and a stronger financial position. The urban group had limited proposals; CLARA for example said: *"I wonder what to say now ..."*.

Table 5.17: Sub-theme 1 - The empowerment of women at home

RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
FORMING SUPPORT GROUPS:	
"We are organizing something for women, just to empower them because in my area, where I am staying, a lot of men are drinkers ... so we made a group and we sit down once a week, discuss our problems with them" (MARILYN)	
NEGOTIATION:	
"... (my husband) he was, he had his own name, eh his word had to be done ... but I did try to understand him. And he stayed at home, had the discussions with him, and he also understood me. Then we tried another style of living" (MARILYN) ***"I have got a tendency of sitting down with them. I have a round table system to say or sit down and talk. UMM. ... I let them take out their feelings" (ZOLEKA)***	***"If I can have the right to say I'm not doing this, I'm tired ... he has to wait for me till I can do it .."*** (CLARA)
(RE-)EDUCATION OF MEN AND CHILDREN:	
"May be if they can be told how to behave at home. Maybe some of them will change. If all the men should go and learn how to keep their families, maybe some will get better (NIKITHA)	***"We (need to) teach the young ones that being a female and being a male, we are the same, so there is no need for them to make us feel that we are just, our place is just in the kitchen"*** **(PEGGY)**

Table 5.17: Sub-theme 1 - The empowerment of women at home	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
STRONGER FINANCIAL POSITION:	
"they must give them money ... SO THAT THEY CAN START WITH THINGS ... yes" (ZOLEKA)	

Sub-theme 2: At WORK

In relating to empowerment at work, the responses varied from deleting the category system and the strict rules to increased renumeration and educational opportunities.

Table 5.18: Sub-theme 2 - Empowerment at work	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
ELIMINATING CATEGORIES:	
"And I think if nursing was just one category, may be we would all ... if we were enrolled nurses, or if we were all trained sisters. Nobody would worry each other or trouble each other ... we would all be equal" (LORAINE)	
REVISE STRICT RULES:	
	"Because to me I see no reason why there is so much strict rule that as an enrolled nurse that I am not supposed to touch the drug cupboard and to keep the drug cupboard key ... like also the suturing of patients as soon as you are taught how to suture the patient, you can suture the patient ... revise Scope of Practice" (PEGGY)

Table 5.18: Sub-theme 2 - Empowerment at work	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
INCREASE RENUMERATION:	
"It is a financial problem" (LORAINE) *"... that I don't get enough salary to meet my needs" (LUCY)*	*"Right, salaries. Right. If I can be offered a salary that is equal to my needs, I can have more power"* (FORTUNATE)
PROVIDE EDUCATIONAL / DEVELOPMENTAL OPPORTUNITIES:	
"So that we can be given the chance to go and do studies, and have these study groups that everybody is getting, in the course of the year. Maybe we can do something like the Bridging course" (MARILYN) *"I know may be I can't do the four year course, may be I can try enrolled nurse. If they can think about us" ; "If you can give us more education, because I felt embarrassed as a nursing assistant you can't do this, you can't do that" (NIKITHA)* *"I think they must give us more study. Like other contemporaries. Like other nurses who go and do the bridging course and sisters who do everything" (VICKY)* *"Well as a woman ... If you are educated enough, you can have power" (MARILYN)*	"... chances of education" (FORTUNATE) "... we need to be motivated to have self-esteem ... to be given opportunities ... to do what they can do freely" (PEGGY) *"Make feel I must go and train ..."* (CLARA)
INCREASE COMMUNICATION:	
"So we are having some meetings, where we learn to express our views" (ZOLEKA)	*"Being are being permitted to voice out whatever problem we have got"* (FORTUNATE)

Table 5.18: Sub-theme 2 - Empowerment at work	
RURAL ENROLLED CATEGORY	*URBAN ENROLLED CATEGORY*
INVOLVE IN MANAGEMENT:	
"If they could involve us in the plans they are doing, there are some policies for the institutions. If they could involve one or two, in all categories ... they give us power to feel that we are also people, we are also needed in this nursing profession; our contribution is valued " (ZOLEKA) *"If that can go on and be recognized in such a way even in our headquarters. HEADQUARTERS, MEANING? Meaning, eh, the Nursing Council. There should be one people representing the nurses. Because that person is really heading the experience, the knowledge and she is having the feeling of how the enrolled nurses, how they feel, in the nursing practice" (ZOLEKA)*	
UPLIFT WORKING CONDITIONS:	
	"We must be in a comfortable working condition with all the sufficient facilities, equipment ..." (FORTUNATE)
REMOVE STIGMA:	
	"Because even that stigma was there long time ago, so it will take time for it to disappear ... the young ones need to bear that in mind" (PEGGY)

5.3.2 Comparing the *enrolled and registered category* of women being NURSES and nurses being WOMEN

The researcher summarised the themes and categories developed for the women as nurses belonging to the enrolled nurse category and used this summary in the comparison with the registered nurse category. Only the registered category was illustrated with quotes from the participants and anecdotal information where perceived to be meaningful.

5.3.2.1 Experiential theme 1: "One day in our lives"

Three out of the four registered nurses interviewed were divorced from their husbands, although TREASURE's husband still stayed with her. Two were also separated from their families (for example their children) and stayed alone in an uncomfortable small dwelling. Both these professional nurses provided (bought) a home for their family in another area; and saw their families only when they were week-end off, for example, GRACE saw her family once a month. ZODWA said: *"I stay alone because of the work"*.

TREASURE and her family encountered financial problems when her husband's van got stolen "*and I mean the insurance did not pay out and you can't move without transport - that is how it all came down. Then we had to sell the house because we could not pay for these three children - we are renting at the moment ...*". It was clear to the researcher that TREASURE had to solve this problem: "*Ya you move up, I mean there is no use sitting on a problem and feel sorry for yourself, because you don't get time to think and see ahead*".

The registered nurses were inclined to relate to their daily tasks at work in fairly broad terms, for example *"it is a continuous process"*; *"a lot of paper work"*, *"just an ordinary day's work"*, *"so we do all these things"* and *"by the time the day ends I am nice and tired with the feet you know"*.

Three of the registered nurses were verbally and paraverbally strong, while the fourth registered nurse was inclined to use short sentences and the minimum of words. All four nurses were friendly and accommodating, although the researcher realized that it was not easy for them to re-orientate themselves from the hectic and apparent routine activities that they were part of and involved in, that very moment - the researcher's visits might have even had a dislodging effect on them. They often referred to how busy they were and the researcher often witnessed the large number of clients waiting in the corridors. The registered nurses had the same strong awareness of routine and time frames:

> *"I come on duty. I sign the register. I write the time I arrive and I start working. I start by ordering the treatment, and after that I do the damp dusting. Then I do the treatment fort the patient, so that I give health education to the STD patients. After that I start working, from 0830 to 1000. Then I go for tea. After that I continue ..."* (ZODWA)

Table 5.19: Experiential theme 1 - "One day in our lives"

ENROLLED CATEGORY	*REGISTERED CATEGORY*
THE CARER AT HOME:	
Early morning carer:	
Waking up early; personal hygiene; preparing children (including to breastfeed small baby) and man of the house.	**Get up between 0500 and 0600; wash; prepare breakfast (GRACE; LEE; TREASURE, ZODWA); "... *in fact routinely I must leave everything tidied up" (GRACE)***

Table 5.19: Experiential theme 1 - "One day in our lives"	
ENROLLED CATEGORY	*REGISTERED CATEGORY*
Late afternoon and late night carer:	
Attending to children and grandmother; domestic duties; fetch water. *Watch television; pray.* *Go to bed relatively early and tired.*	Fetch water in the afternoon, attend church services and/or meetings (GRACE); do the cooking, watch TV (LEE; TREASURE) Studying (ZODWA)
THE COMMUTER:	
Emphasized having to leave early; take more than one taxi. *Needed escort to the taxi rank; unsafe and uncomfortable.*	Either walked to work or made use of one or two taxi's: "*... and then I have to wait for some time on the queue*" (LEE).
THE CARER ON DUTY:	
Routine:	
Work = routine	*Work = routine (ZODWA)*
Domestic tasks:	
Cleaning, dusting and tidying	*Dampdusting (ZODWA)*
Communicating & communication:	
Translating and interpreting for doctors; communicating with relatives of discharged patients	
Being messenger:	
Fetching what is needed for ward and patients; very exhausting.	
Referral:	
	"If you can't help them, you also refer them" (TREASURE) *"It is only if I refer the patient if it is too much for me"* (ZODWA)

Table 5.19: Experiential theme 1 - "One day in our lives"	
ENROLLED CATEGORY	*REGISTERED CATEGORY*
Clinical involvement:	
In terms of attending to routine basic needs of patients and performing selected tasks; for example dressings, immunization and giving out medicine.	***"We do examinations for people ... we give treatment ...*** (TREASURE) ***"... check on the medication"*** (LEE) ***"I have to do the nurse's work who is off-sick ... "*** (GRACE) ***"I give them treatment"*** (ZODWA) ***I am used as a consultant*** **(being an advanced midwife)" (GRACE)**
"Personal refreshment" tasks:	
The walls: Going for tea and lunch.	**Going for tea at ..., going for lunch at ... (GRACE, LEE, TREASURE, ZODWA)**

Reflection:

This theme dealt with the woman as a carer at home and at work as well as being a commuter. Both groups of nurses were thoroughly involved with the traditional and often monotonous duties of a being a woman and a mother - being responsible and caring for the home, the children and the man of the house [6] where and when present. These women were thus placed in the historical carer framework which

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[6] "Man of the house" referred to the male companion who were intricately part of the woman's everyday and life - he could be for example her husband; friend; or even a significant adult family member.

included manuality, maintenance, and emotional commitment imbedded in nature. According to Guillaumin (1995, pp. 229 & 230) the nature to which women are renegated to; the nature which is supposedly internal to women, and which stamps the woman's actions within a specific social relationship, is:

> *"a class relationship imposed on us by the modalities and the form of our life ... the nature argument tries to make us into finite closed beings, who pursue a tenacious course, consisting of repetition, enclosure, immobility, and maintenance of the (dis)order of the world".*

In South Africa, the plight of for example, the woman as a domestic worker was often neglected by scientists as a not distinct social class and group that perform duties outside the standard urban occupational and economic duties (Delport, 1994). The nature of nursing in South Africa as often *doubling domesticity* in terms the the daily tasks of women as *nurses* and nurses as *women* was, according to the researcher, also ill defined and described.

According to McCormack (1976, p.14) political philosophers have emphasized the need for freedom from necessity and labor - the womens' reality often very depleted from those moments of leisure. To reflect as good citizens *"on the just and moral state"*.

THE NURSES AS WOMEN BELONGING TO THE ENROLLED CATEGORY ...

Both the rural and urban groups did in essence not question the above mentioned roles and status - thus signifying a powerlessness or acceptance of being oppressed. The rural group of women did however strongly indicate a concern about and an element of resistance towards men's passiveness and dependence, as well as men's reluctance to fulfill any responsibilities at home; this seemed to be quite pronounced and real in their daily lives. Men's limited concern with the working

woman's feelings of tiredness were also observed by the rural women; but they seemingly did not question the fundamental choice to be and acceptance of being a mother and a carer and performing all these duties within this limited and socially and culturally defined, framework. To the contrary; in the rural setting it was indicated as a failure or wrong to opt for a life of independence as a woman and even a single mother.

Evening activities for both groups revolved around for example preparing supper, giving, expressed as limited or too little attention to children, watching television, praying and going to bed relatively early. The imbedded conflict of not giving enough attention to the children and on the other hand the reality of tiredness and exhaustion related to a full time position in a strenuous health service milieu was evidently present in the dialogue of the women in both settings. Recreational activities mentioned were limited in terms of watching television and resting (sleeping).

Both groups usually made use of so-called public transport in the form of taxi's or buses. The rural nurses, who could only use taxi's, voiced a stronger realization of the inherent discomfort of this transport in terms of safety and stress of not being able to be in time for the last taxi leaving from the remote health setting. The absence of for example street lights in the rural area also caused discomfort for the children of the enrolled nurse - the children had to get up early and accompany the mother to the taxi rank.

The groups communicated a strong awareness of time frames divided the working day into neat boxes where the walls or sides were formed by the distinct tea and lunch times - these walls were perceived to very important parts of an everyday. The maintenance and domestic duties from home were seemingly carried forward to and continued at work; including activities such as bed making, carbolising, damp dusting, providing in the basis needs of the patients and making arrangements for the patients to be discharged and go home. The importance of such maintenance tasks could not be ignored in any well functioning health care system, but needed to be clearly defined or structured, acknowledged, rewarded and provision made for

variation and developmental opportunities. The strong awareness of the presence of routine were clearly expressed by both groups; but limited examples of variation or diverse opportunities presented during the series of interviews.

The rural group added responsibilities in terms of translation and interpretation, while the urban group of enrolled nurses added the exhausting task of being messenger - of running up and down.

THE NURSES AS WOMEN BELONGING TO THE REGISTERED CATEGORY ...

The future of the South African marriage system in terms of the law is seen as promising and exciting, with more and more fair acknowledgement of different kinds of marriages, for example solemnised marriages, customary marriages and civil law marriages (Goldberg, 1994). The day-to-day realities of failed marriages, quasi-independence and responsibilities were however, probably more grey and painful than exciting ...

An important phenomenon observed by and communicated to the researcher was the conscious, and perceived to be painful, choice exercised by these women to divorce from their husbands and to care for their families solely and independently. Their daily lives were thus influenced by this choice, for example, staying alone in a small dwelling and/or even far from their children and significant others - the reason for separation being job opportunities available.

These nurses also related to their daily lives at home in a similar box-like fashion - filled with the dailiness of living in terms of waking up, dressing and tidying up the place of stay. The evening activities were extended to attending meetings of a religious nature, studying and watching television programmes. Commuting as a discomfort was also mentioned by some of these nurses, but not in such developed and qualitative descriptions as the women as nurses belonging to the enrolled

category.

In relating to their days at work, traces of routine and manual maintaining tasks were present, but a clear shift in terms of extended responsibilities of the registered nurse: Examining, diagnosing and treating patients; referral where deemed necessary; as well as clearly demarcated (often too clearly and prescriptive) administrative and managerial tasks. Tea and lunch also seemed to be an important moment in their daily working lives.

5.3.2.2 Theme 2: Signifiers of power: -lessness or -fulness

Signifier 1: Choices

All four registered nurses indicated that they had ample opportunities at home to make and to exercise choices: "*O yes, I am the one who decides what we are going to eat, who is going to which school. I do the whole thing, my husband doesn't worry me about anything*" (TREASURE). GRACE echoed: "*I am just solely responsible for everything. Decisions and what not*". ZODWA stated in no uncertain terms that she divorced "*because I did not want to be ruled by another person*".

LEE explained to the researcher that she made certain conscious decisions when getting married in terms of her choice of husband. She decided that she would never marry a man that was not intelligent; and her husband was also educated. "*So we understand each other, though his income and the work he is doing now, is not the type of work he is used to. He is acting as a person of my standard*". She later indicated that "*he respects me in every way. And I think that is the thing. I may think he is too dependent when he is giving me my freedom, or space*" She also felt that

the fact that she understood and had room for her husband's behaviour also contributed to the respect they had for each other's freedom. She explained her understanding of him in terms of her perception that nurses tend to mother their husbands and that the husbands then became too dependent on them.

Concerning work, the registered nurses also indicated that they had limited if any choice. Zodwa exclaimed: *"Like what? It is a routine thing"*. The women as nurses belonging to the enrolled category indicated a strong limitation in terms of choices at work - mainly related to the constraints of the Scope of Practice, and the approach of the senior category.

Table 5.20: Signifier 1 - Choices

ENROLLED CATEGORY	*REGISTERED CATEGORY*
SELECTIVE PERMITTED CHOICE:	
Mainly allowed in times of crises or when the registered nurse was not available or interested in task(s); created feelings of inferiority and frustration. ***When exercising self-assertiveness in regulating amount of work done by nurse belonging to enrolled category.***	A few choices limited to when, and not to whether: for example making of off-duties and other paper work (GRACE) Depends on the agreement of the authority: *"... and the other thing - if there is a new idea they will find it difficult to accept it ..."* (TREASURE) *" ... even if you can make decisions, but you can not have them carried out"* (LEE)

Table 5.20: Signifier 1 - Choices	
ENROLLED CATEGORY	*REGISTERED CATEGORY*
ESSENCE OF CHOICE:	
Choice determined by consumer (for example patient), senior nursing staff and medical practitioner; regulations; and own interpretation of what was right to do.	The needs of the patient = determinator and allower of choice: *"... whatever the problem that involves that particular patient you have to attend to and sort it out ..."* (GRACE) *"When you are with the client you can decide. You have a client in front of you, she puts a problem to you - then you cannot ask anybody unless you don't know what to do about the problem. Most of the time you decide"* (TREASURE) ZODWA felt that the patients should be motivated to come less during the week because *"we have got a lot of work"*
At home:	
Free at home; only constraint was routine.	Free at home (GRACE, LEE, TREASURE & ZODWA).
RATIONALE FOR ACCEPTING LIMITED CHOICE:	
Accepting an ethical or pistic mission (including equality); to avoid confrontation; prevented by regulations; and accepting limits of negotiated choice.	*"... because with blacks there is that conformity in us. We have got to conform - so with me at times we will say but we really feel this way"* (LEE) Not allowed: *"No, you can't just decide for yourself"* (TREASURE)
NEGOTIATING CHOICE:	
Becomes stubborn and just do ...	

To reflect on the significance of choices ...

"We are at our finest, dancing with our minds, when there are more choices

than two. Sometimes there are ten, even twenty different ways to go, all but one bound to be wrong, and the richness of the selection can lift us onto totally new ground. This process is called exploration and is based on human fallibility" (Thomas, 1979, quoted by Kline, 1993, p.140).

The exhilarating reality and potential of choices are underlined by the above quotation and it was clear to the researcher that both groups of women perceived their daily reality at work to be often devoid of choice - and if present, to be severely limited by their or by others' perceptions of what was allowed or legalised. It seemed as if at least two of the pre-requisites for the exercise of choice were severely traumatised within the working situation.

It was not possible to comment on the ability to make a choice or choices (for example on cognitive, affective and/or psychomotor level), but the participants did explicitly or implicitly convey that they were marginalised in terms of the will and right to make choices - the absence of at least an awareness, will and/or the right to make choices could be seen as indicative of powerlessness. According to Scaltsas (1992) the autonomy of women as for example moral agents, are also severely influenced by the reality that the responsibility of and for caring is imposed on women from other agent(s) in power; leaving in essence a delegated and perceived to be choiceless and given situation.

The rural group of women as nurses underlined selective permitted choice where they had to stand in for or was under the supervision of a registered nurse. They did not seem to think that they had any (other) choices or at least opportunities to choose. This reality created a contradiction in terms. Were they essentially too "stupid" (ZOLEKA) and/or was it a misuse of people's potential and abilities when needed (when they were "desperate")? The rationale for accepting this limited choice were relayed to either a transcendental ethical or pistic mission; or to practically to avoid confrontation.

The urban group of women as enrolled nurses strongly based their rationale for accepting limited choice within the Scope of Practice as defined by the S.A.N.C. - thus a regulatory or legal constraint. The other reasons were based on the reality

that there was nobody else to do the work, as well as, accepting an ethical rationale related to the need to care for everybody (every patient) equally in terms of for example, quality.

Both groups of women as enrolled nurses relatively easily voiced that they could make choices at home, although the binding effect of routine and the ability of the man in the house to accept negotiated choice, were verbalised by the rural group of nurses. It was accepted by the researcher that the women felt that they had some control or more control over their reality at home in terms of choices.

The women as registered nurses also had no problem to affirm their ability created by themselves, to make and the realization of choices at home. At work, choices were often only allowed in terms of when, and not whether. The presence and resultant influence of the patient as the one in need was a major determinator of choice; as well as the nursing authorities often being seen as limiting and not fostering choice. The acceptance of this limiter of choice aggravated by the women being "professional people" and adults. This perceived reality of absence of choice was also intensified by the so-called conforming nature of black women.

Signifier 2: Being needed and/or being important

In referring to being needed; the registered nurses generally conveyed a stronger sense of satisfaction at work. GRACE stated that apart from the pressures of staff shortage which meant that " ... *we tend to overwork ourselves, because we meet the need here at work*", she considered herself satisfied. LEE related her satisfaction to the fact that she was practising what she was interested in; and TREASURE related to her personality and her relationship with patients: "*I mean with my personality and the way I take things, ya, there are many people that I have given advices about. Sometimes they come back and say thank you I did manage, and sometimes the field workers come back and say oh, people are very pleased with you*". ZODWA

also affirmed that she enjoyed her work although there were *"a lot of things that we don't like, but not everyday"*.

The women as nurses belonging to the enrolled category indicated that they found it somewhat difficult to relate to this question - especially the rural group. They did indicate that their presence made a difference to patients and to fellow nursing staff; and PRETTY stated clearly that she enjoyed the company of her colleagues at work.

Reflecting on the significance of "me" and "us" being here (or there)...

The awareness of being important to and needed within a certain and all contexts meaningfully signifies powerlessness or powerfulness - thus pointing to the affective aspects of power and related concepts. According to the participants, they were aware of being needed and of being important at home, but used the concepts more in terms of their maternal and caring role.

The participants from the **rural setting belonging to the enrolled category** conveyed an uneasiness and/or unawareness of being needed and/or important at work - the reason for this was formulated by one of these participants in terms of the patient's inability to convey such acknowledgement. **The urban group of women as enrolled nurses** related more freely to an awareness of being needed and of being important. None of the two groups explicitly indicated during the interviews a communicated awareness of being valued or of being needed by, for example, their peers and senior nursing staff. This perceived reality indicated or signified an increased emotional or psychic burden of powerlessness. **The registered nurses** were able to convey a stronger sense of satisfaction at work in spite of hurdles experienced, for example, they were practising what they were interested in and received positive feedback from colleagues and patients.

Signifier 3: Perceptions of own freedom

The three registered nurses who were separated from their husbands indicated that they enjoyed freedom at home; while the fourth professional nurse who seemed to be relatively happily married, also enjoyed freedom, although she felt that her husband was too dependent on her at times. Interestingly, she linked his dependence with the perception that nurses tended to over-protect and nurse their husbands. This idea was repeated by GRACE who said that the husbands did not appreciate what nurses did for them and rather became even more dependent: "*they become our babies now*".

The perception of a higher degree of freedom at home was also voiced by the women as nurses belonging to the enrolled category. However, the choice and freedom to divorce a husband and to live independently was voiced as a failure and as unacceptable by the community.

"MY" AND "OUR" PERCEPTIONS OF BEING FREE ...

Freedom can be seen as the opposite of oppression; it is often linked to concepts such as democracy, justice and equality.

In relating to freedom, **both groups of women as nurses belonging to the enrolled category** stated clearly that the phenomenon of freedom was much more a reality at home than at work. In analysing and acknowledging the limited freedom and perceived powerlessness of African nurses as women at home; the perceived reality at work could be understood to be severely imprisoned and marginalised. The rural participants associated freedom at home with the freedom to make choices and to create an environment at home that was meaningful to them; while the urban group stated clearly: At home there was no Scope of Practice!

According to Smelser (1988) the powerless, by subjecting to the power of the powerful, actually give freedom to the powerful but at the same time deny or

contradict their (the powerless) own freedom. The women as enrolled nurses thus gave freedom to those (for example the registered category of nurses) or that (the Scope of Practice) above or over them and in that process lost or denied their own freedom.

The women as nurses belonging to the registered category created their own freedom away of or in control of the realities of men. They stated that nurses tend to mother or overprotect their husbands; while on the other hand men tried to misuse - *"jackpotting"* -; and even suppress or oppress these learned woman.

Signifier 4: Perceptions of and related to men

GRACE felt that "*the ladies staying at home doing housework, with a working husband, they are better looked after than we nurses*". According to LEE, nurses as women tend to mother their husbands as they mother their patients: "*Our husbands are very different and I think the cause is due to professional socialization. Because we are too motherly, we mother them ...* ". It seemed as if the women who belonged to the enrolled category had qualitatively a stronger and more negatively experienced perception of for example men's lack of commitment, irresponsibility and inherent controlling nature.

Table 5.21: Perceptions related to and of men

ENROLLED CATEGORY	REGISTERED CATEGORY
WAY AND MEANING OF EXISTENCE:	
Intermittent presence of man:	
Came when he liked; or worked and stayed in another town.	

Table 5.21: Perceptions related to and of men	
ENROLLED CATEGORY	*REGISTERED CATEGORY*
Expectations of men:	
Men had limited room for working womens' tiredness; were in essence demanding; focussed on and used traditional submissive and producer role of woman.	*"Whether she is married or not married. They are enslaved. Now those are cultural beliefs"* (GRACE) *"The other thing is the ethnic group. What I have noticed which contributes to disorganization ... The Zulu (men) are too rigid. They like their voice to be heard, it must be carried out"* (LEE)
ESSENCE OF BEING A HU-MAN BEING:	
Men's freedom:	
Men controlled own way of existence, time, responsibilities and activities.	*"Though at times I feel he is spoilt; he will never say if I am off at 7 OK let me go and fetch her. That is what I always feel bad about"* (LEE) *"He does the ironing,. The only thing with an African man you can't tell him now do this. He does it at his own will. You can't ask him why didn't you do ..."* (TREASURE) *"even working, the men are so irresponsible. They do have the money, but they won't use it for the right cause"* (TREASURE)
Being equal:	
	"Because we are equal" (ZODWA)

Table 5.21: Perceptions related to and of men	
ENROLLED CATEGORY	*REGISTERED CATEGORY*
Men are to be cared for and to be respected:	
Men behaved as they wished (for example became drunk or became demanding) but still expected to be respected.	*"They just forget that we are not their mothers, but their wives ... (so they become) like one of the children"* (LEE) *"Unfortunately we as nurses, as usual, we tend to mother our husband, may be I think from the way we have been exposed in our work situation. And we tend to over nurse our husbands ... instead of appreciating what we do for them, they become our babies now"* (GRACE)
Being rulers:	
	" .., I divorced because I did not want to be ruled by another person. I just want to be free ... and (he) *even controlled me financially."* ZODWA)
IMBEDDED FEELINGS:	
Pain of being a woman:	
Women did not know their husbands and were exposed to loneliness and difficult circumstances.	*"The choosing of a spouse is not the government's problem. It's our individual problem"* (GRACE) *"It was too much for me"* (ZODWA)
Someone to love, respect and share with me as a woman:	
Distracted women from daily suffering and listened to her problems.	*"He respects me in every way. And I think that is the thing ... He is acting as a person of my standard"* (LEE)

THINKING ABOUT AND OF MEN ...

It was clear that men were often described in terms of their perceived power over women; their irresponsibility and selfishness. The imbedded pain for the woman was

described in terms of for example discomfort, hurt and pain.

The women as nurses belonging to the enrolled category and working in a rural health care setting conveyed and indicated a strong awareness of the imbedded realities of being with and relating to a man in the house. They emphasized men's need and actions to control women, to reverse or negate responsibility, to be free, to be respected and to be "themselves". These women were thus aware of the reality of men's power within and over them, but apparently took few steps to counteract or overtly resist these phenomena. They were also aware of the emotional effect of men's needs of and actions on them - the imbedded pain and loneliness ...

The urban group of women as nurses were less explicit and forthcoming in relating to the perceived realities of men - they highlighted apart from the men's perceived irresponsibility and selfishness, the cultural realities of black men who could easily leave their wife if she did not obey; thus indicative of manipulative and cruel behaviour. This behaviour of men could be perceived to be limiting womens' freedom of choice concerning and over her own body and reality. The reality of separation because of job opportunities were expressed in terms of becoming strangers to one another and the possible advantage of less confrontation and more happiness.

The inherent controlling and slave-master relationship between women and men originating from society (for example tradition, ethnicity and culture) was also emphasized by the **registered nurses.** They referred to the spoilt, dependent and irresponsible nature of men; men that could not be forced, only coerced into doing and accepting things not traditionally typical of, and to, men. It seemed as if a male partner who was carefully chosen would solve some of the problems ...

Signifier 5: Relationship with medical practitioners

The registered nurses who practised as midwives and who were working in the community health centre felt that the relationship with doctors depended on the situation and the individual:

> *"Some doctors appreciate the services rendered by nurses. As a result some doctors feel that they can be co-workers almost equal workers ... in the olden days doctors used to feel great and big about everything. Things are changing. They have found out that midwives are more skilled than some of the doctors. Some doctors don't feel happy taking an opinion from a midwife. For instance we being community based, you know a doctor who has done community health, they appreciate our services ... we do almost everything independently ... They appreciate our services, even our diagnoses"* (GRACE).

The lack of interaction between medical practitioners and women as enrolled nurses might have been one of the reasons for verbalising limited tension with this group. The empowerment of more women to become medical practitioners was mentioned; as well as, the perception that the "bossy character" of men tend to remain in spite of education and level of development.

RELATING TO THE MEDICAL PRACTITIONER ...

In the milieu of the **rural setting and in an urban milieu** where primary health care facilities were delivered primarily by nursing personnel to a disadvantaged community, the reality of the (male) medical practitioner was distant and of limited importance. Two women as nurses working in a larger hospital in an urban setting did indicate that "that bossy character still remains"; that an overuse of power was possible. The need for more women doctors was emphasized by one of the women as nurses belonging to the rural group of nurses belonging to the enrolled category; whilst the registered nurses emphasized that the advanced and acknowledged skills

of women as nurses can be powerful in bringing the two groups to a better understanding.

Signifier 6: Perspectives on nursing and nurses

The registered nurses indicated a strong awareness of responsibility and independence, as well as, an awareness of the value of nursing from a religious perspective; while the group of women belonging to the enrolled category emphasized the helping or "to-do-for" role of the nurse; as well as the need to be constantly available.

Table 5.22: Signifier 6 - Perspectives on nursing and nurses

ENROLLED CATEGORY	*REGISTERED CATEGORY*
TO HELP OR SUPPORT:	
To help the needy; to give loving care in a un-imposing way.	***"And you know, just knowing that I have got to do something, which God has created, like helping a person"*** **(LEE)**
TO DO FOR:	
To do everything or to do what was needed for the patient - linked to the oath or ethical code of and for nurses.	
TO FEEL:	
Care emotionally for patients (feel for them).	
TO TREAT AND EDUCATE:	
	"Then I do treatment for the patient ... I give the health education" **(ZODWA)**

Table 5.22: Signifier 6 - Perspectives on nursing and nurses	
ENROLLED CATEGORY	REGISTERED CATEGORY
TO BE ALTRUISTIC:	
Emphasizing dedication and not financial gain; in spite of demanding nature of nursing.	*"... they are our responsibility"* (GRACE) *"We are too motherly"* (LEE)
TO BE AVAILABLE:	
Being on duty 24 hours a day - inside and outside the health setting.	
TO ACKNOWLEDGE OR VALUE:	
	"... as community people and individuals they should have power. They are not picked from the street, they are from the community, they have their own rights. They must have the power, even the nurses as well ... our patients they are supposed to have better power; much more than we have ..." (GRACE)
TO BE RESPONSIBLE:	
	"We are independent because we are responsible. Unlike teachers. If you have a look at teachers, they are professional, but they lead a different life far from us socially. Nurses are independent; as a result their spouses or whoever, tend to be dependent on us most of the time. And our children have the same feeling. That is the trouble of the nursing profession" (GRACE)

WHAT "WE" THINK OF AND ABOUT NURSING AND NURSES ...

Nursing and nurses were portrayed in a traditional and limited way - linked caring in terms of supporting, doing for, feeling and being available for. This, in essence altruistic approach, was very evident in, and more strongly voiced by the rural

group of women as nurses belonging to the enrolled category; possibly indicative of a powerlessness in terms of the ability to develop a broadened personal and collective transformed view of nursing, nurses and the patient or client that emphasized partnership, collaboration and health. Although **the urban group of enrolled nurses** also mentioned service to humankind; they more strongly related to the quality of nursing care to be rendered to the community.

The professional nurses made limited reference to the nature of nursing and nurses; but the awareness of a responsible caring or helping, giving treatment (treating) and the acknowledgement of the rights and power of the patients and community were identifiable in their conversations with the researcher.

According to Morse, Solberg, Neander, Bottorf and Johnson (1990) five perspectives on caring can be identified from the publications of 35 authors publishing on nursing and caring. The responses of the nurses belonging the enrolled category could be classified as either viewing caring as an innate human trait especially of women, as a moral imperative or a fundamental value that needed to be upheld at all costs, and as an affect - because they felt with and for the patient. The quality of nursing care could rather be seen as an indication of measurement or evaluation and not so much a perspective. The registered nurses added the perspectives of caring as a therapeutic intervention (for example while "treating") and as a nurse-patient relationship (for example in counselling).

Signifier 7: Rights versus power

According to TREASURE (a registered nurse) *"amandla is just power, physical power, and you can say even emotional power is there. Then amalengelu is my right to do this, it is my right to do that ..."* She felt that the practices of the society were stronger than the laws on paper, especially in terms of male domination. One of the other registered nurses felt that the rights of patients were not adequately

acknowledged and that made the patient and the community in essence powerless and dependent.

The women belonging to the enrolled category of nurses voiced apart from a right to be and to be treated equal, a needed commitment to the right to refuse, to go to higher authority (when uncertain or when not treated fairly) and to be respected - many of these expressed during the interviews as a call or plead for, rather than as being experienced.

Table 5.23 : Signifier 7 - Rights versus power

ENROLLED CATEGORY	*REGISTERED CATEGORY*
THE RIGHT TO DO OR NOT TO DO:	
Right to refuse tasks outside their Scope of Practice.	***"It is my right to do this, it is my right to do that"*** **(TREASURE)**
THE RIGHT TO BE EQUAL:	
Being the same (=human) forced equal rights; especially in terms of gender.	
THE RIGHT TO ASK:	
Had the right to clarify when uncertain or did not know.	
THE RIGHT TO BE RESPECTED:	
Patients needed to respect woman as a nurse at work.	

RIGHTS VERSUS POWER ...

During the research, the researcher became aware of the complex and intricate relationship between rights and power from and within the perspective of the participants. She also realized that she needed to clarify and construct these relationships within a meaningful theoretical framework:

A right indicates a need and/or request for power and is not a static phenomenon. A struggle for rights signifies in essence an awareness

(knowledge) and confirmation of perceived or real powerlessness; but also signifies action to foster change - this process in itself is empowering. The obtaining, exercising and control of needed rights signifies powerfulness. Rights can be extracted from and functions in relation to

* **Laws and regulations - thus supposedly sanctioned by the majority of the members of the community and;**

* **Rules, policies and formalised conditions and practices - often made and policed by people in positions of power; and**

* **Norms and values - a very powerful source of rights but often seen as vague, "subjective" and difficult to identify, request, operationalize; or even to question, change or to eradicate. Traditional norms and values are socially and historically constructed and imbedded in the heritage from generation to generation.**

It thus became clear to the researcher that power as a noun (a thing), needs to be present and enacted to identify, define, obtain, apply or exercise and monitor or control rights within a certain context. The mentioned process is in essence founded on or within a certain normative or ethical framework, for example, a right can be wrongly defined within or for a certain context. It thus implies that within a given context the application of a right might be viewed or seen as right; in another context as wrong. One may also have power and not the right to exercise it; one may have a right but not power, the power to exercise it.

A challenging perspective was postulated by Rigterink (1992, p.43) where she emphasizes certain contradictions within the rights as a moral phenomenon debate. She mentioned for example that rights are in essence not meant to be competitive - their very existence deleting competition. She also mentioned that the exercising of rights is supposedly based on an independent and unique thought process of the

person(s) involved - but if the person(s) can't think - can a second or another person(s) think for someone else ? Rigterink finally suggests the non-existence and elimination of rights:

> "*Perhaps, if we can deny that any moral concept*" (such as rights) "*can have the status of being absolutely fundamental and, in so doing, deny the existence of rights, we could then say that the hunter had done something wrong after all*" - referring to the hunter that after determining that he had acted within his rights, did nothing morally wrong!

It appeared to the researcher that the intricate relationship between power and rights were not clearly defined or conceptualized by some of the participants. **The rural group of nurses as women belonging to the enrolled category** identified rights such as the right to refuse, the right to go to higher authority, and the right to be respected; whilst **the urban group** more focussed of rights in terms of equality and to be enlightened. Some members of both these groups placed rights as equal to power. The concept of rights was not so evident in the interviews with the registered nurses with only one nurse referring and contextualizing the dilemma of the power of communities to endorse or refuse rights versus the power of legalised rights as found in more so-called westernized societies.

5.3.2.3 Experiential theme 3: Affectivity

> "*The various passions are usually aroused by objects perceived, imagined or remembered, and once aroused they in turn originate impulses to act in certain ways ... the emotion itself seems to be the feeling rather than the doing*" (Hutchins, 1952, p. 415).

All four the registered nurses generally expressed a satisfaction with their work in terms of patient care, and used concepts such as "*comfortable*" (GRACE), "*feeling*

good" (TREASURE); *"... the other thing is, if I have managed to solve a problem, or to assist a delivery if I am able to do it successfully, I feel very happy"* (LEE); and enjoyment (ZODWA). They also indicated that they were happy at home - linking it to their freedom as women and mothers (often single parents). The women as nurses belonging to the enrolled category voiced little, if any, satisfaction in terms of work, but were able to indicate a strong satisfaction in terms of their being a mother at home. They thus underlined or echoed this happiness at home but did not effectively convey a sense or reality of being happy and satisfied at work, except in terms of fulfilling the needs of patients and clients.

The enrolled category of women as nurses were able to relate strongly to being needed and valued at home - they could communicate and relate to an awareness of being valued in a far from ideal rural or urban home environment with its poor transport, limited infra-structure, binding culture and power-man setting. However, they indicated and conveyed barriers in voicing an equally meaningful and strong awareness related to the day-to-day work setting. The **rural group's** limited control over their daily reality at work probably created and/or aggravated this constrained experiences of satisfaction which was often limited to an internal desire to be a nurse and to care for others. The **urban group** more strongly expressed this internal basis or locus of satisfaction or happiness linked to being a nurse and nursing. It would thus seem that the achievement of being a nurse is in essence a powerful experience, but that the realities of daily living at work was not necessarily instrumental in creating, supporting and/or sustaining such an awarenesses fully.

All four registered nurses expressed experiences of satisfaction in their work, especially in terms of patient care. At home they were also happy being free as women and mostly single parents.

5.3.2.4 Experiential theme 4: POWER

Sub-theme 1: Defining power

GRACE tried to relate to the complexity of the concept and identified three "spheres": *I thought of political powers, social powers and even professional powers at home politically and professionally at work ... OK ...*"; while ZODWA expressed power in terms of control; TREASURE in terms of an ability; and LEE in terms of authority. The women from the enrolled category of nurses' descriptions could be classified in terms of an ability, a right, a strength, an authority and an achievement.

Table 5.24: Sub-theme 1 - Defining power

ENROLLED CATEGORY	*REGISTERED CATEGORY*
AS AN ABILITY:	
Linked to an ability to initiate and to do what was right, and positive; and to do it freely. This ability might be given to you or could come from within.	***"For me power is being able to do whatever thing you wish to do, I mean to follow your instincts ... if you have power, you have to follow your instincts and then get results. And you get credited for it"*** **(TREASURE)** ***"So if your junior has got a problem, you are able to help her through"*** **(TREASURE)**
AS A RIGHT:	
A right given to some people to be and to do; for example the "father" in the house and the authorities.	**As a right to share, for example in decision making (GRACE)**

Table 5.24: Sub-theme 1 - Defining power	
ENROLLED CATEGORY	REGISTERED CATEGORY
AS CONTROL:	
	"I think, what can I say, it is something that you can control. You have control over it" (ZODWA)
AS AUTHORITY:	
Embedded in a position of authority.	*"I would say power is the type of operating, you know, authority to run things at home and eh, and how to make decision"* (LEE)
AS STRENGTH:	
Linked to being strong - physically or mentally.	
AS ACHIEVEMENT:	
In terms of enacting positive results or outcomes.	

Sub-theme 2: The power of nurses as WOMEN

ZODWA (a registered nurse) felt strong that women were more powerful than men: being able to work, study, buy a new house and were *"able to do whatever I like as I told you"*. The other registered nurses probably tried to describe the powerfulness of nurses as women in terms of, for example, taking the right decisions for their children, the power inherent in their education (of being educated as a professional nurse) and the power of being appreciated by other people because of your personal qualities.

The nurses belonging to the enrolled category felt that a woman's power was located in her ability to create and maintain and provide in the needs of a family; to make

peace; to endure or conquer and to love.

Table 5.25: Sub-theme 2 - The power of nurses as WOMEN	
ENROLLED CATEGORY	*REGISTERED CATEGORY*
MAINTAINING a FAMILY:	
Create and care for a family.	*"... because I knew what I was doing and I was following my instinct,* (took my child) *to a multiracial preschool;* (paid) *these exorbitant fees for creches ... and I didn't have any money ... I didn't carry on studying so that I could give my kids the opportunity ..."* (TREASURE)
BEING ABLE TO BE EDUCATED:	
	"Well, if you are a learned person, they rely so much on you ..." (LEE)
BEING ABLE TO MAKE PEACE:	
Being able to overcome and conquer with peace; and not by force.	*"They feel that if you are a woman, you are a peacemaker..."* (LEE)
BEING ABLE TO PROVIDE:	
Women had the inherent ability to care for their children and to find ways to provide in the needs of the family and herself.	
BEING ABLE TO LOVE:	
Loving her man and loving her family.	
BEING ABLE TO BE APPRECIATED:	
	" ... if you are appreciated, and they don't have ill feelings about you and you feel appreciated ... you are there for a purpose and people realise your presence ..." (TREASURE)
BEING ENDURING versus SUBMISSIVE:	
Being able to endure the pain and suffering.	*"... we as females, we are enduring. We are submissive"* (GRACE)

Sub-theme 3: The power of MEN

The researcher got the impression that the registered nurses tended to theoretically distance themselves from their own experiences and preferred to discuss men's power in terms of, for example, culture and level of education. Apart from men's physical strength, men were perceived to be domineering and oppressive. According to TREASURE, they (the African culture) now voted for their rights; but she was of the opinion that it would not work because of the man's ability (power) to control the implementation of the rights in the family setting. She quoted examples from the reality of birth control - for example tubal ligation and the use of contraceptive. She also referred to the tendency of their men to suppress a woman and to even hurt her physically or mentally when they perceive you to be a threat to them. This, according to TREASURE, often happened with married registered nurses.

GRACE quoted examples from the cultural tradition of marriage:

> *"I mean, if a daughter-in-law comes to your house, she is the subordinate and you are the mother-in-law. And as a result, that woman would be submissive. Almost for the rest of their lives because of the cultural beliefs ... So the husband has got the power of doing anything he likes with his makoti, his wife, as much as the mother-in-law has power of the wife. So in other words, the magudi has no say ... we know particularly with blacks, we know we are not allowed to have equal rights with a men, particularly at home. A father must have the final decision of whatever. And I think how it should be; even scripturally?* THE BIBLE. *Yes, but it is not like that. So we tend to be exposed to that attitude of 'oh yebo baba'. Even if you say I don't like to stay here; you must stay with my in-laws. I* (the husband) *must bring my sister, you must accept it as a woman, because you were taken from home, bought by lobola, you must be submissive to whatever is going on at home ...* (LOBOLA) *instead of being a Thanksgiving gift, it is a way of giving the men authority ..."*

The nurse as women belonging to the enrolled category emphasized the cultural and historical origin of men's power; but stated that men were of the opinion that the power were given to them by God; thus stated by men as power of a religious origin and divine intervention.

Figure 5.4: Traditionally clothed Zulu men dancing ...

Sub-theme 4: The power of women as NURSES

The power inherent in knowledge and personality, as well as the power to help or support either patients or junior colleagues, are a few examples of the perceived power of women as registered nurses. In referring to the enrolled category of

nurses, the women also emphasized apart from the ability to comfort, the ability to be humble, and to differentiate right from wrong in their daily practising of nursing - clearly normatively inclined power bases.

Table 5.26: Sub-theme 4 - The power of women as NURSES	
ENROLLED CATEGORY	*REGISTERED CATEGORY*
TO COMFORT AND SUPPORT PATIENTS:	
Were able to help, comfort and direct patients concerning the needed nursing care and taking of their treatment without help from the senior category.	***"And you know, just knowing that I have got to do something, which God has created, like helping a person"*** (LEE)
TO SAY NO:	
To refuse responsibilities and tasks outside their Scope of Practice.	
OF NOT BEING PROUD:	
Willing and able to do all kinds of tasks; not having a "that-is-beyond-me" attitude.	***"To be willing and diligent to do things at work"*** (LEE)
TO DIFFERENTIATE RIGHT FROM WRONG:	
Were able to identify and apply what was right and what was wrong.	
TO TEACH / EDUCATE:	
To teach juniors what she was able to teach.	
TO HAVE A PLEASANT DISPOSITION AND PERSONALITY:	
	" ... and personality. Because you know at times, people do a study of person's personality and most of the time they will keep on referring to you, even if you are a junior to the others, but then that gives you power" (LEE) **Knowledge and personality (ZODWA)**

Table 5.26: Sub-theme 4 - The power of women as NURSES	
ENROLLED CATEGORY	*REGISTERED CATEGORY*
TO TAKE DECISIONS RELATED TO JUNIOR STAFF:	
Able to delegate to those below her; for example general assistants.	***"So if your junior she has got a problem, you are able to help her through ... and the answer is there, the solution was made at that particular time. There was no time to go up the hierarchy, this person needed help at that particular time"*** **(TREASURE)**
BEING ABLE TO BE VIEWED AS POWERFUL BY OTHERS:	
	Because of her education, nurses are viewed as important members of their communities: "* ***... Yes. The fact that she is the nurse, she has more suggestions"*** **(LEE)**

Sub-theme 5: Being the most powerful at home

LEE, a professional nurse, indicated that she was the most powerful person at home: "*If I am not there, everything does not run as smoothly ... in his own family I am the most powerful person*". ZODWA said that she was the most powerful at home "*because my father and mother they are pensioners*". TREASURE referred to the power of her mother: "*when things were bad she was the one who picked things up*", but also agreed that she was the strongest person in her own household. GRACE also indicated that "*as a single parent, there is no problem - the problem is when you have a husband*".

The nurses as women belonging to the enrolled category were in two minds; on the one hand they indicated that the man or father was very powerful as related to

culture, tradition and religion; while on the other hand, the woman and mother were powerful in her ability to create and maintain a family.

Sub-theme 6: Being the most powerful at work

In referring to positional power, GRACE indicated that the administrators "*they themselves are still below the people at the regional office. Even regional office will appoint someone else to* ... (indicating with her hand: to be on top ... laughing)". ZODWA mentioned the superintendent; while both LEE and TREASURE also indicated that they themselves also had certain powers. LEE said that:

> "*I would say that I have the most power because they always come back to me and say, but how about this ... so it is that person people think is willing to do things and doesn't go back and say no. Coming forward in decisions, you know, taking part*".

TREASURE referred more to the powerful ability of the senior professional nurse to empower her junior sisters: "*You know, a person that will contribute to you as a person ... she will encourage you to do things, you know projects ... and she will encourage you to go places ...*"

There was a strong agreement amongst women as nurses belonging to the enrolled category that the most powerful person at work was the Head of Nursing Services - voiced by not less than fourteen out of the sixteen women. This power related to position, knowledge, control of information and experience. The S.A.N.C. was also mentioned as a strong force - they were responsible for and behind all these rules and regulations!

Sub-theme 7: The woman and powerlessness at home

TREASURE (a registered nurse), who indicated on various occasions that she suffered financially, explained the trauma of not having adequate financial resources:

> *"I just say like you know if I don't have money. SO IT IS MONEY ... Yes. It is very strong with me, for instance if I go to a school meeting and I want to raise a point. I feel I can't because they would say what is she talking about. She can't even pay the school fees. I feel I can't meet my obligations".*

Another registered nurse, GRACE, argued that the powerlessness of nurses as women could be linked to their choice of husbands. She felt that men cunningly tended to marry nurses because nurses were perceived to be a financial asset:

> *"So when they entice us into marriage they want us to look after them, work for them and give them money. They say we are jack-pots. And yet with an ordinary girl they can't say I am marrying a jack-pot, she has no money, he marries that girl for love or whatever".*

LEE referred to the barriers of power in terms of educational opportunities: *Yes, and those that did not reach the high school level".* She also indicated that childless women were considered very powerless: *"They don't refer anything to you, because there are no children in the room ... you are regarded as having nothing ..."* ZODWA's parents apparently made her feel powerless because she had to obey their rules and constantly had to explain her actions when at home.

The nurses as women belonging to the enrolled category mentioned the effect of violence on their daily lives, as well as, the negative behaviour of men and the lack of financial resources.

Sub-theme 8: The powerlessness of women as NURSES

Two of the registered nurses differentiated between powerlessness in terms of category (class) and in terms of who was inside the category and doing what when being there. Three registered nurses did however indicate that they considered the "*lower category*" as being the least powerful at work; TREASURE summarising it as follows:

> "*I think the ENA's* (enrolled nursing auxiliaries). *You feel this person has a brain, this person has ideas, but just because she is junior, even the community now knows that she doesn't have this* (pointing to epaulettes), *you see what I mean. Most of them in that category are matrics. And they are brainy ... and in a way, no one looks at them. And the nursing assistants, everyone knows they have a basic level of training, they can not do any more. Most people are doing post basic courses, and they don't have any. And you feel sorry for them because some of them try through UNISA. They are ding Social Sciences and they really feel there is no place for them. They had to do some short course just to get a salary to take home ... they have a lot to contribute ... ".*

Two registered nurses felt that every category felt powerless or deprived in some or other way *"because all categories have got people responsible for them"* (GRACE); or that individuals within a category exhibited extreme powerless behaviours; for example "*those who do not come forward and are always lazy*" (LEE).

In discussing the powerlessness of registered nurses, it was indicated more in terms of a limitation of freedom to exercise power. This limitation was discussed in terms of restrictive behaviour of senior personnel, and rules applied. The reality of limited experience was also mentioned. The fact that the more junior professional nurse was graduated and thus able to make certain recommendations was perceived to be

a threat by the senior professional nurse: *"because, eh, she has that inferiority complex, not to rule her, because I have got a degree"* (ZODWA).

An additional problem that was mentioned related to the less than sensitive communication skills of nursing leaders: *" ... I mean I am grown up, you can't just shout at me when I am some metres away from you. There are people that respect me in the community. People that are my relatives, and you shout. What are these people going to think of me?"* (TREASURE).

The powerlessness of the women as nurses belonging to the enrolled category was centred around the inherent class or category system that placed them in a middle position in terms of having to stand in for those below or those above them - depending on the need of the moment. This class awareness was perpetuated in the health care service settings with the nursing auxiliary being considered the least powerful within the nursing class reality and the general assistant in the health care service as such. The regulatory body also strengthened this division with overt symbols of education, for example the epaulettes.

Table 5.27: Sub-theme 8 - The powerlessness of women as NURSES	
ENROLLED CATEGORY	*REGISTERED CATEGORY*
CONSTRAINTS OF HIERARCHIAL QUALIFICATION FRAMEWORK AND EDUCATION:	
Constraints in terms of * *Know what to do; but not allowed in terms of qualification (education) and regulations governing practice;* * *Inferior position (below and under) and delegated authority;* * *Having to ask permission;* * *Dictated policy and procedure within health service; and* * *"Empowered" others who can "ride" you.*	
CHARACTERISTICS OF WORKING SITUATION:	
Being short staffed, left alone in health care setting and the presence demotivated fellow health care providers.	*"Particular type of shoe, the uniform, wear this pattern or that pattern, you know. At home I make all the decisions and all of a sudden you get to work you can't do a thing for yourself. Somebody else has to think for you. I mean we run our homes, children ... ya, and when we are here we are treated like a child"*

Table 5.27: Sub-theme 8 - The powerlessness of women as NURSES

ENROLLED CATEGORY	*REGISTERED CATEGORY*
APPROACH OF SENIOR CATEGORY:	
Harshness and inclination to be comfortable to the expense of others; as well as tendency not to remember and appreciate input of this category in the orientation and adaptation of new registered nurses in and to the health care setting.	*"So now, when they* (with limited knowledge of advanced midwifery) *are in charge, now with advanced midwifery, when we try to voice our opinion about our scope of practice, we tend to be suppressed, because they are in charge ... they turn a deaf ear ..."* *"She thinks her word is final"* *"Even with minor things you feel you have just got to go to the office first and talk to the supervisor ... who are you to jump in sponta-neously?"* The senior without a degree not to be ruled by the junior with a degree.
HAVING TO DO MORE THAN ONE CATEGORY'S WORK:	
Being the "stand-in" person - standing in for those above and those below; and the exhaustion that was imbedded in this reality; strengthened inner need to go and study further.	
LACK OF EDUCATIONAL OR EXPERIENTIAL OPPORTUNITIES:	
Very limited opportunities to go and study; and to thus escape this "middle" position.	*"... and well, if you have less experience because you know you don't have the power ..."* (LEE)
WOMEN WORKING TOGETHER:	
Women not supporting and not caring for each other when working together.	

Table 5.27: Sub-theme 8 - The powerlessness of women as NURSES	
ENROLLED CATEGORY	*REGISTERED CATEGORY*
SYMBOLS OF POWERLESSNESS:	
Epaulettes became symbol of power (for example knowledge) to the patient and to the nursing profession.	
ABSENCE OR PRESENCE OF DOCTORS:	
The more doctors were absent or unavailable; the more independent the functioning of nurses (had to) became.	
ASSOCIATED EMOTIONAL EFFECT:	
Caused unhappiness, passive acceptance, internalization of inferior feelings, depression and frustration; as well as feelings indicating a need to revenge.	*"This depresses me most (to have to be in charge of ... (unit) and not able to work as a consultant"* *"In fact I am not happy about it"* *"It is depressing. It is deflating"*

5.3.2.5 THEME 5: THE EMPOWERMENT OF WOMEN

Sub-theme 1: Empowering at HOME...

The registered nurses mostly dealt with the perceived cultural reality of women as well as the development of women and financial renumeration. It was clear, however, that the group had limited creative ideas in terms of empowerment and empowerment strategies - mostly focussed around ill-defined possibilities such as re-education in terms of gender, general education (for example literacy), a stronger

financial position and returning to an affirmation of religious beliefs. The enrolled group of women added more practical suggestions such as support groups, and understanding and negotiating change.

Table 5.28: Sub-theme 1 - Empowering at HOME ...

ENROLLED CATEGORY	*REGISTERED CATEGORY*
FORMING SUPPORT GROUPS:	
A forum to discuss problems and to provide support to those in need.	
NEGOTIATION:	
Tried to develop an understanding of the man's and other people's feelings and approaches; and to develop mechanisms to cope with the created reality.	
RE-EDUCATION IN TERMS OF GENDER:	
Emphasized need to educate men and children in terms of their view, role, approach and responsibilities at home.	**Women and men should be re-educated in terms of their complementing roles: *" ... just to undo this cultural behaviour in different countries ... everything should be universal ... "* (GRACE)**
STRONGER FINANCIAL POSITION:	
Women to be placed in a stronger financial position to equip them to initiate projects.	***"To get more money to buy a car, as it is I don't have a car because I have little money"* (ZODWA)**

Table 5.28: Sub-theme 1 - Empowering at HOME ...	
ENROLLED CATEGORY	REGISTERED CATEGORY
RELIGIOUS RE-AFFIRMATION:	
	"Now the solution is to go back to God's law ... they must abide by God's word, who made and created us, how He made the woman, how He made the man, for what purpose ... because you know, even in God's word. Jehovah doesn't say a woman must love the husband, he says a man must love his wife. Then a wife must be submissive. He knows that if a man loves you, you automatically feel submissive to that man. And it is the man's role that must come first. He must love her ... you know, you get the solution somehow ..." (GRACE)
EDUCATION:	
	"Literacy ... you know, those women who are illiterate, they are power-less" (LEE).

Sub-theme 2: Empowering at WORK...

Two registered nurses felt that the approach of the senior category needed urgent attention and two indicated the financial dilemma of nurses. Other suggestions related to increased involvement in decision making, a position to apply skills acquired and freedom to apply well founded ideas.

The women as nurses belonging to the enrolled category emphasized the deletion of class (categories) and their inherent symbols and rules, as well as, the

development of more educational and developmental opportunities for this group. A need to be involved and to be part of management and decision making was also expressed.

Table 5.29 : Sub-theme 2 - Empowering at WORK	
ENROLLED CATEGORY	*REGISTERED CATEGORY*
ELIMINATING CATEGORIES:	
The elimination of categories would delete the division and resultant conflict between women as nurses and establish equality.	
INCREASED RENUMERATION:	
Increased financial incentives to be able to meet individual needs.	***"Maybe when our financial status could improve somehow, there could be a little relief"*** **(GRACE)** ***"They have to work on salaries. Or to get incentive for coming*** **(on Saturdays)" (ZODWA)**
INVOLVEMENT IN DECISION MAKING:	
	"If people will just let us use our ideas, carry on if something is right, as long, I mean we know what we are supposed to do and we are professional people and we are trained" **(TREASURE).**
EDUCATIONAL OPPORTUNITIES:	
Strong plea for increased educational opportunities to decrease embarrassment, feelings of inferiority and inequality; and to increase power and to foster the development of a positive self-esteem.	***"Well, education ..."*** **(LEE)**
JOB OPPORTUNITIES:	
	"To get the correct job" **to apply knowledge (ZODWA)**

Table 5.29 : Sub-theme 2 - Empowering at WORK	
ENROLLED CATEGORY	***REGISTERED CATEGORY***
INCREASED COMMUNICATION AND INVOLVEMENT IN MANAGEMENT:	
Being able and allowed to voice feelings, concerns and views; to be involved in the development of policies, rules and related decisions.	
ALLOWANCE FOR SPONTANEOUS ACTION(S):	
	"I would like it if we could do things spontaneously. As long as they are right"
OBSERVING ROLE MODELS:	
	"The one who is a senior, is the role model you know, in a particular way. For instance ... they do listen as how you talk to your patients ... somehow by role modelling the personality can change ... " (LEE)
GOOD PHYSICAL HEALTH:	
	"I would say health status. Because if one is always absent, in fact, they look at that" (LEE)
IMPROVING WORKING CONDITIONS:	
Availability of necessary facilities and equipment; as well as the revision of strict rules that were not meaningful - for example Scope of Practice. ***Remove stigma attached to category system - slowly but surely.***	**More staff to counter-act the heavy load on nursing personnel (GRACE)**

5.4 ANALYSING THE USE AND MEANING OF KEY CONCEPTS

The researcher accepted that an epistemological study included the careful analysis of concepts often used, as well as the analysis of concepts perceived to be meaningful concepts. To complete the description of data, the researcher thus looked at the way in which selected concepts were used and indirectly understood by the different groups. This was done to strengthen the understanding of the concepts most often used in the context of the group, rather than the individuals. The criteria for inclusion were that the concepts identified related meaningfully to the phenomenon under study either directly or indirectly and the concepts were used by more than one participant from more than one group. The researcher made use of selected functions provided by the qualitative analysis software programme, for example string and pattern search; and synonyms for the concepts were identified by the researcher where appropriate. The researcher also made use of three independent colleagues to interpret the meanings of the concepts in context.

Note: The concepts were discussed alphabetically according to the key concept that prompted the search.

5.4.1

Blame, fail, struggle, quit ...

The above mentioned concepts were only found in 20 % (9 out of 44) of the raw data documents, and were mainly used to indicate an awareness that powerlessness could be related to failure or seen in terms of the failure. The failure of women to choose the right husband and men often failing women - suppressing and dominating women instead of loving them, were also mentioned.

5.4.2

Care, love, help and/or support ...

These concepts usually indicate a serious concern, involvement, affection and commitment to the recipient(s) of care, love, help and support and were spontaneously used by the participants in 33 of the 44 (75 %) interviews.

The **enrolled category of women as nurses** incorporated the concepts in referring to the helpless (the patient and the child) and felt that it was a powerful tool of women. In terms of men, they conveyed a strong awareness of men's perceived limited ability to care, love, help and support. At work, although this group felt powerful in terms of addressing the basic needs of helpless people, they felt that they were constrained by a limited legitimization of their power to help, support, love and/or care.

The registered nurses used the concepts in three different ways. The first way was at home where the woman cared for the man (husband), the children and their environment. The care towards the man was often reflected a maternal (as a mother to) and making the man dependent; or as a submissive care towards the man who must love the woman in the first place! Secondly, in nursing, the use of the concepts were mainly related to helping those in need - be it the woman in labour or the client needing psycho-social counselling. The third reference was often in terms of a willingness and ability to care for, help or support the junior category of nurses. It was as if these nurses saw the hierarchial structure and red tape as negatively influencing the ability to care.

5.4.3

Experienced, able and/or know-how ...

Ability refers to a capacity or power to do and are linked to experience - experience being in essence enabling because of the opportunity created for actual observation

or acquaintance with facts and events - thus theory coming alive and real to and for those participating within a specific context. The value of experiential learning to iniate, develop and foster abilities or skills are well documented by for example educationists such as Kolb and Freire; Freire stating explicitly that education was suffering from a narration sickness detaching educational content from the reality and the totality (Freire, 1972; Kolb, 1984).

The concepts of experienced, know-how and ability were found in 19 of the 44 documents (43 %), and by ten of the participants. Although both the groups of women as enrolled nurses emphasized the importance of knowledge and especially experience, the **rural group** indicated a stronger awareness and realization of perceived constriction on the application of nursing and other skills, for example, by the Scope of Practice and by the behaviour of the senior category. The **urban group** of women belonging to the enrolled category indicated that experience was a powerful force; even stronger than qualifications. They also mentioned the value of being a nurse and being part of, or linked to, the nursing profession.

The level of education, amount and quality of experience were also emphasized by the **registered nurses**; but they added the power of position and related responsibility in creating a meaningful working milieu - while they also indicated that the experience of working with different categories and different personalities also increased power.

5.4.4

Feeling good, powerful, have power ...

Although these concepts were not so often used by the participants (in 27 % or 12 out of 44 documents), they were used in meaningful contexts. When referring to the working situation, the **rural group of women belonging to the enrolled category** for example, used the concepts in relation to the powerfulness or value of their experience, of being with (at the bedside of) the patient, and being able to do all "levels of work". The **urban group** also emphasized the powerfulness of being at the

bedside of the patient - they were doing what nurses were meant to do!

The registered nurses used the concepts in terms of position and personal power at work; while at home it was related to the woman's ability to care for the home, to do positive things for her significant others, and to withstand the suppression and oppression of men. The women belonging to the enrolled category of nurses more emphasized men's powerfulness more, although some did relate the concepts to their ability to create and maintain a family.

5.4.5

Free, freedom, and/or available ...

These concepts were used in 21 of the 44 documents (48 %); and always indicated freedom at home versus not being free at work - this was more strongly voiced by the women as enrolled nurses belonging to the enrolled group. All groups also emphasized men's freedom versus womens' limited freedom; they often voiced freedom in the context of choice and of rights. The concepts were used by women as nurses in the different groups in the following epistemological contexts:

Women belonging to the enrolled category of nurses - *rural*:

- In relation to the exercising of rights for example to speak freely;
- The freedom of men versus the women not being free; and

Women belonging to the enrolled category of nurses - *urban:*

- Being able to have power over others; for example to delegate downwards
- To make own choices at home
- To be educated, skilled and able, including the freedom that experience gives
- To voice feelings and/or problems
- The influence of context or situation on feeling or being free

- To utilize opportunities
- newly acquired political freedom
- free to relate and talk to researcher

Women belonging to the registered category of nurses:

- Freedom in relation to choices
- Freedom to speak
- Freedom of a own created space

5.4.6

Happy, glad, good, achieved, positive, conquered ...

These concepts were used by all the groups in different contexts in 28 of the 44 - thus 64 % of the raw data documents. Happiness was spontaneously used in relating to the reality at home with frequent reference to children. The concepts were also used quite freely to indicate the positive emotions imbedded in being a nurse - of being able to help and support patients even in adverse working conditions. The use of power by women at home was seen as mainly positve and achieving; but within nursing as relating to the senior category and as in management structures apparently not.

5.4.7

Powerless, being oppressed, and/or having no power ...

The concepts mentioned are intricately related to ill and often continuously applied unfair treatment of human beings - with the resultant feelings of failure, worthlessness, negativity and aggression experienced by the oppressed. In different contexts, human beings might be in different stages of oppression awareness and

resultant action.

They might be aware or not of:

1 Being oppressed - be aware pre- and intra-oppression;

2 The source(s) or cause(s) of the oppression - determine source(s) / cause(s);

3 The effect(s) and the scope of the oppression - determine effect and scope of the oppression; and

4 How to deal with the oppression - determine action(s).

They are also able to or not to:

5 Deal with the oppression - act on;

6 Monitor and adjust their control and elimination of the oppression - control and adjust timeously; and

7 Develop and foster a contra or an anti-oppression culture and value system.

The concepts of oppressed, powerless and no power were found in eleven of the 44 raw data documents (25 %) and were used by ten different participants. According to the researcher, the **rural group of women as enrolled nurses** used the concepts of powerlessness, oppression and no power more in terms of, for example, their level of and opportunities for education, professional regulation and ethical code, and their position or rank in the nursing hierarchy - as described in stages 1, 2 and 3 above.

The **urban group of women as enrolled nurses** also emphasized position, the regulatory reality and education; but used the specific concepts more in terms of the oppression reality of gender relations, especially in marriage thus also related to stages 1, 2 and 3.

The registered group of women as nurses used the concepts in a less personal,

distant and theoretical way - the perceived realities of general education (literacy), categories and ranks, traditionalist and patriarchal family structure, gender, race and culture (African) were carefully connected to the use of the concepts. The possibility and/or reality of being oppressed to be seen as real within any category of nursing and possibly related to deprivation; submissiveness could be seen as a possible and biblically sound "token" of love within marriage and the oppression of "blacks" being related to a lack of exposure to civilization with its accompanying educational and cultural development.

5.4.8

Profession, professional and category ...

These concepts were found in 17 out of the 44 documents (39 %), and were used in the following contexts by the women as enrolled nurses:

Category:

- **The development of only one category of nurses -**

  to solve all problems; and

- **Categorical position creating responsibility -**

  sometimes a questionable or meaningless placement of responsibility; for example who carries the keys ...

Profession / professional:

- Nursing being more than a profession - a vocation or a calling
- The etiquette of profession is delimiting
- The value of all groups (categories) within and to the profession
- The power and value of experience within and for the profession

The registered nurses referred to category in terms of for example that all categories experience powerlessness in some way; but that the lower categories of nurses probably had the biggest problem. In using the concept profession, the limitations based on registered nurses and the way "professionals" were being treated as children were also mentioned; as well as the role of professional socialization in making different categories nurses feel powerless.

In referring to the reality of being a woman, only the registered nurses used the concept of profession or professional to delineate the effect of being a professional nurse on their family; for example being the reason for nurses as women to make her family and husband too dependent on her by nurturing or mothering them.

5.4.9

 **ace, black, African, Zulu, Xhosa, custom, culture ...**

Although the above mentioned concepts were not theoretically synonymous, it seemed as if most of the participants used these concepts to refer to the realities imbedded in race and culture. It was most often used to refer to the inherent tension created by culture; especially for women who became the victims of men's exercised power. They referred to the following examples in relation to men's powerfulness and gender rights:

- Power was and is a *"Given to men"* - religiously, culturally and historically: Quoting Adam and Eve, lobola and cultural socialization through the ages;
- Men were controlling, oppressive and bossy in nature;
- Women to fill a submissive and powerless space within relationships with men - to carefully say little; to do as told and to be there and caring for the man;
- Men were given privileges; for example he may eat eggs and meat, she may not ...;

- Women to be submissive to her in-laws (husband's family);
- A woman may not have a house without being married;
- Men determine when, how and how many in terms of children - women were manipulated into acceptance; and
- Women without children have a very low status in the community.

The effect of South Africa's political history which in the not too distant past tried to establish separatism in terms of race was mentioned by only a few participants. The reason for the limited discussions and reference to this phenomenon might have been that the participants refrained from talking any "politics" which was a very sensitive issue and in essence a safety risk in KwaZulu-Natal at the time of the research - the conflict between different political parties in the region being very overt and often the cause of intense violence. The participants also might have felt that they needed to be caringly sensitive to the "race differences" between the researcher and the participants.

Another reason might have been the changing political situation in the country that provided and legalised more sound human rights for all citizens of South Africa, and to correct past inequalities - to level the playing field. The rural group of nurses did indicate that the changes were taking place slowly and that they had not really experienced: "We have not seen it ..."; whilst a woman from the urban group of enrolled nurses indicated that "the gates were now opened".

Participants from the registered nurses' group were inclined to compare the reality of the African culture with the reality of the so-called white culture; looking for differences and similarities, often relating to the researcher in a kind, delicate and clarifying way. Whites were considered to be at a higher level of development and were thus more advantaged than blacks, or Africans in particular. They also indicated that Africans would have been different if they had the opportunities that whites had to have grown up in a white community ... The women also indirectly conveyed the very real sacrifices made to give their children the best or better educational opportunities.

In the discussions the researcher experienced or found very few traces if any of an expressed affirmation of being proud of who they were in terms of racial or cultural orientation, but the paraverbal and non-verbal way in which the women related to their context gave a strong message of commitment and pride; of being able to endure and to survive hardship. Sonia Sanchez (quoted by Sharp, 1993, p. 186) described this reality as follows:

> *"With all the reversals ... we have learned that black is the beginning of every thing. It was black in the universe before the sun ..., ... it was black in the mind before we opened our eyes; it was black in the womb of our mother; black is the beginning. And if we are the beginning we will be forever"*

5.4.10

Responsible and/or responsibilities ...

Part of the above mentioned concept relates to the liability to be called to account to a person or for a thing and originally encompassed a pledge or commitment. The concepts were found in eleven of the 44 (25 %) raw data documents; and were used by seven of the participants; four of them from the enrolled category.

According to **the rural group of women as enrolled nurses**, the responsibility to care for patients was in the hands of every nurse and the essence of responsibility at home in the hands and body of the woman. The **urban group of enrolled nurses** used the concepts in relation to certain tasks and attached a strong positive value to it. The **registered nurses** spoke mainly from a self-created independence at home where the responsibilities thus fell on their shoulders and at work the responsibilities were linked to advanced or developed nursing care practices and also to the hierarchial structures within and outside the specific health setting.

5.4.11

Rights ...

The close relationship between rights and power was acknowledged by the participants in their frequent use of the concept. 27 of the 44 (61 %) raw data documents contained the concept 'rights' and was used by 14 of the participants - of whom 12 were women as nurses belonging to the enrolled category.

The concept refers to a right as being an abstract or symbolic but legitimate authority and entitlement of humans (as individuals, groups and or communities), as well as of animals and things. The identification, establishment, exercising and sanctioning of these rights become powerful and often ethically contested human ventures that become sanctioned and are upheld by communities. The inherent dilemma of rights acceptable in a certain culture or tradition opposing or contradicting those rights accepted in a wider context and consequently underlined in law; were for example, mentioned by the registered nurses.

The **rural group of nurses belonging to the enrolled category** used the concept within the context of interpersonal and intergroup activities (to ask, complain or tell), being sanctioned by position, political freedom and being equal to or the same as power. Additional to these uses of the concept, the **urban group** also used the concept in relation to gender (the man or husband) and family. **The registered category** added and emphasized the relation to culture and race; as well as the rights of the health care consumer.

5.4.12

Routine ...

If one conceptualizes routine as a road (very) often travelled; a task so often done, a feeling so often felt or a thought so often repeated; then the use of the concept routine implied and often summarised massive sections of a normal working day for the participants. The concept was found in ten of the 44 (23 %) raw data documents; and were used by ten participants.

The **rural and urban group of women belonging to the enrolled category** used

the concept to summarise a variety of choiceless nursing tasks such as report taking, bed making, dealing with admissions and discharges. The repetitive nature of these tasks were conveyed verbally, paraverbally and non-verbally to the researcher; tea time and lunch became meaningful (but just as routinized) breaks or divisions. The routinization at work continued to the home of the participants - also devoid of choice. **The registered category of women as nurses** also mentioned the routine nature of their work which included more routine administrative and managerial tasks.

5.4.13

Scope of Practice, regulation, law, rules ...

The origin of the concept of scope indicated a target or aim to be looked at (Oxford dictionary, 1991); while regulation is linked to a clear and authoritative direction (originally "a straight stick" = *regula* [Latin]). The above mentioned concepts emerged out of the raw data of eight of the women as enrolled nurses and all four of the registered nurses. The concepts were used in 17 of the 44 (39 %) of the raw data documents and indicated a strong awareness of the legitimized power tools. The **rural group of women** belonging to the enrolled category linked the concepts to as to be obeyed, to be taught and to be used as the guidelines for the profession - thus a passive acceptance.

The **urban group** linked the concepts to a determinator of duties and a limiter of freedom. The power to devise these rules were also invested in someone somewhere else (the S.A.N.C.); the guidelines were fixed and in essence could harm the patient. They thus verbalised a less passive and even aggressive stance towards the perceived reality imbedded in these concepts. These views and subtle revolt were echoed by the **registered nurses** - all power being vested in the written rules, regulations and circulars.

5.4.14

Senior, superior, above and on top (!)

57 % of the raw data documents hosted the above mentioned concepts (25 out of 44); and were used by all three groups. The essence of reference in the different groups related to:

- **Rural enrolled group:**

  Power vested in senior category and in position - can't be questioned;

  The misuse or abuse of power were vested in category and position;

  The possibility to use own power to the benefit of patient and as long as it is within the parameters of the defined Scope of Practice; and

  Patient could be harmed by such a system of rules and regulations, of do's and don'ts.

- **Urban enrolled group**

  Direction of power-exercise: always downward; never up;

  An element of personal power present and acknowledged in (senior) individual;

  Seniority of doctor's role - leads to feelings of powerlessness;

  Own (at times better) skills negated in terms of category and position; and

  Humiliates those at receiving end.

- **Registered group**

  Power of seniority and position wider and more than own health setting;

  The senior could be equal to a role model and be a meaningful support;

  It might be positive to respect seniority; and

The value of education to determine seniority needs to be acknowledged.

From the above, it was meaningful to infer that the registered group had a more positive and articulated view of seniority and position while the enrolled groups of women as nurses conveyed a consistent negative and harming perceived reality when using the concepts. The researcher had a "tongue-in-the-cheek" experience and resultant "feminist" smile when she read that the concept senior originated from the Latin older or old man, and "Comparative of ***senex senis*** **old man**, old" (Concise Oxford dictionary, 1991, p. 1102; bold mine).

5.4.15

Sad, not good, hurt, pain, trouble, bad ...

These concepts depicted and were related to the participants' expressions of various unpleasant experiences or thoughts. The concepts were found in 26 of the 44 raw data documents; thus in 59 % of the documents. Such concepts were used by twelve out of the fourteen women as nurses.

The rural group of women as nurses belonging to the enrolled category used the concepts in the following contexts:

- **Violence -** takes away not only safety but the home itself;
- **Man in the house -** being irresponsible; being wanderers; being rowdy and insensitive; and
- **At work -** only to follow instructions; inferior position; only one that worked hard; absence of medical support for patients; suggestions were not accepted and were suppressed.

The urban group of enrolled nurses used the concepts in the following contexts:

- When powerless and a failure;
- Absence of equality between men and women - men to be accepted as the most powerful within marriage;
- Cultural taboos related to the use of food and the value of men's powers;
- Harshness of medical practitioners and men in general; and
- Previous but still painful political reality - acceptance and humanness determined by skin colour.

The registered group of nurses:

- Mothering husbands - husbands feel inferior and do not care;
- Problem husbands - irresponsible and suppressing educated woman (nurse); and
- Bluntly accepting routine at work created powerlessness.

5.5 CLASSICAL MOMENTS OF EXPRESSIVE WISDOM AND HUMOUR

The women participating in the research, were precious in terms of how they related to me as a fellow-woman and as a researcher. During the interviews many of the women became more relaxed and free to express their feelings, thoughts, and views - also in relation to their diverse experiences as women and as nurses. The unique way in which they clothed their thoughts, for example by using descriptive language and metaphors; or sometimes

even through the bareness or scarcity of their words which were loaded with meaning and feeling. Sometimes humour was disguised; sometimes it was open and free ...

It was clear to me that these women were able authors of their own life stories. The question that remained was related to whether the womens' standpoints were shaped by their daily experienced realities of knowledge; or whether their standpoints were in any way shaping these realities; or whether by the interaction between these ...

The following were examples of moments of wisdom and/or humour and or metaphors - typed in *italics*. The researcher added the context for the benefit of the reader.

Concerning men:

- Choosing a husband that met her requirements: ***"He is acting as a person of my standard"*** (LEE)
- ***"I was married and divorced, because I did not want to be ruled by another person. I just wanted to be free"*** (ZODWA)
- In relating to being responsible for the children: ***"As a single parent there is no problem. The problem is when you have a husband"*** (GRACE)
- Men; they are in essence an ***" irresponsible somebody"***; and for these irresponsible somebodies to marry a professional nurse was perceived to be a financial gain: ***"They say we are jackpots"*** (GRACE)
- Men - ***"they do what they like in their own time"*** (LULU)
- ***"The man is himself. The woman is not"*** (EUPHEMIA)
- The position of women - or is it men - ***"the husband does not like the woman to be above him"*** (VICKY)
- Concerning the man in the house: ***"He has got a big stubborn mouth. He wants me to do everything for him"*** (MARILYN)

- The man that she divorced from told his friends: ***"This one is pestering me; she is giving me a hell of a headache, and I don't love her anymore"*** (ZOLEKA)

- ***"So it is almost 80% of my time I give to him and his freedom"*** (ZOLEKA)

Concerning women:

- ***"It is difficult to be a woman. But it is alright to be a human being"*** (EUPHEMIA)

- ***"We*** (women) ***go about having amandla toy toying [7], but we don't use weapons"*** (ZOLEKA)

Concerning children:

- The children being exposed to not so pleasant forces in a multi-racial school: ***"So if it is part of life, they must experience it now and sort themselves out"*** (TREASURE)

Concerning seniors and being in charge:

- Being the senior sister of a busy unit was not easy and perceived to be very stressful: as the ***"chargeship ... you just dance right round all over"*** (GRACE)

- And where were the authority: ***"And on top is the authority ..."*** *(TREASURE)*

- All these nurses and other health professionals who were hungry for power:

[7] Toy toying indicates an active and strong dancing movement accompanied by strong and vibrant singing performed by a group of people - usually in a public place (for example the street); the purpose usually to convey a political message of for example dissatisfaction, happiness or satisfaction, and anger.

"More than anything, they want positions, they want to be at the top, to lead the gravy train" *(GRACE)*

Concerning the plight of the nurse belonging to the enrolled category:

- ***"If I am afraid of the sister in the ward, I go and tell the other sister"*** (NORMA)
- If they take away all these categories then ***"nobody would worry each other or trouble each other"*** (LORRAINE)
- ***"I got no power because I am not well educated"*** (NIKITHA)
- Taking away all these categories: ***"If they can make everybody level"*** (NIKITHA)
- The nurses belonging to the enrolled category were faced with the reality of being able to do everybody's work: ***"They*** (the enrolled nurses) ***start from the beginning up to the top"*** *(LORRAINE)*
- Being a nurse belonging to the enrolled category was not easy: ***"because other people don't give us the dignity of nurses"*** (NORMA)
- ***"So you see at the end of the day that you are the only one who has done something like nursing. You see you are the only one with painful feet"*** (MARILYN)
- ***"Sisters they examine the patient and then give the order"*** (PRETTY)
- ***"You let your senior ride you, because you are the junior"*** (ZOLEKA)
- ***"I must do what I am told and I must do what I know is right. It is my scope"*** (PRETTY)
- ***"Many things it*** (I) ***is not allowed to do. Because I am smaller than them"*** (EUPHEMIA)
- ***"If they can think about us"*** (NIKITHA)

Concerning nursing and nurses:

- The inherent problem of accommodating aged and physically unhealthy nurses in a very busy service: ***"CSSD unfortunately the set up here is being done by ailing nurses. We*** (they) ***have got the long term illness like arthritis and so on, so unfortunately they are being utilized by maternity and at the same time they are ailing. We cannot just use them anyhow"*** *(GRACE)*
- ***"There is not really a choice. It is a routine"*** (NIKITHA)
- At work the choice can't be not to do it; the choice would be when to do it: ***"When you say I am not going to do it, when are you going to do it?"*** (GRACE)
- Being a capable professional nurse was hard work: ***"By the time the day ends I am nice and tired with the feet you know"*** (LEE)

Other wisdoms:

- ***"I don't stay on the problem - I sort it out"*** (TREASURE)
- Rights can be legalized; but ***"your society is stronger than your rights"*** (TREASURE)
- ***"Power, it is*** (pause)... ***half bad and half good"*** (ZOLEKA)

5.6 REPORTING ON THE CRITERIA FOR EVALUATING RESEARCH

The researcher used the criteria as discussed in 3.1.4 and table 3.1 of the

methodology section as a frame of reference for the discussion.

5.6.1 TRUTH VALUE OR CREDIBILITY

In terms of prolonged engagement the researcher conducted an average of 2,5 interviews per participant; the interviews itself usually lasting from twenty to forty-five minutes. She also used the second and third interviews as well as other spontaneous discussions (for example before or after the interviews and telephone conversations where appropriate) to verify her understanding of what was said during the previous interview(s).

Multiple data sources were used, for example a comparison of the three different groups, an in depth literature and concept analysis, and an analysis of other data sources provided by three of the nurses belonging to the enrolled category and working in the rural setting - being two written documents and one drawing. The researcher also tried to consistently reflect on her own experiences and feelings.

5.6.2 FITTINGNESS

In trying to fit the real data from where the findings originated, the researcher used a three pronged but interactive approach. She first described the raw themes that emerged from and during the data collection using a sample of six interviews. Secondly, she methodically developed experiential themes with their sub-parts using the raw data files from all three groups.

Thirdly, these themes then eventually formed the basis for the development of a theoretical framework which incorporated data from the literature and concept analysis; and which could thus also fit contexts outside the study. The researcher also used three other women as nurses with expertise in or experience of research

and the practice of nursing to independently search data for meaning - these findings were correlated with those of the researcher to strengthen the theoretical foundation of the analysis.

5.6.3 DESCRIPTIVE VIVIDNESS AND CLARITY

As far as possible, the participants' own words and expressions with descriptions of accompanying gestures or sounds where appropriate were used to bring the participants to life for the reader. The unique way and contents of the participants' spoken words as transcribed were used by and highlighted to the reader in for example 5.4. The social context was also vividly described by the researcher in the section dealing with the participants and their settings (see 5.2) and the researcher also used graphic images for example carefully selected photographs to give some real sense of the context in which the research took place.

5.6.4 RIGOR IN DOCUMENTATION AND AUDITABILITY

The researcher was of the opinion that rigor in documentation would lead to auditability (see Table 3.1). She wrote down the steps taken and rationale for these decisions taken in terms of for example sampling (using the premises of the Standpoint theory and adding locality or rurality), data collection and analysis (applying the principles of the phenomenological approach). These were discussed as progressively applied in Section 3 (for example Table 3.2), 4 and 5.

5.6.5 MEANING IN CONTEXT

The unique reality of nurses who were marginalised in terms of class, gender and race were described within their unique existence, space, context and moment in time with often using the participants' own explanations of these four phenomena guiding the researcher. This was very important in terms of, for example, the unique cultural and also the unique profession-created reality of the participants.

5.6.6 PRECISENESS IN ANALYTICAL THINKING AND THEORIZING

In Section 5, the researcher endeavoured to clearly outline the logical and analytical process followed in developing **from** the raw themes, the experiential themes and their sub-parts: thus a preliminary epistemological framework based on the data from all the participants. This framework were combined with other data sources, for example the theoretical framework (Section 2), and the literature and concept analysis data (see Section 6). The final product (Section 6) was thus *part of, indebted to and belonging to not only one; but of and to many ...*

5.6.7 MASTER OF METHODOLOGY

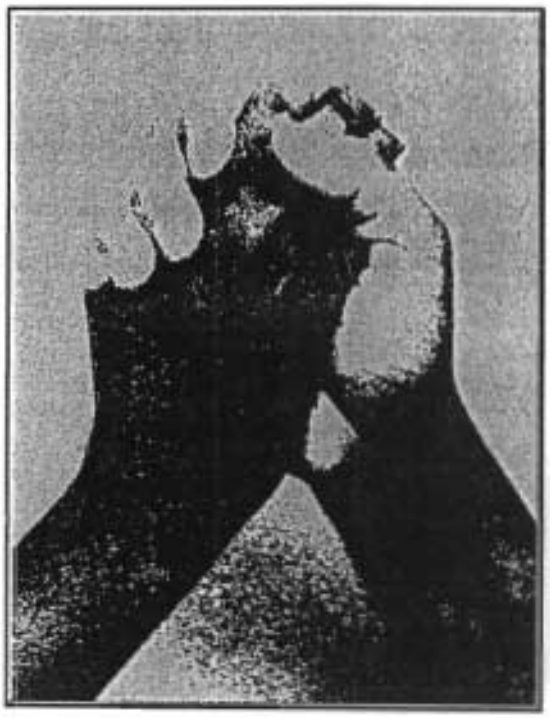
The researcher made a thorough study of qualitative research with special reference to the phenomenological approach, and also received meaningful guidance from an experienced qualitative researcher. In using the self as an instrument, the researcher established and upheld a sensitive and committed rapport with the participants as overtly acknowledged and verbalised by FORTUNATE and GRACE. She constantly

assured the participants that there were no right or wrong answer, and that they were the acknowledged experts of their own lives. The researcher felt that the participants were entitled to, and thus were given, the researcher's full name and work telephone number for future reference.

Where and when requested, the researcher discontinued the interviews (for example LORRAINE), or did not audio tape discussions (for example EUPHEMIA). The request for any additional data from the participants were optional (for example the request for a drawing or essay where only three participants eventually responded); and the researcher did not force any interaction. While interviewing the nurses, the researcher often had to wait for long periods till the participant had finished her most urgent tasks or to come back from tea. The researcher utilized this time to write anecdotal notes or just to observe the day-to-day realities of the health care setting; and was more and more frequently greeted and talked to by staff and patients passing by:

> "The wind was blowing quite unpleasantly through the open corridor and the upright wooden bench on which I sat became quite uncomfortable while waiting for more than an hour. During this time three friendly nurses asked whether I had been helped, a cleaner swept the cement floor rather haphazardly, several women with small bright eyed children loitered up and down, and the gardener cut the three small patches of grass between the two stretches of red brick building. I eventually put my pen and paper away and looked in my rather full basket for something to read. The male nurse who had passed several times and whom I had commented on his fashionable and shining black shoes, apparently could not hold his curiosity any longer. He turned around, looked at my basket; and, as if afraid that he might miss out on I don't know what, said: "Are you selling something?" I laughed and was tempted to say yes, but said no to avoid unnecessary confusion. "No. I am interviewing women as nurses". He looked at me a bit puzzled as if the "women" part sounded strange; and while walking away grumbled: " Why women?". Did he

When requested overtly or sometimes covertly, the researcher shared her own experiences and feelings and tried to stay true to her own self by being spontaneous, friendly, not afraid to touch, and offering help where needed (for example in looking for information concerning a more acceptable or better school for TREASURE's son, and in bringing brochures related to programmes offered at the University of Natal to LEE and the Institute for Nursing, University of Natal when requested by participants).



1. According to Adler (1952a, p. 763) ideas "*are sometimes regarded as objects of knowledge and as representations of reality*". Many philosophers battled with the concept of idea, for example Kant, Locke, James and Aquinas to name a few. The researcher was of the opinion that ideas would include communicated knowledge, thoughts (for example judgement, conception and reasoning) and feelings that became part of the experienced reality of the interaction between the researcher and the participant. The ideas are being accepted as real within

the perceived context; but not necessarily as true. The researcher tried to exercise no normative judgement in terms of for example, right or wrong; and this was clearly communicated by the researcher to the participants.

GOING DEEPER AND WIDER, FORWARD & BACKWARD ...

"It was in those systems (social systems) *that a class system was revealed, a system so perfect that it had long remained invisible. It is an invisibility that the oppressed themselves have only with difficulty destroyed; an ambiguous invisibility, since at the same time the real situation of compulsion is perfectly well known by all women, for it is not possible to live as a woman and not know it (just as it is to live as a member of a minority group without knowing it) ... The fact that there was compulsion and exploitation was obvious to women although it was a matter of indifference to men, but it was devoid of meaning; it fell into the category of unquestioned facts ... And the story of the investigation and discovery of the social logic hidden behind these sex relationships is the story of a synthesis between revolt, activism, analysis, and consciousness"* (Guillaumin, 1995, p. 168-169).

Section 6 portrayed the data summarised in section 5 in an interpreted and meaningful context; relating it carefully with the available literature, the concept analysis and other sources, for example, additional sources provided by the participants, discussions with other researchers, nursing professionals and academics. The first part related to the objectives stated at the beginning of the study in Section 1 (6.1) and the Standpoint theory in Section 2 of the study (6.2) - a deepened and widened return to where it all started. At the end of the section the researcher gave an overview of the retrospective limitations of the actual research process and analysis (going backward) (6.3) and closed with suggestions for the way forward (6.4).

6.1 RETURNING TO THE STATED OBJECTIVES ...

The research project set out to understand the phenomenon of power from the perspective of women as nurses and within the framework provided by the Standpoint theory. The researcher's understanding grew (although would never be complete) during involved data selection and analysis process - leading to the development of an epistemological framework of the power of women. The objectives and the reference in the text were stated in table 6.1.

Table 6.1 The objectives - A "reference list"	
STATED OBJECTIVE:	**REFER TO SECTION:**
6.1.1 Analyse the concept power as found in scientific writings (primarily the social sciences and philosophy)	4.1 - 4.5
6.1.2 Define and analyse the attributes and realities of power; powerlessness and powerfulness as verbalized by nurses as women	5.3., 5.4 & 6.
6.1.3 Analyse the experiences of, and dealing with powerlessness and powerfulness of women as nurses in their daily working lives	5.3. & 6.
6.1.4 Identify the behaviours indicative of a need of and/or readiness to engage in empowerment activities	5.4.1.5, 5.4.2.5 & 6.
6.1.5 Identify the perceived consequences of empowerment for nurses as women in their daily working lives	5.4.2.5
6.1.6 Develop a theoretical epistemological framework of the power of women as nurses.	6.1.6.2

6.1.1 Analyse the concept power as found in scientific writings (primarily the social sciences and philosophy)

The literature review in Section 4 underlined the complex nature of the concept of power (including powerfulness, powerlessness and empowerment). Power was discussed in terms of the relationship between power and authority, power and knowledge and power and politics. It became the focus of studies and deliberations in sciences such as philosophy, political sociology and psychology.

The history of feminism and the theoretical frameworks used in feminist writings

made constant reference to the power relations between men and women, and the development of women's movements to change womens' situations and imbedded power relations were outlined (4.1.2 & 4.3.2). The context of feminism, gender and women in Africa and South Africa (4.4) was portrayed and extended to the reality of a profession and the nursing profession (4.5). The contribution of political (4.3.3) and educational theory (4.3.4) to the knowledge base of power was discussed, as well as the documented reality of nursing education (4.3.4.3).

It became clear that power was a concept laden with explicit or implicit contradictions (4.1.3). In focussing on empowerment, a concept analysis was done to delineate the defining attributes (using the modality theory), the antecedents and the consequences of empowerment. A model and a contradictory case of empowerment was developed. These theoretical underpinnings from the literature were incorporated in developing a comprehensive theoretical framework of the power of women (6.1.6.2).

6.1.2 (& 6.1.3) Define and analyse the attributes and realities of power, powerlessness, and powerfulness as verbalized and experienced by nurses as women in their daily lives

For the purpose of this discussion, the researcher considered it meaningful to combine these two objectives to emphasize and to relate to the interaction between what was said, felt, experienced and dealt with by the participants and the researcher, emphasizing the interaction between these.

I) Describing the concept power and the power of women

The women as nurses participating in the study, **described power** in terms of an ability and as a right (to have); adding concepts such as strength, authority, control

and achievement which could be more related to the inherent attributes, causes or effects of power.

In relating to their **power as WOMEN** the **nurses from the enrolled category** emphasized the maternal abilities of women to create and maintain a loving relationship a family (which was strongly emphasized by the rural group of women) and peace and the ability to endure, whatever bad things which comes one's way (from the urban group of nurses belonging to the enrolled category). The power of endurance seemed to be an exceptionally strong attribute of African women as portrayed by the political history of South Africa. The slogan: "*If you struck a woman, you have struck a rock*" (source unknown) became a symbol of womens' power as individuals and as a power group in South Africa.

Zulu women were also well known for their ability to unite in song and to use song as a collective medium to lament on the political unrest in the region:

"*Balamleni labantu bazobulalana balamleni ...*"

"*Separate these people they will kill each other, separate/ mediate between them*" (Stewart, 1995, p.23).

According to Stewart, this song was performed with slow hand clapping and ululations to evoke a strong sense of urgency and pleading: "*In a transitional society rural Zulu women continue to find a voice through their poetry by articulating concerns and providing a chronicle of the sociological fabric of their daily lives*" (p. 23).

The statements of women as nurses' belonging to the enrolled category were intricately linked to a traditional altruism where women sacrifice what is scarce and needed by themselves for the benefit of others - usually the man or husband in the house, children and significant others. The women as nurses felt that this very altruistic ability made them powerful.

The registered nurses also mentioned these maintenance abilities, but added the ability to think and decide on the best way, which was linked to instinct(!) and also

to education. An emphasis was also placed on the power of women to be appreciated and to be powerful because of their personal characteristics - possibly linked to abilities which transcends manuality, for example, thinking and doing logically and to be appreciated for their inherent abilities.

Ruddick (1992, p. 144, 153-154) advocates the moving away from a barren acceptance and limited practice of motherhood and caring to a progressive and liberating standpoint of peace politics. She states that women have not extended the reality of care beyond *"class, race and neighbourhood"* and argues for the need of women to

> *"fight against women (as well as men) to acquire the power to refuse maternal work ... women in resistance create new values of activity and stubborn decisiveness ... contributing in their own distinctively maternal ways to the many-faceted, polymorphous, collective effort to make peace worth keeping.".*

II) The power of men

... however, were described in terms of a tongue-in-the-cheek "God-given" controlling ability - an ability strengthened by cultural practices and the amount of traditional orientation. They indicated discomfort with this perceived reality but limited action - especially amongst the women as members of the **enrolled category**. Many of the **registered nurses** participating bravely opted to be out of or separated from this painful reality which exists between men and women by, for example, divorce or by being more in control through the careful selection of spouse and maintaining meaningful even reversed dependency roles.

It also seemed as if **registered nurses** acknowledged their own role and responsibility in the man=woman relationship to a greater extent: not even the Government can help here (GRACE)!. These thoughts were underlined by Green (1995, p.150) even in a broader context: *"women have been conscious participants in the social construction of the past"* - to add: and of the present and future ... Throughout the research it became increasingly clear that women were part of what happened, is happening and will happen.

III) The power of women as NURSES

... was essentially described by the **women as nurses belonging to the enrolled category** and working in the **rural setting** in terms of to care or to support; with "add-ons" such as to refuse, to be humble and to differentiate right from wrong. The communicated and overwhelming acknowledgement that the most power in terms of their work as a nurse was vested in the Head of Nursing Services was important in terms of the expectations of, and skills needed for a leader. It was also sad that the reasons for this form of power - which would academically be called position power - was often in terms of for example that the head's word equals law, brooks no opposition; control; and superior education. Only one of the **urban group of enrolled nurses** indicated a personal awareness of the inherent personal qualities and abilities of her nursing services manager.

The urban group added the ability to handle with insight (to think!), to teach and to delegate. It became clear that the rural group's need for empowerment in terms of becoming aware, to define, to develop, to enact and to control their inherent abilities as human beings, women and nurses,were greater than that of the urban group of nurses.

The registered nurses emphasized the power of development or education; personal characteristics such as diligence, willingness, and a pleasant personality; as well as the ability to promptly attend to the needs or problems of junior nurses. They also conceptualized the reality of *everybody having a boss somewhere somehow*, and were assertive in identifying themselves as being the most powerful. They saw the most powerful senior nurse to be the nurse who empowers others.

IV) The powerlessness of nurses as WOMEN

... was described in terms of the reality of frequent violence and insufficient financial resources to provide in the needs of herself and the family were mentioned by the nurses as women belonging to the **enrolled category**. They also described the effect (in essence powerlessness) of the presence of a man or husband in the home - men seen as creating additional responsibility because of their irresponsibility and

their apparent need to control and exercise power. The registered nurses as women related to the powerlessness imbedded in insufficient financial resources, as well as the powerlessness of nurses as women in terms of the barriers of illiteracy and poor choices of husbands. The plight of the childless woman within the Zulu culture was also mentioned.

V) ... and women as NURSES

The women as nurses belonging to the **enrolled category** agreed that their powerlessness was caused and was inherent in the hierarchial qualification framework and the resultant development of categories of nurses. These were perceived to be the source of passive acceptance, frustration, constricted relationships, power games in terms of "I am the senior - you just do what I tell you"; dampened creativity - sometimes to the detriment of the patient, and withstanding or withholding the willingness to take responsibility. These realities were strongly voiced by the rural women as nurses, but also clearly voiced by the urban group - the researcher thus sensing only a quantitative difference in the two groups. They also emphasized that these very structures motivate nurses to educate themselves further, thus, *"for the class and not for the task"* ! The wearing of symbols such as epaulettes aggravated this tension, even in relating to patients that prefer epauletted nurses to care for them -inherently implying a "it is not inside, it is on top" perspective.

The distancing interpersonal approach of seniors as well as, the misuse of the enrolled category of nurses by the very incumbents of the senior and so-called professional category also strengthened their perceptions of powerlessness. The reality that they were often used above and below their abilities depending on the situation and needs of individuals and / or groups was clearly outlined by both the groups of enrolled nurses. It was interesting to note that the registered nurses indicated that powerlessness can exist in and within any category.

All these instances of powerlessness created an attitude of passive acceptance, of hurt, frustration and depression. Some element of contained anger or aggression within the women as nurses belonging to the enrolled category was evident; while

others simply stated: "If only they can think of us..."

The characteristics of the working situation, for example when short staffed, being left alone in the ward, the potential conflict amongst women working together and working with other nurses who did not value nursing care as a meaningful and altruistic occupation were mentioned by the women as nurses belonging to the enrolled category. The rural group also mentioned the added reality of violence, the absence of skilled medical help, the absence of committed religious practices and their struggle to get the same rights as nurses belonging to the enrolled category and working in an urban setting, for example, access to educational opportunities.

The registered nurses felt powerless in terms of the management structures in the health care settings; they felt that they made a positive difference or could make a difference to the working lives of the enrolled category. They felt often limited or constrained in their freedom to exercise their creative abilities; and were also hampered by the leadership and communication skills of management. The strict rules in terms of uniform, the *for-ever **reporting** of what ever to who-ever for who know what reason syndrome;* as well as, a lack of experience were mentioned as examples of applied powerlessness with resultant feelings of unhappiness, deflation and of feeling depressed.

VI) Placing powerlessness in a theoretical framework

The powerlessness of women as nurses radiated from a daily reality imbedded in race, class, gender and geographical location. From the research the following five concepts that encapsulated many of their experiences were identified: severance, routinism, being misused and maternalized, and domesticity. Alienation was used as an umbrella concept to describe the essence of their powerless experiences.

ALIENATION

The result or effect of being considered foreign, different and/or unacceptable from the standpoint of the so-called elitist or superior class, race or gender. Alienation usually carried strong emotional undertones feelings of for example hostility, anger,

pain, sadness, frustration and passive acceptance. The researcher used the concept of alienation to represent the powerlessness of women as nurses.

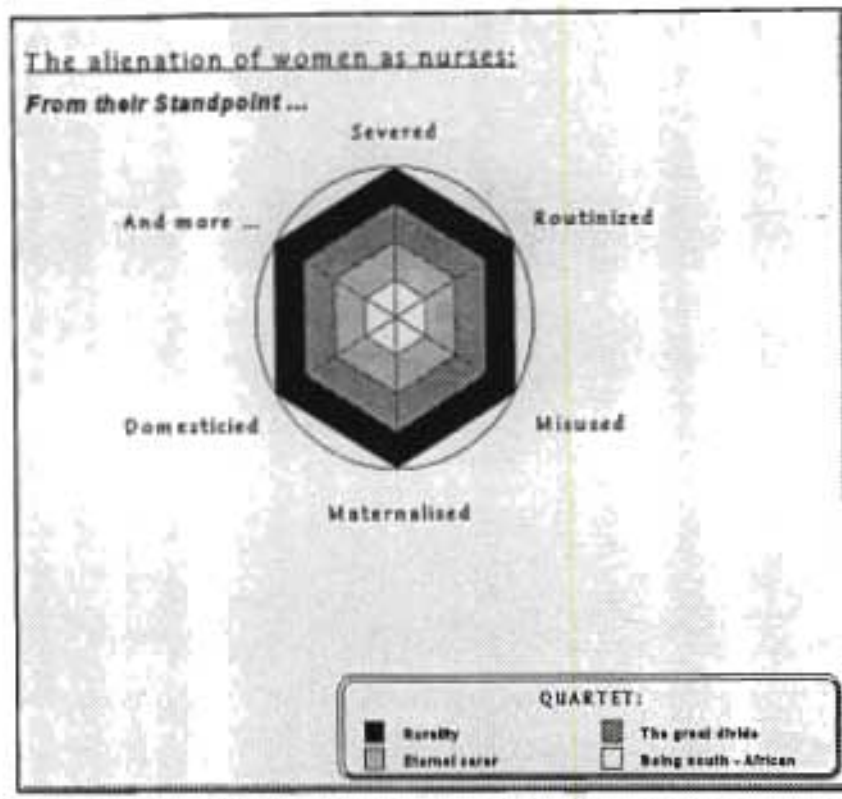


Figure 6.1: The reality of women as nurses' alienation.

As a nurse:

Women as enrolled nurses suffered from the effect of alienation: they communicated feelings of anger, depression, passive acceptance, hostility and unhappiness concerning their conditions at work. They also conveyed rationales such as avoiding confrontation and to be true to a higher and transcendental ethical and/or pistic mission.

As a woman:

At home their awareness of pain was related to the man in the house who was perceived to be aggressive, demanding, controlling and power hungry. The added burden of financial and political insecurity strengthened feelings of desperation and hopelessness in some of the nurses as women, especially in the rural setting.

Severance / Being severed:

Severance refers to the act of dividing, breaking or of being made separate, usually by cutting (The Concise Oxford Dictionary, 1991) - effecting in terms of powerlessness a perceived reality of constrained freedom and choice, of acceptance and/or revolt.

As nurses ...

The enrolled category of nurses was legally and practically made separate or cut off from professional status in the nursing profession in South Africa. They were considered an enrolled category versus the registered category which became popularly known in South Africa as an elitist category of professional nurses. The "great divide" long denied them access to, or representation on regulatory bodies and other professional bodies. They did not share in the greater educational opportunities available to registered nurses. They were also clearly identifiable to colleagues and the public in terms of symbols that had to be worn and their regulated "Scope of Practise" which placed them under the supervision of registered nurses. These nurses, especially in the rural setting, experienced this phenomenon as disempowering.

If one takes into consideration that this category represents half or 50% of the nursing fraternity in South Africa, it becomes clear that the profession in essence, severed half of its own body. In a time of dramatic changes in the health field and professions with limited financial resources and the presence of severe competition from other health workers and disciplines, the organized profession needs a re-orientation in terms of the future of nursing education and composition of the nursing profession. The ideals of standardization, rationality and objectivity in determining and delineating the nursing cadre in South Africa need to be revisited within a visionary context.

As women:

Women as nurses within the traditional African setting were considered to be

different, separate and not equal to men. The man was considered free and was to be treated with respect and dignity. Power was vested in the man, allowing the man to control and manipulate the woman's existence. Women were often denied access or use of certain commodities, ranging from certain kinds of food and cuts of meat to limited opportunities for recreation. Their role and responsibilities were often separate and pre-defined with limited choice, but with routine in abundance ...

☐ Routinism

A regular adherence to a sequence of tasks and responsibilities in a pre-defined and pre-structured and often unchangeable way - with limited imbedded choices.

As nurses:

The every-day of women as nurses was filled with pre-defined routine activities with limited choice and freedom. They had to do as they were told, had to attend to what was given and was left with little if any opportunity to apply their own unique self in terms of for example skills and knowledge. The perceived to be, insurmountable barrier and stipulations of a nationally structured and regulated practice left little room for enjoying the task at hand. The practical application in terms of for example misuse aggravated the awareness and possible frustration and emotional trauma.

The women as nurses were however able to endure such circumstances and to find some consolidation or rationale within a deeper meaning of being a nurse. This deeper meaning unfortunately often mirrored the maternal and carer role and reality of women - nurses as women becoming the eternal carers ...

As women:

The routinism of their daily working lives was carried forward to their time at home. Nurses as women were responsible for the washing, ironing, cooking, cleaning, caring for the children and their homework and caring for the man of the house - maintenance responsibilities that were inherently choiceless and continuous. Many of them internalised and accepted these responsibilities within a cultural and historical framework.

□ Being misused

As a nurse:

This concept related to the wrong or improper use of women as nurses in terms of purpose and/or activities. Within the nursing reality of day-to-day practice the women as nurses belonging to the enrolled category were allowed more advanced tasks when the registered nurse was not available or in times of a crisis. Even worse, the reality of being allowed when the registered nurse was not interested to do the task at hand. The possibilities of being misused could be summarised as follow:

I) To be able, but not allowed;

ii) To be able and allowed unfairly (contra regulated practice);

iii) To be able and allowed based on external circumstances such as a crisis;

iv) To be able, to teach and to be then rejected;

v) To be able but constrained by senior category's use of power; and

vi) To not be able and not allowed to be taught (outside regulated practice).

Whenever they were perceived to be a threat to the senior category of nurses, they were helplessly exposed to domination - *"defenceless against the very weapons of domination they reject"* (Guillaumin, 1995, p.93).

As a woman:

At home, these women were misused in various ways. They were misused as the only and **the** responsible maintainer of home and family, as the ever present carer and comforter. The normative (for example the judicial and ethical) nature of many of the responsibilities at home and at work made them to often accept without questioning, of just doing what needed to be done.

Maternalised / maternalism

At work:

The women as nurses were considered and used for responsibilities and tasks historically and traditionally related to that of a mother, for example caring, support and love - from a naturalist origin. At work they had to attend to the basic needs of the patient in a supporting and caring way.

These tasks usually required little more than a natural and spontaneous caring ability, devoid of extended knowledge and critical thinking skills. They also internalised the essence of nursing being to care, love, to do for, to feel for, to be available, to serve and to support - the nurse as a woman became the eternal carer ...

At home:

... These essences remained true and were also loaded with some sacrifices to the self. The awareness of being loved and needed at home (usually by the children), of being comfortable and having more freedom made these sacrifices meaningful.

Domesticism / domesticity

Domesticity indicated a naturalist reference to the woman's responsibilities and tasks of and in the house, home and family environment.

Women as nurses belonging to the enrolled category were relegated to an array of traditional domestic tasks such as damp dusting, cleaning, washing, feeding, and attending to the basic needs of patients. At home they were to continue these responsibilities for and on behalf of the family with little if any support. The man of the house had limited empathy with the realities of a working mother.

And more ...

Referring to a door left open for any more, if any ...

6.1.4 (& 6.1.5)	Identify the behaviours indicative of a need of and/or readiness to engage in empowerment activities; as well as the perceived consequences of empowerment for nurses as women in their daily working lives

Being a WOMAN

The nurses as women generally envisioned and conveyed limited possibilities or strategies to create, develop and strengthen their power as women. While talking to the participants, the researcher often sensed a vacuum devoid of possibilities and opportunities. The conversations concerning empowerment supported this perception, and discussions before and after the interviews further delineated this vacuum. It seemed as if the nurses became focussed on a few important and well-known possibilities, for example, further education of themselves and the re-education and re-orientation of men. If one however, accepted thinking as already "doing" and as a potential or real part of change, then the nurses as women already began taking the first steps in their own and collective empowerment processes.

The rural and urban group of nurses belonging to the enrolled category ...

The rural group provided a broader spectrum of possibilities than the urban group and mentioned strategies such as support groups and negotiation; formulated the need for financial resources in terms of funding meaningful projects. The urban group of nurses as women also mentioned negotiation but emphasized the exercising of choices and rights.

The women as nurses belonging to the registered category ...

These women also opted to deal with the cultural and traditional reality of women -

men needed to be re-educated psychologically, socially and spiritually in terms of their supporting or complementing roles. The upliftment of the nurse's financial status was also consistently mentioned by the registered nurses. It needed to be mentioned that the salaries and working conditions of nurses were major reasons for strike actions launched by nurses in South Africa during 1995 - these actions thus underlining the strong need for economic empowerment of women as nurses.

Being a NURSE

The women as nurses belonging to the enrolled category placed a strong emphasis on the elimination of so-called categories within the nursing profession, the revision of strict rules and regulations and access to educational opportunities. Added to these were increased and regular opportunities to communicate own needs and problems, uplifting working conditions and removing the stigma attached to being an enrolled nurse or nursing auxiliary - though it will take time to disappear..

The registered nurses again emphasized renumeration and the development of the senior nursing staff or management in terms of sound leadership skills; to be allowed creative yet responsible freedom; to be involved in decision making and educational opportunities and to be placed in a position where one could apply developed skills. The need of sufficient staff to decrease the load of nursing personnel was also a empowerment strategy for these nurses - probably in terms of a more fair and equal distribution of tasks and responsibilities which incorporated creative opportunities for development, education and consultation.

Relating to the consequences of empowerment ...

In terms of the consequences of empowerment for women as nurses the researcher identified the differences between the enrolled and registered group of women as nurses. This group was initially considered to be a more empowered group.

At work the registered nurses:

- Were involved with more gratifying and less domesticated nursing care activities for example examining patients, diagnosing, treating, counselling and referral;
- Reported a relative presence of job satisfaction, recognition of responsibilities and (still limited) decision making;
- Indicated an awareness of the power of personal qualities such as diligence, pleasant disposition and personal knowledge basis;
- Conveyed an awareness of being valued by patients and co-workers; and
- Conveyed an awareness of the ability to empower others.

At home the registered nurse as a woman indicated the ability to:

- Create own freedom from men's perceived "enslavement";
- Take control of personal lives and the lives of dependents;
- Create and foster an awareness in others of worthy to be respected and of being powerful;
- Be submissive and enduring - in essence a contradiction in terms but stated within a certain religious context; and to
- Analyse and "objectively" move away from their cultural realities to view the totality.

6.1.6 Develop a theoretical epistemological framework of the power of women as nurses

6.1.6.1 Completing the definition of terms

In Section 1.6 the researcher stated that a definition of power and related concepts were not appropriate at that stage. During the collection and analysis of data definitions emerged which were considered meaningful within this context, without sacrificing clarity and user-friendliness.

The researcher found that for example literature on nursing management was inclined to discuss power in terms of being able to exert influence on or affect the behaviour of others, or to achieve stated goals - often emphasizing the interpersonal, intergroup and social reality of power. The well known types of power (in terms of others) were usually discussed at length; for example position power or legitimate power, expert, coercive, referent, charismatic and informational power. Power relationships often thus became an unpleasant awareness of unequal positions, roles and tasks, of control and subordination. It is also stated that women are inclined to "*believe power manages them, rather than they are capable of acquiring and managing power*" (Marquis & Huston, 1994, p. 157). A return to a fundamental understanding of and the **development of a comfort zone** around the concept of power and related concepts was thus needed which emphasized a more positive and within the reach and reality of all women as nurses.

Power can be defined as a perceived or real ability to think, feel and/or do within a situational context:

- Human beings have the individual and collective ability (power) to think and do logically within a normative reality of for example right or wrong.
- Power also needs to to be applied or enacted to be experienced directly or indirectly by the doer, the observer and/or the receiver - thus emphasizing the

active nature of power.

- Accepting the intricate and delicate interaction and balance between thinking, feeling and doing; between the observer, receiver and doer.
- Increasing (empowering) or decreasing (disempowering) a human being's ability to think, do and feel would lead to real or perceived powerfulness or powerlessness.

Powerlessness would thus relate to **a perceived and / or real inability or constrained ability to think, do and feel in a specific context**.

Powerfulness on the other hand, **indicates an ability to think, feel and do within a certain context to the relative fullness of one's potential and capacity.**

It needs to be mentioned that power, powerlessness and powerfulness can be exercised individually and collectively; usually all three these concepts are needed to be realized either explicitly or implicitly to indicate the extremes of powerlessness and powerfulness. It can thus be postulated that the absolute extreme forms are in essence not possible if one believes that the human being is always capable of developing and exerting some form of power(fulness).

Empowerment relates to the or a process that fosters the development, achievement and sustainment of power and powerfulness in a defined context.

According to Green who defends feminist humanism, (1995, p.25) one element of humanism is of an epistemological nature which *"accepts that human faculties are capable of discovering some truths; particularly truths about what is better or worse for humans"*. To take this argument further: women - being the essence of this study - are able of discovering truths about what is better or worse for humans in terms of power, powerfulness and powerlessness. Being human, women are sensitive to reason and feeling, to for example fairness, emotion, sympathy, imagination and love within so-called power relations. The created reality of such relationships, conditions, and contexts needs to foster empowerment for both women and men: women and men being equal (but not necessarily the same), within a mutually

identified, defined, agreed upon and controlled need and acceptance of one another, but in essence independent.

6.1.6.2 Creating an epistemological framework of the power of women

In relating to the essences of power, powerfulness, powerlessness and empowerment as stated by women as nurses the researcher developed a comprehensive framework that would embrace and be applicable to the totality of women as nurses' reality. This framework could then be used in nursing management, nursing education and clinical practice to monitor, strengthen, enact and foster the power relations of women as nurses. This approach was considered to be in line with so-called political aims and action as argued by Haraway (1988, p.589) who emphasized the "*politics and epistemologies of location, positioning, and situating, where partiality and not universality is the condition of being heard to make rational knowledge claims*". Pearson (1992) also emphasized situation and context, but adds the need for **an epistemology to be transformational** (incorporating action). A transformational epistemological framework of the power of women as nurses was portrayed in table 6.2 and summarised diagrammatically in diagram 6.2.

The framework emphasized that

- Powerlessness was related and imbedded within the phenomenon which was described popularly in feminist literature as turning *The Other* into the *object* whilst empowering the so-called *subject*. The concept of *appropriation* also relates to treating human beings as things linked to and imbedded in the order and control of nature (Guillaumin, 1995).
- Empowering was a process not definable or containable within only one modality but reached across boundaries, thus illustrating the coherent, retrocipatory and anticipatory moments qualified by the modal nucleus.

- Powerfulness was in essence an ideal and aim constantly striven for, but always out of (a perfect) reach.
- Although the original theory emphasized the hierarchial nature of the fifteen modalities, the hierarchy was not considered more important than the context of what was needed and valued at a given moment in time.
- In the discussion of modalities the implied responsibility of human beings to think, feel and do (summarised as actions) within norms and co-calculating the benefit-risk ratio of such actions, were taken as stated.
- The co-operative development of holistic ways and strategies to empower women as NURSES and nurses as WOMEN to reach the ideal or aim of powerfulness needed extensive attention but did not fall into the scope of this study.

Legend for Table 6.2:

Identified as essences of powerlessness by participants
Identified as essences of empowerment by participants
Added as essences of powerlessness & empowerment by researcher

Table 6.2: Moving from being marginalised and powerless to transformation and powerfulness

MODALITY	Marginalised: POWERLESS	Transforming: EMPOWERING	Transformed: POWERFUL
I) NUMERICAL	*The* "second" category	Create a united cadre [1]	A united force of nurses in the health care services and of women in South Africa
Discrete quantity	Under-utilizing the power of numbers [2]	Affirm & utilize power of numbers	
	Lower (inferior) position within nursing and in relation to man	Create a meaningful position related to uniqueness, skills, equality and unity	Being within co-defined and meaningful positions as a nurse and as a woman

1 Where not stated, the context referred to both women as NURSES, and nurses as WOMEN.

2 Ratio 1:1 with registered nurses; more women than men in South Africa.

Table 6.2: Moving from being marginalised and powerless to transformation and powerfulness

MODALITY	Marginalised: POWERLESS	Transforming: EMPOWERING	Transformed: POWERFUL
	Severed from main group - Standing alone and alienated from the nursing profession and men	Create union and unity	A unified profession; a unified and humane existence in terms of gender
II) SPATIAL Continuous extension	Placed in a constrictive context and structure of category, rules & regulations and of cultural tradition	Revision of strict and disempowering structures and rules; of the bond of cultural tradition.	Nurses and women acknowledged for their contribution in establishing a coherent and integrated reality.
	Confined space attributed to approach of senior category and of man of the house	Fostering a comfortable space & opportunity for all nurses and women	
	Emphasizing the woman's body as an object to look at and to have within the man-woman relationship	Foster a fulfilling relationship with the total woman in her own and unique context Acknowledging & creating ownership of own body (re-affirming)	

Table 6.2: Moving from being marginalised and powerless to transformation and powerfulness

MODALITY	Marginalised: POWERLESS	Transforming: EMPOWERING	Transformed: POWERFUL
III) EXTENSIVE MOVEMENT Perpetual motion	Staticism with limited movement or advancement	Negotiating career and develop-mental opportunities as a nurse & as a woman	The endurer and living (not just existing) with co-created opportunities to move across levels of and into advanced levels of skill and meaningfulness
	Routinism	Prepare for and do a diversity of responsibility and tasks	
	Maintenance	Accentuate pro-cess of becoming	
	Eternal in terms of caring, accepting and suffering	Endure	
	Static practice	Seek and effect change	
IV) PHYSICAL Acceleration & energy	Dominated	Be dynamic, flexible	Women in control and applying unique abilities
	Limited strength / power (only over patients and children)	Identify causal relationship and become a change agent	
	Being forced to do and accept (no choice)	Pro-actively actively resist force	
	Manual nature of responsibilities & tasks	Foster a unique source and application of energy	

Table 6.2: Moving from being marginalised and powerless to transformation and powerfulness

MODALITY	Marginalised: POWERLESS	Transforming: EMPOWERING	Transformed: POWERFUL
V) BIOTIC	A sexist and culture [3] oriented over-emphases of womens' femininity & maternity	Develop own uniquely defined healthy lifestyle; as well as a science and art of "heal(th)ing"	An ability to control the development and utilization of own abilities
	Relegated to nature	Resist naturalism in every form of daily life	
	Limited growth & development opportunities	Create & utilize growth and developmental opportunities	
VI) PSYCHICAL Feelings	A devaluing of emotion as subjective.	Develop constructive psycho-social mechanisms to change self & others & to cope	Power of consciousness; Self-assertion; and release of potential. Sensitivity
	An awareness of for example hopelessness, depression, being sad, painfulness & desertion.		

[3] Culture refers to the culture linked to for example different ethnic groups; as well as the culture of nursing instilled into nurses. According to Dooyeweerd (1955) real power over people is always consolidated in cultural forms and the task of traditional practices are to guarantee the survival and development of cultural forms - see 4.2.4.1.

Table 6.2: Moving from being marginalised and powerless to transformation and powerfulness

MODALITY	Marginalised: POWERLESS	Transforming: EMPOWERING	Transformed: POWERFUL
	Conditioned and labelled to be naturally emotional		
VII) LOGICAL [4] Analysis	Aware of, but accept and "exist" with inequalities	Analyse inequalities and develop strategies for change	The power of individual and collective reasoning to the benefit of the *self and us* as groups and communities
	A naive acceptance of powerlessness	Develop the abilities imbedded in intuition and intellect to deal with information shared	
VIII) HISTO-RICAL Controlled creation	A maintenance of created context, for example in culture, tradition & formalised practices	Develop a comfortable and equal playing ground in relation to culture and tradition	The power to share in the creation and sustainment of present and future contexts
	Accepting that men = culture; the masters & in command	Build and nurture relations of equal entrance, participation and fulfilment	

[4] This modality and those that follow are all normatively structured - referring to the human being's ability to behave or not behave according to own and collective norms.

Table 6.2: Moving from being marginalised and powerless to transformation and powerfulness

MODALITY	Marginalised: POWERLESS	Transforming: EMPOWERING	Transformed: POWERFUL
IX) SYMBOLIC Language of significance	Exist with a pre-determined meaning & value	Voice concerns & create own and collective meaning	Language of power incorporating trust, honesty & truth in: * Verbal, non-verbal and paraverbal & * Text, utterances, actions. Community values nursing & unique value of women
	Labelled an (double) object, for example black and woman	Value self & others & the relationships between	
	Forced symbols, for example epaulettes	Re-evaluate value & design of distinguishing devices and other enforced symbols	
	Significance of being enrolled not registered, not professional	Establish significance in skills, not in devices and labels	
	Limited control over the language of the Other	Create own language of power	

Table 6.2: Moving from being marginalised and powerless to transformation and powerfulness

MODALITY	Marginalised: POWERLESS	Transforming: EMPOWERING	Transformed: POWERFUL
X) SOCIAL INTER-COURSE Relating with & to others	Anti- and de-socialized within profession & with the Other; not being shared with	Inclusive policies in organized professio and participating in all of professional bodies	Value social meaning & support of the regulated nursing profession, nurses & women Co- responsible sharer of interconnected networks - creating a social awareness of women as NURSES & nurses as WOMEN in the organized profession and the community
	Limited connnec-tedness & social awareness	Foster connectedness with others on equal footing	
XI) ECONOMIC Utilization of scarce resources	Extent of economic needs to maintain family force passive acceptance	Sharing the distribution and the utilization of scarce resources	Increased access and control over resources Increaesed economic consciousness
	Poor distribution of resources (knowledge, opportunities)	Contest & campaign for resources based on well motivated rationale	
	Limited control & access to scarce commodities	Negotiate access & control	

Table 6.2: Moving from being marginalised and powerless to transformation and powerfulness

MODALITY	Marginalised: POWERLESS	Transforming: EMPOWERING	Transformed: POWERFUL
XII) AESTHETIC Harmony & beauty	Women an object of beauty to be "gazed" at [5]	Foster an appreciation for beauty & harmony	A creator of harmony and beauty in and with context
	Negative portrayal of nursing and nurses	Campaign for a positive portrayal & voice objection when negative	
	Limited harmony within nursing profession and amongst nurses; & with men	Develop a sense of appreciation for the beauty within the self and in relationships	
	Limited opportunities and development of ability to express creativity	Create moments wider than nursing and dailiness to express creativity	
XIII) JURIDICAL Justice & fairness	Not being treated fairly (misused)	Question the established & resist those who infringe on own & collective rights	
	Equality before law, not within culture & tradition.	Lobby for the enactment of rights	

[5] Although not mentioned by the participants or could be considered to fall outside the reality of this study, the researcher included this phenomenon of powerlessness for completeness.

Table 6.2: Moving from being marginalised and powerless to transformation and powerfulness

MODALITY	Marginalised: POWERLESS	Transforming: EMPOWERING	Transformed: POWERFUL
XIV) ETHICAL To love & do good	Eternal carer	Co-responsible & enacting choice when & in caring	A sharing and shared carer who is also being cared for
	Conforming to, conditioned and exploited as eternal carers	Be alert to the danger signs and act pro-actively	
	Right and wrong are easy to define and enact	*"good and evil are no longer self-evident ... But once we know how uncertain the foundation is, ethical decision becomes a sub-jective creative act"* (Jung, 1962, p. 361)	
XV) FAITH Believe	Transcends exploitation in the name of Altruism.	Direct faith to the essence and value of sharing within self, a group and community; being faithful to the self and others; being faithful to the deeper meaning found in life which transcends reality.	Believe in own and collective ability to transform own and collective reality.

See figure 6.2 on next page for diagrammatical representation.

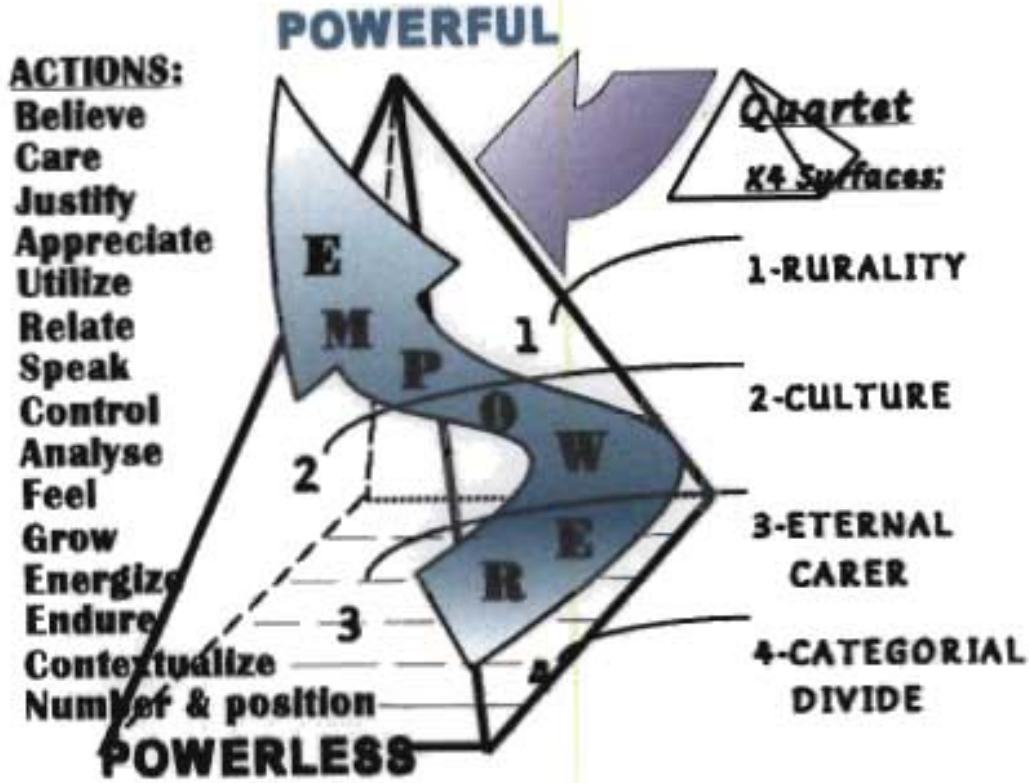


Figure 6.2: **A conceptual framework of empowerment using the quartet of class (categorial divide), gender (eternal carer), race (culture) & locality (rurality).**

6.2 RETURNING TO THE STANDPOINT THEORY

The Standpoint theory was more than a point of departure for this study; it in essence sketched the epistemological framework, the textured direction, context and even some of the boundaries along the road to be travelled. In coming to the end - or is it just another bend - in the road, the researcher returned to the Standpoint elected and accepted, to reflect once more on:

6.2.1 CLASS: A CATEGORIAL DIVIDE

Two of the groups of women as nurses lived and worked in a perceived to be marginalised context - the context of class as developed and entrenched within the nursing profession in South Africa. Belonging to the enrolled "class", they exhibited and conveyed a clear knowledge of being oppressed. The very conceptualization and popularization of *registered nurses being equal to professional nurses* intensified the category divide - implying that the other category was not "professional".

Two of the driving forces behind such a categorial division was the need to differentiate between the levels of nursing knowledge and skills of nurses, and to increase the client and community's protection against the possible trauma of inferior care and malpractice. The category system were sucked into the power realities and power relations of human beings. The reality of women as enrolled nurses was clearly portrayed an actual or potential powerlessness (refer to Table 4.3 in Section 4):

- They perceived themselves to be powerless as, and belonging to a powerless category and group and could see limited if any ways to empower the category - for example by taking away the category system and distinguishing devices;
- At times they felt that they had the power (ability needed within context) to do, but they had limited negotiation power which was in essence defined by the Scope of Practice and other regulations;
- The awareness and day-to-day realities of belonging to a lower or inferior non-professional category instilled feelings of powerlessness, for example depression, unhappiness, a passive acceptance, alienation and even hostility;
- Limited development and educational experiences and opportunities, limited incentives, the misuse of this category of nurses by the senior and registered

category, the clear symbols worn to publicize categorial lines and an inferior personal and collective preparation to cope with the occupation and related tasks at hand were explicit and / or implicit in their daily realities as nurses belonging to the enrolled category.

It was important to note, however, that marginalisation and oppression crosses and infiltrates the very boundaries created and enacted. Registered nurses who actually stated that every category experienced powerlessness also verbalised powerlessness in terms of for example, the approach of the management structure(s) towards registered nurses practising in the clinical setting and the inadequate acceptance of, and reward for, meaningful clinical experience within the health care setting. If one accepts formal management as another class, these perceptions needed to be viewed as meaningful within context.

6.2.2 GENDER: THE ETERNAL CARER

Women as nurses belonging to the enrolled category clearly conveyed the reality of being involved in a double domesticity at work and at home. At home they were responsible to create and maintain themselves, the house or dwelling, the man of the house, the children and significant others; they were responsible for maintaining peace and support in a loving and caring way. At work the house or dwelling was exchanged for the ward or unit and its mostly manual tasks; the man became the senior category of nurse; the children became the patients; enduring in a peaceful caring way to safeguard at least survival ...

The nature of tasks ascribed to these nurses, for example routinization, and the limitations placed on the range of tasks (for example only related to the basic needs of the patient and only under supervision of a registered nurse), were co-responsible for and aggravated the already present feelings of hopelessness and alienation. The power of the senior category was entrenched in both the categories' Scope of

Practice documents; the women belonging to the enrolled category were fearful of the reality of women working together. The dominating presence of men as medical practitioners was not found to be that significant in this study - a realization that re-focussed the researcher's eyes, to shift her gaze more to nursing and nurses themselves ...

The responsibilities and tasks of the registered nurses who participated in the study were perceived to move away from the mere attending to the basic needs of the patients (and of the senior category) to what could be viewed as more satisfying and applied nursing care, for example doing clinical examinations on and diagnosing patients, as well as treatment, consultation and referrals. A strong presence of, for example, routine administrative duties and frustrations with nursing management also clouded their experiences of powerfulness.

At home, the historical and cultural realities were very evident in placing women in a disempowered position - see 6.6.3.

6.2.3 RACE: BEING SOUTH; AND AFRICAN

The Standpoint theory explicitly relates to the "power" of the oppressed to give a epistemologically meaningful representation of communities, societies and the universe. Given the history of nursing in South Africa being often just another expression of a dominant ideology, the researcher sought to understand the intricate nuances of all these in the lives of African women as nurses. It seemed as if the nurse already made at least a superficial, if not deeper, peace with the trauma of Apartheid; and / or had such power to still endure (it is realized that the white researcher's presence could have influenced the presence, flow, and depth of such verbalizations; as well as constraining the freedom to talk about these realities - see limitations, as well as 5.4.3.9).

Racism was a dominant ideology in South Africa for more than forty years; some

sectors of the white population were still addicted to such a misconstrued system of perceptions and values - too afraid to loose (face and) power. According to Guillaumin (1995, p. 30):

> *"Racism is a specific symbolic system operating inside the system of power relations of a particular type of society. It is a signifying system whose key characteristic is irreversibility which it confers on such a society's reading of reality, the crystallisation of social actors and their practices into essences"*

Sharp (1993, p.8) stated emphatically that the *"black woman has earned her own space, that space is sacred"*. The researcher became sensitively aware of this sacred space and the power radiating from and lying dormant within their space. The women as nurses preferred to conceptualize the phenomenon in terms of culture, tradition and of being African. The emphasis being more on the historical and cultural origin and imbeddedness of women's oppression.

The major limiter of power within the women's lives at home being the man who apparently inherited power because of his maleness and continued with the application of power in a negative or oppressing way to this day. He for example controlled and dominated the woman, placed limits on her freedom of existence and forced her into a submissive, maternal, maintaining and caring role. The enrolled nurses as women in the rural setting were strongly relating to these realities; of still being part of it. According to Gcaba (1995, personal communication, 16th November) men in the Zulu cultural tradition would often refer to "*abantabami*" meaning "my children" and this expression then includes his wife. The wife then being seen as part of his children. Men were also involved with the upbringing of the children to a limited extent. A Zulu man once said: "*What do you mean be involved with the children? Have you ever seen a cock involved with the chickens?*" Another said: *"I don't like a house where the hen crows the loudest"*.

The urban group of women belonging to the enrolled nurse category related to this reality in a qualitative lesser extent, whilst three registered nurses participating in the study opted out of this relationship - refusing to keep on sacrificing their freedom and to suffer from the "*jackpot syndrome*". They also realized that the only possible

solution was to marry a man of their own integrity and standing.

The hierarchy of wages in a typical western marriage where the man was in the most senior position and earning more, was often overturned in the African marriage: the woman as a registered nurse being respected by the community and often earning more than her husband. This might have lead to an increased need for domination from the man, to control the woman being a nurse.

The registered nurses as women who divorced were also placed in a difficult position in terms of, for example, re-marriage. Her significant others might try to control her further relationships with men because "*we don't like a house with children with too many surnames*" (Gcaba, 1995, personal communication, 16th November).

6.2.4 Adding locality: rurality

The researcher added to the trilogy of race, class and gender the geographical locality or rurality as a possible and added intensifier of the marginalization of women as nurses. It became clear that the geographical setting had an important and meaningful influence on the day-to-day realities of women as nurses. Examples of these realities could be:

- A stronger awareness and realization of the perceived constricting effects of the Scope of Practice and other regulations;
- Voicing a traditionalist and altruistic view of nursing and nurses;
- Indicating a clear reality of the misuse of power by senior category;
- Indicating a very limited freedom of women at home with irresponsible and wandering husbands;
- Linking oppression of women by men linked to religious beliefs, tradition and

cultural practices;

- Limited access to educational opportunities;
- Limited awareness and /or exposure to changes taking place in the country; and
- Conveying the stress of violence and aggressive political activities in the area.

6.3 REFERRING TO LIMITATIONS

6.3.1 The barrier of language

The researcher was not able to speak the participants' mother tongue (either Zulu or Xhosa) and had to rely on the ability of the women as nurses to express themselves in English. If one takes into account the nature of the study and the nature of the phenomenon studied, it could be perceived as a major limitation. Although English was a subject at school and the education of nurses traditionally being done in English, the women belonging to the enrolled category and working in the rural setting had less, or limited, opportunities to practice their skills in the English language. The patients were from the surrounding areas and usually spoke Zulu and the language of conversation amongst nursing staff in the health setting was mostly in Zulu.

The depth and richness of description might have been lost because of the language barrier. The researcher was however, surprised at the nurses' willingness and ability to express themselves in English, and it was clear that the nurses grew in spontaneity and confidence as the interviews progressed. The fact that the

researcher's first language was also not English, created a shared and often humoristic experience for both participant and researcher.

6.3.2 The barrier of race and culture

Being a white unknown woman from some distant tertiary educational setting created an expected presence of being different and separate at the preliminary meeting where the background to the research, entrance, overview of content, exit, recording of discussions, ethical principles and concerns (if any) were discussed. The women asked limited questions at this stage, but during the first and subsequent interviews related to their sensitivity of this barrier in subtle ways.

The perception that the reality of whites was different came to the surface in the form of for example broadly formulated questions and nonverbal gestures indicating a need for acknowledgement or clarification. According to Gcaba (1995, personal communication, 16th November) Africans were inclined to think and feel that the issue of race pertains to those who use the classification: "*We don't give this classification - they do*", and added: "*the things we do we are doing not because we are black, but because of who we are*". When requested, the researcher thus tried to remain true to herself as a human being and a woman and to honestly convey her perceptions or feelings in a spontaneous and caring way, from her own cultural framework.

6.3.3 The barrier of class

The researcher was a registered nurse and thus belonged to the so-called senior category. Although it was never explicitly mentioned, the participants would have

been clearly aware of this fact. Fortunately the researcher was from outside the particular health setting(s) with no formal or official ties with the health services and managing these facilities.

On two occasions within the rural setting the researcher was questioned concerning her deeper relationship and involvement with the women as nurses belonging to the enrolled category seeing that she was a registered nurse. The researcher related to her meaningful and rewarding experiences working with women as nurses belonging to the enrolled category, her sincere interest and concern concerning the reality of women and gender, and her inherent ability and willingness to be available for these women as nurses, especially as a nurse educationist.

6.3.4 The barrier of education

Nursing education in South Africa had paid limited if any attention to the plight of women as nurses belonging to the enrolled category; also in terms of education. Tertiary educational institutions had also traditionally not been involved with the education or further development of these nurses. It was against this background that the researcher ventured into the lived experiences of the participants. Fortunately the department of nursing at the university from which the researcher came, had been involved in selected continuing education activities for nurses belonging to the enrolled category through its Institute for Nursing. Four of the nurses working in the rural setting, referred to this programme and also requested further information concerning programmes offered at the Institute.

The educational level of the researcher might also have been a barrier initially - it seemed as if the participants felt unsure that they would be able to "answer correctly" and often sought confirmation verbally and nonverbally.

6.3.5 THE BARRIER OF SETTING AND LOCATION

The actual settings in which the interviews took place were far from ideal Apart from the fact that the nurses were actually on duty and thus busy, the physical environment was often not conducive to the development and sustainment of rapport and communication. The situation in the rural setting was better than in the urban setting: an office was vacated and could be arranged and controlled by the researcher to facilitate the conducting of the interview. In the urban setting, a vacant office was no-where to be found; the interviews were conducted in different rooms and offices. The nurses were generally very soft spoken; and two interviews were inaudible to the typist. The researcher battling to make out what was said and pinning it down on paper.

The nurses working in that health care setting were very busy and thus had to remove themselves physically and psychologically from the busy area and re-focus themselves within the interview. Added problems were the irregular duty hours of the respondents who delivered a 24-hour service, some participants going on night duty, becoming sick and going on leave. The researcher also had to travel a considerable distance to the different locations and sometimes had to wait for an hour or more before the participant arrived. Moments of a non-functioning tape recorder, a stranded car on the way to the health care setting (a broken fan belt to be precise) and a pending nurses' strike at one of the settings all made the collection of data a memorable and very human experience.

6.3.6 The barrier of group sizes and number of interviews

Qualitative researchers are often criticized for the perceived "statistically non-significant" size of the "sample" - as if that was an omni-present, and only valid

criterium. The emphasis in this study was to develop an understanding of the power reality of women as nurses, and the principle of theoretical saturation was applied. The limitation that was however present, was that the researcher was not able to interview some of the participants for a third time because of their personal and / or work situation. She did however then contact them telephonically where necessary and possible to clarify her understanding of what they had said in the first and second interview.

The larger group of enrolled nurses working in a rural setting might have influenced (skewed) the comparison between the two groups of women as enrolled nurses; especially if one observed that quite a large number of nurses from the rural setting who were willing to participate were from the so-called sub-category of nursing auxiliaries. On the other hand, these nurses probably were the most marginalized group.

6.4 SUGGESTING SOME WAYS FORWARD

In reflecting on the findings, the researcher made suggestions related to future research, the nursing profession in South Africa, nursing leadership and management, nursing education, gender, nursing and nurses.

6.4.1 Re-searching further ...

Research focussed on the nurse as a woman was very limited in South Africa at the time of the study; and the researcher felt that the need for this kind of research was clearly supported by the study. The research, however, opened up a variety of possibilities in terms of future research:

- A need to focus more on and go deeper into the realities of nurses as women spending their working lives in, for example, rural versus urban health care settings were identified. The relationship between their working lives and their lives before and after hours as women needed to be carefully understood to extract meaning and to together with the women, develop opportunities and strategies for empowerment. The need to identify and describe was considered important, but reaching further in generating co-operatively shared opportunities, strategies and support were considered more important.

- The above process would be positively influenced and aided by a researcher or a group of researchers that understand the language of the women as nurses from the enrolled category working in the rural areas.

- The use of action research where the researcher(s) and the group or community form a collaborative partnership to identify, plan, execute, evaluate and publish research relevant to the needs and to the benefit of the stated group or community. This kind of research could also make a meaningful contribution to the empowerment of such a group or community and the researcher(s).

- Researching the experiences and epistemological understanding of other groups of women as nurses concerning the reality of power and related concepts could further contribute to the development of a meaningful theory of empowerment for women as nurses - nationally and internationally. Examples of such groups would be nurse managers, nurse educators, nurse clinicians, nurse academics and nurse researchers working in different health and educational institutions.

- The collaboration of different academic disciplines researching the reality of women as nurses could make a meaningful contribution, especially in terms of the historical reality of women as nurses in South Africa, and the essences of power relations within nursing management and nursing education.

- The power relationships between the medical and nursing profession needed

to be further investigated; especially in the tertiary health care setting. Social scientists (for example Anthropologists and Sociologists), health services and non-governmental organizations could collaborate with the health professions in investigating these phenomena.

- The impact of the cultural and / or traditional practices on women as nurses, and the inherent tension between westernized and more traditional cultural practices on the lives of women as nurses exposed to modern medical technocracy needed to be emphasized.

- The married and divorced woman as a nurse within certain cultural, traditional and religious constraints became a clear and interesting starting point for future research.

- The essence of nursing and nurses from the perspectives of nurses themselves needed to be dissected with sound philosophical and theoretical skills, and placed within meaningful and acceptable frameworks that could be shared with the national and international community of nurses and health care professionals. Research of women as nurses needed to be applied for women as nurses - establishing their role and contribution to society clearly within troubled times.

- The Standpoint theory proved to be meaningful throughout the study. A possible way to use the concepts of class, gender and race for women as nurses in South Africa, would probably be a quartet of "*categorial divide*" (class), being "*south African*" (culture), "*rurality*" (location) and the "*eternal carer*" (gender)!

6.4.2 The profession

South Africa's nursing fraternity was undergoing immense changes during the time of the study.

- It was hoped that in publicizing the findings of the research, governing bodies such as the S.A.N.C. would take heed of what was said by nurses. It is within the power of such bodies to challenge their own historically and traditional lines of thoughts and actions.

- Changing the current category system to a "good place to be - with moving forward (and not necessarily upward) being possible", needed to be investigated. Deleting the strong emphasis on a one and only "professional" category and replacing it with labels that were human and kind to those belonging to it would foster the often already present willingness to participate and grow within the profession of nursing in South Africa. Levels of advancement rather than categories should be emphasized.

- The perceived negative image of nurses as women belonging to the enrolled category needed to be re-examined and adjusted if needed.

- An acknowledgement of the womens' value at all levels of the profession needed to be put into practice, for example, increasing opportunities for education, development and of taking control of their working lives.

- The perceived constricting effect of current regulations needed to be further investigated and meaningful changes implemented. The perceived limiting and limited reality of even registered nurses also needed attention - it was the system within the system that seemed to be detrimental to the registered nurses' experiences of powerfulness and empowerment.

- The choice for and of distinguishing devices enforced by a regulatory body needed to be carefully monitored and negotiated with the entire profession of

nursing in South Africa. The similarities and differences between these devices could create more division than union; create and foster feelings of powerlessness, even in the presence and through the eyes of the patient and the community.

6.4.3 Nursing leadership and management

It became clear to the researcher that nurse managers were perceived to be very powerful human beings within a given health system, especially through the eyes of the women as nurses belonging to the enrolled category.

- The so-called senior category of nurses and the nursing management needed to be sensitively made aware of this power and simultaneously be guided and supported to carry this difficult load. The development of their interpersonal and communication skills, as well as the skills to empower others needed attention.

- The perception that the nurses as women did not really know or understand or appreciate their "superiors" and their realities was a frightening awareness. Nurse managers and leaders needed to make themselves as human beings known to their co-workers and move beyond a telling or directive mode. Selling (proclaiming advantages), testing (trying out), consulting (incorporate others' views and inputs and acknowledging it) and co-creativity by making space for the shared development and ownership of what needed to be done would foster a climate of commitment and involvement.

6.4.4 Nursing education

Nursing education in South Africa needed to negotiate and lobby for a system of nursing education in South Africa that would emphasize and facilitate the movement of students of nursing between different levels of education.

- It was suggested that students be in essence able to decide how far they are able and willing to go and leaving a comfortable space for those remaining where they wanted to be.
- The development of critical thinking skills of nurses has been emphasized so often; but what was clear to the researcher was some of the participants' limited insight into the totality of the health and nursing world.The search for a simplistic versus a search for a comprehensive understanding and the skills needed for that, needed to be instilled in all learners of nursing.
- Traditionally, the curricula for the enrolled category of nurses provided little opportunity for broader empowerment skills. The content driven nature of these curricula neeeded to be broadened with for example critical thinking and communication skills and other life skills that will foster the development of a total woman and nurse.
- Opportunities to develop and foster a creative, meaningful and proud "me and us" who would be able not to just challenge traditionalist and meaningless practices, but also to build new ones, needed to be created for all "categories" of women as nurses. The reality of women, gender and power could become meaningful essences of any nursing curriculum.
- Tertiary educational institutions such as technikons and universities could become involved in co- creating meaningful learning opportunities for the different categories of nurses; to move away from what was often seen as an elitist approach towards the "lower" categories.

- A liberal approach to education and especially learning that moved beyond doing or acting, but also developing skills related to reflection, connecting, decision making, joint planning and co-ordinated action.

6.4.5 Gender, nursing and nurses

The reality of being a woman was clearly stated by the nurses participating in the study.

- The power of traditional practices, even in the face of strong laws related to human and womens' rights, was evident. The need to change perceptions that was formed and instilled into men and communities needed to be addressed before and simultaneously with the legitimizing of rights. Community involvement in these processes needed to be emphasized, as well the role of health care professionals at all levels that needed to go wider than just counselling on treatment and drugs.

- The perceived absolute and unquestioned power of men needed to be challenged as often and as loud as possible; the power of women needed to be strengthened to counter-act resistance. These skills needed to be shared on a wider basis than just within the health care professions; but also carried into communities. The use of the different media, as well as the early instilling of balanced values in children and young adults through the schooling system needed to be emphasized.

- A programme of empowerment skills workshops, seminars and counselling to support and develop women as nurses within their respective health care settings to manage and overcome marginalization and oppression needed to be urgently enacted.

- An acceptable and practical system of values and code of conduct for nurses

needed to be negotiated with all concerned that would not further jeopardise the woman as a nurse; to not place her in pre-defined categories and ethical frameworks.

6.5 ... SAYING MORE THAN GOOD-BYE ...

Sharing a collage of meaningful moments written and drawn by participants and a few photographs taken by the researcher, for example

... a note by LUCY when sharing her thoughts in writing,

... an address on an envelope (Anita: Control office),

... on the way home following another bus,

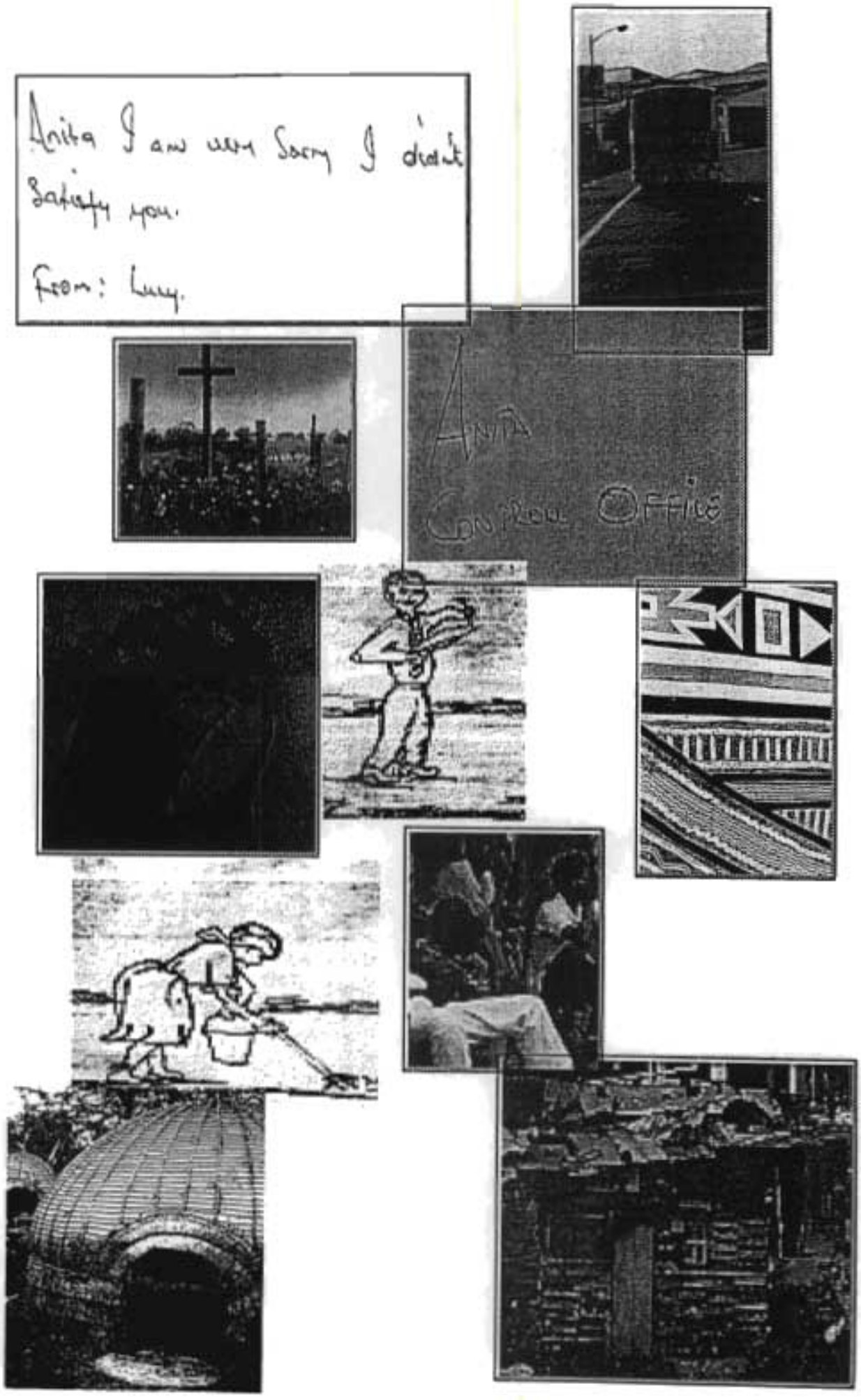
... a cross of a graveyard close-by, ...

... a drawing of a man and a woman working in a factory

... a dwelling and a Zulu hut

... some men

... the power of hands ...


Anita I am very Sorry I didn't
Satisfy you.
From: Lucy.
ANITA
CONTROL
OFFICE

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AZULU-NATAL
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ANNEXURE A

0331 - 952111

FAX 0331 - 426744

Private Bag :X9051
Isikhwama Sepos :Pietermaritzburg
Privaatsak :3200

ENQUIRIES: Dr C.G.H.Mackenzie
EXTENSION: 2779
REFERENCE: 66/1

1995 06 01

Professor L.R. Uys
Head of Department
University of Natal
Faculty of Social Science
Private Bag X10
DALBRIDGE
4014

PERMISSION FOR RESEARCH

Your letter dated 19 May 1995 refers.

It would appear from the attached documentation that the research projects of Ms.M.S.Mabaso and Ms.A.S.Van Der Merwe both involve primarily one-on-one interviews written questionnaires, or both.

As such they are approved in principle.

It is noted however that Ms.Mabaso refers to the study of hospital records in certain instances, confidentiality must be preserved, the authority of the institutional Superintendent sought in each instance and specific authority sought should there be intended use of any information or material which could be deemed confidential.

Should your initial paragraph stating "permission to use your services in different ways" imply other than the above, you are requested to again approach this office.

for SECRETARY: DEPARTMENT OF HEALTH
KWAZULU-NATAL

AJK/uys

ANNEXURE B

NUD*IST

GUIDELINES FOR TRANSCRIBING OF INTERVIEWS (ON WORD PROCESSOR)

- These files are called raw files by NUD*IST.
- Set computer to no more than 72 characters per line.
- Just plain elementary typing style -

  Do **not** use:

  Italics / Bold / Indents / Underlining / Tabs & Other fancy stuff!
- Capital letters are used for emphasis or differentiation.
- To be saved:

  In Wordperfect (for Dos) as **DOSTEXT** (Ctrl F5; 1 = Dos text; 1 = Save)

  In Wordperfect for Windows (preferably) as **ASCII TEXT** (File: Save as; Format: Ascii text (Dos)

  NB Precaution:

  Make two copies of file on different disks: One saved in normal way and on the other disk saved as described above.
- Researcher needs to define headers, sub-headers and text units as used by NUD*IST:

Header:

Brief description of document - used to identify document in NUD*IST. After header **always a blank line**. Specific sections of header to be indicated by a hard return followed by an asterisk (*).

NB: Type two hard returns after the header.

Sub-headers:

Indicated by an asterisk **(*)** - breaking document up into sections (for example specific questions asked). Good idea to do this in uppercase. Followed by hard return.

Text-units:

The smallest unit recognized by NUD*IST - the body text of the document A text unit (for analysis) is between one **hard or carriage return and the next**. The text units will be available to NUD*IST coding and indexing and are automatically numbered by NUD*IST. Can be words, sentences, lines, paragraphs, whole documents.

FOR MY RESEARCH:

- File name to be pseudonym of person plus for example 1 or 2 (indicating the number of interview) - for example **FORTUNA1.PHD** (for the original) **and FORTUNA1.NUD** (for the one saved as text or ascii)
- Header: Pseudonym of person interviewed
  Date of interview
  Number of interview (first, second, third, fourth)
  Key strand(s)
  Location
- Sub-header: Question asked by researcher (even if for example it is repeating what respondent is saying) - please do in uppercase.
- Text unit: Every line spoken by participant (listen for natural pauses or beginning of sentences or "periods")
  Please type (if you can) things like a silence or pause and laughter. do it by placing the concept in parentheses; for example: "I don't know what to say (laughter), may be (pause) it was my husband".
  You can be creative here!
- Please make notes of the things that you are unsure of or which you would like to discuss. You can also phone me. Please also feel free to suggest ways in which we can improve on these guidelines for future use.

Thanking you kindly

Anita.

□□□

ANNEXURE C

University of Natal

Faculty of Social Science
Department of Nursing
Private Bag X10, Dalbridge 4014 South Africa
Telephone (031) 2602499
Fax (031) 2601543

The Head: Nursing Services
Hospital
Durban

Dear Ms

Request to do pilot study at your hospital

I am currently doing my PhD in Nursing and my dissertation is titled:

An epistemological analysis of the power of women as nurses in South Africa.

The study is of a philosophical and qualitative nature. It uses the Standpoint theory which accepts that the perspectives of women who are marginalized on the basis of race, class and gender within a certain community (that is studied) needs to be heard -in this study this will thus mean black enrolled nurses (women only) especially from a rural setting. Their experiences of power, powerlessness, empowerment and powerfulness will be shared in three to four unstructured interviews lasting +- 30 minutes each.

I request your assistance to do preliminary interviews with two (2) of your enrolled nurses to establish the flow, format and meaningfulness of the interviews as invisaged - thus a very important phase. This data will also become part of the final study because of the qualitative nature of the research (where all data are important and meaningful).

Your support will be greatly appreciated.
Thanking you kindly.

Anita S van der Merwe
Senior Lecturer
26 June 1995

ANNEXURE D

EXPERIENCING THE FLOW OF A SAMPLE OF INTERVIEWS USING TWO PARTICIPANTS

The researcher decided to describe the process and content of interview by using the example of the interviews with Fortunate and Peggy. It was decided to use these initial categories to facilitate the search and illuminate the deeper meaning and context of the perceived reality of the power of women as nurses; accepting the premises of the Standpoint theory as a departure point. These categories were further developed and refined by the researcher in section 5.3 of the research report as experiential themes.

PLEASE NOTE:

The names of the participants were indicated in UPPER CASE and the actual words or utterances of the participants in *lower case italics*. The words or utterances of the researcher were indicated in *UPPER CASE ITALICS*. The researcher endeavoured to portray the actual text as transcribed; and "... " usually indicated a pause.

Category 1: EXPERIENCING A WORKING DAY

At the beginning of the first interview the participants were requested to give a description of an ordinary working day in their lives from the moment they wake up till they go to bed again. This was done to get a meaningful understanding of the day-to-day realities of the woman as a mother, wife and / or family member and as an enrolled nurse. The two participants were able to relate freely to their day-to-day realities and this opportunity at the beginning of the first interview also proved to be meaningful in establishing a relationship and rapport between the researcher and the participants. It also served to open up to the researcher the unique worlds of the two participants; and through this request a door was opened between the researcher and the participants - the researcher was tentatively allowed to enter

their day-to-day realities ...

Throughout the discussion the researcher sensed that the two women faced daily realities of intense routine (FORTUNATE: *"Yes it starts all over again. A repetition of one and the same thing "*) with a strong awareness of time frames and procedures (*"routine, giving out medication, checking our temperatures, and so on"* - FORTUNATE). Based on this awareness the researcher thus decided to index the working day according to these time frames that the participants spontaneously used..

1.1 Early morning

Participants were requested to relate freely to the reality of being a working woman - from the moment they wake up - thus before going to work in the morning. FORTUNATE was a very spontaneous and communicated freely verbally and non-verbally. She reached out to the researcher from the very beginning and softly touched the researcher's hand periodically. She was inclined to give detailed and vivid descriptions; and painted rich pictures of her life as a woman and as an enrolled nurse. In describing her early morning activities she said:

> *"I wake up at about 5 o'clock in the morning and then I prepare myself for a while and I usually have all my things ironed the previous day so that I won't rush out the morning. From then I have a bath and after that I pray and get ready. To 6 in the morning ... it is very early, I am staying very far to rush for the bus ... I catch the bus, not the taxi ..."*

PEGGY was more reserved and gave limited detail concerning her early morning activities - she only referred to where she stays (a local township) and to her responsibilities towards her babies as *"my nanny she is new"*. Her husband had a taxi and took her to work.

1.2 Going to work

Both participants emphasized the mode of transport as if it was a very important aspect of their early morning activities: FORTUNATE emphasized that she stayed far and had to rush for the bus; she also preferred the bus as *"the taxis, they sometimes delay"*. PEGGY was taken by her husband to work. Both participants had to arrive at work at about ten to seven.

Nurses in the clinical field belong to the group of workers that have limited choice to abide their uncomfortable hours of duty, for example going on duty early enough to take report from the staff on night duty. This reality influences their daily routine profoundly, especially if they are responsible for a family and children, live far away and do not have their own transport.

1.3 Morning activities

Participants related to their morning activities and responsibilities as an enrolled nurse. FORTUNATE gave a detailed description of the these routine activities:

> *"I arrive at work at about ten to seven. I arrive at work and attend the report and at ten to seven we take the report from the night staff, conditions of the patients during the night and ... after that we do the morning prayers, prayers and we mark the roll call and then we read the policies, should there be any policies or any meetings, yes, of the previous meeting that was held in the hospital, so we know what is happening around in the hospital. And after that we are dismissed and start our work as usual. Checking all the patients giving them a bath as I am in the caesarian section ward, who the patients who are delivering for caesarian section, they need to be handled because they are still dizzy, they are sedated and all those things, so we check on them, we offer them the bath. Then we assist them in whatever daily activities and after that we do the ward routine, giving out medication, checking our temperatures, and we go for tea. (Laugh) It is our privilege, going for tea. And when we come back we do some of the extra work as an enrolled nurse (alright), my scope of practice mostly in the ward. I am responsible for the dressings, giving of medication in the ward and there is an extra job that I am doing, we are administering the polio and the B.C.G. vaccinations. So I am one of the sub nurses responsible for that , I think ... if the other senior nurse is not on duty I do by checking that the babies are immunised, which is very important in order to prevent those communicable diseases. Yes, I immunise them before they go home. And then after that, what do I do, check on the blood pressures in the ward ... then go for lunch".*

PEGGY gave limited detail and just mentioned that she comes to work where she is nursing in the ward where they do the minor operations - *"they come in the morning and get discharged in the afternoon".*

1.4 Afternoon activities

FORTUNATE related to the reality of less staff in the afternoons and the increased responsibilities of the enrolled ("staff") nurse during these very busy afternoons:

> *"Sometimes it's mostly very hectic after lunch you find that we are short staffed now ... We find that maybe in the main ward you are trim. You use a staff nurse and a registered midwife. So it becomes very difficult. You get to adjust yourself and do all the work, make sure that you do all, because I have no subordinate, the sister is the senior - so it gets heavy, up and down .... going to CSD, collecting whatever is not in the wards ... is ordered by the doctor, emergencies orders, so you find yourself getting very much exhausted".*

PEGGY related to her responsibilities when the patient comes back from theatre after a minor operation after preparing them in the morning for the procedure. Some patients need to be admitted eventually because they take *"long to recover - they need to be admitted"*.

1.5 Going home

Going home transport was provided by the specific health service - and FORTUNATE usually left the hospital after report had been handed over to the night staff at about 18:55. The hospital transport then *"dropped"* them at the market, and from there she took an *"Indian bus"* home. Peggy's husband usually came to fetch her at the hospital.

1.6 Before bedtime

"When arriving at home "my dear, there are problems too ..." (FORTUNATE). In relating to her responsibilities at home, FORTUNATE said that she had to *"adjust"* herself at work and at home - she mentioned her granny who was a pensioner *"and always complaining". "... besides I have been nursing on duty ... I have to practise it. I take care of my granny ... or whatever if possible and then I also go and have .... go back to sleep "*. PEGGY concentrated more on the preparations for the following day, cooking supper and also the need to give love to her children:

> *"... the kids are waiting for me after school, so it is frustrating ... because the little one she needs mothers love at that time, I am tired its a night now. So they don't get that love they need from the mother ... Ya that is the difference of the working mother sometimes. But sometimes you feel great as a working mother, when she comes and asks for something, I don't wait for father, I take the money and get it for her".*

Category 2: RELATING TO WHAT IS IMPORTANT IN THEIR LIVES

The participants were requested to relate to the things that are important to them as nurses and as women. FORTUNATE linked this question to the fact that she is a working woman; and that her work was really important to her; but at the same time her familial was just as important.

> *"So a career and now what you call a career woman is also the same as a mother. As if she conveys herself when she is at home, she forgets that she is at work, right and try and convince ... to adjust into this thing and to be a*

family and really whatever is required ...Yes my dear, so a career woman and a housework, I don't know, it goes hand in hand , you can never be just a career woman only. You need to adjust yourself. When you are at home don't forget about your family and when you are on duty concentrating on what you ever you are doing. It goes hand in hand".

FORTUNATE also felt that it was totally different for men - they

"don't care. they don't care about their families. They don't care at all, it is very hectic because you can even see on the roads you find that a man goes off on duty and goes to the beer hall and takes whatever and then comes home drunk ...it is totally different for them, they cannot adjust themselves, they just think about themselves".

PEGGY related important needs and / or responsibilities, for example to develop herself in the profession of nursing and of serving the community. Concerning home she expressed the need of having a car of her own - this need probably underlined the problematic nature and importance of transport in their daily working lives.

Category 3: RELATING TO THE OPPORTUNITY AND / OR ABILITY TO MAKE CHOICES

This category related to the perceived choices that the participant as a woman and as a nurse had; both at home and at work. FORTUNATE felt confident that she was free to make choices at home:

"But at home I am free, really I can make some choices particularly if I am day off. If I don't want to wake up at 5 o'clock, I can sleep at home. That is my choice if I don't want to wake up early I can be late and my family and I understand that this mom is not working, she is day off and must relax".

PEGGY echoed this increased freedom to make choices at home; and mentioned twice that the Scope of Practice is the cause of limited freedom to make choices at work:

" ... because if I am having a choice that I see oh my husband he does not like that thing, but if I like it, ... and so if he does not like it, I need to explain to him, because at work the Scope of Practice does not allow it , but at home he cannot say that because ... at home it is better. And I talk to him, and he understands the point why I chose that. So you can talk about it and work it through. The Scope of Practice does not allow you to do that ... Ya, it is more freedom at home than at work ..."

The situation at work concerning choices seemed to be very limited. FORTUNATE stated very clearly:

"We work according to our Scope of Practice. As an enrolled nurse I have no choice. If my scope says you must do this and this, I go according to the guidelines of my Scope ... What is this freedom? We are working under

certain guidelines my dear, I cannot have any choices" .

When requested to relate to her relationship with a patient she still felt that they did not have any choice but related her answer in terms of treating everybody equally:

> *"No my sweetie. Not at all, there is the thing in our etiquette when we are trained as nurses, junior nurses, we are told that when you are in the working situation you must treat the patient as equal. You do not have any choices, like oh I like that patient because she has nice gowns, whatever, no, you have to treat them as equal. You don't have ... because this one looks better. Then I must give a bit of better nursing care. When nursing care must just be equal, we don't have any choices, by treating this one in a better way than another one. You know, we are all equal to me".*

Peggy also echoed the limiting effect of the Scope of Practice, and that would be the reason for furthering her education:

> *"Because as an enrolled nurse you find that there are things you do and sometimes you find that I can do further or I can do them better than one who is my senior. But because of the scope of practise here, we ... like you know if we are ... or let me the patient come in and you find that ...doctor and I have no psychiatric experience and some of the things I know them better than them. So I find that ... I think this patient ... this patient she might be having this problem and treatment for this and you find that the doctor will ask me to do that just because we are not even a sister but a staff nurse. Sometimes you are interested in that case and you follow up and you find that if the doctor had considered your suggestion your ideas, this patient could have got better sooner than what he is now. She has gone under many investigations because she didn't take that advice. So there are some of those things that limit your choices".*

Peggy also related to the inherent dialectic tension of doing for example the work of senior staff members:

> *"Some of those sometimes you feel great doing them, but physically it is so stressful. Like for instance when you are ... how is , they are not giving medicine, they are not giving injection. So they are supposed to administrate at that time. So there are problems in the ward ...".*

Later in the discussion Peggy shared the painfulness of such experiences:

> *"You know that in life it is so difficult for something that is painful. It has been there for a long time and it won't go over. But when the night time comes, you forget about it. But by that time when it comes ..."*

Peggy seemingly thus related to the intensity of pain associated with the day-to-day moments of having limited choices (and control). Peggy also related to a constraint or limit to making choices at home where the husband's family have certain expectations of her. Her husband might understand her point of view, but not the family.

> *" Sometimes it is, like for instance. In the family, I mean in his family, if he can understand my choices, why I am doing. But when the brothers, mothers,*

sisters come they say no don't do that, they do'nt like that at all. As a family and as a stranger to that family, you are entitled to do what you are doing. There are some of those things". These things were imposed on her because she was from "*another family*".

Category 4: MAKING A DIFFERENCE TO PEOPLE'S LIVES

Participants were requested to indicate whether they felt that were making a difference to other people's lives - both at home and at work. In referring to "at work" FORTUNATE confidently and spontaneously said:

> *"Oh yes very much. Laugh. I don't know whether I am crazy. When I help a patient... nurse please can I have a bedpan, I just offer it with pleasure, why? Because I know that patient just lying there is in need and I am there to help her in whatever she wants. I feel so wonderful being able to help that patient. And I think it makes a very great difference. Because once a patient says thank you to a nurse you feel very much better and she feels relieved from whatever. She wanted to pass urine, I offered her a bedpan quickly ... and I have made a difference to her urinary system because the bladder is empty. I think this is very much the difference when you are the patient".*

PEGGY also laughed shyly but indicated an example relating more to the psycho-social needs of the patient with a cardio-vascular disease and hypertension who were very depressed:

> *"And you try, or some means ... and when you spoke to her, reminding her about her family, about everything you try to make her comfortable and to feel relaxed, while you are checking the BP you talk to her ... you find the BP has gone down before giving different treatment. When you are working you try I mean you try to solve patients problems before they are given treatment "*

In referring to making a difference to people's lives at home, both participants related to examples where they have supported family members in their educational activities and performance, but in different ways. FORTUNATE supported her sister with school work related to health (nursing), while PEGGY tried to support her cousin staying with them and who had failed and was repeating standard seven, through spiritual counselling:

> *"... there is something that is lacking, you are not praying at all. And I ask her am I lying? And she said , yes, that is the thing also I was thinking about. Then she started trying to improve ..."*

Category 5: DEFINING POWER

5.1 Describing power

During the second interview participants were requested to describe in their own words and framework the concept power. Participants were prepared at the first interview that the next interview will relate to the reality of power of women and as nurses. During the third interview the researcher clarified issues from the first and second interview; and also gave the participant the opportunity to discuss anything else that was important to them and which were related to the interaction between the researcher and the participant. The participants seemed interested and keen to discuss the power in all its nuances.

At the actual interviews, both participants waited for a while before they answered. FORTUNATE related to power in terms of best results or *"good outcomes which can happen through the power I have "*. Power according to FORTUNATE is something that comes from inside a person and from *"the influence that I got from my colleagues"*. This influence is acquired through discussions that she and other people have during *"some minor meetings"*. In relating to the emotional experience of having internal power, FORTUNATE stated strongly that

> *"the power that I have within me makes me to feel confident. All right. Everything I do I have that confidence, because of the power within me making me to be strong to face any situation I come across to. Makes me to be strong. Umm, mostly it makes me feel great.* (YA), *ya ...*

PEGGY related to power as something that you can have inside of you and sometimes as something being given to you. She also spontaneously related to an example of the power of being a woman:

> *"Yes, about power? To me I can analyse it as something that sometimes you are given and it sometimes comes on its own. Ability to initiate something, for instance, at home as a female, you have some power that are there for the female, like caring the children and caring for others. Cooking for them, washing for them, giving love, giving that, is the power as a female that we are given to do, it is different if you can leave the child with the male, somebody, he cannot look after the child as you as a female can look after a child. So that is one of the powers as a females we are given".*

FORTUNATE used the example of a pregnant woman who through her pregnancy has the power (strength) to endure all possible *"bad things that can happen to her, during her pregnancy as a woman, just talking as a woman ... "*. She quoted examples of the uncertainty related to the *"kind"* of child the woman carries as well as the power needed to get support from other people and to go through the delivery process. FORTUNATE also emphasized love as a major powertool of women:

> *"Umm, it mostly lies on love. I think. The love that we have plus the power (Umm), it mostly lies on love. I think. The love that we have plus the power,*

that we have can make a wonderful outcome as I have said before the power that I have within me and the, uum and some other... I can get from the other people, the influence that I can have plus the love can achieve wonderful results. I think about power mostly lies on love".

She felt that men also needed the love and the support of a woman. She did however indicate a difference between men and women: men at times not being concerned about and not feeling responsible for their family - men are inclined to misuse the love of their family, misuse the power and the love that they have.

5.2 The power of the nurse belonging to the enrolled category

In discussing the power of a woman as an enrolled nurse FORTUNATE indicated that enrolled nurses do have power to discuss their goals with one another, for example as students facing an examination. In the caring for the patients FORTUNATE indicated carefully that there is power:

"In the nursing care too, (long pause) yes there is power too for nursing care. Take a very critical patient, critical patient coming inside the ward who needs oxygen, who is an emergency for the operating theatre. And the emergency comes in, maybe the patient has been involved in an accident. Right when this patient comes in everybody will be panicking isn't it (uum) because it is an emergency, but through the power that she has within you, can set the tray properly and assist the doctors properly, having a goal insight that you want to achieve to save this patient"

PEGGY related to the powerlessness of women as enrolled nurses. The *"powers"* that are given to enrolled nurses are very limited In the working situation as compared to the powers that a woman have at home. According to PEGGY the Scope of Practice guides and limits the enrolled nurse's power:

"Because you are guided here, as we have said as an enrolled nurse powers that you are given giving medicine, doing dressings, what else? Preparing patients for theatre, and sometimes transporting patients to theatre those are the powers that you are given as an enrolled nurse. But there are things that you want to do but you can't, so those you can say you are disempowered of them. Like giving of drugs, the scheduled drugs, so as an enrolled nurse, we are not allowed; even the sister, you find that she is busy doing something urgent there, so because I am an enrolled nurse you need to wait till you get the keys, whereas maybe you are rushing, they have phoned from theatre, they want the patient in theatre so you are delaying them now. Because we are enrolled nurse, you have to wait for the sister to come with the keys for the cupboard and give you the drug. (UUM) *So there are those things like that ... "*

Category 6: RELATING TO POWERFULNESS

During the second or third interview participants were requested to identify, according to their opinion, the most powerful person at work and at home. Both PEGGY and FORTUNATE indicated that the most powerful person for them in the hospital was the *"chief matron"* (Head of Nursing Services of the hospital) - PEGGY motivated her choice on the fact that the manager had extensive nursing experience, and was able to solve most of their problems because of her education.She was however worried about the *"element that is within us as females that make us not to love one another. (UUM). So I could not get the answer. (Laugh)* (UMM)". FORTUNATE had a deep respect for the woman behind the position who had managed to bring up her children in difficult circumstances. Most of the manager's children were now graduated and were married, and as manager she had the capability of being in charge of other women:

> *"It is not easy to be in charge of the other women who also have got degrees, to stand in front of them, to have that power, to discuss any problems with them that they are encountering as the management of the hospital is concerned. She has got the power. She is a role model to me. UMM. She is kind, she is motherly, she is everything".*

Relating to powerfulness to care for the patient, FORTUNATE stated that the junior nurse had the most power - she based her argument on the fact that the junior nurse usually attends to the patient first when he or she is admitted to the ward. This nurse will do the first observations of the patient, for example measuring temperature, pulse, respiration, and blood pressure - *"I think it starts from the junior nurse, the one who has got more power. Who will be responsible for the vital checkings of the patient. Which will make a picture of the diagnosis first ... ".*

In discussing the most powerful group or institution in South Africa, FORTUNATE pointed to the South African Nursing Council;

> *"because they are the ones who offer the rules and regulations about the practising of nursing, the guidelines that you must go under, all the Scope of Practice and whatever. All those policies are from the S.A. Nursing Council. I think the members are responsible for the whole of nursing as a whole.so they have got more power and control of nursing ".*

In relating to her feelings around the Nursing Council's power, she indicated indirect agreement - *"ya, because when their policy is being introduced, I understand it is revised and it is seconded or whatever, it is favoured by the other people, so I can feel comfortable. I have no alternative".*

At home, the most powerful person for FORTUNATE was her mother who was a divorcee and a single parent. Her mother was a role model to her - she *"has also got the power of being a woman who can be a single parent at the same time; but produces good results (UUM) for her children".* Although PEGGY's mother cared well for her children and *"...mother, you are always next to mother, every girl...",* PEGGY was of the opinion that her father was a powerful figure *"because he was working,*

my mother wasn't working". FORTUNATE also related to personal feelings of powerfulness in relation to things that she had achieved as a staff nurse and which she was proud of; for example the examinations that she passed ("conquered")during her two years of training.

In relating to symbols of power(fulness), PEGGY debated nurses' and patients' approach to distinguishing devices. For her the "epaulettes" were a powerful device which affected patients and patient care. She related to incidences where patients did not feel happy about the way their dressing was done because of it being done by someone without epaulettes. According to PEGGY, patients are inclined to think that nurses with white or maroon epaulettes know better; Irrespective of their experience. Patients also loses hope when they are admitted and there were registered nurse or enrolled nurse - *" ...because he does not see any sister or staff nurse with epaulettes in the ward; so that just affects them".* Patients are also inclined to talk to one another with the old patients telling the new ones *" when you want something you must wait for that one with the maroon epaulettes. She is the one who is in charge, she knows everything. But the one with the white epaulettes, no you must not talk to them, they know nothing those without epaulettes".* PEGGY felt that only the employer and nurse amongst themselves needed to be aware of the professional status of the nurse.

PEGGY wanted to improve her own standard of education and become a "sister". She stated very clearly that her goal would be development (education) and caring for the people; and not just to hear the people say *"look she is a sister now. She is a matron now, she is what and what now...UUM...*

Category 7: RELATING TO THE POWERLESSNESS

FORTUNATE expressed a sadness when she felt powerless and related it to failure:

> *"If I feel powerless, I feel very much sad. If I was given an opportunity to prove myself and found that I have failed, so I felt powerless, so I feel very sad if I am powerless. It makes me feel so sad, like failing to do something that I was offered to, makes me feel powerless and very sad and I blame myself in return. Of why did I fail, why, what made me to fail. SO YOU TRY TO FIND, out the reason that makes me to be a failure. UUM, ya, MAKES YOU TURN BACK, turn back, TO EVERYTHING TO LOOK, uum AS YOU SAY IT MAKES YOU FEEL SAD. Yes it makes me feel sad in such a way that I used to go back and see what are the things to be a failure".*

In terms of her work, FORTUNATE also related to her feelings of powerlessness when her Scope of Practice limited her activities in the ward:

> *"I do sometimes feel powerless, maybe there are some procedures ... I might have the feeling, might have the power to assist that doctor, but due to the certain scope and some regulations I can become powerless. They say in the cases of emergency maybe the registered nurse is not around or has gone to matron's office or whatever, I may have the power ...but due to my scope*

of practise I may become powerless, I would be scared to go next to the doctor and assist him because I know that my scope does not ... SO IT HOLDS YOU BACK. It holds me back. Yes. That is when I feel powerless. (UUM) IF YOU WANT TO DO THINGS , but something is holding you. (YA) LIKE THE SCOPE OF PRACTISE. Scope of practise. ARE THERE OTHER THINGS THAT HOLD YOU BACK. Hold me back! AT WORK AND SO ON? THE WORKING SITUATION MAKES ME FEEL POWERLESS. THAT IS THE MAIN THING. Ya that is the main thing".

In discussing the presence or absence of powerlessness at home, FORTUNATE mentioned that the relationship with her boy friend did have some elements of powerlessness

"In the relationship with my boyfriend there are things, say I want to go somewhere and visit somebody somewhere else, you may find that my boyfriend won't permit me. He will not permit me to go there even though we are not married. If I say I must go there ... so those things would hold me as a woman, who has got the desire to go and visit the friend, but because I have a relationship with this man, a close relationship, if he stops me, I cannot go, because if I go there will be problems ... SO DOES HE NOT PERMIT YOU BECAUSE HE IS A MAN? BECAUSE OF THE RELATIONSHIP? He doesn't permit me because he is a man, he knows that he has more power than I do in (AH I SEE) the relationship. YA, YA, SO WITHIN THAT KIND OF RELATIONSHIP DO YOU FEEL POWERLESS, A BIT POWERLESS? Ya, yes ... there is this thing, they always want to have more power, they always want to govern our lives, even though in these days we are equal. ... WHY DO THEY STILL HAVE THAT DO YOU THINK? Umm, mostly with us ... they know that a woman is supposed to stay at home, be the housewife, bear children and not to be involved in things that are happening as well. SO IT IS PART OF THE CULTURE? Yes, HISTORY AND CUSTOM? Yes, which is still practised. WHICH IS STILL PRACTISED. Even as a woman you have the power, but whatever the man is next to you, he always want to have more power than you do.

She indicated, however, that in coming to work the man had no say!

PEGGY laughed when discussing her powerlessness at home and said that

"Ya it does come. At home the thing that contributes is our culture, with us, African, so there are those things when they say only the males can do this. (Burp) Excuse me, like for instance, if I come from work, I go off at 1 o'clock and go home and at home my husband is not there maybe when I phone the office and find out he is not there to tell him that I need to take a special trip now, (UUM) so if you just decide on your own, no I must go, I need to go, you see, (YA), when you come back, uh,uh,uh,uh,uh, PROBLEMS you will have problems you see, you are doing things on your own now because as a female you are not supposed to do things on your own. Why because you are both adults, he can do it, so why can't I do it. Because when he comes back and reports to me that no, I had a problem with this, it was so important for me to go without reporting to the family, so then I just take it as it is. Just

because I am female I must just agree with everything, whereas he can't as a male. But I am sure to sure with other nations, is it the same? I THINK THERE IS A LOT THE SAME, really. YA ... Because you can find that you have been away, all of you at home, and when you come back you are all tired, you know, but as a family you just can't come in the house and sit on the sofa there and wait for something to eat. So, but him he just pop in the house, take the newspaper, or any magazine to read and sit there and wait for you, whereas you are both tired. Ay, but I thought maybe it was different with other nations".

In discussing the person or persons with the least power, both participants felt that the general assistants (cleaners) had the least power in the health situation; and the auxiliary nurse in the nursing profession.

Category 8: RELATING TO THE MEDICAL PRACTITIONER

In relating to doctors as being mainly men PEGGY said that

" ... (Long pause) ... that bossy character still remains. He can be educated, he can be white, but that bossy thing remains the same. Because they ... you find that he hands things because he is a male. He hands things any how. You see, whereas as a female, now doctor this should not be done like this, because sometimes you find that the way he is doing something will hurt the patient. UUMM. And come and say no doctor, you should have talked like this to the patient, not as you have talked. YA. They don't realise that, what can I say. That harshness they have most of the time it means they don't have that feeling of sympathy. Like for instance if you are comforting maybe the patients, for a HIV, you don't just have to say, O.K. your results are here now and they are just positive. You need to motivate that somebody and think about and put yourself in those boots of being that person, then you will get the facts that of approaching that somebody, because you know it is so hurting and painful YA. So they like disempower the females, but the fact remains, females they do have....It is different from males".

The doctors, are inclined to disregard the knowledge and skills of an enrolled nurse *"and I must wait till I get the order from him"* (PEGGY). FORTUNATE stated clearly that doctors were inclined to

"overuse the power, they become, they exercise their power so much. Because they consider the situations that we are living at homes, because all the time the male is always senior to the woman having more than the woman. Even in the working situation, you find the big man they know that we are the subordinates, they don't treat us so equal. I am telling the truth. They sometimes become more powerful, they exercise their power, as being a man and being the senior, the doctor. UUM. Ya, so you feel powerless when you are working with them sometimes. FOR EXAMPLE OF SOMETHING LIKE THAT ... Uum ... THAT YOU EXPERIENCE ... Yes. There is an example.

Let's take you have a problem in the ward. A patient is having some complications or whatever. Then you find that the doctor on call is a male doctor, alright, then you contact him, say it is at night, you contact that particular doctor, alright and he does not respond quickly to get there. And the patient there is complicating. The more the time it takes that side to come, and assess that particular patient, so they become sometimes so powerful when it comes to that. That's a good example. You contact him to inform him about the patient's condition and he delays to respond to come to the ward. WHY DO YOU THINK DOES HE DELAY? He (is) exercising the power. IS IT BECAUSE, yes it is because of that. UUM, BECAUSE HE DOES NOT COME FOR EXAMPLE AND SAY I AM SORRY I AM LATE, THIS HAPPENED ... no, not at all. He just takes his own time and just comes, doesn't apologise or whatever ... I SEE AND THAT MAKES YOU FEEL POWERLESS ... Ya, sometimes I do really, ya. YA."

Category 9: RELATING TO MEN

PEGGY pondered for awhile on the strong character of men versus the strong character of women being caring:

"Strong character of a man? Uuum (sigh pause) I can't say what it is (laugh) ... BECAUSE YOU SAY WOMEN HAVE THIS CARING, LOVING... yes ... YA IT IS NATURAL ... I agree with you, it is uh, mostly they are cruel. (Sigh) I can say that they have strong characters. They are cruel most of the time. Somebody who doesn't care hurting somebody is cruel. SO THEY ARE THE OPPOSITE. It is opposite. UUM. Really you find that, even with at home, you find in court there is a woman of 55 years old with the same aged male having a divorce at that age a male divorcing a female You can't find a female divorcing a male at that age. What do you expect him, you are traumatising the female. Who will just look at that 55 year old female now. The kids they are so old, they are married, the girls are married and the boys are having their own wives now, who will care for her if you are living all alone at that age now. Just because he has got the young one now. UUM. Really they are so cruel sometimes. Because that thing is more traumatising, the female only, the one you having divorce with. But even with the young females it is a trauma. UMM. Thinking that you can stay about 25 - 30 years with somebody and at last he just leave you like that. DOES THAT HAPPEN OFTEN? It does. With us blacks , it does. Because you find that this man that has been doing these things, several times, but just ignoring them, then at last, you know, let me just leave you like that. HE LEAVES YOU. He leaves you. SO THE MAN HAS THAT ABILITY TO DO THAT TO A WOMAN. Yes, BUT THEY DON'T THINK OF WOMEN. No, shame they don't. UUM. They got that nature like cowards of sympathy, they are born with. (Pause) ..."

FORTUNATE felt strong about men's perceived power to control the woman in terms

of for example, the number of children:

> *"... and because of the cost of living, you decide that no these three kids are enough for me, especially because of your health, you feel that no it is. He say I want another baby and he is not going to carry the baby around, the one who will be giving birth to the baby and the one who is sick, because he is a male. You must agree again and have another one ... SO YOU DON'T HAVE CHOICE THERE. You don't have a choice, why, THAT IS VERY DIFFICULT, ya it is very difficult, really, THE MAN CAN SAY I WANT THE BABY yes, because he is the head at home. If you don't want to; no he will say I am going to take another wife. OHH, to give more babies here, I want more babies, then you will say ok, just because you want to maintain this marriage, you want to stay here. WHY DOES HE SAY HE WANTS MORE BABIES. That is the belief, especially with Africans".*

PEGGY was unhappy with the fact that men were treated differently and that men can control women in terms of choices concerning the number of children:

> *"I don't like it at all. We must all be treated the same, especially we all must, we are having the same blood, same feelings. UUM there is there no difference in that this is the male and this is the female, no difference in the blood, this blood comes from the female and this blood comes from the male. So if something is painful it is painful to us all. You see, so everything must be the same. YA the males mus be told that if the women say I think I want to have 2 children, it must be her choice, because she is the one who is suffering most. She is working, or else she is not working, but she carries the baby for nine full months. UUM. Having this thing, it is so difficult. So just choose I want to have six kids. Six, who carries these six kids, the female. But the female does not have a choice to choose. So with blacks, some of the things need to be cleared out really (Sigh)".*

Category 10: THE "CATEGORIES" WORKING TOGETHER

In relating to the relationship between women of different categories in the working situation, FORTUNATE spoke of the differences in understanding one another in the different categories:

> *"The way the attitude they have within one another when you are an enrolled nurse, when you are a sister and when you are an enrolled nurse and you are a nursing assistant, you know, there are those attitudes sometimes. (UUM) you find that the sister in the ward maybe she is having a problem at home, or personally, but when she comes to work and talks to her subordinates, enrolled nurses and nursing assistants, you try by all means to give that positive attitude to her, but when in turn you find it is an enrolled nurse or somebody under her who is having the same problem, she doesn't take it as we her subordinates have taken it. (UUM) So you use those power as a sister*

(Phone ringing) maybe she is not living in the same world we are living in (UUM) or she is living somewhere else now. She doesn't\' understand the situation we are living in. So those attitudes sometimes they do come with females.

PEGGY also felt that, that attitude was there

"... of the females not loving one another, I don't know how, and some of my friends say that maybe it can be better if we are led by the male. You know. UUM. I ask what is that element that is within us as females that make us not to love one another".

Category 11: EMPOWERMENT

During the second, but mainly during the third interview, the researcher tried to verify with the participants what was said in the previous interview(s). The last interview was also consistently used to give the participant an opportunity to add or to clarify; if needed, what had been said. This interview was also used to close the interview process and interaction in a spontaneous and caring manner. Many of the participants actually requested to keep contact and wished the researcher the best for her future work.

The empowerment of women and of women as nurses were partly discussed in the second and usually more explicit in the third interview. The researcher sensed that many of the respondents actually were thinking about these power issues and felt comfortable to add to what they had said previously.

11.1 The empowerment of nurses belonging to the enrolled category

FORTUNATE felt that one of the most important ways to empower enrolled nurses were salaries that can be equal to her needs. She felt that a better salary will give the enrolled nurse more confidence:

"The confident nurse has more powers and is ever willing to help the patient. Salaries. Secondly, it the working conditions. We must be in a comfortable working condition with all the sufficient facilities, equipment and education in nursing must always be given chances to improve. Education. And the other thing is freedom of choice, although we do have it here. Being are being permitted to voice out whatever problem we have got. But if it can also still be continued it can be wonderful. Yes, I believe the freedom of whatever, CHOICE, of choice. But basically the salaries. Salaries, chances of education, working facilities, good working conditions, hospitals with sufficient equipment that when a patient is admitted in a particular hospital, he must be transferred to the other hospital because this one has insufficient facilities, no,

there must be hospitals that have every equipment and must be convenient to the community and offer wonderful nursing care to the public.

PEGGY referred a more practical approach to the day-to-day nursing care where they as enrolled nurses are not allowed to "carry" the drug cupboard key:

"But with some days, there are busy days and times that will need emergency, so you mean that the patient can die because the sister has the keys needing the drug the drug cupboard, UMM because there was one sister in the ward, there are one sister in the ward and many staff nurses and uum nursing assistants, so with those strict rules that does not allow those people to do those things, do you think the patient the patient may just die".

Later she again referred to this phenomenon of not being allowed to carry the keys; this time in relation to the influence of this practice on the enrolled nurse's self esteem:

"... you find that the cupboards are there, the keys are kept there, but just because you are an enrolled nurse, you cannot touch those keys and take whatever you can take, so the patient says nurse can I please have a soap, or a towel, it is locked, but the only people who kept the keys are the sisters. I see no difference. HOW DOES THAT MAKE YOU FEEL? THAT YOU CAN'T DO THAT? When me and the patient, well you are telling the patient, no I am waiting for the keys, the patients tell him that no, this one, why she can't have the keys. Because she is an adult, so she has that less confidence that she is not educated enough, you know. So if he is being nursed by you alone, not he wait for the sister to come so that he can be able to see that he was cared well enough. Because even the sister she came next to me. (Sigh) YOU SIGH, YOUR EMOTIONS? Ya, you feel why should it be me to be prevented not to have keys. Because I mean she is an adult, she is an adult, sometimes she is younger than myself, I am older than her. At home I do keep the keys anyhow you know. What is the difference it makes at work. Because when you are told you must use the key and leave it here. And you must take care of the things that are locked up. I see there is no need for saying then the only one person who can keep the keys are the professional nurses. They are the only people. Because that leads to people in nursing updating themselves, not for improving the nursing standard, but just for that name of being a superior somebody, you see. UUM. SO IT MEANS THAT YOU ACTUALLY UPLIFT YOURSELF SO THAT YOU GET THE THINGS YOU SHOULD HAVE. Yes, not for improving the nursing of the patients, you see. It contributes. to have self esteem, most of the time, not to be discouraged so if somebody is motivated while she is still young, then that person when she grows up she becomes a very good person. You find that some people they do have some good characters which can make a good contribution to the community. But because they were not motivated, they end up being nowhere, I mean with their characters or qualities they had. For instance in the nursing, because of this categories that we are divided, some people they feel , what can I say. They feel that they are not recognised most of the time. By the people in the profession. For instance if I come with a suggestion as an enrolled nurse, so nobody takes it as something that is

good. You see. UUM. Unlike if the suggestion came up by somebody in charge of maybe the ward. So if you can motivate most of the people that people must be given opportunities you see ..."

She also felt that enrolled nurses working in a big hospital feel more disempowered than those working in a smallish hospital. She felt that the Scope of Practice was the limiting factor and needed to be revised. She also referred to doctors who did not accept the advice of enrolled nurses and felt that if she studied to become a professional nurse, her inputs would be more valued. Concerning the empowerment of black nurses, FORTUNATE related to the changes that took place in South Africa:

"In nursing you find that in black hospitals, like here, there are also white nurses, indian nurses, we are working together under that same working situation, not because they are whites they must be treated differently than us as blacks, no we are treated as equal. And being together with the other nations, you sit down and you discuss, about customs, cultures, religious beliefs and whatever, so you work so good".

PEGGY referred to the equal rights that needed to be given to women as nurses - especially in terms of education, as well as, the very important need to be recognized and valued by others in the profession:

"(Long pause) Whilst I think that we need to be motivated to have self esteem, most of the time, not to be discouraged so if somebody is motivated while she is still young, then that person when she grows up she becomes a very good person. You find that some people they do have some good characters which can make a good contribution to the community. But because they were not motivated, they end up being nowhere, I mean with their characters or qualities they had. For instance in the nursing, because of this categories that we are divided, some people they feel, what can I say. They feel that they are not recognised most of the time. By the people in the profession. For instance if I come with a suggestion as an enrolled nurse, so nobody takes it as something that is good. You see. UUM. Unlike if the suggestion came up by somebody in charge of maybe the ward. So if you can motivate most of the people that people must be given opportunities you see. TO DO WHAT THEY CAN DO. To what they can do freely. UUM. Because even that stigma was there long time ago, so it will take time for it to disappear. So if we teach the young ones to bear that thing in mind".

11.2 The empowerment of African women

In discussing the empowerment of black women, FORTUNATE clearly indicated that she would like the women to be given equal rights to men. She also said that she would like

"To be given an opportunity to enter the gates where I have not been allowed to enter for the previous years. Do you get me dearie. YES I UNDERSTAND. As a black woman, of this nowadays, I must be given the opportunity to open

those gates, which have been gates for us(laugh) for all these previous days. CAN YOU GIVE ME AN EXAMPLE? An example of the gate to go through (laughing) there are so many gates that are closed. Like for instance not me as an individual, but as a black. Things have changed, you find that there are blacks in parliament. That has been A very big day which was closed for the blacks both sexes males, and females, but now it has been opened in such a way that even women are included in the parliament. That is very important gate which has been closed for black women. UUM. AND IN YOUR EVERYDAY LIFE... FOR EXAMPLES SOME GATES IN YOUR EVERYDAY LIFE. Everyday life ... (long pause). NOW ARE OPEN OR ARE BEGINNING TO OPEN. Are beginning open. OR ARE CLOSED, I DON'T KNOW. The gates that now I am free to go to, I can make an example for the primary health care facility, even though I stay in the location, but I am permitted to use the clinic in commercial city. UUM. You know right in the city centre, which they have been very strict before, that if you are from the locations, there are clinics which you must use which are nearer to your place or whatever. But now I am free to go even travelling facilities, I can use those used by the whites before. I KNOW. Even though toilets, the public toilets, now things are working so good, we just using everything now, we are equal AND I THINK IT IS GOING. And there are more good results that are going to be produced, it think it, they are working on it so very well, and there are still more stars and bright things that are coming".

Concerning the changes in the country, FORTUNATE felt

"very comfortable and I cannot expect all the wonders so quickly within these two years or whatever, they are still working on it. We must give them some time. Yes. IF I CAN ALSO RELATE TO YOUR EMOTIONS. DURING ALL THIS TIME THAT THE GATES WERE CLOSED, HOW DID YOU EXPERIENCE THAT? It was a trauma. Because let's say maybe you are walking or going somewhere with someone you love, but you find that because you are blacks you won't be permitted to enter there. It was very traumatic. But we managed, we accepted. UUM reading about history we know what happened and all those things, although it was very sad, we struggle within and we managed to pass. (Laugh) SO DO YOU THINK IT MADE YOU STRONGER. Very much stronger. As we are talking about the power. Something we have within us, influenced by the other people. And always bearing in mind that I want to produce wonderful results. I think the changes that are happening here in S.A. are a very good example of the power. Those people at the top like Mandela, had the power within them, they always had it in mind that one day we want to produce wonderful results we want everyone to be treated as equal. Ya it is working so wonderful.

PEGGY related to the power of cultural tradition to control the lives of African women:

"Yes it is the most of all culture. THAT SPECIFIES WHAT A WOMAN CAN DO OR NOT DO. Yes, what the woman can do, what can be done by a woman, what can be done by a male. You see. It does affect, especially those uneducated people. UUM. They are suffering because of that. It

needs to be cleared out also. YA ... You find that in our culture we blacks, before, children and the women were not eating eggs in the house and chickens, only the men, people were doing that. But with us now, we don't do that at all. YOU CAN ALSO EAT everything, the same. But that boss things of males is still there ... IS STILL THERE. UUM. AND HOW DO YOU FEEL ABOUT THAT What. THAT IT IS STILL THERE. No I feel bad, really. YOU DON'T LIKE IT. I don't like it at all".